Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 24th March 2016
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor Furnell
Councillor Houghton
Councillor Noon
Councillor Parnell
Councillor Tucker
Councillor White (Vice-Chair)

Contacts

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have six 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 Health 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 and 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.

Mobile Telephones: - Please switch your mobile telephones to silent whilst in the meeting.

Use of Social Media: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Public Representations
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

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

COUNCIL'S PRIORITIES:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

CONDUCT OF MEETING

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 of 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.

Dates of Meetings: Municipal Year 2014/2015

2015	2016
23 July 2015	28 January 2016
1 October 2015	24 March 2016
26 November 2015	28 April 2016

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 MINUTES OF THE PREVIOUS MEETINGS (INCLUDING MATTERS ARISING)

(Pages 1 - 10)

To approve and sign as a correct record the minutes of the meeting held on 28th January 2016 and the Extraordinary Meeting held on 1st February 2016 and to deal with any matters arising, attached.

7 BUSINESS CASE FOR THE DEVELOPMENT OF A VASCULAR NETWORK FOR HAMPSHIRE

(Pages 11 - 196)

Report of the Director of Commissioning Operations (Wessex), NHS England, presenting the case for change for sustainable vascular arterial services in Hampshire/Isle of Wight which is consistent with the NHS England Service Specification for Vascular Services, attached.

8 HEALTH AND WELLBEING STRATEGY: UPDATE
(Pages 197 - 228)

Report of the Acting Service Director, Intelligence, Insight and Communications requesting that the Panel consider the achievements from the Health and Wellbeing Strategy 2013-2016, the progress and plans to update the Joint Strategic Needs Assessment and develop a new Joint Health and Wellbeing Strategy for the City, attached.

9 MENTAL HEALTH MATTERS
(Pages 229 - 270)

Report of the Director of Quality and Integration updating the Panel on the progress of the Mental Health Matters consultation, attached.

10 MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE
(Pages 271 - 276)

Report of the Service Director, Legal and Governance detailing the actions of the Executive and monitoring progress of the recommendations of the Panel, attached.

Wednesday, 16 March 2016 SERVICE DIRECTOR, LEGAL AND GOVERNANCE

To approve and sign as a correct record the Minutes of the meeting held on 28th January 2016 and the Extraordinary Meeting held on 1st February 2016 and to deal with any matters arising, attached.

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 28 JANUARY 2016

Present: Councillors Bogle (Chair), Furnell (Except Minutes 25-27), Houghton, Noon and Tucker

Apologies: Councillors Parnell and White

Also in Attendance: Annabel Hodgson, Healthwatch Southampton

20. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panel meeting held on 26th November 2015 be approved and signed as a correct record.

21. **EMERGENCY DEPARTMENT PERFORMANCE**

The Panel considered the report of the Chief Executive of University Hospital Southampton NHS Foundation Trust updating the Panel on the performance of the Emergency Department (ED).

The Panel welcomed the improvements and progress made within the Hospital, but noted that the Trust had still failed to meet their 95% target.

In particular, the Panel noted changes made which included:

- introduction of the Emergency Department “pit-stop bays” at the end of November.
- Overnight consultant care cover Monday to Thursday with the aim of extending this to weekends as soon as possible.
- On site Psychiatric cover until 11pm.

The Panel also noted the following:

- Action to educate those who presented at ED on alternative services.
- The low number of actions outstanding on the remedial action plan.
- That whilst demand might have decreased the cases presenting were more complex.
- When compared to other university hospitals with trauma units in the rest of the country, the Hospital’s performance was below average.

RESOLVED that the progress made by University Hospital Southampton NHS Foundation Trust in achieving the 95% Emergency Department target be considered at the meeting of the Panel on 30 June 2016.

22. **UPDATE ON DISCHARGES FROM UNIVERSITY HOSPITAL SOUTHAMPTON**

The Panel considered the report of the Chief Executive of University Hospital Southampton NHS Foundation Trust and the Acting Director of Adult Social Care, outlining progress being made reducing complex discharges in the Hospital.

The Panel also heard from a Consultant Geriatrician from University Hospital Southampton on issues relating to care of the elderly and impact on discharges at the Hospital.

The Panel noted the good progress that had been made in many areas towards improving safe and timely discharge from hospital, and that the joint work that had been put in was starting to show its results in terms of the increasing number of discharges and improved operational position at the hospital. The Southampton system appeared to be performing better than the Hampshire system.

The Panel were informed of the remaining challenges including:

- There was a discharge target for Southampton of 13 per day.
- Issues around domiciliary care, in particular delays and capacity within domiciliary care agencies to support large packages of care which impacted on weekend discharges.
- Issues around weekend discharges and staffing in nursing and residential homes.

RESOLVED that an update on delayed transfers of care be provided for consideration at the meeting of the Panel on 30 June 2016.

23. **ADULT SOCIAL CARE: KEY PERFORMANCE INDICATORS**

The Panel considered the report of the Acting Director of Adult Social Care outlining performance in Adult Social Care between April and December 2015 using the 12 Performance Indicators previously agreed by the HOSP.

Councillor Shields, Cabinet Member for Health and Adult Social Care was present and with the consent of the Chair, addressed the meeting.

The Panel noted that the 70% target for Adult Social Care enquires resolved at first contact had been exceeded for the first time in the current year and the changes in the Single Point of Access Team that contributed to this were highlighted.

It was noted that data regarding Adult Safeguarding was draft due to time delays - it was agreed that final figures for Quarter 3 be circulated to the Panel.

RESOLVED

(i) that demand and satisfaction data (if available) together with the Key Performance Indicator set, be included in the final quarter performance report for consideration at a future meeting of the Panel;
(ii) that the finalised quarter three performance for Key Performance Indicator 10, Adult Safeguarding enquiries, be circulated to the Panel when available; and
(iii) that the situation of individuals who have completed self-assessment forms but received information or were signposted to alternative services, be reviewed by officers in Adult Social Care to identify satisfaction levels and whether their needs were met.

24. **PUBLIC HEALTH GRANT REDUCTIONS**

The Panel considered the report of the Director of Public Health outlining the approach that the Council is taking in response to reductions in the Public Health grant.

RESOLVED that the Health and Wellbeing Board lead a fundamental review of public health in Southampton, in conjunction with the developing Health and Wellbeing Strategy, to identify how the significant resources available in the City can be used to address the endemic health inequalities experienced across Southampton.

25. **UPDATE ON "GETTING THE BALANCE RIGHT IN COMMUNITY-BASED HEALTH SERVICES"**

The Panel considered the report of the Director of System Delivery, NHS Southampton City CCG, providing the Panel with an update on the progress decommissioning the Bitterne Walk-In Services and the actions that were agreed at the CCG Governing Body and HOSP.

The Panel were provided with a verbal report on the outcome of the CCG Board meeting held on 27 January 2016 to consider the progress. The main conclusion was that Board would continue to monitor progress on a monthly basis as part of their wider performance monitoring process.

RESOLVED that the Panel be provided with both qualitative and quantitative information regarding the impact of the closure of Bitterne Walk-In Service for consideration at the meeting of the Panel on 30 June 2016.

26. **IMPLEMENTATION OF A NICE COMPLIANT FOOT CARE PATHWAY**

The Panel considered the report from NHS Southampton City Clinical Commissioning Group (SCCCG) informing the Panel of plans to implement a National Institute for Health and Care Excellence (NICE) compliant Foot Care Pathway. This provided an outline of the priority area “foot care” and described the case for change and the new model of service delivery.

In addition to representatives from the SCCCG, the Panel heard from the Head of Podiatry at NHS Solent and a Consultant in Diabetes at University Hospital Southampton.

The Panel noted that education and prevention messages were key and that whilst rates for major amputations in the City were similar to the national average, those for minor amputations were significantly higher.

RESOLVED

(i) The Panel recommended that the NICE compliant foot care pathway be implemented as soon as possible;
(ii) that the implementation of the foot care pathway be considered at a future meeting of the Panel; and
(iii) that information be circulated to the Panel regarding national and local plans and campaigns being delivered to raise awareness of diabetes and the health risks associated with it.

27. **MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE**

The Panel received and noted the report of the Head of Legal and Democratic Services setting out progress on recommendations made at previous meetings.

The Panel noted that the budget proposal had been withdrawn.

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 1 FEBRUARY 2016

Present: Councillors Bogle (Chair), Furnell, Houghton, Noon, Painton, Tucker and White (Vice-Chair)

Also in Attendance: Rob Kurn, Healthwatch Southampton

28. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

It was noted that following receipt of the temporary resignation of Councillor Parnell from the Panel, the Head of Legal and Democratic Services acting under delegated powers, had appointed Councillor Painton to replace them for the purposes of this meeting.

29. **INDEPENDENT REVIEW OF DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015**

The Panel considered the report of the Chair of the Health Overview and Scrutiny Panel reviewing the recently published Mazars report commissioned by NHS England to investigate unexpected deaths of service users of Southern Health NHS Foundation Trust Mental Health or Learning Disability services from April 2011 to March 2015. The report highlighted a number of actions for the Trust, commissioners and regulators.

The Chair of the HOSP introduced the key findings and issues arising from the Mazars report:

(i) that there was a lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating unexpected deaths of Mental Health and Learning Disability service users.

(ii) That despite the Board being informed on a number of occasions, including representation from Coroners, that the quality of the Serious Incidents Requiring Investigation reporting processes and standard of investigation was inadequate; no effective action was taken to improve investigations during the review period.

(iii) That 30% of all deaths in Adult Mental Health services were investigated as Critical Incident Reviews or Serious Incidents Requiring Investigation, less than 1% of deaths in Learning Disability services were investigated as Critical Incident Reviews or Serious Incident Requiring Investigation and 0.3% of all deaths of Older People in Mental Health services were investigated as Serious Incident Requiring Investigation.

(iv) In terms of deaths 'categorised as unexpected' within Adult Mental Health services, 60% of all unexpected deaths were investigated as Critical Incident Reviews or Serious Incidents Requiring Investigation; in Learning Disability only 4% of all unexpected deaths were investigated as Critical Incident Reviews or Serious Incidents Requiring Investigation and in Older Peoples' Mental Health services, 13% were investigated as a Serious Incidents Requiring Investigation.

(v) From the review of the evidence, too few deaths were investigated in Learning Disability and Older People Mental Health services. When an investigation did

occur, the report identified the overall poor quality of these investigations and of the subsequent reports.

(vi) That there was no effective systematic management and oversight of the reporting of deaths and the investigations that followed.

(vii) Timeliness of investigations was a major concern – taking on average of nearly 10 months from an incident to 'closing' a Serious Incident Requiring Investigation (SIRI) relating to deaths.

(viii) The Trust could not demonstrate a comprehensive, systematic approach to learning from deaths.

(ix) The involvement of families and carers had been limited - 64% of investigations did not involve the family.

(x) Initial management assessments and investigations did not involve other service providers where this would have been appropriate.

(xi) Despite the Trust having comprehensive data relating to deaths of its service users, it had failed to use it effectively to understand mortality and issues relating to deaths of its Mental Health or Learning Disability service users.

(xii) Commissioners had a role in demanding better information relating to deaths and using it to seek improvement.

It was stated that the Hampshire Health and Adult Social Care Scrutiny Committee were to discuss the report at their meeting on 9th February and reiterated that Southampton represented a small part of the Southern Health Services area which covered six counties.

The Panel noted that there had been an omission from the information in Appendix 3 – Southern Health's Mortality and SIRI Improvement Action Plan. It was agreed that this information be supplied to Panel members at the earliest opportunity.

Representatives from Southern Health NHS Foundation Trust, NHS Southampton City Clinical Commissioning Group (SCCCG) and NHS England (Wessex) provided the Panel with an update on developments since the publication of the meeting papers and addressed questions from the Panel and other interested parties present at the meeting. It was emphasised that the report criticised the Trust's investigation and reporting of deaths rather than the standard of the care provided.

The Panel raised various issues with the representatives present from Southern Health NHS Foundation Trust – including the following points:

- Concerns about Southern Health as an organisation - its leadership, governance and culture.
- The reasons for numerous warnings having been ignored - including concerns from Coroners, commissioners?
- Why opportunities were not taken to inform the Panel of the ongoing inquiry – specifically at the meeting on 26th November as part of the update on CQC Action Plan and the April 2015 Quality Accounts?
- What progress had been made on improvements by Southern Health and any re-assurance that could be offered to Southampton residents?
- Feedback from CQC and Monitor on action plans.
- Whether the report raised issues about the size of the Trust and the area it covered?

Issues raised by the Panel regarding Southampton CCG as commissioners of Services from Southern Health:

- The report referred to commissioners repeatedly raising issues with the Trust about the quality and timings of reports - what more could commissioners have done to challenge Southern Health performance?
- How commissioners would ensure that there was no recurrence and that Trusts follow policies and procedure?
- How CCGs would work collectively to identify issues within service providers and ensure consistent improvements?
- The impact the development of a new service model for mental health services in Southampton would have?
- Whether the SCCCG had confidence in Southern Health as a provider of health services in Southampton?
- The role NHS England (Wessex) played in overseeing improvements?

The Panel also recognised the general issue around the parity of esteem between physical and mental health including those with learning disabilities and other vulnerable people.

RESOLVED

(i) that the full version of Appendix 3, Southern Health's Action Plan for Mortality Serious Incident Requiring Investigation Improvement, be circulated to the Panel and the agenda for the meeting on the Council's website be updated accordingly;
(ii) that the Panel be provided with a Southampton specific breakdown of the key statistics highlighted within the Mazars report;
(iii) that an update on the 'Mental Health Matters' initiative be provided to the Panel at the meeting on 24 March 2016;
(iv) that an update be provided at a future meeting of the HOSP by Southern Health NHS Foundation Trust on progress made implementing the improvement plan and feedback from regulators; and
(v) that the Panel be provided with an update on progress made with regards to the involvement of families and carers in investigations.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		BUSINESS CASE FOR THE DEVELOPMENT OF A VASCULAR NETWORK FOR HAMPSHIRE		
DATE OF DECISION:		24 MARCH 2016		
REPORT OF:		DIRECTOR OF COMMISSIONING OPERATIONS (WESSEX) - NHS ENGLAND		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dominic Hardy**	**Tel:**	**0113 8249853**
	E-mail:	**Dominic.hardy@nhs.net**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY
The purpose of this item is to present the case for change for sustainable vascular arterial services in Hampshire/Isle of Wight which is consistent with the NHS England Service Specification for Vascular Services, and to brief members about the communications and engagement strategy to support the above.

RECOMMENDATIONS:		
	(i)	That the Panel consider the business case for the development of a vascular network for Hampshire which now has clinical approval.
	(ii)	That the Panel note the communications and engagement plan.

REASONS FOR REPORT RECOMMENDATIONS	
1.	To progress the delivery of a sustainable vascular arterial services in Hampshire/Isle of Wight which is consistent with the NHS England Service Specification for Vascular Services.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	An options appraisal for the Vascular Services reconfiguration is included in Appendix 2.

DETAIL (Including consultation carried out)	
3.	A vascular network exists in Hampshire with University Hospital Southampton (UHS) as a major arterial centre (hub) and St Mary's Hospital, Isle of Wight and the Royal Hampshire County Hospital, Winchester as spokes. Major arterial surgery is currently also delivered at Queen Alexandra Hospital, Portsmouth (PHT).
4.	Neither UHS nor PHT are able to meet the service specification for vascular services.
5.	Attempts over several years to resolve these issues have not succeeded largely due to concerns that change would put interdependent services at PHT at risk.
6.	A review by the Vascular Society in 2015 recommended a network solution with a single hub at UHS. This review established the clinical evidence-base

	for change.	
7.	Attached as Appendix 2 is the business case for the Vascular Services Reconfiguration. Appendix 3 outlines the Vascular Services Reconfiguration, Communications, Engagement and Consultation plan.	
8.	The Panel are recommended to consider the business case for the development of a vascular network for Hampshire and note the communications and engagement plan.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
9.	Identified in Appendix 2.	
Property/Other		
10.	Identified in Appendix 2.	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
11.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.	
Other Legal Implications:		
12.	N/A	
POLICY FRAMEWORK IMPLICATIONS		
13.	N/A	
KEY DECISION	No	
WARDS/COMMUNITIES AFFECTED:		None directly as a result of this report.

SUPPORTING DOCUMENTATION			
Appendices			
1.	Briefing paper		
2.	Vascular Services Reconfiguration: NHS Wessex – Business Case		
3.	Southern Hampshire - Vascular Services Reconfiguration, Communications, Engagement and Consultation		
Documents In Members' Rooms			
1.	None		
Equality Impact Assessment			
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.			No
Privacy Impact Assessment			
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.			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

Health Overview and Scrutiny

Briefing paper

Title: Business case for development of a vascular network for Hampshire

Purpose of paper:

- To present the case for change for sustainable vascular arterial services in Hampshire/Isle of Wight which consistent with the NHS England Service Specification for Vascular Services.

- To brief members about the communications and engagement strategy to support the above.

Brief Summary:

1. The last overview and scrutiny update was in October 2015, following a review by the Vascular Society of Great Britain and Northern Ireland (VSGB).

   Since that update, NHS England has been working with partners to develop a business case which includes an options appraisal for vascular services.

2. The business case has been assessed through NHS England's internal assurance process and a preferred option agreed. NHS England's intention is to deliver these services as a network involving University Hospital Southampton (UHS) as the hub, with Queen Alexandra Hospital, Portsmouth (PHT), and St Mary's Hospital, Isle of Wight and the Royal Hampshire County Hospital, Winchester as spokes

Background and Key issues:

1. A vascular network exists in Hampshire with University Hospital Southampton (UHS) as a major arterial centre (hub) and St Mary's Hospital, Isle of Wight and the Royal Hampshire County Hospital, Winchester as spokes. Major arterial surgery is currently also delivered at PHT.

2. Neither UHS nor PHT are able to meet the service specification for vascular services

3. Attempts over several years to resolve these issues have not succeeded largely due to concerns that change would put interdependent services at PHT at risk

4. A review by the vascular society in 2015 recommended a network solution with a single hub at UHS. This review established the clinical evidence-base for change

5. Since the Vascular Society Review, capacity at PHT has worsened due to difficulty in recruiting a replacement surgeon. This results in unsustainable demand in terms of workload and out of hours cover for the remaining vascular surgeons. A contingency plan is being jointly developed by UHS and PHT to support the on-call vascular surgical rota at PHT and ensure the service remains safe in the event of further reduction in capacity.

6. Issues relating to interdependent services at PHT have been addressed by describing a networked solution which will deliver a high level of vascular surgical support on the PHT site which at least matches the current provision.

7. Engagement with CCGs, clinicians and vascular surgeons in Wessex has led to strong clinical consensus around the case for change and the development of a nascent clinical network

8. UHS has developed a high-level capacity plan to deliver the required activity

9. NHS England proposes to engage with patients about their current experience of services and to consider how the evolving service model can improve that patient experience.

Actions required:

1. Members are asked to consider the business case which now has clinical approval

2. Members are asked to note the communications and engagement plan

BUSINESS CASE

Project Name:	Vascular Services Reconfiguration: Tranche 1		
Date:		**Release:**	Draft
Author:	Wessex Vascular Project team		
Owner:	Dominic Hardy		
Client:	NHS Wessex		
Document Number:	V3.4		
Issue Date:	07th March 2016		

Revision History

Revision Date	Summary of changes	Changes Marked
04/02/2016	The resolution of two key issues, namely availability of capacity at UHS and expert clinical opinion on whether PHT interdependent services require 24/7 on site emergency vascular services, has fundamentally changed the recommendations of previous drafts.	

Approvals

This document requires the following approval(s). A signed copy should be placed in the project files.

Name	Signature	Title	Date of Issue	Version
Dominic Hardy				**V3.1**

Distribution

This document has been distributed to:

Name	Title	Date of Issue	Version

Contents

Abbreviations

AAA	Abdominal Aortic Aneurysm
CCG	Clinical Commissioning Group
CEA	Carotid Endarterectomy
EVAR	Endovascular Aneurysm Repair
HASC	Health and Adult Services (Overview and Scrutiny) Select Committee
HDU	High Dependency Unit
HHT	Hampshire Hospitals Trust
HOSP	Health Overview & Scrutiny Panel
IOW	St Mary's Hospital, Isle of Wight
IR	Interventional Radiologists
ITU	Intensive Therapy Unit
MAC	Major Arterial Centre
MDT	Multi-Disciplinary Team
MTC	Major Trauma Centre
NAC	Non-Arterial Centre
NCAT	National Clinical Advisory Team
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NSS	National Service Specification
NVD/NVR	National Vascular Database / National Vascular Registry
ODN	Operational Delivery Network
PCI	Percutaneous Coronary Intervention
PHT	Portsmouth Hospital NHS Trust
POVS	The Provision of Services for patients with Vascular Disease
R&D	Research and Development
rAAA	Ruptured Abdominal Aortic Aneurysm
RHCH	Royal Hampshire County Hospital, Winchester
SOTW	Surgeon of the Week
SWOT	Strengths, Weaknesses, Opportunities, Threats
TIA	Transient Ischaemic Attack
UHS	University Hospital Southampton NHS Foundation Trust
VSGBI	Vascular Society of Great Britain and Ireland
WSH	Western Sussex Hospitals Trust

Purpose of Document

The purpose of the Full Business Case is to evaluate the progress towards reconfiguration of vascular services in Southern Hampshire, to identify business options, and to recommend the option which provides the most desirable, viable and achievable benefits. The Business Case presents the business justification behind this recommendation to support informed decision making.

1. Executive Summary

In March 2013, the National Service Specification[1] (NSS) for Specialised Vascular Services was issued for adoption from October 2013 (See Appendix A). The report states "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".

NHS Wessex established a Vascular Programme in April 2014. The overall objective of the programme is to align vascular services across Wessex with the NSS. The scope of this project, Tranche 1, includes vascular services across Southern Hampshire, with emphasis upon the provision of services at University Hospital Southampton NHS Foundation Trust (UHS) and Portsmouth Hospital NHS Trust (PHT).

Reviews of the reconfiguration of vascular services began in 2008 and there have been various reports and recommendations since that date. However, given the changes and advances which have occurred to date, this business case will concentrate on recent issues. The current configuration is that UHS acts as a hub in a network (Wessex Vascular Network (WVN)) with Royal Hampshire County Hospital (RHCH) Winchester and Isle of Wight Trust (IOW) as spokes, and that PHT operates as an arterial centre in its own right.

The Preliminary Business Case recommendation in March 2014 was that all arterial services be centralised at UHS, with PHT becoming a spoke hospital in the network and with a phased transfer of procedures to UHS. When this proposal was presented to Portsmouth Health Oversight and Scrutiny Panel (HOSP) they identified it as a 'significant change' which would require full public consultation.

A strategic review undertaken following the HOSP presentations identified that further impact analysis was required as several key issues were identified:

- **Patient outcomes**: Historical data suggested that PHT outcomes were a cause for concern. Data for the last two years shows, however, that NSS target outcomes are met or exceeded and the mortality from AAA and CEA elective procedures is 0% (see Appendix B Outcomes Data).
- **UHS Capacity:** UHS identified that additional capacity was not currently available to allow the transfer of vascular services from PHT to UHS and would require new funding to be put in place. UHS estimated a minimum of 24 months to build capacity required.
- **PHT interdependent services:** The issue of interdependencies highlights the dichotomy involving the provision of vascular services in Southern Hampshire. UHS is a major trauma centre and major cardiac centre, whilst PHT hosts a regional renal and transplant centre and hyper acute stroke unit.

[1] A04/S/a 2013/14 NHS Standard contract for Specialised Vascular Services (Adults)

- **Workforce resilience and sustainability:** Without doubt, from the perspective only of resilience and sustainability, a single site operation would provide both, and a far less onerous on call ratio. Equally, both sites are currently at risk if a key member of the vascular team becomes incapacitated.

A draft Business Case published on 1st April 2015 identified that UHS did not have the capacity to undertake PHT arterial services (and no investment budget to provide capacity). Further, PHT believed that interdependent services required on-site emergency vascular services. UHS expressed their disagreement with this view, believing vascular services could be provided from a network hub if PHT were a spoke. The recommendation was that two arterial centres remained and worked in collaboration. This proposal was rejected by the NHS England South Regional Senior Management Team (SMT) as not compliant with the NSS.

Following a review, Fiona Dalton, Chief Executive UHS, identified that UHS had undergone a bed modelling exercise and now believed that they would be able to develop capacity required, and had identified the capital investment required both for vascular ward expansion and for the hybrid theatre build.

This left a fundamental difference of clinical opinion between the two sites as to whether PHT interdependent services required 24/7 on site emergency vascular services, or whether this could be provided by UHS as a Major Arterial Centre (MAC), acting as a network hub. To resolve this question, the Vascular Society (VS) were invited to undertake an expert clinical review.

Paul Blair (President) and Rob Sayers (Vice President (elect)) of the VS undertook a review of Southern Hampshire vascular services, specifically UHS and PHT, on 19th and 20th August 2015. Their findings were:

"*Currently both units are not POVS compliant – Portsmouth have problems with the on call surgical rota and Southampton lack Vascular Radiology*

In terms of the future – it would be possible to make both units POVS compliant and stand alone. This would involve Portsmouth providing vascular services for Chichester and both units would require substantial investment with consultant appointments and development of facilities. However this model would probably only be sustainable in the short term. In the long term both units may have difficulty in recruiting consultants and trainees and 7 day working would need more consultants on a 1 in 8 rota or greater.

The alternative and more appropriate long term sustainable option would be centralisation of services on the Southampton site. This option would likely lead to a high class vascular facility but would require capacity and resource issues to be addressed."

UHS is a designated Major Trauma Centre (MTC) and, as determined by the NHS Standard Contract[2], must provide vascular services; this obviates the consideration of PHT as the sole vascular hub of the network. 'Do nothing' is not an option as neither UHS nor PHT currently provide a compliant service. The two options evaluated in this Business Case (Version 3.1) are:

- **Single Major Arterial Centre (MAC):** All arterial services to be delivered at UHS, with PHT joining the existing operational network which has UHS as a hub, as a Non-Arterial Centre (NAC), in addition to the existing spokes (Winchester and IoW).

- **Two Major Arterial Centres :** UHS and PHT continue as arterial centres, but collaborate to maximise efficiencies, resource utilisation and to provide improved clinical services

Neither UHS nor PHT currently provide a compliant vascular service. As standalone centres, neither provide a 1:6 vascular surgeon and vascular interventional radiologist emergency on call. The loss of a vascular surgeon at PHT in October 15 has made the emergency on call rota unsustainable. PHT would currently need to recruit four additional surgeons to become a viable centre. PHT have been unable to recruit either a permanent or locum vascular surgeon to date.

Cost/benefit analysis suggests that, as standalone centres, to facilitate a 1:6 vascular surgeon and vascular interventional radiologist on call rota, both sites would operate at a loss. Neither site would have contingency. Further, the number of procedures to maintain professional competency would be marginal. Neither network can afford to invest sufficiently to become fully compliant without additional income. The targets set by the VS for AAA are for each surgeon to undertake a minimum of 10 cases per year. Currently 4 at UHS and 1 at PHT are shown to have averaged this in the latest VSQIP outcomes.

All expert clinical reviews undertaken since 2009 have recommended that PHT join UHS in a network, with major arterial services being provided by UHS The lead vascular surgeons at PHT (Mark Pemberton) and UHS (Mike Phillips) are unanimous in their view that the strategic solution is to have one network with UHS as the MAC and PHT as a NAC. In the preface to their clinical vision they state:

"***The Wessex Vascular Network: Clinical Vision***

This is a document to mark out the clinical vision for a network to provide vascular services to Wessex. This area includes the cities of Portsmouth, Southampton and Winchester, the Isle of Wight and most of Hampshire and Guernsey. The population served is approximately 2 million.

[2] D15/S/a NHS Standard Contract for Major Trauma Service (All ages)

There will be one arterial centre ('hub') based at University Hospital Southampton (UHS) with non-arterial centres ('spokes') at Queen Alexander Hospital (QA) in Portsmouth, Royal Hants County Hospital (RHCH) at Winchester and St Marys Hospital on the Isle of Wight.

There will be tertiary services provided to Dorset, Wiltshire and Sussex.

In accordance with the recent Vascular Society report provided to NHS England (Wessex) and the Provision of Services with Vascular Disease 2015, all arterial work (aneurysms, carotid surgery, bypasses, major amputations, and more) will be undertaken at the arterial centre. All patients with urgent and emergent vascular disease will be treated here as well.

The majority of patients, however, will continue to be cared for in the non-arterial centres close to where they live. This will be in out patients, day case surgery, rehabilitation and recovery and day case vascular radiology."

The challenges which will face vascular networks in terms of seven day working, workforce sustainability and sub-specialisation (and the migration from open surgery to endovascular procedures), together with infrastructure investment, are likely to prove prohibitive for smaller networks to provide comprehensive vascular services and remain financially viable. In addition, in a highly competitive environment with workforce shortages, it is likely to prove increasingly difficult to recruit surgeons and IRs when the opportunity exists to join larger world class centres – in which the trainees will be concentrated.

It is recommended that the VS case for moving to a sustainable long term solution of a single hub with a strong network integrating clinical pathways across Hampshire be implemented.

UHS has committed to develop capacity and infrastructure to absorb the totality of PHT arterial services. Initial estimates indicate 1st December 2016 as the earliest date at which transfer could take place. The development of the detailed capacity and transfer plans will be closely monitored and assured; there will be no compromise on quality in favour of timescales.

The recent VS review identified that "*There are busy and successful co-dependencies (diabetic foot services, nephrology and urology) that would require significant support if Portsmouth was to become a spoke hospital*". The VS confirmed that none of these services required on site 24/7 vascular services and that this could be provided by a network hub. There will be a significant requirement for on-site vascular surgeon presence (2-3 surgeons) during normal working hours.

Both hospitals have experienced difficulties in providing 24/7 IR on call rotas. POVS15 identifies "*There is currently a particular shortage of practitioners trained to deliver endovascular therapies out of normal working hours. Collaborative, network wide, on call rotas combining interventional vascular radiologists and endovascular trained surgeons are potential solutions to this problem and need to be developed further.*" A pooling of resources should provide a network wide solution.

The model is assessed in Table 1 NHS England Four Tests:

Table 1: NHS England Four Tests

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
4 key tests	• Support from GP commissioners will be essential	• All CCGs (Southampton City, Portsmouth, West Hampshire, Fareham & Gosport and South East Hampshire) are represented on the governing Vascular Steering Group (VSG) and Vascular Implementation Board (VIB) which consider and approve recommendations (with decisions minuted as appropriate).
	• Arrangements for public and patient engagement, including local authorities should be strengthened	• A Comms and Engagement Strategy has been developed, including stakeholder mapping and outline plans for full public consultation if required. Local HASC/HOSPs are regularly updated and proposals will be presented following SMT approval. It should be noted that in March 2014, Portsmouth HOSP requested a full public consultation. Detailed plans are currently being developed for public engagement with regard to recommendations for a strategic network solution.
	• Clarity about the clinical evidence base underpinning proposals	• The Vascular Society (VS) POVS15[3] states: "*The current Vascular Society advice, based on sound clinical evidence, is that high quality vascular care in the UK is best delivered with the establishment of integrated vascular networks. Such networks should decide upon a single hospital which will provide arterial surgery and complex endovascular interventions. The other hospitals in the network need to continue to provide the following clinical support: - vascular clinics; diagnostics; interventions such as renal access and varicose vein procedures; review of in-patient vascular referrals; and rehabilitation. Day-case (23-hour stay) peripheral angioplasty and stenting can also be performed at these local sites. This provides the patient with direct local access to the vascular*

[3] Vascular Society of Great Britain and Ireland "The Provision of Services For Patients with Vascular Disease 2015"

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
	• Proposals take into account the need to develop and support patient choice	*service. The network will function best for the patient when travel to the arterial centre is only for specific arterial and complex endovascular interventions. The pre- and post- procedure care related to these interventions should be delivered whenever possible at the local non-arterial centre*." • Patients in the Wessex Area do not currently have access to a fully compliant vascular network. The recommendations for a strategic Wessex network with UHS as the MAC intends to provide patients with the choice to access a fully compliant vascular network.

2. Reasons

2.1 Background

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. 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.

Complex Vascular surgery covers:

- Abdominal Aortic Aneurysms (AAA)
- Screening people for AAA
- Strokes (such as Carotid Endarterectomy (CEA) or Transient Ischaemic Attacks (TIAs or mini-strokes))
- Poor blood supply to the feet or legs

There are also roles for vascular surgery supporting other major specialities e.g. trauma, neurosurgery, cardiac surgery, dermatology, clinical laboratory services, nephrology, plastic surgery, and other disciplines.

The Vascular Society of Great Britain and Ireland (VS) produced "The Provision of Services for Patients with Vascular Disease 2012" (POVS 12) as the definitive standard for the provision of vascular services. An addendum was issued in 2014, and a further update was issued in November 2015 (POVS 15). POVS is the document upon which the National Service Specification[4] (NSS) for Vascular Services is based. The POVS 15 Executive Statement states:

"1.1. The Vascular Society of Great Britain and Ireland is actively engaged in providing patients with vascular disease the best possible world-class care. The clinical vascular service should be patient focussed and configured to deliver the best possible outcomes. For elective and emergency vascular interventions it is important that the lowest possible morbidity and mortality rates are achieved. Patients should not be denied timely access to effective interventions due to poorly organised networks and referral pathways. The recommendations in this document give detailed guidance relating to all aspects of service organization and structure. The aim is to assist commissioners, clinicians and service providers to deliver the best possible care for their vascular patients.

1.2. The current Vascular Society advice, based on sound clinical evidence, is that high quality vascular care in the UK is best delivered with the establishment of integrated vascular networks. Such networks should decide upon a single hospital which will provide arterial surgery and complex endovascular interventions. The other hospitals in the network need to

[4] A04/S/a 2013/14 NHS Standard contract for Specialised Vascular Services (Adults)

continue to provide the following clinical support: - vascular clinics; diagnostics; interventions such as renal access and varicose vein procedures; review of in-patient vascular referrals; and rehabilitation. Day-case (23-hour stay) peripheral angioplasty and stenting can also be performed at these local sites. This provides the patient with direct local access to the vascular service. The network will function best for the patient when travel to the arterial centre is only for specific arterial and complex endovascular interventions. The pre- and post- procedure care related to these interventions should be delivered whenever possible at the local non-arterial centre.

1.3. Concentrating arterial surgery and more complex endovascular interventions in one arterial centre has a number of benefits. Evidence shows that clinical outcomes are improved with increasing volumes of procedures. Sustainable on-call rotas can be achieved and effective multi-professional training is facilitated. Lack of exposure to sufficient numbers of training opportunities is the biggest problem facing current trainees. This problem is perpetuated when the training opportunities are distributed around a number of providers performing small numbers of cases in a regional network. Finally there are significant economic benefits to be gained by avoiding the replication of expensive technology and staff in hospitals throughout the network. 1.4. The high volume arterial hospital for the network should provide the following facilities:

a) *A 24/7 consultant on-call rota for vascular emergencies of 1:6 or greater, covered by a combination of vascular surgeons and interventional radiologists to ensure adequate care.*
b) *A 24/7 critical care facility with ability to undertake mechanical ventilation and renal support and with 24/7 on-site anaesthetic cover.*
c) *Wards for dedicated vascular patients should be available.*
d) *At least one endovascular theatre or theatre specification endovascular suite is required, preferably with high quality imaging, advanced applications, and a dedicated X-ray table. (MHRA guidance)*
e) *A minimum number of 60 AAA and 40 carotid procedures (elective and emergency) are undertaken per annum. It is recommended that hospitals performing fewer cases than this, averaged over a 3 year period, should not continue to offer these procedures. Commissioners should monitor these numbers in the round.*
f) *The population covered by the network should be sufficient to generate the required volume of procedures at the arterial centre. A minimum of 800,000 is usually required for this.*
g) *An on-site vascular laboratory should be available.*
h) *Hospitals, vascular surgeons and interventional radiologists should submit cases to the National Vascular Registry (NVR) and publish their outcomes in line with the National HQIP programme. Actions should be taken to ensure all outcomes are satisfactory*
i) *Vascular surgeons should undertake regular review of their practice and outcomes (morbidity and mortality / governance meetings).*

1.5. Network care requires well organised, co-ordinated working between all units. When planning and organising a new vascular network, the full patient pathway from primary care

through to central intervention and return for rehabilitation needs to be clear. Practical and functional emergency and elective pathways should be developed. Emergency transfer arrangements need to be robust. These can follow trauma network principles and national published guidance for ruptured aneurysms.

1.6. The surgical clinical commitments across the network should be shared between the vascular consultants as much as possible, with most having sessions at both the arterial and non-arterial centres. Consideration should be given to other health care professionals involved in vascular care (interventional radiologists, specialist nurses, podiatrists, scientists) working in a similar cross site manner. As networks develop, manpower planning and training will be increasingly important to deliver the correct numbers of these skilled professionals to maintain the service.

1.7. Many patients with vascular disease are elderly with a number of associated co-morbidities. A multidisciplinary multi-professional approach to their care is required. Increasingly, input from other specialists such as diabetes, stroke and elderly care will be central to providing the best care in all units of the network.

1.8. Less invasive treatment options can be advantageous and endovascular technology is constantly evolving to provide new treatment options. For a high quality service vascular surgeons and interventional vascular radiologists need to collaborate and lead effective teams in order to provide the necessary range of interventions on a 24/7 basis.

1.9. In some units complex endovascular procedures are performed by appropriately trained endovascular surgeons while in other centres surgeons and interventional radiologists work together for certain procedures such as EVAR. Providing the arterial centre has appropriately trained clinicians and has satisfactory audited outcomes that meet national guidelines, endovascular interventions may be performed by vascular surgeons or interventional radiologists.

1.10. There is currently a particular shortage of practitioners trained to deliver endovascular therapies out of normal working hours. Collaborative, network wide, on call rotas combining interventional vascular radiologists and endovascular trained surgeons are potential solutions to this problem that need to be developed further.

1.11. The service described above requires good leadership, governance, management and administrative support. Clinical and governance lead roles should exist with responsibility across the network. The clinical pathways in place should be documented and audited. Facilities and time in job plans for regular MDT meetings and, if required, travel across the network is required. Submission of data to national registries and network co-ordination needs administrative support.

1.12. In summary, the Vascular Society believes that every patient has the right to consult with a vascular surgeon close to their local hospital, but they may have to travel to obtain access to more complex diagnostic and interventional facilities. Only in this way can equality

of access and the patients' desire for a local service be delivered alongside the best possible elective and emergency outcomes for individual patients."

The NSS states that all Trusts that provide a vascular service must belong to a vascular provider network and it is envisaged that all arterial surgery will be provided at a vascular centre. The network must:

- Work towards the aim of all leg amputations being undertaken in arterial centres by 2015
- Provide 24/7 in-patient arterial surgery and vascular interventional radiology with an on call rota for vascular emergencies covered by on site vascular surgeons and vascular interventional radiologists (requiring a minimum team of six of each)
- Cover a population to enable each surgeon to perform at least 10 AAA procedures per annum (guideline 800k).
- A 24/7 vascular interventional radiology rota may need to be organised on a network wide basis to ensure services for interdependent specialities are not destabilised.
- Have a specialist vascular multi-disciplinary team (MDT)
- Provide specialist infrastructure and facilities including Outpatient Clinics, Vascular Laboratory, Vascular Ward, operating theatres, Anaesthesia, Intensive treatment Unit and Limb Fitting Service
- Document care pathways
- Provide for co-dependent, interdependent and related services, and relevant networks and screening programmes e.g. AAA screening

In addition, The Royal College of Surgeons has designated vascular surgery as a speciality meaning general surgeons can no longer treat vascular patients.

2.2 History

NHS Wessex established a Vascular Programme in April 2014. The overall objective of the programme is to align vascular services across Wessex with the NSS. The scope of this project, Tranche 1, includes vascular services across Southern Hampshire, with emphasis upon the provision of services at UHS and PHT.

2.2.1 Reviews undertaken

In December 2008 a review began to determine the best solution for providing vascular services across Southern Hampshire. Given the changes and advances which have occurred to date, this business case will not delve into the various papers and recommendations but will reference three key papers. The first of which is the National Clinical Advisory Team (NCAT) Report: Vascular Services Review - South Central 7 October 2011 (see Appendix C). The second is the Wessex Clinical Senate: Recommendations on Vascular Surgery in South East Hampshire 26 September 2013 (see Appendix D). The third is the Vascular Society Review 19th / 20th August 2015 (see Appendix E).

2.2.2 NCAT Report: Vascular Services Review - South Central 7 October 2011

The NCAT report reviewed what NHS South Central was then but for the purposes of this report, only findings relating to UHS and PHT are within scope.

In terms of Case for Change, Section 4.8 of the report identified that a service specification was outlined in 2010 following the convening of two clinical expert panels which recommended a configuration in the South of the region where UHS would act as the hub. The spoke hospitals would include the Royal Hampshire County Hospital (RHCH) (Winchester), The Queen Alexandra Hospital at Portsmouth (PHT) and St Mary's Hospital on the Isle of Wight (IOW).

Section 4.9 identified that, following patient and public engagement, an alternative proposal was the PHT would remain as a separate vascular hub. There was some discussion as to whether Chichester might be a spoke to PHT, but it was considered likely those Chichester patients and surgeons would move to a vascular hub in Brighton.

In terms of Discussion the following sections are considered key:

"6.7. The proposal for an arterial hub in Southampton appears well founded and robust. There appear to be sufficient surgeons in Southampton to be able to provide 24 hour cover, especially supplemented by surgeons from Portsmouth. As with the potential reconfiguration in the north of region, the capacity issues that will face Southampton if Portsmouth joins as a spoke Hospital should not be under estimated. The transfer of arterial inpatient work from Portsmouth to Southampton would mean a virtual doubling of the number of inpatient arterial operations performed at Southampton. Again, extremely robust and detailed capacity

planning and assurances will be needed prior to the transfer of any work from Portsmouth to Southampton.

6.8. The additional proposal that came from patient and public consultation was that Portsmouth should be an arterial hub in its own right. Certainly, Portsmouth has a reasonably busy inpatient arterial practice and has a case load that would be close to that seen in a smaller arterial hub in the rest of the UK. Portsmouth does appear to have manpower issues with a relatively low number of full-time equivalent Consultant Arterial Surgeons. Given the (present) relatively low number of Consultant Surgeons, it does not appear likely that Portsmouth would be a viable arterial hub in the long term without substantial manpower investment. The Commissioners have indicated that long term sustainability is an issue in this current reconfiguration. There was some discussion about whether Chichester would join Portsmouth as a spoke to Portsmouth hub. If this were possible then Portsmouth might attain a critical mass of both patients and surgeons to allow long term sustainability as an arterial hub.

6.9. One of the constant issues that accompany any reconfiguration of inpatient arterial services is the impact that these reconfigurations have on existing services in the spoke Hospitals. This will affect all potential spoke Hospitals in the region, but would be of particular concern in Portsmouth. Portsmouth has a very large inpatient renal practice which does require vascular input. In all of the spoke hospitals, job plans and working practices would need to recognise the co-dependencies and it would be important, in all of the spoke hospitals, but particularly in Portsmouth, that there is a defined vascular surgical presence during the week. The requirement for the number of hours per week will obviously vary according to the hub. In Portsmouth, it is likely that a Vascular Consultant would need to be on site for all of the working week."

The report concludes:

"that in the South Central region there should be no more than four arterial hubs (Southampton, Oxford, Frimley Park Hospital and Portsmouth), but that two would generate internationally competitive centres with long term sustainability.
If there were only two hubs (Southampton and Oxford), there would need to be a rigorous and robust assurance of capacity planning.
PHT would require a significant investment in manpower to have a long term sustainable future as an arterial centre in the absence of acquiring both patients and consultants from Chichester.
The effects of centralising inpatient arterial surgery needs to be modelled for the provision of interventional radiology both at the hubs and the spoke."

The report recommended that an action plan be agreed based upon the conclusions and that any new proposals which come out of patient and public consultation should be subject to advice from an expert panel.

2.2.3 Wessex Clinical Senate: Recommendations on Vascular Surgery in South East Hampshire 26 September 2013

The recommendations made by the Senate can be found in Appendix D. Key recommendations were that:

Services for patients in South East Hampshire requiring vascular expertise should be provided by a single clinical service across PHT and UHS.
As a matter of urgency a single rota for emergency seven day vascular assessment and interventions should be established.
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 UHS.

2.2.4 Health Overview & Scrutiny Panel Proposals March 2014

In March 2014, a further report[5] was presented to the area Health Overview & Scrutiny Panels (HOSPs) of Portsmouth, Southampton and Isle of Wight, and to Hampshire Health and Adult Services (Overview and Scrutiny) Select Committee (HASC), to determine whether proposals would be considered a 'significant change' requiring full public consultation. Various options were considered and the following recommended:

"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 TIA or stroke (such as carotid endarterectomy CEA) and major amputations will be considered at a later date following the successful implementation of the initial phases.)"

The proposed phased implementation, referred to as 'Option 4' is shown at Appendix F. Portsmouth HOSC considered this a significant change necessitating a full public consultation. At that time there was a vigorous and sustained press campaign in Portsmouth to retain vascular services at PHT.

2.2.5 Vascular Society Review 19th / 20th Aug 2015

On 1st April 2015, a draft Business Case was issued which concluded in the Executive Summary:

"A strategic review undertaken following the HOSP presentations identified that further impact analysis was required before any option could be recommended. The NSS states that "All Trusts that provide a vascular service must belong to a vascular provider network and it is envisaged that all arterial surgery will be provided at a vascular centre"; it has been established that 'do nothing' is not a viable option.

Further, it has been established that 'world class' centres might be achieved by centralising vascular services if the capacity exists to do so, interdependent services are not compromised and patients receive equitable service with emergency travel times not exceeding one hour.

[5] 20140311_HOSC paper March 2014 final

UHS is a designated Major Trauma Centre (MTC) and, as determined by the NHS Standard Contract[6], must provide vascular services; this obviates the consideration of PHT as the sole vascular hub of the network.

The two options being evaluated in this business case are:

- ***Centralised Model:*** *All arterial services to be delivered at UHS, with PHT joining as a spoke the existing operational network which has UHS as a hub*
- ***Collaborative Model:*** *UHS and PHT continue as arterial centres in their own right, but collaborating to maximise efficiencies and resource utilisation*

In recognition of the timeframe to date in attempting to resolve this matter, and of the fact that, if a collaborative model is the preferred solution then benefits could accrue immediately, UHS and PHT agreed to enter into a pilot collaboration. The pilot will continue to explore opportunities until a decision has been made regarding strategic direction.

Several key issues informing the recommendation of strategic direction were identified:

- ***Patient outcomes****: Historical data suggested that PHT outcomes were a cause for concern. Data for the last two years shows, however, that NSS target outcomes are met or exceeded and the mortality from AAA and CEA elective procedures is 0% (see Appendix B Outcomes Data).*
- ***UHS Capacity:*** *UHS have identified that additional capacity is not currently available to allow the transfer of vascular services from PHT to UHS and would require new funding to be put in place. UHS estimate a minimum of 24 months to build capacity required.*
- ***PHT interdependent services:*** *The issue of interdependencies highlights the dichotomy involving the provision of vascular services in Southern Hampshire. UHS is a major trauma centre and major cardiac centre, whilst PHT hosts a regional renal and transplant centre and hyper acute stroke unit.*
- ***Workforce resilience and sustainability:*** *Without doubt, from the perspective only of resilience and sustainability, a single site operation would provide both, and a far less onerous on call ratio. Equally, both sites are currently at risk if a key member of the vascular team becomes incapacitated.*

As the impact of these key issues needs to be understood before determining a final strategic choice, work to this point has focussed on understanding these issues in more depth.

It is not currently feasible to centralise arterial services at UHS. Whilst this does not strategically preclude this option, weight of evidence suggests that, notwithstanding the strategic guidance regarding centralisation of vascular services on a single high volume site in the modern clinical network, it is considered that there is a compelling case for arterial

[6] D15/S/a NHS Standard Contract for Major Trauma Service (All ages)

services to remain at PHT, and for UHS and PHT to form a twin-hub collaborative vascular network."

This recommendation that two arterial centres remained and worked in collaboration was rejected by the NHS England South Regional Senior Management Team (SMT) as not compliant with the NSS.

Following a review , Fiona Dalton, Chief Executive UHS, identified that UHS had undergone a bed modelling exercise and now believed that they would be able to develop capacity required, and had identified the capital investment required both for vascular ward expansion and for the hybrid theatre build.

This left a fundamental difference of clinical opinion between the two sites as to whether PHT interdependent services required 24/7 on site emergency vascular services, or whether this could be provided by UHS as a MAC, acting as a network hub. To resolve this question, the VS were invited to undertake an expert clinical review.

Paul Blair (President) and Rob Sayers (Vice President (elect)) of the VS undertook a review of Southern Hampshire vascular services, specifically UHS and PHT, on 19th and 20th August 2015. Their findings were:

"*Currently both units are not POVS compliant – Portsmouth have problems with the on call surgical rota and Southampton lack Vascular Radiology*

In terms of the future – it would be possible to make both units POVS compliant and stand alone. This would involve Portsmouth providing vascular services for Chichester and both units would require substantial investment with consultant appointments and development of facilities. However this model would probably only be sustainable in the short term. In the long term both units may have difficulty in recruiting consultants and trainees and 7 day working would need more consultants on a 1 in 8 rota or greater.

The alternative and more appropriate long term sustainable option would be centralisation of services on the Southampton site. This option would likely lead to a high class vascular facility but would require capacity and resource issues to be addressed. The success of this centralised model would require-

1. ***Significant cooperation from the vascular surgeons to provide adequate services at the hub and spoke hospitals.***
2. ***Capacity issues at Southampton to be addressed.***
3. ***A clinical lead to be agreed and appointed.***
4. ***Clear demonstration by Southampton Trust of a willingness to invest and develop vascular services.***
5. ***A staggered merger should be avoided.***
6. ***Reconfiguration of services is difficult and can be prone to misinformation therefore early engagement between local politicians and professional bodies***

should take place as soon as possible in order to provide accurate information for the public through local media"

2.2.6 Reviews summary

All expert clinical reviews undertaken since 2009 have recommended that PHT join UHS in a network, with major arterial services being provided by UHS The lead vascular surgeons at PHT (Mark Pemberton) and UHS (Mike Phillips) are unanimous in their view that the strategic solution is to have one network with UHS as the MAC and PHT as a NAC. In the preface to their clinical vision they state:

"***The Wessex Vascular Network: Clinical Vision***

This is a document to mark out the clinical vision for a network to provide vascular services to Wessex. This area includes the cities of Portsmouth, Southampton and Winchester, the Isle of Wight and most of Hampshire and Guernsey. The population served is approximately 2 million.

There will be one arterial centre ('hub') based at University Hospital Southampton (UHS) with non-arterial centres ('spokes') at Queen Alexander Hospital (QA) in Portsmouth, Royal Hants County Hospital (RHCH) at Winchester and St Marys Hospital on the Isle of Wight.

There will be tertiary services provided to Dorset, Wiltshire and Sussex.

In accordance with the recent Vascular Society report provided to NHS England (Wessex) and the Provision of Services with Vascular Disease 2015, all arterial work (aneurysms, carotid surgery, bypasses, major amputations, and more) will be undertaken at the arterial centre. All patients with urgent and emergent vascular disease will be treated here as well.

The majority of patients, however, will continue to be cared for in the non-arterial centres close to where they live. This will be in out patients, day case surgery, rehabilitation and recovery and day case vascular radiology."

2.3 Current Status

Southern Hampshire Vascular Network:

UHS	University Hospital Southampton NHS Foundation Trust	HUB
	HHT Hampshire Hospitals NHS Foundation Trust	
	RHCH Royal Hampshire County Hospital, Winchester (some Andover War Memorial Hospital patients referred via Winchester to UHS)	SPOKE
	IOW Isle of Wight Trust	SPOKE

PHT Portsmouth Hospital NHS Trust ARTERIAL CENTRE

UHS acts as a MAC, providing all arterial interventions for Winchester and IOW, with outpatient assessment, diagnostics and vascular consultations being undertaken at the spoke hospitals.

PHT acts as an arterial centre in its own right.

Chichester is a spoke hospital in the Sussex Vascular Network (SVN), with Brighton as MAC hub. PHT has in the past provided services to Chichester and more recently provided services on an informal basis when Brighton were unable to recruit a replacement vascular surgeon to provide services to Chichester. Brighton has now successfully recruited, and services have been resumed from within the SVN.

UHS undertakes AAA screening for the network, including PHT. UHS currently covers a population of 900,000 and Portsmouth 650,000. Due to the demographics of the area, PHT undertake the required number of AAA procedures required by an arterial centre.

Table 1 Major procedure numbers for 2009/10 (HES) and 2013/14 and 2014/15 (providers).

Procedure		**UHS**			**PHT**		
		2009/10	2013/4	2014/15	2009/10	2013/14	2014/15
AAA	Open	45	52	20	32	7	18
	EVAR	25	60	61	6	41	36
	rAAA	17	14	21*	25	17	12
TOTAL AAA		87	126	102	63	65	64
CEA		113	62	71	69	52	81
Bypass Surgery		59	95	79	112	76	90
Major Amputation		30	40	34	52	71	69
TOTAL		289	323	286	286	264	306

* 4 EVAR

As part of the VS review, both UHS and PHT have undertaken a detailed Quality Assurance self-assessment.

2.3.1 UHS Compliance Assessment

UHS successfully operates as a network hub with Winchester and IoW as spoke hospitals. UHS self-assessment rates as almost fully compliant with the NSS.

The first area which UHS highlights as not fully compliant relates to a Core Standard:

"As the new speciality of vascular surgery is established provision will need to be made for the separation of vascular and general surgery with vascular surgeons only treating patients with vascular disease; this will be required at both consultant and trainee level"

UHS identify that five of six consultants are vascular only and that one consultant also supports minor paediatric activity at RHCH. The centre is recognised for vascular training.

In context, vascular surgery was established as a speciality in 2013. Prior to that, most surgeons were registered as general surgeons. The VSGBI has provided a report[7] resulting from a survey of consultant vascular surgeons (ordinary members of the VSGBI) which identifies that 74% of respondents identify themselves as Vascular Surgeons and 26% as General or Vascular surgeons. 77% of overall respondents indicated that more than 75% of their job involved Vascular Surgery.

The report also states that it cannot be assumed that all practicing Vascular Surgeons in the UK are members of the Vascular Society. It identifies that the National Vascular Registry (to which Vascular Surgeons have been expected to submit outcomes activity and data since 2008) identifies 458 surgeons undertaking AAA repair, which many consider to be an index procedure for a specialist vascular surgeon and an essential skill for a Vascular *Generalist*. It is recognised that the separation of vascular and general surgery will take place over time.

A more pressing concern is that whilst Interventional Radiology (IR) is available 24/7, vascular IR is not always available. UHS has recently recruited two vascular interventional radiologists to replace two who have left and will have a complement of 5. Recruitment and retention is an issue as there is a national shortage.

Key service outcomes for 2013/2014 (source: UHS) are tabled in Appendix B; UHS exceeds all targets for which data is available, with the exception of mortality rates resulting from lower limb amputations which is within acceptable criteria. Further work will be required on establishing the position against targets in those areas for which data is not currently available.

UHS do not have a hybrid theatre, but do have IR suites to operating theatre standards as an interim solution. Plans to build the hybrid theatre have been brought forward to 2016 calendar year and have been approved by UHS Board.

2.3.2 PHT Compliance Assessment

PHT operates as an independent arterial centre. PHT is the largest stroke and renal centre in Southern England and both are highly dependent on vascular and vascular IR services. There is a high incidence of diabetes in the population also requiring vascular services. Hospital facilities were built with this in mind.

[7] Vascular Surgery UK Workforce report 2014: Results of a Survey of the Consultant Vascular Surgery Workforce in the UK: Paper 2

In terms of compliance, PHT is not part of a network model in the sense of formally identified hub and spoke providers.

In October 2015, a vascular surgeon left PHT, leaving 2 vascular surgeons and one renal transplant surgeon to provide 24/7 emergency on call services. Since that time, UHS have provided some informal support at weekends. A recent recruitment campaign for a locum failed to secure a candidate and this post has been re-advertised. Attempts to recruit to permanent vascular surgeon positions have been unsuccessful. PHT attribute this to the uncertainty which has dogged the service for several years. Whilst outcomes are good and 24/7 on call cover is provided, sustainability is very much in question.

As an interim measure, it has been agreed that a joint appointment will be made by UHS and PHT to the strategic network solution. This will provide additional resource to support emergency on call at PHT, but the rota will continue to be onerous (and non-compliant).

PHT have recently established a 24/7 IR cover. PHT also has 5 vascular interventional radiologists, facing the same issues as UHS.

Key service outcomes for 2013/2014 (source: PHT) are tabled in Appendix B. PHT exceeds all targets for which data is available, with the exception of mortality rates resulting from lower limb amputations which is within acceptable criteria. Further work will be required on establishing the position against targets in those areas for which data is not currently available.

PHT have purpose-built IR suites which provide the majority of facilities seen in a hybrid lab.

3. Business Options

3.1 Introduction

The NSS states that "All Trusts that provide a vascular service must belong to a vascular provider network and it is envisaged that all arterial surgery will be provided at a vascular centre"; it has been established, therefore, that ‘do nothing’ is not a viable option.

Further, it has been established that 'world class' centres might be achieved by centralising vascular services if the capacity exists to do so, interdependent services are not compromised and patients receive equitable service with emergency travel times not exceeding one hour.

The VSGBI 2014 Workforce Report estimates that the minimum number of surgeons required to provide a safe service is 1 per 150,000 population, the current ratio, with a UK population of circa 63 million and 458 surgeons in the UK on the National Vascular Registry, is approximately 1 per 137,000 and, for large tertiary centres, 1 per 100,000 may be needed. Table 2 below reflects these figures for PHT and UHS.

Table 2 Estimates of Vascular Surgeons required per capita

Network	Population	Vascular Surgeons required per capita		
		1:100k	1:137k	1:150k
UHS (including Winchester & IoW)	900k	9	6.6	6
PHT	650k	6.5	4.8	4.3
UHS + PHT	1550k	15.5	11.4	10.3
PHT with Chichester	880k	8.8	6.4	5.9

6 surgeons are required as a minimum for a viable on call rota.

According to the VSGBI 2014 Workforce report, the UK annual population is projected to increase by 4.9 million over the next 10 years, an annual average rate of growth of 0.8%.

UHS is a designated Major Trauma Centre (MTC) and, as determined by the NHS Standard Contract, must provide vascular services; this obviates the consideration of PHT as the sole vascular hub of the network.

'Do Nothing' is not an option as neither site is compliant. The key options to be evaluated are:

Single Major Arterial Centre (MAC) : All arterial services to be delivered at UHS, with PHT joining as a Non-Arterial Centre (NAC) the existing operational network which has UHS as a hub, in addition to the existing spokes (Winchester and IoW).

Two Major Arterial Centres: UHS and PHT continue as arterial centres, but collaborate to maximise efficiencies, resource utilisation and to provide improved clinical services

Tables 3 and 4 below provide a SWOT analysis of these two options.

Table 3: Single Major Arterial Centre (UHS MAC hub with PHT as NAC Spoke)

Strengths	Weaknesses
• Complies with NSS network model • Increases critical mass of population (1550k) • Strengthens core vascular team numbers, with potential to reduce on call ratio • Facilitates optimisation of resources • Larger centre can attract and sustain vascular workforce and trainees • Outcomes currently meet or exceed NSS targets (where data available) • Recommended strategic solution following an expert clinical review by the VS (supporting opinion of past expert clinical reviews) • Fully supported by clinicians	• Lack of some elements of PHT management buy in • Historic Portsmouth media and public opposition to the single hub model • Increased travel time for Portsmouth patients and families • IR services are provided to most specialities and 24/7 cover needs to be maintained at both sites; this may impact the ability to have a vascular-specific IR on call. • UHS does not currently have capacity to absorb PHT arterial services and this needs to be developed

• Supported by the Boards of both UHS and PHT • Supported by CCGs • Supported by GPs • Co-location of Major Trauma and Vascular Services at UHS • Future proof	• Underused high standard facilities at PHT
Opportunities	**Threats**
• Increased workforce resilience with capacity to absorb future increased workload e.g. seven day working • Increased sub specialisation • UHS to become regional 'supercentre' for complex vascular (rather than London) • Standardise pathways • Maximise efficiencies in terms of R&D, new technologies etc. and resource utilisation • Commissioners can enforce change via contracts • Merger of trusts to obviate conflicts of interest and maximise efficiencies across all areas • Utilise spare capacity at PHT for UHS electives (not necessarily restricted to vascular)	• Capacity issues at UHS may result in degradation of services at either or both sites • On site presence at PHT may prove inadequate to support interdependent services for in patients / non-emergency urgent cases • PHT staff may be unwilling to transfer • Expansion of capacity for vascular may adversely impact other UHS services • PHT ability to recruit and retain Interventional Radiologists for other services if no on site vascular • Inadequate arrangements for repatriation may impact UHS capacity • Financial impact (to be assessed)

Table 4: Twin Major Arterial Centres (both UHS and PHT as MACs)

Strengths	Weaknesses
• Outcomes currently meet or exceed NSS targets • Can be developed from 'business as usual' with inter-dependent services robustly supported • No additional patient travel • Joint MDT already in place • No requirement to develop capacity at UHS • Ability to continue to use good facilities at PHT	• PHT is non-compliant as not in a network • Maintenance of two emergency on call rotas (neither of which is 100% resourced) • Workforce resilience and sustainability; PHT workforce is currently not sustainable • PHT reliance on one key individual vascular surgeon • May need to invest in duplicate technologies • There is insufficient scale of procedures to support two teams. • It is likely that neither service is cost effective without economies of scale • There is no workforce contingency • Recruitment and retention may prove difficult in what are perceived to be two small centres rather than a larger centre of excellence • The VS consider this to be a possible short term solution if Chichester becomes a spoke to a PHT hub. Chichester is already established in the Brighton network who consider Chichester a crucial component. • Service not future proof • Patients may still not have the choice of a fully compliant network
Opportunities	Threats
• UHS to become regional 'supercentre' for complex vascular (rather than London) • Standardise Pathways • Maximise efficiencies in terms of R&D, new technologies etc. and resource utilisation • Explore merger of trusts to obviate conflicts of interest and maximise efficiencies across all areas • Utilise spare capacity at PHT for UHS electives (not necessarily restricted to vascular)	• Seven day working and potentially increasing population will further stretch on call arrangements • Geographical boundaries and parochialism will prevent cross border patient flows and choice • As dependent upon Chichester patient flows, this may destabilise the Brighton network. • Quality of vascular training at both sites may be diluted leading to loss of some training places

3.2 Key Issues

Several key issues informing the recommendation of strategic direction are discussed in the following sections.

3.2.1 Patient outcomes

Historical data suggested that PHT outcomes were a cause for concern. Data for the last two years shows, however, that NSS target outcomes are met or exceeded and the mortality from AAA and CEA elective procedures is 0% (see Appendix B). There is no longer a clinical outcomes basis that supports an urgent transfer of procedures, either emergency or elective, from PHT to UHS in terms of patient outcomes.

2013-14 data for UHS stands at 3% because of two deaths. Caution should be employed in using annual figures with regard to AAA procedures as they are not statistically significant. The VSGBI use 5 year average data in their outcomes report to assuage this factor but, by definition, this data is not current. It is possible that one death can have a significant impact on outcomes data which may, in fact, simply be down to chance. It should also be noted that UHS undertake the more complex and, by definition, more inherently risky procedures. Complex arterial patients are currently transferred from PHT to UHS, with a reverse flow of complex renal to PHT.

rAAA procedures are not included in outcomes data as there is a national mortality rate of up to 90%

Interestingly, the VSGBI Outcomes Report 2013 (for AAA this report gives rolling 5 year numbers) reveals that in the majority of, if not all, centres (including St Georges Vascular Institute) 2-3 surgeons perform the majority of elective AAA procedures. This suggests that sub-specialisation occurs. This is supported by the acknowledgement in the NSS that "a 77% reduction in mortality was observed for every 100 endovascular repairs performed".

Because a minimum of 6 surgeons are required to provide a 1:6 rota for emergency on call, one of the NSS measures is that a centre undertakes a minimum of 60 AAA procedures (emergency and elective) per annum in order that surgeons do a minimum of 10 procedures to gain and maintain experience.

Again, as an example from the VSGBI 2013 outcomes report, St Georges did 626 AAA elective procedures of which:

Surgeon 1	237
Surgeon 2	140
Surgeon 3	99
5 others	less than 60 per surgeon

Of the 5, some could have been new trainees who had less than 5 years data etc. but it illustrates the trend. Even if procedures were averaged out, on the basis of 10 per annum it would take 10 years to get the experience of 100 procedures. In practical terms, this is

achieved by sub specialisation. Clearly, the bigger the centre, the more opportunity to achieve this.

VSGBI outcomes published in 2015 for UHS and PHT are shown in Appendix G. Confirmation of the trend to move from Open to EVAR procedures is given in the St Georges figures. Of a total of 556 AAA procedures, only 11 were open.

The fact that most AAA elective procedures are mainly done by 2-3 surgeons would suggest that sub specialisation is to the benefit of the patient.

Statistics are maintained for mortality rates for rAAA and, whilst not statistically significant, PHT figures show that mortality rates are well below the national average. Following discussions with the clinical leads, it has been agreed to also maintain statistics on rAAA patients where it is not considered that intervention is appropriate. This will provide a more comprehensive picture of all cases of rAAA attended.

One of the key objectives of centralisation of arterial services is to ensure that the emergency on call vascular surgeon has undertaken the minimum 10 AAA procedures considered necessary to maintain experience and, therefore, outcomes.

As can be seen in Appendix G, at the point of publication, PHT has one surgeon who has performed in excess of 50 AAA elective procedures over the five year period and UHS have four. It should be noted that:

- the one surgeon who has sub-specialised at PHT has 0 mortality rate for elective procedures, as have the other PHT surgeons
- the five year average may skew recent experience and, therefore, not accurately reflect current position; one additional UHS surgeon has undertaken 47 procedures.

3.2.2 UHS Capacity

A draft Business Case published on 1st April 2015 identified that UHS did not have the capacity to undertake PHT arterial services (and no investment budget to provide capacity). Further, PHT believed that interdependent services required on-site emergency vascular services. UHS expressed their disagreement with this view, believing vascular services could be provided from a network hub were PHT a spoke. The recommendation was that two arterial centres remained and worked in collaboration. This proposal was rejected by the NHS England South Regional Senior Management Team (SMT) as not compliant with the NSS.

Following a review , Fiona Dalton, Chief Executive UHS, identified that UHS had undergone a bed modelling exercise and now believed that they would be able to develop capacity required, and had identified the capital investment required both for vascular ward expansion and for the hybrid theatre build.

UHS has committed to develop capacity and infrastructure to absorb the totality of PHT arterial services and have developed a detailed capacity and transfer proposal (Appendix H),

including expansion of the vascular ward and building of the hybrid theatre. Initial estimates suggest that the earliest date at which capacity to transfer all major arterial services concurrently, including emergency services, will be available would be 1st December 2016. The development of the detailed capacity and transfer plans will be closely monitored and assured; there will be no compromise on quality in favour of timescales.

A series of work streams are underway to support the proposal and these will provide the detailed plans against which NHS England will assure; these are summarised below.

3.2.2.1 Pathways

Pathways and protocols already exist for the current network. These are being reviewed by the clinical leads to encompass the requirements of PHT as a NAC.

3.2.2.2 Ward Capacity

The expansion of the vascular ward, and related facilities, to manage the additional workload from PHT.

3.2.2.3 Hybrid Theatre

A key technological advance is the 'hybrid' theatre. This is a combined operating theatre and interventional radiology suite which can function either as a conventional operating theatre, or as a radiology facility. Crucially, it allows intra- and post-operative on-table imaging and intervention. Current facilities are either focused around the adaptation of angiography suites to allow limited open access surgery, or the utilisation of portable imaging equipment in a standard operating theatre; both of these solutions provide limitations. The hybrid theatre is a significant investment (circa £2.5 million), but is seen as a key element of vascular services provision, equipped to meet the challenges of complex endovascular procedures and improve patient service and safety.

UHS have brought forward plans for a hybrid theatre build to 2016 to facilitate the transfer of procedures from PHT. This is a critical path work stream to ensure sufficient theatre capacity.

3.2.2.4 Estates

The planning of the estate changes required to facilitate implementation of work streams where required.

3.2.2.5 Therapies / rehabilitation

A pilot has already identified a significant reduction in length of stay for amputation patients by reconfiguring the approach to rehabilitation. This work stream will continue to examine opportunities for length of stay reductions.

3.2.2.6 Renal

Several options have been identified to service vascular patients with renal failure. This work stream will analyse the options, recommend a solution and seek agreement to proposals.

3.2.2.7 Interventional Radiology

This work stream will examine the interventional radiology requirements across the network to propose a solution which will allow a 1:6 vascular interventional radiology emergency on call rota at the MAC, whilst ensuring the needs for interventional radiology at NACs are met.

3.2.2.8 Repatriation

Repatriation of patients, or more specifically potential delays in transfers and repatriation, can cause serious difficulties in terms of bed utilisation and, potentially, delays to rehabilitation. A Chief Executive initiative to address this issue and seek agreement on protocols is underway.

3.2.2.9 Contracting / Finance

This work stream will ensure that all contract and finance negotiations are complete prior to transfer.

3.2.3 PHT Interdependent Services

The VSGBI UK Workforce Report 2014 identifies that "there are many complex interactions between vascular surgeons and other specialists who manage some of the most common and morbid conditions that affect our population such as stroke, heart disease, diabetes, trauma and cancer".

The issue of interdependencies highlights the dichotomy involving the provision of vascular services in Southern Hampshire. UHS is a major trauma centre and major cardiac centre, whilst PHT hosts a regional renal and transplant centre and hyper acute stroke unit.

3.2.3.1 Renal

PHT hosts the regional Wessex Renal Unit (nephrology and renal transplantation) which covers a population of 2.2 million people from Andover in the north, Chichester in the east and Salisbury in the west. Renal failure leads to some form of renal replacement therapy, which will include the options of temporary or permanent, haemodialysis or peritoneal dialysis. Haemodialysis (whether temporary or permanent) requires vascular access. Renal

transplant surgery involves the harvesting of kidneys and their blood vessels and then joining them again to the recipient, this is mostly a vascular operation. In additions, 150-200 native renal biopsies are performed in Portsmouth every year and 2-3% of these will require emergency treatment (usually by an interventional radiologist) for bleeding. Temporary vascular access by way of jugular venous cannulation is also frequently performed and complications of this procedure, although rare, also require emergency treatment by an interventional radiologist.

PHT is a major renal centre and is listed by the Renal Association as having 490 haemodialysis and 104 peritoneal dialysis patients (making PHT the 8th largest centre by number respectively in the UK). All larger renal centres also host vascular services.

The following is extracted from the VSGBI POVS 2012 report:

"5.76 Vascular patients are susceptible to acute kidney injury (AKI) either as a result of contrast induced nephropathy or following intervention. Facilities for haemofiltration must be available in HDU and ITU. Where AKI is recognised, the involvement of a nephrologist, or a physician with an interest in renal medicine, is required to minimise the risk of permanent renal failure.

5.77 Patients with vascular disease often have significant chronic kidney disease and expert nephrology input may help to minimise the adverse effect of surgical intervention on renal function.
Nephrologists provide valuable assistance on the need for, and timing of dialysis in patients with established renal failure.

5.78 Patients with chronic renal failure or those needing dialysis are best managed by a vascular service linked to an in-patient nephrology service. The management of renal artery stenosis and vascular access for dialysis require close collaboration between nephrologists, vascular, renal transplant and interventional specialists to provide optimal care.

5.79 Renal access surgery is a growing part of vascular surgical practice. This work requires careful organisation and a service of sufficient size is best served by the appointment of a dedicated specialist vascular access co-ordinator. Complications of AVF include thrombosis and bleeding and often result in an urgent requirement for renewed vascular access; this necessitates the provision of an on-site emergency vascular service."

The renal centre at PHT is effectively self-contained in terms of vascular surgery services. One transplant surgeon is a vascular surgeon who participates on the vascular on call rota. The VS review identified that this, in fact, was concurrent with being on call for renal which was not considered acceptable practice. There are four additional renal transplant surgeons, all of whom, undertake vascular surgery as part of the transplant process.

There is, however, extensive use of vascular IR and it is essential that these services are maintained.

The VS review found that renal services at PHT could be supported by UHS as a MAC; particularly as the renal surgeons are able to carry out some of the necessary related vascular procedures.

3.2.3.2 Venous access for haemodialysis

There are about 600 patients receiving haemodialysis from the PHT Wessex renal unit and 80-85% of these patients will have had creation of at least one arterio-venous fistula to allow venous access. This is a multi-disciplinary process involving vascular lab investigations with venous mapping (138 patients last year), surgical procedures (212 new and 150 re-dos last year) and management of short and long term fistula problems. Last year the interventional radiologists performed 226 fistulograms and operated on 128 that required fistuloplasties. Thus, on most working days a vascular service intervention will be required for this group of patients, often performed as an urgent procedure. Once again this is a multi-disciplinary team that work together on a daily basis to provide good patient care with surgeons, specialist nurses, interventional radiologists and vascular technicians working together. This is a significant workload.

There is extensive use of vascular IR for routine repairs for vascular access.

The following is extracted from the VSGBI POVS 2012 report:

"4.33 Patients undergoing haemodialysis require a means of access to the circulation to allow the rapid withdrawal and return of blood so that it can pass through a dialysis machine at a rate of at least 300ml/min. Whereas this can be achieved using a double lumen central venous catheter in the short term, long term catheter use is associated with increased infection, higher mortality and central venous stenosis or thrombosis, which compromises further access to the circulation. Central venous catheter use should be minimised. Formation of an arteriovenous fistula, preferably in the non-dominant arm, at least six months before the anticipated need for renal replacement therapy is the ideal. This allows adequate time for maturation before needles can be inserted for dialysis. Some patients will require the insertion of a prosthetic graft between an artery and a vein for access because of poor vessels or the thrombosis of previous arteriovenous fistula (AVF).

4.34 Approximately 100 patients per million population start dialysis in the UK every year, of which 70 will undergo haemodialysis. The total dialysis population was over 20,000 in 2005 (based on 17,409 prevalent patients reported by 62 of the 72 renal units in the UK) and is increasing at about 6% per annum. About a quarter of these are undergoing peritoneal dialysis leaving about 15,000 on haemodialysis (approximately 250 per million population).

4.35 Because of the known failure rate of new AV fistula, it has been estimated that 135 new vascular access operations are required for every 100 patients starting haemodialysis. In addition, 30 new access operations are required per 100 patients undergoing chronic haemodialysis because of intercurrent thrombosis of their fistula. This would indicate the need was about 210 procedures per million population per year in 2005 (total approx 12,600 per annum in the UK), rising to an expected 281 procedures per million (17,140 total) by

2010. It has been estimated that one dedicated vascular access operating list is necessary for each 120 patients on dialysis (including peritoneal) assuming 3- 4 patients can be operated upon per list.

4.36 Most patients can be operated on under local anaesthesia and many of the operations can be performed as a day case procedure. In addition, there is a need for up to 2 IR sessions per week per 100 patients on dialysis for preoperative imaging, postoperative surveillance and for percutaneous angioplasty or thrombectomy of failing or thrombosed AV fistulae and grafts61. Vascular radiologists also deal with central line access problems, particularly where the central veins have occluded. These procedures are time consuming, with a significant morbidity and mortality.

4.37 At present, about two thirds of vascular access is provided by vascular surgeons and a third by transplant surgeons; the involvement of vascular surgeons is likely to increase as more peripheral dialysis units are opened outside transplant centres. There is a considerable under provision of vascular access surgery in the UK, resulting in long waiting times for definitive vascular access and a much higher proportion of patients starting and continuing to dialyse on a central venous catheter compared with other European countries and Japan. There is a need for increased numbers of vascular surgeons and radiologists to become involved with dialysis access formation and maintenance. Vascular surgeons who are required to commence vascular access work late in their careers as part of service reconfiguration need to be properly trained."

It has been established that, in the case of PHT, the renal transplant surgeons undertake all vascular access surgery.

The NSS for Renal Dialysis[8] states:

"Haemodialysis patients are dependent on the maintenance of 'vascular access' to allow repeated connection to the HD machine. The need to maintain a satisfactory vascular access coupled with a high susceptibility to cardiovascular disease, dialysis patients present some of the most serious challenges encountered by vascular surgeons and interventional radiologists. A significant proportion of these interventions are required to be delivered urgently or as an emergency. The safety of dialysis patients while hospitalised with vascular complications of their disease requires special consideration in the commissioning of dialysis services."

"Providers of ICHD (sic In Centre Haemodialysis) should have clear referral pathways be in place for vascular surgery and interventional radiology in order to establish new fistulae and for fistula salvage and maintenance. This includes pathways for urgent interventions.

Providers shall ensure that haemodialysis patients are managed in a safe environment when hospitalised with vascular complications of their disease. There should be 24/7 and urgent

[8] A06/S/a 2013/14 NHS Standard contract for renal Dialysis; Hospital and Satellite (Adult)

on-site cover available from vascular surgeons, interventional radiologists, nephrologists and acute dialysis team."

UHS have proposed the following:

"Transfer of arterial work from PHT would result in 5 patients per annum requiring renal support whilst at UHS for their vascular treatment. The initial thought was that this could be delivered as per the current model for cardiac and neurosurgical patients i.e.: Haemofiltration on ICU.

There is an opportunity to deliver renal support to this pt cohort using one of the new portable "at home" dialysis machines which may be suitable for not only the new vascular patients but would also release bed days and the nursing staff who currently deliver the existing haemofiltration demand. Activity and impact of this is being assessed.

UHS already undertakes renal dialysis within paediatrics (4 machines available). This unit links closely with the P'mth renal unit and staff training with regard to needling of fistula's is supported by the satellite unit at Totton. Similar training arrangements could support the ICU development."

The top ten renal transplant service providers (by patient numbers) were asked to provide details of their model of care in relation to their requirement for vascular surgical support, and to give their views on the requirement for co-location of services. Two responses were received which identified quite different models.

Newcastle has vascular and renal co-located on the Freeman Hospital site, together with the renal and liver transplant unit. Newcastle are also a Major Trauma Centre which is located at Royal Victoria Infirmary, some two miles distant. For historical reasons, vascular surgeons do not do the primary dialysis access work, but are involved with complex problems arising from fistulae and there is significant IR input, with a close interaction between IR and vascular surgery. The view was expressed that renal and vascular are best located together, along with transplant services, but that it was not impossible to work with the units in separate hospitals.

Sheffield Teaching Hospital is located across several sites. Northern General Hospital is the larger acute site and hosts renal which is co-located with A&E, vascular surgery and interventional vascular radiology and the major critical care provision as well as other major specialities. The renal service provides all renal replacement modalities and employs four consultant transplant surgeons who also provide the dialysis access surgery and a 24/7 on call service. Renal surgical problems are initially managed by the renal physician team under supervision of the on call renal surgeon. IR offers a 24 hour service but this is rarely required.

Whilst vascular surgery is undertaken by the renal transplant surgeons at PHT, there is a high dependence upon the current PHT vascular IR service.

3.2.3.3 Stroke

PHT has the largest stroke unit in Wessex with annual admissions to the stroke unit of around 1100 patients per year. It is a hyper-acute stroke unit offering thrombolysis 24/7 for the patients around Portsmouth including those presenting out of hours from West Sussex. A proportion of these will require vascular services input with imaging, Doppler scanning and surgery. The objective of surgery, where it is indicated, is to reduce the risk of a second, more serious and disabling stroke occurring. The round four UK endarterectomy audit indicated that PHT did 92 cases in the one-year audit. It is very likely that there will be in future a clinical standard that these patients are operated on within 48 hours of presentation which will require a very rapid clinical pathway and surgeon availability. The decision about surgical intervention is multi-disciplinary involving stroke physicians, therapists, radiologists, anaesthetists and surgeons. The procedure itself is almost always under local anaesthetic and the hospital stay is short – usually less than 24 hours.

The following is extracted from the VSGBI POVS 2012 report:

"4.39 CEA is a well established evidence based treatment for symptomatic patients with a significant carotid stenosis, including patients with good recovery from recent stroke. Recent research suggests that the risk of stroke is highest soon after the onset of symptoms and that the quicker the surgery is done, the greater the reduction in the risk of subsequent stroke. The latest DoH guidelines on stroke prevention recommend that by 2017, carotid endarterectomy should be performed within 48 hours of onset of symptoms[9]. The establishment of such rapid access treatment requires the development of new referral and diagnostic pathways, and close co-operation with stroke physicians and neurologists. Vascular teams will also need to work flexibly in order that carotid endarterectomy can be expedited, and may need to create referral networks to ensure prompt treatment is always available. Outcomes from interventions should be audited regularly and surgery should only be undertaken by specialist teams with the full range of facilities expected for elective procedures, since the risks of urgent surgery may be higher than in less acute patients"

The NCAT report identifies in section 6.5 that there are models whereby hyper acute stroke units do not have vascular on site and patients requiring CEA are referred to a hub in an expedited fashion.

NICE guidance is currently 14 days. The VSQIP 15 report on outcomes identifies the Days from symptom to surgery Median for CEAs as 9 at UHS and 12 at PHT.

3.2.3.4 Diabetes

The bulk of vascular service work comes from patients with peripheral vascular disease and diabetes. PHT currently run three (and have just agreed with commissioners to move to five) rapid access diabetic foot clinics where patients are seen by the diabetic team. The clinics

[9] Department of Health. **National Stroke Strategy** London 2007 www.dh.gov.uk/stroke

are timed during the week to ensure that a vascular surgeon is available to see the patient immediately to provide advice and / or immediate action.

There has been concern expressed in the past regarding the care of diabetic patients in the area with patients in the Portsmouth and Fareham and Gosport area having a high amputation rate (related to their community diabetic care, compliance with treatment, and availability of expert advice from an MDT at an early stage). The increase in MDT clinics has significantly contributed to improvement in amputation rates of 2.4/1000 major amputations to 1.3/1000 major amputations over three years. PHT has an established weekly MDT involving clinicians from the diabetes team and vascular services to discuss every patient both pre and post amputation to ensure high quality decision making and subsequent care.

The following is extracted from the VSGBI POVS 2012 report:

"5.88 Patients with diabetes form a significant and increasing part of a vascular specialist practice. Protocols for the management of these patients should be developed with diabetic specialist colleagues. Many patients with diabetes present with limb and life threatening ischaemia and sepsis. Such patients need joint care with the diabetic team to optimise care and minimise tissue loss.

5.89 The development of formal pathways of care and/or combined clinics for diabetic foot disease is a potential means to minimise the risk of amputation in this vulnerable group. In the outpatient setting these patients have complex foot problems requiring multi-specialty input. A multidisciplinary foot care team comprising a diabetologist, diabetes nurse specialist, a surgeon with expertise in managing the diabetic foot, a podiatrist and a tissue viability nurse should be available to manage inpatients with diabetic complications. The specialists involved in such a team will be determined by local interest and expertise"

3.2.3.5 Emergency / Urgent Needs

A hospital of the size and complexity of PHT will, on occasion, require urgent vascular surgical or interventional radiology expertise at short notice. PHT has the largest Percutaneous Coronary Intervention (PCI) unit in the region for patients with ischaemic heart disease. Several times a year incidents will occur where very rapid help from a vascular surgeon will be required to resolve a complication of the procedure. PHT is also a National Cancer Centre and thus undertakes a high volume of major cancer operations. Once again complications from this type of surgery will occur and rapid intervention is essential. At the current time there is always a vascular surgeon available and close by to assist in these events.

3.2.4 Workforce Resilience and Sustainability

In considering strategies for vascular services, the POVS 2012 states:

"6.4 The Provision of Surgery for Patients with Vascular Disease (POVS) 2009 document described the case for Centralisation or Networking as the two favoured models of care.

Although each model has in many instances been able to deliver high quality care to patients with vascular disease, it has become apparent that many networks are unable to adequately provide the required 24/7 access to vascular and radiological expertise. When clinical networks are set up to allow for arterial intervention on multiple sites, it is often difficult for on call vascular surgeons and interventionalists to provide adequate care to all patients at all times of the day. This is especially true, and to the disadvantage of patients, when they develop complications on differing sites within the network at the same time, resulting in stretching of the expert cover arrangements.

6.5 In addition, strong volume outcome data is emerging suggesting a benefit for patients receiving their arterial intervention at high volume arterial hospitals with 24/7 cover from a team of specialists dedicated to the treatment of patients with vascular disease. It is also clear from this volume outcome data that the results of vascular intervention are not only dependent upon the mortality and morbidity associated with the primary procedure, but also the availability of experts to deal with complications as and when they occur.

6.6 Coupled with the introduction of the 48 hour week, the reduction in both consultant and trainee numbers which will result from specialty status, and the strict mortality standards set for the provision of aortic aneurysm surgery by the NAAASP, it is apparent that the Society's advice on the provision of vascular services to our patients requires updating.

6.7 The current Vascular Society advice is that high quality world class vascular care can be delivered in the UK with the establishment of high volume arterial centres. Modern clinical networks of care should be established for the assessment and treatment of vascular patients who do not require arterial intervention in network hospitals nearer to their homes."

This highlights a major concern that networks with arterial procedures on more than one site (as proposed in the two arterial centre model) are at risk of not providing a resilient and sustainable 24/7 emergency on call service.

The NSS identifies that a vascular hub must provide a minimum 1:6 vascular surgeon and 1:6 vascular interventional radiologist 24/7 emergency on call rota. Whilst both UHS and PHT provide 24/7 vascular emergency cover, this is not provided by 6 full time equivalent (FTE) vascular surgeons. This means that those involved in the emergency rota are providing cover in excess of a 1:6 rota which is not considered sustainable and which over stretches participants. This is neither in the interest of the surgeons nor the patients.

POVS15 identifies that " *Interventional radiologists are radiologists who have undergone additional specialist training in the practical elements of interventional procedures. Interventional Radiology (IR) procedures are minimally invasive, targeted treatments performed under imaging guidance. A range of procedures are performed in oncology, urology, gynaecology, GI and hepatic conditions as well as vascular disease. Diagnostic radiology remains a core element of IR. There are however additional clinical responsibilities on the interventional radiologist for preintervention assessment, consent and follow–up.*

Interventional Vascular Radiologists and Vascular Surgeons have traditionally worked in collaboration to provide endovascular aneurysm repair and angioplasty and stenting for the treatment of peripheral and aortic vascular disease."

The Royal College of Radiologists (RCR) IR training programme provides training in both vascular and non vascular IR. A fellowship can then be completed in vascular IR for those who wish to specialise. A vascular IR should have basic competency in EVAR, arterial angioplasty and stenting and thrombolysis. High risk vascular IR procedures include Arteriovenous Malformation (AVM), venous intervention, fEVAR, thoracic EVAR and fistuloplasty.

Neither site have been able to provide 24/7 emergency vascular interventional radiologist (IR) cover which has meant that there are occasions where endovascular procedures, which can reduce the need for major surgery, with its associated risks, enable patients to recover more quickly, and reduce their length of stay in hospital, may not be available to emergency patients.

UHS currently has 6 Vascular Surgeons (one of whom supports minor paediatric at RHCH) and 9 Interventional Radiologists, of whom 5 undertake vascular work, who provide a 1:6 emergency vascular on call service.

The recent redeployment of a consultant has left PHT with 2 Vascular Surgeons and 1 part time who is also a renal transplant surgeon leaving a rota of, at best, 1:3. There are also 5 Interventional Radiologists, of whom 1 currently undertakes EVARs, who provide a 1:5 emergency on call service. PHT have Board approval to recruit additional Vascular Surgeons, but have been unable to do so. PHT believe this is due to the on-going uncertainty surrounding service provision. PHT would need to recruit 4 additional Vascular Surgeons to facilitate a 1:6 emergency rota.

Taken as whole these shortfalls against national standards mean that the local NHS is not able to consistently provide the quality of care that patients are entitled to expect; and which is compliant with NHS England's Vascular NSS. This is no reflection on the commitment of staff providing local vascular services. It does, however, highlight the need to change the way in which their services are organised. Elsewhere in the country, patients are already benefiting from changes which have been put in place to deliver the NSS standards

Without doubt, a single MAC would provide resilience and sustainability, and a far less onerous on call ratio for vascular surgery and vascular interventional radiology. Equally, both sites are currently at risk if a key member of the vascular team becomes incapacitated. The workforce resilience issue is an area that commissioners have been closely monitoring. The PHT position is currently unsustainable.

On the assumption of an approximate split of time between in and outpatient services of 50% (based on the approximate split of financial payments), and considering the minimum number of surgeons required to provide a safe service of 1 per 150,000 population, PHT

would require a minimum of 2.15 vascular surgeons on site through the working week to undertake outpatient services alone as a Non-Arterial Centre..

3.2.5 Vascular Services - Financial Break Even Point

UHS identified in 2010 that vascular services were running at a 15% loss.

Whilst UHS has a population of 900k and PHT 650k, the demographics of the PHT population has resulted in some vascular procedures being proportionally higher at PHT (see Table 1).

An estimate of costs (Appendix J) suggests that to staff a 22 bed vascular ward with a minimum of 6 vascular surgeons and 6 interventional radiologists would be in the region of £3.4 million. This would require an income of £6.8 million to cover staffing and infrastructure costs. This would suggest a roughly 25% increase in population to reach a break even point i.e from 900k to 1125k for UHS and from 650k to 837k for PHT, assuming a similar demographic distribution.

The requirement for a minimum 6 vascular surgeons and 6 vascular interventional radiologists to allow a minimum 1:6 24/7 emergency on call rota dictates this as a minimum number, rather than vascular services required by patients. It would appear that the current staffing levels may be more demand-driven.

3.2.6 Public Opinion

Historically, public opinion in Portsmouth, driven by the local media, has been opposed to arterial surgery moving off the PHT site. Efforts have been made to better inform the public and the media and this will be on-going in terms of the Communications & Engagement work stream. Since the announcement of NHS England's decision to pursue a clinically-led solution following the Vascular Society Review, there has been little sensational media coverage. Local clinicians have been speaking informally at various fora supportive of the move to a single arterial centre. The Public reaction indicates two concerns; firstly that moving vascular surgery would result in the loss of other services at PHT and secondly concerns about transport for patients and carers. The communications and engagement strategy seeks to understand more of the detail of these issues in order to ensure the development of the patient pathways are informed by patient experience. The narrative will also offer assurance that dependent services will be supported at PHT. It will also highlight other services which result in patients being treated at either UHS or PHT involving transport between the two centres and demonstrate that for some more specialised procedures quality of treatment outweighs the inconvenience of transport.

3.3 Options Appraisal

3.3.1 Do Nothing

It has been established that 'Do Nothing' is not an option as neither UHS nor PHT are currently compliant with either POVS guidelines or the NSS.

3.3.2 Single Major Arterial Centre

3.3.2.1 Background

All arterial services to be delivered at UHS, with PHT joining as a Non-Arterial Centre (NAC) the existing operational network (now formally designated the Wessex Vascular Network (WVN)) which has UHS as a hub, in addition to the existing spokes (Winchester and IoW).

3.3.2.2 UHS Wessex Major Arterial Centre

As UHS is a Major Trauma Centre (MTC) which must have vascular services co-located, any proposal for a single hub would mandate that it is sited at UHS.

The recent VS review identified that "*There are busy and successful co-dependencies (diabetic foot services, nephrology and urology) that would require significant support if Portsmouth was to become a spoke hospital*". The VS confirmed that none of these services required on site 24/7 vascular services and that this could be provided by a network hub.

The clinicians across both sites are unanimous in their view that the strategic solution is to have one network with UHS as MAC and PHT as NAC. The lead vascular surgeons at PHT and UHS, Mark Pemberton and Mike Phillips, have developed a clinical vision of how services will be delivered (Appendix K) . The clinical vision includes the following description of MAC services:

"*This will be where most arterial procedures (abdominal aortic aneurysm, carotid disease, leg bypass and trauma) and emergency work will be undertaken.*

There will be 10 vascular surgeons serving the Wessex Vascular Network. Three will be contributing to the non-arterial activities at QAH (see above (sic description of PHT as Non-Arterial Centre)), one will have activities at Winchester and one on the IoW. As a group, all surgeons will have the flexibility to provide cover at each of the non-arterial centres, mainly during times of annual, study and sick leave. All surgeons will undertake a SOTW slot at UHS and take part in the on call rota.

The well-established SOTW at UHS will continue but in an expanded form. The additional duties will include managing emergency patients from QAH and liaising with the QAH surgeon over repatriation. This will be reflected in the on call arrangements, where the rota will be 1 in 10. To allow for the increase in volume of work load, particularly at night, the surgeons will be given appropriate time off. For instance a surgeon on call at night or weekend will hand over to the SOTW in the morning and will have no elective duties that day.

There will be five vascular interventional radiologists based at UHS and a rota of 1 in 6 or 1 in 7 will be created with the vascular radiologists from QAH. All the radiologists (UHS and QAH) will undertake complex endovascular and EVAR work at the arterial centre.

A hybrid lab (a facility that can accommodate vascular surgery and interventional radiology at the same time) will be available to undertake vascular procedures, both elective and emergency. There will be 2 EVAR lists (2 days or the equivalent of 4 sessions) per week, which will undertake most of the endovascular aneurysm work from the network. An additional list will be available for other work that requires surgery and radiology at the same time (e.g. combined bypass and angioplasty). The hybrid lab will also be used for TAVI (cardiology) procedures.

The current vascular theatre will be made available for 5 full days per week (currently not in use for approximately 1 day/week when EVAR lists occur and during annual leave) to undertake other vascular procedures and will be run by network surgeons and anaesthetists. This is where most of the carotid (150) and bypass operations (100) will be undertaken as well as other procedures including unplanned work. For emergencies, the CEPOD list will continue to be used.

The vascular ward will move from D4 to E4. There will be an increase in beds from 22 to 34 in a refurbished ward with vascular-orientated facilities including a treatment room. The success of this ward will be dependent on careful repatriation planning to local hospitals. A joint appointment of a vascular nurse specialist or similar will facilitate the transfer of patients between the 2 sites. This ward will receive emergency vascular admissions and transfers on a 24 hour basis.

The current allocation of deanery trainees will need to be directed to where training opportunities occur within the network, irrespective of whether this is the arterial or non-arterial centres. Vascular training will be based at the arterial hub with trainees being allocated to appropriate sessions in the spoke hospitals based on the training requirements. Vascular Surgical trainees and general surgery trainees who are undertaking a period of Vascular Training in the hub will take part in a vascular emergency rota (under consultant supervision) to give them exposure to the management of vascular emergencies.

The Wessex Vascular Network will require a full complement of junior doctors (training and non-training grades) sufficient to support an out of hours registrar-equivalent on call rota which will be based at UHS. Out of hours vascular problems at QAH will be assessed by the general surgery registrar on call and discussed with the consultant vascular surgeon at the arterial centre

A vascular lab where non-invasive vascular investigations take place needs to be re-established in UHS as a matter of urgency. This will require cooperative working between medical physics and radiology.

A weekly half-day multidisciplinary vascular learning/teaching slot will be established for training all grades of clinicians involved in the delivery of vascular care. This will include the discussion of mortality and morbidity and other governance issues.

There will be a weekly MDT to discuss patients across the network using the video conference facilities, so that workers at the arterial and non-arterial centres are fully engaged. Because of the large volumes of cases to be discussed, a separate aortic MDT is likely to be required."

3.3.2.3 PHT Wessex Non-Arterial Centre

As identified in the VS report " *There are busy and successful co-dependencies (diabetic foot services, nephrology and urology) that would require significant support if Portsmouth was to become a spoke hospital*."

The clinical vision developed by Mike Phillips and Mark Pemberton includes the following description of NAC services:

"*There will need to be 2-3 vascular surgeons working at QA. This is a busy city hospital and an on site presence is required to support dependent services such as A&E, diabetes and the renal failure unit as well managing patients with vascular disease under other specialities on the wards and in outpatients.*

This would mean one surgeon at QAH acting as 'surgeon of the week' (SOTW), able to attend A&E, theatres and inpatients at short notice. A facility to see patients on an urgent clinic basis will be provided, supported by the vascular lab. They will also need to review vascular patients who are rehabilitating. If necessary, the SOTW will liaise with UHS if an urgent transfer is required. This service will be 8am-6pm and supported by vascular nurse specialists. Junior doctors are not required (other than foundation doctors on the wards) but can be present for training in out patients, vascular access and in vascular radiology. The current trainees will follow the arterial work to UHS. Out of hours and at weekends, the on call general surgery registrar at QAH will see and assess patients with vascular problems and discuss with the on call vascular surgeon who will be based at UHS. A single session/week list will be required to undertake minor vascular procedures such as debridement.

The second surgeon will be undertaking elective outpatients and peripheral clinics (Havant, Petersfield and Gosport) and attending day case theatre and working on administration. They will also attend patients in preassessment clinic. The 3rd surgeon who works at QA, will, as the other 2 surgeons, work at UHS undertaking arterial elective work and on call and SOTW duties.

Where possible, one surgeon will work extended hours to cover the QAH site in the evening In order to ensure that at least one consultant vascular surgeon is on site at QAH during office hours, flexibility will be built into all network surgeons' job plans and the rota.

Interventional vascular radiology will be available on a day case basis (for angioplasty and diagnostics). Cases for intervention will be discussed in a combined vascular MDT (with the arterial centre) as to suitability as day cases. The cross-sectional imaging service (CT and MR angiography) and Vascular Lab for duplex imaging will continue to be used as now. The vascular radiologists based at QAH will also be attending UHS to perform complex endovascular procedures and EVAR.

Renal failure patients (those undergoing regular dialysis) will be seen and assessed at QAH. Patients who require management of haemodialysis fistulas will continue to be cared for by the separate renal transplant team. Where possible these patients will remain at QAH. If they require urgent intervention, transfer will be made to UHS. If the inpatient stay at UHS is significant, arrangements will be made for temporary haemodialysis in the same way as other specialties (such as neurosurgery and cardiac surgery) undertake at present. This should not be more than 5 patients/year.

Patients with diabetes and peripheral vascular disease will largely be managed at QAH except where there is a need for bypass surgery, complex interventional radiology or major amputation. A weekly MDT (involving diabetologists, podiatrists and vascular surgeons and radiologists) for these patients will be established at QAH.

Other specialists such as anaesthetists will be encouraged to follow their patients to UHS. The vascular lab and therapy teams do not need to change but will work closely with their UHS counterparts particularly with repatriated patients.

The current QAH vascular ward that is shared with urology will receive less patients but will continue to play an important role in admitting and caring for patients for rehabilitation and those that do not require transfer to UHS. As there will be a significant presence of vascular surgeons at the QA site these patients could be cared for under their names. It is important that the QA diabetic and podiatry teams be involved in managing these patients, who will have had minor amputations at QAH or will have returned from UHS having undergone limb-saving procedures such as a bypass and major amputations."

3.3.3 Two Major Arterial Centres

3.3.3.1 Background

UHS and PHT continue as arterial centres, but collaborate to maximise efficiencies, resource utilisation and to provide improved clinical services.

UHS and PHT currently both provide arterial services. UHS operates an existing network with HHT and IoW as spoke hospitals. PHT acts as a standalone centre.

The VS report states "In terms of the future – it would be possible to make both units POVS compliant and stand alone. This would involve Portsmouth providing vascular services for Chichester and both units would require substantial investment with consultant appointments and development of facilities. However this model would probably only be sustainable in the

short term. In the long term both units may have difficulty in recruiting consultants and trainees and 7 day working would need more consultants on a 1 in 8 rota or greater."

St Richards is currently part of the Sussex Vascular Network with Brighton as the hub. At the end of 2014, the vascular surgeon who had provided services to St Richards resigned and Brighton had difficulties in recruiting a replacement or locum. The travel time meant that other vascular surgeons were unable to provide a full outreach service which has resulted in Portsmouth providing some informal out patient clinics (and elective referrals). It is understood that a vascular surgeon has now been appointed by Brighton.

Since 2014, St Richard's Hospital, Chichester has been a non-arterial spoke in the Sussex Vascular Network, with the hub at Brighton & Sussex University Hospitals (BSUH). Clinical services provided at St Richard's Hospital in Chichester consist of vascular outpatient clinics, minor amputations and varicose vein related procedures. Facilities include non-complex interventional radiology and a vascular laboratory.

The Sussex Vascular Network is now compliant with the National Service Specification following the recent appointment of a vascular surgeon. With the establishment of the Wessex Vascular Network, under normal patient choice arrangements, Chichester and West Sussex patients will be able to access elective non-arterial and out-patient services either at the St Richard's site from the Sussex Vascular Network or at the Queen Alexandra Hospital site in Portsmouth from the Wessex Vascular Network. They will be able to have elective major arterial surgery carried out either at BSUH by Sussex Vascular Network staff or at University Hospitals Southampton (UHS) by Wessex Vascular Network staff. NHS England and both Vascular Networks will continue to work with the ambulance services to establish conveyance protocols for patients in West Sussex with a vascular emergency, who may be received at either BSUH or UHS. Both vascular networks seek to advance the principle of "care closer to home" by ensuring that pre-operative and post-operative outpatient visits will be increasingly available at the respective hub sites.

3.3.3.2 UHS - Existing Network Hub - Compliance Issues

UHS already acts as a hub in the existing network with HHT and IoW. The VS review identified that UHS, a Major Trauma Centre, does not currently provide an adequate vascular service as a network hub and, in particular, does not provide 1:6 24/7 vascular IR rota.

Investment is required to address compliance issues. Under a two MAC agreement, it would be difficult to generate sufficient income in order to make the necessary investment.

3.3.3.3 PHT Existing Arterial Centre - Compliance Issues

The NSS states that all Trusts that provide a vascular service must belong to a vascular provider network and it is envisaged that all arterial surgery will be provided at a vascular centre. PHT is not currently in a network but is standalone.

The VS report states "The *vascular surgical rota at Portsmouth is poor. They have 6 surgeons but one does no on call and one is also on the transplant rota at the same time. We have since learned that one surgeon will shortly be leaving. The majority of the vascular work at Portsmouth is done by 1-2 surgeons and according to the National Vascular Registry (NVR) one surgeon does no aortic work and another did no aortas in a 5 year period.*"

The report also identified that one of the on call surgeons is a renal transplant surgeon who is also on call for renal at the same time; this is not acceptable practice.

The surgeon referred to by the VS has now left PHT. By necessity, PHT will continue to act as an arterial centre until a strategic solution is agreed and implemented. PHT do not currently have a sustainable workforce. Contingency planning in October 2015 suggested that the current on call rota could be sustained until mid-December 2015 at which point a locum will need to be recruited. This in fact was unsuccessful and the locum position has been re-advertised. The on call rota is being supported on a voluntary basis by UHS surgeons.

PHT have been unable to recruit permanent vascular surgeons. PHT attribute this to the uncertainty of the future of vascular services at PHT.

In 2009 PHT shared a vascular service with St Richards, Chichester providing a vascular service to a population exceeding 800,000. This service was established by clinicians in order to maximise patient service provision. This service was dismantled when the national vascular reviews were undertaken in 2009. The Chichester HOSC chair requested in March 14 that that the Chichester population should be considered in the Southern Hampshire review of vascular services reconfiguration.

Chichester population is 230k which would increase the total population covered by PHT to 870k. The inclusion of Chichester patient numbers in a network with PHT might marginally increase income sufficiently to reach a break even position, but not if the demographic of the Chichester population was more akin to that covered by UHS. Without the addition of Chichester, the PHT population of 650k does not make the necessary investment in workforce to provide a 1:6 rota for a 24/7 on call emergency service cost-effective. With the addition of Chichester, cost-effectiveness will at best be marginal.

In addition, this would have the potential to destabilise the Sussex Vascular Network with the resulting reduction in population covered.

As identified by the VS, whilst it might be possible to establish two networks were Chichester a spoke hospital in a network with PHT as a hub, this would result in two networks which are unlikely to break even on the cost of vascular services provision, and which are also marginal in terms of procedure numbers. In addition, the VS assumption had been that this would require funding for two additional PHT vascular surgeon posts. PHT would currently need to recruit four additional surgeons to become a viable centre. Neither network can afford to invest sufficiently to become fully compliant without additional income.

In particular, in consideration of AAA procedures, the VS had established a minimum of 60 per annum on the basis that 6 vascular surgeons needed a minimum of 10 procedures to maintain professional competency. In fact, most providers see sub-specialisation occurring whereby a smaller number of surgeons perform the majority of AAA procedures. This is compounded by the fact that where EVARs are performed, the lead surgeon is 'credited' with the EVAR, even though they may not perform endovascular procedures and these may have been performed by a vascular interventional radiologist.

The 2014/15 figures show that PHT carried out 64 AAA procedures, only just reaching the minimum number for surgeons to maintain professional competency. In fact, as previously identified, the majority of vascular work is carried out by 1-2 surgeons. This means that emergency patients may be seen by a surgeon who is not considered to have undertaken the requisite number of procedures required by the VS to maintain professional competency.

3.3.4 Recommendations

The challenges which will face vascular networks in terms of seven day working, workforce sustainability and sub-specialisation (and the migration from open surgery to endovascular procedures), together with infrastructure investment, are likely to prove prohibitive for smaller networks to provide comprehensive vascular services on a sustainable basis and remain financially viable.

In addition, trends suggest that there will be insufficient procedures to maintain currency of skills for vascular surgeons and vascular interventional radiologists unless services are centralised to a smaller number of centres.

Current trends show reductions in ruptured aneurysms due to the (AAA) screening programme. The reduction in smoking, and improvements in diabetic care, are also seeing reductions in vascular procedures, with fewer strokes and gratifying improvements in amputation rates.

Technological advances, and the concomitant investment in supporting technologies has seen a trend towards the vast majority of elective AAA procedures (85%) being EVAR rather than open procedures. This, in itself, requires a different workforce skill set of complex endovascular techniques, with even more complex endovascular and minimally invasive procedures being undertaken, in addition to emergencies being increasingly endovascular procedures.

With the future likely to see a seven day week requiring on call rotas to increase from 1:6 to 1:8, together with the increasing sub-specialisations, not only will smaller units find it financially not viable, but it is likely to improve increasingly difficult to recruit surgeons and IRs when the opportunity exists to join larger world class centres – in which the trainees will be concentrated.

Both hospitals have experienced difficulties in providing 24/7 IR on call rotas. POVS15 identifies "*There is currently a particular shortage of practitioners trained to deliver endovascular therapies out of normal working hours. Collaborative, network wide, on call rotas combining interventional vascular radiologists and endovascular trained surgeons are potential solutions to this problem and need to be developed further.*" A pooling of resources should provide a network wide solution.

It is recognised that in the context of these challenges, and the recommendations of the VS, a strategic solution for Southern Hampshire must be developed. In terms of options, 'do nothing' has already been ruled out as current services are not compliant with the NSS. The options identified by the VS are to make both sites POVS compliant and standalone or to create a longer term sustainable high class vascular facility by centralising services at UHS.

All expert clinical reviews undertaken since 2009 have recommended that PHT join UHS in a network, with major arterial services being provided by UHS. For many years UHS and PHT have provided good vascular services to local patients and currently both have excellent outcomes. It is highly likely that these services have been provided at a loss; this is also likely to be the reason why there is a reluctance to invest in further resource to achieve a full 1:6 complement which procedure numbers may be unable to support in full time employment.

It is acknowledged that the introduction of a hub and spoke network may result in an overall increase in workload as travel between hub and spoke is an overhead. The advantages of scale, however, are likely to outweigh this overhead.

It is recommended that the VS case for moving to a sustainable long term solution of a single hub with a strong network integrating clinical pathways across Hampshire be implemented.

It should be noted that neither PHT nor UHS consider that they are in a position to address existing shortcomings in service until this decision has been taken and that time is of the essence as the PHT workforce is now unsustainable.

Once this decision has been taken, a plan must be developed to address these shortcomings as a matter of urgency. There is already agreement for a joint appointment to recruit a vascular surgeon to the strategic network, who will initially address the shortfall at PHT. There is also a need for the development of network-wide interventional radiology services utilising existing resource from both sites. It is recognised that PHT interdependent services are highly dependent upon IR and this aspect of service must be fully catered for.

4. Expected Benefits

4.1 Compliance with NSS and POVS15

One larger network will generate sufficient income at the MAC to fund the investment required to become fully compliant with the NSS and POVS15 guidance.

4.1 Patient Outcomes

Patients will have the choice to attend a fully compliant vascular network service provider. Wider expertise and excellence should facilitate continued excellent outcomes.

The potential for greater sub-specialisation should mean that more complex procedures will be done locally rather than being referred to London.

Whilst patient outcomes meet or exceed targets at both Trusts, a single clinical network will facilitate compliance with VS standards for 24/7 emergency on call rotas adequately resourced. Neither provider has historically been able to provide this service.

4.2 Cost Effective Service

A network covering a population of 1550k should not only facilitate development of a service which is cost effective and optimises resource, but will future-proof the service if the forecast trends materialise. Neither site on their own could sustain a 1:8 rota either in terms of cost effectiveness or in terms of numbers of procedures to maintain individual professional competency.

POVS15 states "*The provision of an effective vascular service is relatively expensive. Vascular units have high bed occupancies, particularly where repatriation in the network is delayed. The surgery is technically challenging with significant demands on both theatre time and critical care. readmission rates due to disease progression are significant. advances in endovascular treatment may offset some of this expense, but many of those procedures are also technically demanding, and time-consuming and require sophisticated and often expensive facilities and disposables. Replicating these services in every hospital is not cost effective.*"

4.3 Workforce

Not only will a network of this size facilitate the provision of a 1:8 emergency on call rota, it will also provide an attractive environment facilitating specialisation, complex procedures and training and research opportunities. In an increasingly competitive marketplace, with known shortages of skills, this will provide a competitive advantage in recruiting and retaining vascular surgeons, vascular interventional radiologists and trainees of the highest calibre. The numbers also provide contingency in terms of on call servicer provision.

UHS and PHT already have joint MDTs for vascular services and the existing informal links will be formalised.

Clinicians will have increased opportunities for sharing expertise, supporting learning and development, and career development.

In addition, the provision of one rather than two 24/7 emergency on call services will result in cost savings.

4.4 Future Proof Network

If the forecast trends materialise, this strategic solution will future-proof the network.

5. Expected Dis-benefits

5.1 Additional workforce travel between sites

Additional travel should be offset by the cost savings resulting from the provision of one rather than tow 24/7 emergency on call services.

5.2 Additional ambulance by pass and transfers for repatriation

PHT Procedure Numbers 15/16

Procedure	No.	To UHS	LoS UHS (nights)	From UHS	LoS PHT (nights)
AAA Open	18	Private	1	Private	n/a
AAA EVAR	36	Private	1	Private	n/a
rAAA	12	Ambulance	?	?	?
CEA	81	Private	1	Private	n/a
By Pass	90	Ambulance	2-3	Ambulance	?
Major Amputation	69	Ambulance	3-5	Ambulance	?

The detailed numbers of procedures, transfer modes and estimated length of stay are being evaluated in accordance with revised pathways and protocols; these figures will be updated following this work.

5.3 Additional patient and family travel

The visiting hours at UHS are from 15.00pm to 20.00pm and parking charges are from £2.00/hour. Table 6 illustrates the likely travel implications for various options.

Table6 Travel Options

Option	Route	Mode	Time each way (Approx)	Cost return (From)*
Train / Bus	Portsmouth & Southsea Rail Station to Southampton Central Bus Station	Train	40 mins	£11.00
	Southampton Central Rail To Bus Stop (Wyndham Place)	Walk	02 mins	-
	Bus Stop (Wyndham Place) to UHS	Bus	25 mins	£2.50
		TOTAL	67 mins each way	£13.50 return
Coach / Bus	International Port, Wharf Road to Southampton Central Coach Station	Coach	50 mins	£6.00
	Southampton Central Coach to Bus Stop (Wyndham Place	Walk	07 mins	-
	Bus Stop (Wyndham Place) to UHS	Bus	25 mins	£2.50
		TOTAL	82 mins each way	£8.50 return
Car	Portsmouth & Southsea Rail Station to UHS (23 miles @ 0.45 per mile))	Car	33 mins	£20.70 return
Taxi	Portsmouth & Southsea Rail Station to UHS	Taxi	33 mins	£80.00 return

The above times and duration of journey was taken on the base of a person arriving at Southampton General Hospital by 3.30pm on Monday 8th February 2016.

* Transport costs vary depending on time of travel / booking.

5. 4 PHT loss of income

A separate evaluation of financial impact will be undertaken when proposals are finalised. This will include the opportunity for UHS to utilise PHT capacity where appropriate outside of vascular services.

6. Timescale

A high level plan has been circulated with the Business Case. Following approval of recommendations, UHS will develop detailed capacity and transfer plans, together with a target transfer date.

7 Costs

It is anticipated that costs incurred by providers will be met within their existing financial plans.

8. Investment Appraisal

8.1 Contract Income

The following tables show the vascular contract income predicted for 2014/15. These are based upon month 1-6 data provided by Provider and extrapolated to full year (Table 8.1.3 is based upon the transfer plan outlined in Section 3.3.1).

Table 8.1.1 Vascular Contract income as % of Provider Turnover

Provider	Turnover (£m)	Contract Income	% of Turnover
UHS	644.5	5.4	0.8
PHT	476.1	5.3	1.1

Table 8.1.2 Vascular Contract income by Commissioner

Provider	Commissioner	14/15 Plan (£m)	14/15 FOT (£m)	Difference (£m)
UHS	CCGs	3.8	3.6	(0.22)
	NHS England	1.6	1.6	0.04
	Total	5.4	5.2	(0.20)
PHT	CCGs	4.1	3.9	(0.20)
	NHS England	1.0	0.9	(0.10)
	Total	5.1	4.8	(0.30)

Table 8.1.3 Projected income transfer

Phase	Timeframe	Procedures	Cost (£)
Phase 1 (requiring 1 months notice)	Months 1-6	17 rAAA for surgery 14 elective open AAA 10 patients from NAAASP screening programme 10 rAAA non-operative	141,457 104,888 86,102 63,140
		SUB TOTAL	395,587
Phase 2	Months 6-12	34 EVARs	201,654
Phase 3	Month 12-18	52 CEA	209524
Phase 4*	Month 19-21	76 Inguinal Bypass	561,222
Phase 5	Month 22-24	71 Lower limb amputations	1,108,994
		TOTAL	2,476,981

* included 100 Vascular emergencies - no costing available

It should be noted that the contract income figures are based upon 14/15 figures extrapolated from the first 6 months Provider figures whilst the projected income transfer is based upon the 13/14 procedure figures. Whilst this does not provide a direct like for like comparison, the assumption has been made that, for the purposes of a high level overview, this is acceptable. On the basis of the above figures, a working assumption has been made that, in terms of total vascular income, the split is approximately 50:50 in terms of outpatient and inpatient.

8.3 UHS Capital investment

It is understood that UHS capital investment will be from existing capital budget.

8.2 Transition Costs

None identified

8.3 Ambulance Costs

It is understood that these would be incorporated within current contracts.

9. Major Risks

9.1 Inability to maintain sustainable 24/7 emergency on call

It is acknowledged that the PHT emergency on call rota is not sustainable. It is providing 24/7 cover by PHT surgeons working 1:2/3 rota with some voluntary support from UHS surgeons. There is a high risk that this will not be sustainable until a strategic solution is implemented.

Mitigation: UHS have been asked to provide a contingency plan identifying an interim solution of the transfer of all emergency services from PHT to UHS.

9.2 Workforce - inability to recruit and retain full complement

There is a projected shortfall in both vascular surgeons and vascular interventional radiologists in the next five years. In addition, existing surgeons will be retiring.

Mitigation: The strategic solution will facilitate the provision of a centre of excellence for both working and training to attract recruits.

9.3 Seven day working

Seven day working will see a requirement to change working patterns further.

Mitigation: The strategic solution will facilitate a 1:10 vascular surgeon rota which will permit a seven day working rota. .

10 Four Tests and Best Practice Checks

NHS England has developed a guidance toolkit for effective service change[10] which provides an assurance framework. The single MAC model is evaluated against this framework (see Appendix K)

10.1 Equality & Impact Assessment

Evidence
What evidence have you considered? People with diabetes are at a higher risk of vascular disease. Prevalence of diabetes is caused by a number of factors such as an ageing population, obesity and low levels of activity. Another important factor for diabetes is the changing ethnic mix of the population. People from black and minority ethnic communities are six times more likely to develop the disease, suffer from a 50% increased risk of heart disease and have much higher levels of kidney disorders. The care of people with diabetes can also be complex with 25% of people suffering from three or more other long-term conditions. NHS England now has an accessible information standard which needs to be considered/adhered to in the engagement https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-upd-er-july-15.pdf
Age Patients using vascular services tend to be older. Although there is an increasing prevalence of older people using online services it will be important for the communications and engagement process to consider the needs of older people by producing some documentation in print/large print to allow for age-related changes in vision.
Disability • Because a proportion of patients accessing vascular services have diabetes it is likely that some will have visual impairment beyond the usual age-related changes in vision. This means that the consultation will need to be available in alternative formats. These patients will be unable to drive and may have

[10] NHS England: Effective Service Change: A Support and Guidance Toolkit: Publications Gateway reference 00814

difficulties accessing public transport so consideration needs to be given to whether they will be able to attend meetings. • Arterial disease in some patients requires lower limb amputation which will also affect accessibility to attend meetings • Patients with chronic mental health problems and learning disability (particularly Down's) are at increased risk of diabetes and arterial disease. There will be a requirement for easy read versions of documentation
Gender reassignment (including transgender) No impact
Marriage and civil partnership No impact
Pregnancy and maternity No impact
Race Diabetes is more common in people of South Asian origin with earlier onset of significant arterial complications. People of Afro-Caribbean origin are more prone to high blood pressure which may be more difficult to control than in other groups, hence increased incidence of renal disease and stroke. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design. It will also be appropriate to make translations available for people whose first language is not English.
Religion or belief Patients whose religion or belief does not allow blood transfusion or particular blood products will have complications relating to accessing vascular services.
Sex Vascular disease is more likely to affect men than women. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design.
Sexual orientation No impact
Carers As vascular patients tend to be older and may already have disabilities (or develop a disability as a result of vascular surgery/amputation) they may already have a carer or may need the support of a carer. The consultation will seek to engage with carers to understand the impact of the proposals and possible solutions such as community transport for visitors.
Other identified groups. Parts of Portsmouth and Southampton have areas of socio economic deprivation. Smoking, obesity and low levels of activity are more common in areas that have socio economic deprivation. As these lifestyle risk factors are also linked to prevalence of diabetes (and therefore risk of vascular disease) the communications and engagement must consider the communications needs of this group. A review by Ofcom indicates that socio economic deprivation influences access to ICT which can itself be a form of social exclusion.

However, more recent research by Public Health England for the One You campaign shows people aged 40-60 in lower socio economic groups are heavy users of mobile communications including text messaging and digital social media such as Facebook. The mix for the campaign needs to take these preferences into account.

Engagement and involvement
How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available? Sharing of this document with Council for Voluntary Services; Healthwatch; Health Overview and Scrutiny; Establishment of Patient Reference Group
How have you engaged stakeholders in testing the policy or programme proposals? Sharing of this document with Council for Voluntary Services; Healthwatch; Health Overview and Scrutiny; Establishment of Patient Reference Group
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs: TBC as engagement is implemented

APPENDIX A A04/S/a 2013/14 NHS Standard contract for Specialised Vascular Services (Adults)

A04/S/a

2013/14 NHS STANDARD CONTRACT
FOR SPECIALISED VASCULAR SERVICES (ADULTS)

PARTICULARS, SCHEDULE 2- THE SERVICES, A- SERVICE SPECIFICATIONS

Service Specification No.	A04/S/a
Service	Specialised Vascular Services (Adults)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National Context

Vascular disease relates to disorders of the arteries, veins and lymphatics. Conditions requiring specialised vascular care include: lower limb ischaemia; abdominal aortic aneurysm (AAA); stroke prevention (carotid artery intervention); venous access for haemodialysis; suprarenal and thoraco- abdominal aneurysms; thoracic aortic aneurysms; aortic dissections; mesenteric artery disease; renovascular disease; arterial/graft infections; vascular trauma; upper limb vascular occlusions; vascular malformations and carotid body tumours.

The scope of the specialised service includes deep vein reconstruction and thrombolysis for deep vein thrombosis (DVT) but excludes varicose veins and inferior vena cava (IVC) filter insertion.

The prevalence of vascular disease increases with age. Average life expectancy continues to rise especially in males. This suggests that demand for vascular services is likely to increase over time. There are currently an estimated 3m people with diabetes mellitus in England, and prevalence is increasing. Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade.

Smoking is a major cause of vascular disease and over 80% of vascular patients are current or ex smokers. Around 20% of the population over 60 years of age have peripheral arterial disease, with about a quarter of these affected being symptomatic. Approximately 4% of men aged 65 have an enlarged aorta although not all go on to develop a significant aneurysm. The National AAA Screening Programme (NAAASP) will be fully instituted in the next year.

Historically the UK does not compare well internationally for certain vascular procedures. It had the highest mortality rates in Western Europe following elective abdominal aortic aneurysm surgery (7.9% UK vs 3.5% Europe (Vascunet 2008) and is among the slowest nations for uptake of new endovascular technology. Patients are not always treated by a vascular specialist and stay longer in hospital following their surgery than the rest of Europe. There are also significant gaps in the provision of emergency vascular interventional radiology services.

The Vascular Society of Great Britain and Ireland (VSGBI) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) have called for a reorganisation of vascular services for emergency and elective care to optimise outcomes for patients. The Abdominal Aortic Aneurysm Quality Improvement Programme (AAA QIP) was initiated after the UK's higher mortality was recognised.

A minimum population of 800,000 is considered necessary for an AAA screening programme and is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service, maintain competence among vascular specialists and nursing staff; the most efficient use of specialist equipment, staff and facilities, and the improvement in patient outcome that is associated with increasing caseload.

Over the last few years there have been a number of changes in the structure of vascular services which will start to influence and improve service quality, efficiency and clinical outcomes. However more restructuring will be required to deliver high quality services on an equitable basis. A number of services are currently under active review with implementation plans delivering service changes during 2012/13. Progress will need to continue on these reviews and the further reviews required, ensuring the appropriate service configuration is achieved in the next 2-3 years. The context of these reviews also needs to take into account changes in training and the service implications, for all the specialists involved in the delivery of vascular services. Vascular surgery became an independent specialty in 2012.

Local Context

Evidence Base

In outlining the level and nature of service expected from providers, this service specification is written in the light of the recommendations and published evidence of

the Department of Health (DH), the VSGBI, the Royal College of Radiologists (RCR), NCEPOD and all relevant NICE Guidance.

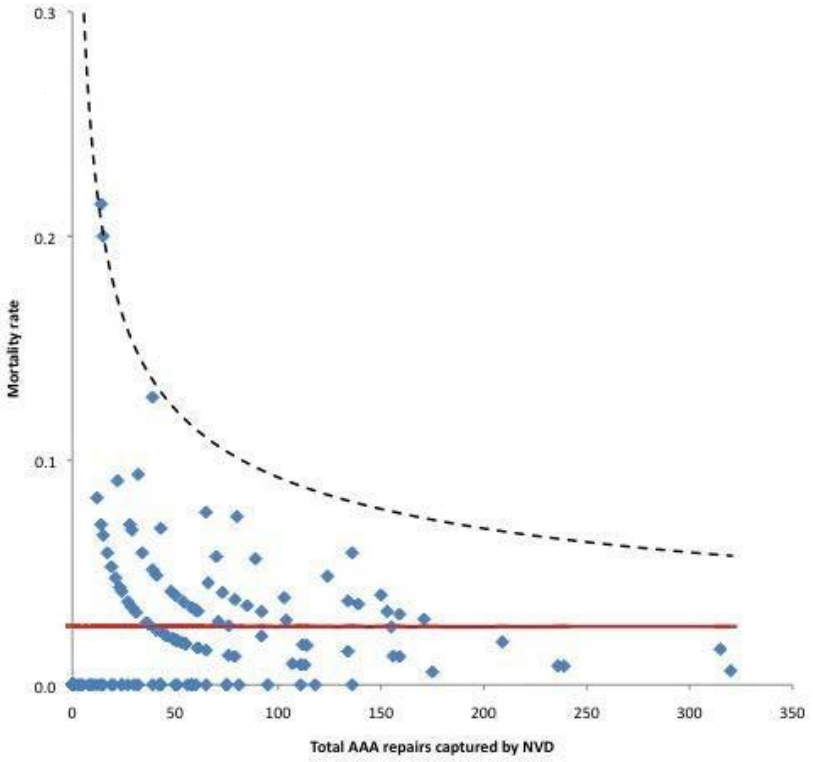
The NCEPOD Report 2005 into patient outcome and death following abdominal aortic aneurysm (AAA) found the overall mortality rate for elective surgery was 6.2%.

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.

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. This result echoes meta-analyses of most complex surgical interventions and should be regarded as definitive and highly informative.

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.

Screening for men over the age of 65 for AAA has been introduced: National Abdominal Aortic Aneurysm Screening Programme (NAAASP) with full roll out to be achieved by 2013. It is hoped that there will therefore be an increase in activity for elective aneurysms and a gradual decrease in emergency aneurysm activity.

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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Ther. 2010 Jun;17(3):356-65.

- Moxey PW, Hofman D, Hinchliffe RJ, Poloniecki J, Loftus IM, Thompson MM, Holt PJ. Volume-outcome relationships in lower extremity arterial bypass surgery. Ann Surg. 2012 Dec;256(6):1102-7.

2. Scope

2.1 Aims and objectives of service

Vascular services are commissioned to provide diagnostics and treatment for vascular disease. The principal specialities involved are vascular surgery and interventional vascular radiology.

The overarching aim of elective and 24/7 emergency vascular services is to provide evidence-based models of care that improve patient diagnosis and treatment and ultimately improve mortality and morbidity from vascular disease.

The service will deliver this aim by:-

- Improving the patient experience, providing equality of access to the full range of vascular diagnostics and interventions and ensuring that patients are receiving a high quality of service, with access to the most modern techniques.
- Developing and sustaining the resilience of vascular services and the workforce providing those services.
- Improving mortality and morbidity rates for people with vascular disease and improving survival rates following hospitalisation.
- Improving complication rates following a vascular admission (short and long term).
- Reducing mortality rates by preventing death from ruptured abdominal aortic aneurysm, stroke, lower limb ischaemia and vascular trauma.
- Providing early intervention and treatment to achieve regional reductions in the incidence of stroke due to carotid artery disease and leg amputation due to peripheral arterial disease.
- Supporting other services to control vascular bleeding and manage vascular complications.
- Working jointly with the diabetic and podiatry service to optimise care, minimise tissue loss and prevent amputation.

Although care for varicose veins is often provided by vascular teams this specification excludes these procedures as they are not included in the specialised definition.

2.2 Service description/care pathway

This service comprises the following elements:-

- Diagnosis and assessment of vascular disease (including the input of the vascular laboratory and diagnostic imaging).
- Outpatient management of patients with peripheral arterial disease.
- Inpatient spells, emergency and elective activity.
- Day case activity.
- Outpatient follow up of patients receiving vascular surgery/endovascular interventions.
- Rehabilitation services particularly for post amputation care.

Service Model

Vascular services need to be organised to allow reasonable volumes of elective activity to exist alongside an acceptable consultant emergency on call rota thus ensuring appropriate critical mass of infrastructure and patient volumes.

There are two service models emerging which enable sustainable delivery of the required infrastructure, patient volumes, and improved clinical outcomes. Both models are based on the concept of a network of providers working together to deliver comprehensive patient care pathways centralising where necessary and continuing to provide some services in local settings.

One provider network model has only two levels of care: all elective and emergency arterial vascular care centralised in a single centre with outpatient assessment, diagnostics and vascular consultations undertaken in the centre and local hospitals.

The alternative network model has three levels of care: all elective and emergency arterial care provided in a single centre linked to some neighbouring hospitals which would provide non arterial vascular care and with outpatient assessment, diagnostics and vascular consultations undertaken in these and other local hospitals.

The network model adopted will follow the principles and governance set out in the national guidance on Operational Delivery Networks.

Vascular Networks

All Trusts that provide a vascular service must belong to a vascular provider network.

The network arrangements must be clearly documented and have clearly articulated governance arrangements. As well as the weekly multi-disciplinary team meetings there will be regular business meetings to ensure an inclusive and coherent approach to audit, education and training.

To avoid any misunderstanding, it is envisaged that all arterial surgery will be provided at a vascular centre, with the facilities outlined below.

Leg amputations should be undertaken in the arterial centres due to the need to improve/reduce the current perioperative mortality rate. It is recognised that, at present, due to capacity pressures, in the short-term, leg amputations may need to continue to be undertaken out-with the centres in designated units. 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.

In circumstances where leg amputations are undertaken outside the arterial centre the patient must be under the care of the arterial network and the procedure undertaken by a vascular specialist. All patients considered for leg amputation including those operated on locally should be be discussed by the vascular multi- disciplinary team and will be given the same opportunities for limb salvage as those treated in the arterial centre. All leg amputation patients/procedures will be included in the network audit.

In-patient arterial surgery and vascular interventional radiology will be available 24/7 within the arterial centre with a vascular on call rota for vascular emergencies covered by on site vascular surgeons and vascular interventional radiologists to ensure immediate access for emergency procedures and post operative care. In practice that means a vascular medical team of a minimum of 6 vascular surgeons and 6 vascular interventional radiologists to ensure comprehensive out of hours emergency cover.

Each surgeon will need to have an appropriate arterial workload (e.g in the region of 10 AAA emergency and elective procedures per surgeon per year and commensurate numbers of lower limb and carotid procedures), which will necessitate an appropriate catchment area to generate sufficient case volume. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required.

A 24/7 vascular interventional radiology rota may need to be organised on a network wide basis to ensure that interventional radiology services for other specialties, in local hospitals, are not destabilised. All participants in the rota must have the appropriate skills and competencies to undertake the full range of vascular interventional radiological procedures. Emergency access to vascular interventional radiology must be within 1 hour from initial consultation to intervention.

Where appropriate, day case and first line diagnostics procedures will be provided locally.

The network may also agree that low risk peripheral vascular interventions can be undertaken locally, to utilise local skills and local interventional vascular radiology capacity.

The scope of this local provision must be clearly defined and the activity must be included in the network audit arrangements. (See appendix A).

With regard to services for patients with chronic vascular conditions arising from venous insufficiency and diabetes, local models of care will be developed.

Each vascular network will have a formalised description of where inpatient, day case and outpatient services are provided in the network.

Local protocols will be agreed to provide high quality specialist care at any non- arterial hospitals in the network. Clear written arrangements will exist for cover of inpatients and the transfer of emergencies out of hours. Formal arrangements will also exist to enable vascular-specialists working predominately at a spoke hospital to support out-patient clinics, ward work and non arterial surgery on appropriate sites across the network.

The provider network will nominate a lead vascular clinician and a lead manager with responsibility for ensuring and maintaining implementation of the standards set out in this service specification and locally agreed policies/protocols.

All patients with vascular disease or vascular complications cared for outside the main arterial centre must have access to the same high quality of care and the same opportunities/choices of care as those patients who are in the arterial centre hospitals.

The vascular service will provide a diagnostic and treatment service through a multidisciplinary team model.

Specialist Vascular Team

Patients with vascular disorders will be cared for by specialist vascular teams. These teams will include vascular surgeons, consultant anaesthetists, interventional vascular radiologists, vascular scientists, nurses, radiographers, physiotherapists, occupational therapists and rehabilitation specialists.

The vascular multidisciplinary team will be hosted by the arterial centre. Clinicians providing emergency care will be part of the vascular services multi-disciplinary team and be delivering both in and out of hours care in the network arterial centre.

Care of patients will be managed through regular multi-disciplinary team meetings which will occur at least once a week. The membership requirements for the multi-disciplinary team meeting will include a range of clinical disciplines and be formalised. The documentation will include statements on minimum levels of attendance for individuals and quoracy. It is expected that all clinicians will attend multi-disciplinary team meeting on a regular basis.

Emergency procedures will be reviewed at the next multi-disciplinary team meeting.

Discussion at the multi-disciplinary team meeting will precede elective vascular procedures being undertaken, although protocols will be developed to ensure that urgent cases are not delayed inappropriately.

The specialist vascular team will also support the care of patients under the management of other specialties.

Infrastructure/Facilities

With regard to the whole vascular service across the network there will be access to the following:

- Outpatient Clinics – will include access to nurses experienced in ulcer and wound dressing. Doppler ultrasound machines should be available. There will be access to Doppler machines in the clinic.
- Vascular Laboratory – the vascular laboratory service will be available for the diagnosis and assessment of arterial and venous disease. (Service availability does not necessarily have to be within the confines of a vascular laboratory).
- Vascular Ward – patients with vascular disease will have access to dedicated vascular beds. There will be sufficient dedicated beds to accommodate the routine elective work and emergency admissions. Beds will be staffed by an appropriate skill mix of nurses who have been trained in the care of vascular patients. Doppler investigation will be available on the ward.
- Interventional radiology suite with access to nursing staff who have been trained in vascular procedures.
- Operating Theatres – a 24 hour NCEPOD emergency theatre will be accessible at all times to undertake emergency vascular procedures.
- Operating theatres – a vascular operating theatre with experienced vascular theatre staff should be available for elective activity.
- Operating theatres – facilities for endovascular aneurysm repair should be available with facilities as described by the Joint Working Group to produce guidance on delivering an Endovascular Aneurysm Repair Service
- Anaesthesia – elective vascular services will have dedicated vascular anaesthetic input into elective services, from anaesthetists experienced in dealing with the vascular patient and with a special interest in this area.
- Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) – Facilities with full renal support must be available on-site to support the vascular service. Bookable HDU/ITU with sufficient beds will be available for elective patients.
- Limb Fitting Service – the vascular service must ensure its patients have access to a local limb fitting service, which meets the standards set by The British Society of Rehabilitation Medicine.

Care Pathways

The following care pathways will be documented by each vascular network:

- Management of acute rupture of AAA
- Investigation and management of unruptured AAA
- Investigation and management of carotid disease (link to stroke care pathway)
- Management of acute limb ischaemia
- Investigation and management of chronic vascular insufficiency
- Management of vascular access for renal patients, if undertaken by vascular specialists
- Management of vascular injury (including complications of angiography)

The following pathways are published by the Map of Medicine:

- Abdominal Aortic Aneurysm Screening
- Peripheral Arterial Disease Pathways including suspected disease, secondary care investigations, surgical revascularisation and shared care
- Venous thromboembolism pathways (VTE) risk assessment and prophylaxis and diagnosis and management

Highly Specialised Interventions

Some interventions/treatment are complex, rare or require other specialist input such as cardiothoracic surgeons e.g. thoraco-abdominal aneurysms. These procedures will only be carried out in arterial centres with the required skills and clinical linkages.

There needs to be a close relation between vascular services and cardiology/cardiac surgery services and whilst colocation is desirable it is not essential.

The introduction of new technologies will need to be managed and developed in line with commissioning policies. This may mean that only a small number of centres nationally are identified as a provider, with a greater catchment population than general arterial centres.

The use of fenestrated and branched endovascular stents for repairing aneurysmal disease of the aorta is an area of developing practice in vascular surgery. A separate commissioning policy will describe the appropriate patient group to receive this treatment and the service provision requirements in order to deliver this treatment.

Commissioners will need to judge whether or not there is a need to develop capacity to meet population need, taking into account existing case series.

2.3 Population covered

Patients will experience varied contact with the service depending on the nature and severity of their condition. Patients will fall outside the scope of this specification when discharged from the care of the specialist vascular team.

The service outlined in this specification is for patients ordinarily resident in England*, or otherwise the commissioning responsibility of the NHS in England (as defined in *"Who Pays?[1]": Establishing the responsible commissioner* and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

Emergency admissions ambulance coverage will reflect the network footprints. Bypass arrangements will operate to ensure arterial emergencies are taken directly to the arterial centre.

2.4 Any acceptance and exclusion criteria

The service will accept all patients who have been referred via their GP or other health care professional to a vascular specialist within secondary or tertiary care, or who have presented as an emergency in secondary care and identified as a vascular emergency. There will also be referrals from the National AAA Screening Programme.

This specification excludes the care of varicose veins as these procedures are outside the scope of the specialised service definition.

Vascular services for children are covered in the specialist paediatric surgery service specification.

2.5 Interdependencies with other services

Vascular services link to a range of other clinical specialties and services: Co-

located services
- Intensive care
- Interventional vascular radiology

Interdependent services
- Stroke surgery and vascular opinion on stroke management
- Limb salvage surgery
- Diabetes specialist hospital services and diabetic community services
- Renal inpatient units
- Interventional cardiology
- Cardiac surgery

- Thoracic surgery
- Major trauma centres and trauma units

Related services
- Rehabilitation services
- Limb fitting service

Relevant networks and screening programmes include:-
- Cardiac/Stroke networks
- Renal networks
- Critical Care networks
- Trauma networks
- AAA screening programme

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

There is a range of guidance available covering vascular services which set out the required service standards. The most significant are:-
- VSGBI: The Provision of Services for Patients with Vascular Disease 2012.
- NHS Abdominal Aortic Aneurysm Screening Programme Guidance for Public Health and Commissioners, July 2009.
- Royal College of Radiologists – Setting the Standards of Providing a 24 hour Interventional Radiology service, September 2008.
- Royal College of Radiologists – Standards in Vascular Radiology – 2011.
- NCEPOD Report 2005 – Abdominal Aortic Aneurysm – A service in need of surgery.
- VSGBI and the Royal College of Surgeons – Training in Vascular Surgery and Standards for Vascular Training – 2011.
- Medicines and health products Regulatory Agency (MHRA) Joint Working Group to produce guidance on delivering the Endovascular Aneurysm Repair (EVAR) Service (RCR, BSIR, VSGBI, Vascular Anaesthesia Society of Great Britain and Ireland(VASGBI), MHRA Committee on the Safety of Devices) – December 2010.

CORE STANDARDS

The core standards which ultimately shape the configuration of vascular services include:-
- As the new specialty of vascular surgery is established provision will need to be made for the separation of vascular and general surgery with vascular surgeons only treating patients with vascular disease, this will be required at both consultant and trainee level.

- Patients with a vascular emergency will have immediate access to a specialist vascular team at the arterial centre with on site vascular surgery and interventional vascular radiology.

The arterial centre in the network will perform a high volume of vascular procedures per year. There is debate about the minimum/ideal volume of procedures. However, 6 surgeons, each with around 10 AAA procedures per surgeon per year would indicate at least 60 AAA procedures per centre. There would be a commensurate number of lower limb procedures.

The arterial centre will also perform a high volume of carotid endarterectomy procedures. A minimum number of 50 is indicated.

All vascular consultants working in vascular networks must routinely enter data onto the following databases/audits:-

- The National Vascular Database
- The Carotid Endarterectomy Audit (CEA)
- National Vascular Registry (when functional)
- The British Society of Interventional Radiology BIAS databases

Endovascular aneurysm repair (EVAR) will only be performed in specialist centres by clinical teams experienced in the management of AAAs. These teams will have appropriate expertise in all aspects of patient assessment and the use of endovascular aortic stent-grafts including the necessary expertise to manage complications encountered during these procedures.

Vascular centres providing post screening AAA repair must meet all the standards set out by the NAAASP

NB: The AAA and CEA volumes quoted are currently indicators but over time as services are reconfigured will become the minimum.

NICE guidance of significance to elective and emergency vascular services, exists as follows:-

- CG10 Type 2 diabetes footcare – (January 2004)
- CG66/87 Diabetes – type 2 (update): (May 2008/May 2009)
- CG68 Stroke - (July 2008)
- CG92 Venous thromboembolism – reducing the risk (January 2010) o CG119 Diabetic foot problems-inpatient management – (March 2011)
- CG127 Hypertension – (August 2011)
- CG147 Lower limb peripheral arterial disease – (August 2012)
- TA167 Endovascular stent-grafts for the treatment of abdominal aortic aneurysms – (February 2009)
- TA210 Vascular disease – Clopidogrel and Dipyridamole – (December 2010)

- IPG52 Endovenous laser treatment of the long saphenous vein - (March 2004)
- IPG60 Thrombin injections for pseudoaneurysms - (June 2004)
- IPG74 Balloon angioplasty with or without stenting for coarctation or recoarctation of aorta in adults and children - (July 2004)
- IPG79 Stent placement for vena caval obstruction - (July 2004)
- IPG127 Endovascular stent-graft placement in thoracic aortic aneurysms and dissections – guidance (June 2005)
- IPG163 Stent-graft placement in abdominal aortic aneurysm – Guidance (March 2006)
- IPG229 Laparoscopic repair of abdominal aortic aneurysm - (August 2007) (February 2009)
- IPG388 Carotid artery stent replacement for asymptomatic extracrarial carotid stenosis – (April 2011)
- IPG390 Endovascular stent-grafting of popliteal aneurysms – (April 2011)
- IPG389 Carotid artery stent placement for symptomatic extracrarial carotid stenosis – (April 2011)

1 Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England. Specifically, this service is for adults with vascular conditions requiring specialised intervention and management, as outlined within this specification.

4. Key Service Outcomes

Abdominal Aortic Aneurysm

Metric	Agency	Definition	Target	Acceptable
Mortality	NVD/NVR	Unit overall elective AAA in hospital mortality (by end 2013)	≤3.5%	<6%
Length of Stay	NVD/NVR	LOS for elective AAA repair	<7d	<10d
Number of AAA repairs per arterial centre	NVD/NVR	Number of AAA repairs (total – elective and emergency)	>60	>50
Mortality: elective repair	NVD/NVR	All cause mortality at 1 year (collect from ONS)	≤15%	≤20%
Time to treatment	NAAASP	% of subjects with AAA ≥5.5cm deemed fit for intervention operated on by vascular specialist within eight weeks	≥80%	≥60%

Carotid Intervention

Metric	Agency	Definition	Target	Acceptable
Stroke rate	NVD/NVR*	Stroke rate 30 days after surgery	<2%	<3%
Mortality	NVD/NVR	Death rate 30 days after surgery	<1%	<2%
Referral	National Stroke Strategy	Delay from symptom to treatment for suitable patients (by 2013)	<7 days	<14 days

*National Vascular Database/National Vascular Registry

Peripheral Arterial Disease – Lower Limb Bypass (PAD)

Metric	Agency	Definition	Target	Acceptable
Mortality	NVD/NVR	Death 30 days after surgery	<5%	<10%
Amputation free survival	NVD/NVR	Amputation free survival 1 year post surgery	Needs Bench-marking in NVR	

Lower limb amputation

Metric	Agency	Definition	Target	Acceptable
Mortality	NVD/NVR	In hospital mortality	5%	≤15%
Procedure	VSGBI QIF*	Patients should undergo surgery on day time lists (between 0800 and 2000)	90%	75%
Procedure	VSGBI QIF	Ratio of below to above knee amputation in unit	>1	1
Outcome	VSGBI QIF	Rate of amputation revision to higher level	<10%	<12%

*Quality Improvement Framework

For clarification - this is an appendix to the specification and not the Business Case

Appendix A

The Provision of Vascular Interventional Radiology Services to Patients at Non Arterial Hospitals within a Vascular Network

What constitutes an MDT?
Major arterial cases that are being considered for intervention should be discussed at a Vascular MDT. The MDT should be held at least once a week and involve all clinicians concerned with the care of vascular patients. This will include vascular surgeons and interventional radiologists and may include vascular nurses, radiographers, radiology nurses, other medical specialities and anaesthetists.

There should be one MDT meeting for each vascular network, where patients can be considered for all available open and endovascular treatments. Clinicians from non- arterial networked hospitals should be encouraged to attend in person, but arrangements for teleconferencing should also be available. In some centres it may be appropriate to have separate specialised MDTs.

What sorts of patients are suitable for peripheral angioplasty or stenting at non-arterial sites?
All major arterial interventions should be performed on the designated arterial site with 24/7 cover from vascular surgery, interventional radiology and anaesthesia/ITU. Subject to locally agreed protocols audited for quality of outcomes against agreed standards, some patients may be managed on non-arterial sites, so long as there are robust arrangements for transfer in case of emergency. These will primarily involve patients which can be managed as day cases. Patients requiring an overnight stay for social rather than medical issues must be managed on a ward experienced in the care of vascular patients; this should include 24/7 cover arrangements for the management of complications. Renal patients requiring intervention can be treated within a designated renal access/transplant centre, so long as there are firm 24/7 protocols for vascular referral if required.

What sorts of workloads are appropriate to maintain skills?

All patients undergoing vascular interventional procedures should be recorded on locally or nationally held databases. Those hospitals with insufficient workload to maintain competency, should discuss transferring their caseload to a designated arterial centre.

How do we measure competency?

All patients undergoing peripheral vascular intervention should be audited through the national databases (e.g. NVR/British Society of Interventional Radiologists Iliac Angioplasty

and Stenting database (BIAS)) and complications discussed at a regular mortality & morbidity meeting. This should be convened centrally and outcome measures should include death or major complication (i.e. bleeding, occlusion, amputation). In addition, details of urgent transfer or request for assistance should be monitored and audited annually.

Should a surgeon be present on site if intervention is being carried out?

All vascular surgeons involved in a vascular network should perform their major arterial cases at a designated arterial hospital, but must provide a daily service to non-arterial sites. This will involve attendance at OPD clinics, ward rounds to review patients, either prior to or after their intervention at the major arterial centre, and to support colleagues from other specialties requiring vascular assistance. There will not necessarily be a vascular surgeon present at all times, but there should be formal on- call rotas to allow for 24/7 cover for all patients in an emergency.

What should the transfer arrangements be if patients require emergency surgical intervention?

These should be decided by agreed protocols and will vary depending on the local arrangements for provision of specialty services and geography. Where 24/7 cover is not possible, this must be provided by the designated arterial centre with robust arrangements in place for review/transfer. This should apply to all clinicians performing arterial or venous catheterisation.

APPENDIX B Vascular: Key Service Outcomes 2013/2014

Abdominal Aortic Aneurysm:

Metric	Definition	Target	Accep-table	UHS	PHT
Mortality	Unit overall elective AAA in hospital mortality	≤3.5%	<6%	3%	0%
Length of Stay	LOS for elective AAA repair	<7d	<10d	NC	NC
Number of AAA repairs	Total – elective and emergency	>60	>50	112	64
Mortality: elective repair	All cause mortality at 1 year (collect from ONS)	≤15%	≤20%	NC	NC
Time to treatment	% of subjects with AAA ≥5.5cm deemed fit for intervention operated on by vascular specialist within eight weeks	≥80%	≥60%	NC	NC

Carotid Intervention:

Metric	Definition	Target	Accep table	UHS	PHT
Stroke Rate	Stroke rate 30 days after surgery	<2%	<3%	0%	0%
Mortality	Death rate 30 days after surgery	<1%	<2%	0%	0%
Referral	Delay from symptom to treatment for suitable patients (by 2013)	<7 days	< 14 days	NC	NC

Peripheral Arterial Disease – Lower Limb Bypass (PAD)

Metric	Definition	Target	Accep table	UHS	PHT
Mortality	Death 30 days after surgery	<5%	<10%	4%	3.8%
Amputation free survival	Amputation free survival 1 year post surgery	Needs benchmarking in NVR		NC	NC

Lower Limb Amputation:

Metric	Definition	Target	Accep table	UHS	PHT
Mortality	In hospital mortality	5%	≤15%	6%	9.5%
Procedure	Patients should undergo surgery on day time lists (between 0800 and 2000)	90%	75%	92	NC
Procedure	Ratio of below to above knee amputation in unit	>1	1	10	NC
Outcome	Rate of amputation revision to higher level	<10%	<12%	N/K	NC

NC Not Collated Source: Providers

APPENDIX C National Clinical Advisory Team (NCAT) Report: Vascular Services Review - South Central 7 October

To: NHS South Central

NCAT Report: Administrator – Judy Grimshaw

Vascular Services Review – South Central Tel: - 020 3299 5172

Date of Visit: 7 October 2011 Email: judy.grimshaw:nhs.net

Visitor: King's College Hospital
Denmark Hill
London SE5 9RS

Professor Matt Thompson, Professor of Vascular Surgery, St George's Vascular Institute

1. Introduction

1.1 NCAT was invited by NHS South Central to review the development and on-going plans for reconfiguration of vascular services in the South Central Strategic Health Authority. The visit took place at the Strategic Health Authority Headquarters in Newbury. The visit took the form of a number of group interviews and telephone conversations.

2. InformationProvided

Prior to visit

- Board of Commissioners Thames Valley Vascular Review recommendation (05.10)
- A paper providing an update on progress of the reconfiguration of the vascular/and major trauma services dated 22nd July 2011. Developing safe and sustainable acute services in South Central. Vascular Stroke and Major Trauma services. Engagement and consultation.
- Board of Commissioners. SHIP vascular review recommendations dated 22.12.2010.
- NHS South Central Cardiovascular Network. MOBBB Vascular Surgery Service Model recommendation. Board of Commissioners summary paper. 27.10.10.
- NHS South Central. Developing safe and sustainable acute services in South Central. Stroke Major Trauma and Vascular Surgery engagement document dated August 2011.

- Project Brief dated 5 August 2011

3. Discussionswereheldwiththefollowing:

3.1 Project Group Members:

Sue Nunney	Consultation Project Manager South of England SHA
Gail Rossiter	Associate Director Communications and Engagement, South of England SHA
Beverley Meeson	Cardioascular Network Manager
Simon Cook Emma McKinney Judy McCulloch	Associate Director, Acute Care Programme South of England SHA Communications Manager, SHIP Communications and Engagement

3.2 Senior Managers:

Steve Fairman	Director of Improvement and Efficiency South of England SHA
Debbie Fleming	Chief Executive Officer, SHIP
Edward Baker	Medical Director, Oxford Radcliffe Infirmary
Steve McManus	Director of Operations, Southampton General Hospital

3.3 Patient and Public Representatives:

Harry Dymond	LINk SHIP
Tony Lloyd	LINk West Berkshire

3.4 Clinicians and General Practitioners:

Cliff Shearman	Professor of Vascular Surgery, Southampton
Mike Phillips	Vascular Surgeon, Southampton
David Gerrard	Vascular Surgeon, Frimley Park Hospital
Sabin Sonneberg	Vascular Surgeon, Basingstoke and Frimley Park Hospitals
Simon Holmes	Medical Director, Portsmouth Hospital
Andy Northeast	Vascular Surgeon, Wycombe Hospital
Peter Rutter	Vascular Surgeon, Wexham Park Hospital
George Boulas	General Practitioner, North and West Reading GP Commissioning Consortium

4. CaseforChange

4.1. The proposal to reconfigure vascular surgery (along with major trauma surgery and Stroke treatments) in the South Central Strategic Health Authority is driven by a desire to improve quality of care for patients undergoing both elective and emergency arterial surgery in the population served by the South Central Strategic Health Authority.

The background to this review is a nationwide review of vascular surgery which is being carried out piecemeal throughout the National Health Service in England.

4.2. The basis of many strategic reviews has been the fact that outcomes from arterial surgery in England are poorer than those reported by international comparators. In particular, a European report suggested that the mortality from aneurysm surgery in the United Kingdom was significantly higher than that reported elsewhere in Europe. Alongside these poor mortality results, there have been a significant number of studies published in recent years that have documented a significant association between the individual hospital operative case load for aortic surgery and outcome. These investigations have demonstrated that outcome following surgery for abdominal aortic aneurysm is highly significantly associated with the case load of the hospital in question. Increasing case load is associated with better clinical outcomes, access to endovascular surgery and an increase in the percentage of patients offered emergency aortic surgery.

4.3. The United Kingdom has recently approved and instituted a National Screening Programme for abdominal aortic aneurysms aimed at men of 65 years of age. This programme is currently being rolled out across the United Kingdom and a population base of approximately 800,000 is required to sustain the activity within the vascular surgical centre associated with the screening programme.

4.4. There is also an association between outcome and the number of carotid endarterectomies performed in the centre. This relationship is not as strong as for aortic aneurysm surgery. However, there are other drivers in carotid endarterectomy at present which may require a change in service provision. There is now widespread acceptance that patients who have neurological symptoms attributable to a carotid stenosis should undergo their operation in a relatively short space of time. The guidelines for performance of carotid endarterectomy differ, but the maximum benefit to patients occurs if patients undergo surgery as soon after their neurological symptoms as possible. The requirement to perform carotid endarterectomy in a short time frame poses significant challenges for the provision of vascular services.

4.5. There are several studies which suggest that the provision of lower limb bypass surgery is diverse within the United Kingdom, with variable outcomes. Again, there is a relationship between volume and outcome in the performance of lower limb bypass surgery.

4.6. Vascular surgery faces work force issues in the future. Vascular surgery is about to

become a separate specialty from General Surgery. This will require dedicated on- call teams supported by Specialists in interventional radiology. Vascular surgery has a significant number of co-dependencies which would include an association with interventional radiology, specialised anaesthesia, specialised nurses, a dedicated critical care unit, and access to non-invasive vascular investigations. There is also a relationship between vascular surgery and interventional cardiology, and renal services.

4.7. In common with many other Strategic Health Authorities, South Central Strategic Health Authority has suggested that there is a requirement to reconfigure vascular surgery provision in order to improve patient outcomes and provide a sustainable service in the long term. There is a desire to create centres with sufficient activity so that outcomes are improved and the service remains sustainable. This will inevitably mean centralising some services where necessary. In addition, there is a commitment to providing strong local services which would include appropriate resources to ensure provision of adequate inpatient consultation, outpatient consultation, local access to diagnostic services, and local access to minor surgical procedures.

4.8. The vascular services reconfiguration in South Central commenced in 2008. A service specification was outlined in 2010 following the convening of two clinical expert panels. The proposed configuration included:

- In the north of South Central: vascular services to be centred on the Oxford Radcliffe which would act as a hub for the north of the region. The Oxford Radcliffe would take patients from its associated spokes which would include Wycombe Hospital, Wexham Park Hospital and the Royal Berkshire Hospital.
- In the South of the region, Southampton General Hospital would act as the hub. The spoke hospitals would include the Royal Hampshire County Hospital, The Queen Alexandra Hospital in Portsmouth and St Mary's Hospital on the Isle of Wight.
- The central part of South Central Region which includes Basingstoke Hospital, would direct their patients to be treated at Frimley Park Hospital in Surrey, which would act as a vascular hub.

4.9. Following patient and public engagement, alternatives to the plan set out above have been proposed. The variants from the plan include the following configuration:

- In the North of South Central region, Oxford Radcliffe Hospital to act as the arterial

hub for spoke hospitals including Wycombe Hospital, Wexham Park Hospital, and the Royal Berkshire Hospital. Wycombe Hospital to continue to perform elective carotid endarterectomy on site.

- In the South of the region, Southampton to act as a hub hospital with spokes including Winchester Hospital and St Mary's Hospital, Isle of Wight. Portsmouth would remain as a separate vascular hub. There was some discussion as to whether Portsmouth Hospital could act as a hub with a spoke hospital in Chichester which would increase both the patient numbers and the number of Vascular Surgeons at Portsmouth. The potential movement of patients from Chichester to Portsmouth is currently the subject of local discussion, but there is an impression that this is unlikely to happen. It is more likely that patients and surgeons from Chichester will move to a vascular hub in Brighton.

4.10 The plan from October 2011 onwards was to convene a further clinical expert panel which would include Jonathan Earnshaw, and David Mitchell as Vascular Surgeons, David Kessel and Iain Robertson as Interventional Radiologists plus representatives from renal services and cancer services. This expert panel would be asked to give an opinion on the options that have arisen out of public and patient engagement (notably the performance of elective carotid surgery in Wycombe and that Portsmouth should become as a vascular hub).

4.11. Following the Clinical Expert Panel various options as outlined above will be put to public consultation at the end of November. There are various forms of public consultation planned depending on the exact geography within the region. It is likely that proposals from South of the South Central region (namely those involving Southampton and Portsmouth) will go to public consultation in November. It is considered unlikely that there will be consultation in the north of the South Central region apart from a wider public consultation of services in Buckinghamshire.

5 Views expressed

5.1 The evidence base regarding configuration is clear. There needs to be a reconfiguration of arterial services in the South Central region to produce vascular centres treating an appropriate number of patients. It is anticipated that increasing the

case load and concentrating expertise in a smaller number of centres will lead to improved patient outcomes and sustainable services for the future.

5.2 The South Central region is keen to make a decision on vascular reconfiguration for the medium to long term, recognising that this is a once in a generation opportunity. The region is looking to make a step change in vascular surgical outcomes.

5.3 There is broad support across the commissioning teams for the change, although there Are some local issues in Portsmouth that will need to be addressed.

5.4 There is difficulty in ascertaining the exact numbers of Consultant Vascular Surgeons within the South Central region due to many consultants having interests in fields outside vascular surgery, whether this is in surgical academia, general surgery, or renal transplant services. The difficulties in defining the exact number of Full-time Equivalents has led to some disagreements requiring the need for centralisation, particularly between Southampton and Portsmouth.

5.5 The South Central Strategic Health Authority defined a relationship between vascular services, major trauma centres and stroke services. There was a perceived requirement that vascular services should be on a major trauma site, but that a network approach might be utilised for stroke.

5.6 It was considered that in addition to vascular reconfiguration, attention needed to be directed towards other co-dependent services that might require a vascular presence on site. There was particular concern about renal services on the Portsmouth site if inpatient arterial surgery moved to Southampton.

5.7 The rationale for reconfiguration of stroke and trauma services was accepted. It was considered that there was too long a delay between panel recommendations and patient and public engagement for vascular surgery. There needs to be a piece of work done to ensure that the proposals to reconfigure inpatient arterial services on the Southampton and Oxford Radcliffe sites are real and sustainable in terms of capacity. There is also the impact to consider on other co-dependent services, particularly renal and cancer services in centres where inpatient arterial services are being withdrawn. It is important that any reconfiguration is sustainable in the long term. There needs to be a clear assessment on the impact on other co-dependent services.

5.8 Team working throughout the patch has been good to date. Team working will be

required to ensure that there is sufficient capacity at the arterial hubs to accommodate work from the spoke hospitals.

5.9 The system for arterial surgery in the south of the region (Southampton, Portsmouth) is broken and a reconfiguration is urgently needed. Reconfiguration can be successfully achieved with sustainable capacity as long as the medical work force is integrated to ensure that adequate consultant presence is provided at all hospitals within the proposed reconfiguration.

5.10 Patients want a regional centre with excellent outcomes. The trade off in travel is worthwhile as long as improved outcomes can be guaranteed.

5.11 The new options which include carotid surgery at Wycombe Hospital and a vascular hub at Portsmouth were not discussed at the original Clinical Expert Panels. These options should not be put on the table for public consultation without having gone through another clinical expert panel to define whether they are viable and in the best interests of the patients.

5.12 There were suggestions that patient involvement in the arterial reconfiguration in the South Central region was not very strong and that patient comments have been largely ignored in the process.

5.13 From a commissioning stand point, one of the Commissioning Consortia were happy with the proposals and no major objections were raised

5.14 Whatever configuration is finally adopted for arterial surgery, it is essential that the services are provided without excessive use of trainees due to changes in the training structure. The drivers for arterial reconfiguration should be quality, but service needs to be sustainable.

5.15 It was recognised that it was key to provide constant consultant presence on the Portsmouth site.

5.16 With regard to Wycombe Hospital, a view was expressed that there was little support for moving elective work although Wycombe would like to centralise emergency surgery on the Oxford site. There was little evidence that moving elective surgery would improve outcomes. There are two and a half Full-Time Equivalent Vascular Surgeons on the Wycombe site.

5.17 A view was expressed regarding Wexham Park Hospital that in view of the low

number of Surgeons at Wexham Park, there was a desire to move services to Oxford to achieve a critical mass and continue arterial surgery.

5.18 With regard to patients at Basingstoke Hospital, there was support that these patients should be treated at Frimley Park Hospital. At present, Frimley Park Hospital is in a Surrey network with St Peter's Hospital, Chertsey. There was recognition that Frimley Park.

Hospital did not provide 24 hour, on-site consultant presence as some of the emergency on- call rota was covered by the Chertsey Surgeons. As Basingstoke only wanted to send their patients for emergency services to Frimley, this would be inconsistent with the suggested provision of 24/7 on site emergency services in the rest of the region.

5.19 It is difficult to talk about vascular services in isolation. The close relationship and requirements for co-locating arterial inpatient surgery and interventional radiology should not be ignored in any potential reconfiguration of services.

5.20 There was a discussion amongst the clinicians' about whether carotid surgery should be treated differently from elective aneurysm and lower limb surgery. There was a disparate range of views expressed. These ranged from the fact that if outcomes were good and a service could be offered then there was little advantage to the patients in moving carotid endarterectomy. The opposing view was that it would be difficult, given the relatively few surgeons on a spoke hospital site, to offer patients carotid endarterectomy within a 48 hour time window given the movement of arterial services to other sites and the absence therefore of regular arterial operating lists. There was a discussion regarding the logistics of the number of lists and surgeons that would be required on a spoke site to be able to maintain an effective carotid surgical practice and to ensure that these patients had access to senior consultant decision makers in the post-operative period.

6. Discussion

6.1. The evidence base for the changes proposed in the South Central SHA reconfiguration can be strongly supported. It is clear that there is a relationship between the number of cases performed in a particular centre and outcomes. There is no definitive number that identifies a particular threshold for each individual procedure. There needs to be a common sense approach to interpreting the

volume outcome data and how units are placed geographically and strategically within the region. Clearly travel times will play a part in the positioning of the arterial hubs. There is evidence in the South Central region that travel times will be reasonable even if only two hubs are commissioned.

6.2. As with the threshold number for operations, there is debate around what size of catchment population is required to support an arterial hub. The National Aneurysm Screening Programme recommends a screening population of at least 800,000 patients to support an arterial hub. It may be, that world class centres can only be fashioned if there is a catchment population of between 1.2 and 1.5 million. Interpreting these population data, it would be suggested that there could be a maximum of four hubs in the South Central Strategic Health Authority region, although two hubs are more likely to achieve world class outcomes with a sustainable service.

6.3. It would appear from discussion during the NCAT visit that the most robustly worked through configuration is a suggestion of two arterial hubs in the South Central region. Issues that have arisen during the patient and public engagement have suggested a compromise whereby Portsmouth is also an arterial hub, and Wycombe remains as a spoke to Oxford, but continues to perform carotid endarterectomy. The proposal for the Radcliffe Infirmary to be an arterial hub appears logical given the geography in the North of the South Central region. The movement of arterial cases from Wycombe, Wexham Park and the Royal Berkshire Hospital will substantially increase the arterial case load at the John Radcliffe Infirmary. This would undoubtedly provide a critical threshold of arterial cases. However, there needs to be a robust assurance process to ensure that there is sufficient capacity in Oxford to accommodate these cases. The reconfiguration proposed in South Central is reasonably radical and will lead to a greater increase in arterial cases than has been seen in other areas of the country. In this particular regard, capacity is key and Commissioners would need to ascertain that there is sufficient inpatient operating facility, sufficient inpatient ward facility, and diagnostic facilities to make this transfer of patients successful.

6.4. The proposal that has arisen following patient and public engagement to retain carotid services at Wycombe needs further careful analysis and discussion. In the

future, it is extremely likely that patients will require carotid endarterectomy within 48 hours of neurological symptoms. This is in order to maximise the absolute risk reduction that carotid endarterectomy confers. There appears to be no discussion about retaining lower limb bypass surgery and aortic aneurysm surgery at Wycombe. The movement of these cases, and the associated movement of the Wycombe Consultants to perform these cases at Oxford, may potentially leave Wycombe with insufficient arterial infrastructure to continue to perform carotid endarterectomy within an expedited time frame. The movement of both patients and surgeons to Oxford outside of carotid

endarterectomy, will also render the arterial infrastructure at Wycombe somewhat sparse and logistically, if Commissioners wish to retain carotid surgery at Wycombe, then robust assurance is needed that these cases can be performed safely and within the expedited time frame that will be required. The Commissioners would also need to satisfy themselves that there is going to be sufficient arterial consultant presence at Wycombe to give patients undergoing carotid endarterectomy access to senior medical decision makers in the post operative period.

6.5. Due to the proposed stroke reconfiguration in South Central, not all of the hyper acute stroke units will have vascular surgery on site. There are models of this type of service elsewhere in the country whereby a network approach is used to ensure that patients requiring carotid endarterectomy are referred from the hyper acute stroke unit to the regional vascular centre in an expedited fashion.

6.6. The arrangement for Basingstoke to perform their arterial elective and emergency surgery at Frimley requires comment and discussion. In the rest of the South Central region, there is a desire from the Commissioners that arterial surgery should be performed in an arterial hub where there is constant elective and emergency cover. Frimley Park Hospital has a large vascular case load and has sufficient surgeons to provide 24 hour cover. However, at the moment, Frimley Park Hospital has entered into an arrangement with St Peter's Hospital in Chertsey to provide a 24 hour rota utilising the Surrey Vascular Network. This means that there is not 24 hour, 7 days a week provision for on-site emergency vascular services at Frimley Park Hospital. In a significant proportion of the year, the cover will be provided from St Peter's Hospital and by the St Peter's surgeons travelling to Frimley. This arrangement would be

significantly different from the emergency cover proposed in Oxford and Southampton in the original two centre proposal, and would be difficult to recommend.

6.7. The proposal for an arterial hub in Southampton appears well founded and robust. There appear to be sufficient surgeons in Southampton to be able to provide 24 hour cover, especially supplemented by surgeons from Portsmouth. As with the potential reconfiguration in the north of region, the capacity issues that will face Southampton if Portsmouth joins as a spoke Hospital should not be under estimated. The transfer of arterial inpatient work from Portsmouth to Southampton would mean a virtual doubling of the number of inpatient arterial operations performed at Southampton. Again, extremely robust and detailed capacity planning and assurances will be needed prior to the transfer of any work from Portsmouth to Southampton.

6.8. The additional proposal that came out patient and public consultation was that Portsmouth should be an arterial hub in its own right. Certainly, Portsmouth has a reasonably busy inpatient arterial practice and has a case load that would be close to that seen in a smaller arterial hub in the rest of the UK. Portsmouth does appear to have manpower issues with a relatively low number of full-time equivalent Consultant Arterial Surgeons. Given the (present) relatively low number of Consultant Surgeons, it does not appear likely that Portsmouth would be a viable arterial hub in the long term without substantial manpower investment. The Commissioners have indicated that long term sustainability is an issue in this current reconfiguration. There was some discussion about whether Chichester would join Portsmouth as a spoke to Portsmouth hub. If this were possible then Portsmouth might attain a critical mass of both patients and surgeons to allow long term sustainability as an arterial hub.

6.9. One of the constant issues that accompanies any reconfiguration of inpatient arterial services is the impact that these reconfigurations have on existing services in the spoke Hospitals. This will affect all potential spoke Hospitals in the region, but would be of particular concern in Portsmouth. Portsmouth has a very large inpatient renal practice which does require vascular input. In all of the spoke hospitals, job plans and working practices would need to recognise the co-dependencies and it would be important, in all of the spoke hospitals, but particularly in Portsmouth, that

there is a defined vascular surgical presence during the week. The requirement for the number of hours per week will obviously vary according to the hub. In Portsmouth, it is likely that a Vascular Consultant would need to be on site for all of the working week.

7. Conclusions

7.1. The evidence base for the changes proposed for vascular services in the South Central region is acceptable and robust. Interpreting the catchment area, there should be no more than four arterial hubs in the South Central region (this would be Southampton, Oxford, Frimley Park Hospital and Portsmouth). The proposal for two arterial hubs would generate internationally competitive centres with long term sustainability.

7.2. The proposals for two arterial hubs at both Southampton and the John Radcliffe Hospital in Oxford would appear to be ambitious, appropriate and are likely to create long term sustainable vascular centres in the South Central region, with units capable of producing results comparable with international competitors. There are however issues regarding capacity planning in both Southampton and Oxford. Although the Operational Managers at these sites are convinced that there is sufficient capacity to accommodate the transfer of inpatient work from the spoke Hospitals, this process should be subject to a rigorous and robust SHA assurance process.

7.3. With regard to the proposals that came out of patient and public engagement, the ability of Portsmouth to act as an arterial hub in its current state is questionable. There are relatively low consultant numbers (FTE) and significant investment in manpower would be required if Portsmouth was to have a long term sustainable future as an arterial hub in the absence of acquiring both patients and consultants from Chichester.

7.4. The proposal to perform carotid endarterectomy in isolation at Wycombe Hospital needs careful consideration as to whether, given the transfer of inpatient arterial consultant sessions to Oxford (to deal with aneurysms and lower limb revascularisations) there is sufficient on-site consultant presence at Wycombe to offer these patients a safe and effective service, in light of the requirement for expedited carotid endarterectomy in the future. It is difficult to recommend an isolated carotid

service in such a setting as this may weaken both hub and spoke.

7.5. The arrangement between Basingstoke and Frimley Park Hospital appears sensible geographically, but Frimley Park Hospital does not meet the requirements of being a vascular hub. Frimley Park Hospital does not offer 24 hour, 7 day a week on-site consultant emergency cover. If this situation is not rectified, then the service offered to the patients of Basingstoke would not be equitable (in comparison to the arterial hubs in Southampton and Oxford) to the rest of the patients in the region.//The effect of moving inpatient arterial surgery on co-dependent services in the spoke needs to be carefully considered. It is likely that cover can be provided with a two hub model if consultants are prepared to work flexibly and are willing to accept the importance of providing high quality diagnostic, inpatient consultation and minor surgical procedures in a spoke hospital. This has particular importance for the renal services in Portsmouth that would require, a full-time Consultant to be based in Portsmouth during working hours.

7.6. The review has concentrated largely on inpatient arterial surgery with regard to the reconfiguration. In the current climate, there is relatively little distinction between interventional vascular radiology services and vascular surgical services. The effect of centralising inpatient arterial surgery needs to be modelled for the provision of interventional radiology both at the hubs and the spoke.

8. Recommendations

8.1. The project team to consider the conclusions as above and develop an action plan to be agreed with NHS South Central.

8.2. New proposals that have come out of patient and public consultation should be subject to advice from a clinical expert panel that is due to convened to consider these recommendations.

APPENDIX D Wessex Clinical Senate: Recommendations on Vascular Surgery in South East Hampshire: 26th September 2014

Recommendation on Vascular Surgery in South East Hampshire

On 26th September 2013, the Wessex Senate Council met for its inaugural meeting. The Council was asked by NHS England (Wessex) to consider three options for reconfiguration of vascular surgery in South East Hampshire:

Option 1 Maintain two independent vascular centres

Option 2 Network model as described in the NHS Contract for Specialised Vascular Services[1] with all inpatient surgery at University Hospital Southampton
N.B. This was the preferred option of NHS England (Wessex)

Option 3 Move all surgery from Portsmouth Hospitals Trust to University Hospitals Southampton

The Senate Council was asked to review these options for vascular services against national and local guidance and to advise on the potential impact on patient outcomes, co-dependencies, co-location of services and standards for inter-organisational and inter-agency collaboration.

Portsmouth Hospitals Trust presented Option 4 on the day:

Continue the present network arrangements for screen-detected aneurysms
Shared multi-disciplinary team for complex cases
Shared training in vascular surgery (replicating interventional radiology model) Shared research
Two way movement of complex cases: Complex EVAR to University Hospitals Southampton and Renal compromise cases to Portsmouth Hospitals
Create the environment where a regional emergency endovascular service could be developed.

The Senate Council reviewed all of the options and found that:

The proposed options for the provision of vascular surgery in South East Hampshire did not identify a sustainable pathway and workforce, which would withstand shortages in key skills and keep up with rapid technological changes. There was a need for greater focus on the

delivery of elective and emergency services with high quality pre and post discharge rehabilitation, re-enablement and psychological support close to where the patients live.

1. There is a need to future-proof any service change

The Senate Council noted that new national medical training in both surgical and endovascular procedures commenced this year. The first cohort of vascular specialists will be working in hospitals in 5 or 6 years' time. In the interim, there is need for both surgical and vascular interventional radiology rotas around the clock, 7 days a week.

2. Option 1

The Senate Council recognised that there were no local circumstances which would justify deviation from the service model for abdominal aortic aneurysm (AAA) as described in the NHS Standard Contract for Specialised Vascular Services[2]. Surgeons need to be able to demonstrate assurance that they are achieving high quality outcomes. Furthermore, a larger number of surgeons would allow for enhanced care due to the ability to sub-specialise in particular areas.

The Senate Council was not persuaded that the Renal Service at Portsmouth Hospitals NHS Trust required co-location with a vascular centre. Transplant surgeons would be expected to have competencies in vascular access and should have access to further vascular surgical advice and expertise when required on occasions.

There are insufficient vascular surgeons undertaking a high enough volume of procedures and insufficient interventional radiologists to provide sustainable 24 hour specialist emergency care independently on the Portsmouth Hospitals and University

Hospitals Southampton sites. Portsmouth Hospitals stated that they have organised adequate out of hours cover from a mixture of locum, vascular and renal surgeons with a vascular interest and by helping each other out in a crisis. However, this is not sustainable in the longer term, particularly when there is also a need to change the current provision of a 5 day a week vascular service to a 7 day service in both Portsmouth and Southampton without additional resources.

The Senate Council does not support two independent vascular centres for the population of South East Hampshire because the model is unsustainable in a 5-10 year time frame. This is due to a forecast reduction in the number surgical procedures due to screening and technological advances in other treatments which will reduce the need for surgery. There is also a national shortage in skilled medical, nursing and allied health care professionals. Future technological advances would require an unsustainable level of investment at both sites and there is a requirement for subspecialist expertise and for the future employment of trained endovascular surgeons.

3. Option 2 and Option 3

The Senate was concerned that the provision of vascular services other than major surgery was not adequately addressed in these options. The Senate noted the high morbidity from diabetes and the significant deprivation in areas of both major cities.

The Senate also considered the need for re-enablement and psychological support for patients and the importance of local delivery of these components of a vascular service to a patient population with mobility problems, including a significant number of amputees.

4. Option 4

The Senate recognised the potential value of a network in delivering clinical synergies. However, this option did not address the issues of sustainability in terms of 24/7 consultant rotas nor did it provide a solution to the anticipated costs of technological advances in a time of constrained resource.

Given the historical difficulties in collaboration between the Trusts, the Senate

was not confident that the described arrangements were sustainable.

5. Recommendation

The Senate Council makes the following recommendations:

1) Services for patients in South East Hampshire requiring vascular expertise are provided by a single clinical service across the Portsmouth Hospitals and University Hospitals Southampton NHS Trusts

2) The single clinical service includes all vascular surgeons, vascular radiologists, together with other staff as the service and commissioners determine

3) The service has a single clinical director and management team who are accountable for patient access, safety, experience and outcomes of the service4) The clinical director and management team are accountable for the sustainability of high quality services, research, innovation, teaching and training

5) The service should ensure that interventional clinicians undertake an appropriately high volume of procedures as determined by the NHS Standard Contract for Specialised Vascular Services[3] and at the same time meet the challenge of
providing local services to support an extended pathway into primary and community care

6) The service should establish, as a matter of urgency, a single rota for emergency seven day vascular assessment and interventions, including radiological, endovascular and surgical procedures and support for the Regional Major Trauma Centre

7) 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

8) The service should bring forward proposals, with implementation dates, for the management of carotid arterial disease and major amputations, with local assessment and re-enablement, in the light of the NHS Standard Contract for Specialised Vascular Services[3], for agreement with commissioners

9) The service should focus on the needs of the local populations for vascular clinical care including diagnosis and day case surgery with demonstrable high quality outcomes, re-enablement and psychological support of patients as close to their homes as possible

10) Commissioners should regularly monitor performance and quality metrics and ensure that vascular outcomes improve in accordance with Domains 1 to 5 of the NHS Outcomes Framework. The metrics should reflect the recommendation to provide care closer to home and the extended recovery and re-enablement pathway.

APPENDIX E VASCULAR SOCIETY REVIEW OF SOUTH HAMPSHIRE VASCULAR SERVICES AUGUST 19-20 2015

Mr Paul Blair, President VS
Professor Rob Sayers, Vice President-elect VS

We were asked by the commissioners to conduct a review of vascular services in South Hampshire. Our findings and recommendations are set out below-

1. There have been several previous reviews that have failed to make progress. The workforce are now demoralised and frustrated by lack of decisions making and action.
2. There are difficulties with geographical boundaries but the catchment population seems adequate.
3. A wider review of the Central South Coast may be necessary in the future. This should include Brighton and Bournemouth.
4. Chichester should be considered in this present review. Concerns were raised about the safety of current vascular support to Chichester .These concerns should be investigated and if confirmed then patient safety issues may need to be addressed as a matter of urgency. We have escalated our concerns via the commissioners.
5. We were given conflicting information and opinion within and between Trusts regarding current working practices and there was a degree of mistrust on both sides.
6. Both sides concentrated on the deficiencies of the other side rather than the positive aspects of their own bid.
7. There were significant differences between the two trusts regarding a willingness to invest in vascular services.

We were able to visit both units (Southampton and Portsmouth) and travel between them. Some specific views about each unit are as follows-

Portsmouth

1. The current practice is probably not sustainable in the long term due to overall low case volume, marked disparity in distribution of cases between surgeons and very low volume of major arterial cases for two surgeons.
2. There was lack of clear clinical leadership in Vascular Surgery.
3. There was an excellent vascular laboratory but no dedicated hybrid room and no dedicated vascular ward (shared with urology).
4. Portsmouth and Southampton currently undertake regular MDT for complex cases with transfer of some cases for treatment in Southampton.
5. There will shortly be 5 vascular radiologists in Portsmouth, all will be on the on call rota and 4 out of 5 are trained in EVAR. There is Trust Board approval for appointment of the 6th. We made considerable efforts to clarify this situation and were re-assured that Portsmouth can provide a full on-call vascular radiology rota.
6. There are busy and successful co-dependencies (diabetic foot services, nephrology and urology) that would require significant support if Portsmouth was to become a spoke hospital.
7. The vascular surgical rota at Portsmouth is poor. They have 6 surgeons but one does no on call and one is also on the transplant rota at the same time. We have since learned that one surgeon will shortly be leaving. The majority of the vascular work at Portsmouth is done by 1-2 surgeons and according to the National Vascular Registry (NVR) one surgeon does no aortic work and another did no aortas in a 5 year period.

Southampton

1. We were concerned about potential lack of capacity at Southampton.
2. The Senior Management Team did not appear keen to invest in Vascular Services unless there was centralisation on the Southampton site.
3. There are appropriate surgical services for an arterial hub currently on site including cardiothoracic and trauma
4. In patients requiring chronic haemodialysis require admission to HDU/ICU, the development of a small dedicated area for intermittent use should be considered.
5. There are 7 consultant vascular surgeons however 2 no longer take part in out of hours on call at weekends.
6. There are only 4 IR consultants.
7. There is no hybrid room but plans to develop one.
8. There is no VSU.
9. There is an active complex EVAR programme.

Currently both units are not POVS compliant – Portsmouth have problems with the on call surgical rota and Southampton lack Vascular Radiology

In terms of the future – it would be possible to make both units POVS compliant and stand alone. This would involve Portsmouth providing vascular services for Chichester and both units would require substantial investment with consultant appointments and development of facilities. However this model would probably only be sustainable in the short term. In the long term both units may have difficulty in recruiting consultants and trainees and 7 day working would need more consultants on a 1 in 8 rota or greater.

The alternative and more appropriate long term sustainable option would be centralisation of services on the Southampton site. This option would likely lead to a high class vascular facility but would require capacity and resource issues to be addressed. The success of this centralised model would require-

7. Significant cooperation from the vascular surgeons to provide adequate services at the hub and spoke hospitals.
8. Capacity issues at Southampton to be addressed.
9. A clinical lead to be agreed and appointed.
10. Clear demonstration by Southampton Trust of a willingness to invest and develop vascular services.
11. A staggered merger should be avoided.
12. Reconfiguration of services is difficult and can be prone to misinformation therefore early engagement between local politicians and professional bodies should take place as soon as possible in order to provide accurate information for the public through local media

APPENDIX F "Option 4"

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.)

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 .
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.

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"

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.

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.

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:
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, reablement 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.

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.

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.

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

Phase 3

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.

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.

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.

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.

APPENDIX G VSQIP Surgeon Outcomes

University Hospital Southampton NHS Foundation Trust

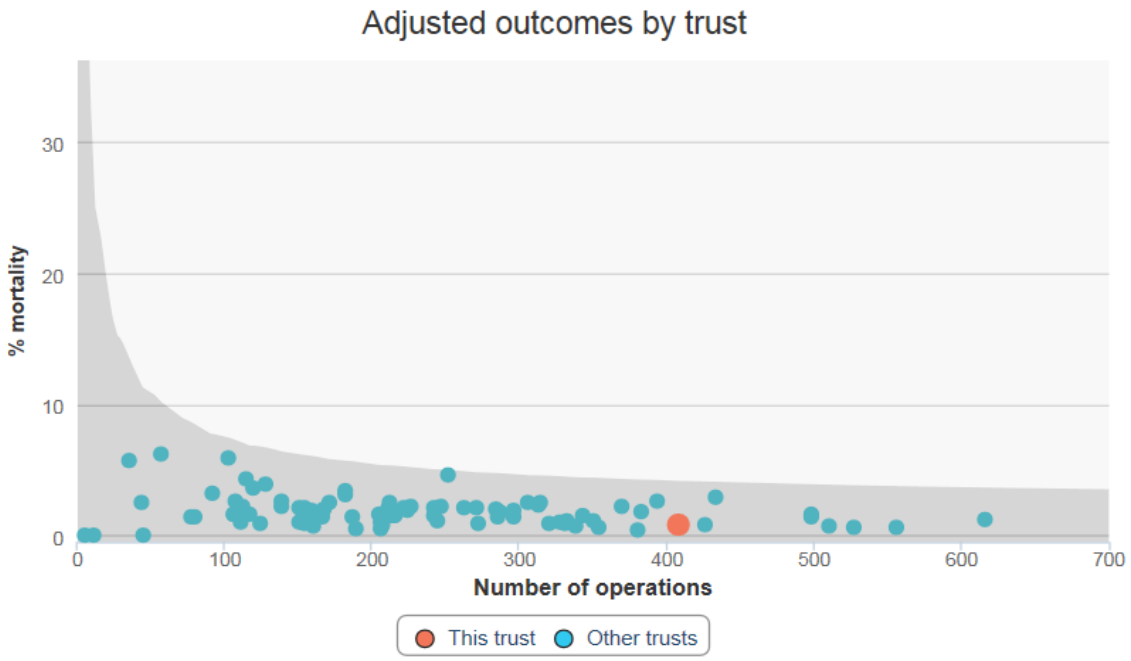
Vascular specialists working at University Hospital Southampton NHS Foundation Trust perform vascular surgery at Southampton General Hospital.

Elective Infra-Renal AAA Repair

Trust outcomes

In the funnel plots below, each dot represents an NHS trust or surgeon. The vertical axis indicates the mortality rate with dots higher up the axis showing NHS trusts or surgeons with higher values. The horizontal axis shows surgical activity with dots further to the right showing the NHS trusts or surgeons who perform more operations.

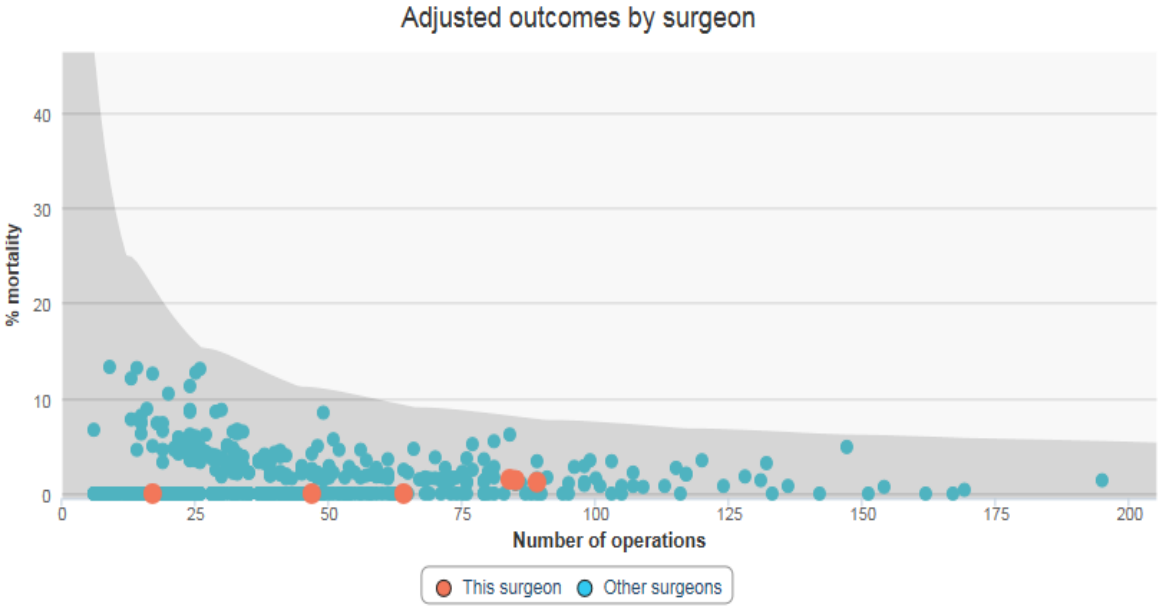
This NHS trust provided information on between 90% and 100% of their expected cases



No. of procedures	Patients discharged alive	Adjusted mortality rate %	Length of stay (days) Median (IQR)

No. of procedures	Patients discharged alive	Adjusted mortality rate %	Length of stay (days) Median (IQR)
408 165 open, 243 EVAR	405	0.8	6 (3,8)

Surgeon outcomes



Name	No. of procedures	Patients discharged alive	Adjusted mortality rate %	Length of stay (days) Median (IQR)
Mr Stephen Baxter [4248202] VS	47 26 open, 21 EVAR	47	0.0	7 (4,8)
Mr Gareth Morris [2373766] VS	84 48 open, 36 EVAR	83	1.5	7 (4,9)
Mr Ian Nordon [4624574]	64 9 open, 55	64	0.0	4 (3,7)

Name	No. of procedures	Patients discharged alive	Adjusted mortality rate %	Length of stay (days) Median (IQR)
VS	EVAR			
Mr Mike Phillips [3179626] VS	85 26 open, 59 EVAR	84	1.4	6 (3,8)
Prof Cliff Shearman [2497217] VS	17 10 open, 7 EVAR	17	0.0	8 (5,9)
Mr Nicholas Wilson [2726209] VS	89 42 open, 47 EVAR	88	1.2	6 (3,8)

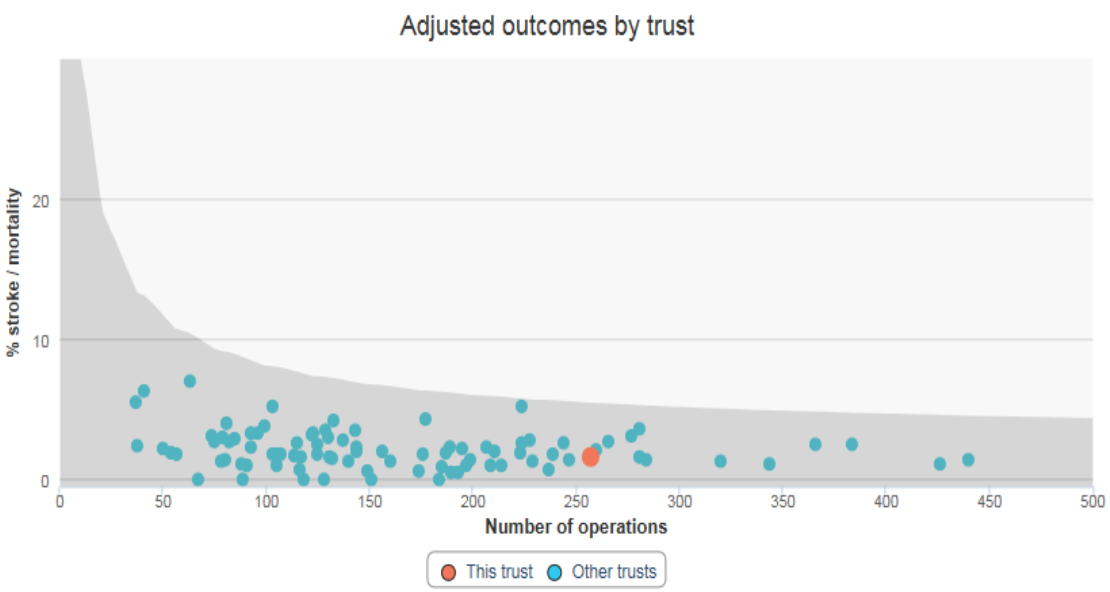
KEY: VS = Member of VSGBI, M = Surgeon operates at multiple NHS trusts, A = Surgeon is newly appointed consultant.
For a surgeon with few procedures, the symbols ▲ and ■ indicate whether the surgeon had outcomes within or outside the expected range.

Carotid Endarterectomy

Trust outcomes

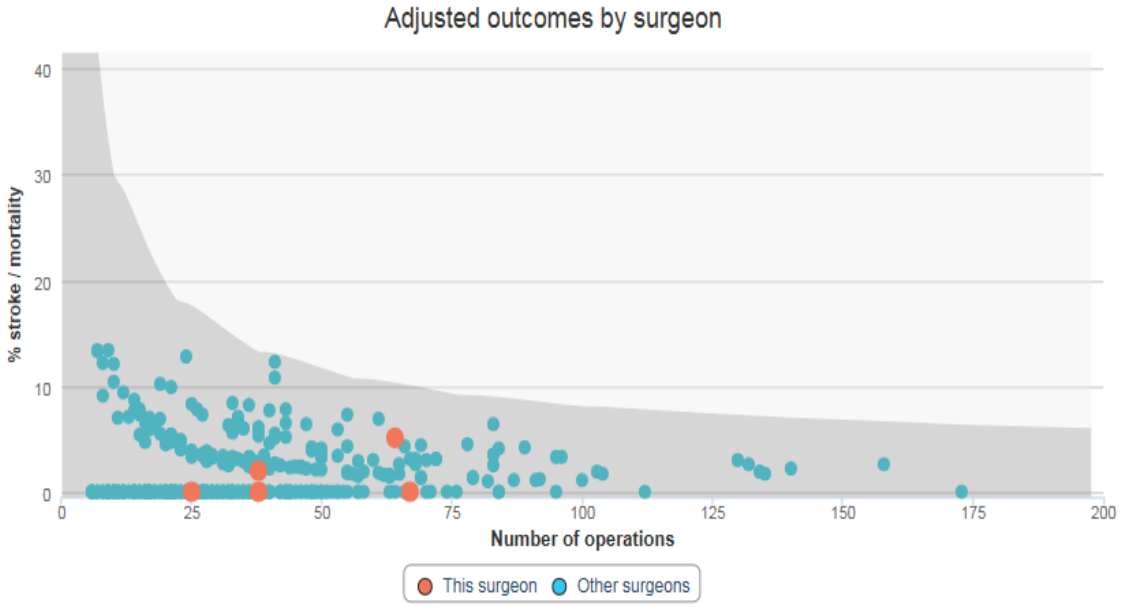
In the funnel plots below, each dot represents an NHS trust or surgeon. The vertical axis indicates the mortality rate with dots higher up the axis showing NHS trusts or surgeons with higher values. The horizontal axis shows surgical activity with dots further to the right showing the NHS trusts or surgeons who perform more operations.

This NHS trust provided information on between 90% and 100% of their expected cases



No. of procedures	Patients discharged alive	Adjusted mortality rate %	Days from symptom to surgery Median (IQR)	Length of stay (days) Median (IQR)
257	252	1.6	9 (6,12)	3 (2,5)

Surgeon outcomes



Name	No. of procedures	Patients discharged alive	Adjusted mortality rate %	Length of stay (days) Median (IQR)
Mr Stephen Baxter [4248202] VS	38	38	0.0	3 (2,5)
Mr Gareth Morris [2373766] VS	64	60	5.1	3 (2,5)
Mr Ian Nordon [4624574] VS	25	25	0.0	2 (2,3)
Mr Mike Phillips [3179626] VS	38	37	2.0	3 (2,5)
Mr Nicholas Wilson [2726209]	67	67	0.0	3 (2,5)

Name	No. of procedures	Patients discharged alive	Adjusted mortality rate %	Length of stay (days) Median (IQR)
VS				

KEY: VS = Member of VSGBI, M = Surgeon operates at multiple NHS trusts, A = Surgeon is newly appointed consultant.

For a surgeon with few procedures, the symbols ▲ and ■ indicate whether the surgeon had outcomes within or outside the expected range.

Portsmouth Hospitals NHS Trust

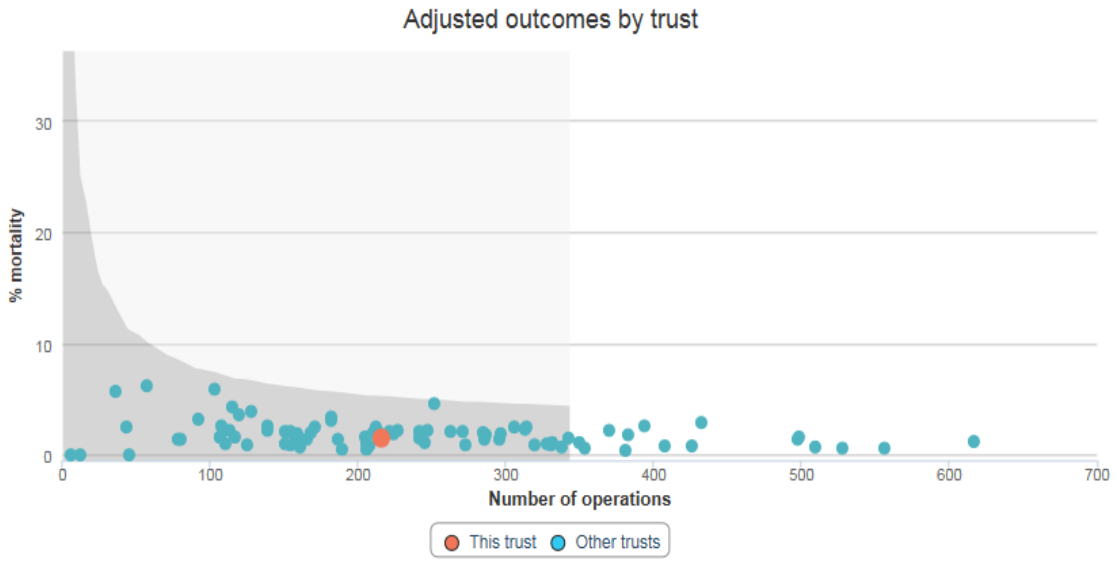
Vascular specialists working at Portsmouth Hospitals NHS Trust perform vascular surgery at Queen Alexandra Hospital.

Elective Infra-Renal AAA Repair

Trust outcomes

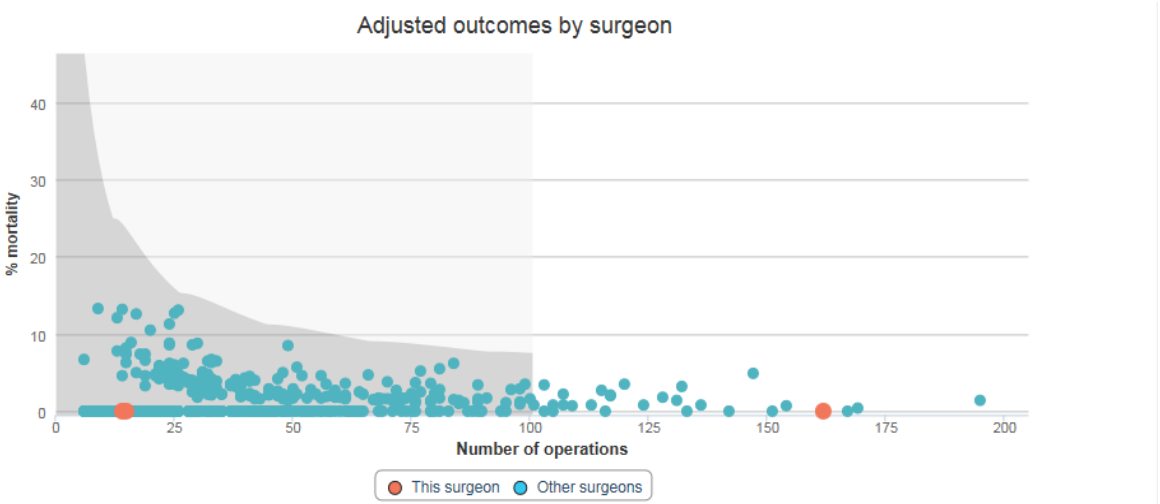
In the funnel plots below, each dot represents an NHS trust or surgeon. The vertical axis indicates the mortality rate with dots higher up the axis showing NHS trusts or surgeons with higher values. The horizontal axis shows surgical activity with dots further to the right showing the NHS trusts or surgeons who perform more operations.

This NHS trust provided information on between 90% and 100% of their expected cases.



No. of procedures	Patients discharged alive	Adjusted mortality rate %	Length of stay (days) Median (IQR)
216 77 open, 139 EVAR	213	1.5	2 (1,6)

Surgeon outcomes



Name	No. of procedures	Patients discharged alive	Adjusted mortality rate %	Length of stay (days) Median (IQR)
Mr Paul Gibbs [3588507]	14 14 open, 0 EVAR	14	0.0	8 (6,9)
Mr Perbinder Grewal [4532992] VS	15 3 open, 12 EVAR	15	0.0	1 (1,5)
Mr Richard Mark Pemberton [3179750]	162 41 open, 121 EVAR	162	0.0	2 (1,5)
Mr Timothy Whitbread [2580508] VS	*	*	▲	*

KEY: VS = Member of VSGBI, M = Surgeon operates at multiple NHS trusts, A = Surgeon is newly appointed consultant.

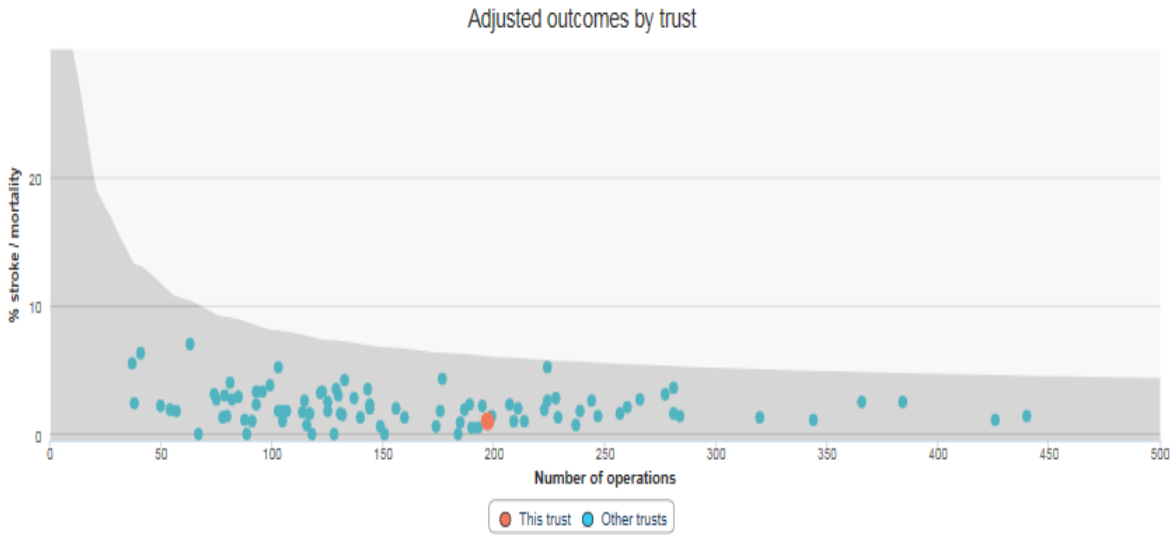
For a surgeon with few procedures, the symbols ▲ and ■ indicate whether the surgeon had outcomes within or outside the expected range.

Carotid Endarterectomy

Trust outcomes

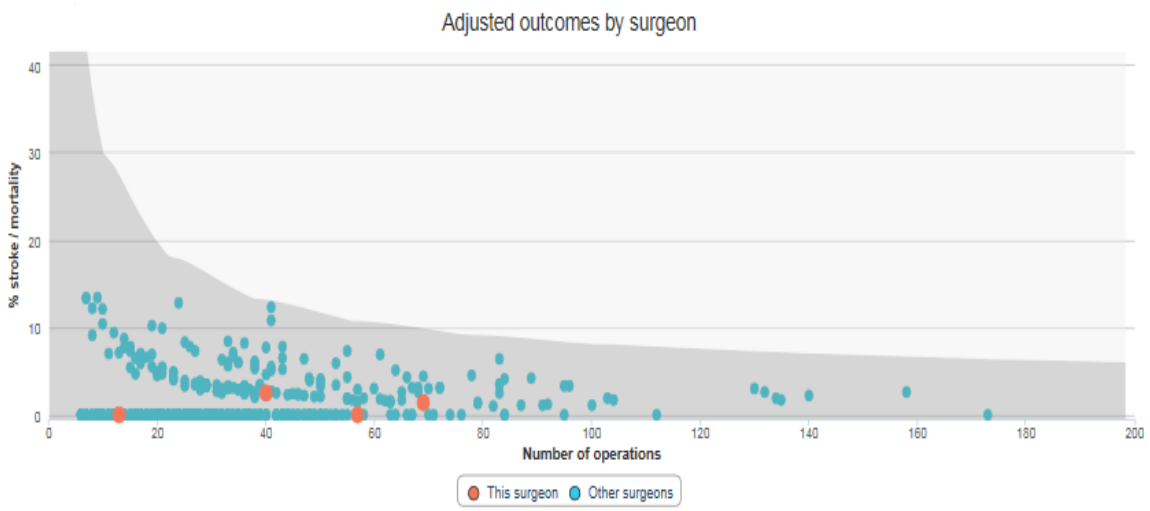
In the funnel plots below, each dot represents an NHS trust or surgeon. The vertical axis indicates the mortality rate with dots higher up the axis showing NHS trusts or surgeons with higher values. The horizontal axis shows surgical activity with dots further to the right showing the NHS trusts or surgeons who perform more operations.

This NHS trust provided information on between 80% and 90% of their expected cases



No. of procedures	Patients discharged alive	Adjusted mortality rate %	Days from symptom to surgery Median (IQR)	Length of stay (days) Median (IQR)
197	195	1.0	12 (7,30)	1 (1,2)

Surgeon outcomes



Name	No. of procedures	Patients discharged alive	Adjusted mortality rate %	Length of stay (days) Median (IQR)
Mr Perbinder Grewal [4532992] VS	40	39	2.5	1 (1,4)
Mr Simon Payne [3115950] VS	69	68	1.4	1 (1,2)
Mr Richard Mark Pemberton [3179750]	57	57	0.0	1 (1,2)
Mr Timothy Whitbread [2580508] VS	13	13	0.0	1 (1,2)

KEY: VS = Member of VSGBI, M = Surgeon operates at multiple NHS trusts, A = Surgeon is newly appointed consultant.

For a surgeon with few procedures, the symbols ▲ and ■ indicate whether the surgeon had outcomes within or outside the expected range.

National Vascular Registry

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APPENDIX H UHS Capacity & Transfer Proposal

Proposal

Wessex Regional Vascular Service

University Hospital Southampton NHS Foundation Trust
(UHS) Portsmouth Hospitals NHS Trust (PHT)
Hampshire Hospitals NHS Foundation Trust (HHFT)
Isle of Wight NHS Primary Care Trust (IOW)

UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST

PROPOSAL FOR THE WESSEX REGIONAL VASCULAR CENTRE FOR THE PROVISION OF EMERGENCY AND COMPLEX ELECTIVE VASCULAR SURGERY
For Southampton, Hampshire, Isle of Wight and Portsmouth

Foreword

UHS submits this proposal to NHS England in support of the recent recommendations from the Vascular society of Great Britain and Ireland (VS) that PHT join the existing Wessex network and that UHS acts as the major arterial centre (MAC) for that network.

Paul Blair (President) and Rob Sayers (Vice President (elect)) of the VS undertook a review of Southern Hampshire vascular services, specifically University Hospital Southampton NHS Foundation Trust (UHS) and Portsmouth Hospital NHS Trust (PHT), on 19th and 20th August 2015. Their recommendation was

"The alternative and more appropriate long term sustainable option would be centralisation of services on the Southampton site. This option would likely lead to a high class vascular facility but would require capacity and resource issues to be addressed."

UHS believes that it can assure commissioners and the public that it has addressed those issues and that implementation of that recommendation is the best for the future of sustainable vascular services in the region.

University Hospital Southampton NHS Trust (UHS) provides local hospital services to around 1.3 million people living in Southampton and Southern Hampshire. It also provides specialist services such as neurosciences, cardiac services, gastrointestinal, respiratory, women and children's and cancer services to more than 3.5 million people within central southern England and the Channel Islands. UHS is a designated Major Trauma Centre (MTC) and, as determined by the NHS Standard Contract must provide vascular services .The Trust is also a major centre for teaching and research in association with the University of Southampton and partners include the Medical Research Council and Wellcome Trust.

Introduction

Background

The options regarding vascular services in Southern Hampshire have been under consideration for several years. In order to move this forward NHS England commissioned the Vascular Society of Great Britain and Ireland to carry out a review of those services in August 2015.

Following the review of services in both in Portsmouth and Southampton the Vascular Society identified a range of issues at both hospitals that needed to be addressed in order to ensure a high quality & sustainable services for the future. The report recommended that the best way of ensuring that vascular provision was resilient would be the extension of the existing Wessex network to include PHT with University Hospital Southampton operating as the MAC.

The report and a subsequent letter to Fiona Dalton , CEO at UHS from Dominic Hardy, Director of Commissioning Operations NHS England – South (Wessex) in October 2015, stated that success would be based on a clear demonstration by UHS of willingness to invest and develop vascular services and the recommendation also emphasised that a staggered merger should be avoided. In order to meet NHS England's deadline for presentation of their option appraisal to the various local health oversight committees in March, UHS have prepared this summary document in order to inform the decision making process.

Specifically UHS were asked to:

- Address bed capacity issues with designation of a VSU (ward) and clarify how this would be achieved.
- Approve plans for the installation of a hybrid theatre at UHS.
- Formalise arrangements for renal pts who would be transferred to UHS for arterial surgery - (5 pts per annum.)
- 1:6 24/7 vascular Interventional Radiologist (IR) rota via a network solution.

A UHS Vascular working group has been established to develop a solution for arterial centralisation.

This group has representation from across the divisions and is working on delivering a sustainable plan which would support the transfer of all arterial work to UHS in quarter 3 2016.

UHS believes that it is ideally placed to deliver this service because it has excellent outcomes, strong multidisciplinary teams and 24-hour vascular and interventional radiology cover. The trust has an excellent EVAR and TEVAR programme that has embraced the adoption of new technologies. UHS also hosts the regional AAA screening programme since January 2011. In

summary, UHS has outstanding results and a committed, clinically excellent service that already delivers excellent patient outcomes.

Current Service Provision Model

Referral patterns and geography currently dictate where and by whom patients are treated, rather than patient need. The current provision at each trust for vascular services is as follows:

UHS, HHFT, and IoW: To support the ongoing move towards complexity and specialisation of services UHS has already developed a network with HHFT and IoW for the provision of vascular services covering a population in excess of 900,000. This model already delivers a co-located vascular service, combining expertise and improved clinical outcomes, with the 2015 National Vascular Registry publications demonstrating UHS to be one of the busiest vascular units in the country with superior outcomes in a number of index vascular procedures. As already identified within the need for change, the current service model underpins the tertiary services provided within Southampton hospitals, for example cardiac surgery, major trauma and stroke

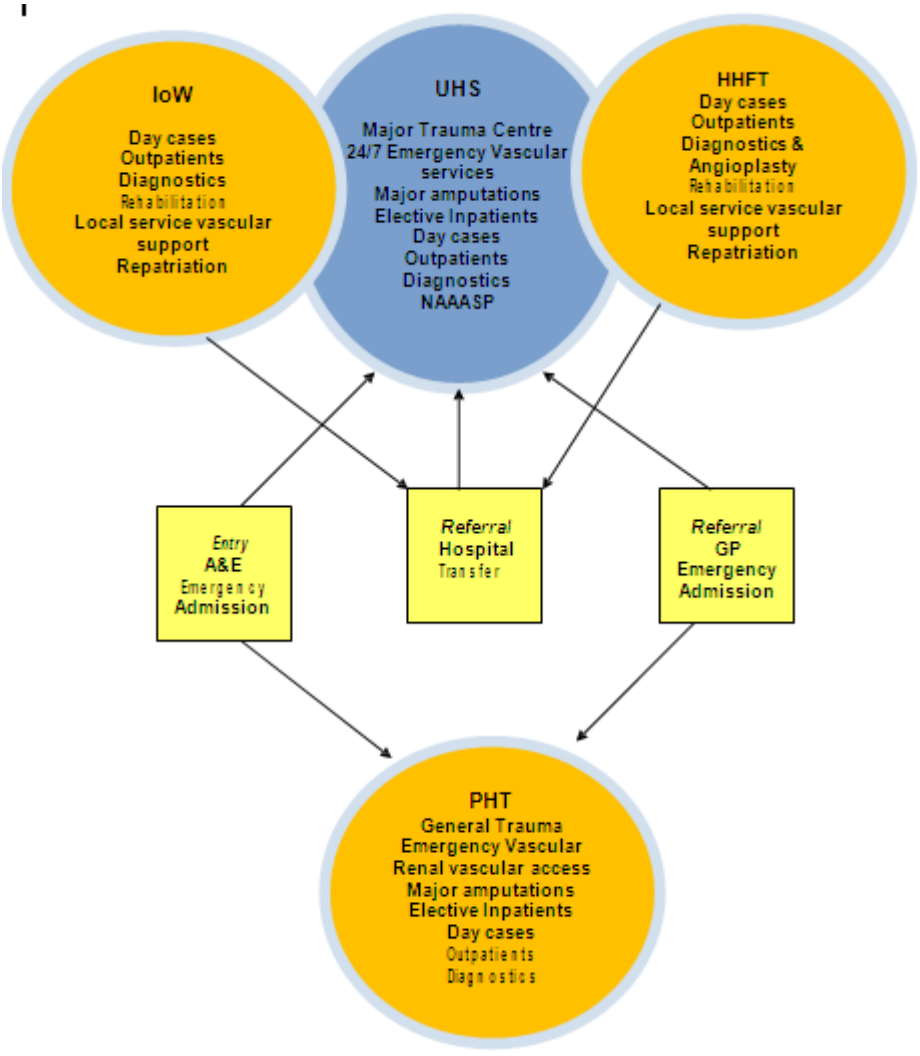
UHS provides 24/7 vascular surgeon cover with 6.5 WTE vascular surgeons and the necessary associated support services. There are five full day vascular theatre lists per week, with additional access to emergency theatre when required. UHS has the following diagnostic facilities on site: MR angiography, CT angiography, non-invasive imaging and interventional radiology (IR). A Hybrid theatre is scheduled for opening in November 2016. Outpatient facilities are provided in the newly commissioned outpatient's area.

HHFT - WINCHESTER HOSPITAL has vascular surgeon cover three days per week, plus outpatient cover. At other times, vascular advice is available via UHS and when required, patients will be transferred to UHS. A theatre is available for minor surgery.

IoW has a UHS vascular surgeon visiting 1 day per week, who undertakes day surgery, outpatient clinics and ward patient reviews. At other times, vascular advice is available via UHS and if required, patients will be transferred to UHS.

PHT: There are vascular 2.5WTE vascular surgeons providing cover, with 2.5 remote clinics per week and 3.25 vascular lists per week for major elective work. The necessary associated support services are present on site including 1 nurse practitioner, 1 vascular specialist nurse and 4 WTE vascular technologists.

Current Referral and Entry Routes



Discharge/Exit Routes

Patients can be transferred from UHS to HHFT and IoW following inpatient care. Plans to discharge back to primary or local hospital care is made as early as possible to enable the patients to be closer to home. A discharge communication, including ongoing management plan, is provided. Work is currently underway, initiated by the CEOs from the network hospitals and operationally overseen by the Chief Operating Officers within those organisations to ensure that repatriation of patients back to their local services is prioritised on a daily basis regardless of the hospitals overall alert status. NHS England is aware of this important work stream and has committed to support any contractual discussions.

Proposed Service Provision Model

The Wessex Regional Vascular Service

NHS Abdominal Aortic Aneurism Screening Programme (NAAASP)

UHS is the designated host for the Hampshire NAAASP service. Staffed by UHS vascular surgeons, vascular technicians and administrative staff, the service commenced in 2011.The relevant data on surgeons outcomes is submitted to the NVD and the unit ensures that the unit estimate for elective mortality for infra renal aortic aneurysm procedures is at 6% or lower, taken from the 30 day mortality data for patients as appropriate. The necessary action can be taken to review the case mix should the mortality rate be higher than this. The unit has adopted the Quality Improvement Framework set out by the VSGBI1.

General

UHS's proposed model for a Wessex Regional Vascular Service, bringing together the services in the four trusts in line with the recent review recommendations, meets the necessary requirements for ensuring the provision of a high quality, robust, sustainable vascular service for Southern Hampshire and is in line with the recent report from the Vascular society of Great Britain and Ireland (VSGBI)

The proposal from UHS is that UHS, PHT, HHFT and IoW work together in a partnership to provide the Vascular Service for Southern Hampshire with UHS serving as the arterial hub the for the system. The clinical service would then have four sites, each playing an important part in service delivery. With similar working arrangements already in place with HHFT and IoW, UHS believes that the inclusion of PHT into the service model would provide the necessary assurances

required for a robust service whilst enabling ongoing improvements in clinical outcome and patient experience. The full range of vascular surgery services would be covered, with robust 24/7 specialist emergency vascular care and input from dedicated, experienced vascular teams.

The proposed service will maintain world class outcomes for all patients within the catchment area who have been referred via their GP to a vascular specialist within secondary or tertiary care and in addition it will ensure that those excellent outcomes are available to all patients across a 24hour period should they present as a vascular emergency out of hours or at weekends. It complies with the appropriate POVS 2015 report national standards and meets the requirements within the NHS England Vascular Surgery Service Specification. The service model being proposed will ensure patients receive the best possible treatment in a timely manner, with improving clinical outcomes and patient experience. This will be supported through the Trust's service portfolio, which includes:

- The regional AAA screening service
- Level one major trauma centre designation
- A centralised, dedicated vascular unit with the appropriate staff, which manages both acute and chronic patients.
- Equity of access for all patients to 24/7 dedicated vascular surgical and IR service at UHS with timely discharge home or to local partner hospital.

When proposing this service model, all aspects of the vascular surgery service specification were carefully considered to ensure compliance, including the minimum numbers and types of procedures that vascular units should undertake, given the link between the volume of procedures undertaken by surgeons and clinical outcomes. The aim is to ensure a reasonable and sustainable elective and 24/7 emergency vascular surgery service providing the highest standard of care equitably and with excellent patient outcomes. The reconfigured Wessex Regional Vascular Service will provide the following assurances:

- The provision of robust 24/7 specialist vascular care for all emergencies in IoW, PHT, UHS, HHFT, with input from both dedicated, experienced vascular teams, which include consultant vascular surgeons and interventional radiologists
- Sufficient throughput volume and associated capacity, plus access to the appropriate staff, equipment and facilities required ensuring optimum clinical outcomes.
- Sufficient throughput volume to ensure that the service is financially viable in the longer term and provides best value for the whole Health care economy.

- Use of the latest technology in UHS for procedures, including endovascular techniques, in order to attain the best possible clinical outcomes and effective use of hospital resources.
- Adherence to evidence based best practice and national guidance.
- Internal service improvement to reduce patient length of stay, together with continuous and effective monitoring around the Patient Care Improvement Framework (PIF) to ensure an improved patient experience, clinical outcomes and appropriate safety and including the need to minimize patient and family travel.
- Accurate recording and audit of procedures and outcomes onto the relevant databases.

Volume Figures

The figures in the next table were provided by NHS England and reflect the appropriate vascular interventions that require an inpatient stay and which would transfer to UHS. UHS has based the proposal on the figures provided and will work with commissioners once the outcome of the options appraisal is made to accurately verify the data. The plan to deliver the increase in capacity, including future proofing the bid, is shown under the separate headings for staffing, facilities and operational delivery.

Indicative case mix from Portsmouth (based on actual activity 15/16 Mth 9 SLF)

	Code	Volume	% uplift on UHS current activity
Fem Pop	QZO3Z	22	98%
Fem distal	QZO2A	18	
Carotid endarterectomy	QZO4Z	56	
Fem endarterectomy	QZO2A / QZO2B	38	
AAA open	QZO1B	8	40%
Amputation	QZ11A/QZ11B	49	144%
EVAR	QZ01A	43	70%
TVAR	AC12R-E	26	69%
Non Elective			
Trauma		25	
Ruptured AAA		17	
AAA for non elective mgmt		10	

Staffing Levels

Staff Requirement

The necessary staff requirement for each specialty is detailed in the table below.

Staff Group	Current Provision		Required Provision for Wessex network	Action
	UHS/HHFT/IOW	PHT		
Vascular Surgeons	6.3	2.5	10	Advertise for network appointment
Vascular Anaesthetists	6	6	TBC	Explore network solution with PHT consultants.
Interventional Radiologists	9 (Vascular 5)	5 (Vascular 1)	6	Network solution for vascular & to support non vascular work at PHT.
ICU – L 3 staff ratio 6.1:1 but rising to 6.8:1 HDU – L 2 staff ratio 3.5:1	UHS: UHS: 39 level 3 beds (Neuro ICU 13 beds excluded) @6.8 :1 HDU 8 beds @ 3.5 :1 (medical & cardiac HDU beds excluded from current provision)	Tbc Tbc	(Additional required) UHS - Level 3 + 1 bed =6.8wte UHS - Level 2 +1 bed = 3.5wte	Options: Deliver from LoS schemes Commission vacant bed space Implement flexible use of CICU/ CHDU capacity Increased monitored beds in VSU – 3 beds
Ward beds – L1staff ratio 1:5	UHS – current 22 beds ration 1.5	Mixed ward 10-12 beds	UHS UHS: 34 beds, ratio of 1.5 (from October 2016)	Bed capacity and AWL delivered as part of CV&T ward reconfiguration

- **Vascular Surgeons**

Onsite, 24/7 service provided at UHS. The current UHS, HHFT and IoW service has 6.3 WTE vascular surgeons. There are 2.5 surgeons plus 1 vacant post at PHT. This vacant PHT post is to be advertised as a joint appointment to the network, hosted by UHS but based in PHT. The consolidation of clinical service will fulfil the requirements of the service specification. In practical terms, this means that for Portsmouth patients, the vascular surgeons will come to UHS to undertake the elective vascular lists and would contribute to the emergency on-call rota.

- **Nursing Staff**

In November 2013 as part of the national response to the Francis enquiry, the National Quality Board published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place at the right time'. UHS had already developed a sustainable model of systematic review for staffing levels on the wards using evidence based and triangulated nationally recognised methodological approach which has been strengthened year on year. The review for 2015 has shown that the current staffing model within vascular meets the national recommendations, which ensures that staffing levels remain safe and effective. This model equates to 1.5wte per bed with a ratio of 68:32; trained and untrained staff. Therefore, the additional beds should be staffed to support these levels. This arrangement will allow better throughput for fast track patients onto the ward and will also reduce the need for HDU level 2 beds with three ward beds fully monitored.

- **Anaesthetists**

On site, 24/7 service provided at UHS. The Anaesthetic / Critical care service has over 90 consultants' anaesthetic staff & is further supported by a number of clinical fellows. All staff who cover theatre sessions are trained to manage vascular emergencies, and there are dedicated vascular anaesthetists available for elective sessions in UHS. There would be an opportunity to network with P'mth vascular anaesthetists should they wish to follow the work and surgeons from PHT.

- **Interventional Radiologists**

On site, 24/7 IR service provided at UHS. All participating radiologists can provide a basic vascular service although advanced vascular intervention (EVAR, Complex stenting, Thrombolysis /Thrombectomy) is currently only provided by 5 radiologists, with the option to train up a 6th. Urgent CTA is available 24/7.

The consolidation of clinical service will mean that the Portsmouth IRs will attend UHS to undertake elective EVAR and complex IR work and contribute to the emergency radiology rota. They would still undertake elective diagnostic and interventional vascular radiology and renal services support at PHT. A networking solution is being explores to ensure that PHT non vascular services would not be compromised.

UHS Facilities detail:

- **Operating Theatre**

Dedicated 5 day vascular lists per week, with additional access to 24hr NCEPOD emergency theatre if required for emergency vascular procedures. Access to radiolucent operating tables, x-ray and specialist consumables readily available. Theatre data shows that currently vascular theatre utilisation runs at < 75 %.

The installation of a Hybrid theatre will support the back fill of the vascular theatre lists which currently remain on standby and empty whilst EVAR procedures take place in the IR suite. A combination of these empty theatre lists on EVAR sessions, lists that are not cross covered prospectively by the vascular surgeons during AL and an increase in theatre utilisation to > 85%, should provide sufficient capacity for the additional open elective cases which would transfer from PHT. If theatre capacity did prove to be a capacity constraint then UHS also has the option of moving vascular theatres to 6 day operating, replicating a delivery model already established in general surgery, T&O, urology , ENT and Neurosurgery.

- **Emergency theatre time**

Indicative requirement 17 AAA cases per annum. The assumption is to allow 6 hours CEPOD time for each of the 17 ruptured AAA cases. The move of some non vascular theatre activity to the Hybrid lab affords some options to UHS around providing additional CEPOD capacity should that be required.

- **Blood Bank and Cross Matching Facilities**

There is a fully staffed Haematology and Blood transfusion service on site, run by state registered clinical scientists and laboratory staff, supported by clinical consultants. This service is manned 24/7

offering a rapid full Haematology service and has full Clinical Pathology Accreditation (CPA) compliance and is registered, ensuring the appropriate level of service and quality.

- **Vascular ward**

UHS already has a 22 bed vascular ward D4. The Cardio-Vascular care group, who manage the service, is working with UHS estates to move vascular to a larger 34 bedded footprint on E4. Bed and nursing capacity has been released from elsewhere in the Care Group to support this move via a number of improvement schemes e.g.:

- Move of all cardiology elective interventions to Day case
- Weekend catheter laboratory service extended to include NSTEMI resulting in shorter LoS.
- Move of surgical admissions to day of surgery admission (supported by the use of Heartbeat House for cardiac admissions)
- Targeted LoS work by physiotherapy which has reduced LoS for elective amputee pts by 10.5 days (demonstrated by pilot)
- Use of UHS @ home for vac dressing patients
- Up to 12 beds available offsite for long stay patients awaiting packages of care or nursing home placement
- Ongoing discussion regarding direct referral to Portsmouth @ Home Service for suitable patients (mirrors the UHS @ home model)

In addition the LoS benefits from installation of the Hybrid theatre (releasing other IR rooms and theatre space) indicate a minimum of 6 beds across the organisation released if the impact on current waiting lists improves by an average of 2 days per patient for pts awaiting procedures such as vascular access.

- **Interventional Radiology & Image transfer**

UHS has all of the necessary equipment for vascular intervention procedures available, with a Hybrid theatre scheduled to open in November 2016. The other 2 interventional rooms are scheduled for replacement in 2017 as part of UHS's multi million pound investment in radiology infrastructure.

The Radiology department has developed a system that enables both trust wide and remote manipulation of images to improve workflow, diagnostic confidence and enable tertiary image review and increase collaboration with partner trusts. Work is ongoing with our PACs provider but the current system allows review of complex imaging by staff appropriately trained to undertake that work. It also allows the imaging performed locally to be reviewed at other sites, particularly at UHS for emergency transfer of patients or indeed prevention of transfer. This will

decrease unnecessary travel, improve utilisation of expensive resources and assist in patient experience. Staff will be able to remotely access and manipulate complex imaging studies both off site and within MDT's and theatres.

- **Non-Invasive Imaging**

The necessary equipment for non-invasive vascular procedures is available at UHS or neighbouring hospitals, where UHS consultants already provide vascular cover. In UHS vascular imaging sits across 2 services, Medical physics covering the venous and radiology covering the arterial. The plan from April 2016 is to amalgamate the service with increased leadership input from vascular surgery.

- **EVAR**

UHS was one of the first centres in the UK to introduce an EVAR service and now has an established, successful EVAR programme with all necessary facilities in place. All patients with detected AAA and deemed suitable for repair are considered for EVAR, with 75 % of elective AAA repair currently performed using endovascular techniques. New devices are also currently being explored, which will improve the service and also increase the percentage undertaken. 15 TEVAR procedures were undertaken at UHS in the past 12 months.

- **ITU / HDU**

UHS has reviewed its current ICU & HDU requirement from vascular surgery over a 2 year period.

Level 3

- 26 elective pts over a 24 month period
- 81 non elective pts over a 2 year period

Level 2

- 175 elective pts over a 24 month period
- 74 non elective pts over a 2 year period

Based on average LoS and occupancy for both units current vascular use is

- Level 3 – 1.1 bed per annum
- Level 2 – 1 bed per annum

Discussion is underway with critical care regarding delivery of the additional 1 level 3 & 1 level 2 bed to support the transfer of arterial work from P'mth.

Pathway changes have already commenced across other areas within Division D , Trauma & Specialist service (includes vascular) which will release ICU beds and staffing , specifically removal of TAVI (femoral) cases, removal of plasma exchange, development of an increased acuity Major Trauma bay in T&O.

Division A, Surgery & Critical Care have several LoS schemes already identified for 16/17which are based on roll out of successful early mobilisation schemes in 15/16 , specifically these relate to releasing capacity across cardiac , trauma & neurosurgical level 3 beds.

In addition ICU is investigating an alternative for pts requiring Haemofiltration which would also contribute to the release of capacity,

If pathway review and LoS schemes do not deliver there remains one bed space that could be opened.

- **Renal patients for transfer**

Transfer of arterial work from PHT would result in 5 patients per annum requiring renal support whilst at UHS for their vascular treatment. The initial thought was that this could be delivered as per the current model for cardiac and neurosurgical patients i.e.: Haemofiltration on ICU.

There is an opportunity to deliver renal support to this pt cohort using one of the new portable “at home” dialysis machines which may be suitable for not only the new vascular patients but would also release bed days and the nursing staff who currently deliver the existing haemofiltration demand. Activity and impact of this is being assessed.

UHS already undertakes renal dialysis within paediatrics (4 machines available). This unit links closely with the P’mth renal unit and staff training with regard to needling of fistula’s is supported by the satellite unit at Totton. Similar training arrangements could support the ICU development.

Table Showing Changes Required For Additional Volume

Facility	Required Provision	Action
Operating theatres	UHS – same provision	Prospective cover from vascular surgeons. Backfill lists vacated to support EVAR Increase current utilisation Option to move to extend to Saturday elective operating.
Vascular Laboratory	Develop vascular lab	Combine services currently delivering arterial and venous imaging under single management structure with increased managerial / operational input from vascular surgeons.
Endovascular theatre	UHS	Plan to be operational by November 2016
EVAR facilities	Increased facilities required	Commissioning of endovascular theatre as above
ITU	UHS - 1 additional Bed.	Pathway redesign to remove cases from ICU underway. One uncommissioned bed space remains available. No estates work required
HDU	UHS – 1 additional bed.	Pathway redesign to remove cases from HDU underway. No estates work needed
Ward Beds	UHS: 10-12 additional beds	Service improvement work streams have already delivered the capacity to support transfer and have facilitated vascular surgery to move into a larger footprint. Work remains on going to reduce LoS further. Some assumptions regarding repatriation of P'mth post surgery have been made as per CEO agreement to support 24 hour transfer (January 2016)

Operational Delivery

- **General**

UHS is ideally placed to deliver this service because it has excellent outcomes, strong multidisciplinary teams and 24-hour vascular and interventional radiology cover. Consultant Vascular surgeons already deliver weekend ward rounds which ensure consistent senior level decision making and intervention across a 7 day period. The trust has an excellent EVAR and TEVAR programme that has embraced the adoption of new technologies. UHS has hosted the

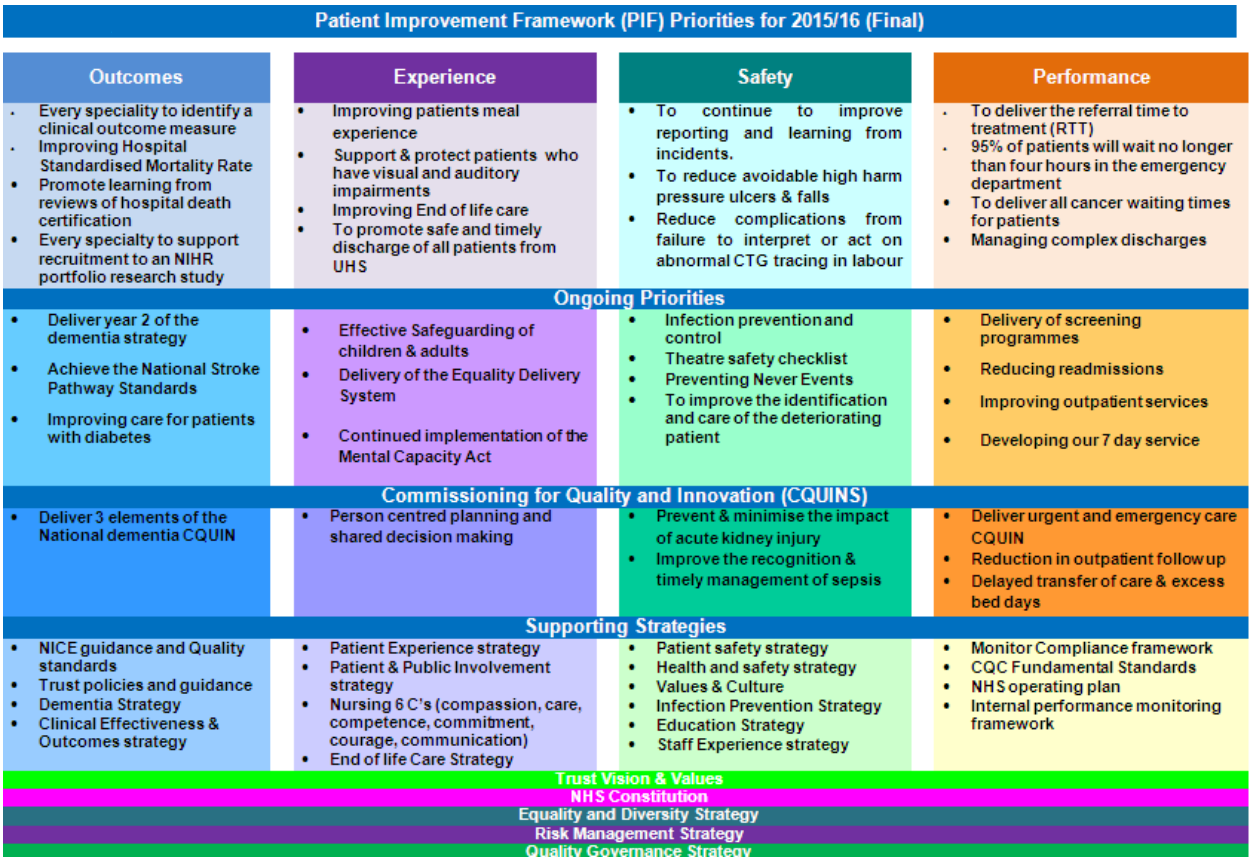
regional AAA screening programme since January 2011. In summary, UHS has outstanding results and a committed, clinically excellent service that is demonstrated in its outcomes.

- **Patient Experience**

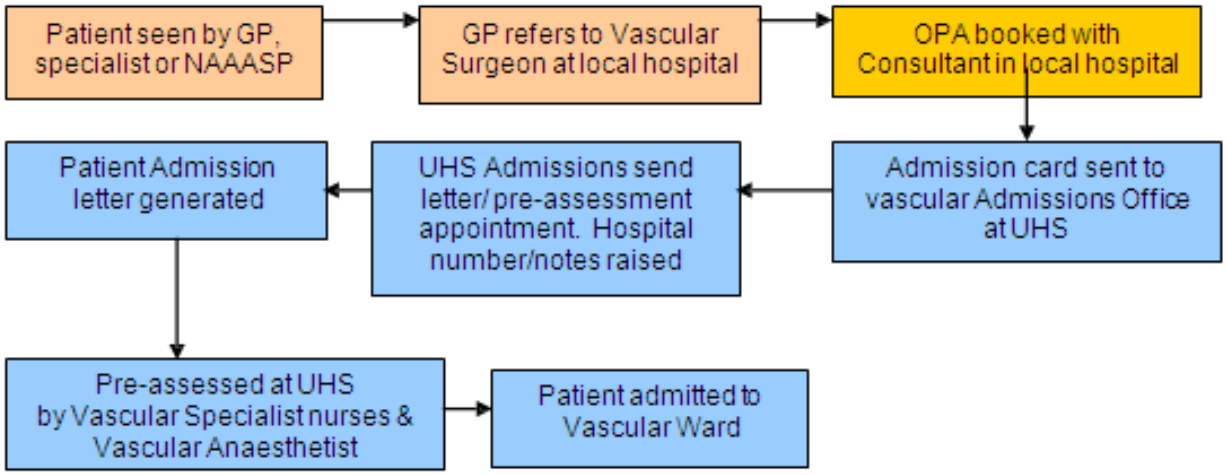
UHS has a robust, dynamic Patient Improvement Framework (PIF), underpinned by interrelated strategies which have evolved since its initial presentation within UHS in 2013. Aspects of patient safety, experience, and clinical outcomes have been key features of the framework and are linked with the national performance targets to ensure effective management of activity and patient experience. This year it has been agreed that the PIF will reflect the Care Quality Commission (CQC) domains and the priorities are presented under the headings of, safe, effective, caring and responsive and well led. The PIF priorities identified have been developed thus far through consultation with UHS staff, clinical commissioning groups, and external stakeholders and from patient feedback. Measurable and SMART performance indicators for each priority are currently under development and consultation on the priorities will be presented as part of the consultation of the Quality Account 2016/2017 during the 30 day consultation.

The Friends and Family Test (FFT) for the vascular service has provided the following results for the first three quarters of the financial year. The trust target for response rate is currently at 20%.

2015 / 16	Response Rate	Positive Response Rate	Negative Response Rate
Q1	78%	97.3%	0.0%
Q2	58%	98.1%	0.0%
Q3	74%	96.9%	0.0%
January	90%	94.7%	0.0%


Patient Improvement Framework (PIF) Priorities for 2015/16 (Final)
Outcomes
Every speciality to identify a clinical outcome measure
Improving Hospital Standardised Mortality Rate
Promote learning from reviews of hospital death certification
Every specialty to support recruitment to an NIHR portfolio research study
Experience
Improving patients meal experience
Support & protect patients who have visual and auditory impairments
Improving End of life care
To promote safe and timely discharge of all patients from UHS
Safety
To continue to improve reporting and learning from incidents.
To reduce avoidable high harm pressure ulcers & falls
Reduce complications from failure to interpret or act on abnormal CTG tracing in labour
Performance
To deliver the referral time to treatment (RTT)
95% of patients will wait no longer than four hours in the emergency department
To deliver all cancer waiting times for patients
Managing complex discharges
Ongoing Priorities
Deliver year 2 of the dementia strategy
Achieve the National Stroke Pathway Standards
Improving care for patients with diabetes
Effective Safeguarding of children & adults
Delivery of the Equality Delivery System
Continued implementation of the Mental Capacity Act
Infection prevention and control
Theatre safety checklist
Preventing Never Events
To improve the identification and care of the deteriorating patient
Delivery of screening programmes
Reducing readmissions
Improving outpatient services
Developing our 7 day service
Commissioning for Quality and Innovation (CQUINS)
Deliver 3 elements of the National dementia CQUIN
Person centred planning and shared decision making
Prevent & minimise the impact of acute kidney injury
Improve the recognition & timely management of sepsis
Deliver urgent and emergency care CQUIN
Reduction in outpatient follow up
Delayed transfer of care & excess bed days
Supporting Strategies
NICE guidance and Quality standards
Trust policies and guidance
Dementia Strategy
Clinical Effectiveness & Outcomes strategy
Patient Experience strategy
Patient & Public Involvement strategy
Nursing 6 C's (compassion, care, competence, commitment, courage, communication)
End of life Care Strategy
Patient safety strategy
Health and safety strategy
Values & Culture
Infection Prevention Strategy
Education Strategy
Staff Experience strategy
Monitor Compliance framework
CQC Fundamental Standards
NHS operating plan
Internal performance monitoring framework
Trust Vision & Values
NHS Constitution
Equality and Diversity Strategy
Risk Management Strategy
Quality Governance Strategy

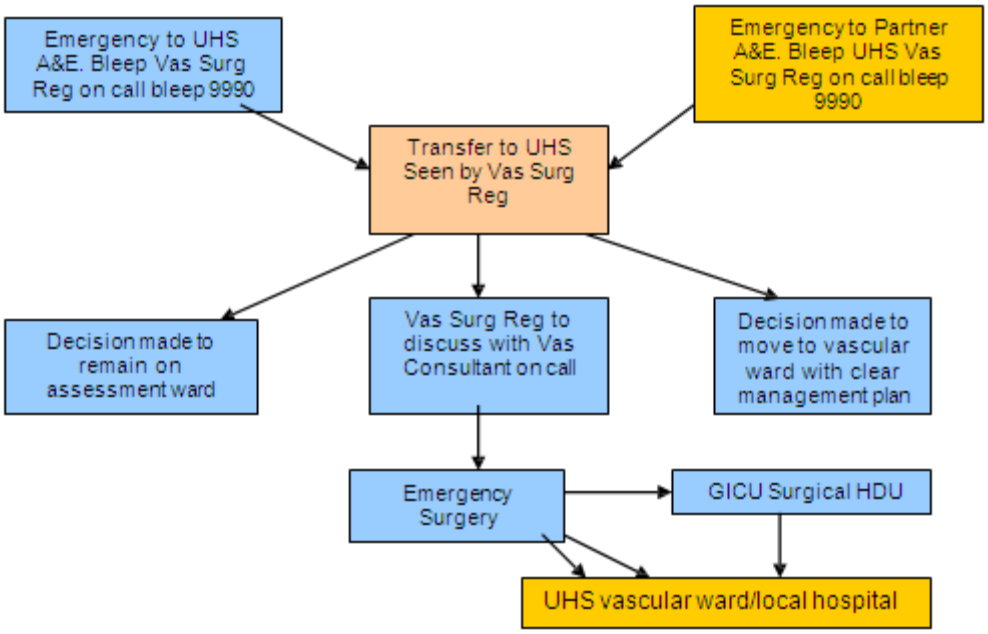
- **Elective Pathways**



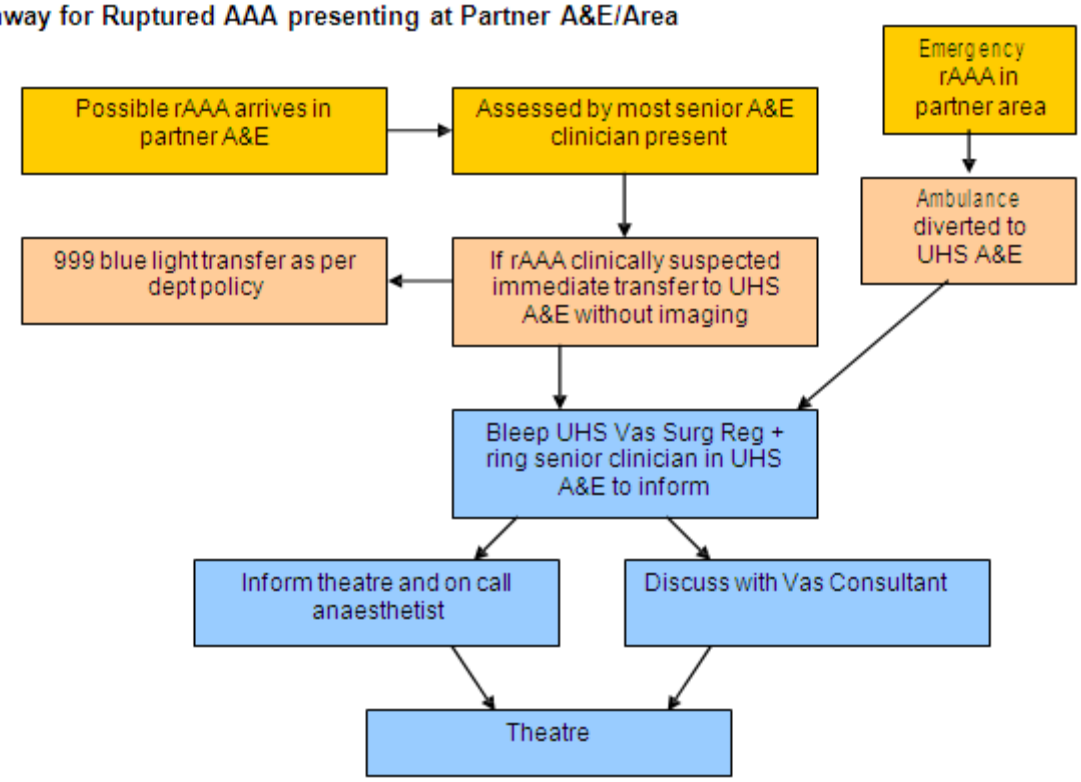
Patients requiring minor surgery or day surgery will continue to have this service provided at the local hospital.

Emergency Pathways

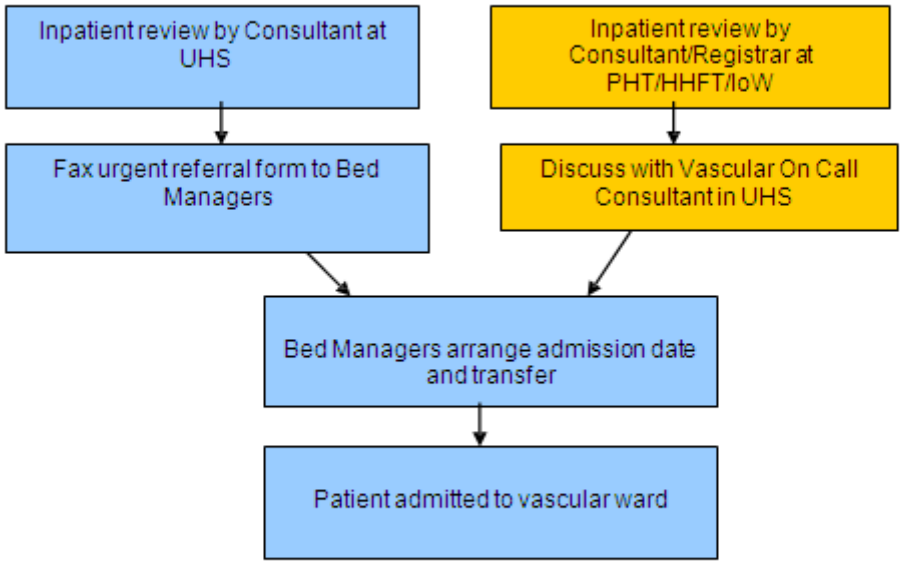
Pathway for emergency transfers (20:00 to 08:00 hrs and at weekends)



Pathway for Ruptured AAA presenting at Partner A&E/Area



Urgent Inpatient Transfer 0800 - 2000 for Non Elective Cases.



The regional transfer unit, currently working and located in the Care Group, is able to expand to ensure sufficient capacity for the vascular patients.

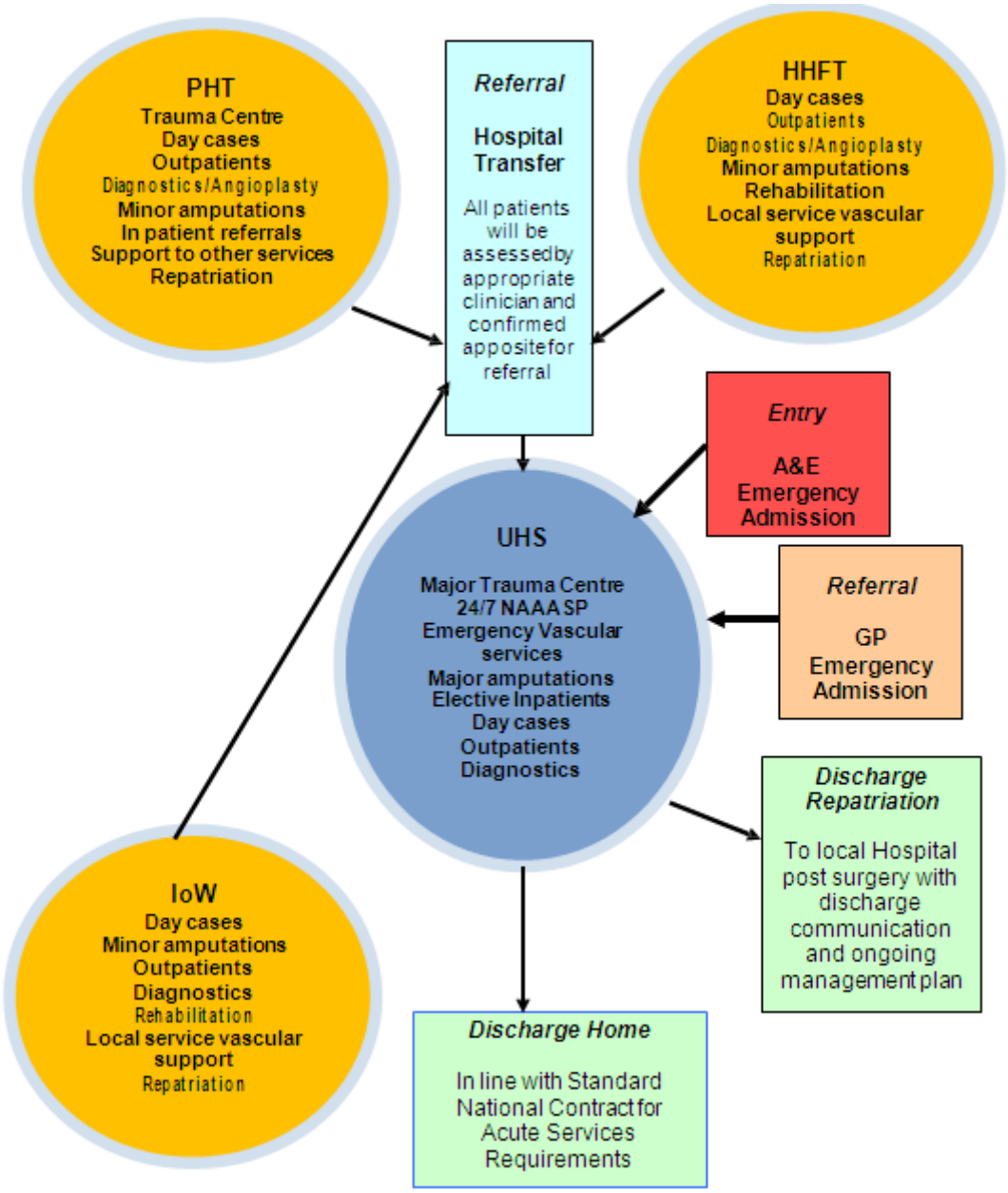
- **GP access to service**

See elective and emergency patient pathways. All emergency GP referrals will be made through the consultant surgeon on-call at UHS, through a single point of access contact number. There will also be GP access to the vascular service at UHS & in PHT where patients can be sent to an urgent daily clinic, staffed by the surgeon of the day and specialist nurses. This service will reduce unnecessary admittance, with clinical assessment and non-invasive imaging being undertaken at the clinic.

- **Direct Patient Access**

Self-presentation will be enabled within the Monday- Friday clinics to be held at UHS and in Portsmouth. Maintaining strong links with the diabetic foot services will enable direct patient self-presentation to the appropriate location.

Proposed Emergency and Elective Referral Entry and Discharge Routes



Service Delivery at Partner Hospitals

Supporting services at partner hospitals will remain viable after the reconfiguration of the vascular service by the continued vascular consultant cover as specified below.

PHT Vascular Service:

- 2-3 vascular surgeons working at QA Monday –Friday supporting dependent services such as ED, diabetes and the renal failure unit as well managing patients with vascular disease under other specialities on the wards and in outpatients.
- QAH would replicate the UHS model with 'surgeon of the week' (SOTW), able to attend A&E, theatres and inpatients at short notice. This service will be 8am-6pm and supported by vascular nurse specialists.
- OP capacity to see patients on an urgent basis to be provided, supported by the vascular lab. Review of vascular patients who are rehabilitating.
- SOTW will liaise with UHS if an urgent transfer is required.
- Out of hours and at weekends: on call general surgery registrar at QAH will see and assess patients with vascular problems and discuss with the on call vascular surgeon based at UHS.
- Weekly theatre list to undertake minor vascular procedures.
- Second surgeon undertaking elective outpatients and peripheral clinics (Havant, Petersfield and Gosport) and attending day case theatre and working on administration.
- Local reassessment clinic will be provided.
- Extended hours to cover the QAH site in the evening
- Interventional vascular radiology will be available on a day case basis (for angioplasty and diagnostics).
- Cases for intervention will be discussed in a combined vascular MDT (with the arterial centre) as to suitability as day cases.
- The cross-sectional imaging service (CT and MR angiography) and Vascular Lab for duplex imaging will continue to be used as now. The vascular radiologists based at QAH will also be attending UHS to perform complex endovascular procedures and EVAR.
- Renal failure patients (those undergoing regular dialysis) will be seen and assessed at QAH. Patients who require management of haemodialysis fistulas will continue to be cared for by the separate renal transplant team. Where possible these patients will remain at QAH. If they require urgent intervention, transfer will be made to UHS.
- If the inpatient stay at UHS is significant, arrangements will be made for temporary haemodialysis in the same way as other specialties (such as neurosurgery and cardiac surgery) undertake at present. This should not be more than 5 patients/year.
- Patients with diabetes and peripheral vascular disease will largely be managed at QAH except where there is a need for bypass surgery, complex interventional radiology or major amputation.

- Current QAH vascular ward (shared with urology) will receive fewer patients but will continue to play an important role for rehabilitation and for those patients that do not require transfer to UHS. Close links between QA diabetic and podiatry teams will be maintained to support managing patients who will have had minor amputations at QAH or will have returned from UHS having undergone limb-saving procedures such as a bypass and major amputations.
  PAH should have 12 bed capacity to accept these patients as a result of the transfer of arterial work to UHS.

HHFT, IoW Vascular Service

- Vascular service cover would remain at the current provision of vascular surgeon cover either 3 days (HHFT - Winchester) or 1 day (IoW) during core hours.
- Outpatient consultations, diagnostic procedures, elective minor surgery and day-cases will be performed and some vascular surgery provision, such as minor amputations, would also be maintained to safeguard the necessary expertise for the treatment of patients in other specialties within the hospital that require vascular surgery input, such as diabetes, cardiology and stroke.

- **Non-English Speaking Patients**

There is a UHS rota for multi language interpreters who are available 24/7 for both emergency and non-emergency patients.

- **Complex Healthcare Issues**

If a patient has complex healthcare issues, they will be appropriately linked to the relevant specialist teams whilst an inpatient. This is more likely to occur in UHS who will host the complex vascular emergency service and all appropriate specialties, such as diabetes, endocrinology, and cardiology, are located on site at UHS.

- **Stroke Strategy Supporting the DoH National Stroke Strategy**.

UHS has focused on delivering the National Stroke Strategy and delivers its stroke services from a hyper acute /acute ward based in the Wessex Neurological centre and a lower acuity ward based in the main building. The service is consultant led and is supported by a team of advanced nurse practitioners and an Early Supported Discharge Team.

- **MDT**

A weekly MDT (involving diabetologists, podiatrists and vascular surgeons and radiologists) for these patients is already established with PHT. Other specialists such as anaesthetists will be encouraged to follow their patients to UHS. The vascular lab and therapy teams in PHT do not need to change but will work closely with their UHS counterparts particularly with repatriated patients.

- **Emergency cover -** The following arrangements are in place.

UHS: the on-call vascular surgeon and team, with 24/7 cover.

PHT: in core hours, the onsite vascular surgeon will manage the patient, with transfer to UHS if required. Outside core hours, the patient will be assessed by the emergency surgical team and transferred to UHS if necessary.

HHFT - WINCHESTER: in core hours, the patient will either be managed by the on-site vascular surgeon or transferred to UHS via the on-call surgeon. This system is currently in operation. Outside core hours, the patient will be assessed by the emergency surgical team and transferred to UHS if necessary.

- **Direct Emergency Admissions to Non-emergency Centres**

Appropriate measures are in place to ensure that any direct emergency admissions would be sent to UHS, which is the designated major trauma centre for the region and as a result can receive patients directly. Clear guidance to the appropriate ambulance service would also be required, which is already in place, and works, for other tertiary transfers and for major trauma.

Direct emergency admissions to PHT would be seen as currently and stabilised before transfer if appropriate (as per the model in HHFT and IoW) There would be sufficient vascular services remaining on site to enable this action.

- **Inter-hospital transfers**

A commitment to repatriate patients to their local Trusts within 24 hours has been endorsed by CEO's in January 2016. Work streams are being led by each organisations COO.

The processes for inter-hospital transfers have been carefully defined, with clear protocols.

Cross transfer of patients from HHFT and IoW to UHS already occurs and works well. Repatriation of patients post treatment or surgery is also in place, with clear guidance and parameters for discharge.

- **Access times for vascular surgeons**

Vascular surgeons who are on call for emergencies will be within 30 minutes from UHS or, as an alternative, resident accommodation will be available.

- **Out of Hours Cover Provision**

The vascular out of hours emergency cover at UHS will be provided by the vascular surgeons on an appropriate rota, which is consultant led and supported by junior staff and advanced nurse practitioners. There will be 10 vascular surgeons with the service reconfiguration, on a 1:10 rota. During this duty, they will be free from elective commitments and will carry a bleep to enable them to be the first point of contact for GPs and hospital referrers. They will undertake a ward round of patients admitted acutely and attend an emergency clinic in the morning, which will prevent further admissions. Weekends will be covered on a rota basis as per the current UHS model.

- **Admission Prevention**

This proposal is based on a consultant delivered service, with a consultant vascular surgeon accepting all GP emergency referrals in UHS via a direct line single point of contact. A surgeon will, if required, initially review these patients in a daily emergency clinic. Prompt admission will be arranged for those requiring further care, although some patients will be reviewed daily in clinic if appropriate rather than being admitted. Consultant input at this stage of care will reduce admission rates, ensure prompt intervention, prevent further deterioration and ensure early discharge. UHS already successfully uses UHS@ home services enabling some pts to stay in their homes with supporting clinic visits and outreach support.

- **Length of stay reduction**

The duty surgeon conducts a daily ward round of all vascular patients, ensuring appropriate investigation and progression of treatment. Patients will generally receive intervention procedure within 24 hours of admission. Estimated dates for discharge are provided for each patient, with the nursing staff engaged in the process.

The ward undertakes 2 x daily board rounds to ensure agreed actions are followed up and acted upon. Robust plans for service improvement, which include length of stay reductions for vascular patients, are currently in progress throughout UHS. The Cardiovascular and thoracic care group hold regular focus groups that involve the appropriate clinical staff, to identify patient pathway blockages and then appoints project teams to work through any proposal to fruition.

- **Data collection and Audit**

UHS has been submitting AAA, carotid and amputation data to the National Vascular Database since January 2008. With database expansion, data from infrainguinal bypass has also

been submitted. Data from HHFT cases undertaken in UHS are also added and the experienced vascular nurse specialists manage data entry. Reports from The National AAA Quality Improvement Programme (AAAQIP) shows good correlation between NVD and HES data. Local data recording for all vascular procedures is held centrally within the trust and there is a robust audit process within the care group to ensure data input is accurate. In addition, regular audits are undertaken within and outside the vascular unit. Appropriate levels of data entry and audit staff are employed within the Cardiovascular and Thoracic care group to ensure the data submissions to the NVD and HES data correlate. This is monitored by the National Carotid Audit and AAAQIP.

Through the Trust governance structure, the Medical Director reviews the report and briefs the Chief Executive, with recommendations ratified by Trust Board.

Existing Unit Outcomes

Latest **unadjusted** outcome data (risk adjusted outcomes, data set to be finalised)

Abdominal Aortic Aneurysm - Data 1/1/10 -31/12/14
Elective infra-renal repair (open & EVAR)

Trust Name	Total AAA	Open	EVAR	Length of Stay (days): Median (IQR)	Deaths	Crude Mortality Rate *	Earliest analysed discharge/death date	Latest analysed discharge/death date
UHS	408	165	243	6 (3,8)	3	0.7%	02/01/2010	19/12/2014

Overall UK mortality rate = 1.7%

Carotid - Data 1/10/11 – 30/9/14

Trust Name	Total CEAs	Length of Stay (days): Median (IQR)	Total number of deaths and/or strokes within 30 days post CEA	Percentage of stroke and/or death *	Earliest analysed operation date	Latest analysed operation date	Delay from symptom to surgery for time period 01/10/13 – 30/09/14 (days): Median (IQR)
UHS	257	3 (2,5)	5	1.9%	04/10/2011	25/09/2014	9 (6,12)

Overall UK rate of stroke /death = 2.1 %

- **Adoption of New Technology**

At present there is sufficient resource to provide elective facilities for EVAR and open AAA repair. As previously referenced in this proposal UHS is due to commission its Hybrid theatre in November 2016.

The management of complex thoracoabdominal aneurysms and dissections has been changed by the adoption of advanced EVAR devices and, in combination with cardiac surgery, 15 TEVAR devices have been placed in the last year. Vascular surgery also allows UHS cardiology specialists to undertake endovascular aortic valve replacement (TAVI), with the unit on target to deliver its contracted activity of 75 cases per annum this year.

- **Geography**

There are good transport to and from UHS, with a local airport and ferry also within close proximity. The hospital is also located close to motorway links to Portsmouth and Winchester. Buses are available outside the main entrance and there is also a taxi rank outside the main entrance, and a free taxi phone in the corridor just inside the main entrance. The nearest mainline train station is Southampton Central and Southampton Airport is 5 miles by train, 3 miles by taxi or bus. The current transfer time is 30 minutes from each hospital site for ambulance transfers. Helipad transfers are undertaken including night flying.

- **Minimising travel**

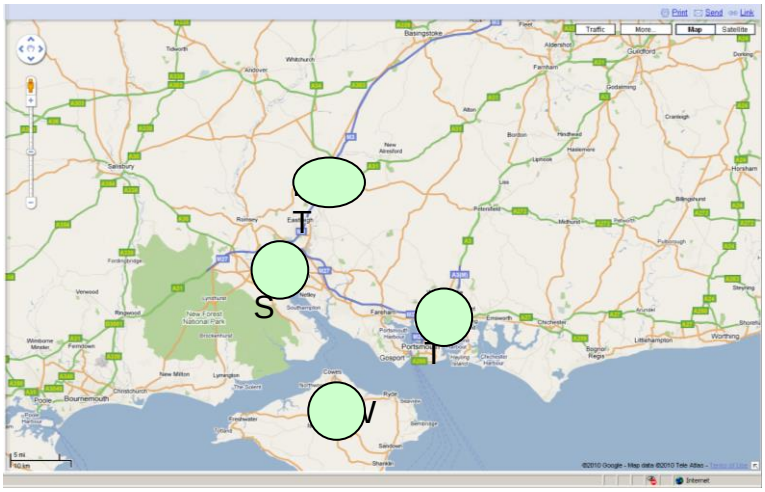
Patient travel will be minimised by enabling them to be seen at their local hospital for appropriate treatment. This will include day case, diagnostic, outpatient appointments as well as minor amputations, which would require an inpatient stay. Complex, arterial vascular work would be carried out at UHS, which would be arranged following the appropriate pathway. The additional benefit for Portsmouth residents is that some procedures currently referred to London due to complexity would be able to be carried out at UHS.

- **Repatriation**

As soon as appropriate, patients will be repatriated back to their local hospital following their treatment or surgery at UHS, which will also reduce the necessity for family members to travel.

A commitment to repatriate patients to their local Trusts within 24 hours regardless of overall Trust operational status has been endorsed by CEO's in January 2016. Work streams are being led by each organisations COO reinforcing the processes for inter-hospital transfers and ensuring that protocols are adhered too.

Map showing location of the four sites for the Wessex Regional Vascular Service



Education and training

Delivering Vascular Surgery Training

The current allocation of deanery trainees will need to be directed to where training opportunities occur within the network, irrespective of whether this is the arterial or non-arterial centres. Vascular training will be based at the arterial hub with trainees being allocated to appropriate sessions in the spoke hospitals based on the training requirements. Vascular Surgical trainees and general surgery trainees who are undertaking a period of Vascular Training in the arterial centre will take part in a vascular emergency (separate to general surgery) rota to give them exposure to the management of vascular emergencies.

In order to run a 10 consultant arterial centre and based on other similar centres of equivalent acuity, the junior medical staff should be as follows:

- 3 F1 and 1 F2 doctors (to share late and weekend duties with urology F1s as now)
- The extra F1 would follow work from Portsmouth
- 2 Core surgical trainees
- 2 Specialty Trainees (ST1-8, two of whom are vascular trainees)
- 2 core clinical fellows or registrar clinical fellows
- 1 post-CCT fellow.

Currently Portsmouth is allocated 3 trainees to vascular surgery and the expectation would be that these trainees will follow arterial work to UHS but all trainees will receive training in Portsmouth (renal access, OP, day case, minor surgery).

6 of these trainees will constitute a middle-grade equivalent rota to provide non-resident out of hours (evening and weekend cover).

- **Nursing**

UHS has taken steps to address junior doctor shortfall and has ongoing training for advanced nurse specialists in most surgical areas, including vascular. Cover is clinical and provided 24/7. Each Division at UHS has a training team who lead for this aspect and they regularly ensure that the plan and training meets the requirement of the service.

- **R&D**

UHS has a strong track record in research, with 2 National Institute of Research funded Biomedical Research Units (BRU). There is also a purpose built, 5-storey research building and a Welcome Trust Clinical Research facility on site.

In 2014 UHS was successful in its bid to one of the 11 designated Genomic Medicine Centres

(GMCs) in the UK.
In partnership with the University of Southampton, the ambition is to develop further strong platforms of research.

Financial Factors

Through the costing analysis carried out at UHS for this proposal, it shows the vascular service over the past 18 months has made a loss of around 15%. It is envisaged that through efficiencies, which can be made by centralising the service, the Trust would be able to deliver the service at national tariff. Capital expenditure is identified in the 16/17 capital plan to equip the endovascular theatre and to refurbish the vascular ward, although the main infrastructure is already in place to be able to deliver the additional activity.

The financial implications (revenue and capital) of this proposal, to centralise all complex elective and emergency vascular surgery to a single centre, have been assessed against the provided activity data from Portsmouth (actual 15/16 Mth9)

Based on that data the additional UHS income at average national tariff including MFF would be:

- **c. £0.5m pa Hybrid lab income**
- **c. £1.8m pa additional non-hybrid activity (Portsmouth transferred activity)**

Income relating to Critical Care activity is excluded from this figure.

UHS can confirm that capacity exists to accommodate this activity.

The development of the endovascular hybrid theatre is within the IISS programme for 16/17 and the Trust capital programme has allocated £750k for ward refurbishment and £500k for non radiological capital equipment associated with the development of the arterial centre. There is already the required capacity for the additional ward and Critical Care beds, so no major capital work to ward infrastructure will be required.

The staffing requirements have been assessed to deliver the required level of activity and it is through the economy of scale that the increased activity brings that will allow UHS to deliver the service within national tariff.

Following a final recommendation the activity planned and associated financial implications will need to be revisited in a more rigorous and robust manner.

Indicative additional activity & income from Portsmouth arterial transfer

(based on actual data from P'mth 15/16 Mth 9 SLF)

Procedure	Code	Volume		Total
Fem Pop	QZ03Z	22		£ 241,774
Fem distal	QZ02A	18		£ 141,228
Carotid endarterectomy	QZ04Z	56		£ 252,403
Fem endarterectomy	QZ02A	38		£ 298,147
	QZ02B			£ -
AAA open	QZ01B	8		£ 46,806
Amputation	QZ11A	49		£ 824,903
	QZ11B			-
EVAR /TVAR		69		£ 501.236
Total				**£ 2,306,497**

Conclusion

It is well documented that the centralisation of specialist services delivers improved outcomes for patients. UHS is ideally placed to fulfil the ambitions of this programme and has the full support from the Chief Executive, the Trust Board and most importantly, the clinical team, who are central to the delivery of a successful clinical model. In summary, the proposal is aligned to the Trusts strategic objectives of Trusted on Quality, Delivering for Taxpayers and Excellence in Healthcare.

APPENDIX I Project Plan

APPENDIX J Vascular Break Even Analysis

Note: This is a high level analysis developed as a 'straw man'. A more detailed financial evaluation is required to develop a break even model.

Assuming a population of 900k and a dedicated 22 bed ward, an estimate of staffing levels is as follows:

Staff Requirements

Staff Group	Current Provision
Vascular Surgeons	6
Vascular Anesthetists	6
Interventional radiologists	6
ICU – L3 staff ratio 6:1 but rising to 6.8:1	13 beds total staffed at 6:1 wte per bed; 1 for vascular
HDU – L2 staff ratio 3.5:1	7 beds total staffed at 3.5 wte per bed; 2 for vascular
Ward beds L1 staff ratio 1:3	22 beds, ratio of 1.3 = 29.65wte; 2wte ANP; 0.4wte Spec nurse

Taking the 'current provision' figures, for a population of 900k, this equates to:

Staff Group	Salary	Plus 30% Overhead	No	Total
Vascular Surgeons	£90,000	£117,000	6	£702,000
Vascular Anaesthetists	£90,000	£117,000	6	£702,000
Interventional Radiologists	£90,000	£117,000	6	£702,000
L3 Nurse (1 * 6.8)	£30,000	£39,000	6.8	£265,200
L2 Nurse (2*3.5)	£25,000	£32,500	7	£227,500
L1 Nurse (22*1.3)	£20,000	£26,000	28.5	£741,000
ANP	£25,000	£32,500	2	£65,000
Spec nurse	£25,000	£32,000	0.4	£12,800
			TOTAL	£3,417,500

Assuming tariff split is 50% infrastructure and 50% procedure costs, this suggests income of £6.835m is required to break even.

Note: UHS calculate that vascular services currently runs at a 15% loss. If 14/15 income was £5.3 million, this would suggest an income of £6.24m is required.

APPENDIX K Four Tests and Best Practice Checks

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
4 key tests	• Support from GP commissioners will be essential	• All CCGs (Southampton City, Portsmouth, West Hampshire, Fareham & Gosport and South East Hampshire) are represented on the governing Vascular Steering Group (VSG) and Vascular Implementation Board (VIB) which consider and approve recommendations.
	• Arrangements for public and patient engagement, including local authorities should be strengthened	• A Comms and Engagement Strategy has been developed, including stakeholder mapping and outline plans for full public consultation if required. Local HASC/HOSPs are regularly updated and proposals will be presented on completion of Stage II Assurance for a decision on consultation. Detailed plans are currently being developed for public engagement with regard to recommendations for a strategic network solution.
	• Clarity about the clinical evidence base underpinning proposals	• The Vascular Society (VS) POVS15[11] states: "*The current Vascular Society advice, based on sound clinical evidence, is that high quality vascular care in the UK is best delivered with the establishment of integrated vascular networks. Such networks should decide upon a single hospital which will provide arterial surgery and complex endovascular interventions. The other hospitals in the network need to continue to provide the following clinical support:- vascular clinics; diagnostics; interventions such as renal access and varicose vein procedures; review of in-patient*

[11] Vascular Society of Great Britain and Ireland "The Provision of Services For Patients with Vascular Disease 2015"

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
		vascular referrals; and rehabilitation. Day-case (23-hour stay) peripheral angioplasty and stenting can also be performed at these local sites. This provides the patient with direct local access to the vascular service. The network will function best for the patient when travel to the arterial centre is only for specific arterial and complex endovascular interventions. The pre- and post- procedure care related to these interventions should be delivered whenever possible at the local non-arterial centre."
	• Proposals take into account the need to develop and support patient choice	• Patients in the Wessex Area do not currently have access to fully compliant vascular networks. The recommendations for a strategic Wessex network with UHS as the MAC intends to provide patients with the choice to access a fully compliant vascular network.
Qipp/ Finance	• How does the proposal support commissioner and provider financial sustainability?	• There is no significant impact on commissioner finances. • Vascular services account for less than 1% of provider income; proposals are unlikely to impact upon provider financial sustainability.
	• Does the proposed change improve quality and reduce cost? How (e.g. reduced duplication, increased efficiency)	• Quality in terms of patient outcome is currently very good at both provider sites. Neither site currently offers a fully compliant, sustainable service and this proposal seeks to secure a strategic and sustainable network solution, particularly in terms of workforce sustainability. • It must b e stressed that this initiative is solely quality driven and does not seek to reduce costs. There is, however, a likelihood of cost saving in the reduction of potential duplication in the future in terms of, in particular, requirements for an increased on call rota, and technological developments.

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
	• What are the savings in financial terms?	• None
	• What capacity is being taken out of the system and where?	• There is an opportunity to consider utilisation of capacity which will become available at PHT if elective arterial services transfer to UHS; this is not within the scope of this project.
	• How, when and where is a saving made? Is it a cash releasing saving?	• None
	• Are the transitional costs (including non-recurring revenue and capital) identified and properly accounted for?	• UHS are currently identifying transition costs as part of the detailed capacity and transfer plan.
	• How will they be funded?	• UHS will fund transition costs?
	• Capital investment implications have been considered in terms of the viability, deliverability and sustainability of the proposal and the economic (value for money) impact	• UHS are currently identifying capital investment costs as part of the detailed capacity and transfer plan, including partial funding of the hybrid theatre (utilised by more than one speciality) and the expansion of the vascular ward. • High level cost/benefit analysis suggests that neither site with current volumes of procedures could break even as a compliant vascular service; it is anticipated that UHS as MAC would become economically viable.
	• Finance links consistently to workforce	• Workforce and activity models have driven income projections and models.

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
	and activity models	
Clinical quality and strategic fit	• Clear articulation of patient, quality and financial benefits	• The benefits are articulated in the NSS[12], which is derived from the VS POVS guidelines.
	• Clinical case fits with national best practice	• The objective is to deliver a sustainable strategic network solution which is compliant with the NSS.
	• Fit with local H&WB strategy and aligned with local commissioning plans	• The current Vascular Programme ensures alignment with CCGs and, therefore, their H&WB strategies
	• Options appraisal (inc. consideration of a network approach, cooperation and collaboration with other sites and/or organisations)	• Following the VS review in August 2015, an Options Appraisal has been developed and used to update the Business Case; the clinical case identifies a network as the optimum solution for vascular services..
	• Macro-impact is properly considered	• In the macro environment, there is strong clinical evidence that larger centres have improved outcomes • This solution provides improved workforce resilience and sustainability
	• Alignment with QIPP workstreams	• No savings or efficiencies envisaged

[12] A04/S/a 2013/14 NHS Standard contract for Specialised Vascular Services (Adults)

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
	• Full impact analysis across CCG / NHS England commissioned services and shared sign up of all parties to analysis	• Governance Structure includes all parties
Activity	• All relevant patient flows and capacity are properly modelled, assumptions are clear and reasonable	• Overall patient flows modelled and capacity modelled accordingly
	• What are the changes in bed numbers?	• See UHS Capacity & Transfer Plan
	• Activity and capacity modelling clearly linked to service change objectives	• See UHS Capacity & Transfer Plan
	• Activity links consistently to workforce and finance models	• See UHS Capacity & Transfer Plan
	• Modelling of significant activity, workforce and finance impacts on other locations / organisations	• See UHS Capacity & Transfer Plan
Workforce	• Do you have a workforce plan – integrated with finance and activity plans?	• No detailed workforce plan has yet been considered pending the Business Case recommendations • A high level clinical strategic vision has been developed, with high level estimates.

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
	• Are you making the most effective use of your workforce for service delivery and is it compliant with all appropriate guidance? • • Consider the implications for future workforce • • Have staff been properly engaged in developing the proposed change?	• Yes • Future workforce implications are a key driver for the centralisation of arterial services in a smaller number of larger units within the UK. • Clinicians have developed a strategic vision upon which the change will be based. Once the recommended solution has been approved, there will be workforce engagement on an individual basis.
	• Has the travel impact of proposed change been modelled for all key populations including the analysis of available transport options, public transport schedules and availability / affordability of car parking?	• It has been established that "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." (sic PHT to UHS) • Travel impact analysis is currently underway. Because of the nature of the patients (elderly and co-morbidities) this is considered to have a significant potential impact.
Resilience	• How will the proposed change impact on the ability of the local health economy to plan for, and respond to, a	• UHS is a Major Trauma Centre and, as such, must have vascular services co-located.

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
	major incident • Has a business impact analysis been conducted for all impacted organisations and appropriate changes made to Business Continuity Plans? • Has the local Health Resilience Partnership assessed the impact on resilience?	• Organisations outside of the providers are not considered to be impacted in any significant way. • ?
Ambulance Services	• Have the implications for ambulance services (emergency and PTS) been identified and impact assessed and appropriate discussions been held with ambulance service providers?	• See UHS Capacity and Transfer Plan
Comms and Engagement	• Are there plans to appropriately and effectively engage and involve all stakeholders (to include: staff, patients, carers, the public, Healthwatch, GPs, media, local authority overview and scrutiny functions, Health and Wellbeing Boards, local authorities, MPs, other partners and organisations)	• A Comms and Engagement Strategy has been developed, including identification of all key stakeholders and engagement proposals. Detailed plans are currently being prepared as part of the Business Case. • Following a previous presentation of proposals to centralise services at UHS, Portsmouth HOSP requested a Full Public Consultation; plans are being made for this eventuality.

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
	and fulfil commitments under s14Z2 and s.13Q of the Health and social Care Act?	
Equality Impact	• There has been an appropriate assessment of the impact of the proposed service change on relevant diverse groups? • Has engagement taken place with any groups that may be affected? • What action will be taken to eliminate any adverse impacts identified?	• An Equality Impact Assessment is required as vascular services affect diverse groups including: ○ elderly ○ asian ethnicity prone to diabetes at an earlier age ○ afro-caribbean ethnicity prone to hypertension and therefore renal problems ○ inverse social class - prevalent in more deprived areas • It is considered that this is generic to vascular services reconfiguration and analysis of other reconfigurations will be made before further action is taken in this regard.
TDA/Monitor	• Is proposal aligned with the TDA's / Monitor's approach	•
IT	• Does proposal make best use of technology? • Assessment of the impact on local informatics strategy & IT deployments • Are there likely to be any data	• No current major technology impact

Criteria	Best Practice Checks	UHS as Major Arterial Centre (MAC) with PHT as Non-Arterial Centre (NAC)
	migration costs? • Are there any implications for specialist or network technology/equipment contracts associated with the service?	
Others	• Consistent with rules for cooperation and competition (Monitor/OFT/CC) • Consideration given to the most effective use of estates	• Yes • A separate project will consider the opportunity to make effective use of capacity made available at PHT

NHS England

Southern Hampshire

Vascular Services Reconfiguration

Communications, Engagement and Consultation

March 2016

Southern Hampshire Vascular Services Reconfiguration

Communications, Engagement and Consultation

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Prepared by: Carol Wood

1 Contents

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1 Introduction

This communications, engagement and consultation strategy outlines how NHS England Specialised Commissioning, in collaboration with NHS England South (Wessex), plans to inform and involve stakeholders, patients and local people in proposed improvements to vascular services in Southern Hampshire in line with the National Vascular specification.

Following a review, the Vascular Society of Great Britain and Ireland (Vascular Society) found that the services currently available at University Hospital Southampton NHS Foundation Trust (UHS) and Portsmouth Hospitals NHS Trust (PHT) were not fully compliant with the society's guidelines for safe high quality care for patients requiring vascular surgery.

The Vascular Society recommended the development of a single vascular surgical hub for Southern Hampshire, based at University Hospital Southampton NHS Foundation Trust (UHS). UHS already operates as a hub with a network for Hampshire Hospitals Foundation Trust (HHFT) and The Isle of Wight NHS Trust (IOW) and the Vascular Society recommended that this network should be extended to include PHT as another spoke.

This was seen as maximising the benefits of other networking arrangements such as that for major trauma.

NHS England has been working with partners, led by senior surgeons, in developing detailed proposals to provide these vital services for the whole of Hampshire.

2 Background

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. 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.

Complex Vascular surgery covers:

- Abdominal Aortic Aneurysms (AAA)
- Screening people for AAA
- Strokes (such as Carotid Endarterectomy (CEA) or Transient Ischaemic Attacks (TIAs or mini-strokes)

- Poor blood supply to the feet or legs

There are also roles for vascular surgery supporting other major specialities e.g. trauma, neurosurgery, cardiac surgery, dermatology, clinical laboratory services, nephrology, plastic surgery, and other disciplines. Vascular patients are often treated by other specialties including cardiology, renal, diabetology and podiatry.

In common with other specialties, there is strong national clinical consensus that patients who need vascular surgery receive better quality care when they are treated by specialists who deal with a high volume of patients and who, therefore, have significant expertise in this field.

Reviews of the reconfiguration of vascular services in Southern Hampshire began in 2008 and there have been various reports and recommendations since that date.

3 Approach

3.1 Legal and policy context

The legal context for this document is the duty to involve the public (section 13Q) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), NHS England has a statutory duty to 'make arrangements' to involve the public in commissioning services for NHS patients.

The section 13Q duty is aimed at ensuring that NHS England acts fairly in making plans, proposals and decisions in relation to the health services it commissions, where there may be an impact on services. The duty requires NHS England to make arrangements for public involvement in commissioning.

Public involvement in commissioning is about offering people ways to voice their needs and wishes, and to influence plans, proposals and decisions about their NHS services. Patients and the public can often identify innovative, effective and efficient ways of designing and delivering services if given the opportunity to provide meaningful and constructive input.

There are four tests that must be met before there can be any major changes to NHS Services:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base
4. Consistency with current and prospective patient choice

In addition, NHS England's service change guidance states:

> ***Effective proposals should have on-going involvement with staff, patients and the public. Proposing organisations should avoid presenting a fully worked up set of service change options to the public unless there has been on-going dialogue.***

In line with this guidance it is proposed to undertake the communications and engagement programme in five distinct phases:

1) Pre-consultation to inform the model
2) Live consultation/engagement
3) Analysis and reporting
4) Decision making and feedback
5) Implementation.

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3.2 Working in partnership

The work will be co-ordinated through the Communications and Engagement workstream which reports to the Vascular Implementation Board and comprises CCG, NHS England Wessex and Trust communications together with representation from Healthwatch.

3.3 Phase one Pre-consultation to inform the model

The first phase will run prior to purdah for local elections in May and is aimed at informing the development of the final proposals. This will be achieved by:

- Holding 5 drop in/listening events in Hampshire and on the Isle of Wight to listen to the experiences and views of the public/patients about how the services could be more responsive to patient/carer needs.

- Establishing a patient reference group to advise and support any formal consultation. The group will include membership from previous and current patients, carers, voluntary sector services which represent the views of service users (eg Stroke Association, Diabetes UK) as well as members of the public who may have no experience of vascular services.

- Build on the initial engagement with the local authority overview and scrutiny committees for Hampshire, Isle of Wight, Portsmouth and Southampton

- Using existing CCG clinical fora to engage with GPs across Hampshire and the Isle of Wight and to build on clinical engagement achieved

through the Vascular Implementation Board. This includes identifying any key local issues that impact on or will be impacted by the review.

- To use existing CCG and Trust communications and engagement channels and forthcoming events to engage with the public (see appendix).

- To brief the Health and Well Being Board about the review.

- To help shape the second phase engagement/consultation.

We will also seek guidance from the overview and scrutiny committees whether the proposals constitute significant service variation and therefore whether a full consultation is required. Given the history of vascular services in South Hampshire it is anticipated that full consultation may be required.

3.3.1 How will the pre-engagement inform the proposals?

We will seek the views of stakeholders and service users in Portsmouth about the proposed changes to:

- Check understanding of what is being proposed
- Identify key issues relating to proposed changes

We will also seek the views of stakeholders and service users in the current University Hospital Southampton network (including Southampton, Isle of Wight and Winchester) to:

- Check understanding of what is being proposed
- Identify key issues relating to existing services and to understand how the changes being proposed can take account of those issues.

Appendix includes the draft questions for the engagement.

3.4 Phase two Live Engagement/Consultation on the final option

- To communicate openly and widely about how the public views in phase one have helped influence the model.
- To communicate openly and widely that no change is not an option. Provide a clear explanation about the option that has been developed, with a proactive campaign and direct engagement with patients, public and key stakeholders with the aims of:
    - ensuring understanding of the reasons for the change
    - enabling commissioners and the service providers to understand issues for patients, public and key

stakeholders with a view to ensuring the final model has taken these into account

Dependent on the views of the Overview and Scrutiny Committees this may take the format of an informal engagement or a formal consultation.

In both cases the objectives will be:

- To provide clear and consistent messages and information to all stakeholders
- To explain the option and the benefits to patients
- To allow patients and the public to voice any concerns/raise issues/ask questions about the chosen option
- To gain views on associated services (for patients undergoing amputation for example)
- To balance any negative perception and concerns
- To increase public confidence in NHS England as a listening and responsive commissioning organisation.

3.4.1 Informal Engagement

- If Overview and Scrutiny agrees that an informal engagement can be undertaken in this phase, the approach will be to inform of the chosen option and asked whether any concerns need to be taken into account in its implementation. This process will not ask for views on options. This will not constitute a statutory process and can be conducted over a much shorter time frame.

3.4.2 Formal consultation

- Should the preferred solution constitute “significant service variation” the phase two consultation and engagement plan will become a formal consultation about the detail of the proposed model seeking to address why there is only one option. It will also ask what concerns need to be taken into account in implementation. In this instance there will be a full 12 week consultation in line with Cabinet Office best practice guidance.

The difference between the informal and the formal process will be in the length of the engagement and also the decision making process.
The formal consultation may also provide some options around, for example, transport or associated services such as access wheelchairs or prosthetics.

3.5 Format

3.5.1 Channels

For both an informal engagement and an informal consultation there will be a mix of channels

Specific drop in events

Held in a range of locations across South Hampshire, in accessible venues and at a variety of times to give people a range of choices.

- These events will give people an opportunity to hear about the proposals, discuss their views and have the opportunity to talk with those involved in the programme – particularly, but not exclusively, clinical leaders.

Attendance at existing community forums/events

- Attending existing community events and forums gives the opportunity to talk about the consultation and find out how they can give their views. These events would be identified by working in partnership with local authority and voluntary sector colleagues to identify suitable forums/meetings.

Working closely with the community and voluntary sector

- The community and voluntary sector have wide ranging communications networks. We will aim to work with the CVS through events they host directly with their clients to get their views – this often works well with hard to reach groups. We will also often supply consultation information through their distribution channels.

Collaboration with CCGs, Trusts and Healthwatch to make use of existing engagement channels

- The workstream members will aim to use all.

Online opportunities to respond to the engagement/consultation

- The consultation will be made available on the NHS England consultation hub. This is the central online resource for all NHS England consultation and engagement projects. It provides a mechanism for consultation documents to be uploaded and for people to provide their feedback.

Engage with staff

- NHS staff will be engaged, with briefings organised at their place of work and including senior trust staff. Staff are key influencers of patient

views and also members of the public and use local health services themselves, so briefings will focus on the case for change as a whole, not just their role as employees.

Robust media approach

- There will be a responsive, agile and robust media handling plan including proactive briefing about the proposals. There are agreed media sharing protocols in existence.

Multi-channel communications

- People get their information from a variety of different sources. Social media and websites together with other existing communications mechanisms such as newsletters will be used.

- As the key clinical leaders are not always likely to be available. We propose to produce videos communicating the consultation's key messages which will be made available on websites and presented at events.

Materials in appropriate formats

- NHS England has an Accessible Information Standard which sets out expectations for communications for those with disabilities (see Section 5).

- Our Equality Impact Assessment also indicates a potential need for translations into languages other than English.

3.5.2 Key messages

There will be a core narrative and a set of key messages around the proposals themselves, using terms that will be applied consistently across all materials.

Overarching messages

We will develop services which are:

- High quality with excellent outcomes for patients;
- Developed in line with the best available evidence to increase the chance of survival for patients;
- Can be sustained, despite future challenges; and
- Offer a good patient experience.

We are committed to:

- Engaging and involving stakeholders, partners and the public to find out what matters most to people;
- Making sure all the feedback received is considered as part of the decision making process;
- Being open and transparent throughout the consultation process.

3.5.3 Core Narrative Key Messages

- There will be more doctors with the right specialist skills available to treat vascular patients through the creation of a Wessex Vascular Network.
- Patients needing non-emergency treatment or out-patient appointments will be seen in clinics at the hospital closest to their home.
- Patients will continue to be treated at Portsmouth for:
    - some simpler procedures and minor surgery (such as the removal of unhealthy tissue from a wound to promote healing) and some minor amputations (eg toes)
    - diagnostic tests and treatments which do not need an overnight stay
    - rehabilitation following major surgery at Southampton
    - support services such as footcare (podiatry) for patients who have had minor surgery
- Portsmouth will continue to provide a vascular ward which will provide care for patients who do not require treatment at Southampton or have returned from Southampton for rehabilitation
- There will be two or three vascular surgeons available at Portsmouth during the daytime every weekday to see patients in outpatients or on the wards
- Out of hours and at weekends there will be an on call vascular surgeon at University Hospital Southampton who can be contacted by surgical teams at Portsmouth, Winchester and on the Isle of Wight
- Portsmouth will continue as the major regional renal (kidney) centre and patients will continue to be treated there for complications that arise from dialysis. There will be a handful of cases each year where a patient who needs dialysis will need urgent/emergency treatment at Southampton which needs an overnight stay and temporary dialysis will be available for them at Southampton during their stay.
- Emergency and most planned major treatment will be provided at University Hospital Southampton where there will be:
    - A refurbished ward with extra beds which will receive emergency patients 24 hours a day
    - An additional vascular nurse specialist who will support the transfer of patients back to their local hospital and/or to home

  - A newly built theatre that can offer vascular surgery and interventional radiology at the same time
- A key to the success of the expanded service at Southampton will be the return of patients home (where they are fit to do so) or transfer back to their local hospital for rehabilitation as soon as possible
- Transport arrangements for emergency (24/7) and non-emergency admission
- Transport arrangements for visitors

Supporting messages

- Surgeons at all of the hospitals have worked together to develop these options
- We want to end uncertainty for patients and for staff
- We want to provide safe, high quality services in line with the recommendations of the experts (Vascular Society of Great Britain and Ireland)
- The need for vascular surgery is reducing due to improving health of the population.
- The impact of a reducing number of smokers and better care for people with diabetes means the demand for vascular surgery will continue to reduce.
- The way vascular services are provided has also changed from major surgical procedures to less invasive techniques which require specialist training and the introduction of preventative surgery which reduces the risk of stroke.
- To ensure services remain safe and high quality it is important that surgeons remain practiced in these specialist techniques which means they should undertake a minimum number of procedures to maintain their expertise
- The number of surgeons available to provide these services is limited and the hospitals in Hampshire have had difficulty in recruiting enough to provide sufficient cover for existing rotas.
- Over the next five years hospitals will move to 7 day working which will increase pressure on having enough qualified staff to cover rotas. It is unlikely that Hampshire will be able to attract enough surgeons to staff two hubs
- No change is not an option

3.6 Timeline

Key dates:

Pre-consultation	Live-consultation / engagement	Analysis and reporting	Decision	Implementation
Feb – April	**June – September**	**September-October**	**November**	**December**
Development of communications and engagement strategy	Consultation / Engagement launch	Responses analysed	Decision taken	Implementation – communication and engagement to be provided by the providers
Stakeholder analysis	Activities logged for audit trail	Report written	Stakeholders updated on outcome	
Establishment of Patient Reference Group	All feedback stored in line with Data Protection		Communicate decision to patients / public	
Plan and schedule pre-engagement event opportunities			Public meeting to announce the decision	
Develop pre-engagement and consultation material				
Work with voluntary sector on reach and breadth				
Production of patient/clinician videos (14 March – 17 March)				
Stakeholder briefings				
Media briefing				

Pre-engagement events schedule including attendance at Health Overview and Scrutiny:

Events need to be held in Southampton, Portsmouth, Gosport, Winchester and on the IOW.

Date	Event	Location	Attendees
March 2016			
Tuesday 15 March 9.30 am	Portsmouth HOSP	The Executive Meeting Room - Third Floor, The Guildhall	Dominic Hardy Liz Mearns Carol Wood
Tuesday 22 March - TBC	Pre engage drop in event	Holiday Inn Southampton Avon Room TBC as negotiating on cost Room cap: 70 9.7 metres by 8.8metres – height 2.9 metres 2-8pm The Hub Atrium (Rebecca) venue hire contact off this week – costs/availability to be emailed over. Southampton Guildhall – call Jodie on 02380 832453 w/c 22	Liz Mearns Emily Grainger Carol Wood Kulvinder Naga Surgeon/Clinician TBC
Wednesday 23 March - TBC	IOW trust members event	1.5 hours presentation/focus group to members	Liz Mearns Carol Wood Pauline Swan Kulvinder Naga Surgeon/Clinician TBC
Thursday 24 March 6.00pm	Southampton HOSP	Civic Centre, Southampton	Dominic Hardy Liz Mearns Carol Wood
Tuesday 29 March 10.00am	Hampshire HASC	Ashburton Hall Winchester	Dominic Hardy Liz Mearns Carol Wood
Tuesday 29 March - TBC	Pre engage drop in event	Winchester Guildhall – voicemail left with booking team re availability on this day and costs	Liz Mearns Pauline Swan Emily Grainger Carol Wood Kulvinder Naga

			Surgeon/Clinician TBC
Wednesday 30 March (pm) - TBC	Pre engage drop in event(s) – Portsmouth ones to happen on the same day	Portsmouth Guildhall Portsmouth Room tentatively booked from 8am-12 noon Room cap: 100 Gosport Community Association – The Theatre Room is tentatively booked from 12-6pm (might change to 1-6pm) Room cap: 150	Liz Mearns Pauline Swan Emily Grainger Carol Wood Kulvinder Naga Surgeon/Clinician TBC
April 2016			
Tuesday 5 April (am)	Pre engage drop in event	TBC – date if needed	TBC
Thursday 7 April (am)	Pre engage drop in event	TBC – date if needed	TBC
Monday 11 April	Isle of Wight HASC 17.00	County Hall High Street Newport	Dominic Hardy Liz Mearns Carol Wood
Wednesday 13 April	SEH CCG Community Engagement Committee	Attended by key stakeholders Meets quarterly (subject to purdah)	Liz Mearns Pauline Swan Emily Grainger Carol Wood Kulvinder Naga Surgeon/Clinician TBC
Thursday 21 April	Gosport Locality Patient Group	TBC (subject to purdah) Attended by all local PPG chairs	Liz Mearns Pauline Swan Emily Grainger Carol Wood Kulvinder Naga Surgeon/Clinician TBC
Tuesday 26 April	IOW existing patient event – Jo Cram to confirm if we can attend to present		Liz Mearns Pauline Swan Emily Grainger Carol Wood Kulvinder Naga Surgeon/Clinician TBC

3.7 Analysis and reporting

During this phase all feedback will be analysed. It is recommended that this work is undertaken independently regardless of whether an informal engagement or a formal consultation is undertaken. A report will also be written following agreed approvals process and signed off.

3.8 Decision making

If a full formal consultation is held there should be an open and transparent decision making process with a meeting held in public where considerations that have arisen during consultation are decided upon.

The report will be available for the public and for overview and scrutiny and will also be presented at the relevant CCG and provider board meetings.

A media and communications plan will be required for the decision.

It is also good practice (and necessary if there has been significant noise) to do this in public.

3.9 Implementation

Communications for this phase to be led by providers.

4 Risks and Issues

All proposals to change hospital services inevitably face some challenges that are not specific to the proposals in question or the area in which they are taking place. These include:

- Emphasis among local people and opinion-formers on importance of hospital, sometimes to the exclusion of other services
- Fear of loss of local services
- Fear that local hospital will become unsustainable
- Concern about travel to get to appointments or visit loved ones
- Fear of longer distances or poor roads leading to safety risks
- Local people and politicians equating services in local hospital with status of the area

In the case of South Hampshire reviewing vascular services is a longstanding issue. There has already been significant media coverage and public opposition to proposals put forward to date. It will be a challenge to clearly communicate the benefits of the change.

The issue is also compounded by the likelihood that one area will feel that it has lost out to the other – as already demonstrated in past media coverage.

NHS England's responsibility is to put forward a service proposal which will give the best possible outcomes to patients across its whole geography. Any engagement/consultation will inevitably generate noise and interest and this is to be expected. What is important is the approach that is applied to engagement/consultation and making sure it is as robust as possible, following due process.

The level of public scrutiny applied to any public consultation should not be underestimated. Legal challenges are likely to relate to communications and engagement activities.

Challenge often comes from a programme's lack of involvement opportunities for the public at the earliest possible stage. It will be important to demonstrate with clear evidence how this has been achieved.

The four health overview scrutiny committees and panels involved with this process have agreed a framework for assessing major service change[1]. The consultation strategy must pay due regard to the expectations expressed in this important document.

Communications Risk	**Mitigation**
We are unable to secure effective clinical engagement, leading to lack of support for proposals	Local lead clinicians are fully involved in the review and are programme board members. External clinical expertise has been used to support the local clinicians using nationally agreed clinical guidance as the benchmark for the review. The clinical model has been developed by the local lead clinicians. Clinical case will be convincingly described and promoted Clinical leaders to provide visible, public support
Inaccurate information causes undue concern among patients/public/stakeholders	All communication to be open and transparent and shared at the earliest opportunity allowing for clarity and consistency of the message. All co-dependencies to be identified and any possible impacts to be discussed and shared with stakeholders. All communications from stakeholders to be coordinated to ensure consistent clear messages.
Inadequate information causes undue concern	Patient reference group established to ensure materials are clear, consistent and comprehensive

[1] Southampton, Hampshire, Isle of Wight and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS provision (revised April 2013)

among patients/public/stakeholders	Ensure the issues most likely to excite local opinion – money, transport and emergency care are adequately covered within the case for change and the consultation document Ensure the consultation document addresses how sustainability and capacity are being addressed
The review causes anxiety which impacts on current services and/or ability to engage effectively	The process to be open and transparent. All concerns to be raised to the Programme Board at the earliest opportunity. Clear communications to be agreed and shared across key stakeholders. Risk and issues logs to be maintained and regularly reviewed through the process. Key stakeholders to be identified and communicated with as early as possible. Process is conducted across the whole of the area where the services are provided including those already operating in a network i.e. Isle of Wight and across South Hampshire in addition to Southampton and Portsmouth Equality impact assessment will identify groups with characteristics which are impacted by the service/service change A mix of approaches will be used to ensure a wide range of voices are heard
Purdah impacts on engagement activity. Local elections happen in Southampton and Portsmouth on 5 May followed by EU Referendum on 23 June.	Guidance to be sought from Health Overview and Scrutiny. Full consultation (if required) to be scheduled after the EU Referendum closes. Timescales for service implementation allow for this amendment. Some pre engagement is scheduled prior to the local election purdah period (7 April to 5 May)
The public and/or local authorities contest service change either through judicial review or through referral to the Secretary of State by health overview and scrutiny committees.	Learning from the Independent Reconfiguration Panel to be adopted as best practice within the communications and engagement process: • community and stakeholder engagement in the planning process • equalities impact assessment and careful analysis of particularly affected groups to ensure the right methods are used to engage • adequate attention given to the responses during and after the consultation including

	maintaining a thorough evidence log of all communications and engagement activities

4.1 Section 1: Equality analysis

Evidence
What evidence have you considered? People with diabetes are at a higher risk of vascular disease. Prevalence of diabetes is caused by a number of factors such as an ageing population, obesity and low levels of activity. Another important factor for diabetes is the changing ethnic mix of the population. People from black and minority ethnic communities are six times more likely to develop the disease, suffer from a 50% increased risk of heart disease and have much higher levels of kidney disorders. The care of people with diabetes can also be complex with 25% of people suffering from three or more other long-term conditions. NHS England now has an accessible information standard which needs to be considered/adhered to in the engagement https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-upd-er-july-15.pdf
Age Patients using vascular services tend to be older. Although there is an increasing prevalence of older people using online services it will be important for the communications and engagement process to consider the needs of older people by producing some documentation in print/large print to allow for age-related changes in vision.
Disability • Because a proportion of patients accessing vascular services have diabetes it is likely that some will have visual impairment beyond the usual age-related changes in vision. This means that the consultation will need to be available in alternative formats. These patients will be unable to drive and may have difficulties accessing public transport so consideration needs to be given to whether they will be able to attend meetings. • Arterial disease in some patients requires lower limb amputation which will also affect accessibility to attend meetings • Patients with chronic mental health problems and learning disability (particularly Down's) are at increased risk of diabetes and arterial

disease. There will be a requirement for easy read versions of documentation
Gender reassignment (including transgender) No impact
Marriage and civil partnership No impact
Pregnancy and maternity No impact
Race Diabetes is more common in people of South Asian origin with earlier onset of significant arterial complications. People of Afro-Caribbean origin are more prone to high blood pressure which may be more difficult to control than in other groups, hence increased incidence of renal disease and stroke. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design. It will also be appropriate to make translations available for people whose first language is not English.
Religion or belief Patients whose religion or belief does not allow blood transfusion or particular blood products will have complications relating to accessing vascular services.
Sex Vascular disease is more likely to affect men than women. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design.
Sexual orientation No impact
Carers As vascular patients tend to be older and may already have disabilities (or develop a disability as a result of vascular surgery/amputation) they may already have a carer or may need the support of a carer. The consultation will seek to engage with carers to understand the impact of the proposals and possible solutions such as community transport for visitors.
Other identified groups. Parts of Portsmouth and Southampton have areas of socio economic deprivation. Smoking, obesity and low levels of activity are more common in areas that have socio economic deprivation. As these lifestyle risk factors are also linked to prevalence of diabetes (and therefore risk of vascular disease) the communications and engagement must consider the communications needs of this group. A review by Ofcom indicates that socio economic deprivation influences access to ICT which can itself be a form of social exclusion.

However, more recent research by Public Health England for the One You campaign shows people aged 40-60 in lower socio economic groups are heavy users of mobile communications including text messaging and digital social media such as Facebook. The mix for the campaign needs to take these preferences into account.

Engagement and involvement
How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available? Sharing of this document with Council for Voluntary Services; Healthwatch; Health Overview and Scrutiny; Establishment of Patient Reference Group
How have you engaged stakeholders in testing the policy or programme proposals? Sharing of this document with Council for Voluntary Services; Healthwatch; Health Overview and Scrutiny; Establishment of Patient Reference Group
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs: TBC as engagement is implemented

5 Associated documentation

NHS England Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning

ppp-policy-statement.pdf

Planning, assuring and delivering service change for patients

plan-ass-deliv-serv-chge.pdf

Accessible Information Standard

access-info-spec-fin.pdf

Independent Reconfiguration Panel (2010) *Learning from Reviews*

6 Appendix I Key Audiences

It is important to identify key audiences and assess them according to the level of interest they have in the issue and their influence on developments. This will enable the messages developed below to be tailored to each specific audience, and will also allow judgements to be made on the amount of effort to devote to each audience. Following are the key audiences we will need to engage with throughout the review, development of proposals and implementation process, working in a phased approach as set out below.

- **Patient and public representative groups** - this includes:
  - Active or recent vascular patients and their carers/relatives
  - Healthwatch
  - Patient panels or health networks run by CCGs/trusts
  - Hospital – patient experience groups
  - VCS organisations interested in diabetes, cardiovascular disease, stroke, amputees,
  - CCG patient reference groups
  - Patient support groups
  - Health and wellbeing boards
  - PPGs
  - Seldom heard groups such as LD partnerships, MH service users, prisoner, BAME communities, veterans
  - Faith groups

- **Public**

- **GPs and GP commissioners** - this includes:
  - Isle of Wight, Southampton, Portsmouth and West Hampshire CCGs
  - Representatives of all GP practices across the CCG membership
  - Any GPs with a particular interest in vascular issues
  - Neighbouring CCGs

- **Council representatives** - these include:
  - council scrutiny committees
  - County, borough/district and parish councils
  - Leaders
  - Health cabinet members
  - Chief executives

- **MPs** - comprising:
  - All members of parliament in the affected areas

- **Campaign groups** - comprising:
  - Any existing campaigns relating to health services in the affected areas

- **Media** - this includes:
  - Local and regional broadcast media, routinely
  - Local print and online media, routinely

Any national or trade media that expresses an interest

7 Appendix II Questions for Pre Consultation Engagement

When thinking about vascular services what is important to you? (rank in order of importance)

- Patient safety
- Expertise/right number of staff
- Increased positive outcomes for patients
- Services based at a hospital which is near to home
- Transport to get to the hospital for treatment
- Transport for visitors whilst I am in hospital
- The way different services interact with each other to provide a seamless service (eg wheelchair/prosthetic services/physiotherapy/occupational therapy)

When thinking about the proposals for changes Do you?

- Understand the need for change
- Feel confident your views will be listened to

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		HEALTH AND WELLBEING STRATEGY: UPDATE		
DATE OF DECISION:		24 MARCH 2016		
REPORT OF:		ACTING SERVICE DIRECTOR – INTELLIGENCE, INSIGHT AND COMMUNICATIONS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dorota Goble**	**Tel:**	**023 8083 3317**
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STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

The current Health and Wellbeing Strategy (HWBS) for Southampton was adopted in 2013 and is due to expire in 2016. There is therefore a need to develop a new HWBS for the City, informed by an updated Joint Strategic Needs Assessment (JSNA). Local authorities and Clinical Commissioning Groups have equal and joint duties to prepare JSNAs and HWBSs, through the Health and Wellbeing Board (HWBB). This report details the progress and plans for the development of the JSNA and HWBS.

RECOMMENDATIONS:

	(i)	That the Health Overview and Scrutiny Panel consider the achievements from the Health and Wellbeing Strategy 2013-2016, the progress and plans to update the Joint Strategic Needs Assessment and develop a new Joint Health and Wellbeing Strategy for the City.

REASONS FOR REPORT RECOMMENDATIONS

1.	Local authorities and Clinical Commissioning Groups have equal and joint duties to prepare JSNAs and JHWSs, through the Health and Wellbeing Board (HWBB).

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)

	Update on Health and Wellbeing Strategy 2013-16
3.	The Health and Wellbeing Strategy 2013-16 included 64 commitments under three themes: • Building resilience and using preventive measures to achieve better health and wellbeing • Best start in life • Aging and Living Well. A summary of progress to date is attached in Appendix 1.

4.	81% (52) of commitments have been completed or are on target to be achieved. Key successes include: • School nursing recommissioned and breast feeding action plan developed. • New Integrated Substance Misuse Service commissioned. • Top quartile performance for needle exchange, blood born virus and hepatitis treatments. • Fundamental review of mental health services underway and due to be completed in May. • City-wide campaign to reduce stigma surrounding mental health issues delivered and Be Well Strategy refreshed. • Better Care programme has established six clusters bringing together health, social care, housing and voluntary staff, introduced clear pathways for falls and integrated a number of health and social care services. • Solent Jobs Pilot resulted in 25% of participants getting into work. • 0-19 Prevention and Early Intervention Strategy is under development. • Teenage Sexual Health Strategy published. • Reduction in the number of care leavers requiring support through a range of support mechanisms and initiatives. • Fuel poverty strategy published. • Improved diagnosis for dementia, with patients supported by self-management goals and a personal programme. Bespoke dementia e-learning package is being delivered across provider services. • Awareness raising undertaken for end of life care planning and extended care for people with non-cancer diagnosis.
5.	The following 10 commitments are 'amber', meaning that, while work is ongoing, it is currently off target. These will be considered as part of work to revise the numbers accessing both drug and alcohol services. • Support more vulnerable people into good quality work, including young people, carers and people with learning disabilities, mental health issues, long term conditions and disabilities. • Develop and deliver early learning for two year olds who are disadvantaged. • Narrow the gap in attainment and outcomes for children with special educational needs and disability (SEND), increasing their aspirations, skills and qualifications. • Make the most of existing services that offer free or discounted access to leisure, learning, transport and care. • Offer an annual health check to carers and promote support networks for carers across the City. • Join up health and social care services so that the number of assessments is reduced and a person's experience of moving between professionals is smoother and less fragmented. • Develop a shared understanding of how best to support people to retain their independence and make changes to practice to improve

	achievement of this objective. • Map current provision to ensure that appropriate national care pathways are incorporated and audited in hospitals and the community. • Have timely bereavement counselling available.
6.	Two commitments are 'red', meaning they are significantly off target. These, together with key actions to address, are below, and will also be considered as part of work to develop a revised Health and Wellbeing Strategy: • Continue to develop high class education provision, raise attainment faster than comparator cities and improve school attendance rates where they are low. Key action: The School Attendance Action Plan is working to increase attendance alongside an extensive programme to improve school attainment, particularly focussing on secondary school performance. • Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service). Key action: Work is continuing to establish an End of Life Register, however delays in the IT infrastructure have significantly delayed progress. This will form a key element of Better Care planning.
	Developing a new Health and Wellbeing Strategy
7.	The revised Health and Wellbeing Strategy (HWBS) will be an overarching partnership strategy which sets out the vision and priorities for improving health and wellbeing in the City. It will set the strategic direction of travel, and inform the development and be underpinned by more detailed strategies and plans, as well as commissioning and service delivery.
8.	The HWBS needs to be informed by the best available evidence and data, compiled through updating the Joint Strategic Needs Assessment (JSNA). At their meeting on 4th November 2015, the Health and Wellbeing Board considered proposals for updating the JSNA and agreed a number of priority areas, based on an initial analysis (attached in Appendix 2): • Early years/ child health • Long term conditions • Taking responsibility for health • Health inequalities.
9.	It was agreed that further analysis would be undertaken on these themes, through work to update the JSNA compendium, public consultation and stakeholder engagement. This will provide a range of qualitative and quantitative information which will ensure an evidence based approach to developing the revised HWBS. It was also agreed that Healthwatch Southampton would be involved in developing and supporting the consultation process.
10.	Following that meeting, a series of task and finish groups were established aligned to the four themes, with relevant health and Council officers. The aim

	of these groups was to support the development of the JSNA, to identify related strategies, services and assets and consider best practice examples. In addition, the groups have supported the design of the public consultation proposals, to ensure these support and enhance existing engagement work.
11.	A session has also been held with Healthwatch's 'Friday Forum', which includes voluntary sector providers and community groups, to gather their views about key challenges and priorities for health improvement in the City.
12.	The first stage of public consultation to support the development of the JSNA and HWBS focuses on taking responsibility for health and behavioural change. A 'healthy behaviours' questionnaire has been sent to People's Panel, as well as targeted groups including tenants, community groups and Healthwatch networks. Patients and service users are also being invited to complete the survey through the task and finish groups' networks, and it is being promoted on Facebook and Twitter. To date, it has received over 500 responses and will run until 25th March 2016.
13.	Workshops with People's Panel volunteers and Sure Start Centre groups are also being held in March. These will enable more detailed and qualitative insight to be gathered around the barriers and incentives for healthier behaviour and taking responsibility for health. Outcomes from this phase of consultation will be used to inform development of the revised HWBS, and public consultation on the draft strategy will be carried out in May using an online questionnaire. This will be supplemented by copies of the questionnaire being available in a variety of public places including Council offices, libraries, doctor's surgeries etc. and promoted through existing patient, user and provider networks, groups and social media.
14.	In terms of next steps, the timetable for the development of the new HWBS is as follows: • Initial public consultation – March 2016 • Developing a first draft and requesting input from key stakeholders – April 2016 • Public consultation on draft strategy – May 2016 • Reporting on evidence gathered from JSNA and consultation, and presenting draft strategy to key Boards and groups (including CMT/CCG, LSCB, LSAB, Cabinet, Connect, HWBB, HOSP) – May 2016 • Presentation and approval (from HWBB, CMT, Cabinet and Full Council) – June and July 2016.
15.	In line with this timetable, it is proposed to consult with the Health Overview and Scrutiny Panel in May. This will provide the panel with an overview of the emerging evidence, and enable them to input into the approach for health improvement in the City going forward.

RESOURCE IMPLICATIONS		
Capital/Revenue		
16.	None.	
Property/Other		
17.	None.	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
18.	None.	
Other Legal Implications:		
19.	None.	
POLICY FRAMEWORK IMPLICATIONS		
20.	The Health and Wellbeing Strategy is a key strategy of the Council. It will provide the vision and priority outcomes for health and social care services across the City.	
KEY DECISION	No	
WARDS/COMMUNITIES AFFECTED:	All	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Health and Wellbeing Strategy 2013-2016: Progress against commitments	
2.	Initial analysis of priority areas for the Joint Strategic Needs Assessment	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		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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HEALTH AND WELLBEING STRATEGY 2013-16: COMMITMENTS - PROGRESS REPORT Q4 2015/16

	ACTION	PROGRESS (RAG)	COMMENT	Updater
	KEY: Green – On track or completed; **Amber –** Off target; **Red –** Significantly off target; Grey – Missing information or status N/A			
THEME 1: BUILDING RESILIENCE AND USING PREVENTATIVE MEASURES TO ACHIEVE BETTER HEALTH AND WELLBEING				
Smoking and Tobacco Control				
1.	Develop and implement a comprehensive Tobacco Control Plan for the City in conjunction with the Police and Customs, which tackles prevention, provision of smoking cessation support, illicit supply of cheap smuggled tobacco, and implementation of tobacco control policies at a local level.	**GREEN**	Tobacco control plan in place and implemented for 2014-15. Smoking cessation services also commissioned. Review of plan undertaken and used to inform for 2015-16 refresh. Trading Standards have moved to Hampshire County Council, this raises concerns over the impact of tobacco control in the city. Working with Hampshire commissioners to develop a Southampton inclusive approach e.g. Helpline, Roadshow.	Public Health, Dr. Bob Coates
2.	Sustain implementation of the national NHS Health Check programme across the City to support early detection/screening for cardiovascular disease and to tackle lifestyle risk factors.	**GREEN**	NHS Health Checks programme implemented across the City as well as additional opportunistic outreach work targeted at key groups within the population to address potential health inequalities. In 2014/15 99% of eligible population were invited for health checks (over 11,000 invitations). Uptake has increased to 40%. 2015/16 year end data is not yet available.	Public Health, Dr. Bob Coates
Obesity and Physical Activity				
3.	Identify and implement options determining better health and support healthy lifestyle behaviours leading to improved diet and physical activity in key target groups e.g. health promoting workplaces, breastfeeding friendly environments, healthy early years and childcare settings.	**GREEN**	A range of activities and services are available to support healthy lifestyle behaviours. These are accessible for children, families and adults and include activities in key settings such as workplaces, early years and schools. The public health nursing service (school nursing) was recommissioned for 1 April 2015. New service specification has a specific focus on healthy weight. The breastfeeding action plan has been developed, with progress monitored by the 0-5 year working group (under the 0-19 commissioning group). Health improvement plan in maternity services specification monitored at maternity trust board meetings.	Public Health, Dr. Bob Coates
4.	Support initiatives and services that are effective in preventing and managing overweight and	**GREEN**	Initiatives and services for children, young people and adults to prevent obesity and manage their weight are supported. Additional insight work is being undertaken to better understand further needs of key target groups.	Public Health, Dr. Bob Coates

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	obesity in our high risk individuals in the children, young people and adults sectors.		Commissioned insight work for obesity in pregnancy to be available by March 2016 to inform future service delivery. Other targeted work with families and is continuing. Health trainer service provide one to one support and weight management groups for those who want to lose weight. All of these services are targeted to the most deprived Each of the services are reviewed annually	
Alcohol and Drugs				
5.	Work together with local agencies to reduce detrimental effects of adults' problem drug and alcohol use, particularly parents.	**GREEN**	New Integrated Substance Misuse Services (SMS) were commissioned from December 2014 and have been subject to a comprehensive redesign process. There are now four main contracts, with a Young People's substance misuse service dealing with young people aged 11-24 years inclusive. Service providers work in partnership in order to deliver holistic treatment pathways across the City. All clients have a treatment plan (focussed on recovery) and issues relating to safeguarding children are addressed proactively. Additional training on substance misuse has been targeted at social workers working with vulnerable adults and children. Service providers work closely with local agencies including police, probation, Youth Offending services, children and adult safeguarding services, JobCentre Plus, Liaison and Diversion Service, CAMHS and adult mental health services, as well as a wide range of other voluntary services targeted at people with a substance misuse problem and their carers. Although national performance reports still show a reduction in performance based on the previous rolling year's data, live information from provider services shows that the number of successful completions for adults is improving steadily.	Public Health, Dr. Bob Coates
6.	Sustain and expand public education initiatives that raise awareness around alcohol and substance misuse and maintain existing schemes that address underage drinking and associated behaviours, including in school settings.	**GREEN**	The younger persons' SMS has been newly commissioned with No Limits. The enables the delivery of comprehensive school and college based campaigns with access to confidential advice and individual treatment planning, where appropriate. The Healthy Southampton communications plan has prioritised alcohol campaigns for 2015 and identified additional resources to support awareness raising. Other examples include Dry January, Take 2, and the Know your number from the Academic Science Network. No Limits undertake the school education programme, 'Buzz'. This is now part of the annual campaign calendar with our communications team. It is difficult to evaluate the impact of these campaigns directly, however, a sustained and consistent message is evidence based approach.	Public Health, Dr. Bob Coates

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7.	Develop and expand the current services through partnership working approaches that develop 'wrap around' services' (including housing and access to Education, Employment and Training) and link health, social care, housing, leisure, night-time activities and criminal justice to include tackling alcohol and substance abuse in the young.	**GREEN**	The new service model for both young people (YP) and adults is designed to enable a multi-disciplinary and multi-agency response to the needs of service users. Effective partnership working with a wide range of statutory and voluntary organisations is given a high priority. This builds upon the established partnership and educational activities that the Young People's substance misuse service (DASH) had previously developed. Since the new service commenced in December 2014, DASH has expanded its offer to young people to include not only engagement at schools and colleges, but has developed in-reach into Southampton University to address the issues of recreational drug and alcohol use amongst the young adult student population and is hoping to develop a similar relationship with Solent University. The service has also expanded its ability to offer meaningful activity and skills based opportunities to young people to build confidence and develop pro-active approaches to finding employment and training opportunities. The service works closely with a range of partners and agencies in order to develop and provide wrap around services, promoting young people's health services and working closely with the Safe City Partnership, police and probation services in order to tackle the problems associated with drug and alcohol problems in the young.	Public Health, Dr. Bob Coates
8.	Increase numbers accessing both drug and alcohol services. This will enhance numbers achieving recovery from alcohol or other drugs.	**AMBER**	Following the redesign of the substance misuse services and what has proved to be a challenging implementation period, we have seen a reduction in the number of service users accessing treatment, particularly alcohol users. Whilst we have seen some reductions in numbers accessing treatment, within some age ranges, nationally, it is felt that there are local issues that must be resolved. Part of the reason for this is that more service users who require an alcohol brief intervention are being seen as part of the "open access" service which means that they are not uploaded onto the National Drug Treatment and Monitoring System and therefore numbers appear to have reduced. In addition, the decision was taken for the Alcohol Specialist Nurse team not to upload onto NDTMS as they did not have compatible IT systems and the types of interventions they are providing do not form part of the national minimum data set. This has also led to a slight apparent reduction in numbers. However, it should be noted that national figures involve a "time lag" based on a rolling year data, which means that performance reports are still being	Public Health, Dr. Bob Coates

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			affected by data from the previous treatment services. Live information received from the current service providers is showing signs of improvement and treatment providers have improvement plans in place which are being monitored by commissioners and senior managers from the Integrated Commissioning Unit. Overall, the number of alcohol services users aged over 50 has risen by 44%, but fallen by 34% for 16-24 year-olds. This is thought to reflect the general downward trend in young people's drinking, although younger groups have always been less likely to access treatment.	
9.	Review drug treatment services, particularly to young people to ensure a value, high quality treatment system reflective of their drug use patterns.	**GREEN**	The new service was implemented following the review.	Public Health, Dr. Bob Coates
10.	Increase the range of effective treatment interventions for crack cocaine and stimulant users.	**GREEN**	Whilst numbers in treatment (as above) for people presenting with concerns around their use if non-opiate drugs are also in need of improvement, taking into consideration the limitations in NDTMS reporting (as above), we do continue to see services offering an increasingly wide range of interventions, individual work, group work and diversionary activities that are suitable for people presenting with issues around their non-opiate drug use. The most recent (Q3 201516) Diagnostic Outcomes Monitoring Report (DOMES) received from NDTMS indicates Abstinence and reliably improved rates at 6 months review are either well within the expected range or nearly at the expected range • Cocaine abstinence rates (6 month review) = 50% (expected range 9.2% - 100%) • Crack abstinence rates (6 month review) = 15.4% (expected range 18.6% - 48.2%) Clearly there is still work to be done to support improvement in these and other measures. The commissioning team are working closely with the providers to ensure improvements are made.	Public Health, Dr. Bob Coates
11.	Develop an appropriate suite of abstinence and harm reduction services for blood borne viruses (BBV), such as HIV etc.	**GREEN**	Needle exchange, BBV screening, and access to new hepatitis treatments was in the top quintile of performance nationally last year. A programme of enhanced HIV surveillance has been agreed with the CCG and Integrated Commissioning team.	Public Health, Dr. Bob Coates

	ACTION	PROGRESS (RAG)	COMMENT	Updater
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Housing				
12.	Endeavour to help people to have access to good quality, energy efficient housing that is both affordable and meets their needs. The priorities below aim to provide opportunities to help promote health and wellbeing in the working age population across the city by working with local employers, improving economic wellbeing and helping particularly young people into employment.	**GREEN**	The Homelessness Prevention Strategy for 2013-2018 is in place and outlines our approach to tackling homelessness. It demonstrates a commitment to build on our experience to provide a comprehensive service that tackles homelessness in Southampton. The strategy focuses on early intervention and prevention where possible and assisting people in need.	Housing, Liz Slater
13.	Provide a comprehensive homelessness service that supports people to make independent choices about their housing future.	**GREEN**		
14.	Work with the voluntary and supported housing sectors and the Homeless Healthcare Team to ensure that provision in the city meets the needs of the most challenging people to safeguard both their housing and health needs and reduce the impact on the general population.	**GREEN** (On Target)	• The HRS review has commenced and successfully aligned all current contracts to end as of March 31st 2017, allowing the full scope of HRS to be considered in a unified way. • Project group has been set up and starting to monitor the projects progress • Engagement events for Adults and YP have been scheduled for 14th March and 30th March 2016 respectively • While maintaining an overview across all HRS services, there is a dedicated focus on each of the following areas; CYP, Adults and Older persons • Work has commenced on researching a wide range of literature relating to HRS including strategies (local & national), legislation (include current Housing & Planning reform Bill), research and other good practice information as sourced. • Reviews of current services have commenced and will inform final report	ICU, Donna Chapman/ Sandy Jerrim

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15.	Having an additional Licensing scheme for all HMOs in the city to help ensure the conditions in the private rented sector are improved and poor or inadequate housing is brought up to acceptable standards.	**GREEN**	Southampton City Council introduced an additional HMO Licensing scheme in four wards (Bevois, Bargate, Portswood and Swaythling) in July 2013. The scheme is working to improve management and conditions in HMOs and reduce the impact on the communities. The scheme was extended in October 2015 to include Freemantle, Shirley, Bassett and Millbrook wards. There is insufficient evidence of poorly managed HMO's in other parts of the city to legally extend the scheme further, however, a Government consultation is currently underway to consider implementing a national mandatory HMO scheme.	Regulatory & City Services, Mitch Sanders
16.	Develop local hubs for quality support and care in the city, for example dementia friendly facilities with support activities and interactions for people with dementia from the wider community.	**GREEN** On target	All mental health services are currently being reviewed and this will lead to a new model of service for all groups including people with dementia and their carers, with initial proposals due for consideration late Spring 2016. A key feature emerging in the review is the need to link with Better Care initiatives to provide holistic seamless services. The need for local services/hub is now part of the work to develop community solutions to support people in their own homes and localities in a number of different ways. A special City Council Inquiry Panel will be looking at the situation for people with dementia and their carers in Southampton, it will assess how the city is progressing and will also identify further actions needed in making Southampton a dementia friendly city using the recognised framework developed by the Alzheimer's Society. Actions will be progressed throughout the inquiry period (September 2015 – March 2016), starting with an application 'working to become dementia-friendly'. A carers support service has recently been procured which offers support to those caring for people with dementia.	ICU, Amanda Luker
17.	Raise awareness of falls and reduce or prevent trips, slips and falls within Council older people's accommodation. Good design can do much in this sector.	**GREEN**	This is being progressed as a key Better Care programme target. A falls action plan is in place with all agencies committed to delivering key actions. A new exercise class programme is being piloted with a local voluntary sector organisation and other partners to reduce repeat falls. A new falls liaison pathway has also been introduced between UHS and Solent NHS Trust to reduce repeat falls. Specific work is being undertaken with nursing homes to introduce "falls champions" to prevent trips, slips and falls. A publicity week is also planned in September to raise awareness of falls and how to prevent them.	ICU, Donna Chapman

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Workplace Health				
18.	Implement a programme of work to support employers in improving the health and wellbeing of their workforce through recognised good practice at work; improve the support for those stopping work due to sickness to get them back into work sooner or to rethink their future job prospects. Harassment and bullying need preventative policies.	**GREEN**	National Workplace Wellbeing Charter implemented through the Well & Working programme, supporting a range of employers to improve the health and wellbeing of their workforce. Work undertaken to better understand the issues around Fit Note and to address the worklessness agenda for those with a health condition. Every review will be assessing the value for money and opportunities for achieving further access across Hampshire.	ICU, Stephanie Ramsey
19.	Support more vulnerable people into good quality work, such as young people, carers and people with learning disabilities, mental health and long term health conditions and disabilities.	**AMBER**	The Solent Jobs Pilot completed at the end of December 2015 with 25% of participants supported into work, 5% over target. The second stage of the Programme has still been delayed by ESF funding processes and we are not expecting approval until March 2016. The City Deal Youth Programme is now underway and 3 key workers are now working in Early Help teams and Youth Offending and Pathways services to provide advice and support to the most vulnerable NEET young people. 72 young people have been supported since mid-August (start of the programme) and 34 have had a positive outcome in relation to employment, education or training. A PID has been taken to the Commissioning Board to develop an integrated employment support service with health and social care services. The project group has been established and is due to report with recommendations for commissioning by summer 2016. This commitment is amber due only to the delay by the ESF funding processes.	Skills & Regeneration, Kathryn Rankin
20.	Promote and develop the 'Time to Change' campaign to reduce the stigma of mental illness in the workplace.	**GREEN**	Successful Citywide anti-stigma campaign undertaken for two weeks in October which included: • 5K park run, • Time to Change pop up village event in Guildhall Square with a recovery choir, local health services, charities over 450 people were held on mental health, • Further work to be undertaken at the Health and Wellbeing board for organisations to sign up to a mental health pledge.	Public health, Sally Denley

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Mental Health				
21.	Adopt a public health approach in the development of strategies which promote wellbeing for the whole population including activities which reduce health inequalities and which promote good mental health across the city.	**GREEN**	The public mental health Be Well strategy has been refreshed and due to be presented for approval by HWBB in May 2016. The majority of the ten pledges have been met.	Public health, Sally Denley
22.	Ensure early access to psychological therapy/services, such as counselling and talk, which help people remain in or return to employment.	**GREEN**	Access to Southampton Steps to Wellbeing (National Improving Access to Psychological Therapies (IAPT) scheme) has met the national ambition for the proportion of people who have received psychological therapies.	ICU, Amanda Luker
23.	Develop and implement a suicide prevention strategy across the city.	**GREEN**	The evidence obtained by the Southampton Suicide audit undertaken jointly with the Coroner's Office will inform a local Public Health Prevention Plan for Southampton. This will be rolled out as part of the Be Well Strategy refresh, following input from Mental Health matters. Safe care approaches to suicide prevention in the CQUIN scheme; includes review and adaptation of risk assessment. By rolling out 'connecting with people' training for clinicians and USI Suicide Prevention Training together with Mental Health First Aid we aim to make Southampton a suicide safer city.	Public Health, Sally Denley; ICU, Amanda Luker
THEME 2: BEST START IN LIFE				
Giving every child the best start in life				
24.	Develop and deliver early learning for 2 year olds who are disadvantaged.	**AMBER**	The 2014-2015 Southampton Childcare Sufficiency Assessment highlighted that where sufficient capacity has not been developed the necessary plans should be in place to achieve this by September 2015. This has been achieved across the city except in the Thornhill area where suitable premises have still not been identified and all existing local provision has already been expanded to the limit. Take up of places increased from 67% to 70% since the Autumn term 2015. More data and intelligence in relation to the best approach to increase take up is informing outreach work and telephone contact with families. Multi agency training held in February 2016 on how to positively promote the offer to parents. Further information from the DfE expected to	Children and Families Services, Sue Thompson

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			continue to increase uptake.	
25.	Develop an integrated early years' service incorporating children's centre provision, family and parenting support services and the Healthy Child Programme.	**GREEN**	With commissioning responsibility for Public Health Nursing services (health visiting and family nurse partnership) moving to the local authority (Public health) in October 2015, work has been underway to explore a more integrated 0-5 year old offer. We are aiming to implement a virtual model of integration with joint management teams comprising health visiting, children's centres and midwifery leadership from July 2015 to achieve greater integration of resources and alignment of health, education and social care performance indicators and outcomes. At the same time, we plan to undertake a review of MASH and Early Help services to inform the future direction of travel, with a view to potentially working towards an integrated 0-19 offer based around localities.	ICU, Donna Chapman
26.	Develop health visiting and maternity services to achieve optimum health outcomes in the early years and tackle inequalities.	**GREEN**	Work continues with Solent NHS Trust, NHS England and University Hospital Southampton Foundation Trust (UHSFT) to improve outcomes in the early years and tackle inequalities. For Maternity Services, this has been negotiated as part of the 2015/16 Service Specification held by the CCG which includes specific reference to key public health priorities, in particular smoking cessation (including the universal implementation of Carbon monoxide monitoring), healthy weight, healthy start, mental health and breast feeding. Work is underway to ensure that the new Maternity Payment by Results tariff is driving a stronger focus on tackling inequalities. For health visiting, the Council is working closely with NHS England (current commissioner) to improve outcomes in the early years, with reference to the 6 high impact areas described by NHSE. This will be further supported by the integrated 0-5 offer described above.	ICU, Donna Chapman
27.	Continue to develop high class education provision, raise attainment faster than comparator cities and improve school attendance rates where they are low.	**RED**	The percentage of primary and secondary schools judged good or outstanding by Ofsted is currently 84.6%, a ranking of 64th in 152 local authorities nationally; this is a cause for optimism. At 17.8%, nearly a fifth of these are graded outstanding. These figures comprise 88.5% of primary schools judged good or better, including 21.2% graded outstanding. 75% of secondary schools currently judged good or better, with 8.3% graded outstanding. KS2: 1% below national average KS4: 6% below national average KS5: 13.3% below national average point score In June 2015 the 'School Attendance Action Plan Group' was formed and has	Children and Families Services, Kim Drake

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			been meeting on a regular every month since. It aims to develop a shared purpose and vision citywide to improve school attendance and raise attainment throughout our schools. Furthermore, it aims to co-ordinate a consistent, collaborative approach to improve school attendance within the City. It is a vehicle for sharing good practice with others, discussing and exploring current issues that are affecting absence and updating policies, procedures and processes to accommodate the ever changing landscape and reasons for absence from school. Representatives from schools, academies, health, police, youth offending service, education services, social care services, early help and external partners attend. Agencies work together to disseminate the message, and to ensure improved school attendance is high on the agenda throughout the City. Work is also expanding into other areas and we have already engaged and shared our message with governors. An invitation to speak to the chamber of commerce, in April 2016, to engage business in the drive to improve attendance and attainment, along with regular local truancy sweeps, in collaboration with the police, are underway. Improving school attendance is everybody's business and this is the message to the City of Southampton & its partners. There are also consequences for those parents/carers who continually fail to send their children to school regularly, despite our collective intervention.	
Intervening early when problems occur				
28.	Develop an integrated assessment process for all types of needs which identifies them early and facilitates a holistic multiagency approach to providing good quality education, health and care services.	**GREEN**	This is a key element of the Better Care programme and implementation of the cluster interagency team model. Six clusters have been established, based around GP practice populations, bringing together health, social care, housing and voluntary staff. The clusters are at varying stages of development but a core principle for all is the use of risk stratification tools to identify people at most risk and shared assessment and care planning. These principles are also being applied for children and their families, where use of the Universal Help Assessment and Family Help Assessment tools are being used by Children's Centres, school nursing, Early Help and the MASH. Work is also underway to explore a more integrated approach to bringing together the 2-3 year old assessments of the Healthy Child Programme and Early Years Foundation Stage. Integrated process established for safeguarding set up through the MASH (Multi-agency safeguarding hub), Early Help teams and scrutiny of services via the section 11 audit process.	ICU, Donna Chapman

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29.	Shift the focus of provision and resources towards prevention, ensuring that the workforce at all levels and across all agencies is equipped with the skills and knowledge to identify needs and intervene early in situations of risk.	**GREEN**	This is a key element of the 0-19 Prevention and Early Intervention Strategy which has 5 key strands: • Implementation of a core parenting offer and family support; • Better use of data, information and intelligence across the system to identify gaps, provide information to staff and families on what is available and share evidence based interventions; • Community engagement and development of capacity within the voluntary and community sector to better meet need at an earlier stage; • Interagency workforce development and training to support prevention • Early intervention and inclusive integrated services. Significant progress has been made in implementing the parenting offer for 0-5s and a parenting toolkit has been launched with schools to support development of the 5-14 years offer. Different models for strengthening engagement of the community/voluntary sector have been explored through the Delivering Differently and Headstart initiatives and will be further supported through the Prevention and Early Intervention Strategy. Further work required on interagency workforce development and equipping staff with skills and knowledge to identify needs and intervene at a much earlier stage. The Better Care Programme has its own workforce development project being rolled out in 2015/16. This will focus on NHS / Council staff in addition to nursing home and domiciliary care staff. Better Care will lead to prevention and early intervention and initial work has commenced on developing a plan for health and social care outcomes.	ICU, Donna Chapman
30.	Develop and maintain a stable, skilled, high calibre and experienced safeguarding workforce which is well managed and supported.	**GREEN**	The Safeguarding Adults Team is fully staffed, apart from a 0.67 FTE Investigator post, which is vacant pending recruitment. In terms of the skill set within the team, it is recognised that there are areas where more specific expertise is needed. This includes Learning Disabilities and Mental Health and actions are being taken to develop these skill areas. The final area for development is the need to broaden the professional vocational base of team members. The team is almost exclusively staffed by colleagues from a Social Care/Work background and would benefit from having staff with a broader professional background (probation/working with offenders etc.) This will be a future objective, to be a multi-agency service.	Adult Social Care, Derek Law

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Supporting children, young people and their families with additional needs				
31.	Increase personalisation and choice through implementation of a core offer and personal budgets, building on the learning from the Government-sponsored SEN and Disability Pathfinder.	**GREEN**	An integrated 0-25 service is being developed across education, health and social care. This includes the integration of Council and Solent NHS Trust staff within a single service structure and the development of a strong person-centred ethos. The SEND offer is published on the Southampton Information Directory and provides information about what is available and how to access services. A revised Impartial Information and Advice Service is being commissioned to meet the requirements of the Children and Family Act.	ICU, Donna Chapman
32.	Narrow the gap in attainments and outcomes for children with SEN and disabilities, increasing their aspirations, skills and qualifications.	**AMBER**	Current work to create a more nuanced set of performance indicators with Education, Health & Care via the SEND Partnership Board will further support targeted activity in narrowing gaps between this vulnerable groups of children & YP and their peers. Agreed regional benchmarking indicators will be incorporated into the SEND dataset to enable comparisons and opportunities to learn from others to improve outcomes.	Children and Families Services, Jo Cassey
33.	Improve outcomes for children looked-after by the Council (corporate parent) building on the findings from the Integrated Ofsted/CQC inspection.	**GREEN** On target	An OFSTED Action Plan is in place. A performance board meet monthly to audit, continually monitor and ascertain where improvements need to be made. A diagnostic of all LAC has identified several cohorts of children for whom permanency plans can be progressed faster. Due to this 100 children are planned to move out of care in the next year.	Children and Families Services, Christine Robertson
34.	Develop holistic approaches to support and challenge for the most vulnerable families in the city through the Families Matter programme.	**GREEN**	Phase 1 completed with 100% families turned around, Southampton ranked 7 of 152 local authorities. Phase 2 commenced in Summer 2015/16 is based on a new set of criteria and families. Links with new families are being established.	Children and Families Services, Simon McKenzie
Supporting young people to become healthy, responsible adults				
35.	Develop Raising Participation Age support for schools and colleges.	**GREEN**	Raising Participation Age has been implemented effectively with schools.	Children and Families Services, Jo Cassey
36.	Redesign substance misuse treatment services for young people to improve uptake and compliance with treatment.	**GREEN**	Procurement and redesign completed in Dec 2014.	Public Health, Bob Coates

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37.	Continue to improve sexual health and reduce teenage conceptions through delivery of the Children and Young People's Trust reducing teenage pregnancy strategy.	**GREEN**	Teenage pregnancy city wide event held in October 2014. Sexual health strategy developed and intentions reviewed quarterly by sexual health steering group. Teenage pregnancy is a key strategic priority. Teenage pregnancy action plan currently being updated, with assurance of delivery from the 0-19 commissioning group.	ICU, Donna Chapman
38.	Make sure young people leaving care are well supported to achieve their aspirations and become independent, self-reliant citizens.	**GREEN** On Target	Latest validated data indicates that there are 127 care leavers over the age of 18 years worked with by the Service. The trend over 5 years contrasts with a 184 in Quarter 1 2012/13 and evidences a significant reduction in the cohort. Corporate Parenting and Participation: The role of elected members has developed significantly within the City since July 2014. The Children and Families Scrutiny Panel led by Elected Members robustly examines the work and performance of services and outcomes for children and young people in the City and includes a targeted focus upon children in care and care leavers. Participation: Services are designed to involve children and young people in participation and engagement activities require greater coordination over the year ahead. Further creative approaches to building capacity are being applied in this area which practically empowers and supports children and young people to input into consultative, decision-making and delivery mechanisms including the Corporate Parenting Committee. A new Children and Families Participation Officer has been appointed to bring out the voice of the child. Employment, Education and Training: There has been significant progress in outcomes and data collection for this group of young people and some additional externally funded resources are now available to work with the Pathways team to improve outcomes further. The City Deal Youth Programme Manager, now in post, will take a lead in co-ordinating effort across different agencies and teams to maximise NEET results for these young people. Care Leavers "in touch" and in suitable accommodation: The city has developed a strategic approach to finding and accessing suitable accommodation for young care leavers and a wide range of options are available including a "staying put" offer for care leavers to continue to reside with their current foster carer(s). Steps have been taken to improve the joint working between the Care Leavers/Pathways Team and the Housing Needs Team. Health assessments for looked after children have been significantly improved	Children and Families Services, Robert South

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			over the past 12 months in both timeliness and quality. This is rigorously monitored and maintained through the partnership of agencies and processes put in place to establish these improvements. Solent NHS Trust and the Local Authority also need to deliver similar improvements in relation to immunisations and dental checks for children in care. This progress has also impacted positively upon the older children/young people as they leave care.	
Theme 3 – Ageing and Living Well				
Tackling poverty				
39.	Make the most of existing services (voluntary, public and private sector) that offer free or discounted access to leisure, learning, transport and care.	**AMBER**	Public Health attended a physical activity lecture in February 2016 led by Active Nation on their new strategy Sporting Future published in December 2015. The strategy has outcomes for health, economic development and community development. Further discussions to take place on how to embed the framework. This work will be included in the Public Health team business plan.	Public Health
40.	Support the development and use of information advice assistance to help people to maximise their income, ensure winter warmth and improve their quality of life.	**GREEN**	Additional advice provision has been made available in the city in response to welfare reforms. Training for staff has been provided on debt awareness. The funding for Local Welfare Provision, which has supported people in crisis since April 2013, is ending in March 2016. The Welfare Monitoring Group have aimed to support people through the Welfare Reforms changes and have achieved a sustainable solution for affordable loans has been secured with the Credit Union. Southampton are progressing the Fairness Commission's report will take forward these issues where possible. In particular, the following recommendations will look to tackle issues of debt and fair access to welfare entitlement in the city: • Promoting and providing learning modules for debt and money management in schools and colleges. • Developing and implementing a programme to increase awareness of and fair access to welfare entitlements, particularly linked to key life-transition points. The Southampton Information Directory signposts people to key services. Significant work has been undertaken to coordinate advice services through the Southampton Advice Services Alliance (SASA) which was established following a successful bid for funding. This has resulted in the establishment of an advice portal and cross-agency specialist advice. The funding has now	Skills & Regeneration, Sara Crawford

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			ceased, although funding has been secured for the specialist advice worker to continue. Work is underway to agree a way forward for the alliance into the future. In July 2015 the HWBB supported the Southampton Warmth for All Partnership (SWAP) to ensure City wide partnership working to address public health, energy efficiency and fuel poverty concerns, especially in the development of bids for future funding. Work on this is continuing. The Fuel Poverty Strategy has been published to work alongside this.	
Prevention and earlier intervention				
41.	Offer an annual health check to carers and promote support networks for carers across the City.	**AMBER**	The process for health checks being offered to carers will be reviewed with local carer and primary care services to establish how they will be offered in the future. As part of this work discussions are taking place in the next few months, with proposals to be outlined in Autumn 2016.	ICU, Sandy Jerrim
42.	Review tele-care and tele-health services in the City, re-shape and re-launch these so that local people are more aware of the ways in which they can use technology to retain their independence.	**GREEN**	Plans being developed under oversight of Health and Social Care System Chief Officers. Diagnostics have been completed and the project has now been implemented.	ICU, Sandy Jerrim
43.	Extend re-ablement services so that people can help to regain their confidence and skills after an illness.	**GREEN**	The integrated rehabilitation and reablement service is designed to intervene rapidly and early when people are at risk of crisis, nursing or rest home or hospital care or are ready to discharge from hospital care back into the community. The service dovetails with the developing cluster teams to promote simple, integrated and shared care pathways for clients and patients. On target.	ICU, Jamie Schofield
44.	Promote healthy, active lifestyles through a dedicated team of Activity Coordinators.	**GREEN**	Through programmes such as health trainers and My Journey residents and visitors are encouraged and supported to be more physically active.	Public Health, Dr Bob Coates
Being 'person' centred and not 'disease' centred				
45.	Increasing the number of people who can say how best to spend the money allocated for their health and care, either through direct payments or personal	**GREEN**	Adult Social Care Direct Payment performance is improving, with 40 additional recipients in 2015/16. The rate has increased to 18.1%; although this is below the target of 22.1% for 2015/16 due to increasing number of eligible service users. Spectrum CIL has been commissioned to provide additional support to individuals as part of a pilot aimed at further increasing uptake.	Adult Social Care, Paul Juan

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	health/care budgets.			
46.	Joining up health and social care services so that the number of assessments is reduced and a person's experience of moving between professionals is much smoother and less fragmented.	**AMBER**	Service functions related to crisis response, rehabilitation, reablement and hospital discharge will be integrated with pooled funding arrangements, single management, referral, governance, planning and performance arrangements to ensure greater fluidity and shared responsibility. The programme is being undertaken in 3 phases: Phase 1. Integration of existing SCC and SCCCG Teams working on hospital discharge, rehabilitation and reablement. Phase 2. Redirecting resources from Brownhill House to further support and grow Phase 1. All consultation complete and approval received to proceed. Implementation underway and alternative provision being sought. Phase 3. Develop out of hospital pathways that ensure timely discharge from hospital again freeing up resources through a reduction in occupied excess bed days. Again these resources will be used to support and grow the functions inherent in Phase 1. The detail of the 'out of hospital' pathways are currently being developed.	ICU, Jamie Schofield
47.	Developing a shared understanding of how best to support people to retain their independence and make changes to practice which improve the achievement of this objective.	**AMBER**	This is a key area of focus of the three Better Care principles. A fundamental element of this is the recommissioning of the long term care pathways and self-management approach. The review of behaviour change will also have an impact. Examples of work underway include: Age UK are piloting Person Centre Planning in three GP practice for people with long-term conditions. Two GP practices are running pilots for the over 50's who use alcohol with long-term conditions. Also piloting with Spectrum community navigation, with workshops being held June 2015. Southampton Advice Services Alliance (SASA) have developed the advice and information website.	ICU, Moraig Forest –Charde
48.	Promotion of a focus on recovery rather than simply procedures for admission avoidance and/or hospital discharge when people need any form of secondary care.	**GREEN**	The integrated crisis response, rehabilitation, reablement and hospital discharge provision will focus on promoting independence by having a community cluster focus at all time, developing self-management planning, involvement in risk stratification processes, developing city wide single care planning and information sharing processes and protocols. Focusing on reconditioning pathways in the tender for behaviour change.	ICU, Moraig Forest-Charde

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Care of long-term conditions, including cancer and dementia				
49.	To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions	**GREEN**	The Better Care Programme aims to address needs of individuals, especially vulnerable older adults. The focus is explicitly on Long Term Conditions and frailty. BCP is in its second year of roll –out. The programme benefits from "pooled" health and social care funding and is given high priority by partner organisations. Prevention and early intervention work relating to the behaviour change review is underway and will have an impact.	Public Health, Bob Coates; ICU, Stephanie Ramsey
50.	Work with GPs to more accurately achieve earlier diagnosis of those most at risk of experiencing dementia	**GREEN**	Focused work undertaken with Primary Care during 2014/15 has resulted in an increased diagnosis rate, preliminary March 2015 data 65%, which is an increase of 10.5% from the March 2014 position. This data will be updated as part of the next phase of the JSNA refresh.	ICU, Amanda Luker
51.	More support for people with dementia to remain in their own homes for as long as it is safe for them to do so.	**GREEN**	Services promoting social inclusion to those living with dementia, working with individuals and families to review and establish self-management goals within a personal programme. Working with the voluntary sector and community settings to improve the health and wellbeing of people living with dementia and to reduce loneliness and social isolation, by participating in a range of activities.	ICU, Amanda Luker
52.	The development of extra-care services for people with long term conditions and those with dementia Launching a new approach to provision of aids and adaptations which encourage better access and information for individuals able to fund themselves and improves response times to those requiring equipment to maintain their independence.	**GREEN**	Extra care provision at Graylings available for individuals with dementia. An innovative project has been running for some time and is being expanded featuring GPS technology to help people with dementia who are at risk of becoming lost and confused in the community. The evaluation of this project is expected in the Summer 2016. This now sits within a range of areas: the wider Better Care agenda; Person centred Planning, Personal Budgets, JES, telecare and telehealth and the Prevention and Early Intervention portfolios. Launched joint equipment store and retail mobility facilities.	ICU / Amanda Luker; Chrissie Dawson
53.	Raising awareness amongst all care and health staff about appropriate responses for people with dementia, mental capacity issues including deprivation of	**GREEN**	NHSE mandate that 80% of front facing staff should receive dementia awareness training. Community Trust has developed a bespoke e-learning package to deliver tier 1 training, and currently reviewing tier 2 and 3 training. An Acute Trust Dementia Strategy is now in place, and linked to the Trust education plan.	ICU, Amanda Luker

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	liberty guidelines and protocols.		VIP training with 5 dementia modules being offered, with additional module being developed. MIND have raised awareness of IMCA/DoLS within hospitals and regularly link closely with residential homes.	
54.	Work with the Clinical Commissioning Group and providers of social care to raise the standard of medicines management across the health and care system.	**GREEN**	Public health advise on medicines evaluation and prescribing policy (across SW Hampshire). CQC and CCG Clinical Governance monitor quality of medicines management. The CCG medicines management team have a comprehensive programme to improve the safety and effectiveness and medicines management.	Public Health, Dr. Bob Coates.
55.	To improve health outcomes of those living with cancer action will be taken to improve understanding amongst the public about the signs and symptoms of cancer and encourage early checks with their GP.	**GREEN**	Public Health have worked with Public Health England, the Saints Foundation and NHS England on cancer awareness programmes including 'Blood in pee' and the 'lung cancer awareness' programmes. These proved to be effective in increasing the number of diagnoses.	Public Health, Dr. Bob Coates.
Improve the response to learning disabilities				
56.	Work with the Clinical Commissioning Group to ensure the implementation across GP practices of annual health and dental checks for people with learning disabilities.	**GREEN**	A city wide plan has been developed covering, engagement with GPs, Wessex AT, Southern Health, LDPB, Choices Advocacy, people with learning disabilities and their carers. Implementation is planned to reach 50% within 2015/16. More work needs to continue on increasing take up. The Primary Care Joint Committee meeting on 14th January 2016 received an update regarding the Annual Health Checks. Four practices have not signed up to the LD DES which potentially leaves approximately 100 patients not receiving their annual checks. 420 patients have received a coded health check (out of 1,148 - as at the time of the meeting). A reminder has gone out the practices about completing the health checks with their patients. The CCG are undertaking a re-engagement exercise currently, with a view to making stronger improvements in 2016/17. This will also look at the quality of the health checks. The CCG is considering a procurement route for the service from other practices (to cover the surgeries who have not signed up to the DES), as well as picking up any under activity. A working group is established to develop the proposal. Feedback has	ICU, Kate Dench

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			been established from the Learning Disability Partnership Board and there is strong link into the group on further developments. It has also been suggested a "disability friendly" award is set up to encourage practices. Regarding dental checks, there are some key actions that commissioners have undertaken to make improvements in dental services. The Community LD Health team share the Dental Passport when working with patients and carers. Additionally, dental checks are well incorporated into the clinical pathways set up for high risk groups (e.g. challenging behaviour). This is further enhanced within the newly let Domiciliary Care Framework so that all home care providers can support individuals with their dental health (based on their support plan). NHS England commissioned specialist dental services that are well established; feedback is positive regarding the use of these services.	
57.	Better coordinate and promote services which support people with learning disabilities and their carers across the City.	**GREEN**	The online Southampton Information Directory (SID) has been developed to include information about all services available and how they can be accessed. Carers in Southampton services are being promoted widely. Advocacy services have been re-commissioned with a strong emphasis in supporting people with learning disabilities.	ICU, Kate Dench
58.	Encourage partners within the Health and Wellbeing Board to lead by example and produce plans for improving employment of people with learning difficulties.	**GREEN**	Further analysis is required to assess whether partner plans are in place and their effectiveness. The Prevention and Early Intervention work stream received a PID from the Head of Skills and Regeneration in order to progress the development of a business case to establish strengthened employment support for the city's most vulnerable groups including people with learning disabilities. Key partners across Health and Social care are supportive of progressing this work. Linked to the Learning Disabilities Housing Project a fixed term part time post has been commissioned from City Limits to engage a group of individuals in employment options. This starts in April 2016 and is expected to last for 12 months.	ICU, Kate Dench
59.	Involve the Learning Disability Partnership Board which includes people with learning disabilities in the City in shaping all improvements.	**GREEN**	The Partnership board regularly requests and receives information from the council, CCG and other partners about current service developments and is in involved in shaping them. The Learning Disability Partnership Board has agreed from 16/17 there will be six priority areas for the board, which are: 1. Health	ICU, Kate Dench

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			2. Employment 3. Community Inclusion 4. Independence 5. Carers 6. Person centred approaches/quality Recent examples of how the board have shaped service developments include: Further development of the Learning Disability Annual Health Check so that there is a mechanism within the city for all people with learning disabilities to access their annual health check (this is in progress). Understanding how the Quality and Safeguarding Team work, work has been undertaken to inform a quality audit tool that can be used in Day Services. Choice's Advocacy have also agreed to explore with Busy People and the Quality Team how we can their expertise in a 'quality checker' role. This is in development.	
End of life care				
60.	Increase public awareness and discussion around death and dying.	**GREEN**	Southampton, in conjunction with Health Education Wessex, provided information and awareness sessions through community groups (for Southampton it was Carers Together). Their remit was to develop teaching and training to raise awareness of EOL care planning amongst voluntary organisations and their members.	ICU, Chrissie Dawson/ Carole Binns
61.	Map current provision to ensure that appropriate national care pathways are incorporated and audited in hospitals and the community.	**AMBER**	Southampton are represented nationally to ensure national directives are implemented. Providers have developed and implemented an 'individualised care plan for the last days and hours of life' based on the Achieving Priorities of Care recommendations. End of Life Care Plans are audited through acute hospitals which includes the review of 'do not attempt cardio pulmonary resuscitation' (DNACPR) processes. The AMBER care bundle (a guide for clinicians), which identifies and supports people to achieve their preferred wishes at the EOL, has been rolled out in our acute hospital. The Transform Programme aims to improve the quality of end of life care within acute hospitals, enabling more people to be supported to live and die well in their preferred place. The programme focuses on both the quality of care provided by acute hospitals, as well as the important role acute hospitals	ICU, Chrissie Dawson

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			have, as one of many organisations that may provide care for people who are approaching end of life. End of life care includes care for people in their last years, months and days of life as well as care after death. Developing an end of life 'rapid response' model with acute and community providers to provide support to patients, their families and carers to achieve their preferred place of care/death.	
62.	Extend palliative care to other diseases besides cancer and ensure access to physical, psychological, social and spiritual care.	**Green**	Countess Mountbatten House was successful in a Department of Health grant to improve the facilities at the hospice, the refurbishment included appropriate surroundings to extend care for people with a non-cancer diagnosis approaching EOL, as a result the hospice has seen an increase in the number of people with a non-malignancy receiving care.	Chrissie Dawson
63.	Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service).	RED	This has slipped for Southampton (and SHIP) as the preferred IT platform has been superseded by the Hampshire Health Record (HHR), with the timescales for the End of Life plans for the end of summer 2015. The EOL care plans which are produced by GP's and Solent Community Teams are uploaded to the HHR as documents under the EOL Care Planning folder. The CCG has commissioned graphnet, the IT supplier of HHR, to develop an automated care plan format which will include all the elements required under EPACCS (Tina has been involved in this). The new care plan formats, which are called CareCentric+ are due to become operational in September this year. They need to go through a period of testing and trialling. This work will also feed into the pan-Hampshire work to develop an interoperability platform under the CHIP Programme. Governance Structures and business cases of the development of this are underway. Dr Mark Kelsey CCG clinical lead is also the lead for the HHR/CHIP. Sean Dawtry is the rep from SCC on this programme.	ICU / Chrissie Dawson
64.	Have timely bereavement counselling available.	AMBER	Family member/carers receive an initial contact from the provider who cared for their deceased relative, with signposting to appropriate services as required. Work is continuing with providers and the voluntary sector to ensure feedback from the national VOICES survey is considered going forward. Bereavement support is provided for in-patients and their families/carers at Countess Mountbatten Hospice. Wider bereavement support is being considered in line with the EOL strategy refresh and developed in conjunction with bereavement charities.	ICU / Chrissie Dawson

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INITIAL ANALYSIS OF PRIORITY AREAS

Child Health / Early Years

1. From 2002 to 2014, the number of births in Southampton has risen by a third, which equates to over 800 extra births per year. These higher levels of birth will increase demands upon a whole range of universal services such as schools, GPs and dentists as well as for targeted and specialised services such as parenting support, speech and language therapy or specialist social care services.

2. One of the key Marmot recommendations was to give every child the best start in life in order to ensure children remain healthy throughout life, reduce health inequalities and (given the increasing demand) to help ensure the provision of health and social care services are sustainable in the future. Therefore, in Southampton the intention is to ensure that all children enjoy good health throughout life, are kept safe from abuse, harm and neglect, enjoy growing up and are able to achieve well academically to increase life chances and be well placed to achieve economic wellbeing.

3. However, this is currently not the case for all children and young people in the city. We know that too many of our children have their potential wasted; not achieving as well as they could at school, having poor health due to obesity, poor diet, poor choices in relation to alcohol etc. Some examples are below:
   - 23.5% of children under 16 live in poverty, which is significantly higher than the England average of 19.2% (2012)
   - Only 51% of children in Southampton achieved 5 or more A*-C grades at GCSE (Inc England & Maths), which is significantly lower than the England average of 56.8% (2013/14 data)
   - Southampton has a significantly higher level of pupil absence from school at 5.1% compared to the England average of 4.5% (2013/14), although this has been falling in recent years.
   - Despite recent improvements, Southampton continues to have a significantly higher teenage conception rate (36.2 per 1000 females aged 15-19) compared to England (24.3) and is the third highest in our comparator group (2013 data).
   - Southampton has significantly higher proportion of children classified as overweight or obese compared to England for both Year R and Year 6 children. For Year 6 children, Southampton has the third highest percentage amongst our comparator group – 37.2% compared to 33.5% for England (2013/14 data)
   - 13.9% of mothers in Southampton report smoking at time of delivery which is significantly higher than the England average of 10.3% (2014/15 Q3 data)
   - Southampton has the highest rate of children in care in the South East Region at 104 per 10,000 children (aged under 18), significantly higher than the England rate of 60; this equates to 500 children in the city and this number is rising year on year (2014 data).
   - Southampton has the second highest rate of alcohol specific hospital admissions in the South East Region at 87.1 per 100,000 population (aged under 18) which is significantly higher than the England average of 40.1 (2011/12 to 2013/14 pooled data)

Long Term Conditions

4. According to the DoH (2010), people suffering with long term conditions represent 69% of health and care spend, 77% of inpatient bed days, 55% of GP appointments and 68% of outpatient and emergency department appointments. The number of people aged over 65 in Southampton is forecast to grow by 19% between 2014 and 2021, the equivalent of an extra 33,000 people. This will mean that the management of long term conditions will make a growing contribution to the overall burden of disease and costs to the local health & social care system. However, many long term conditions and their complications are often preventable.

5. Some of the main issues facing Southampton are below:
    - Premature mortality (under 75s) from cancer in Southampton is 159.9 per 100,000 population, significantly higher than the England average of 144.4
    - Breast cancer screening coverage (amongst women aged 53-70) in Southampton is 69.5%, significantly lower than the England average of 75.9% and 5th lowest amongst our comparator group. The picture is similar for cervical cancer screening.
    - Premature mortality (under 75s) from cardiovascular diseases in Southampton is 93.8 per 100,000 population, significantly higher than the England average of 78.2
    - Premature mortality (under 75s) from respiratory diseases in Southampton is 45.8 per 100,000 population, significantly higher than the England average of 33.2, and the fourth highest amongst our ONS comparator group.
    - Diabetes is a serious life threatening condition and can lead to complications such as heart disease, kidney disease and stroke. In Southampton the diagnosed prevalence of diabetes has risen from 3% in 2004/05 to 5.4% in 2013/14. Diabetic retinopathy is the greatest cause of blindness in working age people and Southampton has a significantly higher rate than England and second highest amongst its comparator group. Up to 80% of type 2 cases of diabetes can be prevented or the onset delayed if people led healthier lifestyles.

Taking Responsibility for Health

6. Much of the premature mortality and morbidity experienced in Southampton could be prevented or delayed if people took responsibility for health and led healthier lifestyles. Some of the main issues for Southampton are highlighted below:
    - The WHO acknowledges that smoking is the single largest preventable cause of death and disability in the developed world. Smoking prevalence in Southampton is 21.5%, significantly higher than the England average of 18.4%. Southampton also has a significantly higher mortality rate attributable to smoking (329.2 per 100,000 pop vs 288.7).
    - Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually. Alcohol specific mortality and mortality from chronic liver disease are both significantly higher in Southampton compared to the England average (2011-13 data).
    - Southampton also has a significantly higher rate of benefit claimants due to alcoholism (201.3 per 100,000 working age population compared to 131 for England in 2014)
    - The human costs of unplanned pregnancy, STDs and HIV are enormous. Treating STDs and their consequences cost the NHS an estimated £1 billion every year. The most costly infection is HIV, with an annual treatment cost of around £15,000 per person. Southampton has a significantly higher rate of new STI diagnoses compared to the England average (899 per 100,000 population aged 15-64 compared to 829). We also have one of the highest teenage conception rates (see above).
    - Levels of obesity have increased over the last 20 years for both adults and children. Obesity is linked to poor health in the longer term and increases the risk of conditions like diabetes, CVD and some cancers. It can also cause joint and back pain, mental health problems and social difficulties. Being overweight can reduce life expectancy by up to 3 years and being obese can reduce it by up to 10 years. Southampton has the second highest prevalence of childhood obesity in Year 6 in the South East and is significantly higher than the England average (21.8 % compared to 19.1% in 2013/14). This picture is similar for children in Year R.

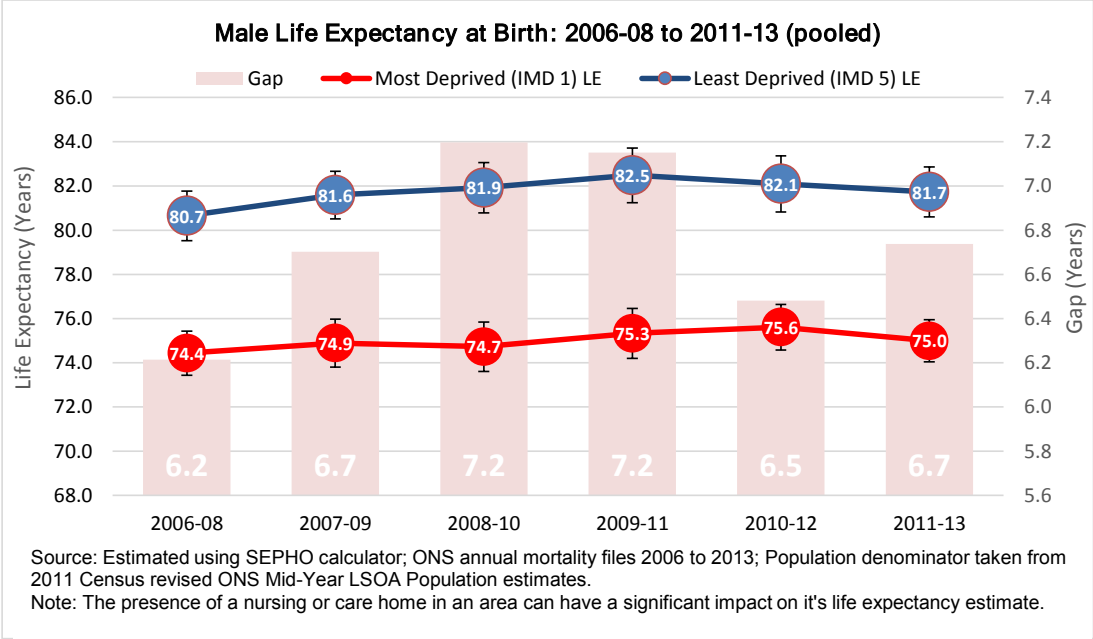
Health Inequalities in Southampton

7. Over recent years health inequalities have persisted between the most deprived and least deprived populations in the City. The current status of health inequalities in the City has been outlined comprehensively in two city publications: the Director of Public Health's Annual Health Report 2014 and the briefing report, Health Inequalities in Southampton City – Analysis of

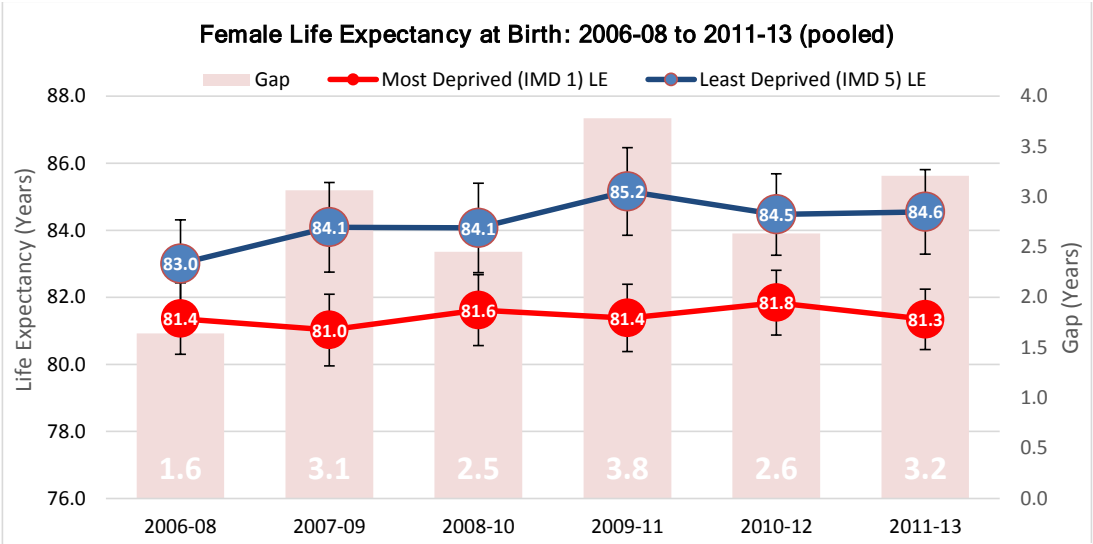
Trends (Refresh November 2014). The Health and Wellbeing Board has received presentations on both of these data sources. A draft Health Inequalities Framework was also presented to the Board in July 2015, and included the recommendation that further consultation and engagement on this issue be undertaken as part of JHWS development in order to:

- Support consensus building on key principles/core themes and progress discussion to agree high impact actions.
- Expand the picture of current activity underway across core themes.
- Implement consultation with local population (community/voluntary groups and wider population).
- Inform the focus of the next iteration of the Joint Health and Wellbeing Strategy.

8. The reports all present a picture of consistent and persistent health inequalities in the city. For illustrative purposes the figures on male and female life expectancy between the least and most deprived populations in the city are outlined below.



Source: Estimated using SEPHO calculator; ONS annual mortality files 2006 to 2013; Population denominator taken from 2011 Census revised ONS Mid-Year LSOA Population estimates.
Note: The presence of a nursing or care home in an area can have a significant impact on it's life expectancy estimate.



Source: Estimated using SEPHO calculator; ONS annual mortality files 2006 to 2013; Population denominator taken from 2011 Census revised ONS Mid-Year LSOA Population estimates.
Note: The presence of a nursing or care home in an area can have a significant impact on it's life expectancy estimate.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		MENTAL HEALTH MATTERS		
DATE OF DECISION:		24 MARCH 2016		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Katy Bartolomeo**	**Tel:**	**023 8083 4162**
	E-mail:	**Katy.bartolomeo@southampton.gov.uk**		
Director	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 8029 6941**
	E-mail:	**Stephanie.ramsey@southamptoncityccg.nhs.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY
The purpose of this paper is to update the Health Overview and Scrutiny Panel (HOSP) on the progress of the Mental Health Matters consultation.

RECOMMENDATIONS:		
	(i)	The Panel is asked to note the content of this report and priorities for local delivery of Mental Health Matters and contribute to the consultation accordingly.

REASONS FOR REPORT RECOMMENDATIONS	
1.	To ensure that the HOSP has oversight of the way in which the proposals were developed and the way in which decisions are made.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None.

DETAIL (Including consultation carried out)	
	Purpose and Scope of the Review
3.	Our priority across Southampton City Council and Southampton City Clinical Commissioning Group (CCG), is to ensure that those people in Southampton who require mental health support get access to the services they need, when they need it, with the outcomes they deserve.
4.	An initiative led by the Health and Wellbeing Board, a Mental Health Matters event, took place in late 2014 which sought to hear people's views in relation to the City's mental health services, in response to a number of concerns being raised about the quality and outcomes we were achieving for people with mental health problems. Mental health has also been identified as a potential focus area in the Right Care work and benchmarking data shows that improvements need to be made.
5.	The main feedback from this event was that people wanted an opportunity to be part of the review of mental health provision, and have a 'blank page'

	approach.

6.	The Mental Health Matters review forms the backdrop to a number of themes within mental health and concurrent work streams and aims to draw all those strands together to provide a coherent picture and pathways these include:
	• Future in Mind and the Child and Adolescent Mental Health Service (CAMHS) Transformation Plan
	• National targets:
	  ○ Access to IAPT (Increasing Access to Psychological Therapies) – Steps2Wellbeing service
	  ○ Dementia Diagnosis Targets
	  ○ Access and waiting time standard for psychosis
	  ○ Waiting time standard for eating disorder services (young person)
	• Parity of Esteem
	• Current mental health changes within main NHS providers
	• Crisis Care Concordat
	• Better Care Fund
	• Links to City wide Early Intervention and Prevention Services

	Progress to Date
7.	Following the mental health round table event there was an engagement period that ran from 6 August 2015 to 16 October 2015. Service user and carer feedback represented 58% of the responses received. Feedback was overwhelmingly positive for a new model of care for Southampton, and included many valuable suggestions and things to consider. A summary of the numbers reached by the engagement is below: Type of feedback — Number Full survey completed — 92 Adapted young person's survey — 70 Group feedback from forums/settings attended — 39 Email feedback — 16 Total — 217 The Mental Health Matters web page was visited 2,263 times and the engagement document downloads 530 times. Social media posts were seen 6,315 times excluding re-tweets or shares.
8.	The feedback from the engagement period has helped to shape and develop the proposals detailed in the Mental Health Matters public consultation attached as Appendix 1.
	Current Phase – Public Consultation
9.	The consultation was launched on 5 February 2016 and will run until 2 May 2016, with proposals coming into effect throughout 2016 and onwards into 2017 through phased implementation.

10.	Consultation overview to date: • Using all networks and means of communication to let people know about the consultation • Good support from stakeholders to help raise awareness of the consultation, some are either running small focus groups and/or are supporting individuals to complete feedback forms • Attendance at existing forums, and various waiting rooms has, and will continue to take place • Approximately 100 responses received so far • On-going analysis of respondents undertaken to identify under-representation of any specific area(s) of the population, to highlight where additional focus/resource are needed during the remainder of the consultation period • Adapted survey being developed to engage young people in the City • Proactive media engagement; series of articles being developed to bring the consultation to life, and to highlight how the City already responds to supporting people with mental health needs.
11.	Feedback on the consultation document can be done via the form at the end of the consultation document, via email, phone or on-line following the link: www.southamptoncityccg.nhs.uk
	Links to the Mazars report
12.	The recommendations from the Mazars report, whilst not directly linked to the Mental Health Matters review, will be taken into consideration with all proposed changes. Through the local Southampton Clinical Quality and Review Meetings (CQRM) and the Hampshire wide CQRM we will continue to work with Southern Health Foundation Trust (SHFT) to implement the recommendations within the Mazars report.
13.	Analysis of the Mazars report led to recommendations for Southampton City CCG to focus on the following key areas: • Response to Mazars report publication – link to quality indicators • Staffing – appropriate numbers and skill mix / ongoing issues with recruitment • Impact on quality outcomes from the organisational change in adult mental health • Delivery and evidence of embedding actions arising from the Care Quality Commission (CQC) inspection • Improving RCAs (root cause analysis) - identification of root causes, sharing lessons learnt and backlog of reviews • Appropriate identification of key risks • Caseload management / appropriate caseload numbers - link to wellbeing of patients and staff.

14.	The Mental Health Matters review alongside changes already underway in SHFT will look to improve the following: • Quality of outcomes for patients by identifying key areas for service development such as improvements in crisis care and services for people with personality disorder. Increasing the routine use of outcome measures and patient feedback in designing and reviewing services. • Staffing – by changing the culture and ethos of services the Mental Health Matters review aims to help the recruitment and retention of staff. This is work that has already begun within SHFT. Mental Health Matters has been engaging with patients, communities and staff members to make the changes within Southampton. Listening and consulting with a wide number of people to ensure that any proposed changes really do reflect what is needed in Southampton. • Caseload management – by developing new services such as personality disorder services, improving psychosis services, developing services for earlier identification and prevention as well as enhancing services for primary care the review will aim to reduce overall caseloads within secondary mental health teams. • Through continued contract monitoring and continued relationships with SHFT management team we continue to identify key risks and have set up a number of multi-agency groups to strengthen the links with other providers and parts of the system to ensure a continuity of care and a sharing of information. Mental Health Matters is looking to further strengthen those links and relationships between organisations so that patient care is provided in a holistic and effective manner.
15.	We believe the proposed model will provide better care for people with mental health needs, but in some ways is not radically different from the system that currently exists.
16.	The differences that individuals can expect to see in how services are delivered in the future are contained in the consultation document pages 7-11 in Appendix 1.
RESOURCE IMPLICATIONS	
Capital/Revenue	
17.	The capital/revenue implications have not yet been identified
Property/Other	
18.	There are no property implications.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
19.	There are no legal implications.
Other Legal Implications:	
20.	There are no other legal implications.

POLICY FRAMEWORK IMPLICATIONS	
21.	There are no policy framework implications.

KEY DECISION?	No	
WARDS/COMMUNITIES AFFECTED:	All wards	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Mental Health Matters Public Consultation	
2.	Mental Health Matters Public Consultation – Summary Document	
Documents In Members' Rooms		
1.	Equality Impact Assessment	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		Yes
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		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.	Equality Impact Analysis – Mental Health Matters Review	

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SOUTHAMPTON CITY COUNCIL

NHS Southampton City Clinical Commissioning Group

Mental Health Matters Public Consultation

CONSULTATION PERIOD

5 FEBRUARY – 2 MAY

February 2016

Contents

Katy Bartolomeo

Senior Commissioner
Southampton Integrated Commissioning Unit

If you need further copies of this document or need it in a different format please contact Amanda.Luker@Southamptoncityccg.nhs.uk
or telephone 023 8072 5568

1. About this document

This consultation document has been produced by NHS Southampton City Clinical Commissioning Group (CCG) and Southampton City Council. We would like your views on proposals to change the way mental health services are provided in Southampton. The proposals have been developed following feedback from service users, carers, GPs and other interested parties as a result of engagement work during August and through to October 2015.

Southampton Integrated Commissioning Unit (ICU) is a joint team for Southampton City CCG and the Council, and is responsible for identifying which services the people of Southampton want and need and for commissioning (which means planning, buying, and checking) these services on their behalf.

Southern Health NHS Foundation Trust is the main provider of working age and older adult specialist mental health services in Southampton.

Solent NHS Trust is the main provider of child and adolescent mental health services (CAMHS) in Southampton.

Dorset Healthcare University NHS Foundation Trust is the main provider of primary care psychological therapies in Southampton.

Solent NHS Trust work in partnership with **CRI***, **Society of St James**, alongside **No Limits**, to provide Southampton's integrated drug and alcohol recovery service. *From 1 April 2016, CRI is changing its name to change, grow, live (cgl).

Glossary of special terms or unfamiliar words

Words used in this document, or at events and meetings, which have special meaning or may be unfamiliar, are defined in the glossary on page 19.

Getting this document in a different language or format

If you would like this document in another language or format, please contact us on the details below. Please remember to include a telephone number or address so we can get back to you:

Amanda Luker
Commissioner
Telephone: 023 8072 5568
Amanda.Luker@Southamptoncityccg.nhs.uk

Time to Change – ending mental health discrimination

The NHS and the Council in Southampton support Time to Change, a national campaign led by Mind and Rethink aimed at ending the discrimination faced by people who experience mental health problems. For more information, please visit www.time-to-change.org.uk

2. Foreword

NHS Southampton City CCG and Southampton City Council are responsible for making sure that local people get the health and social care services they need. We are allocated a budget to achieve this and must use it to plan and buy services.

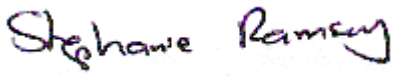
This review has been undertaken in order to make improvements in the quality and outcomes in mental health services.

Mental health has also been identified as a potential focus area in the Right Care programme of work, which looks at information that measures the investment, activity and outcomes, this information tells us that improvements need to be made.

For these reasons, we have undertaken widespread engagement to hear the views of service users, experts by experience, carers, clinicians, and voluntary sector organisations. The feedback received during the engagement period has helped us to shape the proposals set out in this public consultation.

We are now seeking your views to check that we have the detail in these proposals right before we make any decisions, please take a look at the information in this document and send us your thoughts.

We look forward to hearing from you.



Stephanie Ramsey, Director of Quality and Integration

"The CCG is responsible for making sure that local people get the health services they need, and we are committed to ensuring that services which assess and treat mental health conditions are of the same high standard as those for physical health. Mental Health Matters will ensure that people in the city that require mental health support get access to the services they need, when they need it, with the outcomes they deserve"

Dr Sue Robinson, Clinical Chair, NHS Southampton City CCG

3. Developing mental health services: the background

Each year one in four of us will experience a mental health problem. Most of us will know someone who is experiencing or has experienced mental health problems.

The journey so far

Our priority across Southampton City Council and Southampton City CCG is to ensure that those people in Southampton who require mental health support get access to the services they need, when they need it, with the outcomes they deserve.

An initiative led by the Health and Wellbeing Board, a Mental Health Matters event took place in late 2014 which sought to hear people's views in relation to the city's mental health services. The main feedback from this event was that people wanted an opportunity to be part of the review of mental health provision, and have a 'blank page' approach.

This was followed by an engagement period on the Mental Health Matters initiative that set out proposals for the future of all age mental health services in the city. This ran from 6 August 2015 to 16 October 2015.

Service user and carer feedback represented 58% of the responses received. Feedback was overwhelmingly positive for a new model of care for Southampton, and included many valuable suggestions and things to consider. The full engagement report is available on the CCG website.

www.southamptoncityccg.nhs.uk

The proposals detailed in this document will come into effect throughout 2016 and onwards into 2017. In the meantime we are committed to working with colleagues to maintain and improve mental health services in the city to ensure they are of the highest quality, and that people receive the treatment they expect and deserve.

This review is being undertaken in a time of considerable financial challenge. We want to concentrate our investment where it is most needed, for example on helping people to maintain or recover their mental health outside hospitals as much as possible.

We are committed to working with all partners to ensure that we achieve best value from all our investment and this will mean shifting resources to respond to what people have told us, what works and what gives the best outcomes.

The scope of the proposals and this public consultation excludes rehabilitation services, as these will be included in further work which includes supported accommodation.

An equality impact assessment has been completed with contribution from the Equality Reference Group to assess the impact of the proposals, and this is available on the CCG website.

4. Our proposal for future services

How the proposals were developed

We have used all of the feedback obtained locally through the engagement; additionally we have looked at good practice elsewhere and identified a number of features which are included in our proposals.

The proposals

The diagram below shows the range of services that we are looking to include in a comprehensive mental health service. There will be some new services, some of the services will stay the same, and others will change and be improved.

What will the new services look like?

We believe the proposed model will provide better care for people with mental health needs, but in some ways is not radically different from the system that currently exists. The table below gives an indication of what the key similarities, changes and improvements will be.

It is evident that some of the major changes and improvements are about culture and ethos. We do not believe that the changes will cause any disadvantage or adverse impact, the equality impact assessment supports this and we welcome your comments.

Child and adolescent mental health services	
Similarities	**Changes / Improvements**
Family navigator role will continue to provide support to families where children or young people's attendance or attainment in education is impacted by health issues	Family navigators will be extended to include mental health navigation, providing support to patients and carers in the form of information about services in the community which can support families with mental health problems.
Headstart is a new project which helps children in Southampton develop the skills they need to deal with worry and anxiety, the scheme also provides emotional wellbeing training to parents, teachers and school staff	Stronger links will be made with the Headstart project which is working in schools and youth settings to develop prevention and early intervention approaches for children and young people. Along with enabling young people to access the right services quickly, by learning positive ways of coping with these common issues, children are more likely to feel able to deal with challenges in life and succeed in their education.
You will still have access to child and adolescent mental health services psychological therapies and No Limits counselling	Development of a young person's improving access to psychological therapies (IAPT) service which will include a better range of therapeutic and recovery focussed support.
You will still have access to the same range of services currently available in both child and adolescent mental health services and adult mental health services	Child and adolescent mental health services will have the flexibility to provide services for the age range 0-25 years, which is an increase from the current age range of 0-18 years. Eligibility criteria will be reviewed and improvements made to provide better transition from child to adult services. A 0-25 years' service will involve joint working between child and adult services.

Similarities	Changes / Improvements
You will still be able to access community eating disorder services through CAMHS	Development of dedicated community eating disorder services for young people in line with national guidance.
	In line with national guidance; improved perinatal mental health which provides support for women who are at risk of developing mental health problems during pregnancy and the first year post pregnancy, as well as those considering becoming pregnant.
	Employment workers will link into child and adolescent mental health services and No Limits to support those in further education or transitioning into employment.
	Carers will be included and involved in discussions about treatment and care of their loved ones, and will be offered more support and education in their caring role. This will include access to community navigators (a way of linking people up to activities and services in the community that they may benefit from, including non-medical services providing social, practical or emotional support).

Adult mental health services	
Similarities	**Changes / Improvements**
You will still be able to access mental health services through your GP practice	In addition to accessing services through your GP practice you will be able to seek information and support through a range of local community settings. All mental health services will be easier to access and the crisis service will be responsive and available 24 hours a day, 7 days a week. The development of a model of crisis care linked to Better Care Southampton community hubs is being considered.
You will still be able to access 'talking therapies'	There is already increased availability of face to face treatment, and the expansion of group treatment programmes across the service will continue.

Similarities	Changes / Improvements
You will still have access to psychiatrists, community psychiatric nurses and other specialist mental health professionals when you need them	More of your care will be delivered through joint working with your GP. Specialist mental health staff will support GPs and primary care and provide more effective services at your GP practice and at a local level. This means specialist staff such as nurses and social workers will work some of the time in local settings such as your GP practice.
Your GP will still be able to refer you to more specialist services if you need them	You, and your GP, will be confident that these services will respond effectively and rapidly to your needs. Services will include rather than exclude – that means they will respond positively to the needs of people rather than having narrow referral criteria.
	Services will actively adopt an 'ageless' approach to enable an individual's needs to be best met. This means that care and support will be provided based on need and not age alone.
Community navigators are already available to individuals living with dementia, and a number of schemes to expand this type of service are currently underway in a number of areas	In line with Better Care Southampton, community navigator roles will be developed to provide a way of linking people up to activities and services in the community that they may benefit from, including non-medical services providing social, practical or emotional support. They will have strong links to primary care and will work with people before diagnosis and also support them when they have been transferred to primary care from specialist mental health services.
You will still have access Community Mental Health Teams (CMHT) when you need them	CMHTs will be aligned to Better Care Southampton local teams, which mean they will be delivering care closer to your home in a local setting within the cluster (delivered around GP practice populations called clusters).
	A better range of therapeutic and recovery focused support, including the development of services and support for personality disorder, with a therapeutic community being considered. A therapeutic community is a specially designed programme where you work with a group of others experiencing mental health problems to support each other to recover.

Similarities	Changes / Improvements
Work is underway in the community to enhance health and wellbeing	Links will be made to extend current work into mental health support, with the aim of improved access to local community resources, including the development of more peer support groups to address isolation and loneliness.
	Services will actively promote recovery, resilience and wellbeing for individuals and they will encourage co-production which means that the patient and clinician will work together to improve the patient's mental health.
	Services will be established for adults of working age with developmental disorders such as ADHD, high functioning autism and Asperger's.
You will still be able to access a dedicated, supported employment worker who will provide you with early help	Employment workers will work within each Community Mental Health Team; they will provide support to everyone in contact with hospital based or specialised mental health services, including Brief Interventions and Early Intervention Psychosis (EIP). For those who are not in contact with such services there are 18 separate work clubs, community based supported employment and regular employability training delivered within priority areas throughout Southampton as well as employment support provided by IAPT.
	Improved access to psychiatric liaison services within Southampton General Hospital will ensure that if you attend A&E, or are admitted for a physical health condition but also have a mental health problem you will be given information and advice about services to meet your mental health needs.
	Services will be locally focused and more responsive to the diverse cultural needs of people and communities.
	Carers will be included and involved in discussions about treatment and care of their loved ones, and will be offered more support and education in their caring role. This will include access to community navigators (a way of linking people up to activities and services in the community that they may benefit from, including non-medical services providing social, practical or emotional support).

System wide	
Similarities	**Changes / Improvements**
	Greater focus on outcomes (the result or visible effect of an event, intervention or process; any change in a person's state of health after a period of treatment, ideally improvement in symptoms or resolution of a problem) across all services, specifically a focus on the outcomes that matter most to people.
	Creation of Mental Health Alliance where health, social care, community and voluntary organisations will be represented. The alliance will lead development work and improvements across mental health services. The alliance will also take collective responsibility towards the continuation of city wide anti-stigma work, and ensuring mental health is valued equally with physical health.
	Health, social care, community and voluntary organisations will consider and contribute towards service user networks being established, funded and supported to play an active role and contribute towards improving services.
	There will be greater opportunity for the teams who provide mental health services to work in partnership with voluntary sector organisations. This will form an essential part of local mental health services and will ensure continuity of care for those who use the services.

"Here in Southampton we are committed to working to support both children and adults with mental health issues and are placing much more focus on early intervention, recovery and resilience. This will enable people throughout the city to have a better quality of life, despite experiencing a mental health problem, and will ensure we're not simply treating or managing their symptoms"

Councillor David Shields, Chair of the Health and Wellbeing Board

5. Get involved

Have your say on our plans

Your views are extremely important and we would like you to get involved by telling us what you think of our plans.

We are keen to hear from as many people as possible, and we will be working with community and voluntary groups to try and involve people whose views are not always heard.

"Generally, the more that services recognise the breadth of what contributes to good mental health – being in work, having a stable home, having a social and family life, being more confident etc. - the better the identified outcomes will reflect peoples' ability to achieve and sustain their mental health"

Response to engagement

We are asking for your comments on:

- the proposals for future services set out on page 6
- the key similarities and difference or improvements that we have provided on pages 7 to 11
- any other options or ideas that you would like us to consider.

There is a feedback form for you to give your views at the end of this document. There are a number of ways you can find out more, get involved, and tell us what you think.

Please note that this consultation is not asking for feedback on rehabilitation services. We are currently undertaking a review on these services and there will be an opportunity to share your views on rehabilitation at a later date.

Public meetings and events

We will attend as many existing groups and forums as possible to engage with service users, staff and stakeholders. If you would like an individual meeting, or run a community group and would like us to attend and talk about our plans, please call us on 023 8072 5568.

Feedback form

Please use the feedback form at the end of this document to tell us about your views and give comments. Alternatively, you can write, email or telephone:

Amanda Luker
Commissioner
Southampton City CCG
NHS Southampton HQ
Oakley Road
Southampton SO16 4GX

Amanda.Luker@Southamptoncityccg.nhs.uk
Telephone: 023 8072 5568

Online

During the consultation more information will be made available on our website:

www.southamptoncityccg.nhs.uk

You will also be able to give your feedback online.

Deadline for feedback

The public consultation is running from 5 February 2016 to 2 May 2016

The deadline for you to share your views is 12:00 midday on Monday 2 May 2016

6. What happens next?

It is important that this consultation process is transparent and that the NHS is accountable for the decisions it makes.

What happens to the responses?

During the consultation, all the feedback and responses, along with notes of any meetings or forums attended, will be collated and analysed. At the end of the consultation a report will be produced identifying the themes and issues raised.

The report will go to the Commissioning Partnership Board to help them decide how to proceed, and will then follow the NHS Southampton City CCG the Council governance process.

Decision making process

The final decision will be made by the CCG Governing Body, once they have had the time to consider the consultation feedback and responses.

The role of the Health Overview and Scrutiny Panel (HOSP)

The way we have developed our proposals, and the way we will reach a decision on them, is being overseen by Southampton Health Overview and Scrutiny Panel (HOSP) made up of local councillors.

The HOSP has the power to refer both the outcome of the consultation and the decision making process to the Secretary of State for independent review.

The role of Healthwatch Southampton

Healthwatch Southampton is the organisation with statutory responsibility for ensuring the voice of service users and the public is heard. They are responsible for finding out what people think, making recommendations to the people who plan and run services and referring issues to HOSP where they feel it necessary.

Appendix 1:

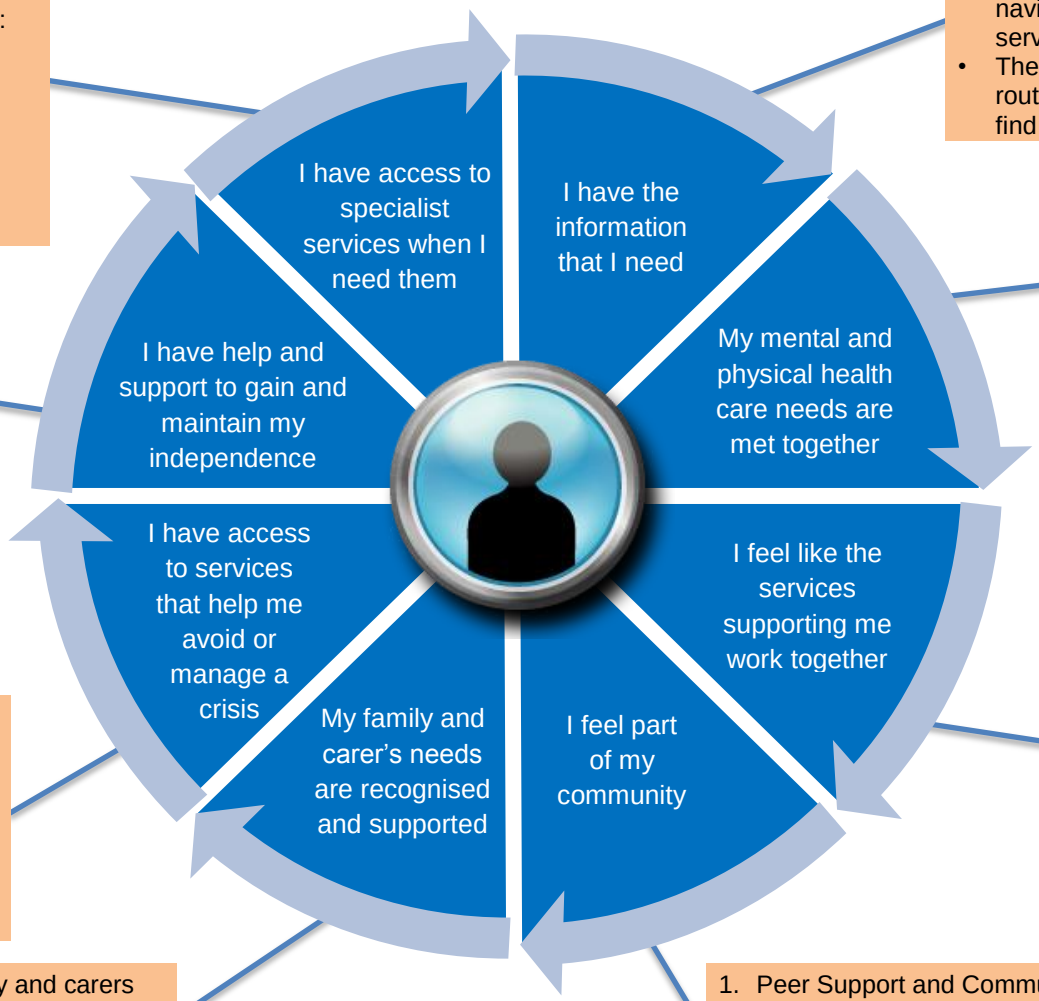
List of groups and organisations we have spoken to in developing these proposals:

- Service users and carers:
  - Steps to Wellbeing Peer Support Group
  - Bipolar Support Group
  - Psychosis Group
  - Depression Alliance Group
  - Homelessness Group
  - Creative Options Group
  - Antelope House peer support worker facilitated service user feedback
  - Children and adolescent mental health services (CAMHS) Attachment Group
  - Attendance within a number of waiting rooms; Brookville, Orchard, College Keep
  - Support group for parents of children and young people with eating disorders
  - Teen Safe House project
- Carers in Southampton
- Members of the Mental Health Partnership Board
- Southampton GPs
- Southern Health NHS Foundation Trust
- Solent NHS Trust
- Dorset University NHS Foundation Trust
- Healthwatch Southampton
- No Limits
- Solent Mind services, and service user forum
- Supporting people housing providers
- Providers of Southampton drug and alcohol recovery service
- Southampton City Council housing teams
- Southampton City Council employment
- Members of 0-19 Board
- Members of the Headstart project group and providers
- Members of Southampton mental health forum
- Southampton schools
- Youth Options
- Members of the equality and diversity reference group
- Members of Consult and Challenge

Appendix 2: What difference will a new mental health model make for people?

- I am assessed quickly, services will be age appropriate, and there will not be different eligibility criteria for different age groups
- National waiting time standards are met meaning I have timely access to specialist services including:
  - Early intervention in psychosis
  - Community & residential rehabilitation
  - Inpatient beds
  - Eating disorder (all ages)
  - Perinatal
  - Developmental disorder (all ages)
  - CAMHS, BRS, SEND

- More people have an awareness of mental health and can provide the help and information I need wherever I go
- There is someone to help me with navigation, advice and signposting to the services I need
- There are clearly defined and accessible routes into services so I know where I can find help when I need it



- My needs are looked at holistically and the recovery ethos is embedded throughout all services
- I am able to have choice and controls over the support I need using personal health budgets and direct payments
- Advocacy is available if I need it
- Services that help me stay independent include:
  - Psychological therapies (all ages)
  - Employment and training
  - Housing support to obtain and maintain accommodation and tenancies

- Mental health and primary care services develop a shared care plan to support me
- Psychiatric liaison within UHS will help meet mental health needs for adults and children
- Integrated care teams with physical and mental health professionals will work together to deliver the support I need

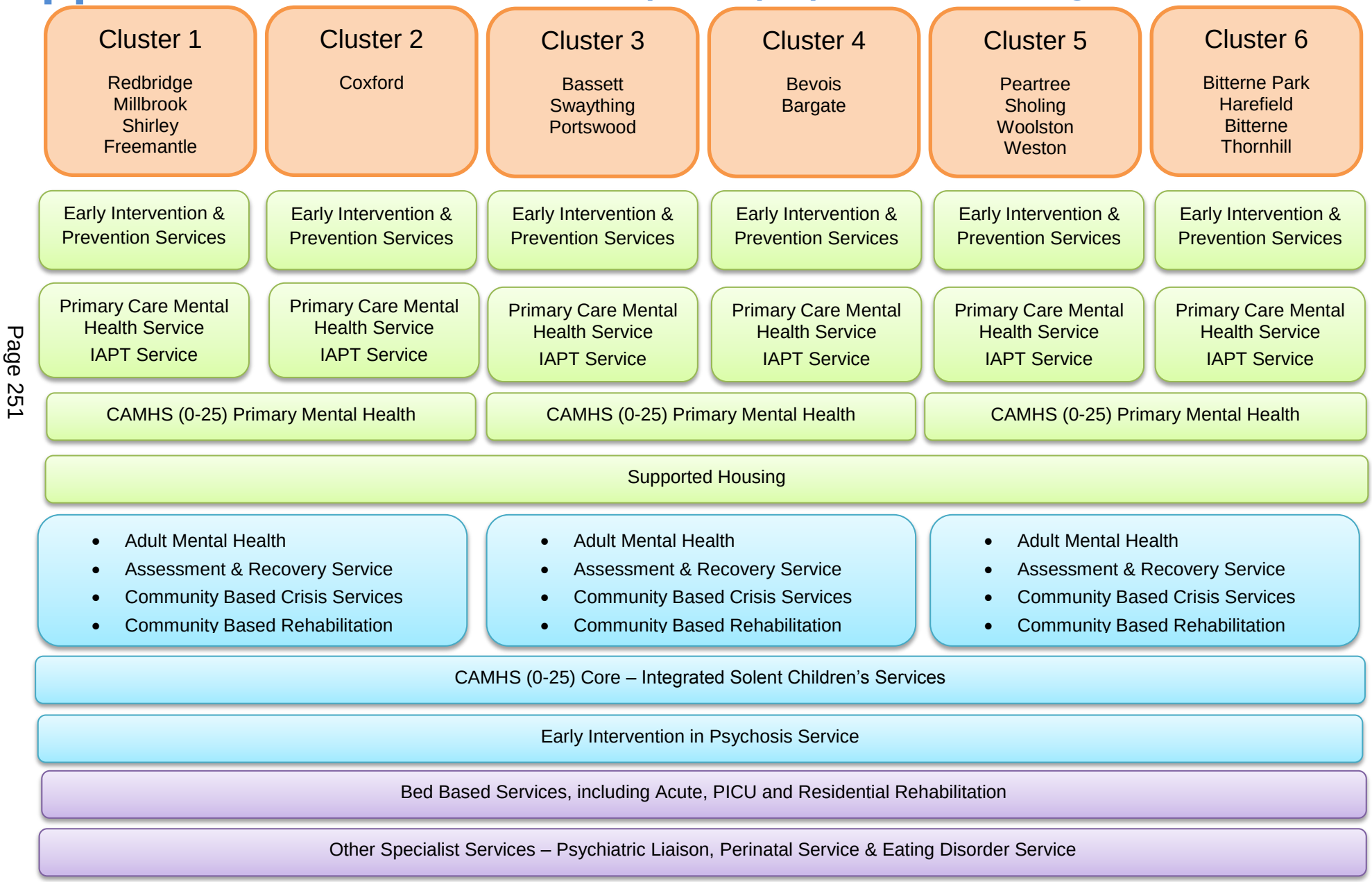
1. Statutory and voluntary services work as one team to meet my needs
2. Increased integration of services and pooling of budgets will mean I'm not bounced between services
3. Services improve their IT and how they share information about me
4. Better transition between children and adults services
5. Stronger links with schools and education to support younger people

- Early intervention and prevention services help me to avoid a crisis
- Flexible community crisis prevention services work flexibly to increase support when and where I need it
- I have support to avoid hospital admissions
- Services are available when I need them, not just 9-5

- Stronger partnerships between services and family and carers
- Carer assessments and support services are more widely available
- Access to information and support is available for my carers

1. Peer Support and Community Navigators help me to access community based services, maintain social networks and be active in the community
2. Services delivered around GP practice populations (called clusters) close to my community

Appendix 3: Better Care Southampton – proposed cluster organisation



Appendix 4:

Context: national and local mental health priorities

The proposals in this document have been developed using the feedback obtained locally through the engagement, and by national and local mental health policies and strategies:

Achieving Better Access to Mental Health Services by 2020, Department of Health, 2014. Introduction of access standards and waiting time standards

Closing the Gap: Priorities for essential change in mental health, Department of Health, January 2014

No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, Department of Health, February 2011

Everyone Counts, NHS England, December 2013
http://www.england.nhs.uk/everyonecounts/

Valuing mental health equally with physical health or "Parity of Esteem", NHS England, 2013
http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/

NHS atlas of variation in healthcare: reducing unwarranted variation to increase value and improve quality', Right Care, 2013

Better Care Southampton, health and social care, along with community and voluntary organisations and other partners working together on a programme to join up your care**.**

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis.

NICE Clinical Guidelines for mental health (www.nice.org.uk)

Local Transformation Plans for Children and Young People's Mental Health and Wellbeing, supports improvements in children and young people's mental health and wellbeing.

The NHS Outcomes Framework, alongside the **Adult Social Care** and **Public Health Outcomes Frameworks**, sits at the heart of the health and care system providing a national overview of how well the NHS is performing, and improves quality throughout the NHS by encouraging a change in culture and behaviour focused on health outcomes not process.

Living well with dementia: A National Dementia Strategy, Department of Health, February 2009

Prime Minister's challenge on dementia 2020, Department of Health, February 2015

The Care Act 2014, Department of Health, April 2014 provides guidance covering the care needs and rights to support of both adults with social care needs and adult informal or family carers.

Autism Joint Commissioning Strategy Southampton, published December 2015

Appendix 5:

Glossary

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Share your views

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You do not have to provide your name.

To what extent do you agree or disagree with these comments?

Child and adolescent mental health services	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
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Young persons' improving access to psychological therapies service (IAPT), and community eating disorder services for young people should be developed					
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Services should be established for adults of working age for developmental disorders, such as ADHD, high functioning autism and Asperger's					
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Service user networks and alliances should be developed and they should play an active role in improving services					
Some resources should be shifted from secondary care mental health services into services such as community navigators, peer support groups					
The proposals will improve services					
The proposals focus on the right things					

Please tell us about any other options or ideas you would like us to think about in relation to child and adolescent mental health services for the future?

To what extent do you agree or disagree with these comments?

Adult mental health services	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
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Some details about you

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Are you?

- ☐ A service user
- ☐ A carer
- ☐ A GP or Practice Nurse
- ☐ NHS Staff Member
- ☐ Other
- ☐ Representing an organisation

If you chose NHS staff member, which NHS organisation do you work for?

- ☐ Southern Health NHS Foundation Trust
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- ☐ Other NHS organisation

What is your role? _____

If you chose representing an organisation, please state the organisation:

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Please tell us your postcode (first four digits only) _____

Are you? ☐ Male ☐ Female ☐ Rather not say

What is your age?

- ☐ Under 20
- ☐ 20-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60-69
- ☐ 70-79
- ☐ 89-89
- ☐ 90+
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How would you describe your ethnic group?

White: ☐ British ☐ Irish ☐ Any other white background

Mixed: ☐ White and Black Caribbean ☐ White and black African ☐ White and Asian ☐ Any other mixed background

Asian or Asian British: ☐ Asian Indian ☐ Asian Pakistani ☐ Asian ☐ Bangladeshi ☐ Any other Asian background

Black or Black British: ☐ Black African ☐ Black Caribbean ☐ Any other Black background

Other ethnic groups: ☐ Chinese ☐ Other ethnic group ☐ Rather not say

Thank you for your feedback. The key themes compiled from all the responses will be one of the pieces of evidence that we will consider when making decisions about next steps.

Please return your form to:

Amanda Luker
Integrated Commissioning Unit
NHS Southampton City Clinical Commissioning Group and Southampton City Council
NHS Southampton HQ
Oakley Road
Southampton
SO16 4GX

Comments can also be emailed to: Amanda.Luker@Southamptoncityccg.nhs.uk
The deadline for feedback is 12:00 midday on Monday 2 May 2016.

Thank you for your comments.

Privacy
Any personal information you give to us will always be processed in accordance with the UK Data Protection Act 1998. We will only use the personal information you provide to deliver the services you have requested, or for our lawful, disclosed purposes.

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SOUTHAMPTON CITY COUNCIL

NHS Southampton City Clinical Commissioning Group

Mental Health Matters Public Consultation

SUMMARY DOCUMENT

CONSULTATION PERIOD

5 FEBRUARY – 2 MAY

February 2016

We're supporting time to change let's end mental health discrimination

Time to Change – ending mental health discrimination

The NHS and the Council in Southampton support Time to Change, a national campaign led by Mind and Rethink aimed at ending the discrimination faced by people who experience mental health problems. For more information, please visit www.time-to-change.org.uk

What is happening?

This consultation document has been produced by NHS Southampton City Clinical Commissioning Group (CCG) and Southampton City Council.

Together with the Health and Wellbeing Board, we would like your views on proposals to change the way mental health services are provided in Southampton. The proposals have been developed using the feedback from service users, carers, GPs and other interested parties as a result of engagement work during August and through to October 2015.

Our proposals

Along with looking at good practice elsewhere, your feedback has helped us to shape the proposals, and we are now seeking your views to check that we have the detail right before we make any decisions.

What will the new services look like?

We believe the proposed model will provide better care for people with mental health needs.

There will be some new services, some of the services will stay the same, and others will change and be improved.

Get involved

Your views are extremely important and we would like you to get involved by telling us what you think of our plans.

A feedback form is included at the end of this document so that you can tell us about your views. You can get someone to help you complete this.

If you would like a copy of our full consultation document, or if you would prefer to complete our consultation online, please visit the CCG website:

www.southamptoncityccg.nhs.uk

Deadline for feedback

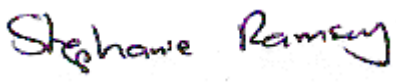
The public consultation is running from 5 February 2016 to 2 May 2016

The deadline for you to share your views is 12:00 midday on Monday 2 May 2016

What happens next?

Shortly after our consultation finishes we will publish a report telling you what people have said about our plans, and how they have been shaped to take account of your views.

We look forward to hearing your views.



Stephanie Ramsey, Director of Quality and Integration

Katy Bartolomeo

Senior Commissioner
Southampton Integrated Commissioning Unit

If you need further copies of this document or need it in a different format please contact Amanda.Luker@Southamptoncityccg.nhs.uk or telephone 023 8072 5568

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE		
DATE OF DECISION:		24 MARCH 2016		
REPORT OF:		SERVICE DIRECTOR - LEGAL AND GOVERNANCE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**Mark.pirnie@southampton.gov.uk**		
Director	**Name:**	**Richard Ivory**	**Tel:**	**023 8083 2794**
	E-mail:	**Richard.ivory@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
This item enables the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.		
RECOMMENDATIONS:		
	(i)	That the Panel considers the responses to recommendations from previous meetings and provides feedback.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To assist the Panel in assessing the impact and consequence of recommendations made at previous meetings.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
3.	Appendix 1 of the report sets out the recommendations made at previous meetings of the Health Overview and Scrutiny Panel. It also contains summaries of any action taken in response to the recommendations.	
4.	The progress status for each recommendation is indicated and if the Health Overview and Scrutiny Panel confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Panel does not accept the matter has been adequately completed, it will be kept on the list and reported back to the next meeting. It will remain on the list until such time as the Panel accepts the recommendation as completed. Rejected recommendations will only be removed from the list after being reported to the Health Overview and Scrutiny Panel.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
5.	None.	

Property/Other			
6.	None.		
LEGAL IMPLICATIONS			
Statutory power to undertake proposals in the report:			
7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.		
Other Legal Implications:			
8.	None		
POLICY FRAMEWORK IMPLICATIONS			
9.	None		
KEY DECISION	No		
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report		
SUPPORTING DOCUMENTATION			
Appendices			
1.	Monitoring Scrutiny Recommendations – 24th March 2016		
Documents In Members' Rooms			
1.	None		
Equality Impact Assessment			
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	No		
Privacy Impact Assessment			
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	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		

Health Overview and Scrutiny Panel: Monitoring Recommendations

Scrutiny Monitoring – 24th March 2016

Date	Title	Action proposed	Action Taken	Progress Status
28/01/16	Emergency Department Performance	1) That an update on the progress made by UHS in achieving the 95% Emergency Department target is provided at the 30 June 2016 Hosp meeting.	Agreed	
28/01/16	Update on Discharges from UHS	1) That an update on delayed transfers of care is provided at the 30 June 2016 Hosp meeting.	Agreed	
28/01/16	Adult Social Care: Key Performance Indicators	1) That demand and satisfaction data (if available) is reported with the KPI set when the final quarter performance is reported to the Panel.	Agreed. A new Adult Social Care Performance Board has recently been established and work is underway to incorporate demand and satisfaction data into an updated dashboard of key performance indicators. This supports the increased emphasis on "customer insight", which forms part of the council's new operating model.	
		2) That the finalised quarter 3 performance for KPI 10, Adult Safeguarding enquiries, is circulated to the Panel when available.	Data for the entire year 2015/16 will be audited and verified and will be reported to the Panel at the same time as the final quarter performance.	
		3) That Adult Social Care review the situation of individuals who have completed self-assessment forms but received information, or were signposted to alternative services, to identify satisfaction levels and whether their needs were met. (KPI 5 – 97% Q3).	A review is underway and the outcome will be reported to the Panel alongside the final quarter performance.	
28/01/16	Public Health Grant	1) That, recognising the importance of	A response to this recommendation will be	

Date	Title	Action proposed	Action Taken	Progress Status
	Reductions	effective public health and the savings required from public health budgets, it is recommended that the Health and Wellbeing Board leads a fundamental review of public health in Southampton, in conjunction with the developing Health and Wellbeing Strategy, to identify how the considerable resources available across the city can be utilised to address the endemic health inequalities experienced across Southampton.	provided at the 24 March HOSP meeting when considering the Health and Wellbeing Strategy agenda item.	
28/01/16	Implementing a NICE Compliant Foot Care Pathway	1) That the implementation of a NICE compliant foot care pathway commences as soon as possible.	Plans progressing for launch of new pathway on 1st April 2016. This includes the newly commissioned Multi-disciplinary Team (MDT) and Combined Foot Care Clinics at UHS and the implementation of the Community based Diabetes Foot Protection Team (DFPT).	
		2) That an update on the implementation of the foot care pathway is provided to the Panel in 12 months' time.	Quarterly service review meetings will be established in 2016/17. Outcome from the service review meetings in year will inform the update to HOSP in January 2017. Outcomes to include: • Number of attendances at MDT • Number of diabetes patients with foot ulcer seen with the DFPT • Patient stories • Admission data of diabetic foot as primary cause of admission.	
		3) That, recognising the importance of prevention, information is provided to the Panel on the national and local plans / campaigns that are being delivered to raise awareness of diabetes and the	• Diabetes UK event for those patients at low risk on 22nd April 2016. This event is supported by the Podiatry Team and the community Diabetes Team. Places	

Date	Title	Action proposed	Action Taken	Progress Status
		health risks associated with it.	for 75 attendees. • Presentation on 11th May at the Residential and Nursing Home Forum – new pathway and education on good foot care • Diabetes Structured Education programme continues to be commissioned for all those newly diagnosed with Diabetes and includes information on foot care. • The Community Diabetes Team also provided professional education and run two stakeholder events each year including a work shop on foot care. • Podiatry service to work in year to engage with primary care and patient groups. • Media coverage in support of the new pathway will also help to raise awareness in the city on good foot care and prevention.	
28/01/16	Update on "Getting the Balance Right in Community-Based Health Services"	1) That the Panel review the impact of the closure of Bitterne Walk-In Service at the 30 June 2016 meeting of the Panel. The report should include qualitative as well as quantitative information.	Agreed	
01/02/16	Mazars Report – Southern Health NHS Foundation Trust	1) That the full version of Appendix 3, Southern Health's Action Plan for Mortality & SIRI Improvement, is circulated to the Panel and the meeting papers on the Council's website are updated accordingly.	Completed on 2nd February 2016.	Completed
		2) That the Panel are provided with a Southampton specific breakdown of the	Information to be circulated to the Panel before 24th March HOSP meeting.	

Date	Title	Action proposed	Action Taken	Progress Status
		key statistics highlighted within the Mazars report.		
		3) That the Panel are provided with an update on the 'Mental Health Matters' initiative at the 24 March 2016 Panel meeting.	Mental Health Matters is an agenda item for 24th March HOSP meeting.	
		4) That, following discussion with the Chair, Southern Health NHS Foundation Trust updates the Panel on progress implementing the improvement plan and feedback from regulators, at an appropriate meeting of the HOSP. The update should include progress made with regards to the involvement of families and carers in investigations.	Agreed	