Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 31st January, 2013
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Pope (Chair)
Councillor Lewzey (Vice-Chair)
Councillor Claisse
Councillor Jeffery
Councillor Parnell
Councillor Tucker
Councillor Keogh

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel

The Health Overview and Scrutiny Panel is responsible for undertaking the statutory scrutiny of health across Southampton. This role includes:

- Responding to proposals and consultations from NHS Trusts and other NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises
- Liaising with the Southampton LINk and responding to any matters brought to the attention of overview and scrutiny by the Southampton LINk
- Scrutinising key decisions of the health agencies in the City and the progress made in implementing the Health & Well-being Strategic Plan and Joint Plans for Strategic commissioning
- Considering Councillor Calls for Action for health matters

Southampton City Council's Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

Public Representations

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

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

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

Dates of Meetings: Municipal Year 2012/13

2012	2013
21 June 2012	31 January 2013
15 August	28 February
10 October	21 March
29 November	

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take.

Access – access is available for the disabled. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

CONDUCT OF MEETING

Terms of Reference

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 – paragraph 5) of the Constitution.

Business to be discussed

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

Quorum

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

Rules of Procedure

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

DISCLOSURE OF INTEREST

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

DISCLOSABLE PERSONAL 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 fo 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 a, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

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

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

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

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

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

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

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 MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 29 November 2012 and to deal with any matters arising, attached.

7 EMERGENCY CARE INTENSIVE SUPPORT TEAM REVIEW

Report of the Chief Officer Southampton City Clinical Commissioning Group seeking support for the recommendations made in the SW Hampshire Unscheduled Care System report, attached.

8 OUTCOME OF THE CARE QUALITY COMMISSION ROUTINE INSPECTION OF SOUTHAMPTON GENERAL HOSPITAL

Report of the Senior Manager, Communities, Change and Partnerships for the Panel to note the outcome of the Care Quality Commission routine inspection of Southampton General Hospital, attached.

9 VASCULAR SERVICES UPDATE

Report of the Director of Nursing, SHIP PCT Cluster for the Panel to note the progress on the continued development of the network since the last Scrutiny meeting on 29th November 2012, attached.

10 JOINT HEALTH AND WELLBEING STRATEGY

Report of the Director of Public Health, for the Panel to note the revised draft Health and Wellbeing Strategy, attached.

11 PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL

Report of the Senior Manager, Communities, Change and Partnerships for the Panel to note the update on progress with the review into public and sustainable transport provision, the impact of proposed subsidy reductions for bus transport to Southampton General Hospital and to agree key discussion areas and attendance at the evidence gathering meeting on 28th February 2013, attached.

Wednesday, 23 January 2013

HEAD OF LEGAL, HR AND DEMOCRATIC SERVICES

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 29 NOVEMBER 2012

Present: Councillors Pope (Chair), Lewzey (Vice-Chair), Claisse, Jeffery, Parnell, Tucker and Keogh (Except min no 29 and 30)

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

RESOLVED that the Minutes of the Meetings held on 27 September and 10 October 2012 be approved and signed as a correct record.

Matters arising

Minutes from 27 September 2012; Minute no 21 – Transfer of Medicine for Older People from Southampton General Hospital to Royal South Hants
The Panel noted a letter had been received from Mark Hackett, Chief Executive of the University Hospital Southampton NHS Foundation Trust dated 28 November 2012. The letter stated that the proposals had been withdrawn and that patients would not be transferring to the RHS Upper Brambles ward because they were unable to recruit enough staff.

The Panel enquired about what would happen to equipment on the Upper Brambles ward given that the move would not take place. An answer could not be provided at the meeting.

Minutes from 10 October 2012, Minute no 22 – Statement from the Chair
The Panel noted an email had been received from Steve Townsend, Southampton City CCG regarding the delay in installing digital mammography equipment in Southampton. It was the intention to install the new equipment in phases between December and mid 2013 and be fully operational by the end of September 2013.

29. **CONSULTATION ON WESTWOOD HOUSE SHORT BREAK SERVICE**

The Panel received the report of the Deputy Director of Integrated Strategic Commissioning, NHS Southampton for the Panel to note the consultation process and feedback received to date and support the PCT's recommendation to its board (subject to the final outcome of consultation being reflective of the feedback so far). (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel noted the following:

- the consultation on Westwood House, Short Break Service commenced on 8 October and was due to conclude on 14 December;
- 17 Southampton families were using Westwood House and had been offered the opportunity for a face to face meeting to discuss the proposals;
- 12 parents had taken up this offer. The majority of these understood and accepted the rationale behind the proposals and welcomed a peripatetic nursing team;

- The 5 families who had not responded would be written to and if they did not want to meet to discuss the proposals, they would be asked to complete a survey.

The Panel expressed concern regarding the fact that staff had not been consulted. It was explained that until the consultation period had concluded it was not possible to formally consult with the staff, however there had been some early engagement with them. It was anticipated that if the service ceased the staff would move into alternative roles so that the expertise would not be lost.

The Panel congratulated the PCT on the engagement and consultation carried out to date on a sensitive issue.

RESOLVED

i) that the Panel noted the consultation process and the feedback received; and

ii) that the Panel supported the PCT's recommendation to its board (subject to the final outcome of consultation being reflective of the feedback so far) that lead responsibility for the short breaks currently provided at Westwood House should transfer to Local Authority commissioned provision, supported by the development of a peripatetic nursing team to be commissioned by the PCT.

30. **SOUTHAMPTON SAFEGUARDING ADULTS BOARD - SERIOUS CASE REVIEW - MR A**

The Panel considered the report of the Executive Director of Health and Adult Social Care, for the Panel to note the action plan developed by the Southampton Safeguarding Adults Board (SSAB) in response to the findings of a Serious Case Review report and the multi agency governance arrangements in place to oversee the delivery of the actions. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Cabinet Member for Adult Social Care was present and with the consent of the Chair provided a brief update to the Panel.

The Panel noted the following:

- The Safeguarding Adults Board was not currently a statutory body. An independent Chair had been appointed to the board. The Chair of the SSAB had requested an impact assessment on actions taken as a result of the Serious Case Review Report for the next meeting of the SSAB;
- the individual at the centre of the case review had not always been easy to engage with. A pan Hampshire plan on engaging with the dis-engaged has been developed and was being used by Southampton;
- The report evidenced the areas which lead to the failure which included quality control and contract management. Procedures had been put in place to address the issues raised in the report. The SSAB would continue to review and monitor the recommendations in the action plan;
- The Safeguarding Adults Board produces an annual report and the Panel agreed it would be considered annually by the Health Overview and Scrutiny Panel.

Joe Hannigan, Southampton Local Involvement Network was present and with the consent of the Chair addressed the Panel. He expressed concern regarding the term "close relative" in recommendation 6. He felt this needed to be addressed and should refer to a defined person. A close relative could be abusive to the service user.

RESOLVED that the Panel noted the action plan developed by the Southampton Safeguarding Adults Board (SSAB) and progress that had been made.

31. **UPDATE ON VASCULAR SERVICES**

The Panel considered the report of the Senior Manager, Customer and Business Improvement providing an update on Vascular Services since the last meeting of the Panel on 10 October. (Copy of the report circulated with the agenda and appended to the signed minutes)

Sara Elliot, PCT SHIP Cluster, Michael Marsh, Medical Director, University Hospital Southampton and Simon Holmes, Portsmouth Hospitals NHS Trust Medical Director were present and briefed the Panel on the present situation.

The Panel noted the following:

- That there was a clear commitment to commission a network model of service because this would provide the most sustainable service for patients;
- Principles for four areas where the two Trusts would work jointly had been agreed – research; training and education; on call service and major aortic cases;
- That there was a commitment to centralise weekend cover for all vascular emergencies based at the University Hospital Southampton (UHS) with the surgeons from Portsmouth joining the surgeons at Southampton from April 2013. The centralised on call service would then move from the weekend to the whole week;
- Emergency aortic surgery would be centralised at the UHS from April 2013;
- Elective AAA open interventions were to be centralised at UHS from October 2013;
- Progress had been made between the two Trusts and further work would be carried out in order to proceed towards the network model;
- Further work would be undertaken to ensure that the service meets the new national service specification once this was published.

RESOLVED

i) that the progress made be noted;

ii) that given the commitment to move towards a network model, it was agreed the Panel should not to refer the issue to the Secretary of State;

iii) that a further update be provided at the next Health Overview and Scrutiny Panel meeting on 31 January 2013.

32. **PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO KEY HEALTH DELIVERY SITES**

The Panel considered the report of the Senior Manager: Customer and Business Improvement seeking agreement to undertake a mini review on public and sustainable transport to key health delivery sites in the City. (Copy of the report circulated with the agenda and appended to the signed minutes)

Councillor Thorpe, Cabinet Member for Environment and Transport and Simon Bell, Public Transport and Operations Manager were present.

Councillor Thorpe outlined the reasons why he had proposed a review be carried out by the Panel.

Simon Bell briefed the Panel on some of the issues in relation to transport to and from the key hospital sites, set out below:

Southampton General Hospital

- 30 buses arrive / depart every hour;
- Insufficient bicycle parking space was provided;
- No recent data on patient travel;
- Bus journeys could take a long time;
- Bus stops were located in different places around the hospital;
- Increasing demand for patient and visitor parking

Royal South Hants

- The evening bus service was proposed to be withdrawn;
- Information was not known on the numbers of staff who use public transport in the evening;
- There was the perception that the car park at the hospital was never full

Adelaide Centre

- Transport links were very poor. Only one bus an hour Mon-Sat

Bitterne Health Centre

- It was felt that the location of this facility was remote from the bus services

The scope of the review was discussed, which included whether to extend the scope further to include car travel and car parking charges or whether to limit the number of sites to only the General Hospital. Concern was expressed regarding limiting the scope to only the General Hospital particularly as it had been reported that the public transport links to the Adelaide Centre were poor, for example. The Panel considered the proposed scope of the mini review. It was felt that a more limited scope would enable a more through and effective review given the time and resources available and therefore the Panel should focus on public transport to the General Hospital. If time allowed, other sites could be included. It was recognised that further reviews could be carried out at a later date.

It was reported that the Overview and Scrutiny Management Committee would need to approve any review the Health Overview and Scrutiny Panel wished to carry out.

RESOLVED that the Panel recommended the Overview and Scrutiny Management Committee approve a mini review into Public and Sustainable Transport Provision to Southampton General Hospital be carried out by the Health Overview and Scrutiny

Management Committee. If time allowed access to the Royal South Hants and Western Hospital/Adelaide Centre sites would also be considered.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		EMERGENCY CARE INTENSIVE SUPPORT TEAM REPORT		
DATE OF DECISION:		31 JANUARY 2013		
REPORT OF:		CHIEF OFFICER SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	Paul Benson / Clare Hardy	**Tel:**	023 8029 6904
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STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE

BRIEF SUMMARY

The South West Hampshire health and social care community faces significant service pressures within its emergency care pathway, with a potential impact on patient care. The community recognises the need to refresh some elements of partnership working locally. The Emergency Care Intensive Support Team (ECIST) is a national team set up to provide support to health and social care communities in reviewing their system for urgent and emergency care. The team worked locally in September 2012 and a number of recommendations are now being implemented to improve outcomes through collaborative working.

RECOMMENDATIONS:

(i) The Board is asked to note the attached report on the SW Hants Unscheduled Care System prepared by the national Emergency Care Intensive Support Team, and support the recommendations made.

(ii) The Board is requests an update of progress with the recommendations in six months.

REASONS FOR REPORT RECOMMENDATIONS

1. There is a need to improve SW Hampshire's unscheduled care pathways and outcomes for patients, and to reduce demand on all the organisations involved.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. There were no alternative options considered.

DETAIL (Including consultation carried out)

3. Following a prolonged period of underperformance against the 4-hour A&E operating standard during Q4 11-12 and Q1 12-13, and with encouragement from the CCG, University Hospitals Southampton (UHS) commissioned the national Emergency Care Intensive Support Team (ECIST) to undertake a review of the unscheduled care pathway within trust. The review took place in mid-June 2012 and the trust is now implementing the recommendations.

4. Concurrent with UHS asking ECIST to review the unscheduled care pathway within the trust, the Southampton City and West Hants commissioners determined that it was also appropriate to ask ECIST to review all aspects of the unscheduled care pathway across the SW Hants health and care system using ECIST's established "Whole System" methodology. The initiation of the Whole System review recognised that while there was work to do within UHS to optimise systems and processes, there were improvements that the wider health and care system needed to be identified and implemented to ensure a fully integrated, efficient and patient-focussed unscheduled care pathway.

5. The ECIST Whole System review took place over several days in mid/late-September and the ECIST report was received in mid-October. The report made a number of recommendations which were accepted in full by the multi-agency SW Hants Unscheduled Care Board and prioritised into a Whole System Action Plan. Implementation has already begun and is being overseen by the Unscheduled Care Board, with involvement of Southampton City Clinical Commissioning Group, West Hampshire Clinical Commissioning Group, University Hospitals Southampton NHS Foundation Trust, Solent Health, Southern Health NHS Foundation Trust, South Central Ambulance Service, Hampshire County Council, Southampton City Council and Care UK.

6. Recommendations were made in relation to each of the following areas:

- Governance arrangements for the system
- Involvement of clinicians in urgent/emergency care commissioning
- Availability of information
- Organisation of primary care
- How community services can help to pull patients towards discharge from hospital
- Streamlining internal processes within University Hospitals Southampton NHS Foundation Trust
- How capacity is managed for the whole South West Hampshire health and social care system
- Discharge planning processes within University Hospitals Southampton NHS Foundation Trust

For further details on the recommendations please see the ECIST report (appendix 1).

7. Service user and carer feedback has been sought; for example the Southampton Voluntary Service Family Projects group have presented the findings of a series of Urgent Care Community Development Workshops. This has helped to provide a user perspective on the current provision of unscheduled care in the city.

RESOURCE IMPLICATIONS

Capital/Revenue

8. There are no capital/revenue implications identified.

Property/Other

9. There are no property/other implications identified.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

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

Other Legal Implications:

11. There are no legal implications identified.

POLICY FRAMEWORK IMPLICATIONS

12. Decisions made as a result of implementing the ECIST recommendations may impact upon future health and social care policy making.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	ECIST Review - Urgent and emergency care in South West Hampshire
2.	

Documents In Members' Rooms

1.	
2.	

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) 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.		
2.		

Emergency Care Intensive Support Team Review

Urgent and emergency care in South West Hampshire

Context

The emergency care intensive support team (ECIST) is a national team set up to provide support to health and social care communities in reviewing their system for urgent and emergency care.

This team was invited to review the patient journey through urgent and emergency care services in South West Hampshire in September 2012. This followed the team's review of hospital based arrangements within University Hospitals Southampton NHS Foundation Trust (UHS) in July 2012.

Representatives from SHIP and all key providers including acute, community health and social care and ambulance were involved in providing information and views to the team. The ECIST also visited several community sites.

The draft recommendations were shared in advance of the final review and so SHIP and providers have already begun to deliver these.

Delivery plans are being updated to include the recommendations as a priority and the health and social care community has welcomed the opportunity to review the system and to develop a collaborative approach to delivering further improvements.

Overall conclusions

i) The South West Hampshire health and social care community faces significant service pressures within its emergency care pathway, with potential impact on patient care. The health community recognises the need to refresh some elements of partnership working locally.

ii) A stronger focus on hospital discharge and timeliness of post-acute transfer is needed as a short term priority. This is required in addition to ongoing work to reduce avoidable

admissions, from closer working across community, primary care and ambulance services. A large number of patients are staying too long in acute and community hospital beds, which may compromise their physical health as a result.

iii) There is a need to develop a 'pull' rather than a 'push' system of discharge, with community services able to identify early and support discharge for their residents. This needs to be supported by timely discharge planning and information sharing initiated early during acute care.

iv) Within community services there has been a strong focus on integrated care to avoid hospital admissions, but this risks being at the expense of early facilitated discharge. A greater focus here would help address some of the severest pressures in the system. There is also scope for more systematic clinical processes in community hospital beds to both reduce length of stay and improve the flow of patients.

v) Work on redesigning patient pathways and joint work between acute and community/primary care services is needed to build on successes to date. This requires further clinical engagement and leadership and a greater pace of change.

vi) Whole-system capacity planning and a formal system-wide escalation planning have an important role locally, yet both require further work as a key priority to mitigate current service pressures.

Recommendations

The recommendations were presented under the headings outlined below:

Governance - i.e. how the system is held to account and how each organisation within the health and social care community delivers what is needed to provide efficient and effective care.

The arrangements for overseeing and planning urgent and emergency care were clear and the team encouraged further involvement of clinicians in development of these.

Commissioning - the team suggested further engagement of clinicians in developing the vision for urgent and emergency care and in wrk on pathways of care across organisations.

Information – to develop a new way of presenting a range of indicators, such as:

- numbers of people admitted to hospital
- numbers of ambulances called and;
- four hour wait times.

These will provide on-going monitoring of services including a daily set of indicators developed especially for GPs.

Primary care (care in GP surgeries) – the team recognised that work was underway to make sure that urgent primary care is organised as well as possible. They recommended that this should include, as a priority, the provision of timely and appropriate home visits or care in a medical day unit to prevent unnecessary emergency admission to hospital where appropriate.

Community services –

In visiting across two NHS provider services, the team were interested in several themes: the respective focus on admission avoidance activity as against facilitating discharge, the responsiveness of community teams, and processes within inpatient facilities.

The team were clear that this required a continuation of the work underway, but also recommended further and increased work on:

- Considering how community services could make more defined offer to acute services, by introducing a guaranteed minimum number of daily supported discharges for acute trust inpatients

- Idnetifying how to increase community team “pull” of inpatients out from community hospitals to virtual wards, or to be supported at home.

- Working with local GPs to both increase the uptake and range of ambulatory care provision at Lymington, and promote professional development links with UHS services.

- Develop more standardised clinical processes, such as Expected Dates of Discharge and clinical criteria for discharge, to improve care co-ordination and decision-making on discharge across community hospital beds.

District General Hospital (Acute) services –
Priorities from the team's July cover the following key areas:

- Pathways and senior decision-making processes in ED within the first two hours, including any capacity constraints that inhibit senior decision-making.

- Inpatient ward processes to improve co-ordination and decision-making, including opportunities to strengthen the impact of a divisional project on reducing internal waits.

- Bed management and patient flow including the functioning of the Operations Centre, and interactions and system escalation plans with other partners.

Capacity management & escalation

The team saw evidence of good whole system working on system resilience, and positive progress over the last 12 months. The team were clear that this required a continuation of the work underway, but also recommended further and increased work on:

- Developing the remit of the System Resilience Group to take on whole system capacity planning, with a role to share information and inform Unscheduled Care Board, and health and social care commissioners on capacity constraints, via an initial short term baseline assessment.

- As a short term priority, developing a system-wide escalation plan, with clearly defined triggers for escalation and named executive leads from each organisation.

Discharge Planning: acute and post-acute beds

The report highlights that bottlenecks at the 'back-end' of the acute pathway are delaying discharge for a large group of inpatients at UHS, and some patients in community hospitals. The team felt these are one of the main problems for the SW Hampshire system. The whole system needs to be actively concerned about the full range of delays to discharge (matching a focus on internal delays within individual organisations).

Recommendations include:

- Establish a short-life group to look at an agreed list of issues of mutual benefit, aiming to reduce 'medically fit' list to a defined threshold over a short period.

- Commit to a short-life project to strengthen 'pull' arrangements for discharge by building stronger relationships and systems for sharing information between acute and community nursing staff.

- Undertake regular, whole-morning multi-agency bed surveys looking at the reasons behind patient delays for stays over 7 days. These would be undertaken by senior nurse and therapy practitioners from community and acute settings, plus social workers.

Onward process and progress

The recommendations made as a result of the review have been accepted by the Unscheduled Care Board, which comprises Executives and senior clinicians from each organisation.

They are being adopted as a priority within the work plan for the whole health and social care community as well as individual Trust delivery programmes.

The details will be agreed by those clinicians and managers involved in the planning for emergency care.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY COMMITTEE		
SUBJECT:		OUTCOME OF THE CARE QUALITY COMMISSION (CQC) ROUTINE INSPECTION OF SOUTHAMPTON GENERAL HOSPITAL		
DATE OF DECISION:		31 JANUARY 2013		
REPORT OF:		SENIOR MANAGER, COMMUNITIES, CHANGE AND PARTNERSHIPS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Caronwen Rees**	**Tel:**	**023 80832524**
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Director	**Name:**	**Dawn Baxendale**	**Tel:**	**023 80917713**
	E-mail:	**Dawn.baxendale@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

The attached paper outlines the outcome of the Care Quality Commission (CQC) routine inspection of Southampton General Hospital in October 2012 and the response of UHS.

RECOMMENDATIONS:

(i) To note the report of the CQC inspection of Southampton General Hospital.

(ii) To note the briefing paper from UHS regarding the CQC inspection.

REASONS FOR REPORT RECOMMENDATIONS

1. The CQC inspection was published in December and highlighted concerns in 4 of the 6 standards. Recent media interest has highlighted concerns around staffing at the hospital.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. A copy of the CQC report on the inspection of Southampton General Hospital is attached at appendix 1. A briefing paper from UHS regarding the CQC inspection and their action plan are attached at appendix 2 and 3 respectively.

RESOURCE IMPLICATIONS

Capital/Revenue

4. None

Property/Other

5. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

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

Other Legal Implications:

7. None

POLICY FRAMEWORK IMPLICATIONS

8. None

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	CQC Inspection Report – Southampton General Hospital.
2.	UHS Briefing Paper
3.	Action Plan

Documents In Members' Rooms

1.	
2.	

Equality Impact Assessment

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

Other Background Documents

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

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Southampton General Hospital

Tremona Road, Southampton, SO16 6YD

Tel: 02380777222

Date of Inspections: 03 October 2012
02 October 2012

Date of Publication: December 2012

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✗ Action needed
Staffing	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	University Hospital Southampton NHS Foundation Trust
Overview of the service	Southampton General Hospital provides a range of general and specialist medical and surgical services ranging from neuroscience and oncology to pathology and cardiology. Specialist intensive care units, operating theatres, acute medicine and emergency departments as well as an eye casualty are provided as are outpatient, day beds and longer stay wards for hundreds of patients are provided.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 2 October 2012 and 3 October 2012, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We assessed the regulated activities, diagnostic and screening procedures, surgical procedures and the treatment of disease, disorder or injury. We inspected acute medical and surgical wards, orthopaedic and medical care of older people wards. We also assessed the discharge lounge and medicines management. The inspection was carried out over two days, six inspectors, a pharmacist inspector and a clinical advisor were part of the inspection's team. We spoke with 64 patients and relatives, 53 staff including nurses, doctors, physiotherapists, occupational therapists and looked at 42 sets of records.

Patients and relatives were overwhelmingly positive about the staff and care that they had received. Patients said that staff were incredibly hard working. One person said staff were "always cheerful and friendly. Patients told us that they were provided with information about treatment options and consent obtained prior to procedures.

Although people were happy with the care they were receiving we identified some instances where inappropriate care had been provided such as the failure to always provide specialised stockings to reduce the risk of blood clots . We found that there were significant staffing vacancies especially for qualified nurses. People told us that "staff kept changing". Staff told us about and patients told us of delays to their medicines not being prescribed and available for discharge.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 12 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We found that specific consent forms had been signed by patients for all surgical, invasive and investigation procedures that would require them. One patient told us that they had been "given three options by their consultant and consent was sought at each stage of their admission to hospital". Another patient we spoke with had difficulty remembering if they had been consulted about their treatment. Staff told us that they had information and were able to understand, however the patient had been very ill at that time. We reviewed the patient's records and saw that consent forms had been signed by the patient for procedures and the records reflected what had happened. We observed a senior doctor seeking consent prior to carrying out an assessment. They had considered the persons level of understanding. This was carried out at a slow pace and allowing the person to respond and we observed very good interaction between the patient and the doctor.

Patients gave positive examples of consent being sought when procedures were undertaken. We spoke with staff who had an understanding of the need to ask permission prior to clinical interventions. Consent to care was apparent in the staff behaviour but was not specifically documented unless the patient refused. We observed how staff in one acute area supported a patient who required a particular procedure to be carried out. Staff and the patient discussed this and the patient then agreed to the procedure. We saw that staff recorded when patients had refused treatment such as medication. We spoke with patients who said that although they were not specifically asked before routine treatments they understood what was happening and why things were done. Most patients were aware of discharge plans. Staff told us that they involved people's relatives if people were too ill or unable to consent to care. Overall people were given information about treatment options and consent was obtained and recorded.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. Where staff had concerns that the person may not be able to make important decisions themselves additional assessments were undertaken to confirm this.

We saw that these specific assessments of people's abilities to make decisions were undertaken either by ward doctors or external specialist. The assessments viewed were in relation to specific decisions that needed to be made and were not aimed at removing all decision making from the person. We also met an external specialist who had been requested to undertake an assessment for a person who had a learning disability. There were therefore suitable arrangements in place to identify people who may not be able to make complex decisions and to ensure that these decisions could be made in their best interests.

Most staff confirmed that they had completed training in the Mental Capacity Act 2005 and were able to talk about their responsibilities in relation to this. The provider sent us training information that showed that the majority of direct patient care staff had completed mental capacity awareness training as part of their induction. We spoke with one staff member who said that they had not had training in mental capacity. However they were able to correctly identify that people had the right to refuse treatment and the action they would take if this occurred and gave examples to support their statements. Therefore staff, including those who had not completed training, were aware of their responsibilities to ensure that people were able to consent to care and treatment.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

The provider had failed to take proper steps to ensure that all people were protected against the risks of receiving care or treatment that iwas inappropriate or unsafe. Care was not always planned in such a way that would ensure the welfare and safety of people.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with 64 patients. Most told us that they had received good care. We looked at 42 sets of records on 13 wards. In some areas they were using care pathways and on another unit we found that there were daily nursing care plans which were clear and comprehensive. However, on other wards we did not find that care planning was used. On these wards nursing and medical notes were completed together and recorded care and treatment provided. People did not raise concerns about their personal or medical care needs but the provider may like to note that not all areas were using care planning.

In all areas we found that risk assessments were in place to identify people who may require additional support in relation to pressure areas, venous Thromboembolism (VTE), falls and nutrition. Whilst many of these had been fully completed and action taken to mitigate the risks we found that risk assessments were not always being completed or action taken to reduce risks and ensure people's safety. An example was that a VTE risk assessment had identified a risk. The doctor had prescribed specialist compression stockings. One day later, when we inspected, the person did not have the necessary compression stockings. We found other concerns about the completion of VTE risk assessments and the management of identified VTE risks. Information provided by the Trust following the inspection showed that appropriately 10% of people did not have a risk assessment or preventative treatment for VTE.

We looked at how the hospital managed the risk of people falling. We were told that a falls risk assessment should be completed at the time of admission. In one ward we found that falls risk procedures were not being consistently followed. For two people this had been correctly followed, for the third the assessment had not been fully completed and there was no evidence that action had been taken to reduce the risk of the person's falling. In another ward we found similar inconsistencies with falls risk assessments not always fully completed and a falls management plan initiated. On one ward we considered a person who had been admitted as a result of a fall at home. They had suffered two falls since admission to hospital and were unsteady on their feet. Staff told us that they did not have equipment to alert them to the fact that the person was out of their chair and walking

around and relied on staff to notice this. There was a risk that if staff were occupied elsewhere this would not be immediately noted and they may fall. On another ward a person was identified as at high risk of falling from the bed and a special bed had been provided. Overall there were systems in place to identify the risk of people falling, however, these may not always be fully implemented and some people remained at risk.

We found that risk assessments had been completed for people and that pressure relieving equipment was widely used. We saw that other specialist healthcare professionals were consulted when necessary such as tissue viability nurse specialists. For example one patient had been seen by the Tissue Viability Nurse Specialist (TVN) and had been prescribed a specific wound care treatment. The wound care plans for this person showed that they were having their pressure ulcer dressing changed regularly. However for another person we could not find a wound care plan and saw that they were having different types of dressing applied to their pressure ulcers. The staff could not tell us why different dressings had been used. On some wards there were records to show that people were being supported to change their position on a regular basis. We spoke to one person who was at high risk and they confirmed that staff helped them to change position. There were systems in place to assess and manage the risks of pressure injuries. However, there was not always a consistent wound management plan when pressure injuries did occur.

We found some instances where we could not confirm that people were receiving the correct care. An example being a person who was receiving their fluids via a tube. Their records showed that at times they only received half of the amount of water prescribed. On the day prior to our inspection they received their insulin and subsequently concerns were raised about the positioning of the feeding tube. The feed was suspended whilst this was checked. However alternative fluids including glucose were not provided. We raised this with the Trust who have reviewed the care this person received. Other people were receiving fluids via an intravenous drip. We looked at the records for one person and it was unclear what they had received.

Another person was receiving their meals on a red tray. These alert staff to people who require assistance with meals and to catering staff that they should not remove the tray without consultation with nursing staff as these patients required their food intake to be monitored. We found that for three people, whose meals were on a red tray, that records of food and fluids were inadequate and saw one person was distressed and their mouth was dry. This person did not have any drinks nearby. For another person we were unable to confirm what meals they had received for the three days prior to our inspection.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People using the hospital were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We spoke with staff who were aware of safeguarding and confirmed that they had undertaken safeguarding training as part of their induction. This was also stated in information provided by the Trust management team which showed that all staff undertook safeguarding training as part of their induction. Staff were aware of what might constitute abuse and most gave examples of when patients had been thought to be at risk from relatives or carers outside the hospital. Staff said that they would report any concerns to their ward manager. Staff were less clear about reporting safeguarding concerns to external professionals such as the local safeguarding team. We spoke to senior managers who explained their processes for investigating concerns relating to safeguarding. For instance, incidents of serious concerns were discussed at a joint critical incidents panel.

Staff were aware that there was a safeguarding matron. Following the inspection the provider sent us further information including their safeguarding action plan. This showed that the trust had identified concerns and that a clear plan was in place to address these. All areas of the action plan had been commenced and approximately half were completed at the time we were supplied with the action plan. This showed that the Trust had identified training and procedural concerns and taken action to address these. We spoke with the Southampton local authority safeguarding team. They told us that they had regular contact with the safeguarding matron and that incidents such as pressure injuries were reported at ward level, however, there was often a delay in these being reported onto the local safeguarding team. The local safeguarding team said they did not have any specific safeguarding concerns about the trust.

We had received notifications of a number of incidents when patients had been placed at risk due to their behaviour or the behaviour of other patients. We also saw an example in a record viewed which showed that a person was aggressive and hitting out when receiving personal care. There was no plan of action in place to show how this person's needs would be met and what action staff needed to take when the person displayed aggression. It was recorded that a behaviour chart should be completed and this was not done. The person's daily record showed that they needed three staff to assist them and that they had suffered multiple skin tears. We asked to see the incidents and accidents records for this

person and a senior staff could not locate them. It was therefore not possible to identify how or when the person's injuries had occurred or what action was being taken to reduce their risk of injury. This placed both the person and staff at risk. The completion of a behaviour chart may provide additional information to help staff determine the best way to support the person. The absence of incident records placed staff at risk of allegations that the person had been injured through inappropriate care and the provider may wish to note this.

We did not specifically discuss safeguarding with patients however people said that they felt safe and did not raise any issues that might indicate any safeguarding concerns. We saw within patients' records that valuables had been identified during admission and a note made of these.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the prescribing, administering and dispensing of medicines for discharge in a reasonable time.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Our previous inspection in March 2012 we found that medication including fluids for intravenous infusion were not stored securely. The provider sent us an action plan telling us what they were going to do to ensure the security of medicines. Whilst action had been taken to address this we saw on one ward that the medicine trolley was left unlocked with the key in the lock. We also saw three people's medicines that had been signed for as administered and these were left on people's tables.

Medicines were stored in locked cupboards and the keys for these cupboards were kept in a key cupboard which was accessed by a code. We were told that there was a protocol to keep this code safe with the key pad codes being changed on a regular basis. In conclusion we saw examples where medicine security was compromised, which could put patients and visitors at risk.

Medicines were not prescribed and given to people appropriately. People who were unable to communicate their pain were at risk of not receiving adequate pain control. This was due to the pain assessment charts not being seen to be used and people's pain not being effectively assessed. On one ward we saw a person was distressed who told us that they were in pain. We noted from their records that they had not received any of their morning medicines at 11:30 that day. We also noted that they had not received any pain medicine since 21:30 the previous night. We brought this to the attention of staff and this person was given their medicines.

Another person said that the last pain relief they had received was given to them at 0900 that morning and at 14:30 (when we spoke with them) they were in pain. They told us that they had not informed the nursing staff or asked for any pain medicine as the staff were busy and they felt they would be discharged at any moment. The person's medication records were not complete when they were transferred to the discharge lounge and had remained on the in patient ward. Discharge paperwork including medication prescription had therefore not been completed when the person was transferred preventing them initially receiving pain relief when required. We were subsequently informed that the Trust

were aware of the issue of delayed discharge medicines and action had been initiated to make improvements. However delays were still occurring when we completed our inspection.

On another ward, we found that a person had been in hospital for 24 hours and had not received their medicines. A member of staff told us that they may have been given their medicine, but we found out that they had not been prescribed. Then we were told that this person may have self medicated. However the medicines were locked and the person could not access them without the staff's help. We looked at their daily records of care and this did not show that they had received their medicines.

In the discharge lounge people told us that they had been waiting for their medicines all day. One person was concerned when they were told in the afternoon that their discharge medicines had not been prescribed. This meant that they would have a long delay as they would have to wait for their medicines to be prescribed and dispensed. This person was later told that the ward's staff could give them their tablets from the stock. One person who was a patient in the hospital regularly told us that they would not wait for medicines as it would take a long time. They went home without their medicines and got them from their own doctor. Another person was tearful at the end of the day when their medicines were still not ready, having waited from around midday. When the medicines were ready, they were sent up to the ward and not the discharge lounge which further delayed them going home. Their family had been waiting with them for these 6 hours. Two people waiting for medicines had been told the night before that they would be discharged, but they experienced delays. The lack of clear processes caused people undue stress and delayed their discharge.

On all the wards we were told that there were concerns about the long delays in discharge as people waited for three to four hours for their medicines. The ward sisters told us that this was due to difficulties in getting people's medicines prescribed and the computer records being completed. One senior nurse told us that there were not enough computers for the doctors to log on and complete information to move the discharge along.

We spoke to the ward pharmacist who explained the level of service provided to ward clinical areas. They told us that although sometimes there are staff shortages they managed to support wards according to their needs. There was a 24 hour on call service and staff spoken with told us that they had good access pharmacy staff and medicine information. People we spoke to were very complimentary about the staff and confirmed that medicine information was given to them as needed.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs. Regulation 22

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not enough qualified, skilled and experienced staff to meet people's needs. People told us that the nurses and medical staff were "very good". We were told that staff responded as "quickly as could be expected" but that "response times were worse in the mornings when people needed help". Other comments included that staffing was "erratic" and that there were "not enough staff". Another person told us that staff had been "excellent, always very patient, and remaining calm despite being clearly extremely busy". On another ward we were told there were "not enough staff, not enough resources and that staff were run ragged". The person said the understaffing had resulted in staff not having enough time for patients and that they did not feel they had been properly involved in decisions about care and treatment. Other people told us that "staff kept changing". We were also told about an incident when people had received meals late, lunch at 15:00, due to shortages of staff. Another person told us that there were problems in the mornings which meant that they had to wait for help to go to the toilet and this meant they had been "desperate" by the time help was available.

A visitor told us that they helped a person with their meals as they were "slumped in bed" and could not manage their food and the nurses "were very busy". On a different ward another visitor told us that that they spent all day on the ward until their daughter came in the evening to take over. This was because their relative had dementia and staff were too busy to provide the level of care and support they needed.

A senior doctor told us that the ward had employed a ward coordinator and that this was working well. They told us this person provided support on daily ward rounds and linked with the nurses. Feedback from the therapists showed that sometimes people did not get seen due to pressures in seeing people receiving rehabilitation first. People were therefore not getting the care they required. A doctor told us that due to a lack of specialist people to take blood samples they had had to do these themselves and had taken 10 samples so far that day. This removed them from other medical duties they should have been doing. Other doctors echoed these views.

At the time of our inspection we found that all wards were fully occupied with patients and

that the hospital was experiencing a period of high demand. We observed that staff were busy and medicines rounds, for example, were in progress at 11-11.30 am on one ward. We also observed that people were left for long periods unsupervised as nurses were busy in other bays. This increased the risk of some people falling. Another issue raised on several wards was the lack of equipment which meant borrowing frames and rotundas from other wards. This meant that staff were spending time going to other wards to find, borrow or return equipment. One staff told us that "there were times on the ward when they were understaffed to a degree", and felt they could not provide the "high quality of care they would like". On all wards we inspected we were told about high numbers of vacancies for nursing staff. Staff told us that the trust depended on high levels of agency staff especially at weekends. This in turn impacted on the care that people received due to the lack of continuity in their care. We were told that nursing staff shortages were a "regular occurrence" and impacted on their capacity to provide care and support. During the inspection we met some of the newly qualified nurses who were completing an induction period.

The trust provided us with information about staffing. This showed that the week prior to our inspection a total of 1670 shifts had been requested. During our inspection we were told that agency nurses had been requested but had not been available. On one ward we were told that an agency nurse was requested for a person who needed individual attention but not provided. To ensure this person's safety a nurse had been moved form another part of the ward and that another nurse now had to manage two areas of the ward on their own.

The trust provided us with information about the action they were taking to address this concern. We were told that they had recruited over 120 newly qualified nurses. Some had commenced working at the trust and others were due to start throughout October 2012. The trust was also recruiting to specified posts and providing a return to practise programme for qualified nurses who had not been working for a number of years. There were plans to recruit staff from overseas. From the analysis we found that the trust was well aware of the overall upward trend in vacancies across the trust from 177.4 in September 2011 to 240 in March-June 2012 culminating at 315.9 in September 2012. Some of these vacancies were due to an increase in the numbers of staff required by the Trust to provide additional services.

Although the trust was working to recruit nurses there remained a significant vacancy rate across the trust. The high use of agency nurses was placing considerable strain on staff and placing people at risk that they will not receive the care they require.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

The provider has failed to ensure that people are protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Accurate records which included appropriate information and documents in relation to the care and treatment provided to each person were not maintained in all instances.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's personal records including medical records were not always accurate and fit for purpose. We looked at a total of 42 people's medical and nursing records. We also looked at some computerised medication administration records. Overall we found that patients' records contained information that was required for the safe and effective care and treatment. In most cases we saw that notes were made of patient's care and treatment on a daily basis which ensured that there were effective records and communication about patients care and treatment. On most wards all staff, nurses, doctors and other health professionals recorded in one set of multi disciplinary notes. This provided a comprehensive record of care and treatment. However, there was a risk that important information could be missed or be harder to find in complex notes with many entries. We saw in one area that highlighter pens had been used to identify important information. This made finding key pieces of information easier and would help protect people.

In some instances we identified concerns with individual records. An example being a food chart where it was already recorded that a person had eaten their pudding when they were still seen to be eating it. We also found other examples where food and fluid charts had not been maintained. We spoke with the nurse in charge of a ward and were told that "sometimes nursing staff catch up with fluid recording later in the day, by asking what a person has had to eat or drink during that day". The failure to record care or fluids when people received them meant that it was not possible to ensure that accurate records were maintained. We found that on some records patients' names and details were not filled in on forms where they should have been.

Most records were kept securely and could be located promptly when needed. Most records were stored in the area next to the nurse's station where staff could locate them. We did find that notes were held on loose sheets of paper and these could be lost. We found pages missing in one set of notes viewed. Concerns were raised by one person who told us that their records were loose and when they had arrived on the ward several hours previously staff had noticed that their personal folder contained records of another person.

We looked at the records and found that these were now bound and maintained appropriately. In one area where there were a lot of admissions and discharges we saw piles of records stacked in areas accessible to people. We were told that it had been a busy weekend and the ward clerk was still dealing with these. We were told that it usually "takes till Wednesday to clear these". The matron in this area agreed that storage of records waiting to be processed was an issue.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider has failed to take proper steps to ensure that all people were protected against the risks of receiving care or treatment that was inappropriate or unsafe. Care was not always planned in such a way that would ensure the welfare and safety of people. Regulation 9 (1) (b)
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the prescribing, administering and dispensing of medicines for discharge in a reasonable time. Regulation 13
Regulated activities	Regulation
Diagnostic and	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations**

This section is primarily information for the provider

screening procedures Surgical procedures Treatment of disease, disorder or injury	**2010** **Staffing**
	How the regulation was not being met: There were not enough qualified, skilled and experienced staff to meet people's needs. Regulation 22
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The provider has failed to ensure that people are protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Accurate records which included appropriate information and documents in relation to the care and treatment provided to each person were not maintained in all instances. Regulation 20 (1) (a) and (2) (a)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 12 December 2012.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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Report on the outcome of the Care Quality Commission (CQC) routine inspection of Southampton General Hospital in October 2012

From : Judy Gillow, director of nursing

Date : Friday 18 January 2013

Background

The Trust is inspected at least once a year by the CQC which regulates healthcare providers in England. In October 2012 a CQC inspection team arrived unannounced at Southampton General Hospital and reviewed the following standards :

Standards Reviewed	CQC Judgement
• Consent to treatment	Compliant
• Care and welfare of people who use services	Minor concerns – action required
• Safeguarding people who use services from abuse	Compliant
• Management of medicines	Minor concerns – action required
• Record management	Minor concerns – action required
• Staffing	Moderate concerns – action required

The report of the inspection was published on the CQC web site in early December 2012 and it highlights some areas where the hospital needs to further develop its systems and processes. This is particularly the case in the instance where the hospital is under significant operational pressure and on “Black Alert” which was the status of the hospital on the day of the CQC visit.

Inspection Feedback

Feedback from patients

The summary of the report highlights the overwhelmingly positive feedback of patients and their families in relation to the hospital’s staff and the care they had received. They noted that the staff were incredibly hard working.

Feedback on the standards reviewed

Many of the 13 wards that the CQC visited were compliant against the standards but in a small number, specific issues were observed that did not reflect the Trust’s defined quality standards or clinical policies and this contributed negatively to the final assessment of the hospital’s compliance.

Feedback from the CQC demonstrated that when the Hospital is under significant operational pressure, the high standard of care patients expect is not always consistently delivered.

The areas of care delivery in which minor concerns have been raised fall into four general categories:

- Drugs administration
- Patient nutrition
- Full completion and documentation of clinical risk assessments and care plans
- Efficient and safe management of discharge including TTOs.

Plans are in place to strengthen the hospital's performance in meeting standards consistently in these areas and these have been agreed with the CQC. The Trust was not asked to take any immediate specified actions or given any enforcement notices in these areas and they will check that compliance in these areas have been reached in their future inspections.

Staffing

The high levels of vacancies in ward-based staff, notably among nurses, was raised as a moderate concern on the basis that it might present a risk to the consistent delivery of high quality patient care.

This has been a recognised challenge at the Trust for the last twelve months during which the hospital has been expanding its capacity to meet growing demand. Filling vacant posts with suitably qualified nurses has become increasingly difficult and after national recruitment efforts failed to deliver the staff required, the Trust has been actively recruiting from overseas as well as taking on and developing newly qualified nurses graduating from the University of Southampton.

Over the last 12 months an additional 110 nurses have been added to the numbers working at Southampton General taking the total nurses in post to 3346. This number will continue to grow as the Trust works through its nurse recruitment plan which the CQC reviewed and approved. Overall the Trust aims to take its vacancy rate in nursing down from 9 percent to around 5 per cent. A vacancy rate of 7% in this staff group would be considered acceptable.

Given recent media coverage it is vital to point out that the CQC report did not describe staffing in the hospital as unsafe. Its concern was that the vacancy rate, which has led to high numbers of temporary staff being used as well as permanent staff being moved between wards might prove a risk to quality of care. The hospital is aware of this risk and has robust procedures in place for monitoring staff levels on the wards and assessing and dealing with any risks as and when they arise. As vacancies are filled during 2013, the number of temporary staff working in nursing posts will also reduce.

The Trust Board of University Hospital Southampton will be overseeing through Judy Gillow, Director of Nursing, delivery of the key actions to demonstrate full compliance to the CQC.

Date : 14th January 2013

Account number	RHM
Our reference	INS1-479995140
Location name	Southampton General Hospital
Provider name	University Hospital Southampton NHS Foundation Trust
E-mailed to:	HSCA_Compliance@cqc.org.uk Janet.Ktomi@cqc.org.uk

The delivery of this action plan will be via a Task & Finish Group chaired by Judy Gillow, Executive Director of Nursing and Organisational Development, reporting to the Quality Governance Steering Group and upwards to Trust Board.

Action	Review Date	Exec Lead	Operational Leads	Current progress
General Compliance Actions				
Organisational Culture • To set up senior clinical leadership group to develop professional behaviours for all staff that demonstrate delivery of the Trust values and encourage multi-professional staff engagement.	March 2013	Michael Marsh/Judy Gillow/Gail Byrne	Divisional Head of Nursing (DHN)/ Divisional Clinical Director (DCD)	• First meeting of Clinical Advisory Group has taken place. • Group will meet and report into Trust Executive Committee monthly.

Regulation 9 (Outcome 4) – Care and Welfare of people who use services				
Ward Leadership/Staff Engagement • To ensure that each Ward has a medical clinical lead to work with the Band 7 Ward Leader to have a joint accountability model for quality delivery and ward quality and patient experience assurance.	March 2013	Michael Marsh/ Judy Gillow	DHNs/DCDs	• Already in place in some areas – role to be strengthened. • Audit currently taking place to identify and address the hot spot areas (analysis underway).
Teamwork to deliver Quality • To set up leadership/teamwork development days for Ward Leaders, Clinical Leads, AHP Leads and Ward Pharmacists and for the Care Group Leadership team.	End of April 2013	Michael Marsh / Judy Gillow	DCDs/DHNs with David Young / Rosemary Chable	• Trust Leadership team – development programme.
Staff Engagement • To set up a Nursing Forum for nursing staff at any level to attend to discuss issues of concern, to share good practice and to be kept up to date with local and national information and feedback.	To commence January 2013	Judy Gillow / Rosemary Chable	DHNs	• First meeting taken place, very good attendance.

Action	Review Date	Exec Lead	Operational Leads	Current progress
Care Planning/Clinical Documentation • To ensure there is a consistent, documented approach on all wards in formal care planning for patients including those who have been risk assessed.	March 2013	Julia Barton	Matrons/Ward Leaders	• Standard principles and supporting policy in development (nursing) • Care planning training to be introduced • Record keeping standards audit recently completed – outcomes and actions required to be disseminated by Derek Waller and picked up by divisional action plans. • Folder development to be taken forward.
• To review the process for undertaking risk assessments (e.g. VTE, SIRFIT, Braden) including professional judgement to improve compliance, documentation and adherence to the resulting plan of care, including the provision of appropriate equipment where required.	February 2013	Julia Barton/ Gail Byrne	DHNs/Matrons	
• To ensure all Divisions have the pain assessment tool incorporated in the patient observation charts.	March 2013	Judy Gillow	Div A DHN/Lead Pain Nurse – J Trim	
Patient Nutrition • Ensure the red tray system is working by undertaking unannounced weekly audits to enable immediate focus on any identified hot spot areas. • Ensure all nutritional and fluid balance charts are completed by undertaking unannounced weekly audits to enable immediate focus on any identified hot spot areas.	Progress report by February 2013	Judy Gillow/ Julia Barton	DHNs/Matrons/ Ward Leaders	• Weekly checks by matrons with feedback to ward leaders to be undertaken • Piloting of new corporate fluid chart underway

Action	Review Date	Exec Lead	Operational Leads	Current progress
Clinical Assurance • Review current peer review model and identify if any changes are required as an outcome from the CQC review. • Review ward quality monitoring processes including the framework for observations for care. • Review Divisional and Care Group Quality Assurance. • Develop Trust-wide policy • To take forward external Peer Quality Review initiatives with Barts Healthcare Trust.	February 2013 Process Feb 2013 March 2013	Judy Gillow Judy Gillow / Michael Marsh Judy Gillow	Julia Barton/Gail Byrne and DHNs Julia Barton / Gail Byrne Julia Barton / Gail Byrne Gail Byrne	Barts DoN has agreed to this joint initiative to meet to agree approach.
Regulation 13 (Outcome 9) – Management of Medicines				
Drugs Administration • To ensure all staff are aware of the importance of following the Trust Medicines Management Policy with a robust monitoring process in place, to include each Division having an audit plan. • Divisions to set up a local audit programme to ensure all aspects of the Medicines Management policy are being followed. • To undertake a review in the wards and Discharge Lounge where the CQC identified issues to ensure all learning has been identified and is built into the improvement actions to achieve consistent practice. • To undertake a full review of the prescribing and dispensing of TTOs in partnership with the service improvement team as part of the wider 'No delays' project. This also needs to be reviewed in the Trust's Patient Flow Committee	January 2013 March 2013 February 2013 April 2013	Martin Stephens/ Judy Gillow Sue Ladds/ Judy Gillow Rosemary Chable/ Sue Ladds Michael Marsh/ Sue Ladds	Sue Ladds, Chief Pharmacist with DHNs DHNs/Matrons DHNs with Ward Pharmacists Sue Ladds	Develop pocket sized reminder for staff (CH/AF) TTO workshop held

Action	Review Date	Exec Lead	Operational Leads	Current progress
Regulation 22 (Outcome 13) – Staffing				
Ward Leadership • To enable all Ward Leaders to become supernumerary to more effectively run the Ward and oversee in more detail the delivery of quality and patient experience standards. This will be a 2/3 year initiative as it will require investment. Proposals currently being drawn up to go to TEC in February 2013.	1st year implementation plan to be reviewed end of February 2013	Judy Gillow	Rosemary Chable with DHNs	This will be part of the detailed annual Ward Staffing review.
Staffing Resource • To ensure the Trust wide action plan already developed for nurses and midwives continues to be implemented to reduce vacancies and the use of agency staff. • To review the actions being taken to address staffing shortages in other clinical groups such as ward clerks, therapists, pharmacists and doctors. • Review the Matrons' job description and identify more overtly what they should achieve in their 50% clinical time within their span of responsibility for their defined number of wards and departments.	Review progress against plan monthly at TEC February 2013 February 2013	Judy Gillow Steve Harris Judy Gillow	Rosemary Chable with DHNs DHNs/DCDs/ Margaret Fahey Rosemary Chable/Gail Byrne with DHNs	Detailed local plans to be reviewed (nursing) Reflect in Divisional/local plans Letter gone out to Divisions to confirm the Matrons' job description and the importance of their clinical time in practice.
Staffing • To ensure the annual Capacity Plan is aligned to an annual Staffing Plan. This will take account of planned additional beds being opened over the year and an associated Staffing Plan with clear guidance that beds will only open once the Staffing Plan is in place.	April 2013	Judy Gillow / Mike Murphy / Alison Thorne-Henderson	DHNs/DCDs/HR Business Partners/ Planning	

Action	Review Date	Exec Lead	Operational Leads	Current progress
Phlebotomy • Review the identified issues in the Phlebotomy service and draw up an action plan to address.	March 2013	Judy Gillow / Michael Marsh	Kamal Sandhu/Nick Hurlock with DCDs and DHNs	Scoping review to be implemented
Regulation 20 (Outcome 21) – Records				
• To review the management of clinical records particularly in respect of loose filing. Identify any challenges to resolution and recommend how they should be addressed.	March 2013	Judy Gillow	Paul McMahon	
Please note Issues relating to record keeping standards will be covered under the Regulation 9 actions.		Derek Waller/Judy Gillow		

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		VASCULAR SERVICES UPDATE		
DATE OF DECISION:		31 JANUARY 2013		
REPORT OF:		DIRECTOR OF NURSING SHIP PCT CLUSTER		
CONTACT DETAILS				
AUTHOR:	**NAME:**	SARAH ELLIOT	TEL:	023 8072 5630
	E-MAIL:	SARAH.ELLIOTT@HAMPSHIRE.NHS.UK		
STATEMENT OF CONFIDENTIALITY				
N/A				

BRIEF SUMMARY

Changes were recommended to the vascular service pathways as a result of guidance developed by both The Vascular Society of Great Britain and Ireland (VSGBI) and The National Confidential Enquiry into Patient Outcome and Death (NCEPOD). They stated that the best outcomes are achieved in specialist vascular units with dedicated vascular teams available 24 hours a day, seven days a week, using new technologies that improve clinical outcome.

The Overview and Scrutiny Panel and the Cluster PCT have been concerned to maintain the momentum of the emerging development of a vascular services network between University Hospitals Southampton and Portsmouth Hospitals NHS Trust

This paper reports progress since the last Overview and Scrutiny panel on the 29th November 2012

RECOMMENDATIONS:

(i) The Panel support the continued development of the network

REASONS FOR REPORT RECOMMENDATIONS

1. To update the panel as requested.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. **Commissioning Intentions 2013/14**

Debbie Fleming has written to the two trusts clarifying which vascular procedures will be commissioned from each trust for the coming financial year. These commissioning intentions have been developed in line with the new national specification for vascular services and detail the changes in patient flow in line with the specification.

Commissioners have been receiving reports from the Medical Directors of the trusts. It is understood that that there is a further meeting between the Vascula Surgeons on the 29th January and an update on that meeting should be availal to the HOSC on the 31st

January.

4. **Strategic Planning Group Meeting**

This took place on the 12th December 2012. The meeting received the nationa service specification that had been published for consultation that day. This is very similar to the

draft specification that came out in July, with the exception of a suggestion tha amputation procedures might not move to the arterial centres until 2015. The service specification is appended to this report and if accepted as it stands by NHS

Commissioning Board after consultation, is likely to support the development c the

network.

PHT and UHS agreed to produce a more detailed action plan and the share th joint rota and job plans. Three work streams were proposed:

- Development of ambulance protocols and training
- Split tariffs or alternatives for repatriation of amputees for rehabilitation, (or alternative financial arrangements)
- Development of agreed pathways as listed in the service specification

RESOURCE IMPLICATIONS

Capital/Revenue

5. None

Property/Other

6. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

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

Other Legal Implications:

8. None

POLICY FRAMEWORK IMPLICATIONS

9. None.

KEY DECISION?	Yes/No
WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	NHS Commissioning Board Service Specification for Vascular Services

Documents In Members' Rooms

1.	N/A

Equality Impact Assessment

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

Other Background Documents

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

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	N/A	

NHS Commissioning Board

A4

2012/13 NHS STANDARD CONTRACT
FOR ACUTE, AMBULANCE, COMMUNITY AND MENTAL HEALTH
AND LEARNING DISABILITY SERVICES
(MULTILATERAL)

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	**A4**
Service	Specialised Services for Vascular Disease (Adults)
Commissioner Lead	Cathy Edwards
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; stroke prevention (carotid artery intervention); venous access for haemodialysis; suprarenal and thoraco-abdominal 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 DVT but excludes varicose veins and 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 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 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 service 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 incorporate the change in vascular surgical training. Vascular surgery became an independent speciality 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.

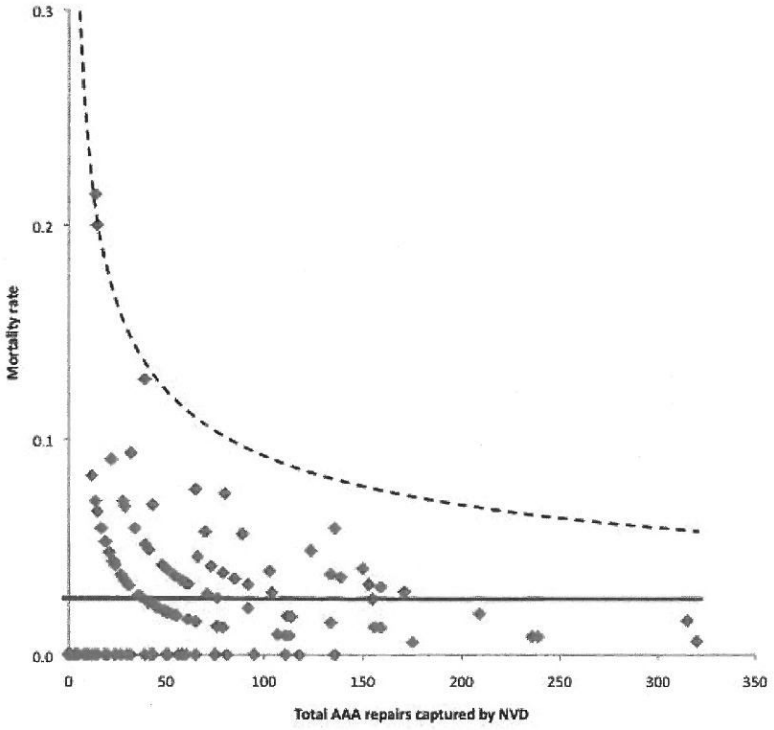
  - The NCEPOD Report 2005 into patient outcome and death following abdominal aortic aneurysm (AAA) found the overall mortality rate for elective surgery was 6.2.

  - 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 2001 (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 are 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 Outcome of Infra-Renal AAA 2012, and it remains noticeable that some low volume units have mortality rates vastly in excess of the national average:



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

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

Karthikesalingam et al.).

- Two recent studies have investigated the effect of endovascular repair on the volume-outcome relationship for elective aneurysm surgery. The studies demonstrated that:
  - Hospital volume was significantly related to elective aneurysm mortality for open repair, endovascular repair and the combined (open + endovascular) group (Holt, Poloniecki et al. 2009). There was a significant difference between endovascular mortality between the lowest and highest quintile providers (6.88 vs. 2.88%), and a 77% reduction in mortality was observed for every 100 endovascular repairs performed.
  - Higher volume hospitals were more likely to adopt endovascular therapy (44% in high volume hospitals vs. 18% in low volume hospitals)(Dimick and Upchurch 2008).
  - Hospital volume was an independent predictor of mortality.
  - Results were defined by the total aneurysm caseload rather than either endovascular or open cohorts alone i.e. hospitals with a large, predominantly endovascular, caseload also reported better than average results from open aneurysm repair.

- The most important aspect defining the provision of aneurysm (or any other) services must be the acceptability to patients. There is a clear trade off between the advantages associated with a high-volume centre and the difficulties caused by prolonged travel times for both patients and relatives. The acceptability of increased travel times was assessed in a study of 262 patients (Holt, Gogalniceanu et al.). Patients were asked to complete a questionnaire that was calibrated against the time an individual was willing to travel to access specific attributes of an aneurysm service. Approximately 92 per cent of individuals stated a willingness to travel for at least 1h beyond their nearest hospital in order to access services with a lower peri-operative mortality, lower non-fatal complication rates, a high annual caseload of aneurysm repairs, and routine availability of endovascular 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 interventional 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.

- Dimick, J. B. and G. R. Upchurch, Jr. (2008). "Endovascular technology, hospital volume, and mortality with abdominal aortic aneurysm surgery." J Vasc Surg 47(6): 1150-1154.
- Holt, P. J., P. Gogalniceanu, et al. "Screened individuals' preferences in the delivery of abdominal aortic aneurysm repair." Br J Surg 97(4): 504-510.
- Holt, P. J., A. Karthikesalingam, et al. (2012). "Provider volume and long-term outcome after elective abdominal aortic aneurysm repair." Br J Surg 99(5): 666-672.
- Holt, P. J., A. Karthikesalingam, et al. "Propensity scored analysis of outcomes after ruptured abdominal aortic aneurysm." Br J Surg 97(4): 496-503.
- Holt, P. J., J. D. Poloniecki, et al. (2007). "Meta-analysis and systematic review of the relationship between volume and outcome in abdominal aortic aneurysm surgery." Br J Surg 94(4): 395-403.
- Holt, P. J., J. D. Poloniecki, et al. (2009). "Effect of endovascular aneurysm repair on the volume-outcome relationship in aneurysm repair." Circ Cardiovasc Qual Outcomes 2(6): 624-632.
- Holt, P. J., J. D. Poloniecki, et al. (2007). "Epidemiological study of the relationship between volume and outcome after abdominal aortic aneurysm surgery in the UK from 2000 to 2005." Br J Surg 94(4): 441-448.

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 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 service to optimise care and minimise tissue loss.

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.

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 amputation including those operated on locally will 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 amputation patients/procedures will be included in the network audit.
- In-patient surgery and 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 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 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), 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 interventional radiology rota may need to be organised on a network wide basis to ensure 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 interventional radiology must be within 30 minutes.
- 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 catheter laboratory capacity. The scope of this local provision must be clearly defined and the activity must be included in the network audit arrangements.
- 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 radiologists, vascular scientists, nurses, radiographers, physiotherapists, 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.
- 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.
- Operating Theatres – a 24 hour NCEPOD emergency theatre will be accessible at all times to undertake emergency vascular procedures, with access to radiolucent operating tables, x-ray C-arms and specialist consumables. Imaging equipment should be good quality multislice CT (not 1st generation) plus workstation with appropriate software for endovascular planning. High quality imaging e.g. 12"C arm with addition/subtraction unit either in theatre or x-ray theatre suite. The elective vascular service will have access to dedicated theatre nurses with specialist training in vascular procedures.
- 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.
- ITU and 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 stable 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 very 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.

Pregnancy

- *Pregnant women with pre-existing conditions as discussed in this specification require assessment and/or management from highly specialist tertiary maternity care delivered within a dedicated multidisciplinary service staffed by a maternal medicine specialist, a physician, and supporting multidisciplinary team with extensive experience of managing the condition in pregnancy.*
- *In view of this, nationally commissioned condition specific services must have outreach arrangements with highly specialised tertiary maternity units with access to appropriate tertiary medical, surgical, fetal medicine, clinical genetics and level 3 Neonatal Intensive Care services. These specialised maternity services must have a critical mass of activity to maintain expertise, ensure best practice, training opportunities and for the organisational infrastructure, staffing, facilities and equipment to be clinically and economically efficient. They should have robust risk management and performance monitoring processes.*
- *All such women must receive personalised pre-pregnancy and maternity care planning from specialised tertiary maternity services to allow optimal disease management in the context of the pregnancy. This will reduce avoidable morbidity, mortality and unnecessary intervention for mother and baby.*
- *Women with conditions as discussed in this specification must be referred immediately once they are pregnant to plan their care. This must include access to termination of pregnancy and specialist advice re contraception .The individualised care plan must cover the ante natal, intrapartum and postnatal periods. It must include clear instructions for shared care with secondary services, when appropriate including escalation and transfer protocols and clear guidelines for planned and emergency delivery.*

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.

[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.

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 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.
    - MHRA Joint Working Group to produce guidance on delivering the Endovascular Aneurysm Repair (EVAR) Service (RCR, BSIR, VSGBI, 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 involving surgeons, radiologists, anaesthetists, clinical vascular scientists, specialist nurses, occupational and physiotherapists.

- The arterial centre in the network will perform a high volume of abdominal aortic aneurysm repairs 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.

- 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
    - The Aortic Aneurysm Repair Audit
    - Amputation Audit
    - The British Society of Interventional Radiology BIAS databases
    - TEVAR
    - IVC Filter Registry

- 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 interventional radiology 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)
    - CG119 Diabet foot problems-inpatient management – (March 2011)
    - CG127 Hypertension – (August 2011)
    - CG147 Lower limb peripheral arterial disease – (August 2012)
    - TAG167 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)
    - IPG079 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)
    - IPG399 Carotid artery stent replacement for symptomatic extracrarial carotid stenosis – (April 2011)

4. Key Service Outcomes

Performance Indicator	Indicator	Threshold/Target	Method of Measurement	Frequency of Monitoring
Carotid Endarterectomy				
Time from first presentation (stroke or TIA) to carotid endarterectomy (percentage of appropriate symptomatic cases operated on within 2 weeks)	Maximum benefit of operation derived from early intervention	100% (tolerance 90% to allow for patient choice)	NVD	
Stroke rate (self-reported, 30 day) • Disabling • Non-disabling	Key Indicator	Target 2%, less than 3% acceptable	NVD/HES	
30 day mortality	Key indicator	Target 1% (from UK carotid interventions audit)	HES	
Post-operative length of stay	Shorter stay indicates good use of resources	< 3 days (median from UK Carotid interventions audit)	HES/NVD	

Number of carotid endarterectomies performed per unit per year	Higher volumes associated with improved outcomes	Minimum threshold-30 cases per year	HES	
Aortic Surgery				
Elective infrarenal aneurysm mortality rate: • Case-Mix adjusted	Key Indicator	Target – 3.5% (Vascular Society) Demonstration of mortality within Vascular Society funnel plots	HES/NVD	
Ruptured infrarenal aneurysm repair mortality rate	Key Indicator	Demonstration of mortality within Vascular Society funnel plots	HES/NVD	
EVAR-Mortality rate • Case-Mix adjusted	Key Indicator	< 1%	HES/NVD	
Waiting time for assessment and intervention	2/52 wait for out-patient assessment 8/52 wait for intervention	Target 100%	?	
Length of stay (elective and emergency)	Shorter stay indicates good use of resources	Elective - <9 days median from HES Emergency <10 days median from HES	HES	

Number of cases operated on per year per unit (elective and emergency)	Higher volumes associated with improved outcomes	>50 per unit (Vascular Society Quality Improvement Framework for AAA)	HES	
Amputation for Critical Limb Ischaemia				
30 day mortality – casemix adjusted	Key Indicator	Demonstration of mortality within Vascular Society risk adjusted funnel plots	HES	
Amputation rate per 1000,000 population – case-mix adjusted	Appropriate figures demonstrate good limb salvage rates and adequacy of care for patients with diabetes or CLU	Range 10-76 per 100,000 depending on casemix	HES	
Waiting time for assessment and intervention	2/52 wait for assessment 8/52 wait for intervention	Target 100%	?	
Lower Limb Ischaemia: Infrainguinal bypass				
30 day mortality rate following infrainguinal • Casemix adjusted	Key Indicator	Target: Demonstration of mortality within Vascular Society funnel plot, National average 4.2% (Fourth National Vascular Database Report, Vascular Society report 2004)	HES	

Post-operative length of stay (infrainguinal bypass) casemix adjusted	Shorter stay indicates less complications, good use of resources and appropriate rehabilitation	Norms: Elective – median 8 days Emergency – median 14 days (HES)	HES	
In hospital graft occlusion rate a. Diabetic b. Non-diabetic	Marker of technical success of operation	Norms and benchmarks need to be established	NVD	
Ratio of prosthetic to vein grafts used	Vein graft associated with better outcomes	Target: Prosthetic graft rate 0% (Tolerance up to 25%) (Based on rate of 35% in Fourth National Vascular Database Report, Vascular Society report 2004)	HES/NVD	
In-hospital surgical site infection rate	Key Indicator	Norms and benchmarks need to be established	HES/NVD	
Waiting time for assessment and intervention	2/52 for assessment 8/52 for intervention	Target 100%	?	

Venous intervention (open, percutaneous or endovenous)				
Improvement in symptomatology and quality of life scores	PROMS provide an assessment of symptomatology and improvement in quality of life	Positive improvements in symptomatology score and quality of life score	PROMS	
Percentage of cases performed as day case	Indicates good use of resources	Target 100%	HES	
Global Measures:				
Readmission rate-stratified as: • Directly related to vascular admission • Indirectly related • Not related	Appropriate rates indicates good quality care with low complication rates and good discharge planning	Norms and benchmarks need to be established. Current procedure specific benchmarks available at Dr Foster	HES	
Completeness of data submission to NVD (percentage)	Indicates engagement with clinical governance and quality improvement	Target 100% completion	NVD/HES	

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL			
SUBJECT:	JOINT HEALTH AND WELLBEING STRATEGY			
DATE OF DECISION:	31 JANUARY 2013			
REPORT OF:	DIRECTOR OF PUBLIC HEALTH			
CONTACT DETAILS				
AUTHOR:	**Name:**	**Martin Day**	**Tel:**	**023 8091 7831**
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The Health and Social Care Act 2012 requires the production of a joint health and wellbeing strategy. The Health Overview and Scrutiny Panel has previously commented on the consultation draft strategy document. This item presents the revised draft strategy document to the scrutiny panel.

RECOMMENDATIONS:

(i) That the scrutiny panel notes the revised draft Southampton Joint Health and Wellbeing Strategy

REASONS FOR REPORT RECOMMENDATIONS

1. To enable to scrutiny panel to review the progress being made on the development of the Southampton Joint Health and Wellbeing Strategy.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. Production of the strategy is a duty imposed by the Health and Social Care Act 2012.

DETAIL (Including consultation carried out)

3. The Health and Social Care Act 2012 places a duty on the council and the clinical commissioning group (CCG) to prepare a joint health and wellbeing strategy which will address priority needs identified in the joint strategic needs assessment. The shadow health and wellbeing board (HWB) has led the process of developing the strategy.

4. Since the shadow HWB adopted a draft strategy early in the summer of 2012, extensive consultation with stakeholders was undertaken. A variety of engagement mechanisms were used including mailouts, attendance at meetings, web-based responses and postal responses.

5. The Health Overview and Scrutiny Panel considered the draft strategy at a workshop session and fed back a number of detailed comments in response to the draft strategy document. These included: making the strategy more focused with a smaller number of actions being required where impact and improvements could be measured and compared with other local authorities; improving the quality of the information cited from the JSNA and making a better link between JSNA data and intended actions; including dementia as a specific challenge that needed to be addressed; and adopting innovative actions which would lead to improvements over the medium and longer term.

6. The Act also requires engagement to be undertaken with local Healthwatch and with the public. Where Healthwatch is not implemented until April 2013 Southampton LINk was engaged in the process, and organised 2 events for the public to share their views on the draft strategy.

7. A wide range of comments came out from the consultation process. However there were a number of recurring themes identified:

- The whole life-course approach set out was generally supported, but not all priorities in the draft strategy related to a life course approach
- There was a repeated view that drug and alcohol issues should not be confined to a section of the strategy referring to adolescents and young adults
- The importance of addressing lifestyle issues including diet, smoking, and exercise
- Recognition of need for health and social care services to work together effectively
- The need to relate actions to potential impact and outcomes
- There was strong support for investment in preventative actions to save costs downstream
- The need to make links with and alignment to other relevant strategies
- The importance of end of life care and experience
- Learning disability issues were seen to be underdeveloped and under-represented
- The impact of increasing demands from dementia is under-represented
- The impact of non-health issues (e.g. – housing, environmental issues) on mental health.

8. The Health and Wellbeing Board reviewed the consultation feedback, and in the light of the comments made revised the structure of the strategy document from 6 priorities to the following 3 themes:

- Building resilience and prevention to achieve better health and wellbeing
- Best start in life
- Ageing and living well

Each theme sets out an introductory context and some headline data from the joint strategic needs assessment. It then sets out a number of actions that will deliver improvements to health and wellbeing and reduce health inequalities, and the identified outcome measures. These come mainly from the national outcomes frameworks against which progress can be tracked, not only over time in Southampton, but also against progress in other local authority and CCG areas.

9. The shadow Health and Wellbeing Board is holding is next meeting on 23rd January after the documents for this meeting have been published. A revised document incorporating the changes made at that meeting will be circulated to members of the scrutiny panel in advance of the meeting to enable members to make informed comments. The version of the draft strategy which the HWB will be considering is currently published with the papers for this meeting. It can be located on the city council website via the following link:
http://www.southampton.gov.uk/modernGov/documents/s15260/Final%20Draft%20V3.pdf

10. During the course of the consultation a commitment was made that respondents would be informed of the changes made as a result of the consultation exercise. This will be undertaken once the shadow HWB has considered and approved a revised draft document. The final draft strategy will then be approved by the HWB in March 2012 and then formally presented to the Cabinet and Southampton City Clinical Commission Group for formal adoption in April 2013.

RESOURCE IMPLICATIONS

Capital/Revenue

11. The resources for delivering the actions set out in the Joint Health and Wellbeing Strategy will be determined through the annual city council and CCG commissioning and budget cycles. Publication of the strategy will be met from existing budgets.

Property/Other

12. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.The duty to produce a joint health and wellbeing strategy is set out in section 193 of the Health and Social Care Act 2012.

Other Legal Implications:

14. None.

POLICY FRAMEWORK IMPLICATIONS

15. None.

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None
2.	

Documents In Members' Rooms

1.	None
2.	

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) 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.	
2.		

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY COMMITTEE		
SUBJECT:		PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL		
DATE OF DECISION:		31 JANUARY 2013		
REPORT OF:		SENIOR MANAGER, COMMUNITIES, CHANGE AND PARTNERSHIPS		
CONTACT DETAILS				
AUTHOR:	NAME:	CARONWEN REES	TEL:	023 80832524
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STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

At the meeting on 29 November the panel agreed to undertake a short review into public and sustainable transport provision to Southampton general hospital. This paper updates the Panel on progress and seeks agreement on the next steps.

RECOMMENDATIONS:

(i) The panel note the update on progress with the review into public and sustainable transport provision to Southampton general hospital

(ii) To note the impact of proposed subsidy reductions for bus transport to the General Hospital and consider if they wish to respond to the current budget consultation.

(ii) The Panel agree who they would like to attend the evidence gathering meeting on 28 February and key areas for discussion.

REASONS FOR REPORT RECOMMENDATIONS

1. The Panel agreed to undertake a review into public and sustainable transport provision to Southampton general hospital.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. Following the Panel meeting on 29 November the Terms of Reference for the review were updated as discussed and agreed by OSMC on 13 December. The Terms of Reference are attached at appendix 1.

4. Further work has been undertaken to map all the bus services that currently service the General Hospital has been undertaken. The map at appendix 2 and 3 show peak and off peak services respectively and indentifies which services, or elements of services, are affected by proposal to remove

subsidies as part of the 2013/14 budget. Further information regarding the removal of subsidies and possible effects will be presented at the meeting. Work is on going to identify pedestrian and cycle routes.

5. The Chair of the Panel and officers met with Harry Dymond, LINK Chair, to discuss how Southampton LINK could support the review. Headline issues raised with LINK recently include criticism of bus services changes including lack of information, access to the General from the east of the City and disabled parking provision. The LINK will prepare a summary of issues raised with them in relation to hospital access for the meeting February and attend the meeting to provide evidence.

6. Officers have been in touch with UHS to request any information in relation to hospital travel including:

- No of people who access the hospital at different times of day
- Visiting hours
- Staff shift hours
- Average staff to patient ratio on site
- Patient feedback on public transport
- Staff/Union feedback on public transport
- Information on reliability
- Impact information – i.e. Missed appointments due to transport
  Schemes you have in place/planned regarding public transport
- Barriers to improvement

A meeting is being sought with UHS to discuss these issues before the Panel meeting in February. UHS have also been asked to provide contacts for union or staff travel groups who would be able to provide evidence to the Panel.

7. The Chair has also contacted all Members via the Members Bulletin to seek input from Councillors on particular issues that have been raised with them. Only one response was received which highlighted problem in Shirley ward with respect to hospital users and hospital workers parking in residential areas would could potentially be relieved by better transport routes to and from the hospital.

8. It is proposed that the meeting on 28 February is used to gather evidence from stakeholders on sustainable transport to the General Hospital. The Panel will want to consider inviting representation from the following groups:

- UHS – Managers, Governors and staff representatives
- Southampton LINK
- SCC Transport Officers leading on buses and sustainable transport
- Local bus companies

The Panel will also want to consider any key questions for stakeholders and areas of focus.

RESOURCE IMPLICATIONS

Capital/Revenue

9. None.

Property/Other

10. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

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

Other Legal Implications:

12. None.

POLICY FRAMEWORK IMPLICATIONS

13. None

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	Terms of Reference
2.	Peak time buses serving the General Hospital
3.	Off peak buses serving the General Hospital

Documents In Members' Rooms

1.	N/A

Equality Impact Assessment

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

Other Background Documents

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

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	N/A	

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Appendix 1

HOSP - Mini Review Terms of Reference

Public and Sustainable Transport Provision to Southampton General Hospital

Aim of the Review:

To try and discover how easy it is for our residents to get to their General Hospital using public transport. For those residents who do not drive, have had to give up driving or are simply too ill to drive, what alternatives are there? Is there suitable public and sustainable transport provision? What other means of travel are available?

Scope:

The review will consider access to Southampton General Hospital. If time allows, access to the Royal South Hants and Western Hospital/Adelaide Centre sites will also be considered.

For the purposes of the review public and sustainable transport will include, buses, trains, cycles and walking.

The scope does not include car travel, however it is accepted that a basic understanding of the current position and how this impacts on the use of public transport will be required. Car parking charges are not in scope.

Objectives:

1 Find out if there is suitable provision for residents to travel to/from hospital – be they staff, patients or visitors.

2 Find out what public or community transport is available, whether it is cost effective and at suitable times.

3 Find out which areas, if any, are affected by lack of public transport

4. Consider any barriers to walking or cycling.

5. Consider any actions required to secure improvements

Methodology:

29/11 - Introduction, overview and agreement on the way forward

13/12 - OSMC to agree review.

24/1 - Short item – review of background evidence and preparation for evidence gathering session

28/2 - Evidence gathering session with officers, transport providers and health site managers.

21/03 - Short item - agree report and recommendations.

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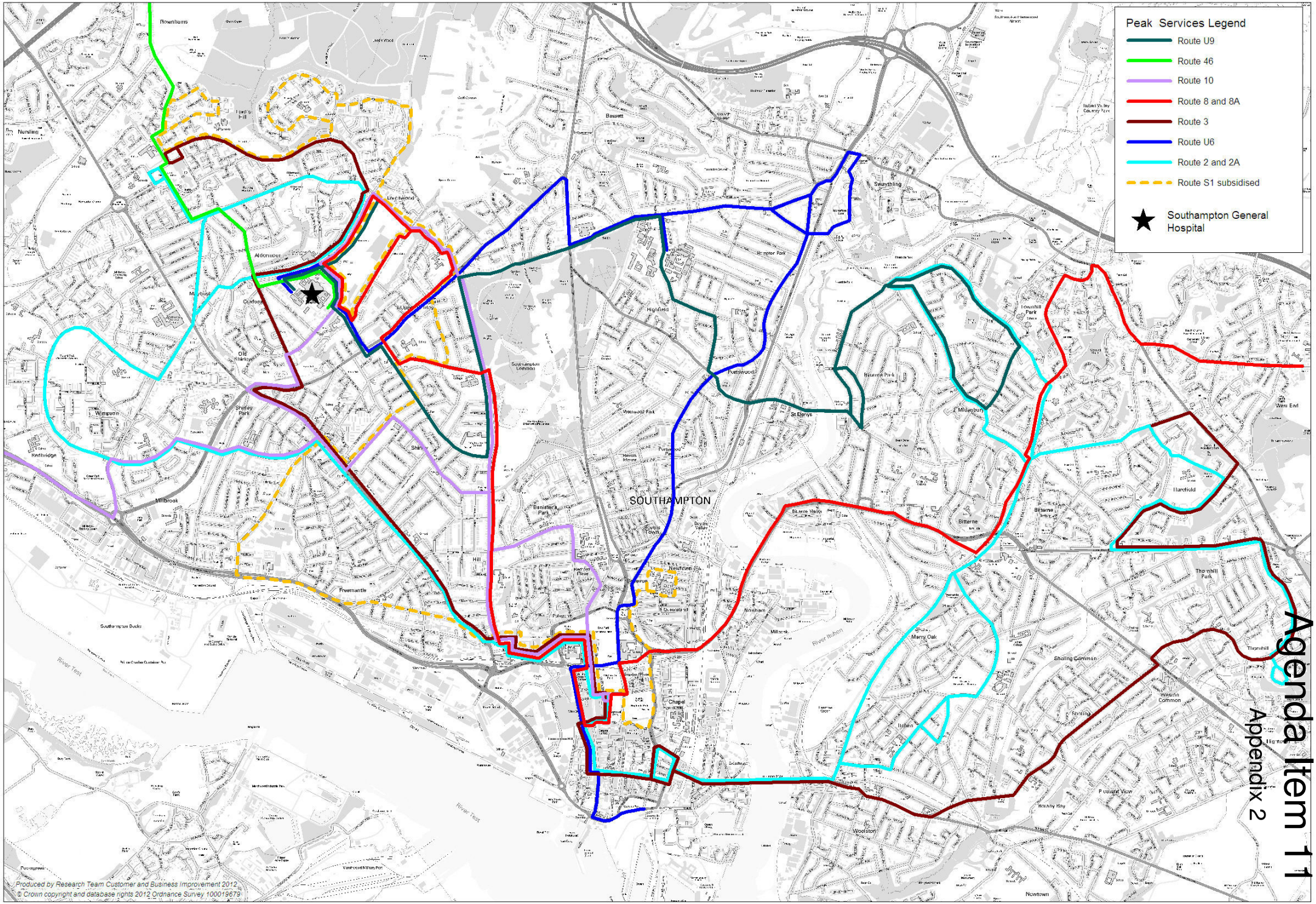
PEAK SERVICES



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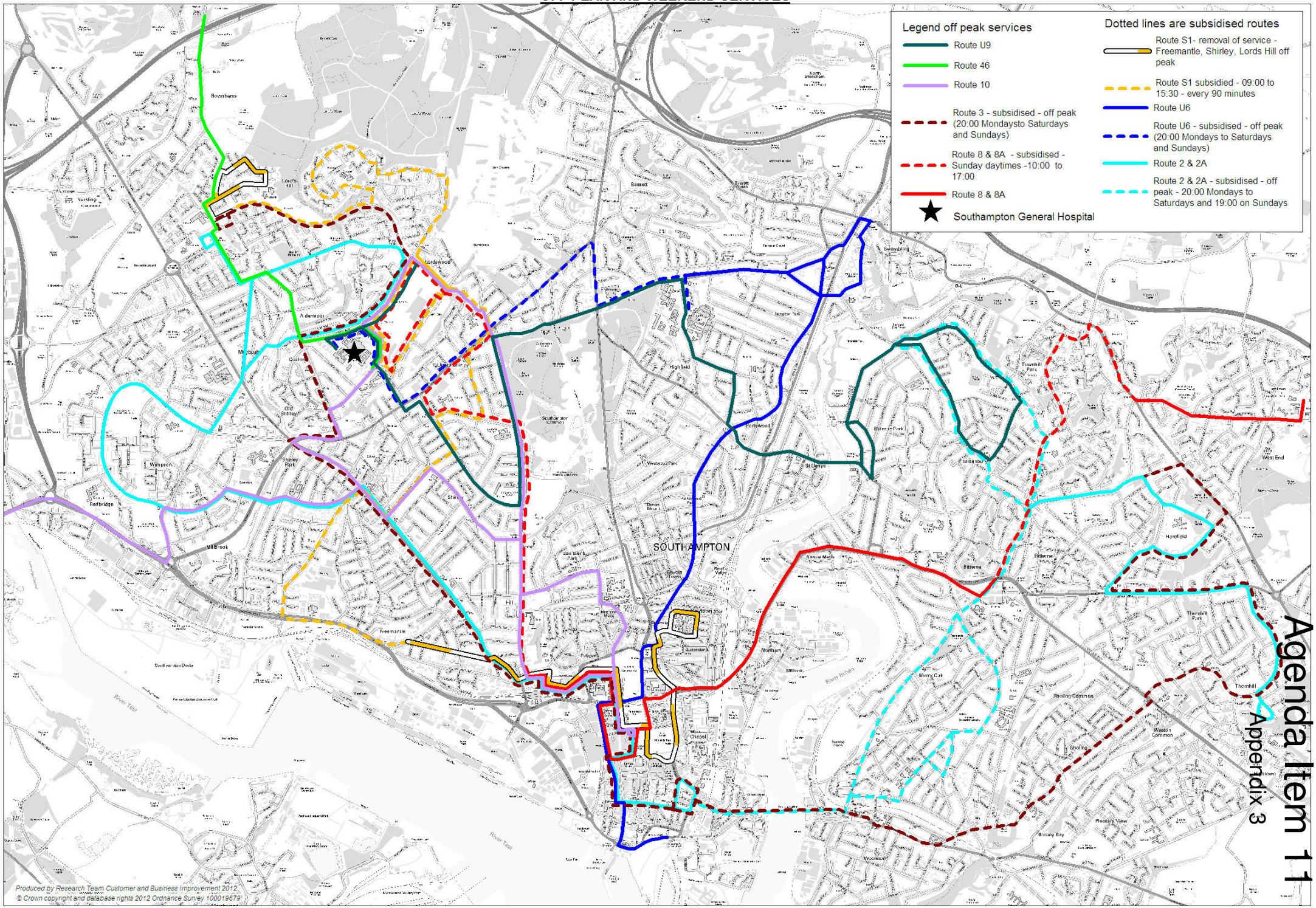
OFF PEAK AND WEEKEND SERVICES



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