PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY
DEFENCE SECONDARY CARE AGENCY
PORTSMOUTH HOSPITALS NHS TRUST
ROYAL HOSPITAL HASLAR

funding

CLINICAL COLLABORATION STEERING GROUP

3.30pm. Friday 18 December 1998
Solent Hotel, Rookery Avenue, Whiteley, Fareham PO15 7AJ

AGENDA

1 **Welcome to new members and apologies for absence**

2 **Notes of Meeting held 15 June 1998** Attachment 1

3 **Matters Arising**

4 **MOD Ministerial Statement on the Defence Medical Services** - Chief Executive, DSCA to report

5 **PFI Bid by Portsmouth Hospitals NHS Trust** - Chief Executive, PHT to report

6 **Health Authority planning and establishment of Primary Care Groups** Chief Executive, P&SEHHA to report

7 **Progress report from Sub-Group on integration of children's services** Attachment 2

8 **Planning for change in 1999** To agree action plan

9 **Any Other Business**

10 **Date of next meeting** - To be agreed

Distribution:

Portsmouth & SE Hampshire HA
Penny Humphris, Chief Executive
Sue Robson, Acting Director of Commissioning
Defence Secondary Care Agency
Major General Chris Callow, Chief Executive
Maggie Somekh, Director of Corporate Development
Portsmouth Hospitals NHS Trust
Dick Bishop, Chief Executive
Sarah Smart, Director Strategic Alliances

Royal Hospital Haslar
Brigadier Guy Ratcliffe, Commanding Officer
Surgeon Commander Rodney Taylor, Medical Director
Royal Defence Medical College
Commodore Ian Jenkins, Dean
Portsmouth Healthcare NHS Trust
Max Millett, Chief Executive
Gosport Primary Care Group
Dr Jane Barton, General Practitioner

From:

Shirley Hardy, Clinical Collaboration Project Manager
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Attachment 1

Portsmouth and South East Hampshire Health Authority
Defence Secondary Care Agency
Portsmouth Hospitals NHS Trust
Royal Hospital Haslar

CLINICAL COLLABORATION PROJECT BOARD

Notes of the Meeting held 15 June 1998

Present:	Maggie Somekh	Chairman
	Dick Bishop	
	Shirley Hardy	
	Penny Humphris	
	Surgeon Commodore Ian Jenkins	
	Brigadier Guy Ratcliffe	
	Sue Robson	
	Sarah Smart	
	Surgeon Commander Rodney Taylor	
Apologies:	Ron Smith	

No	Discussion	Action

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1 Notes of Meeting held 8 April 1998

The notes were agreed as a correct record of the meeting

2 Matters Arising

2.1 Postgraduate Medical Education

Commodore Jenkins confirmed that he is now in contact with Paul Weaver at Portsmouth Hospitals NHS Trust around PGME issues.

2.3 Project Budget

Shirley Hardy presented project budget reports to the end of May showing expenditure of £62,634.56 out of the £100,000 allocated by the DSCA and Health Authority and said that she thought that the final adjusted figure might be closer to £60,000. The use of the unspent budget would need to be agreed between the two organisations who had sponsored the project. This was noted.

4 Portsmouth and SE Hants Health Authority

Penny Humphris reported that the first meeting of the Health Improvement Plan (HIP) Steering Group had now been held, with representation from RH Haslar, and the 1998 Public Health Report would be published shortly to support the new HIP work. The local health priorities to be covered are perinatal mortality and asthma, and information will be structured on a local authority basis to support local authority involvement in the HIP work, and the evolving Primary Care Groups (PCGs). The Steering Group is to be supported by local groups, including one for Gosport which will need to include RHH as well as Gosport Council and the Hampshire Social Services Area Team.

The Health Authority is also out to consultation on the structure of PCGs and is proposing separate groups for Gosport and Fareham, with a shared management infrastructure. Dr Jane Barton has been mandated to lead the developing Gosport PCG and will be supported by John Kirtley and Hugh Janes from the HA. Work is also proceeding on Clinical Governance, again involving RH Haslar. Brigadier Ratcliffe said that Haslar would be delighted to host a local meeting on this subject, which is also under consideration within the DSCA, and Penny Humphris said that this might tie in with a planned away day being organised by Max Millett, chief executive of PHCT, involving Professor Martin Severs and others who might contribute to the development of this concept in Portsmouth. Sarah Smart proposed the head of the Clinical Effectiveness Unit at York University as a useful speaker for a wider meeting of local CDs. GR

3 **Portsmouth Hospitals NHS Trust**

Dick Bishop reported that the clearance of the East Wing at SMH was going ahead and that planning approvals for the development of the QAH site were expected this week to enable the land swap with the Council to proceed. The Trust was planning to re-submit its PFI bid in the next round, scheduled for September and would need a decision from the MOD on the inclusion of any Service component by at least the end of August. The Trust chairman had recently made this point strongly to the Surgeon General and indicated that the Trust needed to go forward without MOD if necessary for inclusion in this round. Future rounds might come after Hampshire and the IW moved into the new South East Region of the NHS in April 1999, when Portsmouth would have to compete for a priority position and when available private sector funding would in any case be much reduced.

Asked if the bid could be modified to include the DMS at a later date, Dick Bishop said that NHS proposals could be reformulated after the inclusion of private sector partners, who were selected following OJEC advert, but any post-advert planning would have to include these partners and could therefore be more complicated. The total PFI process could be expected to take 5-7 years from DoH agreement to support a public/private partnership in Portsmouth, with 2 years from OJEC advert to agreement on principles with private partners, and then 3 years+ for building design, construction and commissioning.

The Trust is already gearing up to new ways of working and would expect to be working to all the protocols for the new hospital some two years before opening. Output specifications for all services, including those of interest to a private sector partner, such as IT, facilities management etc, are required prior to OJEC advert and the Trust planned to finish all this work by December for advert early in the New year, if the Portsmouth scheme is approved. Good output specifications are critical to the success of the PFI and the DSCA needs to be involved now if there are to be MOD services included in the scheme. This input would be particularly important in areas such as IT requirements, HR policies for civilian employment, library and educational facilities etc. It was agreed that Sarah Smart should supply the DSCA with a list of the output specifications being developed so that the workload involved in contributing to this could be scoped at RH Haslar. A meeting would also be set up for Sarah Smart and Karen Southwell to meet with Maggie Somekh, Stephen Campion and Shirley Hardy. SS

5 **DSCA Strategic Review**

Maggie Somekh reported that decisions on the future Service requirements for a core hospital are now being considered at Surgeon General's level. The DSCA work is continuing to develop principles for effective MDHU services, while the SG's Control Group is looking at the requirement for a core hospital and has commissioned further efficiency/effectiveness investment appraisals from DERA which are expected to delay any decisions until after the end of August. The next meeting of the SG's Control Group is scheduled for 24 June, and the DSCA is seeking to make everybody aware of the implications of missing out on the NHS timescale for consideration of the PFI scheme in Portsmouth. The DSCA also meets regularly with Peter Mankin from the South and West office of the NHS Executive who leads on NHS relations with the Services, and it is unclear as yet as to whether this responsibility will transfer to the new South East Region and whether NHS continuity will be lost.

Asked if the NHS was still going to be expected to tender competitively for a core hospital, Maggie Somekh said that discussions with the NHS had led to a view that, if this approach was followed, the list of possible tenderers should be very restricted to match MOD requirements. Dick Bishop said that although this might reduce the number of NHS organisations working on tenders, and simplify the process of adjudication for the MOD, it would still be a huge amount of work for any Trust invited to tender, and it is unlikely that PHT would take this on, given the heavy NHS agenda and requirements of the PFI process.

3 **Future Progress in DSCA/NHS Relations in Portsmouth**

All members of the Project Board were concerned at the impact of this uncertainty on working relationships and the future of collaboration in Portsmouth, which had not progressed much since the announcement of the DSCA Strategic Review at the same time as the Collaboration Conference in October 1997. Maggie Somekh said that her personal view was that, whatever the outcome of MOD deliberations on the future scope and location of the DMS core hospital, collaboration needed to continue to develop in Portsmouth and some continuing presence would continue to be required to meet local Service needs. This might be a large MDHU rather than the core hospital, but it did not detract from the need to use Haslar effectively in the interim, and to build closer collaboration with the NHS in Portsmouth.

Dick Bishop said that this evolution would be possible, but there had to be recognition of the deadlines imposed by the PFI process. The NHS Trust needed to put forward a clear bid with or without MOD involvement to be included for consideration in the autumn 1998 round. Maggie Somekh said that this was recognised, and she and colleagues would be meeting clinicians at Haslar on the 22nd, before the next meeting of the SG's Control Group, to try and get a clearer picture as to how they saw the longer-term future of DMS services in Portsmouth and Gosport developing and the support for guarantees of a minimum MDHU relationship. Dick Bishop said that at present any purely Trust bid would be based on the current workload patterns, but that a MOD decision to retain Haslar and expand as the core hospital for the long-term would mean that the PFI would have to be scaled back, and a formal decision on this would be needed before the OJEC advertisement. The Trust had to recognise that if they did not get selected in the autumn round, they might not get a PFI scheme and the necessary change to NHS capital stock in Portsmouth could take many years to finance.

Brigadier Ratcliffe said that he believed that all staff at RH Haslar are committed to making a continuing collaborative contribution to NHS health care in South Hampshire and to meeting the needs of the local and wider Service population. However, they could not understand why

the NHS had supported Gosport as the location for the core hospital at the time of DCS 15 and now withdrawn this support, or why MOD had accepted this NHS advice and then not invested in the hospital's staff and facilities to take on its planned Service role. Staff want to collaborate with the NHS in areas such as cancer services, but not to leave the site which is their *alma mater* and critical to staff morale. If asked to move to another location in Portsmouth or elsewhere, so many clinical staff will leave the Services that there will be nothing to transfer.

Commodore Jenkins pointed out that all clinical specialties have recently been accredited for medical training at current volumes of clinical activity and standards praised. There is no reason why this should not be maintained for the foreseeable future, although higher staffing levels would also require higher levels of activity. His organisation would not be able to support any change to close, relocate, downsize or convert to MDHU status which did not guarantee to provide the level of Service training opportunities currently available at RH Haslar and the effective links with the Wessex Deanery.. In his opinion, replacement would require a multiplicity of MDHUs. Considerations also went further than just the future of RH Haslar. The Royal Defence Medical College has relocated to Dolphin, which is also the base for a 200 bed Field Hospital supported by Haslar.

In face of these differing views and organisational priorities, the Board was agreed on the importance of early decisions and clear direction from the MOD to enable projects to proceed, to protect staff morale and working relationships and to provide a context for future collaboration in Portsmouth. There might be some indication of direction from the meetings at Haslar and of the Surgeon General's Group in the week beginning 22 June, but it is not currently possible to define a clear joint programme of work for the NHS and Haslar. Penny Humphris stressed the value of continued communication, but it was agreed that the Project Board should not set a date for any future meeting until the position is clearer.

SJH - 24 June 1998

Attachment 2

CHILDREN'S SERVICES - ROYAL HOSPITAL HASLAR

Report to Clinical Collaboration Steering Group - December 1998

1. At the meeting of stakeholders held 19 November 1998, at RH Haslar a sub-group was set up to work from the following assumptions:

   - The cessation of children's day and inpatient services on the RHH site
   - The provision of an integrated children's service between RHH and both Portsmouth Trusts to meet the needs of the local community
   - The continued provision of outpatient and diagnostic services for children at RHH
   - The provision of alternative arrangements to meet all DSCA training requirements
   - The provision of a good quality minor injuries service to children on the Gosport peninsula, linked to collaborative A&E services rather than dependent on GP medical support.

2. The sub-group (Brig Guy Ratcliffe, Sue Robson, Sarah Smart, Paula Turvey and Shirley Hardy) met on 1 December to review an impact statement produced by the specialties offering children's services at RHH and to plan for change in line with the above assumptions. The sub-group identified issues which can be categorised as follows:

   - Protection of training posts for junior medical staff at SHO (specialist and GPVT training) and SpR level. No pre-registration RSCN training takes place at Haslar
   - Professional skills maintenance and development for fully trained medical and nursing staff required for both Service commitments and CME/CPD
   - Provision for patient services in respect of both local Gosport children and Service/MOD dependent children seen in clinics abroad or referred to RHH from abroad
   - The links between the viability of purely children's services and the wider range of emergency and elective services at RHH which are required to support care of adult patients, and all the training posts based on this range and volume of casemix

3. Mr Rob Wheeler spoke to the sub-group at the beginning of the meeting as a consultant paediatric surgeon from the Regional Service in Southampton with current experience of working in the NHS and at RHH. He said that he believed that ward D6 offered one of the best environments in the UK for elective paediatric surgery and that people could have confidence in this while plans were made for an alternative pattern of service in Portsmouth and Gosport. This should be of a comparable or better standard so that local people could know that they would benefit from the changes proposed. Sarah Smart supported this latter point and said that the changes provided the Trusts with an opportunity to review their own arrangements for children's services and to develop integrated services based on higher standards than were possible with the current more fragmented and isolated arrangements.

4. The specialties and staff groups providing children's services at RHH were reviewed in turn and a way forward identified in terms of discussion of narrowly children's services. It was agreed that these children's service issues should be progressed as soon as possible and the wider implications of integration of

children's services left for follow up in January. The initial work would look primarily at arrangements which would protect training posts in relation to the paediatric elements of their work, the provision of opportunities for consultant staff to work as part of wider district children's services and any arrangements required to maintain services to MOD dependent children. These discussions would be bound to throw up wider issues about the whole pattern of work and training which would need to be addressed in the wider context of Ministerial announcements about the future of DSCA services in Portsmouth and Gosport. This should be possible in January, and some specialties will not have meetings programmed until the New Year for this reason. See paragraphs on the individual specalties below.

5. Medical Paediatrics: The current day and outpatient service at RHH contains elements of non-acute general paediatrics and of community paediatrics and therefore change requires joint planning with both Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts. The following action has been agreed:

    - PHCT (PT) to set up a meeting involving Surg Cdr Kershaw and Dr Vencat Raman to look at protection of the community paediatric element of the Service GPVT post, the action required to establish consultant links and new arrangements for Gosport patients currently attending RHH for conditions normally managed by community paediatrics and for MOD dependants requiring community paediatric assessment or follow-up
    - PHT (SS) to set up a meeting involving Dr Richard Hallett and Lt Col Moorthy to agree arrangements to protect the acute on-call requirement in respect of the GPVT post, the action required to strengthen consultant links and experience and any additional arrangements required to maintain the non-acute medical paediatric service currently provided to children on the Gosport peninsula
    - Immediate action to be taken (SS) to review and strengthen where necessary the protocols for the stabilisation and transfer of child A&E attenders presenting at RHH

6. Dermatology: Collaboration discussions have been taking place to look at closer integration in this specialty throughout 1998, so a further meeting will be set up to look at arrangements for children's outpatients and admissions which protect DSCA training posts.

7. General Surgery and Anaesthetics: The general surgical service at RHH is provided/supervised by Mr Rob Wheeler from Southampton independently from other links between the Southampton Regional Service and PHT. Sarah Smart reported that PHT is already looking at the possibility of setting up an elective general surgical service for children at SMH where paediatric cover is available and that the transfer of work from RHH could form part of that. The Trust (SS) will set up a meeting involving Mr Wheeler and Mr P Malone from Southampton, Surg Cdr P Barker and Major J Field (anaesthetist), Mr G. Sutton and Dr M Wood (anaesthetist) to look at the provision of an alternative children's surgical service in Portsmouth in line with the best current standards. This meeting will also look at the closer integration of anaesthetic services to protect DSCA training and the professional skill base of consultants.

8. ENT: This specialty forms 50% of the day and inpatient case load at RHH and the volume is not considered to be occasional practice. However this specialty is not viable in isolation and therefore arrangements need to be made for an integrated

service with PHT. A meeting is being set up between Miss A Davis and Surg Cdr H Cox to look at the requirements to allow children to be treated at QAH by RHH surgeons and then for wider changes in the organisation of specialty work which will protect the DSCA training posts.

9. Oral Surgery: Discussions on integration of the children's exdontia service will look at the role which RHH surgeons can play in keeping waiting times down and the need to maintain skills and to provide a service to children from MOD families abroad who currently come back to RHH. This is a requirement for most of the specialties which provide children's clinics in Gibraltar and Cyprus

10. Accident & Emergency, Trauma and Plastics: The children's workload in the Trauma Directorate is closely linked to the provision of an A&E service for children and a meeting is planned for January to bring together PHT and RHH consultants to plan for closer integration in these specialties to protect DSCA training objectives. The Trust is initiating urgent work on a model for hub and spoke emergency services in which the central A&E Dept supports local minor injures departments and this will be discussed with PHCT and the HA and new PCGs, as well as RHH, as it may have relevance throughout the Portsmouth & SE Hants area and relieve pressure on the QAH department. The RHH plastic surgery department has some planned lists for waiting list patients referred from the Salisbury contract and this local service will also need to be accommodated at QAH. The impact of change in arrangements for children's emergency work will also need to be followed up with the anaesthetic departments.

11. Nursing: A number of the RSCN Service nurses currently working at RHH are interested in developing their skills into A&E. The appropriate post-registration course is available in Portsmouth and all Service and civilian staff could be offered opportunities to remain in children's work or re-employment in the Trust. PHT can also offer refreshment training for RSCNs serving overseas.

12. Other clinical services: A number of other specialties are involved in the provision of children's services at RHH and need to be followed. These include ophthalmology, which has been restricted from undertaking NHS children's work at RHH for more than 12 months, and diagnostic imaging and pathology which support the medical and surgical services. A collaboration meeting will be set up to look at ophthalmology and impact statements collected from the imaging and pathology departments prior to any meetings.

13. Discussions will continue during January to resolve the practical problems involved in the integration of children's services in a way which protects DSCA objectives, and also to address the wider issues of service delivery between PHT and RHH which may arise from this. As proposals emerge, they will need to be considered by a wider planning group, including the PCG and PHCT, to ensure that access to services for Gosport patients is protected and an overall strategic plan developed for service delivery on the Gosport peninsula. Firm plans and a timetable for action should be available to the Steering Group by the end of January.

SJH/03/12/98