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

CLINICAL COLLABORATION PROJECT

Monday 24 November 1997 at 12 noon
Conference Room, Finchdean House

AGENDA

1 **Apologies for Absence**

2 **Notes of meeting held 3 October 1997** — Attachment 1

3 **Matters Arising**

2.1	Porstmouth Hospitals Trust Development Programme	Attach. 2
2.4	Project Budget - October Report	Attachment 3
5	Collaboration Conference Report	Attachment 4

4 **Collaboration Conference - Action Checklist** — Attachment 5

15	Board membership	
16	Summary of current collaboration	Attachment 6

5 **Any Other Business**

6 **Date of next meeting -** Monday 12 January 1998 at RH Haslar

Distribution:

Portsmouth & SE Hampshire HA
Penny Humphris, Chief Executive
John Henly, Director of Commissioning
Defence Secondary Care Agency
Ron Smith, Chief Executive
Brigadier Guy Ratcliffe, CO RH Haslar
Maggie Somekh, Director of Corporate Development HQ
Portsmouth Hospitals NHS Trust
Dick Bishop, Chief Executive
Sarah Smart, Lead Manager for Strategic Alliances

Shirley Hardy, Clinical Collaboration Project Manager

Hoslar Clinical Collaboration RG

B/f 5 Jan for meeting with RO on 6th.

Dear Colleagues

Thank you for your contribution to the day and I hope my conference report accurately reflects the discussion and presentation and provides a basis for continuing partnership.

The next Project Board meeting is Monday 24 November 1997, 12 noon, at Finchdean House.

Please find enclosed draft Agenda for the next meeting, can I have comments or additions by end of week.

Code A

pp Shirley Hardy
Clinical Collaboration Project Manager

CLINICAL COLLABORATION CONFERENCE

MARRIOTT HOTEL, PORTSMOUTH - 27 NOVEMBER 1997

Conference Report and Action Plan

Present:

Portsmouth & South East Hants Health Authority:

Code A	Chief Executive
Code A	Director of Contracting
Dr Elizabeth Jorge	Director of Public Health Medicine

Defence Secondary Care Agency:

Ron Smith	Chief Executive
Maggie Somekh	Director of Corporate Development
Surg Cdr Richard Dale	AD Medicine

Portsmouth Hospitals NHS Trust:

Dick Bishop	Chief Executive
Dr John Bevan	Medical Director
Mr David Birnie	CD Surgical
Prof Duncan Colin-Jones	CD Medical
Dr Louis Merton	CD Clinical Support Services
Dr Richard Hull	Leader Change Programme
Sarah Smart	General Manager

Royal Hospital Haslar:

Brig Guy Ratcliffe	Commanding Officer
Brig Ivan Houghton	for CD Critical Care
Surg Capt Mark Edmondstone	CD Medicine
Surg Capt Mike Farquharson-Roberts	CD Trauma
Surg Cdr Lionel Jarvis	CD Clinical Support Services
Lt Col Simon Mellor	CD Surgery
Gp Capt Bernie Forward	Director of Nursing

General Practitioners:

Dr Jane Barton	Commissioning GP Gosport
Dr Brendan Coonan	GP Gosport
Dr John Hughes	Commissioning GP Havant & Vice Chair Commissioning Bd
Dr James Warner	Chairman, Portsmouth & SE Hants LMC

Portsmouth Health Care NHS Trust:

Tony Horne	Director of Operations
Dr David Jarrett	Lead Consultant Elderly Medicine
Bill Hooper	Divisional General Manager, Fareham & Gosport
Rosemary Salmond	Specialty Services Manager

Royal Defence Medical College

Surg Commodore Ian Jenkins	Dean

Isle of Wight

Dr Peter Old	Director of Public Health, Isle of Wight Health Authority

Clinical Collaboration Project

Shirley Hardy	Project Manager

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1 Aims and Objectives

The Conference was opened by Penny Humphris and Ron Smith - the Project sponsors - who welcomed participants and set the aims and objectives for the day.

Project Aims:

- provision of high quality health services for local people
- provision of best possible medical support to the UK armed forces in peace and war
- best use of public money

Penny Humphris then presented the Portsmouth and South East Hampshire Health Authority mission statement and strategic objectives.

Mission Statement: *To enhance the health of the people in Portsmouth and South East Hampshire by the commissioning of services for:*

- *the promotion of good health*
- *the prevention of disease*
- *the treatment of illness*
- *the provision of rehabilitation and care*

Strategic Objectives:

- supporting the development of the range of services provided in primary and community care settings
- making optimum use of the facilities at existing community hospitals
- rationalisation of the DGH services in line with current best practice, moving to the provision of acute services from a single site

The Health Authority, like the NHS more generally, is awaiting guidance from the new Government and a Green Paper on public health and a White Paper on arrangements to replace the internal market are expected this year. Meanwhile the Authority's concerns continue to centre around the provision of an equitable service to the whole population of 530,000, the needs of those in the 10 most deprived wards, which include two Gosport wards, the expected increase in the over 75 and over 85 population bands, key health issues including cancer, CHD and stroke and the achievement of improvements in clinical effectiveness.

Next, Ron Smith set out the aim and business objectives of the Defence Secondary Care Agency.

The Aim *of the DSCA is to make available to Commanders in Chief appropriately medically trained secondary care Service personnel, when required, for training, exercises and deployment.*

Business Objectives:

- timely and appropriate development and training - with access to the clinical casemix required for this
- effective treatment and outcomes linked to fast tracking of Service personnel
- cohesive and flexible tri-Service organisation

The numbers in the Defence Medical Services had now been reduced to those with a war role and all personnel were regularly required to deploy to the land army, the fleet, to RAF commitments such as aero-med and on operations such as Bosnia. The level of these commitments had increased for individuals, but had to be recognised and accommodated because of the scope and national importance of the support role of DMS personnel in

relation to the whole Armed Forces. In that sense DSCA targets were bigger than those of the health authority.

The presentation then moved on to explain **the financial regime** in which the Collaboration Project currently operated. The Health Authority has a baseline resource allocation of £248.2m in 1997/98, as compared to it equity target (calculated on the basis of the needs of the resident population) of £249.7m. Both the baseline allocation and the equity target are reduced by the NHS calculated value of the MoD funded service received by Health Authority residents at RH Haslar. This top-sliced value is currently calculated at £7.8m, so that the Health Authority's net position this year was an allocation of £240.4m.

Revenue growth of around 1% p.a. is forecast, which means that resources will continue to be very constrained, and the Health Authority both needs a service from the DSCA proportional to the allocation lost, and would need this funding replaced by the NHS Executive if the Service contribution to local healthcare decreased.

Ron Smith said that both MoD and the DSCA believed that the NHS got very good value for the top-slice. The so called 'free good' to the NHS is not in fact free - it comes from the Treasury into MoD funds rather than to the NHS, and to that extent, the DSCA recognised that Defence is providing a service to the local community in Gosport, and that the DSCA has a clear public duty to meet as far as possible NHS requirements and standards relating to patient care. The DSCA military objectives had to come first, but the objective was to provide a comparable service to that of any NHS hospital to the population served.

Penny Humphris confirmed that the Health Authority recognised both the constraints under which the DSCA operated and the 'added value' which their presence gave to the area. They then moved on to describe joint concerns.

Joint Concerns

- the implications of Calman on medical staff training and the value of strategic alliances across clinical specialties
- shifting service delivery patterns and the impact of e.g. Calman on cancer services or published standards for PICU, and in the near future ITU and vascular services
- Royal College accreditation - which is as relevant to the Defence Medical Services as to the NHS, as MoD has to train to the same standards and offer satisfying careers to Service personnel
- optimal future investment to avoid unnecessary duplication and inappropriate use of public funds
- effective use of the total resource to meet military and civilian objectives

The Project principles (circulated to participants in advance) had been jointly developed between all the organisations supporting the project, and recognised the main roles of the NHS and MoD. They embodied a win:win philosophy and recognised the equal contribution of all staff. They formed the criteria for consideration of possible future models of service in the Portsmouth area.

2 Building a Model

Some possible models were presented as a basis for later group discussion and the development of alternatives. These were:

- maintain two DGHs (QAH/SMH and Haslar)
- single site DGH supported by smaller hospital(s) at Haslar (and St Mary's?)
- single site DGH only

- single site DGH with community hospital network
- other options?

Comments and views from participants identified some additional issues for consideration by groups:

⇒ the need for a community hospitals network supporting any DGH arrangement
⇒ the need to take a wider view of the local healthcare system, to include the Isle of Wight, Southampton, Chichester etc.
⇒ the realistic timescale for a move to a single site DGH
⇒ the pressure to shift service delivery away from acute services to primary and community care settings
⇒ the need to preserve military identity and to improve retention of the Service workforce
⇒ provision for Service personnel to deploy frequently and sometimes unexpectedly
⇒ the reliance of both the NHS and MoD on PFI for any new major capital developments
⇒ the requirement for the model to guarantee the places needed for MoD staff training
⇒ a hub and spoke model of service delivery as an alternative to those suggested.

The inputs led to the overall point for consideration by groups. Is there a better way of organising health care delivery in the Portsmouth area which meets both NHS and DSCA objectives, and which is based on co-operation rather than competition?

3 Is there a model?

Groups made slow progress in their first session in which different objectives often obscured the search for a common vision.

Group A Report:

- PHT/RHH liaison is a must. Haslar is not big enough to operate independently in 1998, but
- the military ethos must be preserved, so
- MoD will need to contribute more to maintain the status quo or have less! Flexibility to deploy needs integration with the NHS
- A one site DGH is the eventual aim, but in the interim a hub and spoke model would probably work best
- Acute and emergency service go at the hub, what goes in the spoke? If it is acute it needs A&E and ITU

Group B Report:

- What does military ethos mean? — Military wing staffed by military personnel; Mess on site and quartering; Adequate casemix; Scope for clinical sub-specialisation
- What are essential specialties for the war effort? — A&E, trauma & orthopaedics; Surgery; Anaesthetics; Medicine
- What is a DGH? — Emergencies and high dependency elective cases; High tech services; Services requiring high tech support
- What is a smaller hospital - is it a Community Hospital plus?

- What does the Gosport population need?
- No consensus on a single DGH site, but support for:
  clinical integration (joint clinical teams)
  co-ordinated approach to training
- Haslar and PHT together have the resources to serve the P&SEH population
- Is the model PHT as DGH + enlarged community hospital integrated with GWMH?

Group C Report:

- What is military ethos? Safe haven
  Staff accommodation
  Patient accommodation (hostel)
  Defence Medical College
- What about Gosport? Casemix and critical mass inadequate
  GPs want to retain current level of service
  Scope for GWMH and RHH to work more closely together, using model of radiology
- Single site DGH offers casemix and critical mass for training and experience, but where does this leave military and Gosport? Community hospitals need to vary to meet local requirements.

Further issues emerged in discussion following the report back from the three groups:

- There would be a considerable cost attached to transferring the identified elements of 'military ethos' from Haslar to another DGH site.
- DSCA participants need to feel that clinical collaboration involves an equal partnership, and that both MoD and the NHS have learnt lessons from the experiences in the MDHUs.
- General Medicine has made sufficient progress in clinical discussions to feel comfortable to relocate all emergency services to QAH and to use RHH for 'cold' cases. The surgical specialties are not of the same view, and change cannot happen piecemeal.
- The Portsmouth area could support 14 orthopaedic surgeons and there are 7 at Haslar and 6 in PHT which comes close to the target. The orthopaedic SAC would, however, be unlikely to allow 7 Specialist Registrar posts to continue. The MoD wants to keep their training base in this Specialty and not to merge just for administrative convenience. Service training is better integrated and supervised than is usually the case in the NHS. CEPOD comments do not apply where MoD can afford higher levels of junior staff supervision, but were under threat in the MDHUs.
- This example points the way to the development of a consultant based service where collaboration could reduce costs overall, but at the same time dilute MoD standards.
- There is clear scope for one health organisation in Portsmouth (?with a DSCA lead in the management of acute services) but also a strong feeling that A&E and ITU should be retained at Haslar until there is adequate investment to enable everything to be achieved on a single site.

At the end of the morning, there were some clear common concerns (military ethos, the needs of the Gosport population), some shared views on the advantages of collaboration, but no clear model for analysis in the groups in relation to applicability for emergency services, elective services and outpatient, diagnostic and community services. Code A suggested that the groups should reconvene and try and look for a model from the bottom up, looking at the needs of different specialties and these different categories of service - while continuing to consider the aims and principles involved.

5 What can we achieve?

In the afternoon, the groups reported back in reverse order.

Group C Report:

- The End-point: it's too soon to see the vision
  each organisation needs to draw up criteria to test the model
- But there are seemingly irresistible pressures leading to
  collaboration/collegiate working/integration
- Portsmouth has legitimate aspirations to develop acute services towards a single site
- The Services need to retain Haslar as a concept
- The requirements now are to:
  develop greater clarity about the role of the military
  develop interim schemes which are robust
  understand the balance between Service and civilian workload in each specialty and the potential scope/pace of change
  develop plans which go beyond current models of care - the approach to healthcare provision and the DGH are changing fast, with new technologies such as telemedicine
- Use this to plan for the way forward:
  there is a green light for clinical collaboration
  build around individual clinical services
  recognise the A&E needs of the Gosport peninsula
  aggregate up from this to a future vision

Group B Report:

- Emergency Services need to be:
  consultant led
  offer high dependency care
  be multi specialty (what about neuro and burns/plastics?)
  be accessible (geographically and timely)
  based on one major unit supported by minor injuries centres
  provided with good diagnostic support/coronary care
- Elective Services involve:
  some clinically high dependency work with high tech backup
  some suitable for day case/outpatient management, +
  need to differentiate on the basis of individual patient risk
  recognise high cost of capital investment (avoid duplication)
  volume of activity to ensure reasonable expertise
  provision for co-location of linked specialties
- Low Dependency Services cover:
  day care - outpatients - physio/OT/rehab.
  pharmacy/alternative therapies
  chronic maintenance - direct access
  community inpatient and respite care
- Military requirements - how would these be met (Role 4)?
  both high and low dependency
  military fast tracking option
  nuclear/biological casualties
- WHERE? High Dependency?
  Low Dependency?

- Ideally Single site 'high dependency' unit - QAH most accessible site for whole population served
  (But not a short term option - this is at least 7 years away)
  Plus multiple low dependency units

- Interim
  - Partnership approach
  - Use what already exists effectively now (equipment etc.)
  - Joint appointments - clinical, managerial and IT
  - Haslar appointment to PHT Board?
  - IT links
  - Standardise procedures and processes
  - Joint training links (e.g. medical staff)
- Formalise what is already happening
- Go for incremental joint development

Group A Report:

- Develop the interim model which would take a great deal of planning and selling but which would lead towards the final model (single site). This could involve:
- Fully co-ordinate some services now:
  - Out patients
  - Diagnostic services
  - Day cases
  - IT/management of patient services
- Acute Emergency Services: all on QAH site with training posts, military admin cell, aeromed evacuation facility etc.
- Royal Hospital Haslar:
  - Major elective medical and surgical work
  - HDU - able to ventilate short-term
  - Physician presence
  - Acute opinion service
- Appropriate emergency services for the Gosport peninsula, not GP dependent
- Implications to be worked through:
  - Combined training recognition
  - Two-site working
  - Appropriate ambulance protocols
  - Provision for elderly care
  - Nursing services
- Take account of other partnerships with Southampton, Isle of Wight and Chichester (and ? Salisbury for burns/plastics)

6 Where do we go from here?

The progress made by all groups during the afternoon was warmly welcomed and felt to provide a basis for successful clinical collaboration in Portsmouth in the future. All groups had recognised that there has to be change in patterns of service delivery and working relationships. The status quo is not an option. Collaborative/collegiate working is now a must for both the NHS and the DSCA, and it involves looking more widely than just the organisations so far involved in the Clinical Collaboration Project, or indeed in Portsmouth. There is no easy quick fix. The work needs to be done specialty by specialty, bottom up. Progress needs to be made jointly and needs to be organised to ensure that progress in one specialty does not de-stabilise working arrangements in another to the detriment of patients or training objectives.

Next steps arising from the conference discussions were then identified:

- Review for overlap and scope for rationalisation of all organisational:
  - Capital Assets
  - Investment plans
  - Business Plans
- Progress co-ordination of IT and patient records - including links to primary care

- Undertake shared analysis of current training posts and future training requirements
- Test capacity of QAH to function as a single site DGH meeting all NHS and MoD needs
- Agree definition of military ethos requirements (Service overhead) and training requirements
- Progress collaboration specialty by specialty, building from rationalisation of OPD services, leave cover etc. ?Merge clinical directorates
- Arrange exchange of honorary contracts to facilitate this
- Share post-graduate education, clinical audit etc.
- Develop shared processes and structures for strategic development - including clinical protocols - to develop vision of what shared service will look like in five years time
- Review A&E and other direct access emergency services to meet the needs of the Portsmouth area and the Gosport peninsula
- Assess impact of change on services for elderly patients with multiple pathologies, so that this key area of service demand is not missed ?managed more effectively

7 Managing Change

All present recognised that the many excellent ideas which had emerged from the conference represented a challenging change agenda for both the NHS and the DSCA in Portsmouth. This change would need to be managed and arrangements would need to be more inclusive, co-ordinated and robust than the current Project structure. Key actions to achieve this were felt to be:

- Establish communication and consultation arrangements to keep all interested parties involved and aware of planned change, including staff
- Report all initiatives and progress on identified work up to the Clinical Collaboration Project Board, through the Project Manager (Shirley Hardy) or the Project Lead in Portsmouth Hospitals NHS Trust (Sarah Smart) - next Board Meetings scheduled for 24/25 November 1997 and 12 January 1998
- Enlarge the Board to include all interest groups represented at the Conference, i.e. bring in Portsmouth Healthcare NHS Trust, GPs, Royal Defence Medical College and the Isle of Wight.
- Recognise the need to begin negotiations with the SACs and to carry them on changes which involve medical training
- Produce a summary of the present position on collaboration as a starting point and a Joint Statement of Intent as a result of the Conference to provide a framework for future work
- Progress iteratively with the DSCA Review which is on-going
- Assign individual responsibility for all agreed service and process objectives and timescales for action/report.

Finally, all present were thanked for their contribution to the success of the day, asked to build on the relationships and communication across organisational boundaries which had been established, and to continue to focus on the Joint Aims set out at the beginning of the day. The issues identified in paragraphs 6 & 7 would be taken forward by the Project Board.

Shirley J Hardy — 5 November 1997