NHE000415-0001

Portsmouth and
South East Hampshire
Health Authority

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22 September 1999

Ms Penny Humphris
Chief Executive
Portsmouth and SE Hants Health Authority
Finchdean House
Milton Road
Portsmouth PO3 6DP

Penny - copy of letter for info. Clare.

Dear

PORTSMOUTH PARTNERSHIP BOARD MEETING: 30 SEPTEMBER 1999

I enclose the agenda and papers for next week's meeting of the Partnership Board which will take place in the Large Conference Room at Finchdean House, starting at 1.30pm. Lunch will be available before the meeting from 1pm.

I look forward to meeting you then.

Clare Moriarty
Project Manager

Enc

Distribution to:
Penny Humphris, Chief Executive, Portsmouth & SE Hants HA
Dr Jane Barton, Chair, Gosport PCG
John Kirtley, Chief Executive, Gosport PCG
Major General Chris Callow, Chief Executive, DSCA
Maggie Somekh, Director of Corporate Development, DSCA
Dick Bishop, Chief Executive, Portsmouth Hospitals NHS Trust
Sarah Smart, Director Strategic Alliances, Portsmouth Hospitals NHS Trust
Brigadier Guy Ratcliffe, Commanding Officer, Royal Hospital Haslar
Surgeon Commander Rodney Taylor, Medical Director, Royal Hospital Haslar
Air Commodore David Rainford, Dean, Royal Defence Medical College
Max Millett, Chief Executive, Portsmouth Healthcare NHS Trust
Dr Graham Winyard CBE, Regional Post-graduate Dean, Wessex Deanery

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

PORTSMOUTH PARTNERSHIP BOARD

Meeting to be held on Thursday 30 September 1999 at 1:30pm in the Large Conference Room, Finchdean House

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AGENDA

1. **Apologies and welcome**
2. **Notes of last meeting held on 6 July 1999** — Attachment 1
3. **Matters arising**
4. **Update:**
   - 4.1 **report from DSCA on CDM and MDHU position**
   - 4.2 **report from HA on public consultation and next steps** — Attachment 2
   - 4.3 **progress report on PHT PFI**
5. **Integration of clinical specialties:**
   - 5.1 **report** Impact of ITU closure. — Attachment 3
   - 5.2 **proposed project plan** — Attachment 4
6. **A&E changes:**
   - 6.1 **notes of meeting** — Attachment 5
   - 6.2 **project plan** — Attachment 6
   - 6.3 **communications**
7. **Any other business**
8. **Dates for future meetings**

Circulation List
Penny Humphris, Chief Executive, Portsmouth & SE Hants HA
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ATTACHMENT 1

Portsmouth & S E Hampshire Health Authority & Gosport PCG
Defence Secondary Care Agency & Royal Hospital Haslar
Portsmouth Hospitals NHS Trust
Portsmouth Healthcare NHS Trust
Royal Defence Medical College

PORTSMOUTH PARTNERSHIP BOARD

Notes of the Meeting held 6 July 1999 at Royal Hospital Haslar

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Present:	Major General Chris Callow	Chairman
	Dr Jane Barton	
	Dick Bishop (up to item 5.2)	
	Stephen Campion	
	Col Kathy George for MD RHH	
	Shirley Hardy	
	Tony Horne for CE PHCT	
	Penny Humphris (up to item 5.2)	
	John Kirtley	
	Brigadier Guy Ratcliffe	
	Sarah Smart	
	Maggie Somekh	
	Dr Graham Winyard	
Observers:	Air Commodore Warwick Pike	
	Mike Blackwell	
Apologies:	Max Millett	
	Air Commodore David Rainford	
	Surgeon Commander Rodney Taylor	

No	Discussion	Action

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1 NOTES OF LAST MEETING

The notes of the last meeting of the Partnership Board, held 24 May 1999, were confirmed.

2 MDHU CONTRACT

Kevin Green, AD FIN DSCA HQ made a presentation about the new standard form of MDHU contract. This provides for two agreements, one covering the employment of DMS staff within the Trust (The Host Agreement), and one covering the treatment of Service personnel within the Trust (The Treatment Agreement) and is based on a direct financial relationship between the DSCA and the Trust and the elimination of the 'Free Good'. This standard format should be applicable to the Portsmouth MDHU and proposals are being developed for the necessary PES transfer to remove the P&SE Hants HA Free Good from April 2001

3 COMMUNICATIONS AND REPORTS

2.1 MoD/NHS Finance Meeting – 5 July 1999
A meeting to look at these funding issues, including the Memorandum of Agreement for the PES transfer, had been held on 5 July. The intention is to link the transfer to a virtual MDHU contract which takes account of the continued MoD funded infrastructure available to PHT at Haslar. The more immediate funding issues related to interim

arrangements should be dealt with by the Integration Project Finance & Contracts Working Group, which would be meeting for the first time on 21 July. Dr Winyard pointed out that discussions to date had not looked at the full implications of the funding treatment of junior hospital doctors. If the Host Agreement made a 50% charge to the Trust for their service contribution, Trusts with an MDHU were being placed at a disadvantage as compared to other Trusts who got Service juniors free on rotations. There could also be a shortfall in NHS Deanery funding for the education component if Service doctors were withdrawn. Maggie Somekh suggested that this was unlikely as Service training numbers would need to increase, but it was agreed that these issues needed to be considered further.

2.2 **SG/DSCA/NHSE Meeting – 24 June 1999**
This meeting at Eastbourne Terrace had been set up to get high level MoD/NHSE agreement to the prinicples of joint management to support the Portsmouth MDHU project. A high degree of commitment had been achieved although there is still a need for greater clarification around the size of the MDHU and the development of the CDM. Maggie Somekh said that she had been tasked with the preparation of the two initial briefs for SG by the end of July and it was agreed that there would be time to develop this in parallel with the HA consultation on Gosport services and the Trust work on the PFI business case.

2.3 **House of Commons Defence Select Committee**
This Committee is continuing to hear evidence in relation to the Defence Medical Services and looking at both the future of RH Haslar and the development of the CDM. The questions were searching, but the Committee included a well informed membership which should lead to an interesting report – due September.

2.4 **Meeting with Gosport Borough Council and the Task Force – 1 July 1999**
This meeting with Gosport Councillors and Task Force members had included some difficult exchanges and concern about the presence of a Portsmouth News reporter as a member of the Task Force at a private meeting. The discussion had established the principle of dialogue, and plans are being made for a workshop in November to get experts to work through specific issues around the possible models for accident and emergency and ambulance services. Members of the Task Force had agreed to take part together with other stakeholders. The discussion at the meeting had covered the DSCA concerns about patient volumes and casemix for training, the likely Trust PFI timetable and the requirement for the RHH site beyond 2002, linked to reconfiguration of patient services.

2.5 **Communications meeting – 17 June 1999**
A meeting of communication managers/leads from the various partnership organisations had taken place on 17 June and agreed to continue meeting to coordinate project communications under the leadership of Sue Galley from the HA. Mike Blackwell, DSCA, suggested that a staff briefing should be put out following each Board meeting and this was agreed.

3 TRUST PFI AND DSCA MDHU REQUIREMENT

Dick Bishop said that the PFI announcement was expected during July and the Trust would then wait for both the MDHU requirement and the initial direction from HA consultation to produce a revised Business Case for the project. The Trust was likely to be given a tight timetable with a requirement to go to OJEC advertisement early in 2000. Penny Humphris said that the Health Authority hoped to produce a final consultation document in late 1999/early 2000 which would be broadly acceptable to the local population.

General Callow said that he recognised the need to end uncertainty around the MDHU specification for both the Trust and the DSCA staff and Maggie Somkh confirmed that she was holding meetings with many specialties to Haslar to try and confirm the best split between MDHU and CDM services. Meetings on imaging, pathology, burns and plastics and hyperbaric medicine are already programmed as this information will be required by the 7 Trusts selected to bid for the CDM. These are: Lothian, Newcastle, Leeds, Birmingham, Oxford, Bristol North and Guy's/St Thomas'. Progress was also being made on the Portsmouth MDHU accommodation requirement and it appeared likely that this would be too big for parenting and that military messing accommodation would need to form part of the PFI.

Work is also progressing on the manpower plan in conjunction with SG's office to get better information on both staff entering training and the potential placement of staff completing training to inform the work on MDHU and CDM staffing. Maggie Somekh confirmed that she hoped to have the first draft of this work with SG by the end of July and available for consultation with Defence Consultant Advisors. Dr Winyard suggested that the work on junior medical staffing needed to be linked to the national SWAG, which he chaired, and that the information on excess and shortage specialties might help the DMS to develop more flexible recruitment. It was agreed that a meeting involving the two Deans, General Callow and Lilleywhite should be arranged to progress medical staffing issues including the expansion of DMS posts and associated funding issues. There were also wider MoD personnel issues, including pension arrangements, which currently limit flexibility in DMS employment.

4 JOINT MANAGEMENT ARRANGEMENTS

There had been a combined meeting of the PHT and RHH Executive teams on 28 June to consider the development of closer working relationships leading to joint management arrangements. A further meeting had been arranged for 28 July. They had developed seven principles which they hoped to put to the Board as the basis for interim management. Brigadier Ratcliffe said that his team was still unclear as to what joint management would mean for Haslar and has requested a further meeting on 9 July at which SG and DSCA represenatatives could be present together with Dick Bishop and Sarah Smart for PHT. Dick Bishop said that the open discussion between both teams had been the strength of the first meeting and that he did not want to continue discussions unless his whole operational team could be present.

After discussion, it was agreed that the 9 July meeting should go ahead for MoD organisations to ensure that RHH would be supported in any agreements on joint management arrangements and that the principles could then be confirmed for 28 July.

5 RISK ASSESSMENT AND CONTINGENCY PLANNING

5.1 Children's Services

Although planning is continuing for the closure of ward D6 at Haslar from 31 July, there are still a number of outstanding issues to be resolved:

- Location of children's out-patients currently run at Haslar and links with community paediatrics in PHCT – a meeting to deal with these is booked for 9 July – Gosport PCG to be invited.

- Arrangements for children's plastic surgery currently undertaked at Haslar as a sub-set of the Odstock contract. A meeting to consider this with the HA is being set up as soon as possible. All other surgical specialties which required access to theatre time at QAH have been offered this and provision for children's general surgery has been offered to both the CD at SGH and Prof Barker, and should be actioned directly with colleagues in the Trust.

- The four civilian RSCNs at RHH have been given until 12 July to indicate whether they wish to be seconded to 'suitable alternative employment' in the Trust or to resign and the two Service RSCNs were also considering their career options, which would probably lie outside children's services. They were not trained for A&E work which was the main requirement identified by PHT to take on the service. Sarah Smart said that the Trust would welcome all transfers and would appreciate help from the military nurses even if this was on a short term basis to allow time for Trust recruitment.

- The transfer of funding was linked to the staffing issue, but the Trust requirement was for either the six staff available and required or the funding for PHT recruitment to replace this. Maggie Somekh pointed out that the funding issues around interim service transfers had not been resolved – beyond an undertaking to support the marginal costs of any service change - and the Trust needed to plan only for developments which would be affordable after 2001 in the context of the PES transfer and MDHU contract. This was accepted, as was the requirement to manage some start up and double running costs in the interim and it was agreed that these issues should be resolved by the Finance and Contracts Working Group on 21 July.

- Agreement on the protocols and public communications to support the change in children's A&E services at RHH from 1 August. Brig Ratcliffe said that he had draft protocols for the department based on transfer of medical cases to SMH, general surgical cases to SGH and A&E, ITU and other surgical cases to QAH. It was estimated that this would increase the requirement for ambulance service transfers by some 20 cases per week. A draft wording for communication with GPs and the public in Gosport is also available and could help to reduce the number of inappropriate self-referrals to the department after the ward closes. John Kirtley was asked to follow this up with Brig Ratcliffe and Sue Galley to ensure that the communication was clear and effective and it was agreed that the service should be carefully audited and monitored over the first few months to see what more needed to be done.

5.2 Accident and Emergency

Agreement has been reached with the Single Services in relation to GPVT SHO appointments to the Haslar A&E for August 1999 and February 2000 but the experience was not considered suitable for surgical SHOs and there were great reservations about this arrangement continuing for more than 12 months after children's work transferred, further reducing patient numbers. Although all parties would wish to sustain this service to the local population into 2001, there was a real risk that staff could not be found and a need to plan and recruit now for an alternative MATS service. Dr Winyard agreed that it would be wise to assume that the service could not use doctors in training beyond August 2000 and the current standards and requirements would need to form part of the HA workshop with local stakeholders and the public made aware of the problems being faced and the need to plan for an alternative service. Col George confirmed that there would continue to be a senior A&E trained nurse manager at Haslar after the posting of the current nurse manager.

5.3 ITU and Anaesthetics

Discussions had continued on the best approach to the management of SHO and consultant staffing shortages in ITU and anaesthetic services at RHH. These had initially considered the transfer of medical and management responsibility for the unit to PHT but it did not appear to be feasible for the Trust to recruit the necessary civilian medical staff to support this from 9 August when the RHH staffing shortfall would bite. The current proposal was therefore the transfer of 2 ITU beds to QAH and the use of the unit at RHH for 2/3 military staffed HDU beds. This would be in line with the current use of the 4 bed unit at Haslar which takes mainly HDU patients from the hospital and ITU cases which are transferred in. The integration would include one RHH consultant, rotational

arrangements for nursing staff and opportunities for new junior medical posts which could be filled by Service as well as NHS trainees.

ITU would form the main item for discussion at the Clinical Integration Working Group meeting that afternoon, with relevant clinicians present, and the Board was advised to accept their recommendation of the most viable option for immediate implementation, given the short period of time before Service staffing shortfalls would in any case force the closure of the Haslar unit with loss of ITU capacity for the local population. The Board accepted this and asked PHT and the Trust to develop new protocols for integrated working as quickly as possible. Brig Ratcliffe expressed concern that the Trust HoD was only prepared to take on one of the DSCA consultants, but was advised that this was because the other two consultants were not trained to undertake paediatric intensive care – which formed part of the PHT, but not the RHH caseload – and it was agreed that this would also be examined further at the Working Group meeting. The decision of the meeting would also need to be jointly agreed and communicated, as for A&E.

The shortfall on anaesthetic staffing is due to be considered at a meeting on 8 July, in the light of the decision on ITU and the impact of that on DSCA staff availability.

5.4 Trauma and Orthopaedics

There appeared to be some continuing lack of clarity on the actual Service consultant numbers that might be at RHH by the end of the year. The number appeared to be 2/3, although the CD – Trauma had indicated that there might be others accrediting who could be directed to Haslar.. An early meeting would be arranged to progress planning for this specialty.

6 PARTNERSHIP PROJECT DIARY AND DATES FOR FUTURE MEETINGS

The Partnership diary was received for information and Shirley Hardy asked for any new dates to be supplied to her.

The date for the next two meetings were revised as follos:

Thursday 30 September from 1.30 pm at Finchdean House

Monday 1 November at 12.30 pm at RH Haslar

SJH/7/7/1999

ATTACHMENT 2

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

ANALYSIS OF THE COMMENTS RECEIVED ON THE OUTLINE PROPOSALS FOR FUTURE HEALTH SERVICES FOR THE RESIDENTS OF GOSPORT AND SOUTH FAREHAM

1. INTRODUCTION

1.1. This report provides an update on the future health services provision for Gosport and south Fareham and an interim analysis of the comments on the outline proposals circulated in May 1999.

2. UPDATE ON FUTURE HEALTH SERVICES PROVISION

2.1. The Partnership Board continues to meet to oversee the various strands of work arising from The Ministry of Defence's decision to close the Royal Hospital Haslar. The Defence Secondary Care Agency (DSCA) is preparing the specification for the Ministry of Defence Hospital Unit (MDHU) to be based on the Queen Alexandra Hospital site and this will be available shortly to assist in planning future developments. Portsmouth Hospitals NHS Trust has received approval from the Minister to proceed with the Private Finance Initiative. This is primarily to enable the rationalisation of acute services from St Mary's Hospital to Queen Alexandra Hospital, but will also now include the MDHU requirement.

2.2. Inpatient paediatric services were transferred from Royal Hospital Haslar to Portsmouth Hospitals NHS Trust from 1 August 1999 and, as a consequence, seriously ill or injured children will be taken to the accident and emergency department at Queen Alexandra Hospital. Royal Hospital Haslar has advised the Health Authority that intensive care services will not be able to be provided after 31 August 1999 due to a lack of consultant staff. Consequently arrangements have been made for additional intensive care beds to be provided at Queen Alexandra Hospital and for high dependency beds to be maintained at RH Haslar. There are some other services where Royal Hospital Haslar may not be able to sustain services and discussions are taking place to ensure contingency plans are in place for this eventuality.

2.3. A meeting was held with the Save Haslar Task Force in early July to discuss the concerns about the proposed future provision of health services. The Health Authority recognised the level of public concern about ambulance services and accident and emergency services and suggested that the Task Force and Health Authority should hold a joint day to which experts would be invited to explore all possible ways of providing these services in the area. Arrangements are in hand for this to take place in October. It has also been agreed that further meetings should take place between the Task Force and Health Authority during the autumn.

2.4. Work is continuing on the development of the detailed proposals for the future provision of services, taking into account comments received in response to the outline proposals. Consideration is also being given to possible locations for the facilities to be provided in Gosport and the Health Authority has informed the Defence Secondary Care Agency of its interest in part of the Royal Hospital Haslar site. A document for formal public consultation will be prepared during the autumn and published at the end of the year with a three-month period for comment.

3. CONSULTATION ON OUTLINE PROPOSALS

3.1. The document detailing the outline proposals was published on Tuesday 25 May 1999. The purpose of the document was:

- to gather the views and opinions of the public as to their views for the future provision of health care in Gosport;
- to explain fully to the public that the decision to close the Royal Hospital Haslar had been made by the Ministry of Defence for reasons concerned with the defence medical services strategy;
- to provide accurate information regarding the existing provision of health care for residents of Gosport and south Fareham, and the services provided by the Royal Hospital Haslar;
- to explain to the public the parameters within which future health care provision in Gosport has to be planned and delivered.

3.2. The document was circulated to the following organisations and individuals:

- all members of the Gosport and south Fareham public who made contact with Portsmouth and South East Hampshire Health Authority expressing a view on the closure of Royal Hospital Haslar;
- libraries in Portsmouth and South East Hampshire;
- Gosport and Fareham GPs;
- the Secretary of State for Health;
- NHS Executive (South East Regional Office);
- MPs in Portsmouth and South East Hampshire;
- Portsmouth and South East Hampshire Community Health Council;

- Gosport Borough Council;
- Fareham Borough Council;
- Hampshire County Council;
- Portsmouth City Council;
- all other local authorities in Hampshire and the Isle of Wight;
- Gosport Voluntary Action;
- Fareham Council for Community Services;
- Portsmouth Council for Community Services;
- Portsmouth HealthCare NHS Trust;
- Portsmouth Hospitals NHS Trust;
- Hampshire Ambulance Services NHS Trust;
- Southampton University Hospitals NHS Trust;
- Royal Hospital Haslar;
- media covering the Hampshire area and specialist health publications;
- Southampton & South West Hampshire Health Authority;
- Isle of Wight Health Authority;
- West Sussex Health Authority;
- Local Medical Committee;
- Local Pharmaceutical Committee;
- Local Dental Committee;
- Local Optometrist Committee.

3.3. In addition, the summer edition of HealthCheck, a free newspaper produced by Portsmouth and South East Hampshire Health Authority and distributed to all homes in the district, contained a summary of the outline proposals. The document was also available on the Health Authority web site.

4. PUBLICISATION OF OUTLINE PROPOSALS

4.1. The opportunity to comment on the outline proposals has been publicised widely, not only in the outline proposal document itself and the summer edition of HealthCheck, but also in the Portsmouth 'News' on five occasions. In addition, the 'Save Haslar Taskforce' has encouraged members of the public to contact the Health Authority to register their views on the closure of the Royal Hospital Haslar. The telephone 'Comment Line', e-mail address and postal address have all been well promoted as ways of submitting views and comments on the outline proposals.

4.2. The opportunity to submit comments on the outline proposals commenced on 25 May 1999 and will conclude on 31 August 1999. The Health Authority will then use these comments and views to consider further ways of providing health services locally and to prepare detailed proposals, including the consideration of location, facilities and costs. Formal consultation on these detailed proposals will be undertaken in late 1999/early 2000, led by Portsmouth and South East Hampshire Community Health Council.

5. ANALYSIS OF COMMENTS

5.1. As at 24 August 1999, Portsmouth and South East Hampshire Health Authority had received a total of 6,539 separate items of correspondence or calls relating to the outline proposals or the closure of the Royal Hospital Haslar. These comprised:

- 4,784 signatures from residents of Gosport and south Fareham asking that the Royal Hospital Haslar be retained as a tri-service hospital and as a hospital serving the local community;
- 1603 letters, of which 63 were from organisations and 1540 were from members of the public;
- 143 telephone calls;
- 7 e-mails;
- 2 faxes.

5.2. In addition, the Health Authority has recently received approximately 12,000 signed slips, collected by Gosport Borough Council, objecting to the Health Authority's proposals for future health services in Gosport and south Fareham on the following grounds:

- comprehensive accident and emergency facilities should be provided in line with the statement made by the Secretary of State for Health;
- the proposals do not take account of the inaccessibility of QA hospital to the residents of Gosport and Fareham;
- the proposals do not take account of the road infrastructure problems which could result in the needless loss of life;
- the proposals will result in longer waiting lists and will place an increased burden on the already over-stretched Portsmouth hospitals.

5.3. Analysis of the additional comments contained within these slips will be undertaken in the near future.

5.4. Excluding these 12,000 slips, there have been 3,719 specific comments made on the proposed closure of the Royal Hospital Haslar and the outline proposals for future health services for the residents of Gosport and south Fareham. An analysis of these is set out in Table 1 and graphically displayed in Chart 1, below.

5.5. The key issues arising from this analysis are:

- over 99% of all the comments made expressed dissatisfaction over the Ministry of Defence's decision to close the Royal Hospital Haslar. 19% of comments were critical of specific issues in the Health Authority's proposals for the reprovision of health services following the closure of the Royal Hospital Haslar;

- nearly 60% of all of the comments identified the transport problems between Gosport and Queen Alexandra Hospital in Cosham, with the congestion of the A32 between Gosport and the M27, and the difficulty in reaching Queen Alexandra Hospital in an emergency, raising the greatest concern;

- the second greatest concern was the distance that outpatients and visitors from Gosport would have to travel to get to Queen Alexandra Hospital. Poor public transport links, the cost of travel and difficulties in parking at Queen Alexandra Hospital also featured prominently;

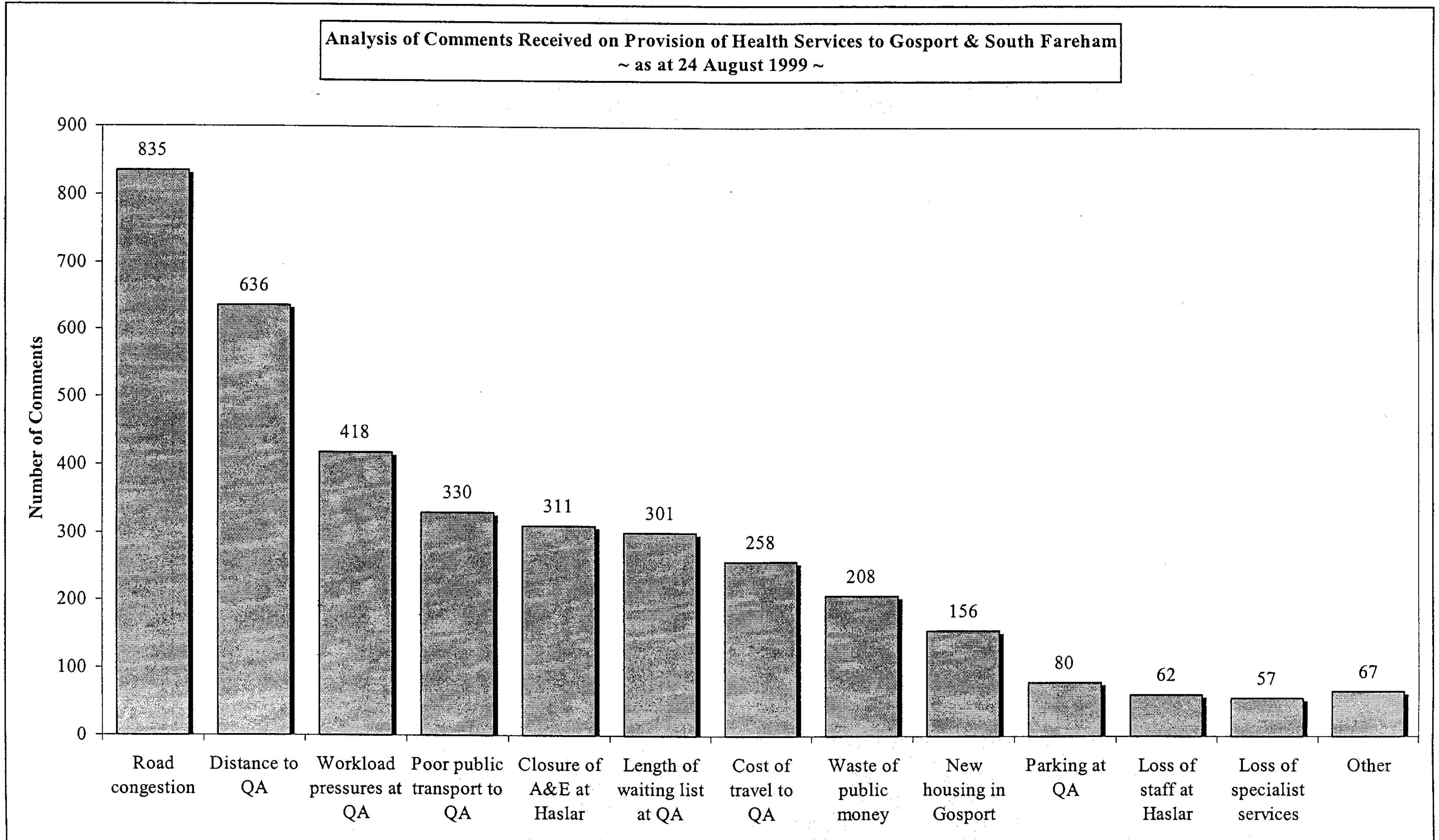
- 8% of people submitting comments expressed their dissatisfaction with the proposed closure of the accident and emergency unit at the Royal Hospital Haslar and 0.4% expressed dissatisfaction with the proposed future model of accident and emergency care;

- the staffing shortages, winter workload pressures, waiting lists and MRSA infection at Queen Alexandra Hospital that have been reported in the media recently led to a number of people expressing their concern about the ability of Portsmouth Hospitals NHS Trust to cope with the additional workload brought about by the closure of the Royal Hospital Haslar.

Table 1: An Analysis of the Comments on the Outline Proposals for Future Health Services for the Residents of Gosport and South Fareham

Comment	Number of comments	Percentage of total comments
The congestion of the road out of Gosport	835	22%
Distance to Queen Alexandra Hospital for outpatients and visitors	636	17%
Workload pressures at Queen Alexandra Hospital	418	11%
Poor public transport between Gosport and Queen Alexandra Hospital	330	9%
Closure of the A&E unit at Royal Hospital Haslar	311	8%
Length of the waiting list at Queen Alexandra Hospital	301	8%
Cost of travel between Gosport and Queen Alexandra Hospital	258	7%
Waste of public money in closing Royal Hospital Haslar	208	6%
Increased Gosport population caused by the new housing development	156	4%
Parking at Queen Alexandra Hospital	80	2%
Loss of clinical staff at Royal Hospital Haslar	62	2%
Loss of specialist services at Royal Hospital Haslar (e.g. hyperbaric oxygen)	57	1.5%
Need for an A&E helicopter retrieval service	34	0.9%
Discontent with the satellite A&E proposals	14	0.4%
Closure of paediatrics at Royal Hospital Haslar	11	0.3%
Inadequacy of proposals to develop telemedicine at Royal Hospital Haslar	3	0.1%
Threat to intensive care services at Royal Hospital Haslar	2	0.05%
The impact of Kosovo on Royal Hospital Haslar	2	0.05%
Threat to cardiology services at Royal Hospital Haslar	1	0.03%
Total	**3719**	

Chart 1: Analysis of Comments on the Outline Proposals for Future Health Services for the Residents of Gosport and South Fareham



P. P. Board 30 Sept.

MDHO Spec on way ; contains patient nos.
Manpower plan

Late

I.T.U. Problems : joint management problematic
Rodney : issues not appreciated at time have emerged

- cannot provide previous level of gen. surg. limited to minor & some intermediate
- problem over retrieval arrangements : no capacity
- reduction in on-call anaesthetics to 1 cons /1 SHO
- because P'mouth ITU full problem for planned cases : 7 patients waiting
- cannot deal with major trauma
- hyperbaric now Grade 2 - (was Grade 1) because no local team (cannot sustain people in resus)
- can't take medevacs who need ITU
- issue for medicine
- anaesthetic support
- effect on w. lists as only selected cases
- effect on content of training posts

? 4 patients through 2 beds in 1 night

NHE000415-0016

ATTACHMENT 3

RESTRICTED-MANAGEMENT

UPDATE OF CLINICAL SPECIALTIES –14 SEPTEMBER 1999

D/DSCA/13/9/4/14

Haslar Partnership Board file

Your copy

Speciality	Date of last meeting	Position statement and action plan
Oral Surgery	21/7/99	Currently joi[n] department a[…] management […] of junior staf[f] […] (proposed). **Actions:-** 1. 2 day cas[…] 1 out hrs) 2. 3 in patie[…] free in pa[…] 3. 6 in-patie[…] 4. Release o[…] i.e. Gene[…] 5. Surg Cap[…] day cases […] from Aug […]
Orthopaedics	9/8/99	Work commenced on looking at possibility of joint management of waiting lists Minimum of 2 Mil consultants to be retained at RHH plus 2 civilian consultants. Locums required until new consultants accredit in Mid 2000. Essential to maintain A&E cover and Aeromed cover, contain rising waiting lists. Reduced registrar cover from 4 to 1 in Sept then none from December. Only by increasing Consultants by at least one can we sustain 2 registrars in New Year. **Actions:-** 1. SG(D Med PT & Pol) DP&S and CA to meet to discuss reduce the operational commitments of consultants early **September.** 2. PHT to recruit 2 consultants on fix term contracts until mid 2000. 3. Joint management of waiting lists to commence as soon as possible recognising that it will require the full IT link to be operational before they can be totally merged. Service waiting lists will be kept separate for the moment, but running parallel with the joint management of civilian waiting lists. 4. Operating theatre statistics will be shared by both hospitals in order to ensure the best use of theatre resources. **Action: Specialty Director Orthopaedics and Associate Clinical Director Orthopaedics**

ATTACHMENT 3

RESTRICTED-MANAGEMENT

UPDATE OF CLINICAL SPECIALTIES –14 SEPTEMBER 1999

D/DSCA/13/9/4/14

Speciality	Date of last meeting	Position statement and action plan
Oral Surgery	21/7/99	Currently joint on call rota. Proposal for integrated department agreed under management of PHT with local management remaining at RHH. Shared on-call Integration of junior staff across two sites. All in-patients at QA (proposed). **Actions:-** 1. 2 day case lists to transfer to RHH from PHT. (1 in hrs 1 out hrs). Confirm can be absorbed into existing lists. 2. 3 in patient lists to transfer from RHH to PHT creates 3 free in patient theatre lists at RHH. 3. 6 in-patient beds required at QA + 3 theatre slots. 4. Release of beds and theatres at RHH releases space for i.e. General Surgery. 5. Surg Capt Holland to investigate ability to do 5 extra day cases a week as part of waiting-list requirements from August with new SpR. Action Stephen Campion
Orthopaedics	9/8/99	Work commenced on looking at possibility of joint management of waiting lists Minimum of 2 Mil consultants to be retained at RHH plus 2 civilian consultants. Locums required until new consultants accredit in Mid 2000. Essential to maintain A&E cover and Aeromed cover, contain rising waiting lists. Reduced registrar cover from 4 to 1 in Sept then none from December. Only by increasing Consultants by at least one can we sustain 2 registrars in New Year. **Actions:-** 1. SG(D Med PT & Pol) DP&S and CA to meet to discuss reduce the operational commitments of consultants early **September.** 2. PHT to recruit 2 consultants on fix term contracts until mid 2000. 3. Joint management of waiting lists to commence as soon as possible recognising that it will require the full IT link to be operational before they can be totally merged. Service waiting lists will be kept separate for the moment, but running parallel with the joint management of civilian waiting lists. 4. Operating theatre statistics will be shared by both hospitals in order to ensure the best use of theatre resources. **Action: Specialty Director Orthopaedics and Associate Clinical Director Orthopaedics**

		5. Ward Day Surgery, Anaesthetic and HSDU capacity. Figures are also required to support the integrated orthopaedic service. **Action: Specialty Director Orthopaedics and Associate Clinical Director Orthopaedics and Wing Cdr R Lenoir, Consultant Adviser Anaesthetics** 6. Orthopaedic equipment. Use of existing DSCA equipment in the MDHU will be clarified and where appropriate incorporated into the MDHU contract. **Action: AD/Fin** 7. Integration of professional structures will require transitional arrangements to be discussed with the two teams. **Action: Specialty Director Orthopaedics and Associate Clinical Director Orthopaedics** 8. Clinical Heads of Service. Agreement needs to be reached on clinical leadership in the integrated organisation and how that is decided. **Action: Specialty Director Orthopaedics and Associate Clinical Director Orthopaedics** 9. Meeting to be arranged before the end of September to bring together the outcomes of the various discussions outlined above between the two Heads of Department. **Action: DCD and Sarah Smart** 10. **VO to investigate training issues**, when clinical configuration agreed.
General Surgery		**General:** Suggest PRHO and SHO posts to rotate between QA and RHH to maintain training at both sites? commence Aug 2000 or possibly Feb 2000. Suggestion from Sarah Smart at recent meeting that medium term aim could be to centralise inpatient Surgery to two sites QA and RHH prior to eventual amalgamation on single site. Waiting to understand RHH intention with regard to SHOs ? rotate through PHRT or not. **VO to contact PB.** Awaiting combined PRHO rotation from GS and MW, to then be taken to Dean. Needed to ensure input to Soton matching system, finalised 5.10.99? will RHH reinstate posts that have disappeared. (PRHO rotation complicated by including Urology on this site and Ortho on RHH site.) **Breast Surgery:** Discussions have taken place to provide support to the single breast surgeon at RHH (Professor Barker) by a surgeon from QA; possibly Mr Weaver or possibly the new breast appointee to ensure continuity of the open access breast clinic. This would also require an operating list to be made available to that surgeon to support patients seen in that clinic – possible one vacated by oral surgery and SHO support from RHH.

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		Vascular Surgery: With the loss of ITU the most major cases will have to be performed at QA. One RHH surgeon (WgCdr Whitbread(may transfer to QA. Lists at RHH – Monday all day – would then be backfilled by QA surgeons – no definite names as yet. **Colorectal Surgery:** Overall strategy to centralise colorectal malignancy at QA. RHH colorectal surgeon (SurgCdr Cripps) now planning to leave at option point (? July 2000) and relucant to move to QA in the interim. This issue now needs further discussion. ? role of LtCol Vassallo. **Upper GI/Laparoscopic Surgery:** Radical surgery for malignancy to take place at QA (as now), diagnosis staging and palliation at both sites. Potential to increase laparoscopic services at RHH as lists become available utilising short stay facilities – see below. RHH Upper GI surgeon (WgCdr Watkins) to remain based at RHH for the foreseeable future. **Acute Services:** Unresolved as yet but wish from both sides to retain as long as possible. Difficulties to be overcome include anaesthetic support and sustaining consultant rotas if some RHH consultants move to QA. Possibility of rota at RHH being supported by QA consultants who live in appropriate geographical area. **Short Stay Surgical Facilities:** Possibility of QA staffing unused ward (?F2) if theatre space available.
General Medicine	1.6.99	Medicine not dependant on continuation of 24 hr anaesthetic cover. Direct admissions could be maintained at RHH. Not appropriate to centralise admissions until RHH closes to reduce patient movements. Plan for direct geographically based GP admissions to 3 sites linked to sub-specialty specialisation on each site. Consultant cover falls below critical point in Feb 2000 when 2 consultants go. Renal and Oncology (Oncology is dealt with elsewhere in this report). Remaining 5 not adequate to maintain emergency cover because of other commitments. Gastro consultant will fledge mid 2001 then 2nd gastro and respiratory in 2002/3. 4 Naval SHOs to join August Cardiology consultant mid 2001 or 2002. Actions:- 1. Trust to appoint new consultants for RHH. Job descriptions to be prepared (Cardiac & Endocrine). 2. DP&S has given approval to posts for funding for 2

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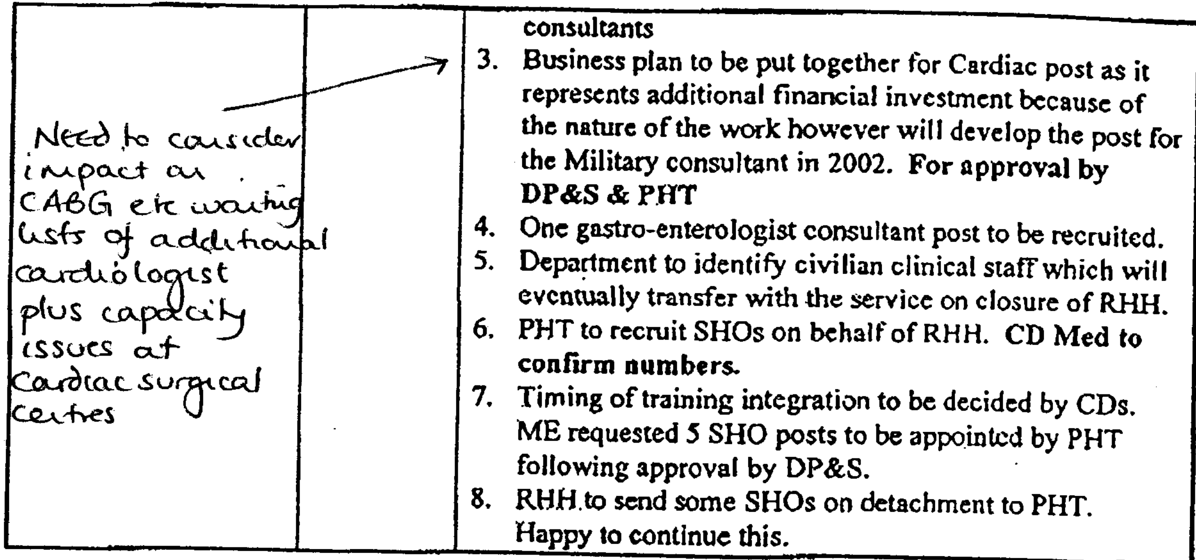

Need to consider impact on CABG etc waiting lists of additional cardiologist plus capacity issues at Cardiac surgical centres		consultants 3. Business plan to be put together for Cardiac post as it represents additional financial investment because of the nature of the work however will develop the post for the Military consultant in 2002. **For approval by DP&S & PHT** 4. One gastro-enterologist consultant post to be recruited. 5. Department to identify civilian clinical staff which will eventually transfer with the service on closure of RHH. 6. PHT to recruit SHOs on behalf of RHH. **CD Med to confirm numbers.** 7. Timing of training integration to be decided by CDs. ME requested 5 SHO posts to be appointed by PHT following approval by DP&S. 8. RHH to send some SHOs on detachment to PHT. Happy to continue this.

Oncology	Needs to be done in context of forthcoming Regional review of cancer centres but likely to be in the right direction (Review looks likely to start late 1999)	Specialities are working together with joint protocols. RHH oncologist leaving. HA/PCG plan satellite cancer services on the Gosport peninsula. Breast cancer services very stretched with single military consultant away 50% time. Some support given by Code A from PHT. Colorectal surgery also under pressure with split site working Action plan:- 1. Local chemo service and medical cover for nurse led service to be planned by PHT/RHH 2. DSCA to fund civilian consultant post appointed by PHT until April 2001. 3. Rationalisation of cancer surgery between PHT/RHH to support single Cancer Centre to be planned. Potential for expansion of breast cancer service by RHH with additional consultant resource input to be planned. 4. Colorectal surgery proposed to be centralised at QA and supported by satellite op and colonoscopy/day surgery service at RHH. 5. Integrated lung cancer service to be planned to support Medicine at RHH. See Surgery and Medicine.
Cancer Services Group Professions Allied to Medicine	11.08.99.	Group considering ways of developing an integrated and seamless service for the District. Including links to St. Richards, RHH IOW and Southampton. Issues to be considered include: Integrated care pathways, education and training, R&D, communications between services, hospitals and professional groups, IT and development implications, referral practice, recruitment and retention of staff.
Paediatrics		PHT has now taken over responsibility for Paediatric services with the closure of paediatric ward at RHH July 31st 1999. Paediatric A&E services have been downgraded to MATS from that date. Access for surgeons who wish to operate on children have been arranged at PHT facilities. 1 RSCNs and funding for 5 civilian posts agreed have been transferred to PHT. **Action plan:-** 1. Arrangements for continuation of community work by remaining Service Consultant, particularly in association with Service families to be finalised with Portsmouth Healthcare Trust by HC Haslar. 2. TUPE issues for RSCNs at RHH to be resolved. 3. Future of plastics service to be determined.
Urology		Single integrated dept. PHT moving additional DSU & clinical sessions to RHH. Military Consultant Urologist left at the end of 1998. PHT has appointed a locum civilian consultant on DSCA behalf who will be replaced by a Military consultant in 2001.
Ophthalmology	8.6.99	New eye procedures suite at QA April 2000. Increase day

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		surgery capacity. Speciality under pressure to meet targets this year. RHH have one Military consultant and one locum civilian consultant (awaiting security clearance?) plus one civilian associate specialist on a permanent contract. Work limited by available theatre time. I main theatre and a DSU theatre on Mon a.m. DSU theatre on Wed afternoon. PHT believe that the present facilities do not meet Royal College guidelines for the posts. Trust waiting list is over 1 year, RHH is 16 weeks. **Actions:-** 1. Want Mon p.m. DSU and Fri p.m. DSU need to clarify availability of staffing for theatres and wards to support this. Regular eye team to be established to work with consultants in pre-operative assessment, DSU, main theatre, ward and on follow up. 800 cases per year should be achievable in 4 DCU session and Mon a.m. sessions in main theatre. 2. Rationalisation of waiting lists to be carried out, with Dear Dr. referrals shared between GWMH and RHH clinics and waiting lists to be merged on basis of clinical priority. Clowe and Liz Warner to follow up with Stephen Campion. 3. Additional variable costs of transferred work and the scope to develop the OMA role at RHH to support this. C Lowe and Stephen Campion to action 4. Common protocol for anaesthetists to be agreed for the identification of patients suitable for day surgery 5. Next meeting 7th September QA 6. Additional detailed action plan for 2000/2001 identified in meeting notes 8 June 1999

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Imaging Nuclear Medicine Also need to determine which elements of future district service will be delivered at QAH and which in the local facility in Gosport	17.8.99	It is likely that when RHH closes the distinctive military research and academic element of imaging will move to the CDM. Until that time all services will remain at RHH. CDM arrangements will be confirmed in January 2000. Until then for planning purposes the RHH department will provide PHT with a breakdown of workload into local Service, NHS and out of district Service (roughly 45K NHS, 7K local Service, 21K out of area Service). Also a list of the rooms required to maintain the district service and the additional requirements for the out of area and distinctive work. So that the PFI bid can contain both options. Staffing requirements will also be based on these two options to enable future planning. In the interim it would be desirable if RHH could offer a session to PHT either at Gosport War Memorial or QA in return for the session that QA would like to provide to RHH in support of breast cancer work. At present this is not feasible. Interdepartmental meeting to be held early September to define the PFI output spec. RHH staff members of PHT IT procurement group. Discussions regarding best use of capital resources and future purchasing plans to be held. **Action:** **Surgeon Commander L Jarvis** Nuclear medicine department at RHH provides a district service including some specialist work for PHT. Currently taking 100 cases/month from PHT. **Actions:-** 1. Agreement must be reached regarding the future configuration of this department in relation to PHT in order to ensure the maintenance of appropriate civilian clinical posts to sustain the service in this area. There are currently two vacancies, 1 technician and 1 consultant. 2. Meeting to be held urgently to discuss this in order to progress these two appointments by PHT on behalf of RHH.
Pathology	1.7.99	It has been agreed in principal by COS/SG that pathology services will remain as they are at RHH until the closure of the hospital. At that time the district service will move to QA, but elements of training and specific military pathology are likely to move to the Centre for Defence Medicine. Final decisions about this will be taken in January. Meanwhile the department are specifying the size of laboratory facilities they will require, and this is being discussed with SG's department. Similar work of that required in imaging needs to be carried out between the pathology department at QA and RHH. **Actions:-** 1. The two departments are working on the elements of

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? Mortuary !		district service which will definitely pass to QA when RHH closes, and the likely staffing to accompany that plus an alternative plan which would include all the facilities of the department to enable this to be included as part of the PFI outputs. Manpower plan due mid-October. 2. Also meeting to discuss combined IT and joint capital planning.
ENT	28.7.99	The ENT departments are moving towards integration. On-call rotas at the weekend are currently shared 1:8. All emergencies go to QA and transfers from RHH on Sat a.m. of any cases that are not manageable over the weekend, plus all casevacs. Registrars provide cross cover, and integrated SHO package is about to start to maintain training. Consultants at RHH work at PHT doing theatre sessions/joint clinics. Action plan:- 1. Paediatric work to QA theatres from 1 August plus surgeons. 2. Wing Cdr Skipper to take over Tues a.m. op clinic from Surg Cdr Cox. 3. Surg Cdr Cox theatre sessions available from Nov to enable day-case work to transfer to RHH from QA 4. SHO post vacant from October at RHH, PHT to advertise. Waiting Dean's approval (although not strictly necessary). 5. PHT to appoint ENT consultant to replace Cox. This will either be fixed term to allow for entry of Service consultant in 2002 or permanent civilian contract if department can absorb both. To be discussed on Sept 9th at departmental meeting. 6. Locum to be appointed by PHT from Nov by PHT.
Anaesthetics	27.7.99	As of this August RHH manage 5 main theatres and 2 daycase theatres. From August this capability would reduce from anaesthetics point of view to 4 main theatres and 2 daycase theatres. In August 2000 RHH is not likely to maintain training approval in the absence of A&E and ITU and paediatrics, so would be without trainee on-call cover. RHH will be dependent on PHT for consultant on-call cover. PHT has agreed to provide consultant non-resident on-call if required. RHH Anaesthetist working at PHT to maintain his paediatric skills. **Actions:-** 1. PHT to recruit a locum anaesthetist to ensure manning of all theatres from 1.9.99 followed by a substantive appointment in November. 2. Better utilisation of theatres to be considered across RHH and QA with consideration being given to single clinical and managerial leadership of this area. 3. Anaesthetic training and consultant teams to be

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		integrated by August 2000. Code A to determine training issues. 4. Integration of the pain service with all referrals to be pooled through PHT, to be organised. 5. DSCA to consider posting C Edwards in March into the integrated department of pain medicine. 6. It is understood that there may be a requirement for a further two civilian anaesthetic posts to be recruited by Portsmouth? To be clarified. **Action:** **HC RHH and Med Director RHH**
Dermatology Surely dermatology is a service which can be delivered in the main in local settings? I would expect a significant dermatology service to continue to be delivered in the Gosport area.		Agreement to fully integrate services. A decision still requires to be made under the advice of clinical staff on which site dermatology services should be provided. The dermatology department on the RHH site is being moved to improved accommodation at RHH this year. **Actions:** 1. Move all dermatology to SMH. ? 2. Query what services may remain at RHH. **Action Plan:** Meeting to be arranged in order to clarify the options and make proposals to the Integration Project Board.

ITU	13.7.99	**Decision made to close ITU beds at RHH because:-** a. SHO training approval to be reduced to 12months from 18 months because of throughput of ventilated patients falling below 200 with 60% ventilated b. 3 SHOs short in July out of 5 (2/3 too junior) c. Of 19 consultants, 5 vacancies and 4 leaving. Need 1 ITU and 1 anaesthetist in August. Of 14 current posts, 2 are consultants nearing retirement and 2 are staff grades. d. Within above are 5/6 ITU consultants. 1 goes to Southampton August, 1 retires summer, 1 going to interview. e. For additional background see Anaesthetics f. It has not been possible to redirect work to increase throughput. g. It is high risk to rely on recruitment of locum civilians to these posts **Actions:-** 1. ITU beds at QAH to expand to 11 August 31st 1999. 2/3 HDU beds to remain at RHH long-term. 2. 1 military consultant to be integrated with the QA team. Remaining RHH consultants to gain their intensive care experience at other NHS Trusts. 3. ITU retrieval service to be reviewed by QA and where possible, extended. 4. QA to increase middle grade staffing in the expanded unit, including opportunities for the appointment of Service trainees to these posts. (Dependant on funding). 5. Maintenance of service to Hyperbaric chamber under on-going discussion. Navy wish chamber to relocate to QA asap and will negotiate direct with Trust. 6. Trust to plan ITU expansion of space over next year. 7. 14 Military nurses to be transferred to QA on 6 month rotations to staff existing and additional ITU beds. Any gapped posts to be funded by DSCA as civilians until April 2001. A number of ITU nurse posts will then be "operationally sensitive" and will continue to be funded by DSCA. A number of these nurses have indicated that they are being posted, leaving etc. This matter is currently being investigated and succession planning ensured. 8. Outstanding issue concerning the ability to appoint middle grades. Currently between the OD at PHT, DB, SS and the DSCA.
I gather DERA is also having discussions with SUHT on locating the chamber there		
A&E	9.9.99	Currently joint on-call. The A&E department at RHH ~~will~~ is expected close at the end of August 2000 for the following reasons:- a. With the closure of Paediatrics and ITU services

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		training accreditation for Anaesthetists will be likely to come under threat. b. The training accreditation of A&E SHOs will be withdrawn next August and the single services will not support their trainees going to RHH when there are superior placements elsewhere. The Wessex Regional Dean has recommended that we should not continue to rely on trainees to run the department beyond August 2000. c. The throughput of work is well below the level required by the NHS for an A&E department at around 20,000 attendances which will drop by a further 600 with the transfer of Paediatric A&E attendances after July. (recommended minimum 35,000). ? 30,000 d. The employment of civilian locums has already proved difficult and because of variable experience and competency requires levels of supervision which are not supportable with our current consultant cover. The level of clinical risk engendered by these arrangements is not believed to be tenable. e. The infrastructure at RHH will not be able to support A&E properly. **Actions:-** for the possibility of closure 1. Plan ~~to close~~ A&E department at RHH 1 August 2000. Project plan for this September 99. 2. Paediatric A&E policy requires to be agreed and distributed widely. **Action: Medical Director RHH and Consultant Adviser Orthopaedics RHH** 3. Train Nurse practitioners both Military and civilian to ~~run a Minor Accident Treatment Service~~ work in accident departments from August 2000. 4. ~~Detailed planning and public consultation to be led by Portsmouth Health Authority during October 1999. Urgent need for public awareness of this requirement for change and the reasons.~~ Event to discuss possible future models of A & E services to be run by PHA with Task Force in October 99. Subsequently, public communications will be needed. 5. All specialties now planning on the basis of this likely change shifts in configuration of services necessary between RHH and QA. 6. SHO posts to be transferred to Portsmouth Trust A&E from August 2000. Funding to be agreed by **DP&S** 7. Rationale document to be prepared by **Dr Sandy Carss** PHT to support ~~public statement to be made by Partnership Board 30 Sept~~ future communications. 8. Agreement required to transitional funding arrangements for 6 nurse practitioners and release of 3 military nurses for training. **AD/Fin** 9. Plan to stop SHO training posts at RHH from Aug 2000?. Whether any further posts will be required at QAH (currently have 2). Code A **to investigate.**
Burns & Plastics		The burns consultant at RHH is expected to leave at the end

This needs much wider consideration ~~sooner~~ before plans are developed. I think we need to look strategically at plastic services before developing new services locally.. I am not sure if this is seen as replacement for what is done now at RHH or additional work currently done elsewhere		of 99 and this together with the changes in intensive care impacting on nurse staffing, means that RHH will no longer be able to provide a casevac service for burns patients. Alternative arrangements need to be in place from November of 99. As a result of this it will not be possible to commission a burns unit at RHH. There are enough skilled personnel to support a plastic surgery unit at RHH. It is proposed this could be located on the childrens' unit on D6 which has now become vacant. **Action:** 1. Meeting to be arranged to include HA PHT Odstock and RHH to discuss the future of plastics and burns service at RHH and in the Portsmouth area. 2. A manpower plan to be developed to support the commissioning of ten beds for plastic surgery for use on a Monday to Friday basis to be made available elsewhere at RHH for those patients who may require longer than 5 days stay. 3. Discussions to be held with the Health Authority and Region together with the three single Services to ensure support for the development of plastic surgery at RHH.
Cardiology Knock on surgical impact		PHT currently provide monthly cardio clinic at RHH. Business case being developed by PHT to support appointment of civilian consultant on fixed term contract until Service consultant becomes available in 2001. This will strengthen medical team at RHH in the interim but represents a service development as there is no cardiologist currently on the team.
Psychiatry ? are there a few NHS psychiatric patients who find their way into RHH ?		The future location and nature of the psychiatry service at the RHH will be discussed in the psychiatry working group which is reviewing all the community psychiatry resources of the Defence Medical Services. This is a service which meets the needs specifically of Service patients and therefore is unlikely to be appropriately re-located to Portsmouth NHS Trust, or Portsmouth Community Trust.
Neurology	June 96	RHH has generalist technicians and a full-time neurologist in post. No particular issues. Most of the neurologist's work is out patient based but he needs in-patient beds for 2.4 patients/wk. On integration he will join the team of 2 neurologists at PHT.

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HSDU	24/9/97	In 1997 Portsmouth NHS Trust reviewed their services. The outcome of this review is not known to the author of this paper. Questions to be answered: 1. Is the current service at RHH sustainable until the proposed closure of RHH in 2005? 2. Does it have any spare capacity which could be used to support Portsmouth NHS Trust should this be required. 3. What service does it currently provide outwith the RHH site to other MOD users, and how is it proposed that this should be delivered when RHH closes in 2005. 4. Is there any requirement for an interim development to provide a service to both Portsmouth NHS Trust and RHH which would replace the existing facilities. **Actions:** 1. Propose a meeting to discuss these issues and to bring everyone up to date on these matters. To be arranged by Code A and Code A.
Gynaecology	May 97	Issues raised at that time: 1. RHH would like to have gynaecological options readily available at RHH and queried if PHT could transfer clinics from Gosport War Memorial Hospital to RHH. 2. Query - could PHT provide a continence adviser for RHH. 3. Portsmouth would be interested to provide an oncology service to Service patients. Agreement was reached to leave the transfer of clinics and continence adviser, but for PHT to provide gynae advice on request to RHH and fast track Service staff if requested.
Pharmacy		Pharmacy services are currently provided to the RHH by the Medical Supplies Agency under a recently formed contract. Discussions will require to be held between PH, RHH and MSA as to how the service would be provided after April 2001, and subsequently in 2005 when RHH closes. Discussions will also need to be held with MSA in relation to other clinical supplies and a meeting is to be arranged by Code A together with the interested parties to discuss this.
Infection Control and Occupational Health	24/9/98	Infection Control nursing staff have started sharing standards and activity analyses, and agree a need for a centralised service and have come up with a proposal for discussion to include the doctors. The post for the Occupational Health consultant at RHH has been extended for a further three months of the locum, in order to allow discussion with PHT as to the future provision of Occupational Health services across RHH and PHT sites, including the possible appointment by Portsmouth of a consultant on behalf of RHH. **Action:-** 1. Meeting to be arranged to discuss this matter. Code A & Code A
Consultant		Posts agreed:-

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Appointments Agreed and Under Discussion		1. A locum consultant in urology until filled by military consultant in 2001. 2. A consultant post in oncology. 3. A locum ENT from November 1999. 4. An SHO post in ENT from October 1999. 5. A locum consultant post in anaesthetics from 1 September 1999 to be followed by a substantive post in November 1999. **Under Review:-** 1. A substantive post in ENT from February 2000 dependent upon discussions with the department as a military ENT consultant will be available in 2001. 2. A cardiologist is proposed for RHH and a business plan has been developed in order to develop the funds to make this a "proper job" + endocrinologist. 3. It has been agreed in principle that Portsmouth recruit 2 consultants on fixed-term contracts in orthopaedic surgery. A letter of confirmation is required from DP&S. However, this matter is being progressed. 4. Consultant in General Medicine and Gastroenterology from Spring 2000. 5. 5 Medical SHOs per year to rotate to RHH from PHT rotation (36 months, 9x4 month posts). 6. 5 A&E SHO posts to transfer to PHT August 2000.
Bed Management		Joint protocols, daily contact.
Dietics		
Diabetes		
DSC		PHT provides services to RHH. **Action:** Need to quantify
Physiotherapy		Need to agree process/policy with PHCT **Action:** SS to set meeting.

UPDATE OF NON-CLINICAL SPECIALTIES -14 SEPTEMBER 1999

D/DSCA/13/9/4/14

Specialty	Date of last meeting	Position Statement and Action Plan	Comments
IMT WG		1. Aiming for single PAS 1.4.99 – to be followed by other systems integration. 2. Cabling underway. 3. Project Manager appointed. 4. Project Director and team agreed. 5. Project plan being produced. 6. Plans to fully integrate departments. 7. Initial work underway on combined activity and W lists. **Action:** 1. Staff consultation. 2. Bringing IT and Service Planning together to combine information.	
Operational WG Update		1. Not yet met.	
Finance & Contracts		1. Baseline April 99 position produced plus subsequent changes. 2. Being written – policy for interim SLA. 3. To be agreed at next meeting – joint business planning objectives.	
HR WG Update		Work underway on following: 1. Joint recruitment policy (recruitment freeze lifted). 2. Consultative document. **Action:** 1. Meeting being arranged with PHCT to agree principals. 2. Agreed to provide proper induction to transferring staff.	
Capital WG Update		Intend to produce: 1. Combined asset register. 2. Policy for asset disposal. 3. Joint capital programme	
Non-Clinical WG Update		1. PFI Work to ensure RHH understand the output spec process and are in a position to agree the volume, quality and variable elements to the final output spcs. Work to ensure RHH staff as fully	

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		briefed on the PFI as PHT staff. Need to have joint policy through the HRWG to ensure that both our staff move equally towards the PFI issue, and that neither are advantaged at the expense of the other. 2. Interim Group will work through all common areas to look at economic and practical issues facing us both that might lead to earlier integration.	
Clinical Education WG Update		ENT PHT appointing SHO on RHH behalf. Waiting Dean's approval (although not strictly necessary). SURGERY Waiting to understand RHH intention with regard to SHOs? rotate through PHRT or not. Code A to contract Code A Awaiting combined PRHO rotation from Code A, to then be taken to Dean. Needed to ensure input to Soton matching system, finalised 5.10.99? will RHH reinstate posts that have disappeared. (PRHO rotation complicated by including Urology on this site and Ortho on RHH site). MEDICINE Generally not pushing training integration until CDs request otherwise. Awaiting ME to determine number of SHO posts he requires PHT to appoint on his behalf. Presume they are to be based at RHH? ITU Outstanding issue concerning the ability to appoint middle grades. Currently between the OD at PHT, DB, SS and the DSCA. ANAES Plan to fully integrate training from Aug 2000. Code A to determine training issues. AE Plan to stop SHO training posts at RHH from Aug 2000? whether any further posts will be required at QAH (currently	

		have 2). Code A to investigate ORTHOP Code A to investigate training issues, when clinical reconfiguration agreed.	
Communications Sub-Group			
PFI			
Communications Sub-Group			

(cross referenced with PFI Project Plan 14.9.99)

ID	ⓘ	Task Name	Duration	Start	Finish
1		OVERVIEW - KEY MILESTONES	0 days	Thu 01/07/[illegible]	[illegible]hu 01/07/99
2		Joint consultative Document & Recruitment Policy	22 days	Wed 01/09/99	Thu 30/09/99
3		Appoint SPMs	21 days	Fri 01/10/99	Sun 31/10/99
4		Consequences of Aug 2000 clinical changes	22 days	Mon 01/11/99	Tue 30/11/99
5		Combined Waiting List Monitoring	22 days	Mon 01/11/99	Tue 30/11/99
6		Single management and clinical leadership of specialities	20 days	Mon 03/04/00	Sun 30/04/00
7		Proxy PES Financial System	20 days	Mon 03/04/00	Sun 30/04/00
8		Public Consultation	65 days	Mon 03/01/00	Fri 31/03/00
9		Single HIS	20 days	Mon 03/04/00	Sun 30/04/00
10					
11		A&E changes to service	44 days	Mon 03/07/00	Thu 31/08/00
12		Agree MDHU Spec in OBC (2005)	20 days	Tue 04/01/00	Mon 31/01/00
13		PFI OJEC	22 days	Tue 02/05/00	Wed 31/05/00
14		MDHU contract negotiation (2001)	84 days	Tue 04/01/00	Sun 30/04/00
15					
16		MDHU Contract/PES transfer	345 days	Wed 05/01/00	Mon 30/04/01
17					
18		CLINICAL INTEGRATION WORKING GROUP	0 days	Thu 01/07/99	Thu 01/07/99
19	✓	Clinical Integration: Define nature of clinical merger	22 days	Wed 01/09/99	Thu 30/09/99
20		Clinical Integration: Agree Priorities	22 days	Mon 02/08/99	Tue 31/08/99
21		Clinical Integration: Specialities agree reconfiguration for Aug 2000	65 days	Wed 01/09/99	Tue 30/11/99
22		Clinical Integration: Bed consequences of reconfiguration	23 days	Wed 01/12/99	Fri 31/12/99
23		Clinical Integration: Cessation of AE? Anaes leading to ? Reconfiguration	23 days	Tue 01/08/00	Thu 31/08/00
24		Final Clinical output spec - PFI	21 days	Tue 01/02/00	Tue 29/02/00
25		Paeds: Move paediatrics	22 days	Mon 02/08/99	Tue 31/08/99
26		Paeds: Agree protocols	22 days	Mon 02/08/99	Tue 31/08/99
27		Paeds: Secure funds/staff	22 days	Mon 02/08/99	Tue 31/08/99
28		Oral Surgery - reconfiguration	0 days	Thu 01/07/99	Thu 01/07/99
29		General Surgery Reconfiguration	0 days	Thu 01/07/99	Thu 01/07/99
30		General Medicine - establish new ACD	21 days	Fri 01/10/99	Sun 31/10/99
31		Opthalmology - WLI to RHH	22 days	Wed 01/09/99	Thu 30/09/99
32		Opthalmology - RHH move to QAH	20 days	Mon 03/04/00	Sun 30/04/00
33		ITU: Move ITU	18 days	Tue 07/09/99	Thu 30/09/99
34		ITU: Secure Funds/Staff	65 days	Mon 02/08/99	Fri 29/10/99
35		ITU: Sort Middle Grades	43 days	Wed 01/09/99	Fri 29/10/99
36		ITU: Hyperbaric - Capital Analysis move	65 days	Wed 01/09/99	Tue 30/11/99
37		ITU: Project Plan to increase beds	285 days	Mon 02/08/99	Thu 31/08/00
38		Cancer Integration - 2 week wait	87 days	Fri 01/10/99	Mon 31/01/00
39		AE: Project Plan AE	239 days	Wed 01/09/99	Fri 28/07/00
40		AE: Recruit staff	66 days	Mon 01/11/99	Mon 31/01/00
41		AE: Public ~~Campaign~~ Consultation	153 days	Wed 01/09/99	Fri 31/03/00
42		~~AE: Execute MIU Gosport~~ Implement Plan	240 days	Wed 01/09/99	Mon 31/07/00

Aug '99 | Sep '99 | Oct '99 | Nov '99 | Dec '99 | Jan '00 | Feb '00 | Mar '00 | Apr '00 | May '00 | Jun '00 | Jul '00 | Aug '00 | Sep '00 | Oct '00 | Nov '00 | Dec '00 | Jan '01 | Feb '01 | Mar '01 | Apr '01

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Strategic Alliances

PHT: RHH Draft Integration Plan
(cross referenced with PFI Project Plan 14.9.99)

VERSION 1.0 Aug 99 - April 01

ID	Task Name	Duration	Start	Finish
85	IT: Merge waiting list mgmt	456 days	Tue 03/08/99	Mon 30/04/01
86	IT: Merge activity counting	0 days	Thu 01/07/99	Thu 01/07/99
87	IT: Merge activity recording	87 days	Mon 02/08/99	Tue 30/11/99
88	IT: Single HIS	20 days	Thu 01/02/01	Wed 28/02/01
89	IT: Integrate cancer monitoring	0 days	Thu 01/07/99	Thu 01/07/99
90	IT: Single request system	0 days	Thu 01/07/99	Thu 01/07/99
91	IT: Merge casenotes	0 days	Thu 01/07/99	Thu 01/07/99
92				
93	MDHU PFI	0 days	Thu 01/07/99	Thu 01/07/99
94	MDHU spec required	22 days	Mon 02/08/99	Tue 31/08/99
95	Agreement to MDHU spec (2005 model)	131 days	Mon 02/08/99	Mon 31/01/00
96	Negotiation of MDHU contract (2001 model)	412 days	Mon 04/10/99	Mon 30/04/01
97	PFI: Output spec extracted for MDHU	110 days	Mon 02/08/99	Fri 31/12/99
98	PFI: Final adjustments to non-clinical specs	21 days	Tue 01/02/00	Tue 29/02/00
99	PFI: Capital consequences identified for MDHU	152 days	Mon 02/08/99	Tue 29/02/00
100	MDHU contract starts	21 days	Mon 02/04/01	Mon 30/04/01
101	PFI: (OJEC)	23 days	Mon 01/05/00	Wed 31/05/00
102	PFI: OBC Trust Board	23 days	Mon 01/05/00	Wed 31/05/00
103				
104	CAPITAL WORKING GROUP	0 days	Thu 01/07/99	Thu 01/07/99
105	Capital: Consequences ITU 15 beds	284 days	Tue 03/08/99	Thu 31/08/00
106	Capital: Consequences of reconfiguration (beds theatres)	23 days	Wed 01/12/99	Fri 31/12/99
107	Capital: Hyperbaric	65 days	Wed 01/09/99	Tue 30/11/99
108	Capital: Principles of a policy for disposal of Haslar (equipment) assets	22 days	Mon 01/11/99	Tue 30/11/99
109	Capital: Combined asset register	22 days	Mon 01/11/99	Tue 30/11/99
110	Capital: Long term Gosport Provision	23 days	Wed 01/12/99	Fri 31/12/99
111				
112	NON-CLINICAL WORKING GROUP	0 days	Thu 01/07/99	Thu 01/07/99
113	Non clinical: Extract Non-clinical Output spec from MDHU	152 days	Mon 02/08/99	Tue 29/02/00
114				
115	PROJECT MANAGEMENT	0 days	Thu 01/07/99	Thu 01/07/99
116	Management: Agree JIMT terms of Ref	22 days	Mon 02/08/99	Tue 31/08/99
117	Management: Appoint SPMs	66 days	Fri 01/10/99	Fri 31/12/99
118	Management: Single ACD/GM Leadership of specialities	172 days	Thu 02/09/99	Fri 28/04/00
119				
120	COMMUNICATION	0 days	Thu 01/07/99	Thu 01/07/99
121	Gosport consultation	85 days	Mon 03/01/00	Sun 30/04/00
122	PIP	346 days	Tue 04/01/00	Mon 30/04/01

Timeline: Aug '99, Sep '99, Oct '99, Nov '99, Dec '99, Jan '00, Feb '00, Mar '00, Apr '00, May '00, Jun '00, Jul '00, Aug '00, Sep '00, Oct '00, Nov '00, Dec '00, Jan '01, Feb '01, Mar '01, Apr '01

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Legend: Task, Split, Progress, Milestone, Summary, Rolled Up Task, Rolled Up Split, Rolled Up Milestone, Rolled Up Progress, External Tasks, Project Summary