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

PORTSMOUTH PARTNERSHIP BOARD

09.30am. Monday 24 May 1999
Blue Room, Officers' Mess, Fort Blockhouse, Gosport

PROGRAMME

9.15 Coffee available

9.30 **Opening Session:** Questions to be answered today

10.00 **Reports:** Portsmouth & S E Hants HA
The Healthcare Plan for Gosport

Portsmouth Hospitals NHS Trust
Clinical Integration of Acute Services

Defence Secondary Care Agency
The Portsmouth MDHU Requirement

10.30 **Discussion**

12.30 Lunch

13.30 **Formal Board Meeting**

AGENDA

1 **Apologies for absence**

2 **Notes of Meeting held 22 April 1999** Attachment 1

3 **Matters Arising:**
2 **Communications**

4 **Risk Assessment and Contingency Planning** Attachment 2

5 **Timetable for Change**

6 **Partnership Project Plan & Staffing** Attachment 3

7 **Any Other Business**

8 **Dates agreed for future meetings:**
Tuesday 6 July, 10.00 at Royal Hospital Haslar
Thursday 16 September, 9.00 at Finchdean House
Monday 8 November, 12.30 at Royal Hospital Haslar

4.00 Close

Agree communications plan: { public (CHC) paediatric
TUs
staff

Distribution:

Portsmouth & SE Hants HA and Gosport PCG
Penny Humphris, Chief Executive
Dr Jane Barton, Chair PCG
John Kirtley, Chief Executive PCG

Defence Secondary Care Agency
Major General Chris Callow, Chief Executive
Maggie Somekh, Director of Corporate Development

Portsmouth Hospitals NHS Trust
Dick Bishop, Chief Executive
Sarah Smart, Director Strategic Alliances

Royal Hospital Haslar
Brigadier Guy Ratcliffe, Commanding Officer
Surgeon Commander Rodney Taylor, Medical Director

Royal Defence Medical College
Air Commodore David Rainford, Dean

Portsmouth Healthcare NHS Trust
Max Millett, Chief Executive

Observer:

Air Commodore Warwick Pike, Director Personnel & Services
HQ DSCA

From:

Shirley Hardy, Integration Project Manager
Building 80, Royal Hospital Haslar, Gosport PO12 2AA
Phone Code A Fax Code A

17 May 1999

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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 22 April 1999

Present: Major General Chris Callow Chairman
Dick Bishop
Shirley Hardy
Penny Humphris
John Kirtley
Max Millett
Air Commodore David Rainsford
Brigadier Guy Ratcliffe
Sarah Smart
Maggie Somekh
Surgeon Commander Rodney Taylor

Observers: Group Captain Duncan Mitchell
Commander Tony Taylor

Apologies: Dr Jane Barton

No	Discussion	Action

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1 Notes of the meeting held 17 March 1999

The notes of the last meeting of the Partnership Board, held 17 March 1999, were confirmed as an accurate and helpful record of discussions.

2 Communications and Intelligence

2.1 HoC Defence Select Committee

Brigadier Ratcliffe reported that the HoC Defence Committee visit to RH Haslar on 14 April. Had looked primarily at defence issues and particularly concerns about DMS staffing. Mr Peter Viggars MP had handed over the Task Group plan for health services in Gosport. Maggie Somekh said that she had a copy and would circulate this. It included a fundamental misconception about the scope to expand a Portsmouth PFI to include an MDHU and concentrated on the perceived strengths of Haslar and ignored weaknesses. Penny Humphris suggested a joint DSCA/PHA response to cover both defence and NHS issues. This should put the planned closure of Haslar in the context of clinical integration funded by a PES transfer of funds from MoD to DoH to fund civilian work, and positions for MDHU staff in the management structure of the Trust. It was agreed that Maggie Somekh, Penny Humphris and Dick Bishop should agree a common response by 5 May. Surg Cdr Taylor said that Mike Hancock MP had also visited separately and had the same brief as the other HoC committee members.

MS | SJH

MS | PH | DI

2.2 Press contacts

Penny Humphris said that she and her Chairman had been directly briefing the Portsmouth Evening News' Gosport reporter, who attended the Task Group meetings, on the HA approach to a development of a plan for

healthcare on the Gosport peninsula and public consultation. This had helped to increase understanding of the different responsibilities of the organisations involved in change.

2.3 Heath Authority Awayday

Penny Humphris also reported that the Health Authority had organised an awayday for key stakeholders on 20 April, facilitated by Nigel Edwards of the London Health Economics Consortium. They had looked at some interesting health needs information and there had been a high degree of agreement on realistic models of care for the future. This would be pulled together into a public consultation document which would include examples of the sort of care Gosport people could expect to receive in situations which concerned them. The target date for publication is 24 or 25 May. PH

2.4 Common Communications

Shirley Hardy said that she still had no responses on organisations' PR support and it was agreed that she would work with Penny Humphris to put this communications co-ordination in place before the publication of the HA Gosport consultation document. PH/SJH

3 Integration Project

Sarah Smart said that the first meeting of the Integration Project Board had taken place on 20 April. This had provided senior managers and clinicians from both PHT and RHH with their first opportunity to sit down together and to understand how integration would be managed and their own contribution to that. All present wanted more information on the context in which they are expected to work and the final vision for services in the area. This should be available for the next IPB meeting on 25 May, following publication of the HA consultation document and the Partnership Board's own workshop on 24 May. There had been a high level of commitment to integration, but concern about the timetable and issues of project support to allow people with very busy jobs to contribute properly to this work.

The Board recognised its own responsibility to work with PHT and the DSCA to both scope and resource the Integration Project, and to use the time available on 25 May to plan the short-term change programme, in the context of the HA's longer term plan being published for consultation. This planning would need to take account of the areas of risk in current RHH services and the protection of military training requirements.

4 Risk assessment and action to manage risk

4.1 Anaesthetic and ITU services

Sarah Smart reported that. discussions had taken place between anaesthetists in PHT and RHH covering both adult and children's services. The two departments are very willing to work together, but PHT does not see it as feasible to take on another emergency rota to cover a third acute site in Portsmouth. There is also a willingness to advertise additional jobs once the work content has been clearly identified, but again a concern that any posts with three site obligations would prove unattractive for recruitment.

The discussion on consultant staffing requirements to maintain an ITU or HDU at Haslar currently requires a response from RHH on the length of time that the DSCA can sustain this service without PHT input. The PHT consultants are not prepared to support an off site ITU, after their experiences of trying to do this at SMH, so if the Services cannot support an ITU at RHH, the shortfall of beds will need to be made up by extension of the facilities at QAH. This will require building works which could take up to 12 months and should be authorised immediately if this is an area of risk. PHT were asked to continue to work up this plan and to create capacity so that it is available if required. GR/RT SS

4.2 Trauma and orthopaedic services

There has been limited progress in the discussions of risk management in this specialty since the last Board meeting. The CD at RHH, who had indicated that he might be able to maintain consultant cover into 2000, had been away on operational duties, now extended to early May, and nobody else seems to have the full picture. PHT has made an appointment to its 9th consultant post, but this is one of the RHH consultants. This may assist collaboration, but does not add to the total number of consultants in the area. Dick Bishop said that PHT required 15-16 orthopaedic consultants to cover its current population, never mind the additional civilian and military population served by RHH. This currently requires at least 6 consultants and so there is a considerable combined shortfall. External recruitment is likely to be of only limited effect because of the gap between demand and NHS Specialist Registrar accreditations. The Dean said that the Services would be accrediting 7-8 Sp Rs over the next 3 years and it was agreed that the DSCA would examine the scope for increased Service staffing prior to the next meeting in this specialty, to be held when the CD returned. cc

4.3 Accident & Emergency Services

.Sarah Smart reported that clear staffing criteria had now been agreed for the continued provision of children's A&E services at RHH, in line with Action for Sick Children and other national guidelines. Brigadier Ratcliffe welcomed this information and agreed that it was most unlikely that the DSCA would be able to meet these, given that children's services is not part of military medical requirements. General Callow agreed that a decision would need to be made on an end date for this service because it is not acceptable in terms of clinical governance for the Agency to provide services which do not meet current standards.

A decision to close the children's A&E services raises difficult choices in relation to alternative provision between:

- A mixed emergency service at RHH with full adult A&E services and an A&E managed minor treatment service for children
- A purely minor treatment service for all age groups.

The former requires the public to remember the distinction and to make the right choice of service provider in an emergency while the latter downgrades the whole level of provision on the peninsula. Either decision will cause public concern and should be subjected to public consultation. Maggie Somekh suggested that the adult service might continue at RHH and the children's service transfer to GWMH to help the public to make the distinction between A&E and minor injuries, but there were concerns about staffing and backup at GWMH which is currently a GP run service.

Sarah Smart said that she believed that it would be feasible to provide an adult only service at RHH, and to maintain SHO training slots, if all A&E SHOs are pooled and rotated between QAH and PHT, or if additional staff are brought into RHH to allow Service SHOs to spend part of their post at QAH for broader experience. PHT consultants are concerned that pooling would make the SHO posts unattractive, but she believed that more information was needed on the feasibility of both these staffing options.

There was broad agreement that the mixed service should be retained if at all possible to allow time for consultation and the development of other services on the peninsula, but that the balance of risk between ease of access and quality and clarity of local services should be further assessed. Dick Bishop said that they all had a responsibility to be realistic and professional in considering these very difficult choices and General Callow pointed out that this had to be set in the context of growing and unpredictable

operational demands on the Defence Medical Services. Penny Humphris said that the HA was committed to proper processes of public consultation, but that it was difficult when the MOD could change its health provision without consultation and this might restrict the Authority's options for consultation.

It was agreed that the A&E consultants should be asked to further develop these options for consideration by the Board at the awayday on 24 May 1999. They could be looked at in the context of the other risk areas such as ITU and surgical services. SS

4.4 Children's services

Sarah Smart said that clear plans had now been agreed for the transfer of all children's inpatient and day case services from RHH to QAH or SMH. These would protect the clinical interests and training requirements of the DSCA, and although there could be some offsetting transfer of adult work to RHH, would have financial implications because not all the funding could be released from DSCA funds to PHT. Brigadier Ratcliffe said that RHH was losing RSCN staffing because of the uncertainty and might find it difficult to staff the children's ward, D6, beyond July.

Following further discussion, it was agreed that an autumn closure would probably be unavoidable, but that more work needed to be done by the HR sub-group on staffing issues, and a link made to the decision on A&E services before a final date could be set. Patients booked for admission to RHH could then be given alternative dates at QAH, SMH or possibly SGH in relation to general surgery – although it was hoped that this service could be expanded at SMH in collaboration with SUHT. SS/MS

4.5 Cancer services

Shirley Hardy said that this was emerging as another area of risk for RHH, and raised many of the same issues which had been discussed in relation to other services. The catalyst would be the loss of the Service oncologist from RHH in February 2000, but the key surgical specialties – breast and colorectal – are now single handed and may need to consolidate with services in Portsmouth. It has been suggested that combined breast surgery services should be further developed at RHH and major colorectal work consolidated at QAH. John Kirtley confirmed that the Gosport PCG strongly supported the retention of local cancer services, such as the day chemotherapy services, and it was agreed that a replacement oncologist should be recruited by the Trust, but with a job description and interim funding which protected Gosport services and reflected DSCA requirements in respect of cancer services for military personnel. The wider issue of development of integrated cancer services would be picked as part of the imminent NHSE regional review of Portsmouth's Cancer Centre status and the linked RHH Cancer Unit. SS

4.6 Timetable

The Board recognised that while each of these areas of risk might individually be manageable, together they suggested that it might be very difficult to maintain the current character of RHH as an emergency site. The Board might have to consider the timescale for a move to a 'hot/cold' relationship between the PHT and RHH sites and the management of this in terms of both military staffing requirements and appropriate services for the Gosport population. The Integration Project Board should be able to plan for service rationalisation in a way which protected the Service role in emergency services and most of the training posts, but the Partnership Board would need to control the pace of change for the civilian population of Gosport, in line with the planned public consultation.

The Dean expressed concern that single site integration of emergency services, even with the same population served, might lead to a loss of training recognitions and it was agreed that all issues would have to be resolved at the workshop on 24 May, and that it would be helpful to have external input, as in January. Penny Humphris was asked to see if Nigel Edwards, could work with the Board on this date, as he has already contributed to the HA's strategic planning and understood the issues. PH

5 Educational Impact Assessment

Surg. Cdr Taylor presented information on the medical training post requirement for the integrated Portsmouth hospitals and it was agreed that this would now be dealt with through the DSCA MDHU requirement. The DSCA would be putting forward the number of posts which it required in Portsmouth, including nursing, technical and other posts, and the Trust would respond as to the number which could be accommodated. The DSCA will then need to confirm the number of posts which can be filled on a year by year basis, in line with the availability of Service manning, and to agree how vacant slots can be covered by the NHS until Service personnel are available. Maggie Somekh asked the RHH Executive Team to work with Shirley Hardy to produce this information for the MDHU requirement. GR/RT/SH

6 MDHU Requirement

Maggie Somekh confirmed that the DSCA and RHH are working on the Portsmouth MDHU requirement, using the standard MOD contract format, but including relevant local detail in relation to both the Host and Treatment Agreements. The Host Agreement would set out the numbers and requirements in relation to Service staffing, as 5 above, and the Trust would need to relate this to the transferred Service and civilian patient workload and identify its staffing requirements over and above the Service staff availability to deliver the work. The Trust has requested detailed RHH workload information including length of stay, theatre sessions, bed utilisation etc. to enable them to plan to take on RHH staff and work, while RHH is working on other areas such as the military accommodation and infrastructure requirements. Sarah Smart said that the patient information is also needed for the work requested by the Region on contingency planning. The full MDHU requirement is also required for inclusion in an updated PFI Outline Business Case, which has to be supplied to the DoH by the end of April, although a PFI announcement is now not expected before the second half of May. SH/MS

Sarah Smart further confirmed that this revised OBC would only relate to the MDHU requirement, as the Trust had declined to put in an expression of interest in relation to the Centre of Defence Medicine. This was purely because the timescale for initial response to Glasgow was very short (10 May) and clashed with a whole range of other urgent Trust work with the DSCA around integration with RHH etc. The CDM paperwork issued was complex and unclear, but appeared to rule PHT out in any case. Even if PHT was successful at this pre-qualification stage, the tender stage would require even more work which would clash with the Trust timetable for PFI specifications and OJEC advertisement, which is now timed for the end of the year.. The Trust would be very willing to look at provision of this requirement, if requested to do so by MOD, but could not give the complex CDM tendering process priority over its other NHS work. MOD representatives agreed to take this back and thanked Sarah Smart for such an honest explanation of the Trust position. CC

It was also pointed out that the process of integration between PHT and RHH into the MDHU, also had implications for the civilian staff working at RHH who had to be managed in line with Civil Service procedures. These were based on the search for suitable alternative employment, for staff made redundant by service change, within the Civil Service and the balance between this policy and the need to retain clinical skills in the combined service would have to be sorted out in the HR Working Group.

The MDHU Treatment Agreement will cover the clinical services required for Service personnel and to support DMS clinicians in overseas hospitals and operational settings. Shirley Hardy said that the collection of information to support the Host Agreement is progressing well, but that she was more concerned about the development of the Treatment Agreement which needs to be more comprehensive than those of other MDHUs to reflect Haslar's existing role as the core hospital, and its back stop and co-oordinating role in Service patient care. Some of this functionality might transfer to the CDM, but until this had been agreed for another location, it must be protected in Portsmouth. It might necessitate the development of clinical protocols for Service patients in areas such as cancer services, where there can be unacceptable variations in local NHS services offered to Service personnel. These variations were currently overcome by the availability of services in the core hospital and the transfer of this responsibility, together with medevac and other military clinical support services, will need to be costed by the Trust as part of the negotiations for the MDHU contract, if this functionality is required in Portsmouth, rather than at the CDM.

7 Project Plan

The Board noted the range of activities listed in the Project Plan and asked Shirley Hardy to update this for circulation to Board members. SH

8 Dates of future meetings

Confirmed as:

Monday 24 May - All day Workshop at Fort Blockhouse

Tuesday 6 July - 10.00 am at Royal Hospital Haslar

Thursday 16 September – 9.00 am at Finchdean House

Monday 8 November – 12.30 pm at Royal Hospital Haslar

SJH/25/04/1999

STRATEGIC ALLIANCES

PHT;RHH

AE SERVICES

Draft Response to request from Partnership Board for contingency plan. Based on meeting with C Cahill 28.4.99

The following are asked to confirm this response by 17th May 1999

Chris Cahill (and through CC, AE consultants in PHT/RHH
Maggie Somaiah
Guy Ratcliffe/ Shirley Hardy

cc P Humphries, D Bishop, D Birnie

Proposal
Cease children main AE by September

Response
Approx. 600 children will transfer to QAH (10% RHH attenders)

There will be revenue consequences related to the marginal cost of the RHH transfers, and to the under-funded baseline of current children AE provision at QAH.

Proposal
Provide minor injuries children somewhere in Gosport peninsula

Response
On balance, more sensible to leave this service at RHH. Will need very good publicity programme and protocols.
? assume minor injuries service ceases at GWMH

Proposal
Continue adult major AE 18 months

Response
Relies on RHH SHOs rotating up to QAH and being back filled at RHH. Suggestion that current 5 SHO posts would be enough on basis of 1 on duty at any one time, with 2 spare to back fill.
Completely dependent on DSCA guaranteeing 5 filled posts.
PHA would struggle to recruit on DSCA behalf (has difficulties already)
CC will double check Royal College view on pooling and rotating (QAH advises against this latter option)

Proposal
Move to final hub spoke model 18 months

Response
Have proposal to do this earlier if requested, but recognise that although AE may be able to move more quickly, hot cold consequences will take longer. This proposal is still in early draft but is enclosed and is about an initial service, that will need to be developed into the full nurse practitioner service.
Hub spoke model would result in approx. 10000 more attendance's to QAH. This could be accommodated within revenue increase identified for a time, but would need to be complemented by a spoke at SMH reasonably soon afterwards

Proposal
Maintenance of training approvals

Response
See above

S Smart 29.4.99

CONFIDENTIAL

STRATEGIC ALLIANCES PHT:RHH

RISK AND CONTINGENCY PLANNING FOR CIVILIAN SERVICES

Draft 1.2

1.0 INTRODUCTION

1.1 This paper identifies the risks and contingencies related to the cessation of RHH (Royal Hospital Haslar) services provided to the PSEHHA (Portsmouth and South East Hants Health Authority) civilian population.

1.2 This paper assumes an absence of military manning with the single objective being the continuation of civilian services.

1.3 Clearly the wider picture requires continuation of both health service and military requirements, and this is best managed by the planned process of merger which unites the two organisations into a single entity. For completeness, the impact of moving military work to QAH is included at Append B and D

2.0 HISTORY

2.1 In 1996, Portsmouth Hospitals NHS Trust consulted on a strategy designed to address concerns about 3 site working (one site at Queen Alexandra Hospital and two sites at St Marys Hospital). These concerns included poor quality of care through lack of service integration and difficulties of junior doctor cover.

2.2 The resulting strategy proposed centralising all acute services on one site, with a developed spoke on the support site.

2.3 It was clear that the Royal Haslar Hospital (RHH) faced problems similar to those caused by split site working, compounded by the low numbers in its catchment population. It was considered that the future of RHH was dependant on significant integration with a large District General Hospital (DGH), to allow military staff access to the high volumes and complex casemix necessary to their training.

2.4 A process of partnership between the two organisations began, focused on clinical collaboration to achieve integrated high quality services.

2.5 In 1997, the Trust submitted an Outline Business Case (OBC) for private finance initiative (PFI) development of the Queen Alexandra site.

The OBC included two Haslar options; one for its integration on the QA site, and the other for its expansion to DGH status.

2.6 During 1997/8 it was becoming clear that RHH was in difficulty due to low patient volumes and a number of single/two handed specialities. The Defence Secondary Care Agency (DSCA) commissioned a review of the whole of defence medical services (DMS) to include the future role of Haslar.

2.7 In September 1998, the Trust resubmitted its proposal for PFI, leaving aside the option of full integration with Haslar pending the outcome of the DMS review.

2.8 In December 1998, the plan to integrate Haslar with PHT onto a single acute site was announced.

2.9 The Trust then embarked on a process of formal integration with RHH, based on incremental change within a timescale linked to the proposed PFI scheme. The reconfiguration of services was driven by the district strategic plans being developed by the Health Authority.

2.10 It was immediately apparent that incremental change was not possible due to significant difficulties maintaining acute services on the RHH site. This situation is compounded by the planned departure of further consultant staff, and the crisis in the Balkans.

3.0 PLANNING PRINCIPLES

The contingency plan is based on the following principles

3.1 Within the context of the Health Authority plans for the future of Gosport Health Services based on meeting population need and the provision of local services that are safe, integrated and sustainable.

3.2 Avoidance of sudden collapse and maintenance of access times.

3.3 Best use of current estate and manpower, minimising short term capital investment.

3.4 Where possible, gradual and planned relocation of services to the QAH site.

3.5 Continuing partnership with stakeholders.

4.0 ACTIVITY AND FINANCE

4.1 RHH serves (mainly) the Gosport population with civilian services and activity identified at appendix A.

4.2 In a scenario of no military manning, it is clear that to continue the RHH civilian activity, additional human and capital resources would be required over and above that currently available to Portsmouth Hospitals Trust (PHT).

4.3 Portsmouth Hospitals Outline Business Case estimated the bed requirements and revenue associated with a transfer of civilian activity (Appendix C being revised). The revenue costs estimate (dated 1997) would need to be flexed to take account of different scenarios including the ongoing employment of RHH civilians and the costs of additional capital.

4.4 Based on revised OBC activity assumptions and other data, (Appendix D and E) RHH civilian work would require the following beds and theatre capacity (present day)

Inpt beds	*Day Case Beds*	*Theatres*
54 medical beds	*Total 3 average*	*3 main*
39 surgical beds	*12 max*	*1 day*
22 orthop beds		
115 total		

4.5 Further information is required concerning civilian posts at RHH and costs of alternative sources of capital.

5.0 SOURCES OF RISK

Risks to RHH services originate from a number of interrelated sources

1. *Recruitment to, and retention of, military and civilian posts*
2. *Viability of hospital services*
3. *Training approvals (principally medical)*
4. *Local perceptions*

5.1 Recruitment and retention

Uncertainty over the future of RHH coupled with a gradual decline in DSCA manning has over time reduced the capability of RHH. This problem is compounded by forecast applications for premature voluntary retirement.

Civilian recruitment has been negatively affected in many specialities by both uncertainty over the future of RHH and the relative unattractiveness of posts in an establishment where patient activity and sub-specialisation has declined.

5.2 Viability of Hospital Services

Low levels of patient activity coupled with poor manning have reduced the viability of services such as paediatrics.

The decision to close RHH to paediatrics has knock on effects on a number of other important specialities such as A&E and anaesthetics.

5.3 Training Approvals

Post graduate training approvals are affected by reductions in the size and scope of the RHH activity and are vulnerable in AE, ENT, anaesthetics, GPVT.

5.4 Local perceptions

There is considerable support for the continuation of services at RHH. This support may make consultation on proposed changes difficult.

Alternatively, concerns over reductions in RHH capability, might produce a flow of patients to Portsmouth Hospitals in advance of plans to accommodate such work.

6.0 HIGH RISK SPECIALITIES

6.1 There are a number of key and inter related specialities where risk in one can have a profound impact on others

6.2 The current RHH relies on continuing adult AE, ITU, Anaesthetic and acute surgical and medical services. A collapse of any one of these renders a cessation of hot services at RHH inevitable in order to avoid split site single rota emergency take.

6.3 Collapse may be as a result of internal speciality issues or as a consequence of difficulty in another eg. inability to maintain hot admissions at RHH in the main specialities of orthopaedics, medicine and surgery renders the AE non viable.

6.4 A complete absence of military staffing would require PHT to effectively civilian man a third site with significant recruitment and Royal College

difficulties. The Royal Colleges and BMA advise against consultant and trainee rotas covering more than one emergency take site.

6.5 Given the likelihood of reduced capability in one of the above specialities occurring over the 2 years, it could be argued that the best contingency is to plan for cessation of hot and possibly cold services at RHH now.

6.6 The process of reduced capability has commenced in key specialities:

6.61 CHILDREN SERVICES

Haslar is not able to sustain elective or emergency children services due to low volumes of work, lack of on site middle grade doctors exposed to high volumes of children work, and lack of acute paediatricians able to attend for emergencies. Options to continue children work at RHH have been discounted as they would require considerably more activity than is locally generated, plus the approval for the appointment of middle grades in AE and Paediatrics and recruitment to a stand alone paediatric consultant rota.

6.62 AE SERVICES

Adult only AE services (with volumes below 15000) can only be sustained by continuing a two site on call consultant rota (RHH is single handed), and by the rotation of junior doctors to QA to sustain training approvals. This latter point is reliant on the ability of the DSCA to recruit and retain sufficient numbers to be released for the rotation. It is not possible for Portsmouth Hospitals to recruit to and oversee, a full civilian manned AE service at RHH.
AE is also dependant on continuing ITU, anaesthetic and acute surgical and medical cover.

6.63 24 hr ANAESTHETICS

Portsmouth Hospitals would not be able to sustain 24 hour anaesthetics services at RHH if they were required to cover this site with the current single consultant rota (would effectively mean manning a third site). A separate civilian rota might be possible out of hours. Manning an elective only site is clearly preferable.

6.64 ITU SERVICES

RHH is not able to guarantee maintaining this service beyond 18 months or so. It would be difficult and unwise to attempt to continue this service

with full civilian manning overseen by the QAH department. The difficulty in the recruitment of enough ITU trained staff, makes this option non viable. The inability to sustain ITU undermines AE and other acute services.

6.65 ACUTE SERVICES

RHH is currently dependant on Portsmouth Hospitals for a single consultant emergency rota across 2/3 acute sites in Urology, Maxillo facial, AE.

RHH is also forecasting difficulties in sustaining Orthopaedics beyond January 2000 with 75% consultant staff due to leave. It is unlikely that sufficient civilian consultant appointments could be made to sustain a RHH only out of hours on call rota.

More information is required as to the sustainability of acute surgical and medical services.

6.66 CIVILIAN MANNING: LOCAL SITUATION

To be included

7.0 CONTINGENCY

Contingency options are essentially:

1. *Preserve RHH capability (avoidance of collapse)*

2. *Civilian Manning for*
   - *2.0 Hub-hot and spoke-hot*
   - *2.1 Hub-hot and Spoke- Cold (5 day and day surgery), post acute/ rehab, ambulatory, outpatients and diagnostic centre.*
   - *2.2 Hub-hot and Spoke-Cold (day surgery), post acute/ rehab, ambulatory, outpatients and diagnostic centre*
   - *2.3 Hub-hot/cold and spoke post acute/rehab, ambulatory, outpatients and diagnostic centre*
   - *2.4 Hub- hot/ cold/post acute/ rehab and spoke ambulatory, outpatients and diagnostic centre*

3. *Capital infrastructure RHH v GWMH*

7.1 Preservation of RHH capability

Requires maintenance of training approvals by continuing/ increasing either volume of work at RHH, or trainees access to volume of work at PHT through rotation.

Requires full consultant manning by DSCA/ NHS to ensure 'stand alone' out of hours cover at the RHH site.

7.2 Civilian Manning

7.20 Hub-hot and spoke-hot using RHH site

Advantages
- *Capital capacity available*
- *May preserve some existing civilian staffing*
- *Politically acceptable ie no change to local provision*

Difficulties
- *Would require continuing AE and ITU presence*
- *Inability to civilian consultant man separate RHH on call resulting in unacceptable 2/3 site on call cover.*
- *Would require PHT junior doctors to cover 3rd site likely to be unacceptable to colleges*

7.21 Hub-hot and spoke- cold (5 day and day surgery), post acute/ rehab, ambulatory, outpatients and diagnostic centre

- *Would require*

	Spoke	*Hub*
Beds	*? 12 Day* *? 10-15 five day*	*?100 inpt*
Theatres	*2 Day* *? 1 main*	*? 4 main*

? = awaiting 5 day surgery figures
Requires analysis for post acute bed numbers

Advantages
- *Keeps substantial service in Gosport*
- *In line with district strategy for single site acute hub and developed spoke*
- *Not dependent on AE/ ITU*
- *Out of hours surgical and anaesthetic cover at weekends not a problem*

- *Could further reduce capital requirement in hub by increasing surgery or post acute in spoke (1 for 1 model)*

Difficulties

- *Would require third site resident junior/ middle grade cover out of hours during week*
- *Would require establishment of Gosport MATS (minor accident treatment service)*
- *? medical manning of post acute/ rehab*

Example planning scenario based on this configuration using RHH site and RHH/ PHCT civilians

- ✓ *Establish civilian manning available at RHH and PHCT.*
- ✓ *Plan to establish MATS and ambulance service changes*
- ✓ *Plan for capital infrastructure required for ITU at QAH (may require relocation of CCU?)*
- ✓ *Determine beds, theatre and manning requirements at RHH for maximum location of Gosport and possibly Fareham population day surgery, five day surgery and post acute/ rehab.*
- ✓ *Organise extra capacity at PHT if not enough freed by above ? relocate more services off site to community hospitals around district.*
- ✓ *Free up community hospital beds*
- ✓ *Establish clinical leadership of post acute/ rehab*

7.22 Hub-hot and spoke-cold (day surgery), post acute/ rehab, ambulatory, outpatients and diagnostic centre.

Would require

	Spoke	*Hub*
Beds	*12 day*	*115 inpt*
Theatres	*2 day*	*5 main*

- *Would require further bed analysis for post acute/ rehab*

Advantages

- *Would avoid need for out of hours for spoke (depending on post acute requirements)*
- *Could reduce capital requirement at hub by increasing day surgery or post acute in spoke*

Difficulties

- *Would require Gosport MATS*
- *? manning of post acute/ rehab*

7.23 Hub-hot/cold and spoke-post acute/ rehab, ambulatory, outpatients and diagnostic centre

- *Capital requirement at PHT;*

Beds	*115 inpt*	*12 day*
Theatres	*5 main*	*2 day*

Further bed analysis required for post acute/ rehab

Advantages

- *Easiest to man from surgical/ anaesthetic viewpoint*

Difficulties

- *Significant hub capital development in theatres and beds although latter could be offset by post acute/ rehab in spoke, and former by using theatres elsewhere (BUPA)*
- *? manning of post acute*

7.24 Hub-hot/cold/post acute/rehab and spoke ambulatory, outpatients and diagnostics centre

- *Access to capital at PHT, would require*

Beds	*115 inpt*	*12 day*
Theatres	*5 main*	*2 day*

Advantages

- *Easy manning*
- *Most economic in long term?*

Difficulties

- *Most difficult to achieve in advance of PFI both politically and in terms of capital structure.*

8.3 Capital infrastructure RHH v GWMH

8.31 RHH

advantages
Ready access to suitable capital
disadvantages
Interim capital investment wasted if no long term future

8.32 GWMH

advantages
Long term future, capital investment has long life
disadvantages

- *Significant capital investment for theatres and diagnostics to be used for surgery.*
- *Requires GP sign up to reuse of beds*

8.33 RHH and GWMH retained

advantages
Least short term capital investment although in long term may be wasted investment.
disadvantages

- *Split provision if both need out of hours cover*
- *Less impetus to sort use of community hospital beds*

SUMMARY

4 issues compete for pre-eminence; manning, access to capital, ideal configuration and political expediency.
It could be argued that given the inability to avoid the first, the issue over manning should drive practical contingency plans.
This being the case, contingency planning would require retraction of most services to the QAH site with only outpatient, ambulatory and diagnostic services, and possibly day case and post acute services being retained in the Gosport locality.

Access to capital at both GWMH and PHT would not be possible without either significant additional investment, re-ordering of current capital priorities or off siting non acute/ hospital services from these sites.

Annex A

APPENDIX A

PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

ROYAL HOSPITAL, HASLAR

1998/99 ACTIVITY BASELINE

Speciality	1998/99 baseline								
	FCEs ordinary			Day Cases	Total FCEs	OPA New	OPA FU	Total OPA	A&E Attends
	Elective	Non-elect	Total Ord FCEs						
Accident & Emergency	0	27	27	0	27	0	0	0	20350
Anaesthetics	11	4	15	151	166	48	184	232	
Dental/Oral Surgery	99	9	108	236	344	1025	1821	2847	
Dermatology	21	13	34	1	36	1629	1684	3313	
ENT	508	101	609	20	629	979	2084	3063	
Gastroenterology	121	4	125	917	1042	0	0	0	
Haematology	12	0	12	12	24	144	2968	3112	
General Medicine	605	2448	3053	132	3185	1164	5645	6809	
Ophthalmology	71	3	74	127	200	600	2481	3081	
Orthopaedics	604	603	1207	117	1324	2513	4201	6714	
Paediatrics	40	21	61	11	72	197	781	978	
General Surgery	692	908	1600	123	1723	1432	2683	4115	
Urology	419	169	588	340	928	399	1597	1996	
Total	3203	4311	7514	2187	9700	10130	26130	36260	20350

Other Activity (inc. GP direct access)	Target
Clin. Measurements	1331
Chiropody	0
Dietician	25
Nuclear Medicine	103
Pathology	807
Physiotherapy	101
Anti coagulant (Haem.)	2000
Radiology	2021

ROYAL HOSPITAL, HASLAR
MILITARY ACTIVITY PROJECTIONS
TOTAL INPATIENTS AND DAY CASES

APPENDIX B

SPECIALTY	BASELINE 1999/00	YEAR 7 2006/07
DERMATOLOGY	26	21
GENERAL MEDICINE	387	504
HAEMATOLOGY	2	3
ORTHOPAEDICS	1497	1397
GENERAL SURGERY	1004	1247
ENT	542	500
OPHTHALMOLOGY	34	38
ORAL SURGERY	621	795
RADIOTHERAPY	45	52
ANAESTHETICS	1	1
PAIN RELIEF	90	99
GASTROENTEROLOGY	441	598
UROLOGY	678	634
GRAND TOTALS	**5368**	**5890**

BED NUMBERS			
BASELINE		YEAR 7 - 2006/07	
IPs	DCs	IPs	DCs
in Gen Med		1	0
7		7	0
in Gen Med		0	0
24		21	0
10		10	1
8		3	0
0		0	0
in ENT		6	0
0		0	0
0		0	0
0		0	0
0		0	1
5		2	1
54	**2**	**50**	**4**

Based on OHT throughput and casemix
AND 1998/9 RHH outturn

Haslar Scenarios

The Business Case assumes that the current working arrangements with Royal Hospital, Haslar will continue, ie that Haslar will continue to provide clinical services to the value of £7.7 m per annum for Portsmouth and SE Hants Health Authority. However the Trust has considered two further scenarios as follows:

Scenario A: Transfer of all activity to Portsmouth Hospitals Trust

This scenario assumes that:

- All military and civilian work will be transferred to Queen Alexandra Hospital
- The costs of delivering all civilian activity will be met by Portsmouth and SE Hants Health Authority
- The costs of delivering all military activity will be met by the Ministry of Defence

The Trust has estimated the additional costs (see enclosed OB1 form) and number of beds which will be required to deliver the civilian activity in 2001/02. This has been based on 1995/96 outturn, uplifted to reflect the population projections and additional trends identified in the original service planning exercise.

The results are shown below:

Additional beds • Inpatients • Daycase	 104 5
Additional capital costs	£5.67 million
Annual revenue costs (50% marginal rates)	£6.60 million
Net saving to P&SEHHA	**£1.10 million**

APPENDIX D

THEATRE USE at RHH

Current theatre allocation on RHH site

Main Theatres	*5*
Day Theatres	*2*

Weekly Sessional Allocations civilian and military

	Main Theatr	***Civ***	***Mil***	***Day Theatr***	***Civ***	***Mil***	
Spec							
Ortho	*18*	*8 (46%)*	*10*	*3.5*	*1 (27%)*	*2.5*	
G Surg	*11*	*8 (77%)*	*3*	*4*	*2 (66%)*	*2*	
Uro	*4*	*3(68%)*	*1*				
GU				*2*		*2**	**?*
MaxFa	*4*	*1(23%)*	*3*	*1.5*	*1(74%)*	*5*	
ENT	*6*	*3(55%)*	*3*	*2**	*1(65%)*	*1*	**inc. derm.*
Opthal	*1*	*1(78%)*		*3*	*3(98%)*		
Plast	*3*	*2(65%)*	*1*	*2*	*1(58%)*	*1*	
Pain				*2*	*1(70%)*	*1*	
Total	*47*	*26*	*21*	*20*	*10*	*10*	

Table shows current allocations with civilian military split calculated from 1998/9 activity outturn data

ROYAL HOSPITAL, HASLAR
CIVILIAN ACTIVITY PROJECTIONS
TOTAL INPATIENTS AND DAY CASES

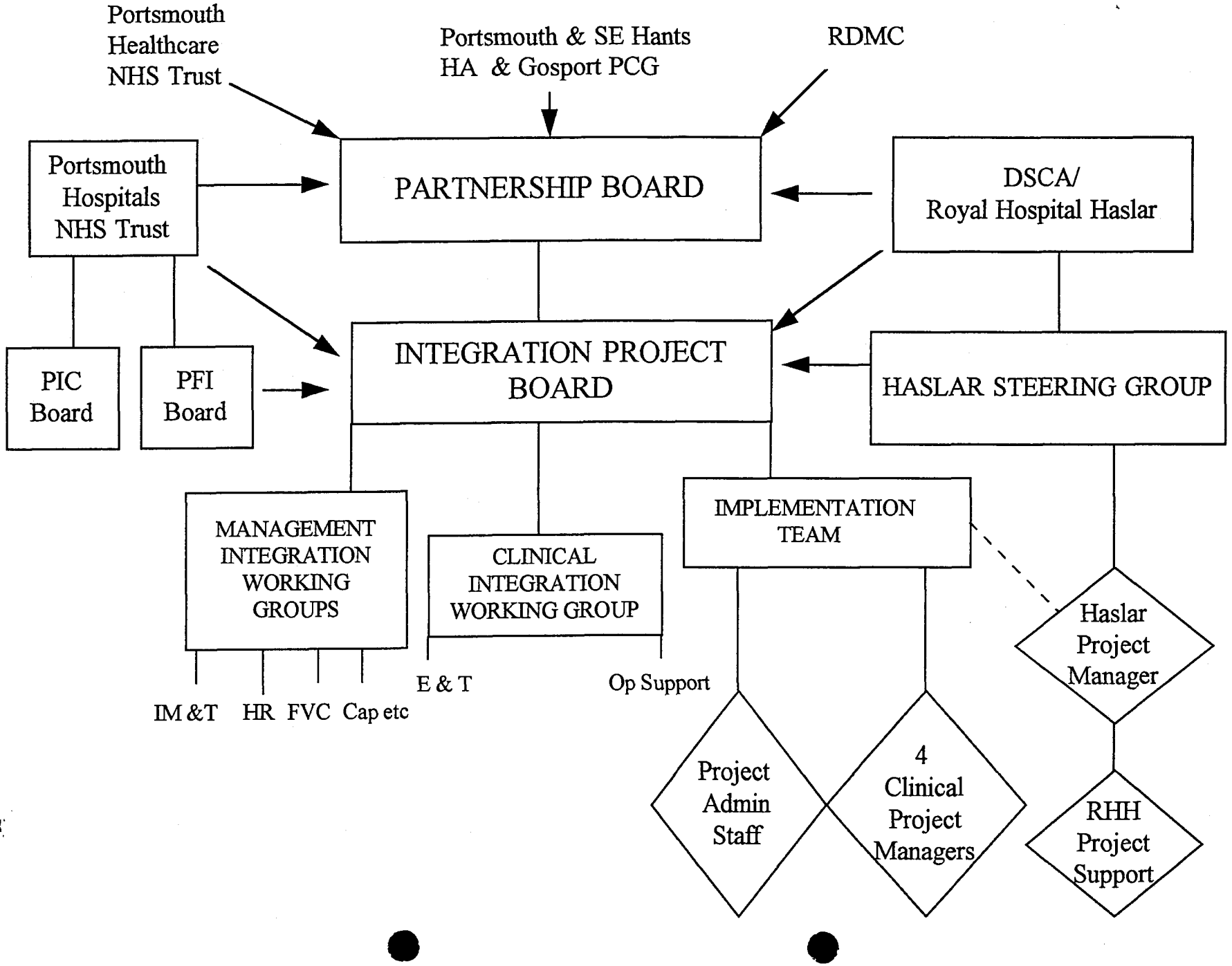
APPENDIX E

SPECIALTY	BASELINE 1999/00	YEAR 7 2006/07
DERMATOLOGY	35	34
GENERAL MEDICINE	3185	4134
HAEMATOLOGY	24	32
ORTHOPAEDICS	1324	1274
ACCIDENT & EMERGENCY	27	33
GENERAL SURGERY	1723	1964
ENT	629	560
OPHTHALMOLOGY	201	212
ORAL SURGERY	344	406
ANAESTHETICS	166	166
GASTROENTEROLOGY	1042	1427
UROLOGY	928	735
PAEDIATRICS	72	77
GRAND TOTALS	**9700**	**11056**

BED NUMBERS			
BASELINE		YEAR 7 - 2006/07	
IPs	DCs	IPs	DCs
in Gen Med		1	0
54		55	0
0		0	0
22		21	0
0		0	0
23		28	0
6		4	0
0		0	0
in ENT		1	0
0		0	0
0		1	2
10		4	1
0		0	0
115	**3**	**115**	**4**

Based on PSEHHA 98/9 activity baseline and PHT throughput

PORTSMOUTH PARTNERSHIP AND ACUTE SERVICES INTEGRATION PROJECT



PORTSMOUTH PARTNERSHIP PROJECT PLAN AND TIMETABLE

MAY 1999

ACTIVITY	LEAD	SUPPORT	ACTION	DATE DUE	RESULT
Risk Assessment					
Children's Services	PHT	RHH	Plan to Board	24 May	
A&E	PHT	HA/PCG	Plan to Board	24 May	
Anaes/ITU -staffing	DSCA/RHH	PHT	Rept to Board	24 May	
" - ITU accomm	PHT	HA	Design/build	Apr 2000	
Orthopaedics	DSCA/RHH	PHT	Rept to Board	24 May	
Cancer services	PHT	DSCA/RHH	Appoint oncologist	Feb 2000	
Gosport Services					
Contingency Plan	PHT	PHA/DSCA/PHCT	Plan to NHSE	? May 99	
Public Plan	PHA	PCG	Begin consultation	25 May	
Interim Plan	Integration Pro Bd	Partnership Bd	Workshop	24 May	
Integration Project					
Integration Project Board	PHT/RHH	DSCA	Next Meetings	25 May 29 June	
Clinical Integration	PHT/RHH			15 June	
Clin Educ Sub Gp	PHT/RHH	Deans		?	
Clin Ops Sub Gp	PHT/RHH			?	

ACTIVITY	LEAD	SUPPORT	ACTION	DATE DUE	RESULT
Integ. Project Man. HRM Working Gp Finance/Contr. W G Capital W Gp IM&T Working Gp Non-clinical W G Project Man team	 PHT/DSCA PHT/DSCA PHT/DSCA PHT/RHH PHT/RHH PHT/RHH		Meetings	 25 May ? ? 18 May ? ?	
DSCA Requirement MDHU requirement CDM requirement	 RHH Steering Gp SG office				
Trust PFI Clinical brief Non clinical specs OJEC Advert Select Partners	PHT	P&SEHHA	Announcement	?	

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 22 April 1999

Present:	Major General Chris Callow	Chairman
	Dick Bishop	
	Shirley Hardy	
	Penny Humphris	
	John Kirtley	
	Max Millett	
	Air Commodore David Rainford	
	Brigadier Guy Ratcliffe	
	Sarah Smart	
	Maggie Somekh	
	Surgeon Commander Rodney Taylor	
Observers:	Group Captain Duncan Mitchell	
	Commander Tony Taylor	
Apologies:	Dr Jane Barton	

No	Discussion	Action

1 Notes of the meeting held 17 March 1999

The notes of the last meeting of the Partnership Board, held 17 March 1999, were confirmed as an accurate and helpful record of discussions.

2 Communications and Intelligence

2.1 HoC Defence Select Committee

Brigadier Ratcliffe reported that the HoC Defence Committee visit to RH Haslar on 14 April had looked primarily at defence issues and particularly concerns about DMS staffing. Mr Peter Viggers MP had handed over the draft Task Group plan for health services in Gosport. Maggie Somekh said that she had a copy and would circulate this. It included a fundamental misconception about the scope to expand a Portsmouth PFI to include an MDHU and concentrated on the perceived strengths of Haslar and ignored weaknesses. Penny Humphris suggested a joint DSCA/PHA/PHT response to cover both defence and NHS issues. This should put the planned closure of Haslar in the context of clinical integration funded by a PES transfer of funds from MoD to DoH to fund civilian work, and positions for MDHU staff in the management structure of the Trust. It was further agreed that Maggie Somekh, Penny Humphris and Dick Bishop should agree a common response to the Select Committee by 5 May. Surg Cdr Taylor said that Mike Hancock MP had also visited separately and had the same brief as the other HoC committee members.

MS | SJH

MS | PH | DB

2.2 Press contacts

Penny Humphris said that she and her Chairman had been directly briefing the Portsmouth Evening News' Gosport reporter, who attended the Task Group meetings, on the HA approach to the development of a plan for

healthcare on the Gosport peninsula and the planned public consultation process. This had helped to increase understanding of the different responsibilities of the organisations involved in change.

2.3 Heath Authority Awayday

Penny Humphris also reported that the Health Authority had organised an awayday for key stakeholders on 20 April, facilitated by Nigel Edwards of the London Health Economics Consortium. They had looked at some interesting health needs information and there had been a high degree of agreement on realistic models of care for the future. This would be pulled together into an outline public plan for comment consultation document which would include examples of the sort of care Gosport people could expect to receive in situations which concerned them. The target date for publication is 24 or 25 May. PH

2.4 Common Communications

Shirley Hardy said that she still had no responses on organisations' PR support and it was agreed that she would work with Penny Humphris to put this communications co-ordination in place before the publication of the HA Gosport consultation document. PH | SH

3 Integration Project

Sarah Smart said that the first meeting of the Integration Project Board had taken place on 20 April. This had provided senior managers and clinicians from both PHT and RHH with their first opportunity to sit down together and to understand how integration would be managed and their own contribution to that. All present wanted more information on the context in which they are expected to work and the final vision for services in the area. This should be available for the next IPB meeting on 25 May, following publication of the HA consultation document and the Partnership Board's own workshop on 24 May. There had been a high level of commitment to integration, but concern about the timetable and issues of project support to allow people with very busy jobs to contribute properly to this work.

The Board recognised its own responsibility to work with PHT and the DSCA to both scope and resource the Integration Project, and to use the time available on 24 May to plan the short-term change programme, in the context of the HA's longer term outline plan being published for consultation. This planning would need to take account of the areas of risk in current RHH services and the protection of military training requirements.

4 Risk assessment and action to manage risk

4.1 Anaesthetic and ITU services

Sarah Smart reported that. discussions had taken place between anaesthetists in PHT and RHH covering both adult and children's services. The two departments are very willing to work together, but PHT does not see it as feasible to take on another emergency rota to cover a third acute site in Portsmouth. There is also a willingness to advertise additional jobs once the work content has been clearly identified, but a concern that any posts with three site obligations would prove unattractive for recruitment.

The discussion on consultant staffing requirements to maintain an ITU or HDU at Haslar currently requires a response from RHH on the length of time that the DSCA can sustain this service without PHT input. The PHT consultants are not prepared to support an off site ITU, after their experiences of trying to do this at SMH, so if the Services cannot support an ITU at RHH, the shortfall of beds will need to be made up by extension of the facilities at QAH. This will require building works which could take up to 12 months and should be authorised immediately if this is an area of risk. PHT were asked to GR | RT

continue to work up this plan and to create capacity so that it is available if required. SS

4.2 **Trauma and orthopaedic services**

There has been limited progress in the discussions of risk management in this specialty since the last Board meeting. The CD at RHH, who had indicated that he might be able to maintain consultant cover into 2000, had been away on operational duties, now extended to early May, and nobody else seems to have the full picture. PHT has made an appointment to its 9th consultant post, but this is one of the RHH consultants. This may assist collaboration, but does not add to the total number of consultants in the area. Dick Bishop said that PHT required 15-16 orthopaedic consultants to cover its current population, never mind the additional civilian and military population served by RHH. This currently requires at least 6 consultants and so there is a considerable combined shortfall. External recruitment is likely to be of only limited effect because of the gap between demand and NHS Specialist Registrar accreditations. The Dean said that the Services would be accrediting 7-8 Sp Rs over the next 3 years and it was agreed that the DSCA would examine the scope for increased Service staffing prior to the next meeting in this specialty, to be held when the CD returned. CC

4.3 **Accident & Emergency Services**

.Sarah Smart reported that clear staffing criteria had now been agreed for the continued provision of children's A&E services at RHH, in line with Action for Sick Children and other national guidelines. Brigadier Ratcliffe welcomed this information and agreed that it was most unlikely that the DSCA would be able to meet these, given that children's services is not part of military medical requirements. General Callow agreed that a decision would need to be made on an end date for this service because it is not acceptable in terms of clinical governance for the Agency to provide services which do not meet current standards.

A decision to close the children's A&E services raises difficult choices in relation to alternative provision between:

- An adult only service in Gosport
- A mixed emergency service at RHH with full adult A&E services and an A&E managed minor treatment service for children
- A minor treatment service only for all age groups.

The first was felt to be inadequate in that all children would have to go to a hospital off the Gosport peninsula in an emergency; the second would require the public to remember the distinction between what was offered for adults and what for children, and to make the right choice of service provider in an emergency; while the third option would downgrade the whole level of emergency healthcare provision on the peninsula. Any decision to reduce the current service will cause public concern and should be subjected to public consultation. Maggie Somekh suggested that the adult service might continue at RHH and the children's service transfer to GWMH to help the public to make the distinction between A&E and minor injuries, but there were concerns about workload, staffing and backup at GWMH which is currently a GP run service.

Sarah Smart said that she believed that it would be feasible to provide an adult only service at RHH, and to maintain SHO training slots, if all PHT and RHH A&E SHOs are pooled and rotated between QAH and RHH, or if additional A&E staff are brought into RHH to allow Service SHOs to spend

part of their post at QAH for broader experience. PHT consultants are concerned that the first pooling option would make the SHO posts unattractive to potential recruits, but she believed that more information was needed on the feasibility of both these staffing options. SS

There was broad agreement that the mixed service should be retained if at all possible to allow time for consultation and the development of other services on the peninsula, but that the balance of risk between ease of access and quality and clarity of local services should be further assessed. Dick Bishop said that they all had a responsibility to be realistic and professional in considering these very difficult choices and General Callow pointed out that this had to be set in the context of growing and unpredictable operational demands on the Defence Medical Services. Penny Humphris said that the HA was committed to proper processes of public consultation, but that it was difficult when the MOD could change its health provision without consultation and this might restrict the Authority's options for consultation.

It was agreed that the A&E consultants should be asked to further develop these options for consideration by the Board at the awayday on 24 May 1999. They could be looked at in the context of the other risk areas such as ITU and surgical services. SS

4.4 Children's services

Sarah Smart said that clear plans are about to be agreed for the transfer of all children's inpatient and day case services from RHH to QAH or SMH. These would protect the clinical interests and training requirements of the DSCA, and although there could be some offsetting transfer of adult work to RHH, would have financial implications because not all the funding could be released from DSCA funds to PHT. Brigadier Ratcliffe said that RHH was losing RSCN staffing because of the uncertainty and would find it impossible to staff the children's ward, D6, beyond July.

Following further discussion, it was agreed that a late summer closure would probably be unavoidable, but that more work needed to be done by the HR sub-group on staffing issues, and a link made to the decision on A&E services before a final date could be set. Patients booked for admission to RHH could then be given alternative dates at QAH or SMH. SS | MS

4.5 Cancer services

Shirley Hardy said that this was emerging as another area of risk for RHH, and raised many of the same issues which had been discussed in relation to other services. The catalyst would be the loss of the Service oncologist from RHH in February 2000, but the key surgical specialties – breast and colorectal – are now single handed and may need to consolidate with services in Portsmouth. It has been suggested that combined breast surgery services should be further developed at RHH and major colorectal work consolidated at QAH. John Kirtley confirmed that the Gosport PCG strongly supported the retention of local cancer services, such as the day chemotherapy services, and it was agreed that a replacement oncologist should be recruited by the Trust, but with a job description and interim funding which protected Gosport services and reflected DSCA requirements in respect of cancer services for military personnel. The wider issue of development of integrated cancer services would be picked as part of the imminent NHSE regional review of Portsmouth's Cancer Centre status and the linked RHH Cancer Unit. SS

4.6 Timetable

The Board recognised that while each of these areas of risk might individually be manageable, together they suggested that it might be very difficult to maintain the current character of RHH as an emergency site. The Board might have to consider the timescale for a move to a 'hot/cold' relationship between the PHT and RHH sites and the management of this in terms of both

military staffing requirements and appropriate services for the Gosport population. The Integration Project Board should be able to plan for service rationalisation in a way which protected the Service role in emergency services and most of the training posts, but the Partnership Board would need to control the pace of change for the civilian population of Gosport, in line with the planned public consultation.

The Dean expressed concern that single site integration of emergency services, even with the same population served, might lead to a loss of training recognitions and it was agreed that all issues would have to be resolved at the workshop on 24 May, and that it would be helpful to have external input, as in January. Penny Humphris was asked to see if Nigel Edwards, could work with the Board on this date, as he has already contributed to the HA's strategic planning and understood the issues. PH

5 Educational Impact Assessment

Surg. Cdr Taylor presented information on the medical training post requirement for the integrated Portsmouth hospitals and it was agreed that this would now be dealt with through the DSCA MDHU requirement. The DSCA would be putting forward the number of posts which it required in Portsmouth, including nursing, technical and other posts, and the Trust would respond as to the number which could be accommodated. The DSCA will then need to confirm the number of posts which can be filled on a year by year basis, in line with the availability of Service manning, and to agree how vacant slots can be covered by the NHS until Service personnel are available. Maggie Somekh asked the RHH Executive Team to work with Shirley Hardy to produce this information for the MDHU requirement. GR | RT | SH

6 MDHU Requirement

Maggie Somekh confirmed that the DSCA and RHH are working on the Portsmouth MDHU requirement, using the standard MOD contract format, but including relevant local detail in relation to both the Host and Treatment Agreements. The Host Agreement would set out the numbers and requirements in relation to Service staffing, as 5 above, and the Trust would need to relate this to the transferred Service and civilian patient workload and identify its staffing requirements over and above the Service staff availability to deliver the work. The Trust has requested detailed RHH workload information including length of stay, theatre sessions, bed utilisation etc. to enable them to plan to take on RHH staff and work, while RHH is working on other areas such as the military accommodation and infrastructure requirements. Sarah Smart said that the patient information is also needed for the work requested by the Region on contingency planning. The full MDHU requirement is also required for inclusion in an updated PFI Outline Business Case, which has to be supplied to the DoH by the end of April, although a PFI announcement is now not expected before the second half of May. SS | MS

Sarah Smart further confirmed that this revised OBC would only relate to the MDHU requirement, as the Trust had declined to put in an expression of interest in relation to the Centre of Defence Medicine. This was purely because the timescale for initial response to Glasgow was very short (10 May) and clashed with a whole range of other urgent Trust work with the DSCA around integration with RHH etc. The CDM paperwork issued was complex and unclear, but appeared to rule PHT out in any case, as the Trust did not meet the criteria specified. Even if PHT was successful at this pre-qualification stage, the tender stage would require even more work which would clash with the Trust timetable for PFI specifications and OJEC advertisement, which is now timed for the end of the year.. The Trust would be very willing to look at provision of this requirement, if requested to do so by MOD, but could not give the complex CDM tendering process priority over its other NHS work. MOD representatives agreed to take this back and thanked Sarah Smart for such an honest explanation of the Trust position. CC

It was also pointed out that the process of integration between PHT and RHH into the MDHU, also had implications for the civilian staff working at RHH who had to be managed in line with Civil Service procedures. These were based on the search for suitable alternative employment, for staff made redundant by service change, within the Civil Service and the balance between this policy and the need to retain clinical skills in the combined service would have to be sorted out in the HR Working Group.

The MDHU Treatment Agreement will cover the clinical services required for Service personnel and to support DMS clinicians in overseas hospitals and operational settings. Shirley Hardy said that the collection of information to support the Host Agreement is progressing well, but that she was more concerned about the development of the Treatment Agreement which needs to be more comprehensive than those of other MDHUs to reflect Haslar's existing role as the core hospital, and its back stop and co-oordinating role in Service patient care. Some of this functionality might transfer to the CDM, but until this had been agreed for another location, it must be protected in Portsmouth. It might necessitate the development of clinical protocols for Service patients in areas such as cancer services, where there can be unacceptable variations in local NHS services offered to Service personnel. These variations were currently overcome by the availability of services in the core hospital and the transfer of this responsibility, together with medevac and other military clinical support services, will need to be costed by the Trust as part of the negotiations for the MDHU contract, if this functionality is required in Portsmouth, rather than at the CDM.

7 Project Plan

The Board noted the range of activities listed in the Project Plan and asked Shirley Hardy to update this for circulation to Board members. SH

8 Dates of future meetings

Confirmed as:

Monday 24 May - All day Workshop at Fort Blockhouse

Tuesday 6 July - 10.00 am at Royal Hospital Haslar

Thursday 16 September – 9.00 am at Finchdean House

Monday 8 November – 12.30 pm at Royal Hospital Haslar

SJH/04/05/1999