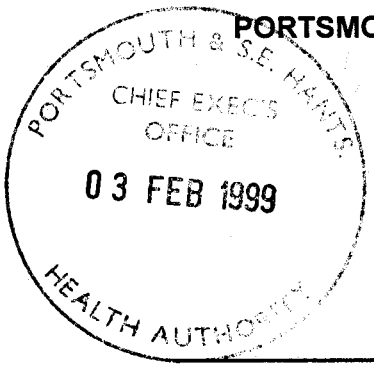
- AHT - maintaining viability of Haslar
- HA - needs
- MOHU - PFI partnership — timescale

PH

- CDM paper 2 wks ahead of 3 March
- leader spec.



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

PORTSMOUTH PARTNERSHIP BOARD

- PFI announcement
- MOHU definition
- HA - Gosport needs assessment

10.45am. Friday 5 February 1999
Finchdean House, Milton Road, Portsmouth

AGENDA

1	**Apologies for absence**	
2	**Notes of Meeting held 18 December 1998** Bob Paulton	Attachment 1
3	**Matters Arising** - Communications	
4	**Report of Workshop held 25 January 1999**	Attachment 2
5	**Royal Hospital Haslar - Risk Assessment** Report from Hospital Commander	To be tabled
6	**Discussions on Clinical Integration to Manage Risk** Report from Sarah Smart & Shirley Hardy	To be tabled
7	**Royal Hospital Haslar - Information Baseline** Report from Hospital Commander	To be tabled
8	**Development of a Structure to Plan and Manage Partnership and Integration** Proposals from Penny Humphris & Sarah Smart	To be tabled
9	**Recruitment & HR Plan** Progress report from Sarah Smart & Maggie Somekh	
10	**Any Other Business** — G.B.C.	
11	**Dates agreed for future meetings:** Wednesday 17 March 10.00 am at RH Haslar Thursday 22 April 09.30 am at Finchdean Monday 24 May - All day Workshop at Fort Blockhouse	

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
Commodore Ian Jenkins, Dean

Portsmouth Healthcare NHS Trust
Max Millett, Chief Executive
Tony Horne, Director

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

29 January 1999

Portsmouth and South East Hampshire Health Authority
Defence Secondary Care Agency
Portsmouth Hospitals NHS Trust
Royal Hospital Haslar
Portsmouth Healthcare NHS Trust
Gosport Primary Care Group
Royal Defence Medical College

CLINICAL COLLABORATION STEERING GROUP

Notes of the Meeting held 18 December 1998

Present:

Penny Humphris Chairman
Dr Jane Barton
Dick Bishop
Major General Chris Callow
Shirley Hardy
Tony Horne
Surgeon Commodore Ian Jenkins
Brigadier Guy Ratcliffe
Sue Robson
Sarah Smart
Maggie Somekh
Surgeon Commander Rodney Taylor
Paula Turvey

No	Discussion	Action

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1 **Welcome to new members**
The Chairman welcomed representatives from Portsmouth Healthcare NHS Trust and the Gosport Primary Care Group to the Clinical Collaboration Steering Group.

2 **Notes of Meeting held 15 June 1998**
The notes of the meeting were accepted by those who had been present.

3 **Ministerial Statement on the Defence Medical Services**
General Callow said that the Ministerial statement had covered a broad review of the Defence Medical Services (DMS) and addressed a wide range of issues including support to operations, recruitment and retention of DMS personnel, Service healthcare provision, a new MDHU at Northallerton, and closer working with the NHS, as well as the future of Haslar. The Minister had said that RH Haslar would close when suitable alternative arrangements had been made for Defence secondary care and allowed for MDHU negotations in Portsmouth as well as a tendering process to establish a Centre for Defence Medicine (CDM). The immediate priorities were to keep Haslar viable until suitable alternative arrangements to meet Service and civilian needs are in place.

In discussion, it was confirmed that the CDM had replaced the concept of the core hospital and was different only in the sense that it did not imply MOD ownership of separate hospital estate. There were a number of possible locations for such a centre, but any move away from Portsmouth would imply agreement on access to a share of the local NHS population base. It was hoped that a specification for the CDM could be available by April. The requirement for an MDHU in Portsmouth has also not been determined as yet and could be in the range of 50-150 beds. The

DMS are currently 30-40% below establishment and so DSCA services cannot expand faster than manning permits. The ultimate target may be as many as 9 MDHUs to meet training and Service healthcare requirements. Training is increasing, including nurse training which is based on Portsmouth University and currently needs placements for around 100 student nurses at any one time in the Portsmouth area. The Services are now committed to working with the NHS and are looking for the win:win situations.

Surg. Commodore Jenkins stressed the importance of protecting the Service medical training posts within the various Wessex rotations and said that this was important to the NHS as well as the DMS. Erosion of medical training opportunities and increased premature retirement (PVR) by DMS staff could collapse the rotations very quickly. NHS representatives suggested the need for an early move to DSCA/Trust partnership to support all the training posts in the Portsmouth area and pointed out that there was no shortage of clinical work to be done. The resources of all organisations need to be merged to create the right interim configuration of services and to work towards a final outcome which works for everyone.

Sarah Smart said that the Trust was committed to full clinical integration to make the best use of resources to meet the total Service and NHS requirement through joint agreements with local Primary Care Groups (PCGs). This could involve greater use of RH Haslar (RHH) in the interim. Dick Bishop said that healthcare for the civilian population was expected to grow at 13% p.a. with challenging NHS targets, such as max. 13 week delay for 1st OPD appointment and 20% reduction in day/in-patient waiting lists + 7% annually thereafter. This would push the output growth rate up to 6-7% and Portsmouth Hospitals Trust (PHT) would not have the capacity to achieve this in advance of expansion at the Queen Alexandra Hospital (QAH). The Trust is already working with St Richard's Hospital (SRH), BUPA and RHH and believes that everyone will need to work together to solve shared problems. The Trust was however concerned about the date of 2002 in the Ministerial statement as new accommodation is unlikely to be in place by then. DSCA representatives said that the date was intended to reassure people that change was not going to be immediate and that it might well be that discussions about a Tri-Service MDHU in Portsmouth would grow into the CDM, as no civilian caseload is currently available to the DSCA outside Portsmouth.

Sarah Smart also pointed to the need to free up financial barriers at the earliest possible time. Maggie Somekh said that this had just been discussed at a meeting with representatives of the NHS Executive in both the South & West Regions and the new South East Region. It would be a couple of years before money could move between Government departments in the PES round, but both organisations were committed to creating the necessary flexibility to allow change to proceed in Portsmouth. The DSCA might be able to make the Free Good available as virtual cash and shared the aim of a seamless civilian service and seamless cash arrangements for it.

4 **PFI bid by Portsmouth Hospitals NHS Trust**

Dick Bishop said that the Trust had been hoping for an announcement on their PFI bid before Christmas, but the timing is now uncertain. They remain hopeful that Portsmouth will be on the list and the Trust is working on interim objectives to meet Government targets. The new SE Region of the NHSE is supporting local delegation of interim capital schemes costing £1-2m and the Trust is taking active steps to try and solve its recruitment and affordability problems. The change in casemix created by the waiting list reduction is an expensive problem for the Trust.

5 **Establishment of Primary Care Groups**

Dr Jane Barton said that the Shadow Board of the Gosport Primary Care Group had held its first meeting and was made up of 7 GPs together with representatives from the Health Authority, Social Services and the local community. There would be an election for nurse representatives and the Board is planning to talk to the Trusts and RHH about services for the local community by about February. Brigadier Ratcliffe said that RHH had welcomed Dr Barton to the Hospital Board and would be talking to local GPs shortly about the implementation of the Ministerial Statement which protected the future of RHH in the interim period. Penny Humphris said that the Health

Authority would be working with all the PCGs to replace the existing system of contracts for services with Long Term Service Agreements based on partnership and collaboration.

6 **Development of an Implementation Action Plan**

Penny Humhris suggested that PHT and RHH should undertake a stock-take of the position in each of the clinical specialties and the identify the short term action required to achieve collaboration or clinical integration. Dick Bishop said that the Trust would need to re-structure to manage PFI and its other change plans and now wanted to take RHH into this process as well. Sarah Smart then provided further information on this and tabled Trust ideas for joint structures covering the following:

- Cross representation at organisational board level
- The development of a Stakeholder Group to oversee change and representative of all interest including MOD, DoH, P&SEHHA, PCGs and LAs
- The creation of a PHT/DSCA Partnership Board to provide strategic management across a wide range of shared concerns such as the development of an MDHU (or possible a CDM), the interim viability and use of RHH, the PFI project, the development of corporate objectives and the practical and cultural issues which would need to be tackled to achieve integration
- An Integration Project Board to work in more detail on these interim management issues to achieve integration of resources and services in line with DSCA and NHS requirements
- A range of working groups to support the integration project covering areas such as clinical integration, HRM, Finance, Capital, IM & T and non-clinical services
- DSCA input into the Trust PFI Project Board which will be working very closely with the Trust PIC Board to progress new development on the QAH site based on new approaches to clinical and other work. The Trust was in effect planning for a re-engineered hospital and hoped for RHH involvement in this change programme which would begin with workshops in January and February to develop new generic patient processes

General Callow said that the DSCA is very aware that the Service involvement would double the workload faced by the Trust to re-engineer and develop its PFI, but that he had to focus on the immediate threat to the current survival of RHH. He believed that the medium-term future of the DMS is good, but wanted to focus on immediate collaboration requirements in which everyone would have short-term gains and achievements as this would give the right signals and assist DMS recruitment and retention. Brigadier Ratcliffe said that everyone at RHH was feeling very bruised and surprised by the introduction of 2002 as an apparent end date to the life of the hospital without any alternative specification or location for a CDM. The DSCA would begin to consult on this in the New Year but current anxiety levels are very high.

Penny Humphris suggested that more 'waiting list' work could be located at RHH to maintain activity, but Brig Ratcliffe said that staffing levels prevented this, unless the Trust could transfer work and staff. General Callow confirmed that he was seeking to transfer more Service nurses to RHH to make it possible to re-open the closed surgical ward, but said that he found people suspicious of collaboration which was seen to be all one way and in favour of the NHS. Commodore Jenkins said that he believed that people were becoming more open to collaboration and involvement with the Trust, but he did not understand why, if the HA wanted to move to a single acute site for Portsmouth, it was prepared to support clinical integration and increased use of RHH in the interim. Dick Bishop saw parallels between this question and the earlier discussions about the change in concept from 'core hospital' to CDM. What is envisaged in the interim is a single DGH on more than one site with all clinical services working together from a single hub and supporting distributed services in the spokes. These would continue for as long as

their facilities were needed or to provide access for local residents to outpatient and ambulatory services. The Trust wanted to try and make the interim configuration work in this way. Maggie Somekh said that staff at Haslar currently had a sense of impotence in relation to the future and needed to be involved in planning for the future in a way which would keep them engaged and to see immediate gains such as NHS support to re-open the surgical ward on a 5 day basis.

Sarah Smart said that she believed that joint management of work through fully integrated clinical teams using all the NHS and DSCA resources available would be the only way to work in the interim and that this could keep RHH open and enable the DSCA to meet its training requirements. Commodore Jenkins questioned whether this was what the Defence Review Team meant by protecting the interim viability of RHH, but General Callow said that he believed that the only way in which it could be done was in partnership with the Trust to achieve shared long-term aims. If RHH is no longer seen as a threat, it can be seen as a valued partner. There is mutual advantage for both organisations in the short-term to prevent a down-ward spiral in activity and the loss of training recognitions. The next 6 months would be critical, but as long as RHH is open it will be resourced by MOD.

Dr Barton said that there was an urgent need to explain what is envisaged to the people of Gosport who are very anxious about the loss of local DGH services. Statements have been made about keeping RHH open until there is a viable alternative and about consultation with local people, but there will need to be a real marketing initiative to convince the local people that any alternative can work. Everyone present agreed on the need to increase trust and confidence around the management of the change which the Ministerial Statement had launched and recognised clear partnership structures as one way of achieving this. Brig. Ratcliffe said that he had already confirmed his support for partnership with Dick Bishop and recognised that consultation and marketing had to work with two different groups with different interests:

- RHH staff
- Gosport people and GPs

This analysis was supported and the need to do more to handle the Press, the local Council, MPs etc. was recognised to prevent a crusade to keep RHH open distracting hospital staff from playing a full part in the Partnership agenda envisaged.

Dick Bishop said that a number of clear statements could be made to support this, such as:

- RHH will not close in the near future
- All parties will work to preserve appropriate local services in Gosport
- A&E services will continue for the foreseeable future
- The change programme would be based on Partnership not Trust takeover

Ian Jenkins suggested that the most important commitment that could be made would be for the NHS to help to sustain paediatric services at RHH as this would make it possible to sustain A&E and all the other services and make it possible to increase volumes of activity again.

Sarah Smart and Penny Humphris expressed concern at the suggestion that the decision of 18 November on the early planned closure of in and day patient children's services at RHH should be re-opened, but recognised the impact that this would have on the viability of the whole A&E and linked adult services and the need to plan for these in parallel with planning for children's services. They are committed to the development of new models for A&E services which could meet safety standards and training needs and provide a good quality service to Gosport people.

Penny Humphris said that the HA was keen to look at models in other parts of the country and Maggie Somekh said that the DSCA could arrange a visit to Northallerton where a small hospital was sustaining A&E and providing the right environment for an MDHU.

7 **Children's Services**

Penny Humphris said that she was sorry that time was now too short to discuss plans for the transfer of children's services in any detail, and proposed acceptance of the progress report from Sarah Smart and Shirley Hardy. They, together with Paula Turvey, were planning a series of meetings during January 1999 to look at all the requirements for change and would bring a report for decision to the next meeting of the Group. Dick Bishop said that ideas were already coming forward such as the transfer of children's ENT lists to QAH and their replacement by extra adult lists at RHH. Ian Jenkins said that he did not believe that this would work in training terms and that RHH would lose recognition for junior medical posts which would severely affect the whole Wessex rotation. Trust representatives questioned this and said that the total level of patient activity was not being changed, and might well increase as a result of the new arrangements, and said that they believed that it should be possible to link posts to new patterns of work in a way which protected all posts and met Royal College requirements. Brig. Ratcliffe said that he would not be able to agree to any change in the current pattern of services at RHH until he was satisfied that suitable alternative arrangements are in place.

Penny Humphris said that the Group needed to identify the most critical areas for immdediate work and suggested that these are:

- Future models for A&E services looking at both service and training issues: - Trust/HA lead
- The new pattern for children's services, including the protection of out-patient and diagnostic services on the Gosport peninsula: - Trust/RHH lead
- Development of new financial arrangements between the DSCA and NHS to support change:– HA/DSCA lead

8 **Future meetings**

Penny Humphris said that there were still some very fundamental differences of view between members of the Group about the way forward, although she believed that participants had accepted the need to move on from collaboration to partnership and this could be reflected in a change of name to Partnership Steering Group. A longer time slot would probably be useful to develop a shared action plan which can meet the need of all parties and a whole day should be set aside for this, followed by a shorter business meeting.

The following dates were agreed:

Monday 25 January 1999 – All day Workshop at Fort Blockhouse, Gosport

Friday 5 February 1999 – Partnership Steering Group Business Meeting, Finchdean House 10.30

SJH/1-Jan-99

PORTSMOUTH PARTNERSHIP WORKSHOP
Fort Blockhouse - 25 January 1999

Attended by representatives of:

Portsmouth & SE Hants HA and Gosport Primary Care Group
Penny Humphris, John Kirtley, Dr Jane Barton

DSCA HQ, RH Haslar and Royal Defence Medical College
Major General Chris Callow, Surgeon Commodore Ian Jenkins
Brigadier Guy Ratcliffe, Surgeon Commander Rodney Taylor,
Maggie Somekh, Shirley Hardy

Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts
Dick Bishop, Sarah Smart, Max Millett, Tony Horne, Bill Hooper

1 Introduction and Welcome

Penny Humphris introduced the Workshop objectives and facilitator, Steve Boardman of Finnamore Managment Consultants. He proposed ground rules for the day to avoid:

- monopolising conversation and debate
- breaking the trust of other workshop members (for example though subsequent indiscretion outside the workshop)
- unnecessary use of jargon
- undermining each other, through sarcasm, rudeness or trivialising any contribution
- interrupting each other
- sitting in unhappy silence, instead of pointing out when something is not in line with agreed working principles

2 Portsmouth Hospitals NHS Trust - Change Programme

Sarah Smart described the range of change being planned and managed by PHT as part of their PIC, PFI and Partnership programmes. This covered:

- The Trust's strategic objectives relating to service re-engineering and rationalisation onto a single acute site, linked to a PFI development and supported by local community hospitals
- The change programme developed from this around Partnership. PFI and Processes to Improve Care (PIC)
- The implications for the Trust of the MOD decision to close Haslar, including the need to reconfigure and integrate clinical services and the implications of this for services from the QAH site and in Gosport
- The progress of clinical collaboration between PHT and RHH to date
- Interim capital schemes required to facilitate the closure of the East Wing at SMH within 3 years and withdrawal from the finger wards at QAH to allow the PFI scheme to go ahead
- Progress on PFI, initially at risk, to meet the planned timetable of OJEC advertisement in June, shortlisting of 2 or 3 potential private sector partners by the end of October, close with a chosen partner by December 2000,

agreed design by the end of 2002 and occupation of the new building in 2005/6

- Development of a clinical brief for the new building based on whole healthcare system patient processes and whole hospital policies, to be achieved over the next 6 months, building on the PIC re-engineering work
- The links between this and the wider Partnership agenda to achieve clinical integration with RHH and co-ordinated and co-operative patient-focused working relationships with other local Trusts and the new PCGs
- Development of new structures to manage all this.

In discussion following the presentation the following points were made:

◊ Public consultation to date had been based around the Trust's strategic objectives in relation to rationalisation and reconfiguration and did not cover change in relation to the DSCA and Gosport. There needs to be a wider public consultation on the implications of the planned MOD closure of Haslar

◊ The Trust's strategic plan has been agreed in detail with the Health Authority with affordability as a key objective. The financial framework needs to be extended to take account of the Ministerial announcement and the changes arising from it, and the PES transfer of funds from MoD to DoH achieved as soon as possible

◊ Discussions with the public on what is possible for the future must be contained within that financial framework of affordability

◊ The Ministerial announcement that Haslar will not close before 2002 has not been helpful and has caused more anxiety and uncertainty than it has allayed as nobody understands the reason for this choice of date which is not linked to the likely PFI completion date of 2005/6

◊ Portsmouth Hospitals is committed, whatever the national political decisions, to local progress based on shared corporate objectives between the Trust and the DSCA and is prepared to offer the DSCA a full place in Trust structures to achieve change

4 The DSCA requirement for a new MDHU

Brigadier Guy Ratcliffe presented the current DSCA view of the MDHU requirement in Portsmouth based on the likely specification for a large Tri-Service unit which would protect existing DMS training arrangements, whatever the chosen location for the Centre for Defence Medicine. This covered:

- The definition of an MDHU - a military unit in which medical military personnel undertake clinical practice alongside their NHS counterparts in an NHS Trust, but remain available for deployment on military operations, exercises and training
- The use of two contracts (SLAs) covering the value of DSCA staff working in the Trust and the payment to the Trust for services to military patients
- The core DSCA specialties and others which might be located in a Portsmouth MDHU
- The definition of a turbulence factor in the calculation of the value of DSCA staff working in the Trust

- The size of unit which might be required in relation to the size of the Trust taking account of consultant ratios and training requirements
- The training and military and administrative infrastructure and other requirements
- The standards and requirements for the treatment of military patients
- The next steps in relation to the work on the MDHU and CDM requirement, the contribution to the Trust programmes and integration of services and the timescale for change

The discussion following this presentation covered the following points:

◊ The effect of 30% undermanning in the Defence Medical Services on the DSCA's ability to run both an MDHU in Portsmouth and a CDM located elsewhere

◊ The importance to the DMS of the current training opportunities in Portsmouth when the levels of training need to increase rather than reduce

◊ The value of applying learning from experience in existing MDHUs to progress on the development in Portsmouth and the possible benefit to be gained from Partners' visits to these MDHUs

◊ The need to manage the implications of current Service undermanning in relation to the number of wards required and cover for Service consultant posts, if DSCA numbers drop rapidly, to protect training slots.

◊ The need to work with both the RDMC and NHS RPG Deans to assess combined postgraduate training capacity if clinical services are integrated between RHH and PHT

◊ Continuing uncertainty about the reason for the 2002 closure date for RHH given by the Minister and the need to ensure that no unilateral change takes place until suitable alternative services have been put in place

◊ The need to link closure to both the interim capital programmes of both organisations and the target PFI completion date of 2005/6 and the need to move beyond thinking about bricks and mortar to create a stable interim pattern of clinical services in the area based on a single access door and a virtual MDHU structure

This last proposal was strongly supported and everyone agreed that RHH is likely to remain open until around 2005 but that interim reconfiguration of clinical services will create a virtual MDHU arrangement much sooner than this. This conclusion led to the following comments:

◊ RHH specialties such as orthopaedics which are at risk because of proposed resignations might be affected by a clear understanding of future arrangements and opportunities arising from integration with the NHS in Portsmouth which can maintain viability

◊ The evidence from the CO's interviews with consultants (59 to date) suggests that many are indeed considering their futures because of this uncertainty. Some have been unsettled by the past 5 years of change in the DMS and do not want any more, but others might be influenced by a clear vision for the Centre for Defence Medicine and information on its likely location and on the plans for RHH and for integrated services in Portsmouth

◊ Everyone is aware that RHH will collapse if nothing is done and is assuming that this is going to happen because they do not know of any alternative plans. A common view of the way forward must be agreed and supported by everyone to create the necessary stability and confidence

It was then agreed that these common elements might be:

1) A Tri-Service MDHU will be established in Portsmouth
2) RHH will closure only when alternative services have been put in place
3) Integration and reconfiguration of clinical services will be required to make it viable in the interim
4) This needs to be communicated to everyone - in a common way - NOW

5 Health Authority and PCG work on a new model for Gosport

Penny Humphris presented on behalf of the Health Authority and Gosport PCG and said that their first concern must be the provision of appropriate local services to the 78,000 population in Gosport who face a difficult journey to get to Trust hospitals in Portsmouth. Key issues were:

- The development of a district strategy for healthcare based on the categorisation of healthcare services into basic services provided at local level, intermediate services provided at both local and central locations and high level services provided centrally
- Agreement on principles such as a needs led solution, the development of a hub and spoke model which allowed as many services as possible to be provided at local level, a holistic approach to provision and care pathways and the use of research and best practice to underpin care.
- The interim viability of the Royal Hospital Haslar in view of information about staff morale, Service recruitment and retention problems and the impact of this on GP and patient confidence in Gosport
- The need to agree on issues which could underpin planning for change, such as the acceptability or otherwise of providing a general anaesthetic service off the central site, the requirement for diagnostic support and the potential contribution of telemedicine, the role and development of primary care and the effective use of existing resources and capacity
- The Health Authority vision for the future - see attachment
- The need for bottom up planning involving local people and stakeholders such as the Local Authority and the requirement to develop and consult on an alternative vision for services on the Gosport peninsula

In discussion, it was agreed that there was an urgent need for a better information base on the civilian patients currently attending RH Haslar and the CO agreed to provide this to the HA.

6 Shared values

Steve Boardman summarised the themes coming out of the three presentations and pointed to linkages between them as shown below:

PHT	MOD	PHA
One acute site	Training in Portsmouth	Local/central
SMH for comm, hosp	1:3/4 staff ratio	Principles of care
	Military ethos	
Clinical brief	6-8 ward	Viability of RHH
PFI ITN	MDHU	Local G'port services
	Stability & morale	Reduce uncertainty

All these points described the need for change involving the different organisations represented at the workshop and the need for shared values and objectives. There seems to be a core set of issues which are common to any change process and which can be modified to gain ownership by the group involved in managing any particular change. Steve Boardman then suggested a set of core objectives which were modified in discussion to reach agreement in relation to the Portsmouth Partnership project as follows:

CORE VALUES:

- Each individual member of the Partnership Board accepts the change and accepts corporate responsibility for the need to produce appropriate plans

- The organisational changes will inevitably involve the creation of a different culture. The positive characteristics of existing organisations should be valued, but the emphasis should be on the future, not on the past

- Planning processes should be clear, open, explicit and integrated. These plans should include:
  - ⇒ a commitment to promote the change among stakeholders
  - ⇒ an acceptance that conflict will need to be managed constructively within the process

- The new organisational arrangements should be geared towards fostering the development of clinical, educational and non-clinical alliances with other agencies and organisations

7 Core Objectives

Along side the need for core values, there is a need for common or shared objectives to create 'joined up' thinking and planning across the organisations involved. Up to this point, much of the planning for change has been driven by PHT and the PFI timetable and this has not taken account of the development of PCGs and their views. There is a tension between:

a) the fast but very prescribed pace set for agreement on the Trust PFI project over the next 3 years

b) the time needed for a natural evolution of PCG thinking in the context of New NHS structures and

c) the risk of short-term collapse of key services at RH Haslar which need to be tackled now to protect DSCA and NHS requirements

Concern was expressed that some continuing uncertainty about M0D requirements, especially in relation to the CDM, might have a negative impact on the PFI timetable, but there was general agreement that this should not be a problem if there was clarity and consistency in the DSCA requirements and if these could be available by April in relation to both the MDHU and CDM - albeit the CDM tendering process would take longer to resolve. The immediate task related to the integration of the clinical workload between RHH and the Trust so that this area of joined-up thinking could go forward into the PFI, the only add-on would then be the non-clinical military requirement. This approach would focus on integrated and flexible service planning rather than capital based solutions based on alliances between all relevant groups in the local health economy and health and social care system. The joint planning would need to be underpinned by joint management of communications and promotion of shared messages.

After further discussion, agreement was reached on core objectives, and it was noted that these were very similar to those agreed by the Clinical Collaboration Project Board in August 1997.

CORE OBJECTIVES:

- To provide the best possible healthcare within available NHS and DMS resources

- To provide appropriate education and training opportunities for DMS and NHS staff

NB **Clinical Collaboration Partnership Aims agreed August 1997:**

- The provision of a comprehensive and well integrated health service to the population of Portsmouth and South East Hampshire
- The effective training and availability of Defence Medical Services personnel to support the armed forces in time of war, associated operations and preparation for war, and the provision of rapid secondary healthcare to general Service personnel to maintain their operational readiness
- The best use of public money allocated to the DSCA and P&SEHHA through the MoD and DoH votes

8. Working assumptions

Discussion then turned to the lack of clarity about those aspects of the change programme which had been agreed and could be used as a firm basis for planning. Problems still exist such as the 2002 date given for the closure of RHH, the extent of commitment in all 3 Services to an MDHU in Porstmouth and the impact this could have on Service staffing, the acceptability and viability of any interim configuration of acute services at Haslar as part of the integration of clinical services and the extent to which the timescale for planning and consultation with local people is at odds with the

timescale for clinically necessary change. As a result of this discussion a set of working assumptions was agreed by all organisations as a basis for common planning and communications.

SHARED ASSUMPTIONS

A. An MDHU will be established in Portsmouth - ultimately on the main acute site (QAH)

B. The MDHU will be Tri-Service, representative of all the Defence Medical Services

C. The specification and location for the Centre for Defence Medicine is yet to be determined. If this is to be in Portsmouth, the specification will be additional to the MDHU requirement

D. A range of services will continue to be provided from the Royal Hospital Haslar until alternative arrangements have been made which meet both NHS and MoD needs

E. The process for reprovision is likely to take 5-7 years

F. In the interim, the configuration of services provided from hospital sites in the Portsmouth area will change and evolve to maintain the quality and safety of healthcare for NHS and Service patients and the training of NHS and Service staff

G. Healthcare services will be provided as locally as possible to NHS patients, to the extent that this is clinically practicable and affordable

9 Action Plan

Attention then turned to the need for an Action Plan to follow on from the Workshop, covering both the immediate timescale (3 months) and the slightly longer 6/9 month period in which both RHH risk, PFI and DSCA requirement issues need to be resolved.

IMMEDIATE ACTION PLAN - January-March

	TASK	LEAD	SUPPORT	DUE
1	Risk Assessment	GR	Existing Group SS/SH	5/2
2	Planning arr. for clinical integration	SS	HA/PCG/PHCT MS/SH	5/2
3	PFI ITN DSCA input specs.	MS	SS/HA/GR/SH	end May

4	RHH Information baseline	GR	PH to provide MDS to GR by 29/1	5/2
5	Consultation & comms. strategy	PH	SH to fax 25/1 text Strategy for	26/1 17/3
6	Recruitment &HR Policy	SS/MS	HR Integration Gp. Process plan for	5/2
7	Educational Impact Assessment	IJ	RT/PHT/RGPD	17/3

MEDIUM TERM ACTION PLAN - March- September

1 Funding Issues
- Finance DSCA/HA
- Contractual DSCA/PHT

2 Interim Capital Programme DSCA/PHT

3 PHT/RHH Integration
- Managment
- Clinical - including 'early wins' (paediatrics, A&E, burns & plastics)
- Non-Clinical
- Information for : planning and PFI
  clinical care
  contracts/SAFF etc.
- Education & Training
- HR & staff consultation (TUPE etc)

4 Develop planning structure for wider reconfiguration leading to Public Consultation HA
- Needs led/bottom up/local
- Using existing structures
- Retaining affordability

5 Requirements for PFI ITN

6 Communications

SJH/29/01/99

A Vision

Local

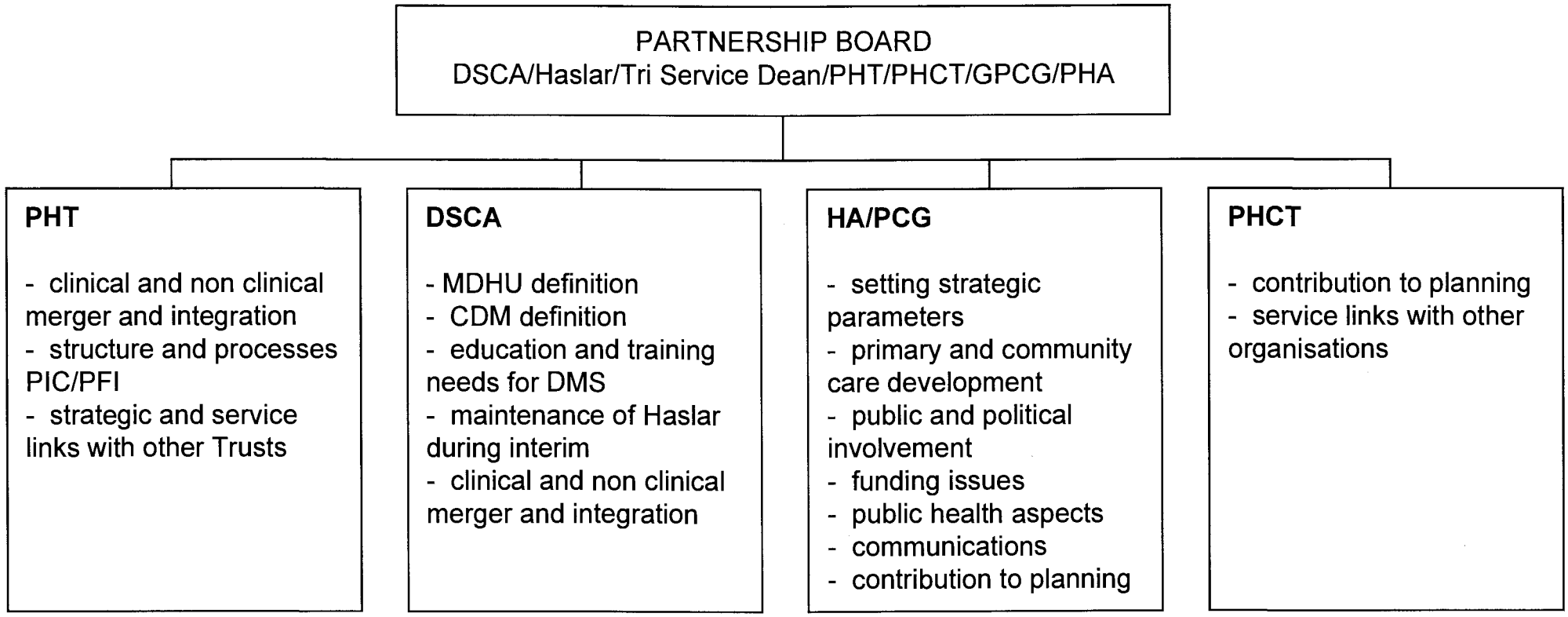
- extended primary care
- community based therapies
- ambulatory care facility
  - fast track, one stop outpatients
  - routine outpatients
  - minor accidents treatment centre (nurse practitioner led within district-wide service)
  - day surgery
    (NB. to level not requiring DGH support facilities)
- intermediate inpatient care
- enhanced ambulance services

Central

- outpatients requiring DGH support
- all inpatients
- accident and emergency departments

DRAFT

MOD/NHS Partnership Structure



Role of Partnership Board

- to ensure the health needs of Gosport people are identified and affordable plans developed to meet them within the guidance on best clinical practice
- to identify and meet training and education needs
- to ensure the involvement of the public
- to coordinate all related work programmes ensuring compatibility with other strategies of all partner organisations
- to ensure the information required is available and shared
- to implement a shared communication strategy
- to identify the impact of plans on future financial arrangements and ensure finance follows patterns of service delivery
- to ensure the maintenance of service quality and effectiveness during the period of change