South East Clinical Senate

Hampshire Thames Valley

South East

Clinical

senate

Review of the

Hampshire Together: Modernising our Hospitals and Health Services

Pre-Consultation Business Case

DATE: May 2022

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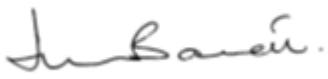
Foreword

The regional Clinical Senates were established in England to provide strategic, independent, clinical advice to commissioners and health systems, to help them make the best decisions about health care for the populations they are responsible for. NHS England and Improvement also strongly recommends a Clinical Senate review of major service change proposals before they go out to public consultation. In that light, the South East Clinical Senate (Hampshire Thames Valley) was asked by the north and mid Hampshire clinical commissioning groups with Hampshire Hospitals Foundation Trust as Hampshire Together to review the draft Pre-Consultation Business Case (PCBC), for proposed major changes to where and how sustainable acute hospital care would be delivered in the future, and to provide recommendations.

A multi-disciplinary independent clinical review panel of health and care professionals with a wide range of expertise and experience was brought together to review the draft PCBC and following this have produced a range of recommendations for how the PCBC could be improved and made more fit for purpose prior to public consultation.

We would like to thank the north and mid Hampshire commissioners and clinicians in taking time to present the proposals to the panel and field their questions. I would particularly also like to thank all the members of the Clinical Senate panel for giving of their own time to participate in this review.

Finally, a thank you to the support team of the Clinical Senate for coordinating the review and bringing the report together.



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Chair, South East Clinical Senate, Hampshire Thames Valley

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1. Introduction and context of the MoHHS programme

The Hampshire Together Modernising our Hospitals & Health Services programme (MoHHS), comprising Hampshire, Southampton, and Isle of Wight (IoW) Clinical Commissioning Group (CCG) and Hampshire Hospitals Foundation Trust (HHFT) are preparing the Pre-Consultation Business Case (PCBC) for the reconfiguration of acute care across north and mid Hampshire.

The PCBC makes the case for change for significant investment to transform how acute and planned health and care services are delivered across north and mid Hampshire. It also articulates improvements to local care that will enable the acute care transformation. The objective of Hampshire Together is to enable delivery of high quality, sustainable and financially viable clinical services that meet the needs of the north and mid Hampshire population.

The Clinical Senate undertook an independent clinical review of the MoHHS programme PCBC on the 1st and 2nd October 2020. The Senate was asked to provide a second review as the programme was notified by the Department of Health and Social Care (DHSC) of conditions to secure capital funding as part of what was then known as the Health Infrastructure programme (HIP) and has since been renamed as the New Hospital Programme (NHP). This review took place 1st December 2020 and was added as an addendum to the original report. The Hampshire, Southampton and IOW CCG are returning for a third time to ask the South East Clinical Senate (Hampshire Thames Valley) to review their updated PCBC and three clinical reconfiguration options. Two of these options remain largely unchanged since the previous reviews. The main change being the addition of a variety of minimal clinical reconfiguration options (options A1, A2 and A3 below) to meet the requirement of the new, reduced capital allocation.

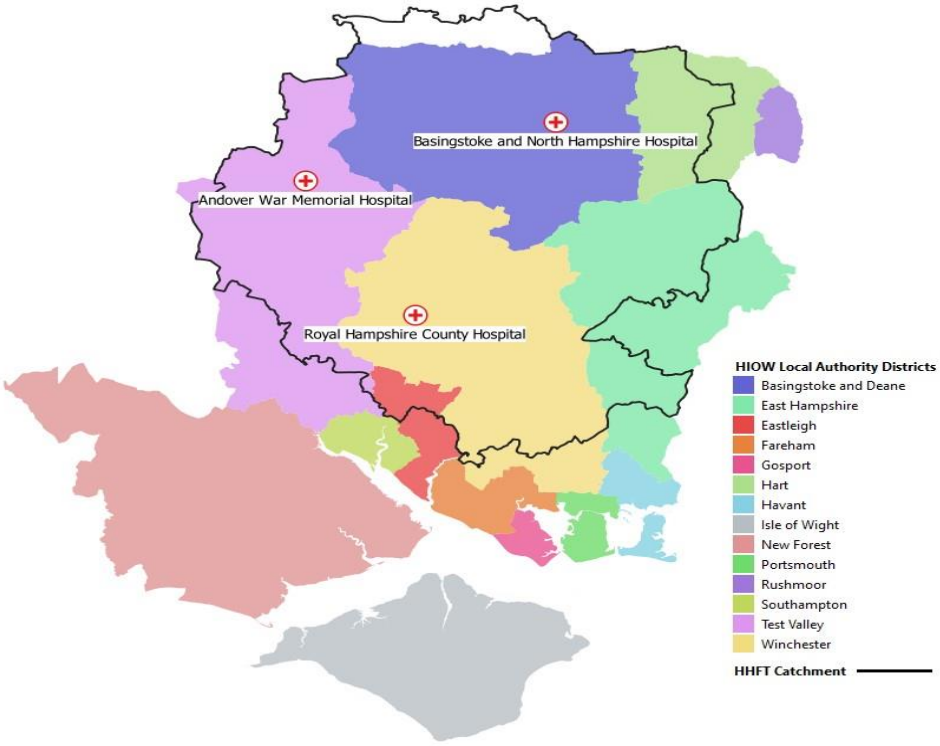
The Hampshire Hospital Foundation Trust currently provide services over 3 main sites:

- Andover War Memorial (AWMH)
- Basingstoke and North Hampshire Hospital (BNHH)
- Winchester Royal Hampshire County Hospital (RHCH)

AWMH currently provides inpatient rehabilitation, maternity services, a day surgery unit, a minor injuries unit and an outpatient unit. The site also houses the Countess of Brecknock Hospice, which provides inpatient beds, day care, and a base for the hospice at home and community palliative care service. Andover is out of scope for this review.

BNHH provides inpatient beds to support a full range of planned and emergency services. These include specialist services for rare or complex illnesses, including liver cancer, colorectal cancer and pseudomyxoma peritonei. The site includes a Diagnosis and Treatment Centre (DTC) and the regional haemophilia service.

RHCH provides inpatient beds to support a full range of general hospital services including accident and emergency, general and specialist surgery, general medicine, intensive care, rehabilitation, chemotherapy, diagnostic services, outpatient clinics and paediatric care. The site also houses Florence Portal House (which provides maternity, neonatal, breast screening and some gynaecology services) and an education centre.



Following an initial options appraisal process for this Clinical Senate review the following shortlist of options were identified for further consideration:

- Options A1, A2 and A3 where **acute step-up and step-down beds are provided at RHCH,** remotely to the specialist acute hospital site with the specialist acute hospital at either Basingstoke North or Junction 7 of the M3. Under option A3, step-down beds would also be provided at Basingstoke North.
- Options B1 and B2 where **emergency services are on a single site with an A&E at RHCH** and a specialist acute hospital at either Basingstoke North or Junction 7 of the M3.
- Options C1 and C2 where **emergency services are on a single site**, other than an urgent treatment centre at RHCH, with a specialist acute hospital at either Basingstoke North or Junction 7 of the M3.

Following further appraisal of the options it was decided options B1 and C1 should be discounted because they did not meet (were red rag rated for) strategic fit and business needs, mainly because of the material high risk of patient flow to other providers. The specialist acute hospital

new build would be on a constrained site (Basingstoke North), reducing the opportunities for co-location and future development. There would be additional complexity, cost, and clinical risk of building on a constrained site that is delivering current clinical services during the building phase. The following options are being taken forward for consultation and are for review by the Clinical Senate. MoHHS have identified an indicative preferred way forward for longer term sustainability, a preferred option for consultation within the indicative capital envelope dictated by the conditions imposed by the Department of Health in December 2020 and three other options for consultation, as shown in the table 1 below.

Option	Specialist acute hospital	Specialist acute hospital (A&E and paediatrics split across two sites)	Complex planned and emergency care	Planned surgery centre	Freestanding midwife led unit	Urgent Treatment Centre	Step-up/ step-down hospital beds	Outpatients, diagnostics, and therapies	Cancer centre
Option A1 (500 bed new build at Basingstoke North)	Basingstoke North only		Basingstoke North	Winchester (with refurb)	Winchester (with refurb) and Andover	Basingstoke North and Winchester (with refurb)	Winchester (with refurb)	Basingstoke North and Winchester (with refurb)	Basingstoke North
Preferred option for consultation: Option A2 (500 bed new build at J7 of M3)	Junction 7 of M3 only		Junction 7 of M3			Junction 7 of M3 and Winchester (with refurb)		Junction 7 of M3 and Winchester (with refurb)	Junction 7 of M3
Option A3 (500 bed new build at J7 of M3)	Junction 7 of M3 only		Junction 7 of M3			Junction 7 of M3 and Winchester (with refurb)	Winchester (with refurb) BN (with refurb)	Junction 7 of M3 and Winchester (with refurb) and BN (with refurb)	Junction 7 of M3
Option B2 (800 bed new build at J7 of M3 with A&E at Royal Hampshire County Hospital)		Junction 7 of M3 and Winchester (with refurb)	Junction 7 of M3			Junction 7 of M3 and Winchester (with refurb)		Junction 7 of M3 and Winchester (with refurb)	Junction 7 of M3
Indicative preferred way forward: Option C2 (800 bed new build at J7 of M3)	Junction 7 of M3 only		Junction 7 of M3			Junction 7 of M3 and Winchester (with refurb)		Junction 7 of M3 and Winchester (with refurb) **	Junction 7 of M3

Table 1

2. Methodology

The Clinical Senate assembled a broad based panel of senior clinicians and professionals, who provided their own time and expertise to the review. The panel membership is listed in appendix C1. Great care was taken to avoid conflicts of interest, and all panel members were required to sign a confidentiality agreement (appendix C2).

The draft PCBC and appendices with supporting information were provided to the Clinical Senate team on 7th April 2022. The relevant appendices for the Clinical Senate review were filtered by the Clinical Senate chair (see appendix B for the list of materials provided), and key lines of enquiry (KLOE) were developed (appendix A). The PCBC, relevant appendices and key lines of enquiry were shared with the panel, prior to a preparatory meeting (via digital platform, Microsoft TEAMS) of the panel which was conducted one week in advance of the main panel meeting to orientate the members, discuss the KLOEs and address any questions.

The panel meeting was held on 5th May 2022. The panel day was shared with members of the Modernising our Hospitals and Health Services (MoHHS) programme team, including members of the Hampshire and Isle of Wight Integrated Commissioning System and senior clinicians from the CCGs and HHFT, who presented summaries of the PCBC and took detailed questions from the panel. The full agenda for the panel day is shown in appendix C3, and the membership of the MoHHS presenting team in appendix D.

The notes from the meeting and comments made were synthesised in to a first draft, which was circulated to the panel for comment. The final draft was then prepared for submission to the MoHHS programme board for matters of accuracy on 26th May 2022, and for review, comment then sign off by the Clinical Senate council.

3. Key recommendations

The commitment of the MoHHS programme team is evident. There is wide stakeholder engagement all of whom on panel day articulated well the vision and purpose of the programme and have clearly worked together to propose compelling changes for the health services in north and mid Hampshire. The programme's partnership working and integration with system wide plans is to be commended. The draft PCBC for this third Clinical Senate review is much improved and has attended to many of the recommendations of previous Clinical Senate reviews. In this report the Senate panel have outlined key recommendations, highlighted an area of concern that is the proposed accident and emergency department (A&E) at the RHCH, Winchester and identified areas to further strengthen the PCBC.

Health Inequalities

COVID has shone a light on the inequalities that exist within our health and social care systems. Tackling these inequalities and attention to public health needs of communities must be central to reconfiguration proposals. As such this report contains detailed recommendations with regards to health inequalities which we strongly advise the MoHHS programme to consider.

RHCH A&E

The Clinical Senate panel have significant concerns about the proposed model for A&E at RHCH and are not confident the proposals are safe. The Clinical Senate does not support this option. Detailed recommendations are made in this report alongside an alternative the programme may wish to consider; that of the RHCH site becoming the first frailty emergency centre in the country.

Maternity

The draft PCBC was submitted immediately following publication and release of the final Ockenden report[1] and as such does not make reference to it. It is important the final PCBC makes it clear how the MoHHS programme proposals enable compliance with the immediate and essential actions for maternity services set out in the report.

Workforce

It is very apparent that the MoHHS programme value staff wellbeing, this was clear in the PCBC, the additional workforce strategy and on panel day. However, the evidence presented to the Clinical Senate with regards to workforce requirements to enable the reconfiguration to be realised remains high level. The previous Senate reviews highlighted the need for more detailed workforce plans, and this must now be a priority for the programme.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

Patient and Public Engagement

The depth and breadth of the public and patient engagement in 2020 is well articulated in the PCBC. The panel heard how this work has been ongoing and about the involvement of key stakeholders such as Maternity Voice Partnerships (MVP). The PCBC would significantly benefit from this iterative and live element of the engagement process being included.

Do minimum options

The number of do minimum options presented were confusing to the panel and are likely to confuse during the course of consultation.

4. General themes

4.1 General points relating to the PCBC

R1. **It is evident the PCBC has addressed many of the concerns expressed in the previous Clinical Senate reviews and is now a much stronger document. The clearer narrative makes it easier to read and navigate however it is lengthy and repetitive in parts. The Senate is aware that the changes to requirements with regards to PCBC writing may have contributed to this, such as the alignment of the PCBC with the Strategic Outline Case (SOC) and specific requirements with regards to the New Hospital Programme. However, the programme's most recent work, for example with regards to clinical, patient and public engagement could appear in the main document and older work be bullet pointed with information in the appendices. This together with some judicious use of tables to display information would reduce the size of the document and give a focus on the future, rather than on the situation as it is, which would be beneficial.**

R1.1 It is critical that more evidence-based information and data is included throughout the PCBC to support and strengthen plans. This is particularly the case for the clinical pathways. A table summarising the impacts of existing programmes affecting key proposals would be beneficial, for example the impacts of the community transformation programme referred to in section 5.2.5.6 of the PCBC. Specific recommendations pertaining to those pathways are referred to later in this report.

R1.2 We recommend MoHHS consider how the options are presented. Attention also needs to be paid to the readthrough from previous PCBC iterations with regards to nomenclature. A description of how the new alphabetical options are similar or different from previous numerical options and how the individual options differ from each other would be helpful to the reader.

4.2 Case for change

The case for change centres around the benefits of centralisation of services and the separation of acute, emergency services from planned care; modernizing existing and future estate to enable people to do the jobs they have trained to do; and linking their hospital-based transformation to transformation of what they term 'local care'. Their concept of 'local care' encompasses integration across health including mental health, public health and prevention, social care, third care and voluntary sector services; together with support for more local and community care. Their aim is to deliver as many services as possible as close to patients' homes as possible.

R2. **The review panel heard that some services have already been centralised and that this was working well, urology and trauma and orthopaedics were cited as examples. The case would benefit from data supporting the benefits to patients and staff of the centralisation of these services. Where centralisation of other services included in their proposal has realised benefits elsewhere in the country this should be referenced and the expected benefits for MoHHS modelled. Similarly, where the proposed separation of emergency and complex care from routine planned care has already occurred, data and modelling to show the expected benefits would strengthen the case for change.**

4.3 Population growth and demographic projections

R3. **Population demography and projections are clearly described, but the detail provided is high level, with some but not all of the health needs of that population described. The section on long term conditions (section 4.2.4 of the PCBC) alludes to many of these but a simple table showing at a glance how their catchment population compares in terms of common long term conditions and inequalities would be beneficial. The table should detail current and predicted prevalence of conditions such as hypertension, cardiovascular disease (especially stroke, ischaemic heart disease and chronic heart failure), diabetes, obesity, chronic obstructive pulmonary disease, chronic kidney disease, liver disease, dementia, depression and other mental health conditions.**

R3.1 The panel heard how the demographic of age had been looked at but that further work is required to understand its impact on the service. It is important that modelling fully explores this particularly owing to the flat bed base assumption.

4.4 Demand and capacity and bed modelling

R4. Projections of demand do not take in to account increasing incidence of disease and acute hospital service use. Only high level data has been provided but this is sufficient to demonstrate that it will increase. The impact of COVID (although very difficult to quantify) is an omission and how this will affect demand going forwards for example, for undiagnosed cancer, needs to be considered.

R4.1 Table 4.3 details the proposed impact of the Hampshire and Isle of Wight Integrated Care System programme on activity. We also heard during the panel that community transformation has had an impact on both admissions and length of stay and were told that patient initiated follow up had shown benefits to outpatient services. The case would be considerably strengthened by data and evidence to support these assertions.

R4.2 The Senate recommends using sources of national comparative data in the modelling and assumptions. For example, the Cardiovascular Disease Prevention Audit (CVDPREVENT) is a national primary care audit that automatically extracts routinely held GP data and which has now produced comparative reports. This tool provides open access to the data, with clear, actionable insights for those tasked with improving cardiovascular health in England.[2] As an illustration a comparison of the percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy in Hampshire and Isle of Wight can be found.[3] The data includes inequalities together with system and national comparative data on a number of cardiovascular disease markers.

R4.3 Baseline activity and bed modelling is detailed in section 5.2.5.7 of the PCBC. We recommend checking that the impact of the COVID pandemic, in particular the impact on intensive care bed requirements for the future, has been adequately considered.

R4.4 There will be a potential impact on other providers, and this is referred to in sections 6.7.2.2, 7.4.1.4, 7.4.2.4, 7.4.3.4, 7.4.4.4 and 7.4.5.4 of the PCBC. We would recommend obtaining letters of support acknowledging their acceptance of these impacts for the preferred option(s) from the affected stakeholder organisations.

[2] https://www.cvdprevent.nhs.uk/home
[3] https://www.cvdprevent.nhs.uk/data-explorer?period=3&area=31&indicator=7

R4.5 Articulation of engagement with Specialised Commissioning for the intensive care and cancer pathways and public health and social care with regards to prevention pathways and discharge planning would also strengthen the PCBC.

R4.6 The flat bed projection is predicated on the success of out of hospital services, LOS and SDEC. How this is going to work and the scaling up of these services is fundamental to bed modelling and needs to be further evidenced in the PCBC.

R4.7 Using additional population projections to 2039/40 it has been identified that further beds will be required, and this will need expansion of the new build. The panel heard that the MoHHS plans can be flexed to meet the implications of this additional analysis. It would be helpful to explicitly describe how easily this can be achieved by the different options in the PCBC.

4.5 Clinical Standards

R5. It would be helpful for the Clinical Standards summary to be added as an appendix to the PCBC and to show how well each of the options under consideration delivers these standards. We recommend including a RAG rated table within the options appraisal section of the PCBC to enable performance against the clinical standards to be seen at a glance (green = fully met, amber = partially met (define), red = not met).

5. Review of presented options

5.1 All options

R6. **All options leave NHS estate that would no longer be in use with the services transferring into a new hospital build. One of the concerns, particularly with A1, A2, A3 and B2 options would be that there could be clinical services remaining on the old sites that could end up being isolated with 'empty' space. Further written information was provided by the MoHHS programme at the request of the Clinical Senate in relation to this issue. Land and commercial assessment reviews have been completed in conjunction with NHP. Mitigations vary between the options owing to option B2 and C2 requiring a larger new build reducing remaining existing estate for both BNHH and RHCH and the A options relying on a smaller new build which in turn, demands increased usage of the existing estate. In all cases, both clinical design and disposal planning would ensure remaining services are co-located, along with clinical adjacencies rather than being isolated. The PCBC would be strengthened if this information were included.**

5.2 Do minimum options A1, A2 and A3

The description of the do minimum options is confusing both in the PCBC and on the slides presented to the senate. The number of beds for each option varies. It is unclear with option A1 and a new build of 500 beds if there would be further space to expand capacity on this site when capital is available.

R7. **The Senate panel recommend reducing and clarifying the do minimum options. More specific recommendations pertaining to these options have been made further in the report. These are planned surgery, step up/step down beds and diagnostics.**

5.3 Option B2

R8. The Clinical Senate panel have significant concerns regarding the safety of a service designated and sign posted locally as Accident and Emergency (A&E) on the RHCH site at Winchester and do not support this option. The Senate is not confident that the clinical model for an A&E at RHCH is safe without all the essential supported co-location of acute medical and surgical services.[4] This will result in patients attending the A&E at RHCH not receiving equity of access to emergency care. In addition, in this option there is insufficient interventional radiology (IR) to support the specialist services across the 7 day working week 24 hours a day and would need addressing. The provision of rehabilitation beds only at the RHCH means that there is no capacity for A&E admissions.

R8.1 The ability to stabilise a patient prior to transfer can be challenging. Patients, who self-present on either site and suffer cardiovascular collapse, require the same level of initial assessment and treatment if they attend an A&E department where advanced airway management and level 3 expertise is available 24 hours a day, 7 days a week. Street signage to A&E in Winchester would need to direct all to a new Emergency Department and not to RHCH.

R8.2 Option B2 with an A&E that receives children and has an alongside Short Stay Paediatric Assessment Unit (SSPAU) presents potential risks given the scope of services planned to be provided on this site. The option would also significantly weaken the opportunities presented by all other options given the need to maintain a paediatric presence at the RHCH. The option would need to detail measures to reduce risk, ensuring the safety of children and young people (CYP) presenting to the emergency department 24 hours a day, 7 days a week. This includes but is not limited to:

- The scope of practice as described in the Directory of Services as used by NHS111.
- The communication of the scope of practice to the local population and primary care.
- The environment dedicated to CYP within the emergency department.
- The training requirements of staff working in the emergency department relating to paediatric practice (Safeguarding, APLS etc).
- The protocols and guidelines supporting staff working in the emergency department.
- The safeguarding procedures and practice in place in the Emergency department.
- The anaesthetic, ENT, radiology, orthopaedic and general surgery support available.

[4] The-Clinical-Co-dependencies-of-Acute-Hospital-Services.pdf (secSenate.nhs.uk)

- The scope of telemedicine support with the acute site.
- The protocols and guidelines supporting ambulance staff conveying CYP.
- Clarification on the arrangements for children conveyed by the ambulance service in cardiac arrest.
- The workforce modelling appropriate to expected activity (paediatric nursing/medical support), including the possibility of rotation with the centralised acute site A&E.
- The arrangements in place for paediatric support to the regular review of audit/training/complaints/incidents in the emergency department.
- The arrangements in place for timely and safe transfer of CYP from Winchester to the acute site.
- The named consultant paediatrician lead and named paediatric nurse lead.

5.4 Option C2

R9. **Where emergency services are on a single site, other than an urgent treatment centre at RHCH, with a specialist acute hospital at either Basingstoke North or Junction 7 of the M3 is clinically sound. The panel's concerns with regards to this option are related to acquisition of the land which has been addressed above. This option presents travel challenges for staff and patients which need to be explored in greater detail.**

6. Urgent and emergency care pathways

R10. **The urgent and emergency care pathway is incomplete and does not highlight the ability to move from community or Urgent Treatment Centres (UTC) directly to Same Day Emergency Care (SDEC). SDEC should be demonstrated as the key component of community/UTC modelling. For option B2 the PCBC diplomatically describes the ability to maintain two Emergency Departments (ED). This is extremely contentious from a clinical pathway perspective. Providing ED's on two sites would require fully functioning SDEC units and AMU's on both sites and emergency teams with critical care back up. Without this, the bed base at the RHCH would only be able to provide community hospital care, such as rehabilitation and patients awaiting community placement. It is also often better to maximise discharge potential from the initial place of treatment directly into community capacity, rather than cohorting Medically Ready For Discharge (MRFD) patients in step down beds.**

R10.1 For option B2, it was unclear to the Senate panel how either an A&E or SDEC service could be made to safely work at the RHCH. The panel highlights the following questions:

- What would be the arrangements for a patient developing a medical or surgical emergency whilst awaiting treatment at the RHCH? For example, what is the chest pain pathway? This is a good way to focus on the patient

pathway and is particularly relevant in the 2 site ED model. In this scenario a patient may self-present with indigestion which is then identified as acute coronary syndrome. Emphasising the current efficiencies of the different models may be useful.

- What would be the arrangements for paediatric emergencies self-presenting at the RHCH?
- What is the emergency escalation response to step up/step down beds? Only having step up/down beds means that there is no capacity for A&E admissions.
- How would the public understand not to present at the RHCH with a medical or surgical emergency likely to require hospital admission? (especially if the local authority signage suggested an A&E was still present).
- The PCBC needs to articulate how senior frailty support to ED/SDEC is provided.

R10.2 The inclusion of patient stories is welcomed. We would recommend also including some more common emergencies, for example acute chest pain, stroke, acute abdominal pain and rapid onset progressive shortness of breath. To note; in the example of testicular torsion in an 11 year old (7.5.1) under the Royal College of Surgeons surgical core curriculum testicular torsion should be managed without the additional delay to a highly time-sensitive pathway of transfer to a site where urology surgeons are present.

R10.3 The Senate panel expressed concerns about walk-in patients' ability to access the correct pathway. Figure 5-7 demonstrates patient flow through streaming in the urgent treatment centre into the ED then out of the ED and into SDEC/acute medical unit. The MoHHS team articulated that the current building layouts funnel services through ED and that this should be rectified in the new build. It would be helpful for the reader if this was made clear in the PCBC.

R10.4 The panel heard how the now established clinical communications centre helps navigates services, referrals and offers clinical advice to GPs, South Central Ambulance Service (SCAS) and NHS 111 through clinical administration or through accessing specialist advice if required. Pathways are being developed to ensure the patient arrives at and is treated in the right place. We recommend more detail regarding this service is included in the PCBC together with supporting evidence.

R10.5 For options A1, A2, A3 and B2 more inter-hospital transfers will be required between HHFT sites and the ability to manage those is of concern. The Senate panel heard how Hampshire hospitals worked closely with SCAS to develop pathways so as to minimise transfers when they centralised services for

emergency urology, inpatient trauma, and stroke services. There is also the REACT ambulance transfer service outside SCAS provision which has been used during the pandemic very effectively and will continue to be used to transport patients. Including this information in the PCBC would help support the developing pathway design.

6.1 Urgent treatment centres

Providing adequate GP cover for a 24 hour, 7 day a week service in an UTC on one site is highly valuable but very challenging to achieve. It is not clear how this will be achieved on 2 sites, where do these patients go if UTC staff are not available and what are the mitigations? We recommend further clarity regarding these points.

6.2 Emergency Department (ED)

R11. Nationally demand for A&E services continues to increase albeit COVID initially interrupted this. A&E performance nationally has also continued to decline.[5] Further detail regarding how the reconfiguration of services intends to address this is required. Presently the level of detail necessary to support provision of MoHHS 7 day emergency service; acute medicine, anaesthetics, emergency medicine and surgery is not clearly articulated for all options presented in the PCBC.

R11.1 The provision of emergency airway management at the proposed RHCH A&E if patients deteriorate needs to be much more developed.

7. Same day Emergency Care (SDEC)

R12. SDEC does not equate to non-life threatening conditions, simply they can be diagnosed, and treatment can be established in one day. With the exception of chest pain almost all patients who do not require oxygen and can walk, can start their journey in this environment if accepted after discussion with a community practitioner. However, admission rates of 10-20% are required and access to critical care services must be available. How this model would safely work at the RHCH needs further consideration.

[5] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

8. Acute medicine

R13. Acute medicine is fundamentally unsafe without critical care back up. Escalation for patients admitted to RHCH needs to much clearer in the PCBC. Escalation to support on an alternative site to RHCH means SDEC operations at RHCH will be significantly impeded, the majority of acute medical patients with full escalation will need to be managed at the acute hospital.

More clarity is required for how community referrals to acute medicine will be managed. In a two-site model, ideally patients should be triaged based on resources available to each site and not necessarily on the location of the patient.

9. Critical Care

R14. Critical care staffing does not meet current guidelines for provision of intensive care services. It does not meet the standard of consultant review within 12 hours of admission, this would require 2 consultant ward rounds, and this is not evidenced in the PCBC. Overall, more detail is required to fully understand the proposals to centralise critical care onto the acute site and the relationship with the proposed post anaesthesia care unit on the non-acute site and likely transfer requirements.

10. Step up/step down beds

R15. We heard from the MoHHS team the challenge of recruiting geriatricians. This will potentially affect the efficiency of the step up/step down pathway. However, we also heard how Hampshire hospitals are currently doing something similar with cardiology which is working very effectively with all staff supportive of the model. Once centralisation of services has been achieved there will be the ability for generalists at RHCH to be supported by sub-specialists. The learning and transferability of the model being used for cardiology needs to be evidenced in the PCBC. This will support plans for the step up/step down pathway currently being considered.

11. Diagnostics

R16. The radiology service delivery would be improved by the proposals to move to purpose built departments and a split between planned and emergency care. The move to community diagnostic hubs is supported. The Senate note a planned community hub in Andover and possibly similar services provided at Winchester and Basingstoke enabling the delivery of diagnostic services with reduced travel times for patients. However, the PCBC would be strengthened by more detail on plans for patient pathways in radiology. There was mention of managed service contracts and the Wessex imaging network but little detail on how this would translate into more comprehensive plans for cross-sectional imaging (MRI and CT). MRI and CT are expensive items which will consume a considerable amount of the allotted budget. It would be helpful to provide more information on how these modalities will be distributed across the region.

R16.1 More detail is required on current and future plans for patient transfer between acute and non-acute sites and would benefit from application of prior learning. For example, the Senate panel heard that out-of-hours-emergencies occur rarely, approximately 10 complex patients per year. There is the potential due to current transfer pathways for this to be an underestimate. We heard how vascular surgical emergencies are diverted elsewhere. The learning from the current well-developed system for transferring vascular patients to neighbouring vascular units could be utilised when considering the transfer of sick or deteriorating patients from the non-acute to the acute site.

R16.2 The panel supports the centralisation of Interventional Radiology (IR) services for reasons of cost, staffing and co-location. The current network model with a service delivered by 3 IR consultants and patient transfer to nearby units out of hours is not sustainable. Centralisation would enable investment in the latest technology to be optimised within a central regional hub. IR facilities are very expensive (for comparison, the new purpose built facility in East Kent cost £4.5 million). Centralisation avoids duplication of these precious resources. Investment in new facilities helps with staff recruitment and retention. Co-location with particular emergency services, such as obstetrics, general surgery and trauma are also important to ensure rapid access to life-saving procedures. For example, RCOG guidelines[6] include IR in the pathway for the management of post-partum haemorrhage. Future service expansion such as mechanical thrombectomy for acute stroke would also be possible with co-location of stroke services and IR.

[6] https://www.rcog.org.uk/media/4nbn0ffm/goodpractice6roleemergency2007.pdf

R16.3 Good planning around the delivery of diagnostic services will be crucial in addressing bottlenecks in the patient pathways, helping to reduce length of stay and bed occupancy. This is particularly important in the context of the programme's plan to maintain the current bed base into the foreseeable future. The panel heard about service equipment contracts and planning with other services such as the lung cancer screening programme will result in an additional CT scanner. Hampshire hospitals have recently joined the Salisbury, Isle of Wight and South Hampshire (SWASH) consortium picture archiving and communication systems (PACS) which will enable image sharing with local Trusts and in the future has the potential for insourcing and outsourcing of images. It would be helpful for this to be referenced in the PCBC and the panel recommend the continued involvement of the radiology department in decisions regarding service provision.

12. Community services

R17. The integrated care programme plan is a key enabler of the new clinical models proposed in the PCBC. It incorporates learning from COVID-19, which will support recovery, restoration, and renewal, ensuring capacity and demand can be safely managed. Evidence and data to support how the transformation of community services enables the acute reconfiguration remains insufficient in the PCBC. The approach of having patients seen in the most appropriate place either in primary care or community services and reducing patients seen in ED/SDEC when this is not the right place for them is clearly sound. However, a significant proportion of these pathways rely on GPs having primary care/community choices available to them on a regular and sustainable basis. If this were not available, then the premise around the model of care for the ED is affected. Detail of the analysis about capacity of these services and therefore their impact on the emergency services is required in the PCBC.

R17.1 The inclusion of the data behind the ICS community prevention, supporting the assertions that patient initiated follow up (PIFU) is working well, and LOS reduction would significantly strengthen this important part of the pathway design. If available this should be local evidence or alternatively it could be from other areas in the country where similar work has already been successfully implemented.

13. Mental Health

R18. The parity of esteem agenda[7] highlights the need to ensure mental health is valued equally and on the same terms as physical health. Current information around mental health seems to reflect the NHS LTP and is more detailed than in previous PCBC iterations. Current proposals reflect what other healthcare providers have put in place for mental health services. The MoHHS could further strengthen the plans for mental health by articulating the specific impact the reconfiguration will have on mental health service users, families and carers.

R18.1 There are currently 5 section 136 places of safety and havens within the mental health Trusts. However, when these become full the A&E department becomes a place of safety. We heard that liaison teams work well with the A&E staff but did not see data. There is a recognised need to look at how the transfer of care is achieved appropriately and consider how the mental health trusts can flex when the section 136 suites are full. The PCBC needs to reflect this reality and consider how the needs of these patients while in the A&E environment can be best met.

R18.2 A previous recommendation of the Clinical Senate was to provide more detail with regards to suicide prevention. We heard all staff have 'zero suicide' training in the integrated care system and a key component is that it is everyone's responsibility to identify this risk. This and the work with various groups and alliances could be further highlighted in the PCBC.

R18.3 During the panel presentation we heard that the children's liaison psychiatry service had decreased the numbers of children admitted with overdose. The PCBC would be strengthened by provision of data to support this.

R18.4 It is important that plans engage with mental health services, innovate around the actual needs of this group of service users and consider the impact on the police and ambulance services.

[7] parity-report.pdf (england.nhs.uk)

14. Maternity and Neonatal Services

R19. The clinical case for change and the proposal for a single site for obstetrics and neonatology is sound. However, for both obstetrics and neonatology there is a need to make clear the benefit of the reconfiguration to women and birthing people. This should be done by explaining how the configuration enables the Trust to comply/exceed standards and targets described in the Ockenden report,[1] Saving Babies Life Care Bundle, version 2 (SBLCBv2),[8] the Better Births report[9] and NHS LTP.[10]

R19.1 It is important that the language used is culturally inclusive. Nonbinary and transgender people use maternity services. The PCBC currently refers to women only we recommend this be changed to women and pregnant/birthing people.

R19.2 The Senate panel heard how the MoHHS programme had engaged with the RCOG vice president for workforce and strategy planning and other Trusts having dealt with the same challenges. It is recommended that MoHHS describe their work in this area. The local maternity and neonatal system (LMNS) and regional maternity team would be able to assist with identifying and accessing mentoring opportunities within and outside the region should this be required.

14.1 Maternity pathway

R20. There are significant potential outflows for some of the options described in the PCBC. The MoHHS team articulated how by maintaining pre-birth pathways and increasing choice they would maintain current catchment areas. However not all women and pregnant people who are low risk choose a low risk place of birth. Greater detail is required with regards to modelling for numbers of births on all 3 sites (new acute specialist, RHCH Midwifery Led Unit (MLU) and Andover MLU). We received additional written information from the MoHHS team that this work is being planned. We recommend this work is detailed in the PCBC.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf
[8] Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf (england.nhs.uk)
[9] national-maternity-review-report.pdf (england.nhs.uk)
[10] NHS Long Term Plan » Online version of the NHS Long Term Plan

R20.1 The Senate panel heard how escalation during times of high acuity is managed across the LMNS as a whole and there are good relationships between maternity providers. However, the potential impact on neighbouring Trusts and mitigations planned to reduce this need to be much more explicit in the PCBC. Letters of support for MoHHS plans from neighbouring providers would be beneficial.

R20.2 More detail is required regarding the bed capacity and obstetric theatre modelling on the acute specialist site.

R20.3 The choice of birthplace on offer to women and birthing people under the new proposals is excellent. However, the Senate panel has concerns about the sustainability of 2 free-standing MLUs. We recommend the PCBC is explicit about sustainability. Learning from other Trusts who operate 2 free-standing MLUs such as Maidstone and Tunbridge Wells may be beneficial.

R20.4 Organisational culture has been identified by the final Ockenden report[11] as a significant issue for maternity services to address. Working cultures are affected by change. We heard MoHHS has good examples of positive working cultures for example Andover MLU. The panel recommends it is demonstrated how this learning be transferred to RHCH.

R20.5 More detail is required regarding transfer rates from midwifery led units to the obstetric unit and how these are/will be supported by SCAS.

R20.6 It is possible with increased complexity and morbidity in the pregnant population that an increase in midwifery led unit births may not be realised. It is recommended the programme utilise trajectories for population health and take account of this impact on maternity services.

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

14.2 Neonatal pathway

Potential loss of level 2 neonatal intensive care (local neonatal unit for high dependency) is a key driver for centralisation of neonatal intensive care with obstetrics as neither of the 2 separate units meet the minimum requirement of 500 days of combined intensive and high dependency care per year.[12] Level 3 neonatal intensive care services (neonatal intensive care unit for complex care) are available at Southampton, Portsmouth and Chertsey.

R21. The modelling for cot numbers is unclear. The PCBC needs to state the impact positive or negative on other neonatal units in the network, comparing the impact on the number of birthing people and babies needing transfer to Southampton or other units now or if the reconfiguration did not take place.

R21.1 The PCBC should explain how the reconfiguration plan addresses actions arising from the unit and network GIRFT reports and from implementing the recommendations of the Neonatal Critical Care Transformation Review.[13]

R21.2 The PCBC could be clearer on how the configuration enables the Trust to meet BAPM,[14] RCPCH,[15] NHSE standards[16] which support the delivery of improved outcomes and experience for babies and their families and on how the configuration enables the Trust to improve the experience of babies and their families through the development of Family Integrated Care and effective Transitional Care.[17]

[12] https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf
[13] https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf
[14] Resources | British Association of Perinatal Medicine (bapm.org)
[15] Resources | RCPCH
[16] NHS commissioning » E08. Neonatal critical care (england.nhs.uk)
[17] Neonatal Transitional Care - A Framework for Practice (2017) | British Association of Perinatal Medicine (bapm.org)

15. Paediatrics

The clinical case for change and the proposal for single site paediatrics is sound. The proposals which include provision of a dedicated paediatric emergency department are particularly strong. During the panel meeting the MoHHS team clarified that paediatric surgery would be on the acute specialist site. Recommendations specific to RHCH at Winchester are covered specifically under 'review of presented options' on p13.

R22. The modelling for bed numbers is unclear. The PCBC needs to clarify the bed modelling and dedicated paediatric theatres including the separation of elective and emergency beds if applicable.

R22.1 The PCBC could be strengthened by including the following:

- Referencing liaison with and support from the Wessex paediatric network groups.
- Explaining how the reconfiguration supports the development of more effective Teenager and Young Adult (TYA) and transition services, potentially to age 25.
- Explaining how the configuration supports the development of Paediatric Oncology Shared Care Unit (POSCU) service and the potential to augment local service delivery.
- Clarifying the age criteria for admission to the adult ICU and making clear the ambition for paediatric high dependency unit beds.
- Detail the expected provision of parent accommodation on the acute site.
- Provide clarity on the scope of paediatric surgery to be provided.
- Provide clarity on the scope of ambulatory paediatrics to be provided (including maintenance of Care Home assessment Team (CHAT).

R22.2 The MoHHS team clarified the arrangements already in place to support Children and Young People (CYP) presenting with mental health issues. This could be further strengthened by stating how the configuration would support the further development of the integration of physical and mental health services on the acute site.

R22.3 The PCBC could be clearer on how the reconfiguration enables the programme to meet or exceed RCPCH,[18] NICE standards,[19] national audit standards[20] (such as diabetes and epilepsy) and supports improved outcomes and experience for CYP and their families.

16. Planned Surgery and Complex Outpatient Centres

R23. Since the previous Clinical Senate reviews more details have now been included in the PCBC. However, the challenge of making sure the right patients are in the right place remains and was acknowledged by the MoHHS team. We heard how robust protocols will be in place and how the programme has utilised learning from South West London Elective Orthopaedic Centre (SWLEOC) and use of the UCL Surgical Outcome Risk Tool (SORT). Further information about how this learning has been applied to the MoHHS model together with detail regarding risk assessment of patients triaged for the planned surgery site needs to be included in the PCBC.

R23.1 Evidencing the local learning articulated during the panel review would also strengthen the planned surgery pathway. For example, currently elective arthroplasty patients are managed on the cold site with the on call team on the hot site. The Senate heard how this works well and there is data to demonstrate this.

R23.2 Plans for elective surgery are heavily dependent on staffing. We heard of plans regarding Advanced Nurse Practitioners (ANPs). There is a need for more developed plans regarding staffing the RHCH at night. Again, use of data from local learning such as the example given of reduced admission and transfer avoidance and use of the ANP workforce in the urology transformation of services is recommended. Workforce is addressed in more detail below.

R23.3 From the discussion on panel day the efficiencies for the service and patients of bringing outpatients, diagnostics and day treatment together is undoubted. A clearer description of what is meant by 'complex outpatients' and the benefits to patients in the PCBC would be helpful.

[18] Facing the Future standards for paediatric care | RCPCH
[19] Children and young people | Topic | NICE
[20] National Audit of the quality standards for Paediatric Gastroenterology, Hepatology and Nutrition ('PGHAN Audit') | BSPGHAN and National Paediatric Diabetes Audit (NPDA) | RCPCH

17. Workforce

R24. It was acknowledged during the panel meeting that more detail concerning all aspects of the workforce has now been included within different sections of the PCBC. Each of these separately considering the impact on the workforce for specific areas giving indicative workforce examples. The Senate panel are also aware that the development of comprehensive workforce models across services is part of the next steps in the business case. However as with previous Senate reviews lack of detail has significantly constrained the ability of the Clinical Senate panel to evaluate the deliverability and sustainability of workforce plans for the options presented. Whilst it is recognised that developing workforce plans for the programme is a challenge at this stage more detail was expected and must now be a priority for the MoHHS programme.

R24.1 We recommend that the executive summary would benefit from some simple bullet points emphasising how the vision for the future of Hampshire Hospitals will better enable staff to do the jobs they have trained to do in sustainable, fit for purpose working environments. This could include what is going to be so special about working in Hampshire Hospitals that will not only retain the existing workforce, but also pull people into the organisation and develop a self-sustaining production line for the future workforce.

R24.2 Staff wellbeing is clearly important to the MoHHS team. For all organisations guarding against moral injury resulting from staff not being able to do the job they trained to do needs to be a priority.[21] We recommend a unified strategy encompassing how the Trust is going to look after all people currently working for them and enable transition into different ways of working. The MoHHS programme is a fantastic opportunity to put in place measures that allow people to do their jobs properly and fulfil their potential.

R24.3 Given the timeframe the MoHHS programme needs to start building and/or evidence training programmes, competency development, graduate pathways, and alternative workforce strategies such as physician associates and apprentice pathways. Engagement with local Higher Education Institutes to understand their forecasting with regards to undergraduate places for nursing, midwifery, and allied health professional training and if this is expected to meet local demand would help longer term workforce modelling.

R24.4 We recommend consideration of Health Education England's (HEE) projected requirements for medical, nursing and allied health professionals (AHPs) with use of their workforce tableaus where appropriate.

[21] caring-for-doctors-caring-for-patients_pdf-80706341.pdf (gmc-uk.org) and word template (kingsfund.org.uk)

R24.5 The number of staff the programme will need to recruit should be stated. There is a general vision that the new model will provide an attractive opportunity for recruitment and retention in the future. However, this requires further detail in order to establish a clear strategy. A clear timeline for recruitment of workforce against implementation plans is required to help mitigate risks.

R24.6 The exact proportion of single patient rooms recommended for new hospital builds has yet to be published by the NHP. It has been suggested by the National Medical Director that 'we need to move in our hospitals much more to single rooms being the default for privacy and dignity, for infection control and for flow issues'. This is likely to have workforce implications, but these can be mitigated by innovative digital patient safety systems designed to enable good safety around deterioration, falls preventions and mental wellbeing to achieve the benefits in terms of infection prevention and control risks and enabling flow. Single patient rooms have been mentioned in the PCBC but there is insufficient detail concerning the implications and how these may be mitigated.

Area specific workforce concerns and recommendations are detailed below:

UEC and A&E

- Indicative figures for the 2 main emergency care options were included in the panel presentation but not in the draft PCBC and neither were these figures mapped to activity. An overall description of the HHFT workforce demography is available in the Workforce Plan 2019-2022, but this is not broken down into specific areas. From data available to the panel consultant staffing appears very high and nursing and health care assistant levels appear too low. More likely a single consultant can be available to same day emergency care/emergency department and acute medical unit activity with an additional consultant for part of the day depending on inpatient load and splits between frailty services and acute medicine. This comment is based on the expected activity in the PCBC, which appears low. In well-developed same day emergency care environments, it can be expected to achieve 80% of all daylight acute medical activity in this way, if frailty and acute coronary syndrome pathways are excluded. We recommend the programme completes further work regrading workforce predictions mapped to activity and presents it clearly in the PCBC.
- More detail is required regarding the role and training requirements of the Advanced Nurse Practitioners (ANPs).
- There appears to be no additional workforce planning information for centralised emergency services over and above that described in panel presentation slides. In particular the workforce to cover RHCH at Winchester for the elective patients overnight is not the same as if there were a full A&E at the RHCH. Again, it was acknowledged during

the panel presentation that workforce planning was a work in progress. However, overnight staffing at the RHCH site requires more detail across all workforce areas.

- There is a lot of variability of consultant hour cover between specialities in acute care at the emergency site. Emergency Medicine had consultants for 16 hours and the Acute Medicine Unit 12 hours a day. There needs to be much more information on the medical workforce plan.

Maternity

- The workforce modelling for all 3 sites is unclear for midwifery and obstetrics (although Andover is outside the scope of the review). Greater consideration needs to be paid to how this is presented.
- The workforce plan in the PCBC shows band 5 midwives in the MLU. We heard on panel day that band 5 midwives will remain in the hospital for the first year as recommended by the Ockenden report. This needs to be corrected and made clear in the PCBC.

Neonatology

- It would be beneficial for the workforce modelling to describe the scope of advanced clinical practice for nursing and physician associate roles and to include allied health professional (AHP) support.
- It would be beneficial for the workforce modelling to describe the plans for tier 1, tier 2 and tier 3 staffing, meeting BAPM standards for a Local Neonatal Unit.

Paediatrics

- The workforce modelling is unclear and needs to reflect Royal College of Nursing (RCN), Royal College of Emergency Medicine (RCEM) and Royal College of Paediatrics and Child Health (RCPCH) standards for all members of the multidisciplinary team.
- It would be beneficial for the workforce modelling to describe the scope of advanced clinical practice for nursing and physician associate roles and to include AHP support.
- The workforce modelling could be strengthened by reference to critical dependencies on anaesthetics and radiology especially.
- The workforce modelling for paediatrics at RHCH including the Short Stay Paediatric Assessment Unit (SSPAU) is unclear and needs to reflect RCEM and RCPCH standards.

Diagnostics

- The Senate panel heard there is a comprehensive plan for workforce and currently there are 2 apprentice radiographers. IR is provided through a networked service with Frimley and Southampton. There are currently 3 interventional radiologists with a 4th in the process of establishment/recruitment. The aim for the future is to move from the networked service to a hybrid model 7 days per week through the use of diagnostic radiologists

providing certain interventions. How this might be sustainable for the future needs to be evidenced in the PCBC, particularly in the absence of an acute vascular surgical inpatient service.

- Diagnostics is included in the facility available to step up beds, step down beds, as well as all of the other acute/sub-acute sites. Will staffing be available for all of these diagnostic services?
- Radiographers and radiology nursing staff are also central to provision of both diagnostic and interventional radiology. This workforce needs addressing in the PCBC.

Community

- Detail about how the community workforce is being grown to facilitate the acute programmes plans would be beneficial.

18. Transport and Travel

Travel, ease of access to services, public transport and parking are key concerns whenever service reconfigurations are proposed. The engagement feedback described in section 3.15 of the PCBC details the concerns surrounding these areas very clearly. Transport times are shown within the PCBC for each of the different options but plans for the additional public transport options that may become available under the new build options need to be described.

R25. The Clinical Senate panel heard that plans for air ambulance access are being discussed. Given that the proposal is to centralise emergency services onto one site alongside a trauma unit and other specialist services the Senate panel recommend elaboration of these plans in the PCBC.

R25.1 During the panel meeting we heard that over 100 care pathways had been developed with the ambulance service into acute and emergency care across the region and that these are linked to provider directories of services. How this work in practice will ensure that the right clinical problem is transported to the appropriate clinical service should be more detailed.

R25.2 Section 2.5.6 of the PCBC describes the ambulance service and gives data on the number of emergency calls but does not describe ambulance conveyances, turnaround times and the likely impact of centralisation of emergency hospital services on the ability of the ambulance service to meet their key quality indicators.[22] Further articulation of these areas would strengthen the PCBC.

R25.3 The proposed centralisation of emergency care would involve an increase in inter-hospital transfers. The PCBC details the numbers of planned care patients predicted to require transfer for emergency care and there is a similar description of the likely requirements for transfer of mothers and babies from the midwifery led unit. The data is less clear for the proposed front door models for RHCH. We recommend including a clear description of how developing emergencies on the 'cold' site at the RHCH will be safely transferred to the new 'hot' site and within a timeframe that does not negatively impact patient outcomes. This needs to be risk assessed and the model to do this needs to be shown.

R25.4 We heard from the MoHHS team that Hampshire hospitals have the cheapest parking costs in the region. While there is recognition that the MoHHS programme is a number of years from implementation parking charges, transport and their impact on individuals requires further development. We recommend this includes consideration of older people and frailty in terms of willingness and ability to use fast-roads networks.

R25.5 Travel times for all the options increase. It would assist the reader to assess the travel impact if more pictorial representation in the form of travel isochrones were included in the PCBC. Inclusion of the population numbers that fall within these limits would be beneficial.

19. Population Health and Inequalities

R26. It is important that health inequalities are robustly addressed, this section in the PCBC could benefit from more detail. People potentially affected by inequalities (people with protected characteristics and/or living in areas of deprivation and/or other group that experiences inequalities) may consume considerable health care resources as demonstrated in the Integrated Impact Assessment (IIA, p12). These groups for example will be more adversely impacted than the general population by increased travel times, including the potentially very significant changes to public transport, and by digital exclusion.

[22] https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2021-22/

R26.1 It is important to note that many of these groups are not homogenous and will have different needs and will be affected by the options differently e.g. the specific services they use and where they may live. Thus, further thought could be given to sub-groups within those with protected characteristics such as disability inclusive of physical, sensory and cognitive impairment, mental health conditions and long-term conditions.

Other groups that may also be affected by health inequalities are:

- Looked after children and young people
- Carers
- Homeless
- People involved with the criminal justice system (noting Winchester has a large prison)
- People with substance misuse issues/addictions
- People and families on low incomes
- People with poor literacy/health literacy
- People living in deprived areas
- People living in rural areas
- Refugees, asylum seekers or those experiencing modern slavery

The above are all groups now considered when developing new service specifications or policies in the national specialised commissioning team.

R26.2 Increased understanding of the current situation and experience faced by people from these groups would be helpful. For example, more detail on why non-elective spells are higher in people living in more deprived areas or why the 'non-white' population has more than 4 times rate of elective spells compared with 'white' (IIA on p12) would provide some further insight. The panel recommends demonstrating any other analysis of the hospital data has been undertaken by the programme team

R26.3 The IIA (p12) states that people experiencing health inequalities will disproportionately benefit but it appears this is simply because they use services more – there is no evidence they will gain any more benefit than anyone else presenting with the same disease at the same stage. From the evidence provided there is the potential for health inequalities to increase unless well thought out plans are put in place to mitigate risks such as increased travel times, digital exclusion and increasing complexity of the health system.

R26.4 It is unclear if the impact on people living in rural and on urban areas has been sufficiently considered especially with respect to travel. It is difficult to interpret 'the population is relatively evenly distributed' (IIA p9) compared with what is demonstrated in the accompanying population density map. Further clarity is required.

R26.5 Trusts are required to have a health inequalities plan as part of the new acute contract. This could be a way of demonstrating how MoHHS wish to progress this agenda going forwards. Identified issues should be feeding into population health management plans. There should also be a synergistic relationship with this and other plans such as engagement, transport, sustainability and personalised care. Part of this could include how the programme meets the requirement of Core20Plus5 as an organization and collectively with system partners.

R26.6 The NHSEI operational planning guidance 2022/23 has a focus on targeted intervention for health inequalities. It would be helpful to be able to see how the ICSs understanding of its Core20PLUS5[23] population feeds into the MoHHS reconfiguration. The approach enables the biggest impact on avoidable mortality in the most deprived populations and contributes to an overall narrowing of the health inequalities gap.

20. Clinical Engagement

The Senate panel heard how many nursing teams currently rotate and teams are very engaged. Away day discussions are happening with senior nurses to help prepare teams for the change. The degree of change will be different for different teams.

R27. The PCBC describes the engagement process with patients, public and staff together with engagement reports up to November 2020 and minutes of the Patient, Staff and Stakeholder Advisory Group up to June 2021 accessed through Useful documents : Hampshire Together. It is recommended that these reports and minutes be updated to indicate the further development of proposals. Referencing what staff think now and what percentage of staff are impacted and how. Including the clinical and non-clinical workforce.

[23] 20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf (england.nhs.uk) and https://www.england.nhs.uk/publication/core20plus5-an-approach-to-reducing-health-inequalities-supporting-information/

21. Patient and Public Engagement

R28. The depth and breadth of the engagement in 2020 is well articulated in the PCBC. The panel heard from the MoHHS programme team how work has continued in this area and they are working closely with patient groups. A local strategy for patient and public population engagement has been produced, for example. There is a need to capture, consolidate and include these 2021/22 examples in the PCBC.

R28.1 We heard how patient and public representatives are involved in the programme workstreams and how small patient groups are helping to shape the options. It was clear it is a very live iterative process. The programme should celebrate this work in the PCBC and demonstrate the inclusion of seldom heard, minority and deprived population groups.

R28.2 It would be of value to provide further information on how the wider public are contributing to the co-design. There is a need to hear from seldom heard groups. For example, older adults and carers, people with neuro-diverse needs, people in contact with the criminal justice system (Winchester Prison) and the mental health sector.

R28.3 The Hampshire Together website is promoted within the PCBC, information on the website appears to be at least a year old. If the website is to be promoted it should be updated.

R28.4 The published engagement study in 2020 was carried out by ASV. There is currently no information about ASV. Providing further details about ASV would add validity to the process and negate further questions in the future.

R28.5 The Maternity Transformation Programme recommends Maternity Voice Partnerships (MVPs) as the vehicle of co-production of maternity services.[24] The Clinical Senate heard during the panel discussion that the MoHHS programme are working closely with their MVP. No reference is made to made to the MVP in the PCBC. Capturing and articulating work with the MVP is key.

R28.6 The extensive public and patient engagement exercise has included participants from many groups that are affected by heath inequalities however none of their experience has been captured from the 'health inequalities' perspective. It identified very relevant concerns, but it is unclear how much the programme team have considered those concerns. The local public health team may be well placed to suggest ways you can use their current data (both

[24] NHS England » Maternity Transformation Programme

quantitative and qualitative) to help describe how these will be addressed, or if any further analysis would be useful.

22. Digital and Communication

R29. Remote and virtual clinics were used interchangeably by the MoHHS team during panel. It is noted the term 'virtual' is used in the PCBC. Remote clinics and virtual clinics mean different things to different people and indeed are different from healthcare setting to healthcare setting. For consistency and to avoid confusion it is recommended that a consistent nomenclature be used, and definitions be provided.

23. COVID-19

R30. The narrative in the PCBC needs to reflect a return to operational productivity, acknowledging the challenges exacerbated by the COVID-19 pandemic and that business as usual poses. The reconfiguration plans should clearly articulate how the priorities detailed within the 2022/23 NHSEI operational planning guidance can be realised. [25]

R30.1 The PCBC highlights that plans have been adapted to consider changes and learning that have resulted because of the pandemic. It refers to how the pandemic has demonstrated the NHS can work in new and innovative ways. A number of examples are cited in the PCBC with regards to COVID-19 learning:

- Plans over the next 12 months to build on learning from increased availability of community beds to support the flow and discharge of patients and innovative alternatives to inpatient care.
- The single point of access (SPA) pathway introduced in 2020.
- The way in which outpatient appointments are delivered and digital advancements during the pandemic.
- Effects of 'lab to bag' concept for community pathology testing.
- Learning from how digital services during COVID-19 benefited both patients and staff.
- Learning from development of virtual wards.

However, these are not accompanied by data to enable assessment of their impact. Providing data to support these examples which would improve the strength of the arguments being made.

R30.2 The PCBC talks about COVID success and states that 'Our experience through the COVID-19 pandemic has demonstrated that we have the ability and willingness to embrace new and accessible ways of working. It has also demonstrated that digital services can benefit both patients and staff'. We

[25] 20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf (england.nhs.uk)

recommend including a table of the positive aspects of this that will be retained and quantifying the impact. This could also be linked to sustainability.

R30.3 The PCBC also describes how COVID-19 has heightened awareness of the deficiencies in the current estate in terms of infection prevention and control (IP&C). Here it would be helpful to describe the potential positive impacts on IP&C of each of the options. For example, systematic review of published data on single patient rooms suggests that the evidence supports single patient rooms as an effective intervention for IP&C.[26]

24. Sustainability

R31. The NHS was committed to meet carbon reduction targets of 34% by 2020 and 80% by 2050 (on a 1990 baseline), in line with the UK Climate Change Act of 2008. Sustainable health care and the NHS Green agenda are well referenced in the PCBC and the plans the MoHHS programme are making in this area are commendable. However, the PCBC details a 25-30% drop in operational emissions depending on the option under consideration, offset by an increase in travel-related emissions. It is therefore not possible to understand the overall effect on the carbon footprint of each of the options. We recommend estimating the carbon footprint converting data on travel, consultations, hospital admissions or other activity into kilograms of carbon dioxide equivalents (CO_2e) using Green House Gas (GHG) 'emissions factors'. (Generic GHG emissions factors are published by the UK government, or alternatively, healthcare-specific guidance is available from the Greener NHS).[27]

R31.1 For all options travel times will increase and therefore transport CO_2 emissions will increase. It will be important that affordable public transport is in place, particularly for options that include a new build at junction 7.

R31.2 The programme should consider specifics such as electrical charging points for ambulances and NHS service vehicles.

R31.3 For further information regarding sustainable health care we recommend the information supplied by the Centre for Sustainable healthcare[28] and the Greener NHS Programme.[29]

[26] Taylor E, Card AJ, Piatkowski M. Single-Occupancy Patient Rooms: A Systematic Review of the Literature Since 2006 Health Environments Research & Design Journal 2018, Vol. 11(1) 85-100 DOI: 10.1177/1937586718755110
[27] Greener NHS » Sustainable Development Unit archive (england.nhs.uk)
[28] https://sustainablehealthcare.org.uk
[29] https://www.england.nhs.uk/greenernhs

25. Conclusion

The extensive work MoHHS have undertaken to strengthen the current version of the PCBC is evident with many of the previous Clinical Senate recommendations being addressed. In this third review further recommendations are made with an emphasis on the need to support and enhance modelling and assumptions with the inclusion of local data or applied learning from elsewhere in the country. Clearer articulation of the proposed do minimum options would also be beneficial for the programme.

The Senate panel have significant concerns about the proposed model for an A&E at the RHCH and are not confident the proposals are safe. They have suggested an alternative; that of the RHCH site becoming the first frailty emergency centre in the country, which the MoHHS team may wish to consider.

Tackling inequalities and attention to public health needs of communities must be central to reconfiguration proposals. Existing inequalities within our health and social care systems have been highlighted and exacerbated by the COVID-19 pandemic and need to be a priority for service reconfiguration schemes. This report makes detailed recommendations regarding inequalities which we urge MoHHS to consider.

The panel recognises developing workforce plans for the programme is a challenge, however at this stage more detail was expected and must now be a priority. The MoHHS programme is a fantastic opportunity to put in place measures that allow people to do their jobs properly, fulfil their potential and guard against moral injury.

Clinical Senate recommendations are not mandatory but reflect the considered opinion of a group of independently acting clinicians and others after reviewing the material shared with them within the timescales required. It is hoped that the range of recommendations in this report will help to ensure that the proposals going forwards are clear, supported by the evidence provided, address quality and safety requirements, and are shown to improve the quality of care for the population of north Hampshire and mid Hampshire.

26. Appendices

Appendix A: Key Lines of Enquiry (KLOEs)

A. General KLOE

1. Has the Case for Change, and the health needs of the population been clearly identified?
2. Are projections for changes in demand realistic? Taking account of:
    - Factors increasing demand (population ageing, population growth and increasing incidence of acute and chronic conditions)
    - Factors reducing demand (prevention, better long term care, demand management, more proactive primary/community based care)
3. Have clinical standards been identified, and are they sufficiently comprehensive as the framework for delivering high quality care and added value (improved patient outcomes from the available resources)?
4. Is sufficient detail provided on the total beds required (total beds, adult non elective, specialty based, paediatrics, elective surgery and step up/step down beds), based on projected demand and demand management?
5. Are there any major inconsistencies in the proposed reconfiguration of services with the NHS Long Term Plan?

Workforce

6. Is there a coherent and realistic workforce strategy that takes account of the full range of the clinical workforce and the opportunities provided by new roles and ways of working?

Health Equalities/inequalities

7. How will the planned reconfigurations improve health outcomes and impact on inequalities for the populations of North and Mid Hampshire?
8. Has the need for equity of access across services been taken into account?
9. Has the impact on the various equality groups been quantified?
10. Are parking costs considered into the equality planning – particularly when combined with the recent inflationary rises.
11. What are the equality impact considerations around those patients taken to hospital by ambulance but who need their wheelchair/carers, etc.?
12. Did the impact assessment consider older people and frailty in terms of potential reluctance to use fast-roads network?

Engagement (patient, public and clinical)

13. Has there been meaningful patient and public involvement in coming to the options being proposed?
14. How has the engagement to date sought to be inclusive of seldom heard, minority and deprived population groups?
15. Has the breadth and depth of clinical engagement been sufficient?

Transport

16. What is the air ambulance access plans?
17. What is the engagement with the pre-hospital critical care paramedic providers regarding the operational impact to resource longer transfers?
18. Are travels time and their impact on ambulance shift planning, recruitment and rota changes planned for?

19. What are the strategies to lower public transport times for J7 as this will affect staff and patients/relatives?
20. What training and dissemination is planned for ambulance staff?
21. How do you support the alternative referral pathways and enable alternative dispositions other than the emergency department? Historically non-emergency department are challenging to access for ambulance staff.

Mental Health

22. Are the s.136 places of safety and havens and their locations considered in terms of proximity to the new build?
23. Is there a s.136 suite built into the design of the new hospital proximal to ED?
24. How will in-hospital mental health services be considered to meet needs and specifically around those MH service users that will present with coexisting disease – i.e. drugs/alcohol/injury and MH problem?

Sustainability

25. What approaches have been taken to ensure that the future clinical model for takes full account of sustainable healthcare requirements for the future?
26. Do operational greenhouse gas emissions include calculations around increased ambulance transport times?
27. Does the plan include future proofing for electric charging for ambulances?

COVID-19

28. Has the relevant system learning from COVID-19 been taken into account as part of the plans?
29. What learning has been captured from the experiences of patients and their families in accessing services and information during the pandemic?
30. Have the potential impacts of increased requirements of heightened infection, prevention and control been considered?

Digital innovations

31. What digital innovations have been/will be introduced and what will be their impact on different steps in the patient pathway?
32. Has any consideration been given to virtual consultations/ virtual wards?
33. How will digital technology be used to impact self-management?
34. Are there plans for the necessary digital clinical information sharing across the multiple care delivery sites across the trust, and alignment of the digital strategies?

B. Service specific KLOE

1. Urgent and emergency care

a. General comments on the patient pathways.

b. Is the patient pathway between the acute specialist emergency and non-acute hospital site (including UTC and ambulatory care service,) clear and sound (including the overnight pathways when the UTCs may be closed)?

c. Are there clear and sound criteria for admission to the proposed non-acute hospital site (i.e. Winchester) vs a centralised acute hospital bed?

d. Does the patient pathway support safe transfer from acute specialist emergency hospital to non-acute site in order to deliver care closer to home?

e. Is there confidence that the ambulance triage and transfer pathways and capacity issues have been sufficiently addressed?

f. Are the benefits and risks (including mitigation) of centralising the various major acute services on to one site clearly articulated?

- A&E (ED)
- Acute medicine pathway
- Emergency surgery pathway
- Critical care
- Liaison psychiatry
- Other major specialties including cardiology and stroke medicine
- Support services including diagnostics, radiology, pharmacy and AHPs.

g. Will the co-location of the various key clinical support specialties and services support the proposed model?

h. How does the proposed model make best use of digital solutions, remote consultation, telemedicine (including learning from the COVID-19 Pandemic)?

i. Is there a clear and deliverable workforce plan? Do the plans take suitable account of the need for clinical teams to work across site (i.e. cross site rotas)?

j. Is there evidence of adherence to clinical standards that are relevant to delivering high quality U&EC?

k. Will the current and planned primary and community based services and initiatives be of sufficient efficacy and capacity to deliver a new UEC pathway?

2. Planned care (focussing on elective surgery and procedures, not outpatient services)

a. Comments on the distribution of elective surgical services (complex and non-complex planned surgery)

b. Is there evidence that robust risk assessment processes will be in place to determine the cohort of patients that can safely receive surgical care at a dedicated planned care centre at Winchester?

c. Are there mechanisms in place in order to determine most appropriate pathway for post-op patients needing escalation in care/critical care if on non-acute site

d. Are the workforce challenges relating to multiple site surgical services addressed?

e. Will the co-location of the various key clinical support specialties and services support the proposed model?

f. Will the planned capacity for elective surgery (beds, theatres, critical care) be sufficient?

3. Non acute hospital services at Winchester

a. Are the criteria for admission sufficiently described?
b. Is there a clear and sound pathway for patients who deteriorate in a non-acute hospital bed?
c. Will there be sufficient capacity in the community to discharge patients and maintain flow?
d. Is there clarity about the bed modelling across the trust for non-acute hospital and acute hospital beds
e. How is clinical risk to be managed and owned for these patients not in an acute hospital?
f. Is the staffing model for non-acute hospital wards sufficient and appropriate including any new clinical roles, or the availability of 'specialists', and the out of hours cover?
g. Do the plans take suitable account of the need for clinical teams to work across site between acute specialist and non-acute hospital (i.e. cross site rotas)?
h. Will there be sufficient on site supporting clinical services at the non-acute hospital?

4. Paediatrics

a. General comments on the patient pathways – including outpatient services in the non-acute hospitals.
b. Is the patient pathway between any separately sited UTC and the paediatric ED and PAU at the specialist acute emergency hospital, clear and clinically sound?
c. Will the co-location of the various key clinical support specialties and services support the proposed model?
d. Is the interface and pathways between the acute hospital paediatric service, primary care and the community paediatric service (paediatricians and paediatric nurses) described (so that unnecessary transfers to hospital can be avoided)?
e. Is there a clear and deliverable workforce plan?
f. Are there sufficient published clinical standards referenced in the PCBC?
g. Is the paediatric surgical pathway clear and sound?
h. Is the paediatric medical inpatient pathway clear and sound?
i. Are there any issues in relation to paediatric critical care capacity?

5. Maternity and neonatal

a. General comments on the configuration of birthing pathways obstetric led services, and the provision of the MLU and OLU?
    - Capacity of proposed
b. Will the co-location of the various key clinical support specialties and services support the proposed model?
c. Is there a clear and deliverable workforce plan?
d. Do proposals enable compliance with the immediate and essential actions for maternity services set out in the Ockenden (2022) report?
e. Is the neonatal pathway clear and sound?
    - Neonatal Network perspective.
    - GiRFT review, findings and next steps.
f. What assessment has been made in respect of the proposed closure of Winchester level 2 neonatal unit?
    - Is a single level 2 unit on the acute site sufficient to meet demand?
g. Are there sufficient published clinical standards referenced in the PCBC?

h. Are the plans aligned to the Hampshire and Isle of White Local Maternity Systems (LMS) and national strategies?

C. KLOEs relating to the - shortlisted options (A1, A2, A3, B2, C2) for future hospital configuration

a. Across the options for service reconfiguration are there option-specific issues that need highlighting in relation to:

- Impact on quality of care and clinical outcomes
- Equitable access for the population across the CCGs
- Clinical co-dependencies between services
- Impact on specific major inpatient clinical services that may need relocating (e.g., urology, cardiac, emergency surgery)
- Workforce implications
- Capacity (A&E, beds, theatres, critical care)
- Patient flow.

b. Is the impact on neighbouring hospitals clearly described for each option, and are there any associated issues of concern not described in the PCBC?

c. Is the impact on surrounding acute trusts clear for each of the options (including specialist/tertiary services)? Consider UEC, paediatrics and maternity for each.

Appendix B: Resource material provided by Hampshire Together

Document Number	Document Name
1	MoHHS PCBC
2	Hampshire Together – Listening Exercise Independent Analysis Report Executive Summary.
3	Integrated Impact Assessment (IIA) executive summary
4	Workforce plan 2019-2022

Appendix C: South East Clinical Senate (Hampshire Thames Valley) Review Group membership, declarations of interest and agendas

1. South East Clinical Senate Council Hampshire Thames Valley Review Group Membership

Name	Roles
Jane Barrett	Clinical Senate Review Panel Chair
Steve Barden	Lead Clinician for Ambulatory Care and Acute Medicine, University Hospitals Sussex NHS Foundation Trust
Steve Bourne	Patient and Public Partner
Mike Carraretto	Consultant in Anaesthetics and Intensive Care Medicine, Royal Surrey County Hospital
David Davis	Paramedic Practitioner, SECAmb
Mark Hancock	Medical Director, Oxford Health NHS Trust
Melanie Hill	Deputy Director of Strategy and Business Development, East Kent Hospitals University Foundation Trust
Des Holden	Medical Director, Kent Surrey Sussex Academic Health Science Network
Anna Humphreys	Public Health Registrar, PHE South East (observer)
Robert Kaikini	Interventional Radiologist, East Kent Hospitals University Foundation Trust
Jacqui Kempen	Head of Maternity for South East London Local Maternity and Neonatal System
Tina Kenney	Director for Clinical Partnerships, Buckinghamshire NHS Foundation Trust
Rakesh Kucheria	Orthopaedic Surgeon, Frimley Health NHS Foundation Trust
Salwa Malik	Consultant, University Hospitals Sussex Foundation Trust and RCEM South East England Regional Chair
Sarah Markham	Patient and Public Partner
Matt Smith	Consultant in Public Health, Public Health Team – Southeast
Paul Stevens	Chair, Kent Surrey Sussex Clinical Senate
Isobel Warren	Integrated Care Programme Manager, Joint Commissioning, East Sussex County Council
Ryan Watkins	Consultant Paediatrician and Clinical Director, Royal Alexander Children Hospital, University Hospitals Sussex Foundation Trust
Helen Bell	Programme Manager, South East Clinical Senates
Emily Steward	Head of Clinical Senates, `NHSEI South East Region

2. South East Clinical Senate Council Hampshire Thames Valley Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest	Confidentiality Agreement
Jane Barrett	None	None	None	None	√
Steve Barden	None	None	None	None	√
Steve Bourne	None	None	None	None	√
Mike Carraretto	None	None	None	None	√
David Davis	None	None	Trustee of Thames Valley Air Ambulance	None	√
Mark Hancock	None	None	None	None	√
Melanie Hill	None	None	None	None	√
Des Holden	None	None	None	None	√
Anna Humphreys	None	None	None	None	√
Robert Kaikini	None	None	None	None	√
Jacqui Kempen	None	None	None	None	√
Tina Kenney	None	None	None	None	√
Rakesh Kucheria	None	None	None	None	√
Salwa Malik	None	None	None	None	√
Sarah Markham	None	None	None	None	√
Matt Smith	None	None	None	None	√
Paul Stevens	None	None	None	None	√
Isobel Warren	None	None	None	None	√
Ryan Watkins	None	None	None	None	√
Helen Bell	None	None	None	None	√
Emily Steward	None	None	None	None	√

3. Clinical Senate Council (Hampshire Thames Valley) Review Group Agendas 5th May 2022

South East Clinical Senates (HTV) Third Review, 5th May 2022:
Hampshire Together: Modernising our Hospitals and Health Services

*(Please note: Clinical Senate Panel **only** Pre meet 12.30 -13.00)*
Via TEAMs link Click here to join the meeting

Item	Time	Item	Lead
1.	12.15	**Registration/Join TEAMS**	
2.	12.30	**South East Clinical Senate Expert Review Panel *only* pre-meet.**	**JB**
	13.00	***Hampshire Together: Modernising our Hospitals and Health Services to join the meeting***	
3.	13.05	**Welcome, Introduction, context and approach to the review.**	**JB**
4.	13.15	**Presentation from the Hampshire Together team**, summarising the revised and additional reconfiguration options, including criteria used for further options shortlisting.	**Hampshire Together Panel**
5.	13.50	**Discussion and Q&A** between the Clinical Senate panel and the Hampshire Together team, relating to the key lines of enquiry and the presentation.	**JB**
	15.20	***Hampshire Together: Modernising our Hospitals and Health Services to leave the meeting Comfort Break***	
7.	15.30	**Panel Discussion:** Key findings, evidence base and emerging themes for recommendations.	**JB**
8.	16.45	**Summing up, next steps**	**JB**
9.	17.00	**Meeting close**	**JB**

Appendix D: Hampshire Together Panel (MoHHS) membership

Name	Roles
Lara Alloway	Chief Medical Officer, Hampshire Hospitals Foundation Trust
John Black	Medical Director, South Central Ambulance Service
Andrea Burgess	Associate Medical Director for Clinical Strategy, ENT Consultant, Hampshire Hospitals Foundation Trust
Ruth Colburn Jackson	Managing Director – North & Mid Hampshire CCG
Fay Corder	Associate Director of Midwifery, Hampshire Hospitals Foundation Trust
Ben Cresswell	Medical Director, Surgical Division, Hampshire Hospitals Foundation Trust
Julie Dawes	Chief Nurse, Hampshire Hospitals Foundation Trust
Charlotte Hutchings	Clinical Director – North & Mid Hampshire, GP
Dominic Kelly	Associate Medical Director for Clinical Strategy, Consultant Cardiologist, Hampshire Hospitals Foundation Trust
Katrina Kennedy	Associate Director of Allied Health Professionals, Hampshire Hospitals Foundation Trust
James Kerr	Associate Medical Director for Clinical Strategy, Emergency Medicine Consultant, Hampshire Hospitals Foundation Trust
Natasha Kerrigan	Programme Director, Hampshire Hospitals Foundation Trust
Lorne McEwan	Clinical Director for Winchester & Rurals, GP
Alison McGinnes	Consultant Nurse in Frailty, Hampshire Hospitals Foundation Trust
Dominic Moor	Consultant in Anaesthesia and Intensive Care Medicine, Hampshire Hospitals Foundation Trust
James Morris	Consultant in Public Health Medicine, University Hospitals Southampton
Avideah Nejad	Clinical Director for Obstetrics, Hampshire Hospitals Foundation Trust
Shirlene Oh	Chief Strategy & Population Health Officer, Hampshire Hospitals Foundation Trust
Victoria Osman-Hicks	Clinical Director of Psychiatric Liaison, Consultant Liaison Psychiatrist, Southern Health
Katie Prichard-Thomas	Deputy Chief Nurse, Hampshire Hospitals Foundation Trust
Naomi Purdie	Consultant Nurse for Frailty, Southern Health
Naomi Ratcliffe	Associate Director for Clinical Strategy and Integration, Hampshire Hospitals Foundation Trust
Derek Sandeman	Chief Medical Officer, Integrated Care System
Julia Shaw	Clinical Director for Paediatrics, Hampshire Hospitals Foundation Trust
Adam Smith	Lead Nurse for Mental Health, Southern Health and Hampshire Hospitals Foundation Trust
Alex Whitfield	Chief Executive, Hampshire Hospitals Foundation Trust
Isobel Wroe	ICS Transformation Director, Integrated Care System