IRP

Independent Reconfiguration Panel

ADVICE ON CLOSURE OF WARD G5 END OF LIFE CARE WARD AT QUEEN ALEXANDRA HOSPITAL, PORTSMOUTH HOSPITALS NHS TRUST

Submitted to the Secretary of State for Health

31 March 2011

IRP

Independent Reconfiguration Panel

6th Floor
157 – 197 Buckingham Palace Road
London
SW1W 9SP

Tel: *020 7389 8045/8046*
Email: *info@irpanel.org.uk*
Website: *www.irpanel.org.uk*

Press Office
Tel: *020 7025 7530*
Email: *IRPpressoffice@grayling.com*

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RECOMMENDATIONS

- **The qualities that patients, their relatives and their carers most value in end of life care are peace, dignity, privacy, respect for personal and cultural needs, and compassionate care. These qualities should underpin all end of life care, including that provided by Portsmouth Hospitals NHS Trust (PHT) and should be used as a benchmark to assess progress against the Panel's further recommendations below.**

- **Portsmouth PCT and Hampshire PCT should support the emerging GP commissioners for Portsmouth and south east Hampshire to engage the public and patients in a re-appraisal of their end of life care strategy and plans. The process should also engage the local authorities and relevant providers, and be completed in time to inform commissioning plans for 2012/13. The output should make it clear what is required from providers in terms of the quality of end of life care. It should also demonstrate how more people will get the end of life care they choose, especially supporting more people to die at home if that is their choice.**

- **The Panel accepts that for clinical, operational and financial reasons it would be unsustainable to reopen G5 itself as an end of life care ward.**

- **PHT's Medicine for Older People, Rehabilitation and Stroke (MOPRS) clinical service centre must develop a comprehensive operational plan for end of life care, including quality, workforce, training and standards. The plan must also address the relationship of the model to the overall pathway for end of life care, including effective working arrangements with specialist palliative care.**

RECOMMENDATIONS

- **PHT's End of Life Care Steering Group should be augmented with a reference group drawn from the public and patient groups. The Steering Group should undertake formal evaluation of the changes to end of life care in MOPRS, including systematic feedback from carers and relatives, and report its findings and recommendations to the Trust Board and commissioners by November 2011.**

- **An audit of the facilities to support end of life care should be carried out within three months, involving the members of the End of Life Care Reference Group. The audit should include the availability and use of single rooms, as well as facilities to support relatives and carers. Action to address any deficiencies identified should be taken without delay.**

- **The Trust Board should ensure that the business plan for MOPRS in 2011/12 is updated to reflect these recommendations and address specifically what further action and investment is required to achieve the highest possible end of life care in MOPRS.**

- **PHT should review its approach to public and patient involvement, and its communication strategy, in the light of the lessons to be learnt from its handling of the closure of G5.**

- **Portsmouth Health Overview and Scrutiny Panel (HOSP) should, with the local NHS, review its policy and procedures to ensure relevant issues can be identified and acted upon in a timely manner.**

- **South Central Strategic Health Authority (SHA) should ensure that the NHS follows the recommendations of this report without delay or omission.**

Abbreviations used in this report

CIP	Cost Improvement Plan
CQC	Care Quality Commission
CT	Computed Tomography
HOSC	Health Overview and Scrutiny Committee
HOSP	Health Overview and Scrutiny Panel
IRP	Independent Reconfiguration Panel
LCP	Liverpool Care Pathway
LINk	Local Involvement Network
MAU	Medical Assessment Unit
MOPRS	Medicine for Older People, Rehabilitation and Stroke clinical service centre
MRI	Magnetic Resonance Imaging
ONS	Office for National Statistics
PET	Positron Emission Tomography
PCT	Primary Care Trust
PFI	Private Finance Initiative
PHT	Portsmouth Hospitals NHS Trust
SHA	Strategic Health Authority
SUI	Serious Untoward Incident
wte	whole time equivalent

OUR REMIT

What was asked of us

1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are included in Appendix One.

1.2 On 6 October 2010, Cllr Lynne Stagg, Chair of Portsmouth City Council Health Overview and Scrutiny Panel (HOSP) wrote to the Secretary of State for Health, Andrew Lansley, exercising powers under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. The referral concerned the decision of Portsmouth Hospitals NHS Trust (PHT) to close the G5 End of Life Care Ward at Queen Alexandra Hospital, Portsmouth (Appendix Two).

1.3 The Secretary of State wrote to Dr Peter Barrett, IRP Chair, on 25 October 2010 requesting that the IRP undertake an initial assessment of the referral in accordance with the agreed protocol for handling contested proposals for reconfiguration of NHS services. NHS South Central (the strategic health authority - SHA) provided initial assessment information. The IRP set out its initial assessment advice in a letter to the Secretary of State of 30 November 2010 (Appendix Three).

1.4 The Secretary of State responded to Cllr Stagg on 6 December 2010 advising that he had asked the IRP to undertake a review of the decision. Terms of Reference were set out in the Secretary of State's letter of 6 December 2010 to Dr Peter Barrett (Appendix Four). The Panel was asked:

With due regard to the Panel's amended general terms of reference as agreed between DH and the IRP, the Panel is to advise by 31 March 2011:

a. whether it is of the opinion, taking account of the views and plans of local commissioners, that the proposals for change will enable the provision of safe, sustainable and accessible end of life care at Queen Alexandra Hospital, Portsmouth and if not, why not;

b. on any other observations the Panel may wish to make in relation to the changes; and

c. on how to proceed in the best interests of local people in light a of a and b above and taking into account the issues raised by Portsmouth City Council's Health Overview and Scrutiny Committee [sic] *in their referral letter of 6 October 2010.*

OUR PROCESS

How we approached the task

2.1 The SHA, Portsmouth PCT, Hampshire PCT and PHT were asked to provide the Panel with relevant documentation and to arrange site visits, meetings and interviews with interested parties.

2.2 Portsmouth HOSP was invited to submit documentation and suggest other parties to be included in meetings and interviews. Representatives of Hampshire County Council Health Overview and Scrutiny Committee (HOSC), Portsmouth Pensioners' Association, the Save G5 Campaign, the Rowans Hospice, Wessex Local Medical Committee, Carers UK and Portsmouth LINk were also invited to submit evidence.

2.3 An IRP press release, advising that the Panel would be undertaking a review, was issued on 8 December 2010 (Appendix Five). The Panel Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 6 January 2011 informing them of our involvement (Appendix Six). The letter invited people who felt that they had new evidence to offer or who felt that their views had not been heard adequately during the formal consultation process to contact the Panel.

2.4 A sub-group of the full IRP carried out the review. It consisted of four Panel members, Paul Roberts who chaired the sub-group, Fiona Campbell, Nicky Hayes and Brenda Howard. Sub-group members and other Panel members, Peter Barrett, Sanjay Chadha, and Linda Pepper visited Queen Alexandra Hospital and other relevant locations. The sub-group undertook five days of oral evidence taking. On one of those days, another Panel member, Ray Powles, joined the sub-group. Members were accompanied on visits and at evidence sessions by the IRP Secretariat. Details of the people seen during these sessions are included in Appendix Seven.

2.5 All local members of parliament were invited to submit views and offered the opportunity to meet the Panel. Three MPs asked to meet the Panel and meetings were held with Caroline Dinenage (Gosport) and Damien Hinds (Alton and Petersfield) on 15 February 2011 and Penny Mordaunt (Portsmouth North) on 22 February 2011.

2.6 A telephone conversation was held with Professor Sir Mike Richards**,** National Clinical Director for Cancer and End of Life Care on 5 January 2011.

2.7 A list of all the written evidence received – from the SHA, PCTs, NHS Trust, scrutiny committees, MPs and all other interested parties is contained in Appendix Eight. The Panel considers that the documentation received, together with the information obtained in meetings, provides a fair representation of the views from all perspectives.

2.8 Throughout our consideration of these proposals, our aim has been to consider the needs of patients, public and staff taking into account the issues of safety, sustainability and accessibility as set out in our general and specific terms of reference for this review together with the matters raised by the Portsmouth HOSP in its referral.

2.9 The Panel wishes to record its thanks to all those who contributed to this process. We also wish to thank all those who gave up their valuable time to present evidence to the Panel and to everyone who contacted us offering views.

2.10 The advice contained in this report represents the unanimous views of the Chair and members of the IRP.

THE CONTEXT

A brief overview

3.1 Charles ward, Queen Alexandra Hospital - a 12-bedded nightingale ward with one cubicle - was established in 1989 to provide palliative and end of life care for older patients with terminal conditions. At the time the ward was conceived, the provision of alternative care options for patients at the end of life was limited with no hospice care. Community/district nursing services were not set up to provide end of life care and there was little or no night time care provision. As a result, patients were admitted to hospital for end of life care and Charles ward provided this care away from acute wards.

3.2 The inpatient service remained on Charles ward, with some reduction in bed numbers, until 2004 when it transferred to Ashdown One ward at St Mary's Hospital in central Portsmouth. The ward comprised three four-bedded bays and two single rooms. Bed numbers varied between eight and 14 with at least four beds being used for non-end of life care patients as required. In 2008, the service moved back to Charles ward, Queen Alexandra Hospital – this time with 13 beds available.

3.3 As part of the occupation of the new private finance initiative (PFI) building at Queen Alexandra Hospital, the service was relocated to ward F1 in June 2009. The ward had 22 beds, subdivided into one six-bedded bay and eight single rooms allocated to end of life care. An additional eight-bedded bay provided care to older people with acute medical care needs.

3.4 In December 2009, to allow the move of a rehabilitation ward onto F1, the 14 end of life care beds were moved to ward G5, an all cubicle, isolation/infection control facility within the PFI part of Queen Alexandra Hospital.

3.5 The dedicated end of life care ward was part of PHT's Medicine for Older People, Rehabilitation and Stroke clinical service centre (MOPRS[1]). Throughout its existence, patients were admitted to the ward under consultant geriatrician care. The ward team consisted of registered nurses and health care workers employed within MOPRS. The

[1] Previously known as Division of Medicine for Older People (DMOP)

team had no staff with specialist qualifications in palliative care although several of the nursing team worked on the ward for several years and developed significant skills and experience in caring for patients at the end of life. An End of Life Steering Group had been in existence in the Trust since January 2007 to support the improvement of end of life care throughout the Trust, including staff training, the interface with community teams and bereavement support.

3.6 In February 2010, MOPRS was asked, as part of its business planning process, to examine how it could achieve cost improvements in 2010/11. This co-incided with consideration of possible options for remodelling end of life care for patients over the age of 65 and it was decided that an options appraisal should be developed in liaison with the PHT End of Life Steering Group. A stakeholder engagement approach was agreed on the assumption that any proposed changes would not represent a substantial development or variation to the services involved. By the end of February 2010, reports had appeared in the Portsmouth News about the potential closure of G5 following initial engagement with staff about recent developments.

3.7 Portsmouth Local Involvement Network (LINk) contacted the PHT public and patient involvement lead on 3 March 2010 regarding a story in that day's edition of the Portsmouth News and seeking clarification. The LINk Chair also contacted the Portsmouth HOSP support team to notify them of events. A meeting was held between PHT and the Portsmouth LINk on 10 March 2010 at which attendees were advised that *"a draft business plan had been drawn up outlining the business/quality needs of the department with specialist medical views as to the possibility of closing G5 ward"*[2] . On 22 March 2010, G5 staff were briefed on the potential options under consideration.

3.8 Representatives of MOPRS attended a meeting of the End of Life Steering Group on 23 March 2010 and presented a discussion paper on options. The Group was tasked with reviewing and enhancing the discussion document by 30 March 2010 before it was submitted to MOPRS management team.

[2] Note of Options for End of Life Care meeting with the Portsmouth LINk Steering Group, 10 March 2010

3.9 Presentations of the options were made to the Trust Patient Experience Council and the Trust Council of Governors in April 2010. Also in April, an engagement paper produced by MOPRS, explaining the issues and seeking views was distributed to interested groups including *"patient representatives, PHT staff and partner organisations"* but not the Portsmouth HOSP or Hampshire County Council HOSC. Portsmouth LINk sent the engagement paper to various organisations inviting comments, including Portsmouth Pensioners, Community First, Visual Impairment Group, Age Concern, Disability Forum, Learning Disability Partnership Board and Carers Forum. The engagement was initially intended to run to 21 May 2010 but was subsequently extended to mid-June.

3.10 Feedback from respondents was incorporated into a further options paper. A second meeting with the Portsmouth LINk was held on 8 June 2010 to discuss the option preferred by the MOPRS management team - closure of G5 and utilisation of some G5 staff to provide an end of life support team. Under this option, patients would be cared for on acute wards and a dedicated team of nurses would operate peripatetically providing supervision to staff on the wards in the care of patients at the end of life. The service would cover specific wards initially but be developed over time to meet the needs of the whole hospital population.

3.11 The PHT Quarterly Report (Issue 10: June 2010) presented to the 10 June 2010 meeting of the Portsmouth HOSP, advised that *"Discussions continue within the Trust with regards to the best model of provision of palliative care across the Trust and G5 in particular. The Trust has kept the Local Involvement Network (LINk) and the Patient Experience Council involved"*. The HOSP minutes of the meeting did not record any discussion of the issue.

3.12 On 28 June 2010, after receiving feedback from the Trust Council of Governors and Portsmouth LINk, a business case outlining options was presented to the PHT End of Life Steering Group which endorsed the MOPRS management team's preferred option (although minutes of the meeting are not available).

3.13 On 7 July 2010, the business case was presented to the PHT senior management team. It contained three options (one with three sub-options):

1 *"Do Nothing".*

2 *Close G5, release full saving as Cost Improvement.*

3 *Close G5, reinvest a proportion of the savings into one or more of the following options:*

a) Deliver a time-limited project, involving 2-3 of the experienced trained nurses on G5 to deliver an educative programme within the older people's services at PHT.

b) Establish permanent extended nursing roles (protected shifts within working week) for key ex-G5 staff to drive and progress the End of Life agenda within the Clinical Service Centre.

c) Create a consultant nurse-led service, responsible for maintaining high quality End of Life Care.

The business case stated that Option 3b was the preferred option as "*it addresses the specific concerns raised by the loss of a dedicated inpatient area for older people at the end of their life, and provides a platform for embedding knowledge and skills within the acute nursing workforce…… This will result in an enhanced quality of care for the <u>total</u> population within PHT, and enable swifter progression towards the End-of-Life care standards set out in the Quality Contract"*. The business case also stated that the preferred option would require *"Reinvestment of £160k of the savings realised from the closure of G5, resulting in a £605k net saving"*. The preferred option was endorsed by the PHT senior management team. The local press was briefed about the plans.

3.14 A phased plan to reduce capacity on G5 ahead of closure was enacted on 1 August 2010. G5 closed on 12 August 2010 with the transfer of patients still on the ward to a re-designated eight-bed area in F4, an acute Medicine for Older People ward, but under the management of the G5 team, until 6 September 2010. The new model of care commenced on 13 September 2010.

3.15 Following representations made to PHT, Trust representatives attended a meeting of the Portsmouth HOSP on 26 August 2010 and informed the HOSP of the closure of G5 and redeployment of the nursing team. The HOSP Chair, Cllr Lynne Stagg, wrote to the PHT Chief Executive, Ursula Ward, on 27 August 2010 to express concern about the lack of

consultation about the ward closure and to request that the decision be either reversed or deferred until a public meeting to discuss the matter had been held.

3.16 Ursula Ward replied to Cllr Stagg on 21 September 2010 responding to the points raised, confirming that the new model of care had been implemented and that the decision to close ward G5 was not reversible.

3.17 Trust representatives attended a further meeting of the Portsmouth HOSP on 23 September 2010, at which the HOSP resolved to refer the matter to the Secretary of State on the grounds that i) the closure of the ward amounted to a substantial variation and that consultation had been inadequate, and ii) the closure was not in the interest of the health service.

3.18 A further piece of context relating to the involvement of Hampshire County Council HOSC emerged in the course of the IRP's review. The HOSC was first informed by PHT of changes to its end of life care on 27 July 2010. The views of the HOSC were invited and an informal meeting took place with PHT on 16 August 2010 when clarification on the changes was provided. Further supporting evidence was requested in September 2010 and was provided in October 2010. At its meeting on 30 November 2010, Hampshire County Council HOSC *"accepted the case put forward that these changes were intended to provide a consistent and improved service for people requiring end of life care as well as their relatives and carers".*

INFORMATION

What we found

4.1 A vast amount of written and oral evidence was submitted to the Panel. We are grateful to all those who took the time to offer their views and information. The evidence put to us is summarised below – firstly background information followed by a brief description of the changes to end of life care at PHT, the reasons for referral by Portsmouth HOSP, issues raised by the public and others, and finally other evidence gathered.

4.2 **Portsmouth Hospitals NHS Trust**

4.2.1 PHT carries out its Care Quality Commission (CQC) (see also section 4.6) registered activities on four main sites:

- Queen Alexandra Hospital, Cosham – main acute site
- St Mary's Hospital, Portsmouth
- Petersfield Community Hospital (operated by Hampshire Community Health Care)
- Gosport War Memorial Hospital (operated by Hampshire Community Health Care)

4.2.2 The Trust provides a full range of emergency and other care services for approximately 650,000 people in Portsmouth and the surrounding area of south east Hampshire. As well as acute services, the Trust provides a range of specialist and tertiary services for Portsmouth, south east Hampshire and beyond including the Wessex Renal and Transplant Unit and a designated Cancer Centre. It is also a provider of education and training of under and post-graduate students including nurses, doctors and pharmacists. It hosts a large Ministry of Defence hospital unit, providing clinical training for military staff.

4.2.3 NHS Portsmouth and NHS Hampshire are the main commissioners of PHT services. The activity levels at PHT are set out on the following page:

Activity levels year February 2010 – January 2011

Year February 10 – January 2011 Activity levels Portsmouth Hospitals NHS Trust	
A & E attendances	121,658
New Outpatients seen	157,868
Follow-up outpatients seen	280,881
Elective patients treated	55,064
Emergency patients treated	66,650

Data source: PHT hospital system

4.3 PHT facilities and estate

4.3.1 The new Queen Alexandra Hospital consists of a 14.1 hectare site with a mix of building types and age. The front part of the site is a new PFI build, opened in 2009, which replaced much of the early 20th century estate on the site. Two clinical blocks dating from the 1970s have been retained, one of which houses the MOPRS wards. These blocks connect directly with the new build allowing transfer of patients.

4.3.2 Prior to this consolidation of facilities, acute beds for older people were split across two sites. 62 were located at Queen Alexandra Hospital in the early 20th century estate and 103 were located at St Mary's Hospital, Milton, including the end of life care ward. Patients who were assessed on the Medical Assessment Unit (Queen Alexandra Hospital) as needing an acute bed within the Department of Medicine for Older People usually faced a transfer to St Mary's Hospital in central Portsmouth, a journey of around four miles.

4.3.3 The new hospital has enabled acute services from the original Queen Alexandra Hospital, St Mary's Hospital and The Royal Hospital Haslar in Gosport to be provided from one site. To accommodate all these services the new Queen Alexandra Hospital is more that double the size of the previous hospital and has:

- Circa 1200 acute beds
- 29 operating theatres
- A 24-bedded Critical Care Unit
- Surgical, respiratory and coronary high care
- Three CT scanners; one PET/CT scanner and two MRI scanners
- Four linear accelerators

In the newly built part of the hospital, there is a maximum of four inpatient beds in a room and a third of the beds are in single rooms with en-suite facilities. The number of single rooms across the Queen Alexandra Hospital site is 272 and within MOPRS is 40.

4.3.4 The site now has 800 patient and visitor parking spaces - double the previous amount - of which 102 are disabled spaces. There are some 1,400 car parking spaces for staff and a park and ride facility 1.8 miles away with 1,200 spaces.

4.4 PHT financial profile

4.4.1 The *Auditor's Local Evaluation and Use of Resources scores for 2009/10*[3], which summarises the findings of the 2009/10 audit of NHS trust and primary care trust accounts, show that PHT was one of the ten bodies that failed to achieve financial balance in the year. The PHT deficit was £15m, representing 3.4 per cent of its turnover of approximately £440m.

4.4.2 The Trust has a challenging cost improvement target for 2010/11 of £37m. This includes the impact of cost reductions associated with demand management schemes. The *March 2011 Finance Report* updates Trust Board members on the 2010/11 cost improvement programme. It states:

"Of the £31m internally agreed savings identified so far the Trust is reporting a small under-achievement of £300k at the end of month 10. The Trust was anticipating to deliver savings of £23.0m at the end of January however it has delivered savings of £22.7m.

In terms of the total target of £37m that the Trust needed to achieve to deliver a break-even year end position, the Trust has achieved savings of £22.7m against an overall target of £29.1m. ……..this shortfall relates to a £6m planning gap identified at the start of the year that the local health system has been unable to resolve."

[3] Auditor's Local Evaluation and Use of Resources scores for 2009/10. Summary results for NHS trusts and primary care trusts. Audit Commission. 2010. Source of financial accounts DH.

This projection takes into account an assumed level of contract over-performance will be payable from PCT's and also factors in the impact of any residual winter pressures costs and remaining cost improvement programme schemes.

4.4.3 The MOPRS Cost Improvement Plan (CIP) for the three years to March 2012 is set out in the table below:

Financial year	CIP £	CIP Found £	Variance £ shortfall/surplus
2009/2010	(716,000)	675,000	(41,000)
2010/2011	(1,454,640)	1,519,209*	64,569
***Current best estimate* 2011/2012**	(1,333,000)+		

Note: * CIP found includes the shortfall from the previous year
+ Includes patient transport from 2011/12, accounting for circa £500k of total CIP target

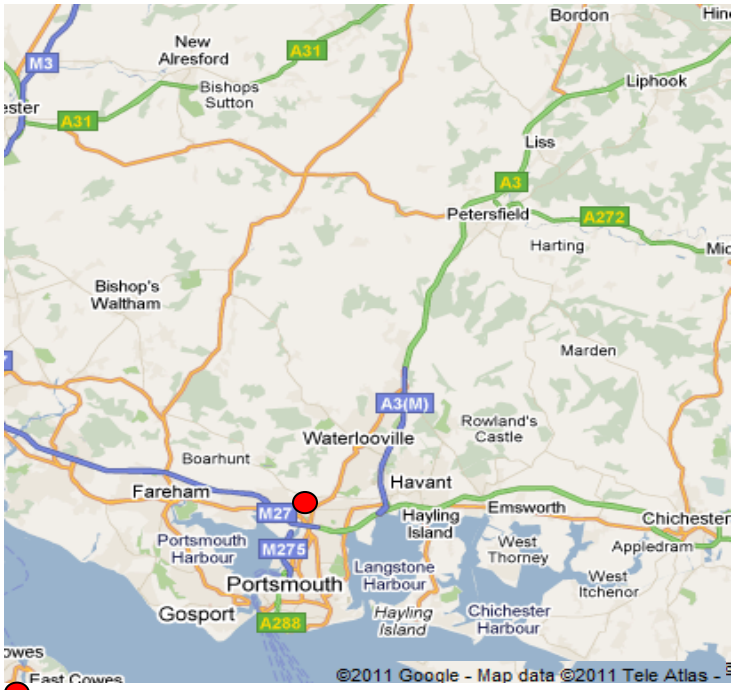
4.4.4 The new Queen Alexandra Hospital is a Private Finance Initiative (PFI). The PFI capital cost was £256 million with the Trust currently reporting annual repayments of around £43 million (subject to movement in the Retail Prices Index) reflecting new build works, retained estate works (eliminating backlog maintenance), provision of all Facilities Management (FM) services, ongoing life cycle maintenance, risk transfer on FM and Estates matters. The annual PFI repayment represents approximately 10 per cent of the Trust's turnover. The contract length is until 15 June 2040.

4.5 Geography, demography, access and transport[4]

4.5.1 Queen Alexandra Hospital is located in Cosham within the Portsmouth City Council local authority area. In terms of NHS boundaries, it is within Portsmouth PCT and adjacent to Hampshire PCT. PHT treats patients mainly from five local authority areas: one unitary (Portsmouth City) co-terminous with Portsmouth PCT and four district/borough areas (Havant, Gosport, Fareham, and East Hampshire) that are within Hampshire PCT. Historically, residents of Portsmouth, Havant, Gosport and the majority of East Hampshire and Fareham look towards Queen Alexandra Hospital as their local acute hospital. PHT also provides care for people living towards Winchester and Eastleigh.

[4] This information is largely drawn from DH Health Profiles 2010, Hampshire Joint Strategic Needs Assessment Refresh (2010), Portsmouth Joint Strategic Needs Assessment (2010), Core JSNA data set, and HCC facts and figures website.

4.5.2 PHT provides emergency and other care services to around 650,000 people with approximately two thirds Hampshire residents and one third Portsmouth City residents. The following map shows the main population areas and the location of Queen Alexandra Hospital.



Approximate Location of Queen Alexandra Hospital

4.5.3 The table below provides population statistics[5], by local authority, for the main local authorities served by PHT.

Population of the main local authorities whose residents receive acute services from PHT as number and percentage of total population

Local authority	Total Population	Population aged > 65	Population aged > 85
Portsmouth City	203,503	27,483 *13,5%*	4,507 *2.2%*
Gosport Borough	79,965	13,815 *17.3%*	1,936 *2.4%*
Havant Borough	116,535	24,776 *21.3%*	3,356 *2.9%*
East Hampshire District	111,934	20,467 *18.3%*	2,881 *2.6%*
Fareham Borough	111,499	22,352 *20.0%*	3,149 *2.8%*
England		*16.3%*	*2.2%*
South East		*17.0%*	*2.5%*

Source: ONS Mid-2009 Population estimates Experimental statistics for Joint Strategic Needs Assessment

[5] Small Area Indicators for Joint Strategic Needs Assessment Developed by APHO on behalf of DH (2010)

4.5.4 Portsmouth is a compact city covering 15.5 square miles with around 79 per cent of the population living on Portsea Island. The city is the most densely populated local authority area outside of London (48.8 people per hectare). Havant and Gosport border Portsmouth city and are also urban in nature. By contrast, the local authority areas of East Hampshire and Fareham are more rural and are, on the whole, more affluent although some of the rural wards in these areas score relatively highly on the indices of deprivation.

4.5.5 Approximately 27,000 (13.5 per cent) of Portsmouth residents are aged 65 and over. Between 2011 and 2026, the population aged 65 and over is expected to increase by 28 per cent. 232,000 (18 per cent) of the Hampshire population is aged 65 and over. An estimated 27.3 per cent of the population of Hampshire will be aged 65 or older in 2033.

4.5.6 The English Indices of Deprivation 2007[6] are the Government's official measure of multiple deprivation at small area level. These Indices show that Portsmouth City unitary authority is ranked 92nd in the district rankings (1 being the most deprived), and puts the authority in the 20 per cent - 40 per cent most deprived group. Hampshire County Council area is ranked the 10th least deprived of the 149 principal authorities (that is, counties and unitary authorities). Whilst large parts of the Hampshire County Council area remain relatively unaffected by multiple deprivation there are significant concentrations in Havant and some more localised pockets in Fareham and Gosport.

4.5.7 The black and minority ethnic population in Portsmouth city is estimated to be 14 per cent of the total population with Chinese, Indian and Bangladeshi communities comprising the largest ethnic groups. For Hampshire, non-white ethnic groups make up only two percent of the Hampshire population. Asian ethnic groups make up the largest non-white categories across Hampshire. The age structure of the non-white ethnic groups differ from the white groups in that there are relatively few people over retirement age.

4.5.8 Cosham is approximately three miles from the centre of Portsmouth. The M27/A27 Coastal route and A3(M), which passes through Havant, provide the main trunk road access to Cosham. The hospital is about 10 minutes from the motorway with good road

[6] Source: Department of Communities and Local Government

access, mainly dual carriageway. The M275 connects Portsea Island with the M27 although as a major port, naval base and cross channel ferry terminal this can become congested at times and especially in the summer months.

4.5.9 Examples of approximate return distances to Queen Alexandra Hospital, Cosham include: Portsmouth City Centre - eight miles; Havant - eight miles; Southsea - 11 miles; Fareham - 12 miles; Gosport - 20 miles; Petersfield - 33 miles.

4.5.10 Commercial bus services run frequently from Portsmouth city centre and surrounding areas with some buses stopping within the hospital grounds and others on the main road a short walking distance from the hospital main entrance.

4.5.11 The nearest train station is Cosham. Local trains run to Hilsea, Fratton, Portsmouth and Southsea to the south; to Porchester and Fareham to the east; and Bedhampton, Havant and Petersfield to the west.

4.5.12 For family, friends and carers visiting inpatients PHT provides the following support:

- Concessionary rate parking for Blue Badge holders (£1.50 per 24 hours).
- Concessionary rate parking (£1.50 per 24 hours) for patients or their next of kin in particular circumstances.

The standard car parking rate ranges from £1.50 for one hour to £15.00 for up to 12 hours.

4.6 Healthcare Commission[7] annual assessment and Care Quality Commission licence

4.6.1 The Healthcare Commission assessment of PHT for 2007/08 and 2008/9 is set out in the table below:

	2008/9 rating		2007/08 rating	
	Quality	**Financial management**	**Quality**	**Use of resources**
Portsmouth Hospitals Trust	Excellent	Fair	Excellent	Good

[7] On 31 March 2009, the Healthcare Commission merged with the Commission for Social Care Inspection and the Mental Health Act Commission to form the Care Quality Commission

4.6.2 From April 2010, all NHS Trusts are required to be registered with the CQC. Registration is a licence to operate. To be registered, all health and adult social care providers must show they are meeting new essential standards of quality and safety across all of the regulated activities they provide. The CQC continually monitors providers and has a range of enforcement powers that allow them to act if they find that a particular service is not meeting essential standards.

4.6.3 In March 2010, PHT received an unconditional licence from the CQC to provide services.

4.7 End of Life Care – National Context

4.7.1 Around half a million people die in England each year, of whom almost two thirds are aged over 75. Most deaths (58 per cent) occur in NHS hospitals, with around 18 per cent occurring at home, 17 per cent in care homes, four per cent in hospices and three per cent elsewhere.

4.7.2 The 2008 *National End of Life Care Strategy (DH)* sets out key areas for action to improve end of life care based on the best available research evidence and on existing experience. The key areas can be summarised as follows:

1 Raising the profile

Improving end of life care will involve primary care trusts (PCT) and local authorities (LA) working in partnership to consider how best to engage with their local communities to raise the profile of end of life care.

2 Strategic commissioning

As the services required by people approaching the end of life span different sectors and settings, it is vital that an integrated approach to planning, contracting and monitoring of service delivery should be taken across health and social care. A strategic approach to commissioning led by PCTs and LAs is vital with all relevant provider organisations involved in the commissioning process.

3 Identifying people approaching the end of life

Caring for those approaching the end of life is one of the most important and rewarding areas of care, although it can be challenging and emotionally demanding. Staff need to

have the necessary knowledge, skills and attitudes and appropriate training to deliver this type of care effectively.

4 Care planning

All people approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan.

5 Co-ordination of care

Within each local health economy mechanisms need to be established to ensure that each person approaching the end of life receives coordinated care, in accordance with the care plan, across sectors and at all times of day and night.

6 Rapid access to care

As the condition of a person may change rapidly, it is essential that services can be accessed without delay.

7 Delivery of high quality services in all locations

Commissioners need to review the availability and quality of end of life care services in different settings.

8 Last days of life and care after death

Increasingly, the Liverpool Care Pathway[8] (LCP), or an equivalent tool, is being adopted by those providing end of life services. Originally developed for cancer patients, the LCP has been successfully modified for use for people with other conditions.

9 Involving and supporting carers

The family, including children, close friends and informal carers of people approaching the end of life, have a vital role in the provision of care. They need to be closely involved in decision making, with the recognition that they also have their own needs.

[8] The Liverpool Care Pathway (LCP) is an integrated care pathway that is used at the bedside to ensure the delivery of appropriate care for people who are in the dying phase of their illness and after death.

10 Education and training and continuing professional development

Ensuring that health and social care staff at all levels have the necessary knowledge, skills and attitudes related to care for the dying will be critical to the success of improving end of life care.

11 Measurement and research

Good information on end of life care is needed by patients, carers, commissioners, clinicians, service providers, researchers and policy makers.

4.7.3 Since publication of the *National Strategy*, implementation has been driven through the NHS Operating Framework, PCTs' commissioning plans, targeted investment and the development of quality standards with associated comparative data collection.

4.8 **End of Life Care – Local Context**

4.8.1 In the context of the *National Strategy*, and the expectations that have flowed from it, Portsmouth PCT and Hampshire PCT have both pursued implementation programmes.

4.8.2 In Portsmouth a baseline review of end of life services was carried out in 2007/08 alongside the establishment of a 24 hour community palliative care service.

4.8.3 The commissioning intentions of NHS Portsmouth are broadly to extend both generalist and specialist palliative care beyond the hospice and hospital environments and into patients' homes. The NHS Portsmouth 2010 – 2011 Operating Plan and 2010 – 2014 Strategic Plan set out a number of end of life care work programmes which aim to: *reduce palliative care deaths in the hospital setting, develop care pathways for people with dementia and palliative care needs, ensure a single point of access to community services, provide health and social care needs assessments and individual care plans, ensure carer involvement, develop a locality-wide register so that people can receive priority care when needed, increasing the number of people with non-malignant disease who are accessing palliative care services to die at home and ensure appropriate staff training for generic health and social care services*.

4.8.4 NHS Portsmouth's expectations for end of life care at Portsmouth Hospitals NHS Trust are:

- All patients in last 48 hours of life, if death is expected and appropriate, should have their care documented on LCP
- Education to be provided on LCP
- Evidence of unified Do Not Attempt Cardio Pulmonary Resuscitation (uDNACPR) policy implementation
- Processes in place for identifying patients at the end of life
- Appropriate patients to be offered Advance Care Plan – including expressing preference for preferred place of death
- Level 1 communication skills training for all staff involved with distressed patients and families
- All providers to work co-operatively to deliver end of life strategy and participate in education strategy
- Bereaved relatives to be offered written information

4.8.5 For NHS Hampshire, the implementation plan for end of life care services involved a detailed consultation, involvement and engagement programme in 2008 which led to the production of a *Joint End of Life Strategy* with Hampshire Council a few months in advance of the *National Strategy* but still entirely consistent with the national model. This local joint strategy was refreshed in March 2010. The main elements are:

- *Person centred pathway of care*
- *Improved support in primary care*
- *Greater public awareness of choice of place of death*
- *Agreed standard for delivery of end of life care*
- *A reduction in the number of unnecessary admissions to hospital*

4.8.6 NHS Hampshire has set out the role of PHT within its end of life strategy. This role consists of eight components: *identification of those at the end of life to ensure appropriate and adequate support; healthcare professionals to have the necessary competencies to initiate and discuss end of life care choices; robust integrated care planning process; fast track assessments for continuing health care; implementation of care pathway for the dying; specialist palliative care teams supporting individuals across*

the end of life care pathway including linking and liaising with primary care; accommodation that is available and suitable for end of life care, and; monitoring demographics of patients receiving end of life care and quality of care delivered.

4.8.7 To support this approach, NHS Hampshire has agreed quality standards that are incorporated into the end of life contract for services and which are monitored. These include: *quarterly monitoring of complaints, staff training, participation in the local end of life care groups to ensure quality, submission of data to the* National Care of the Dying Audit *and through the 10/11 CQUIN[9], a financial incentive to implement staff training and systems for identifying patients who should be on the LCP*. It has also focussed on creating the out of hospital model including district and community nursing services to reduce admissions to hospital for those who are at the end of their life.

4.8.8 Outside PHT and people's homes, specialist palliative care provision can be accessed by local residents at the Rowans Hospice, a local charity based in Purbrook with 19 en-suite bedrooms. GP beds are provided at five local community facilities: Jubilee House, Portsmouth; Gosport War Memorial Hospital; Havant War Memorial Hospital; Petersfield Community Hospital, and; Chase Community Hospital. These beds can be accessed by end of life patients providing certain clinical and eligibility criteria are met.

4.9 End of Life Care in PHT

4.9.1 PHT's focus on end of life care preceded the publication of the national strategy in 2008. Since 2007, PHT has had a multidisciplinary End of Life Care Steering Group. In May 2008, it organised an end of life care away day, which involved over 100 staff and patient representatives, with the aim of improving the quality of end of life care. It focussed on five different aspects: improved choice, dying in hospital, carer support, supported discharge and the Mental Capacity Act. This was one of the first such workshops in the UK and its output included six key recommendations:

1 *Respect and provide for patient and carer privacy and dignity, ensuring provision of side rooms and quiet rooms on all wards.*

2 *Staff training and education.*

3 *Cross sector (secondary-to-primary health care, health and social care, voluntary sector) planning and communication to support patient choice and best care placing the patient and not organisations at the centre of our efforts.*

4 *Investment in hospital specialist palliative care staff and resources.*

5 *Review and invest properly in Trust bereavement services.*

6 *Enable senior nursing staff with a special interest in this field to broaden their roles to support excellent communication around end of life issues, including DNAR (do not attempt resuscitation) discussions and care after death.*

4.9.2 These recommendations were shared with the PHT Executive, local PCTs, the SHA lead and the Department of Health.

4.9.3 More recently, the Trust has brought back into the hospital setting the acute element of the specialist palliative care team to facilitate more input into the general end of life service. In addition to delivering the service outlined by commissioners for end of life care, including receiving a financial incentive to implement training in the use of the LCP, the Trust has also worked on the key levers for rapid progress towards high quality end of life care in acute hospitals.

4.9.4 End of life care is provided by all of the following clinical services in PHT:

- Medicine and Older People
- Adult Medicine
- Surgery
- Paediatrics
- Cancer Care
- Renal
- Critical Care
- Neonate Intensive Care Unit
- Trauma and Orthopaedics
- Emergency Department
- Head and Neck

[9] CQUIN – Commissioning for Quality and Innovation

4.9.5 In 2009/10, there were just over 2,100 deaths in PHT. Of these, 1,900 were patients over the age of 65 years.

4.9.6 Since it was established in 1989, the dedicated end of life care ward has moved on several occasions. The number of beds provided has varied between 10 and 14. Only in its final location, on G5, from December 2009, were all the beds in single rooms.

4.9.7 Between 2006 and 2010, patients on all wards within PHT could be referred direct to the end of life care ward by both medical and nursing staff. A process was in place to assess appropriateness of transfer according to eligibility criteria. If the patient was appropriate and the patient and/or their families wished to move to the end of life care ward then they would be transferred as soon as a bed became available. If the patient or family chose not to transfer then care continued to be provided on the patient's existing ward.

4.9.8 Patients admitted to the Medical Assessment Unit (MAU) who required end of life care were seen and assessed by the Medicine for Older People MAU specialist nursing team who could then refer direct to the ward and arrange transfer. If no beds were available, the end of life care ward operated a waiting list.

4.9.9 The end of life care ward team consisted of registered nurses and health care support workers. The medical cover for the ward was provided by a consultant geriatrician with day to day cover provided by a SHO on Medicine for Older People rotation. The team aimed to provide high quality physical, psychological and emotional care to patients and provide support to their relatives and carers.

4.9.10 All patients within PHT who have complex symptom control issues or require specific psychological support can be referred to the hospital specialist palliative care team. This included patients on G5 before it closed.

4.9.11 PHT also provides inpatient rehabilitation services at Gosport War Memorial Hospital and Petersfield Community Hospital. If a patient deteriorates and they require end of life care then this would be provided by the ward staff. The patient would not be transferred back to the end of life care ward at Queen Alexandra Hospital. From December 2009 to

November 2010, 23 patients received end of life care in Petersfield Community Hospital and nine patients received end of life care in Gosport War Memorial Hospital.

4.9.12 The end of life care ward relocated to G5 in December 2009 and closed in August 2010. The following activity tables cover this period.

Source of admissions to G5 December 2009 – August 2010

Source of referral	Percentage
Acute medicine CSC (includes MAU)	35.4
Surgical CSC	6.2
Head and Neck CSC	0.4
Musculoskeletal	1.4
Cancer CSC	2.6
MOPRS CSC	54.0

Data source: PHT INFoCOM

All Patient deaths in MOPRS care 1 December 2009 – 31 August 2010

Area	G5 Ward	MOPRS Ward - Not G5	MOPRS - Outlier	Grand Total
Portsmouth	128	83	1	212
Fareham	60	45	2	107
Gosport	56	34	1	91
Waterlooville	41	27	2	70
Havant	48	15	1	64
Hayling Island	22	17		39
Southampton	17	12		29
Emsworth	8	9		17
Petersfield	8	7		15
Liss	11	4		15
Liphook	1	1		2
Other	4	1		5
Grand Total	404	255	7	666

Data source: PHT PAS record system

4.9.13 The following table shows the distribution of deaths across the MOPRS bed base during the period 7 September 2010 – 31 January 2011 following the closure of G5. All of the wards, with the exception of F3 Acute Stroke Unit, operate a minimum age criterion of 65 years old.

MOPRS deaths during period 7 September 2010 – 31 January 2011

	Month					
Ward	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Grand Total**
Ark Royal (Rehab)					1	1
Cedar (Rehab)	3	2		1	2	8
F2 (Acute)	6	11	8	14	18	57
F4 (Acute)	12	15	10	18	9	64
D1 (Rehab)	1		1		1	3
G1 (Rehab)					1	1
G2 (Winter Ward)			1		1	2
G3 (Acute)	8	19	17	11	20	75
F3 (Acute Stroke)	6	14	14	16	17	67
Grand Total	36	61	51	60	70	278

Data source: PHT PAS record system

4.10 **The changes that have been implemented**

4.10.1 Following the closure of G5, all patients now receive end of life care on their primary ward with one dedicated nurse from the end of life support team being available on demand between 08.00 and 23.00, seven days per week.

4.10.2 The purpose of an end of life support team member is to:

- *Support the delivery of high standards of physical, psychological and emotional care to patients at the end of life and their families*
- *Support the management of patients at the end of life to facilitate the transfer of these patients to their preferred place of care*
- *Work in partnership with ward staff to develop staff skills in provision of high quality end of life care*
- *Support the full implementation of the LCP*

4.10.3 The team consists of seven members of staff (3.6 wte). During the hours of operation, there is one member of the team on duty. Access is by bleep or through contact during the routine daily ward visits by the duty member of the team. Currently referral to the team can be from any of six MOPRS wards (F2, F4, G3, F3, D1 and G1) and one Musculoskeletal ward (D3) covered by the new service. The next phase is to extend the service to cover the Emergency Department and MAU.

4.10.4 G5 closed on 12 August 2010 with the transfer of eight patients to other wards under the management of the G5 team. Three of these patients were on the LCP and were accommodated in single rooms. From 6 September 2010, there was a familiarisation and preparation time for the new support team, which formally commenced work on 13 September 2010.

4.11 **Local scrutiny committees**

4.11.1 PHT relates to two scrutiny committees, Portsmouth HOSP and Hampshire HOSC. In late July 2010, both Portsmouth HOSP and Hampshire HOSC were advised by PHT of the proposed changes to G5.

4.11.2 Portsmouth HOSP resolved to refer the matter to the Secretary of State for Heath. The HOSP's letter of 6 October 2010 cited the following grounds:

1 *"The Panel is concerned that the closure of G5 Palliative Care Ward amounts to "substantial variation" of the provision of a service and the Portsmouth HOSP is not satisfied that consultation has been adequate. The Portsmouth HOSP requests that the Trust reconsiders its original decision and properly consults on the matter before reaching a final decision.*

2 *The Panel is concerned that the proposed closure is not in the interests of the health service and seek the intercession of the Secretary of State for Health to determine whether this closure is in the best interests of the health service in Portsmouth and to take such action or desist from taking such action as The Secretary of State may direct."*

4.11.3 Hampshire HOSC opted not to refer the matter to the Secretary of State for Health. Instead, it requested clarification of the changes from PHT, established local views and reviewed relevant documentation. At its meeting on 30 November 2010, Hampshire HOSC resolved:

- *"That the HOSC be provided with additional information on the experience of relatives and carers when this was available as well as an indication of improvements in staff confidence as a consequence of the changes.*

- *Members accepted the Trust had been able to demonstrate the improvements in services as a result of this change although there was further work to be done to roll the model out across the Trust.*

- *The HOSC would work with Portsmouth HOSP to agree any further action required once the report of the IRP was published."*

4.12 **Issues raised by the public and others**

4.12.1 In reviewing the changes to end of life care for the over 65s that have been implemented by PHT, many views and pieces of information were presented or sent to the Panel by a wide range of contributors.

4.12.2 ***Accessibility***

As the proposals involve the closure of an end of life care ward with the alternative provision and support remaining on the same site no significant access issues specifically in the context of end of life care provision were raised with the Panel. However, the opportunity was taken to raise the issue of centralisation of services on the Queen Alexandra Hospital, Cosham and the removal of many of the services from St Mary's Hospital. The Panel was told that this had reduced accessibility to general hospital services for central Portsmouth residents.

4.12.3 ***Safety***

On several occasions, reference was made to adverse events in the past - notably at Gosport Memorial Hospital - that were felt to provide relevant context to discussion about the care of older people and their needs at the end of life. The Panel was also told of a serious untoward incident (SUI) that occurred in 2008 in the Department of Medicine for Older People. The incident concerned all aspects of nursing care on an acute ward. It was emphasised that this was a quality issue relating to ward management and nursing standards. As a result, a quality turnaround programme had been introduced. The incident had not occurred on the main Queen Alexandra Hospital site and had been a catalyst, along with the opportunity presented by the PFI build, to consolidate acute medicine for older people services on the Queen Alexandra Hospital site.

4.12.4 ***Loss of the qualities most valued at the end of life by patients, relatives, carers and friends***

The Panel heard many personal stories from individuals who had been recently bereaved indicating what had been important in their end of life care experience. A recurring theme during these evidence sessions was the high value people placed on the environment provided by G5, in particular the feeling of privacy that enabled them to say goodbye to their loved one. They appreciated not being pressurised by a lack of bedside space and knowing that final moments could not be overheard by other people in the next bed or just behind a curtain. The quiet, calm and peaceful environment of G5 had been greatly valued and had enhanced their experience of end of life care. People also valued the time nurses had available to support them in addition to their role of caring for patients.

4.12.5 Some people with experience of end of life care on a general ward felt that the situation had been difficult because other patients would recover and go home. They also felt that the situation must have been equally difficult for the patients not receiving end of life care on the ward. In their view, this emphasized the need to offer separate facilities for care of the dying.

4.12.6 Some individuals who had direct experience of a relative or friend being cared for on G5 told us that they did not see how the high quality end of life care provided on G5 could be delivered on a busy acute ward. They felt that staff time, support and privacy could not be replicated. On the other hand, others told the Panel that they had experienced very good end of life care on general wards, praising the staff for their care and compassion.

4.12.7 The Panel heard of instances where, despite Trust policy, visiting had not been flexible in general wards and of the awkwardness felt when a number of relatives and friends had wanted to be together at the bedside. The need was highlighted for staff to be aware of different cultural needs when caring for end of life patients and particularly around the moment of death. The view was expressed that a busy ward could not always accommodate these needs.

4.12.8 During Panel visits to Queen Alexandra Hospital, members observed how busy general acute wards can be, notably during meal rounds. The Panel also visited the Rowans Hospice and Jubilee House which, in contrast, appeared calmer and quieter.

4.12.9 Written evidence reviewed by the Panel – including the End of Life Steering Group minutes of meetings and the Trust End of Life Care Away Day Report – showed that the qualities most valued in end of life care had been identified within PHT as the basis for delivering better end of life care. Oral evidence from clinicians within the hospital and from other organisations, including GPs, painted a similarly consistent view and understanding of what is essential to meet the needs of people at the end of their lives.

4.12.10 ***Lack of local strategy and plan for end of life care***

The Panel heard some evidence from relatives that the option of dying at home had not always been offered or supported. Others felt that the NHS did not place priority on care of older people at the end of their life, sometimes criticising the apparent lack of an overall plan for improving services. In their view, without an agreed strategy and plan, there were no clear guidelines for making service changes or to judge whether a change would deliver more effective end of life care for local residents.

4.12.11 The Panel learnt that the Portsmouth PCT Strategy Group had lapsed and, therefore, there had been little opportunity recently for agencies to come together to develop plans or discuss end of life provision. The Panel heard that this had, on occasion, been frustrating for some partner agencies. The Panel was told that the Strategy Group had now re-formed and would meet for the first time in February 2011. Draft minutes were subsequently provided to the Panel that showed a wide membership.

4.12.12 Hampshire PCT described a more comprehensive approach and explained how this was being taken forward.

4.12.13 Patients at PHT are mainly registered with GPs from either Portsmouth PCT or Hampshire PCT. The Panel heard from both PCTs that their commissioning of services is designed to increase the number of people who have access to services that support them dying at home. If successful, this would reduce the number of people dying in PHT. Hampshire PCT advised that it is actively seeking to ensure more people will be supported to exercise their preference to die at home rather than in hospital. Currently the Panel were told that 43 per cent of Hampshire residents die at home. This is above the

national average of around 38 per cent. Portsmouth PCT also indicated its intention to increase the number of people supported to die at home.

4.12.14 The Panel heard that both PCTs considered the new service at PHT to be consistent with their end of life commissioning plans. However, the Panel heard no evidence that the two PCTs had worked together to ensure their separate approaches to end of life care, when taken together, would form a comprehensive and coherent strategy for the area.

4.12.15 GP commissioners told us that with the new commissioning arrangements in transition and elections taking place in March 2011 they had not yet had the opportunity to discuss end of life care and how they would like to commission services. They did confirm that the overall direction would be to see more people supported to die at home.

4.12.16 ***The case for closing G5 had not been demonstrated***

Those opposed to the changes felt strongly that closing G5 was to the detriment of quality of end of life care at PHT. G5, and its predecessors, had provided good quality care and the alternative would not match this. Some felt that PHT's argument for change - that G5 only provided for about a quarter of all older people who died at the hospital – was "levelling down". They also felt that PHT had not demonstrated how the benefits of the new model would be delivered, but rather that they were motivated by saving money at the expense of the care of older people.

4.12.17 The Panel heard from Trust management that one of the drivers for change was the desire to improve the end of life experience for all patients in the hospital and that, while it was acknowledged that patients on G5 received good quality end of life care, only 28 per cent of patients received their end of life care on G5. The other 72 per cent received end of life care on wards elsewhere in the hospital and the new model was intended to improve end of life care for these patients.

4.12.18 In May 2008, the End of Life Steering Group organised an away day involving over 100 clinicians and patient representatives. With regard to dying in hospital, there were four key recommendations:

1 *Adequate provision of quiet rooms and side rooms on all wards. Privacy for dying patients and their relatives is imperative and a vital marker of the quality of care our Trust delivers to its dying patients. A private room should not lead to patient and carer isolation from staff.*

2 *Dying patients should as a normal rule be allowed to have their terminal care on the ward on which they have been nursed to that point, remaining with staff with whom they and their families are familiar. Obviously if it is a patients wish to go home or to the hospice to die, every effort should be made to safely support that wish.*

3 *Staff training and education in end of life care again highlighted as critical to being able to deliver a high standard of end of life care within our organisation.*

4 *The Trust must invest in developing its specialist palliative care team which is too small to meet the needs of the hospital caseload at this time. From the current staffing level of 1 whole time equivalent (wte) consultant and 3 wte palliative care nurses it is strongly recommended that a second wte consultant and 4 more wte nursing staff should be employed by the Trust. This will give the facility for the team to provide a proactive service to all patient groups 7-days a week. This resource will be synergised by the development of ward champions as described under Carer Support recommendations.*

4.12.19 Following advice from the End of Life Steering Group, options for replacing G5 with a new model of care were developed and tested in an outline business case that identified five key criteria:

- *Privacy and dignity for patients at the end of their life*
- *Ward nursing skills in providing high quality End-of-Life care, and the loss of a cadre of nurses experienced in this area*
- *The ability of ward nurses to provide adequate time, compassion and support to patients and their relatives at the end of life*
- *Facilities for relatives who wish to spend extended time with their loved ones*

- *Environmental factors, specifically the impact of agitated, and potentially noisy patients*

4.12.20 The Panel heard that a range of clinicians and stakeholders were engaged and their views represented in the criteria for testing options. However, there is limited evidence that these groups were involved in the appraisal of options leading to the final decision. No minutes were available to the Panel of the End of Life Steering Group meeting that decided to recommend the closure of G5 and establishment of the end of life support team to the Trust Senior Management Team.

4.12.21 The Panel considered the outline business case which identified benefits of the new model compared to retaining G5 including *cost savings, equal access to high quality end of life care for patients, reduction in temporary staffing on other wards, release of medical resource to enhance older people's services, increase in appropriate use of the LCP, support and supervision for acute ward staff, accelerating transfer of knowledge and skills required to enhance the quality of end of life care*. The contents of the outline business case, as seen by Panel, and the arguments it makes for the changes to end of life care appear not to have been widely disseminated.

4.12.22 The Panel received a similar presentation to stakeholders regarding the financial aspects of the changes to end of life care provision at PHT. Members also received a copy of the outline business plan and detailed information on lengths of stay. Written evidence provided to the Panel indicates that the decision to close G5 coincided with the need to deliver a 2010/11 £1,454,640 cost improvement plan in the clinical service area. The Panel heard from clinical staff that the decision was presented in MOPRS management meetings as part of its cost reduction programme. The Panel spoke to three of the consultant geriatricians in MOPRS. During these sessions, no indication was given that the changes were clinically wrong - one consultant specifically stated to the Panel that had it been felt that the new model was clinically wrong the decision would not have been supported.

4.12.23 Senior nursing staff told the Panel that there had been occasions when it had not been possible to fill the beds on G5 - either because end of life patients had chosen to remain on their primary ward with nursing staff they knew and in a familiar routine, or because

of the practical difficulty of making the transfer. This contributed to making G5 expensive to run as the nurse staffing level remained the same irrespective of beds occupied.

4.12.24 Nursing staff outlined the difficulties experienced by staff on G5 as a result of the physical layout. Built as an isolation facility, each pair of single rooms has double doors that make the rooms soundproof. Some patients, particularly those unable to use the call bell system, had found it difficult to attract staff attention. Additionally, the position of the nurse station meant that it was not easy to see all the patient areas.

4.12.25 The Panel heard that within MOPRS some services had been redesigned to support patients at the end of life. In stroke care, for example, around 20 per cent of patients had received care on G5. The CQC had confirmed to PHT that this option was not in line with national clinical policy for care of stroke patients. The Panel was told that the impact of the implementation of this policy would have been to reduce the number of patients who could be treated on G5.

4.12.26 ***Lack of confidence in the sustainability of the new service***

Throughout the review, the Panel heard praise for the quality of care that had been provided on G5. However, we received more mixed messages about the experience of end of life care on other wards. We heard from a number of people that whilst the nurses had been caring, they were frequently very busy attending to the needs of acutely ill patients on the ward. As a result, the particular needs of patients with end of life care needs, and their relatives and friends, were not always fully met. Most people who raised this with the Panel, indicated that they did not feel it was a particular individual's fault but simply that staff did not have enough time.

4.12.27 People opposed to the change told the Panel that they found it very difficult to understand how one duty nurse, from the new end of life support team, could provide an improved quality of care. It was suggested that the time taken to walk between wards meant that there was less time available to spend with patients. Others felt that the Trust was not committed to sustaining the role of the end of life care support team because questions had been raised about how long the team would exist for and whether, should staff leave,

they would be replaced. Finally, many of those with concerns about the changes, felt that PHT was unclear about what benefits would be delivered and when.

4.12.28 The Panel requested a copy of the new end of life support team *Implementation Plan and Operational Policy*. In particular, we sought detail of the role and scope of the new service, staffing levels, process for accessing the team, times available, quality and outcome measures, evaluation process and sustainability plan. Some of this information was received late in the process. During oral evidence sessions with PHT, further day-to-day operational detail was provided.

4.12.29 The Panel heard interim findings from the new Trust end of life care questionnaire given to bereaved relatives and carers. 171 questionnaires had been completed between November 2010 and February 2011 with an overall Trust satisfaction rate of 84 per cent with 140 positive comments about care. Since the beginning of the survey, the overall satisfaction level has stayed at above 80 per cent. The Panel was told that for MOPRS the satisfaction level was currently 87 per cent, which is an increase from 82 per cent in December 2010.

4.12.30 The Panel heard that MOPRS had responded to the initial findings of this questionnaire and was planning to focus the end of life support team on wards that have consistently lower satisfaction ratings. The rollout of the end of life support team service would, therefore, reflect the needs of the service rather than following a pre-determined programme. PHT explained that it had initially focussed on establishing the team but was now beginning to focus on how to sustain the service into the future including the idea of end of life champions.

4.12.31 Everyone who spoke to the Panel agreed that the availability of single rooms was a key issue in providing high quality care for patients at the end of life. The Panel was also told that single rooms are important in delivery of infection control policy. In this context, it is important that there is clarity about the availability and use of single rooms in MOPRS. The Panel received confusing data on this matter. We reviewed the MOPRS bed occupancy data and were made aware of the very challenging capacity problems that had occurred over the winter. We were also told that a review of bed utilisation and capacity across the Trust had been started.

4.12.32 The Panel was advised that it is MOPRS policy to offer single rooms to all patients identified to the end of life support team where timescales make it appropriate to do so. Compliance with policy is maintained by the end of life support team. Further, the Panel was advised that, to 14 February 2011, 198 out of the 209 patients who died in hospital and received input from the end of life support team were offered a single room (94.7 per cent). Of the 198 patients who were offered a single room, 164 were moved to a single room, 10 declined and 24 were not moved to a single room. Of these 24 patients, nine died on the same day, eight died within one day and seven died two days or more following referral to the team.

4.12.33 ***Lack of public involvement and consultation***

The Panel heard from many people that, in their opinion, insufficient effort had been made by PHT to involve local groups and organisations, or even to inform them effectively of the decision or explain the rationale clearly and answer their queries.

4.12.34 Some members of local interest groups expressed the opinion that PHT's public and patient involvement often translated to "*always discussing issues and seeking involvement from the same small group of organisations"* . These groups were not always considered to be representative and local people did not always naturally relate to them. Those opposed to the changes told us that they had sought information from PHT about the steps they had taken to consider what type of involvement to do. In their opinion, PHT could not demonstrate that an adequate involvement process had been undertaken appropriate to the scale of the service change.

4.12.35 A common theme put to the Panel during the evidence on public involvement and consultation was *"it could have been done so much better"*. Strong views were expressed that a wider range of opinion was not only available but was also keen to be heard. This was in contrast with the Trust's observation that it was hard to involve people. This gap in expectations was felt by some to be symptomatic of the Trust's general approach and lack of transparency.

4.12.36 Some people expressed the view that the Trust had not only failed to involve people in its planning for end of life care changes but also that it should have undertaken a public consultation.

4.12.37 During the review, the Panel was invited to attend a public meeting on Thursday 17 February 2011 organised by the Save G5 campaign group. Generally, the opinions expressed at the meeting reflected those described above.

4.12.38 The Panel also received a copy of a petition in response to the statement *"We the undersign call upon Portsmouth Hospitals NHS Trust and the Secretary of State for Health, Andrew Lansley, to re-open the G5 palliative care ward at Queen Alexandra Hospital, Cosham"*.

4.12.39 Both Portsmouth PCT and Hampshire PCT confirmed that they had not specifically requested a change in the end of life service offered by PHT. In evidence-taking, both PCTs indicated that they felt they might have been more involved and received more information in advance of the closure. The Panel did not receive evidence that they had sought out this information at any stage before the closure.

4.12.40 Portsmouth HOSP and those opposed to the change considered that PHT had not been open and transparent at their meetings about the future of G5 and in their responses to questions about changes to the service and consultation.

4.12.41 For their part, PHT told the Panel that, in February 2010, they had considered how to involve people and that they had taken the decision that the potential changes to end of life care were not a substantial variation. With hindsight, they acknowledged that there had been gaps in their involvement, engagement and communication. They also felt that their efforts to communicate the case for the changes had, on occasions, not been recognised.

4.12.42 The Panel was informed that the *Southampton, Hampshire, Isle of Wight and Portsmouth HOSC arrangements for assessing substantial change in NHS provision* had not been used by PHT. Despite informal contact having been made between PHT and Portsmouth HOSP on several occasions during the months leading up to the closure, no evidence was

presented to the Panel that either side took advantage of these opportunities to discuss the service proposals. We were also informed by Portsmouth HOSP that following its decision that the service change amounted to a substantial variation, PHT still declined to undertake a period of consultation and declined to suspend the closure of the ward.

4.12.43 The Panel heard that, in July 2010, Hampshire HOSC sought the view of Hampshire PCT as to whether the changes to end of life care at PHT were consistent with the PCT's end of life strategy. In September 2010, the HOSC was assured by Hampshire PCT that the developments were consistent. Following further review and discussion, the Hampshire HOSC decided not to refer the matter to the Secretary of State for Health. The HOSC did, however, confirm to us that it was not content with the way the involvement and engagement process had been undertaken.

4.13 Relevant policy and other documents

4.13.1 During the review, the following policy and documentary sources were brought to the Panel's attention and have been considered as part of the evidence:

- *End of Life Care Strategy: Promoting high quality care for all adults at the end of life. Department of Health, July 2008.*
- *End of Life Care Strategy: Second Annual Report. Department of Health. August 2010.*
- *10 questions to ask if you are scrutinising end of life care for adults. Centre for Public Scrutiny, 2010.*
- *National End of Life Care Programme: The route to success in end of life care – achieving quality in acute hospitals, NHS August 2010.*
- *End of Life Care Strategy: Quality Markers and measures for end of life care. Department of Health, June 2008.*
- *National End of Life Care Programme. Quality Markers for Acute Hospitals.*
- *National End of Life Care Programme: the route to success in end of life care in acute hospitals – your guide. NHS, June 2010.*
- *Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people. PHSO, February 2011.*

OUR ADVICE

Adding value

5.1 Introduction

5.1.1 The Secretary of State for Health asked the IRP to undertake a review of the closure of the end of life care ward (G5) at Queen Alexandra Hospital, Cosham, part of Portsmouth Hospitals NHS Trust. The closure had been referred to the Secretary of State by the Portsmouth Health Overview and Scrutiny Panel on the grounds that it had not been consulted and that the closure was not in the interests of local health services.

5.1.2 G5 was closed on 12 August 2010 with the transfer of patients still on the ward to a re-designated eight-bed area on F4, an acute Medicine for Older People ward, but under the management of the G5 team until 6 September 2010. Between 6 September and 13 September there was a familiarisation and preparation time for the new end of life care support team. The end of life care support team formally commenced work on 13 September 2010. As a result, patients aged 65 years and over now receive end of life care on their primary ward with staff being able to seek advice and support from a dedicated nurse from the end of life care support team between 08.00 and 23.00, seven days per week.

5.1.3 Our review commenced at the start of 2011. The Panel has reviewed the written evidence presented to it and the relevant national policy documents. We took evidence from the Portsmouth HOSP, Hampshire HOSC, Portsmouth Hospitals NHS Trust (PHT), Portsmouth PCT, Hampshire PCT, South Central SHA, GP commissioners, an LMC representative, consultant medical staff, clinicians from PHT affected by the proposed change, local stakeholder groups and members of the public. We also visited Queen Alexandra Hospital, Jubilee House and Rowans Hospice to see the facilities and services provided.

5.1.4 This review is unusual for the IRP on two counts. First, the disputed change is one of how care is delivered within a hospital and, as a consequence, was not of direct interest to local NHS commissioners. Secondly, the service change was implemented prior to the Panel starting work. The closure of G5 at Queen Alexandra Hospital took place some 25

weeks prior to our first visit to Portsmouth. This did, however, provide us with the opportunity to talk to relatives and carers of patients with end of life care needs who had received their care since the closure of G5 and gather evidence about experience of the new service arrangements.

5.1.5 The Panel has considered all the evidence received and the issues raised with us before reaching its conclusions. In doing so, our focus has been the best interests of patients receiving end of life care in an acute hospital setting in Portsmouth and the surrounding area - now and in the future.

5.1.6 **Overall, we conclude that turning the clock back on the changes that have been implemented is not in the best interests of local health services. Equally, looking to the future, the best interests of people with end of life care needs will only be served by further actions on the part of PHT and others. We set out these actions below.**

5.2 **Accessibility**

5.2.1 Under the terms of references for this review the Panel was asked to advise on the accessibility of the changes to the PHT end of life care provision. The change involved the closure of an end of life ward with the alternative provision and support remaining on the same site. No evidence was received to suggest that this change had led to significant accessibility issues and we conclude that there have not been any.

5.3 **Safety**

5.3.1 The Panel was told about a serious untoward incident (SUI) in 2008 within the Department of Medicine and Older People. This concerned ward management and nursing standards on a site away from the main acute hospital. As a result, the Trust put in place a 24 month Quality Turnaround programme for the clinical service area. As is the case with a SUI, both the Trust Board and SHA had been kept informed and senior management provided Board level assurance.

5.3.2 The SUI did not involve the end of life care ward which at the time was based at Queen Alexandra Hospital site. The Panel did not hear any evidence from any party that the service provided on G5 ward was unsafe. Equally the new service arrangements to date have not raised any issues of safety during the review. Therefore, the focus of this review

has been on positive opportunities to improve quality of care for patients, relatives, carers and friends.

5.4 **Quality of end of life care**

5.4.1 The Panel was very impressed by the thoughtful and considered contributions we received from members of the public - including people who had been recently bereaved but still took the trouble to come and speak to us about their experiences and also from Portsmouth residents who simply felt strongly about how their community should have the best end of life care. We were greatly moved by these contributions and very grateful to all those that talked to us. In all conversations, the Panel heard only praise for the care provided on G5 and its predecessors.

5.4.2 We were also impressed by the commitment and passion that many staff expressed about the quality of end of life care they wanted to deliver to patients.

5.4.3 We were struck by the consistency of view among members of the public and interest groups about what constituted good quality end of life care. The Panel noted that these views were consistent with both national strategy and that of the PHT End of Life Steering Group. It is crucial that this consistent view is incorporated into the Trust's end of life care provision and underpins its further development.

5.4.4 It became clear that people, including those opposed to the changes, felt that the quality of end of life care is the most important issue rather than the retention of G5. The Panel agrees.

5.4.5 People want high quality care to be provided by compassionate staff with expertise and experience in end of life care. They want a physical environment that provides sufficient bedside space and the option of a single room. They also want facilities for carers including quiet rooms, refreshment provision, and flexible visiting. Above all, they want end of life care provision that encompasses the key qualities that they most value.

5.4.6 **Recommendation One**

The qualities that patients, their relatives and their carers most value in end of life care are peace, dignity, privacy, respect for personal and cultural needs, and compassionate care. These qualities should underpin all end of life care, including that provided by Portsmouth Hospitals NHS Trust (PHT) and should be used as a benchmark to assess progress against the Panel's further recommendations below.

5.4.7 During the review, the Panel noted the focus of end of life care strategy at a national level and the examples of good practice across the country. A picture emerged that indicated end of life care has been a priority on the national, regional and local agenda for a considerable number of years. However, for Portsmouth and the surrounding area, the closure of G5 at a time of financial pressure and transition in the NHS has brought end of life care into sharp focus. This has exposed concerns about fragmentation of services, a loss of priority and a lack of focus on providing the quality of care that meets the needs and preferences of the dying.

5.4.8 As the *National Strategy for End of Life Care* clearly states, the services required by people approaching end of life span different sectors and settings and so it is vital that an integrated and strategic approach is adopted by commissioners of services with all the relevant providers involved. The NHS Operating Framework for 2011/12 sets clear expectations for end of life care.

5.4.9 In this context, the opportunity exists to capitalise on the interest of the local population by engaging the public and relevant interest groups.

5.4.10 **Recommendation Two**

Portsmouth PCT and Hampshire PCT should support the emerging GP commissioners for Portsmouth and south east Hampshire to engage the public and patients in a re-appraisal of their end of life care strategy and plans. The process should also engage the local authorities and relevant providers, and be completed in time to inform commissioning plans for 2012/13. The output should make it clear what is required from providers in terms of the quality of end of life care. It should also demonstrate how more people will get the end of life care they choose, especially supporting more people to die at home if that is their choice.

5.4.11 The Panel heard that currently a high proportion of patients receive end of life care in hospital and although, for some, this would be their choice for others it may not be the case. The assumption is, therefore, that as choice for end of life care improves, the proportion of people dying in hospital will decrease. However, this report focuses on those who will die in hospital, for whom the challenge remains how to provide high quality end of life care.

5.4.12 We received evidence that, on occasion, patients had not always wished to transfer to an end of life care ward, preferring to stay with the clinical team who had been looking after them. Clinicians told us that continuity of care in these situations was an important consideration and, for many patients, transferring them to an end of life care ward would not be appropriate or provide better quality better end of life care.

5.4.13 Further, in the case of the stroke service, a number of patients had received care on G5. The CQC had confirmed to the Trust that this pathway was not in line with the national clinical policy and guidelines that describe the best care in hospital for patients with stroke. We accept that the loss of this cohort of patients undermines the viability of G5.

5.4.14 The Panel also accepts that the physical layout of G5 posed challenges for the nursing team. Built as an isolation facility providing all cubicle accommodation, its primary function is to ensure patient isolation. Each room is behind double doors which has the effect of soundproofing the rooms. We acknowledge that the physical layout of the ward could make its operational running challenging with normal staffing levels - particularly in caring for patients unable to use the call bell system. The Panel accepts the view that the location of G5 within the hospital was not ideal being physically isolated from other ward areas in the hospital.

5.4.15 The Panel heard that an option appraisal was undertaken and a business case prepared which set out the benefits of the proposal to close G5 and establish an end of life support team. However, we did not hear any evidence that the rationale for the option selected had been widely communicated during the discussions with interest groups and, therefore, this added to the view that the decision taken was for other reasons rather than an objective option appraisal.

5.4.16 Assessing the financial evidence presented to the Panel, we understand why local people had concerns that the motive for the closure of G5 was purely financial. Having seen the presentations used locally, we can appreciate the view that the facts about costs remained unclear and, as a result, there was suspicion about the whole process. We heard from members of the public that they understand the financial realities and wished PHT to be more open about them.

5.4.17 The Panel heard evidence that indicated the service reconfiguration became a more serious proposal during the cost improvement programme work for the financial year 20010/11 when the MOPRS had a cost improvement target of £1,454,640. The cost of running G5 per annum was £760,000 and that after reinvestment in the end of life care support team there would be a net saving of circa £600,000. The Panel accepts that this saving is not generated by reducing expenditure on end of life care - the patients are still receiving care in the hospital - but by other measures within MOPRS resulting in a reduction in length of stay. As a result, the MOPRS should need less beds to deliver their care generating the cost saving. We also acknowledge that G5 was relatively expensive because of its physical isolation in the hospital and capacity of 14 beds.

5.4.18 In light of all the above, the Panel accepts that there is not sufficient justification for proposing to increase the provision of beds on a dedicated end of life care ward. Following the closure of G5, nurses that worked on the ward have been re-deployed into other teams across the hospital, including being part of the end of life support team. We accept that it would be difficult to re-establish the G5 nursing team without negative impact on other clinical services.

5.4.19 **Recommendation Three**

The Panel accepts that for clinical, operational and financial reasons it would be unsustainable to reopen G5 itself as an end of life care ward.

5.4.20 The new model and the end of life support team has been established since September 2010. However, the Panel found significant gaps in PHT's approach to implementation such as the lack of a clear operational policy for the service. The Panel was concerned

that the Trust can neither demonstrate the service scope and its priorities nor how the desired quality of end of life care will be achieved. To the public, this may appear to support the view that the new service is not an improvement on the old one. As one person put it *"with only one member of the end of life support team on duty at any one time how can they effectively deliver a service to all end of life patients?"*. The Trust needs to address the gap between its aspiration and implementation, involving the public and patients more in the further development of end of life care.

5.4.21 **Recommendation Four**

The Medicine for Older People, Rehabilitation and Stroke clinical service centre (MOPRS) must develop a comprehensive operational plan for end of life care, including quality, workforce, training and standards. The plan must also address the relationship of the model to the overall pathway for end of life care, including effective working arrangements with specialist palliative care.

5.4.22 The Panel acknowledges that work has started on relative and carer feedback of the service through the introduction in November 2010 of a questionnaire based survey. To date 171 questionnaires have been completed with an overall satisfaction rate of 84 per cent and 140 positive comments about care.

5.4.23 However, the Panel received little evidence that there is a plan for the systematic evaluation of the new service, either in terms of clinical end of life quality measures or relatives' and carers' experience. This will be key piece of work for both developing the service and demonstrating the Trust's long term commitment. It is the Panel's view that by undertaking this in partnership with relative and public representative groups, it will significantly contribute to rebuilding and strengthening the Trust's relationship with key stakeholders and enable the wider community to have confidence that their views are being listened to and taken into consideration.

5.4.24 The Panel would expect the outcomes of the evaluation to be presented to local commissioners and the Trust Board to ensure it influences future commissioning and organisational plans.

5.4.25 The Panel was impressed by how well public and patient's groups made the distinction about the quality of care previously provided on G5 and G5 as a physical location. Almost unanimously, they made it clear to us that it was the quality of care that they were most concerned about. The public's interest should be harnessed by the Trust to ensure relatives and carers are fully involved in developing plans for the future of the service.

5.4.26 **Recommendation Five**

PHT's End of Life Care Steering Group should be augmented with a reference group drawn from the public and patient groups. The Steering Group should undertake formal evaluation of the changes to end of life care in MOPRS, including systematic feedback from carers and relatives, and report its findings and recommendations to the Trust Board and commissioners by November 2011.

5.5 **Sustainability**

5.5.1 Throughout this review, in both written and oral evidence, one of the recurring themes the Panel heard was that the environment is key to good end of life care. The Panel concluded that a critical component of this environment is the availability of single rooms and appropriate space for relatives around the wards and hospital. The latter was described on one occasion as the need for *"oases"* within the hospital that offer relatives and carers an appropriate environment for times when they are not at the bedside of their relative or friend.

5.5.2 The Panel noted that the availability of single rooms was a critical factor for patients, relatives, family and carers to ensure they have a quiet and private space in which to spent their final hours together and are able to observe cultural beliefs without feeling that they are impacting on staff or other patients in the hospital setting. To facilitate this it will be important to ensure ongoing staff training around end of life care.

5.5.3 The Panel received mixed messages about the availability and use of single rooms in MOPRS. PHT told the Panel that it was committed to ensuring that a single room was offered and available to all patients at the end of life. The Panel concluded that this commitment is key to the sustainability of the new model of care along with providing appropriate facilities to support relatives and carers who wish to be with the dying.

Urgent work needs to be undertaken in partnership with patient and public groups to identify improvements in both the physical environment and facilities available for relatives and carers. In addition, PHT must demonstrate that it has the bed capacity and number of single rooms to deliver its commitment.

5.5.4 **Recommendation Six**

An audit of the facilities to support end of life care should be carried out within three months, involving the members of the End of Life Care Reference Group. The audit should include the availability and use of single rooms, as well as facilities to support relatives and carers. Action to address any deficiencies identified should be taken without delay.

5.5.5 The Panel considers that it is important the leadership within the Trust visibly demonstrate their commitment to end of life care for the public to have the confidence that their concerns are being listened to and addressed. The Trust Board and senior management team must take a leadership role and ensure that the work of the End of Life Care Steering Group and its Reference Group are translated into actions within the MOPRS business plan, the Trust's capital programme and the Trust's facilities plan.

5.5.6 **Recommendation Seven**

The Trust Board should ensure that the business plan for MOPRS in 2011/12 is updated to reflect these recommendations and address specifically what further action and investment is required to achieve the highest possible end of life care in MOPRS.

5.6 **The rigour of public involvement and consultation processes**

5.6.1 The Panel heard much evidence about the lack of involvement of representative groups and the wider public in developing the proposals and views were expressed that PHT does not actively seek out a range of views but uses a limited number of organisations who some people do not feel can always fully represent the views of the whole community. Equally, because end of life care at PHT is not commissioned as a service, no evidence was presented that the PCTs had been actively involved in the process and, therefore, had sought to involve interest groups.

5.6.2 The view was expressed to the Panel that PHT's involvement activity was not proportionate or appropriate to the level of interest expressed locally. We acknowledge that PHT had discussions with Portsmouth LINk, the Trust's End of Life Steering Group, and the Trust's board of governors, all of whom the Panel heard supported the change. However, in our view, the mechanisms used by PHT are not sufficiently robust to have the support of the local community.

5.6.3 Throughout the review, the Panel observed defensiveness on the part of PHT and an unwillingness to respond actively to their critics. PHT underestimated how sensitive the closure of an end of life ward would be, how strongly local people would feel about the provision of end of life care and their desire to be actively involved. We heard very similar statements from a wide range of stakeholders that can be summed up by the phrase *"with so many missed opportunities it need not have ended up here"*. It appears that PHT identified these risks in the run up to their decision but did not involve the public and patients early enough and in the right way.

5.6.4 Although the new model of care is compatible with the overall direction of the *National End of Life Care Strategy* and associated clinical guidelines, with hindsight the efforts of PHT to involve and engage have been flawed. The fact that local commissioners did not feel the need to get involved and the issue bypassed the interest of local scrutineers until late in the day does not mitigate PHT's responsibilities in this regard, nor justify their lack of pro-active communication when it was needed.

5.6.5 **Recommendation Eight**

PHT should review its approach to public and patient involvement, and its communication strategy, in the light of the lessons to be learnt from their handling of the closure of G5.

5.6.6 The Local Authority (Overview and Scrutiny Committees Health Scrutiny Function) Regulations 2002 require NHS organisations to consult relevant health overview and scrutiny committees on any proposals for substantial variations or developments to services. What constitutes a substantial variation or development is not specified.

Consequently, it is not a decision that the local NHS should make unilaterally but rather, in accordance with good practice, through open dialogue with its scrutiny committee(s).

5.6.7 The Panel learnt that work had been undertaken across Hampshire, Portsmouth, Southampton and the Isle of Wight local authority areas to agree the arrangements for assessing substantial variations in NHS services and that these had been refreshed recently. However, we were concerned to see that the resultant documentation *Southampton, Hampshire, Isle of Wight and Portsmouth HOSC arrangements for assessing substantial change in NHS provision* had not been used by PHT and that during the early months PHT senior management, HOSP members and Portsmouth City Council officers had not taken opportunities at other meetings to raise and resolve the issue at an earlier stage.

5.6.8 The Panel agrees that Portsmouth HOSP was not consulted. Its decision that the closure amounted to a substantial variation came after the event in September 2010. There were opportunities for both PHT and the HOSP to have avoided this position. In the light of our recommendations above, starting the clock again is not an option. Consequently, it is is our view that nothing more could be gained by further consultation with Portsmouth HOSP about the closure of G5. Lessons must be learned for the future, the need to re-build public confidence recognised and the opportunity must be grasped to work together constructively on end of life care for the future.

5.6.9 The Panel reflected on the different approaches of the Hampshire HOSC and the Portsmouth HOSP to considering the service change. It was clear to us that Hampshire HOSC had a good understanding of the issues involved having relatively recently undertaken work around end of life care and they were, therefore, able to react in a more considered way. Although not content about the PHT approach to the specific decision, Hampshire HOSC felt that the decision was the right one.

5.6.10 Although the potential ward closure and the resulting anxiety was in the public domain from a much earlier point than the formal approach by the HOSP, both parties appear to have failed to react to this fact, seek clarification or work together to resolve the issue. This lack of communication between PHT and the HOSP is difficult to understand or explain, particularly as Portsmouth HOSP members had been undertaking a piece of work

around alcohol related issues necessitating site visits to Queen Alexandra Hospital during July and August 2010. Even with this contact, the Panel saw little evidence that the opportunity was taken to discuss the closure of G5.

5.6.11 We feel that there are lessons for PHT about its approach to the scrutiny function. In our view, their unilateral decision to proceed on the assumption that the proposed change was not substantial was flawed. Equally, Portsmouth HOSP need to assure themselves that they have the procedures in place to ensure they are informed in a timely manner of potential NHS service change.

5.6.12 **Recommendation Nine**

Portsmouth HOSP should, with the local NHS, review its policy and procedures to ensure relevant issues can be identified and acted upon in a timely manner.

5.7 **Managing transition**

5.7.1 Taking into account the current transition from primary care trusts to general practitioner consortia, the strong views and concerns of the local community to the changes to end of life care which need to be addressed urgently and the need to re-build relationships, South Central SHA must be more closely involved to ensure our recommendations are taken forward in a timely manner.

5.6.1 **Recommendation Ten**

South Central SHA should ensure that the NHS follows the recommendations of this report without delay or omission.