SHIP Unscheduled Care
Engagement Report

Introduction

The draft unscheduled care strategy sets out the vision and direction for development of unscheduled care services over the next three-five years and has been produced in collaboration by NHS Southampton, NHS Hampshire, NHS Isle of Wight and NHS Portsmouth (SHIP), working with South Central SHA.

The strategy outlines the current position, the drivers for change, the proposed model of unscheduled care and steps that could be taken to reach this.

The aim, based on clinical evidence and patient experience, is for urgent care to become more accessible, closer to home, include chronic illness management and be based around primary care consortia. Emergency care models aim to be centralised around major trauma networks for the best outcomes.

The draft strategy describes the vision for unscheduled care about "what" is proposed as a good model for improved services. It is not designed to be prescriptive at this stage in determining "how" it should be managed or delivered.

We began initial discussions around the model to analyse and inform its development prior to a final strategy being produced. The final strategy will then be given to each PCT in SHIP for them to work with local communities, clinicians and commissioners to determine how best the agreed model should be co-designed and delivered locally.

This report therefore details the engagement conducted during this first phase.

Overview of activity undertaken

Engagement began on July 23, 2010 for a period of eight weeks. Communications was led by NHS Hampshire, co-ordinating engagement across all four PCT areas through a lead in each PCT. An extensive stakeholder list was drawn up and then mapped (appendix 1) to ensure all relevant and interested parties would have access to the draft document and have the ability to feedback and comment.

Activity commenced and progressed as detailed in the activity table in appendix 2. A letter from Dr David Paynton (appendix 3) was distributed to invite review and comment of the draft strategy. This was accompanied by an executive summary of the proposals and a copy of a summary set of slides, with the dedicated email address for feedback.

Alongside the full draft strategy document an easy access summary was produced and each PCT produced a dedicated webpage with information, attached documents and the dedicated email address for comments, questions and responses.

A second letter was distributed when the full draft document was available on each webpage and included the link and email address for responses with the deadline for comment, September 24, 2010 (appendix 3).

The easy access summary document was sent to each LINk organisation with the request to send on to all of their members and it was also sent to the relevant patient and public group for each PCT, including:

- NHS Southampton City patient panel
- NHS Hampshire Sign up members
- NHS Isle of Wight patient council
- NHS Portsmouth 100

Storyboards were also produced for use at meetings and newsletter articles were written and included in PCT publications, highlighting the webpage and feedback route, including:

Organisation	**Publication**	**Coverage**
NHS Southampton City	Staff newsletter 'City Check Up' and intranet	Approx 4,000
NHS Hampshire	'Staff Update' newsletter and intranet	Over 400 staff
	Stakeholder newsletter – Dialogue	Over 350 Hampshire stakeholders in the voluntary sector, partner organisations, local authority and registered interested parties
NHS Isle of Wight	Staff Newsletter and Intranet	Approx 3000

The storyboards were available at three of the PCTs AGMs, which occurred during the engagement period, with the summary document, feedback forms and details of the website address. At NHS Hampshire's AGM a Let's Talk Health event also occurred within which a presentation was given on the unscheduled care strategy and tables of attendees held discussions around key points. This feedback was all collected and collated to be incorporated into the final draft of the strategy. This feedback can be seen in appendix 4.

A third letter was distributed from Dr David Paynton when there was a week left for comment. This was targeted at the stakeholders groups we had not yet received any feedback from to ensure they were aware of the deadline date and to encourage feedback, to ensure comment was received from the full breadth of stakeholders in our plan. The details of this can be seen in appendix 2 and 3.

Appendix 2 also highlights other meetings attended where discussions were held and feedback received including:

- Department of Health
- South Central Clinical Network
- LMC Wessex and LMC Chair
- South Central OSC
- Hampshire OSC
- Southampton Panel B and OSMC
- Portsmouth HOSP
- Dr John Watkins, Clinical Director, Portmsouth
- Isle of Wight PBC forum
- John Hughes, Clinical Director, Hampshire Community Health Care

Overview of feedback received

118 responses were received in total. 110 responses received via yourviewscount@hampshire.nhs.uk plus five feedback forms and three letters. This does not include feedback from AGM discussions and separate meetings which was fed back on an ad-hoc basis.

The full feedback summary of key themes can be seen in appendix 5. However the top five feedback themes were:

Top five comments:	
Agree with proposals, it will provide a more efficient NHS that concentrates more on the patient, appropriate way forward, gives GPs chance to engage constructively with change that is needed, concise and compelling with real benefits for patients, **would make me feel more comfortable as a patient**, community feel can only be beneficial, improvement on current provision,	35
24/7 GP care will overload the system, not enough fully trained professionals to spread through the community, GPs already find it hard to find extra man hours, **the high standard of current day-time primary care and OOHs must not be lost** – they are the solution not the problem as GPs who know their patients will intrinsically admit less often, government seems determined to force plans to make GPs responsible for everything, will GPs be willing to accept changes?	26
Patients need to take responsibility for care and use services appropriately, **education is key** to reduce demand as people learn to cope with their condition, (however some people cannot take responsibility for their own health – need to ensure the needs of people with learning difficulties are taken into account restoring patients confidence in the system will be a key determinant to the success.	21
Costs – Is the money saved in A&E proportional to the costs needed to enhance primary care? It is not clear how much would be saved. **How much will it cost to set up**? This relies on the availability of investment and outcomes from the re-negotiation of the GP contract.	17
Isle of Wight already doing a lot of what	12

is suggested. Is there a link between IOW existing processes and these proposed processes? 'Beacon' centre should be applied elsewhere.	

Feedback was received from the following groups demonstrating good coverage of the range of stakeholders identified:

Stakeholder group	**Number of response**
Patient /public	31
GPs/PBC	29
Voluntary Sector	11
NHS Southampton City staff	4
Solent Healthcare (inc CEO)	3
IOW PCT staff	3
LINks (West Sussex and Hampshire)	2
NHS Hampshire staff	2
BME development community workers	2
Nurse practitioner	1
NESC	1
IOW ambulance	1
SHIP contracts team	1
SUHT critical care outreach nurse	1
Southampton City Panel B OSMC	1 (supportive of direction)
Portsmouth Hospitals Trust	1 (supportive of proposal)
LMC member	1 (supportive - work with local GPs)
RCGP	1 (positive comments)
John Denham MP	1 (concern for walk in centres)
Eastleigh Borough Council	1 (supportive)
SCAS	1 (supports and reflects in own strategy)
Frimley Park Hospital	1 (supportive)

Future plan

Engagement will continue as we move forward with the strategy.

Initially, all feedback will be incorporated into the final draft of the strategy before making both the feedback summary and the updated strategy document available for all stakeholders through the web pages. We will also be sending a thank you letter out to all who responded, with this web link, for them to view how feedback has been incorporated should they wish.

Once this final strategy with the overarching principles of improved unscheduled care services is approved by all PCT boards, the SHIP board and the SHIP OSC it will be given to each PCT to develop into a local plan to begin implementation. It is proposed this is led through local GPs and system reform boards.

At this stage each PCT will form its own group and conduct engagement throughout the development of the local plan and its implementation. This will be monitored by the SHIP programme board and will also involve close work with local voluntary sector organisations to ensure their role is fully considered and incorporated.

This work will also take the above stakeholders and feedback into account to ensure the current activity is continued and we will ensure each overview and scrutiny committee/panel remains fully engaged and updated throughout.

It is also proposed that a campaign to educate the public on the use of unscheduled care through the Choose Well campaign is progressed, updated with information from the local development of the unscheduled care strategy. This will help to ensure patients know where to go for the most appropriate treatment for their condition as well as educating them to take responsibility for their own health.

Economic modelling has been completed to identify costs and savings for each PCT and we are encouraging learning from the IOW model as far as possible to ensure the successes from this can be incorporated into the strategy if appropriate.

Action

We hope to have demonstrated extensive and effective engagement to date and ask the OSC to allow us to move to the next phase, to finalise the overarching strategy document before passing this onto each PCT to begin engagement around local implementation plans.

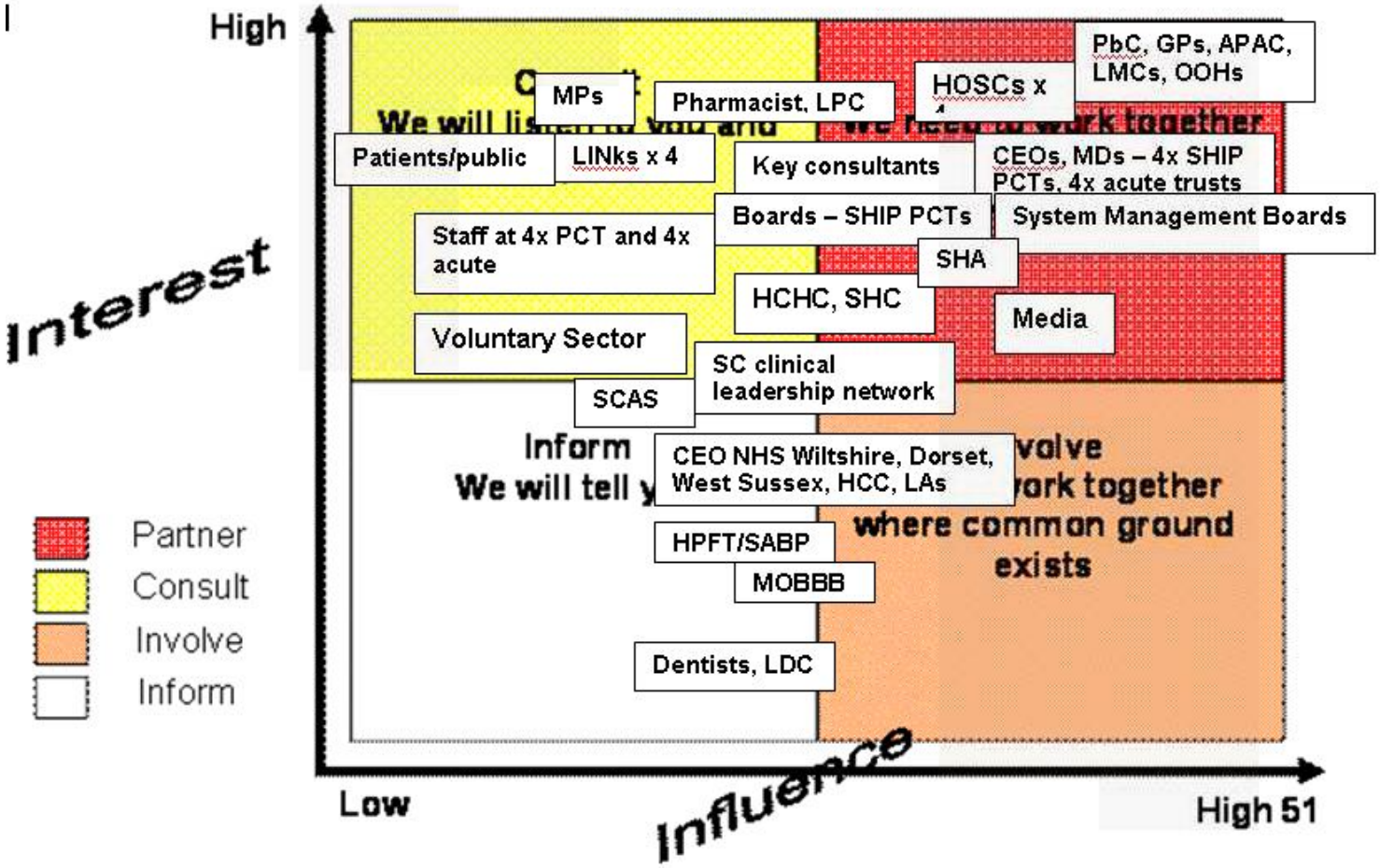
Appendix 1 - Stakeholder list and map

Internal:

- CEOs SHIP
- Medical directors SHIP
- Boards of SHIP orgs and SHIP board
- System Management Boards
- PbC locality leads
- APAC chairs and lead GPs
- Staff at all SHIP organisations

External:

- CEOs Acute Trusts
- CEO Salisbury NHS Foundation Trust, NHS Wiltshire
- CEO NHS Dorset
- CEO NHS West Sussex
- Key consultants across SHIP
- South Central Clinical Leadership network
- CEOs – Hampshire County Council, Portsmouth City Council, Southampton City Council, Isle of Wight Council and 11 Local Authorities
- Hampshire Partnership Foundation Trust/Surrey and Borders Partnership Trust
- MOBBB
- LINks x 4
- Hampshire OSC (SHIP OSC)
- Southampton OSC (SHIP OSC)
- Portsmouth HOSP (SHIP OSC)
- IOW OSC (SHIP OSC)
- GPs
- LMCs
- OOHs providers
- Dentists
- LDC
- Pharmacists
- LPC
- Hampshire Community Healthcare/Solent Healthcare
- Editors of major local media and health reporters
- Patients/carers/public
- Voluntary sector – Hampshire Voluntary Sector Consortium, Community Action Hampshire, Councils of Voluntary Service, carers groups
- SCAS
- SHA
- MPs


High
Interest
Low
Influence
High 51
Partner
Consult
Involve
Inform
MPs
Pharmacist, LPC
HOSCs x 4
PbC, GPs, APAC, LMCs, OOHs
Patients/public
LINks x 4
Key consultants
CEOs, MDs – 4x SHIP PCTs, 4x acute trusts
Boards – SHIP PCTs
System Management Boards
Staff at 4x PCT and 4x acute
SHA
HCHC, SHC
Media
Voluntary Sector
SC clinical leadership network
SCAS
CEO NHS Wiltshire, Dorset, West Sussex, HCC, LAs
HPFT/SABP
MOBBB
Dentists, LDC
where common ground exists

Appendix 2 - Unscheduled Care Strategy Engagement Activity

Date	Stakeholder	Engagement Activity	Lead
29 June	John Hughes – Clinical Director HCHC	Discussion around approach	DP
1 July	Department of Health	Informal discussions to clarify approach	DP
5 July	South Central Clinical Network	Discussion around approach	DP
13 July	CEO HCHC and Unscheduled Care lead	Meeting/discussion	DP
20 July	LMC Chair Nigel Watson	Meeting/discussion	DP
20 July	CEOs 4x PCTs and 4x acute trusts, HCHC, SHC, HPFT and SABP, SCAS, HCC, Ports, Soton, IOW councils, 11 Las,	Summary doc, exec summary and cover letter offering meeting. Ask to share with their key consultants.	HON
20 July	LMC	Letter to LMC chair with document and feedback mechanism. Highlight planned activity with GPs and offer meeting to discuss further.	HON
20 July	South Central HOSC	David to attend Major Trauma work presentation	DP
21 July	SHIP Unscheduled Care Comms Group	Meeting to discuss key messages and actions.	HON, EM, JC, EW
22 July	NHS Hampshire Board	Lisa Sheron to provide update to board	LS
22 July	NHS Southampton Board	David or Sheila to provide update to the board	
23 July	PbC, GPs, APAC chairs, lead GPs - Soton, Ports, IOW, HOSC Chairs, LINk chairs,	Letter with GP messages via email to all GPs and PbC leads with PDF document attached and signalling discussions at APACs and asking for feedback to be sent through PbC leads and APAC chairs. Offer presentations at PbC locality meetings.	HON, EM, JC, CP
26 July	SHIP Board	Provide update	DP
27 July	Hampshire HOSC	David to attend to give Unscheduled Care presentation	DP
30 July	SE System Management Board	Info sent to directors, chairs and members	HON
30 July	North & Mid Hants SRB	Info sent to directors, chairs and members	HON

30 July	North & East SRB	Info sent to directors, chairs and members	HON
30 July	South West SRB (Chairs/chief execs)	Info sent to directors, chairs and members	HON
2 August	OOHs providers	Letter to OOH providers with document and feedback mechanism. Highlight planned activity with GPs and offer meeting to discuss further.	HON, EM, JC, CP
2 August	CEO NHS Wiltshire, Dorset, West Sussex, Surrey, Berkshire East and Berkshire West, MPs	Summary doc, exec summary and cover letter for info and for any comments	HON
2 August	LPC/pharmacists	Letter via email to LPC chair with documents attached, asking to share with pharmacy contacts	HON
2 August	LDC/dentists	Letter via email to LDC chair to inform of engagement asking them to share with dentists	HON
2 August	Voluntary Sector	Letter via email to CAH, CVSs to inform of engagement and ask for comment	HON, EM, JC, CP
2 August	Southampton LINk	Attend meeting to discuss strategy	DP
4 August	MPs, LINks, Councillors, Voluntary Sector, Partner Organisations	Article for NHS Hampshire's Dialogue newsletter and other Soton, Ports and IOW newsletters highlighting unscheduled care engagement and directing to online document and feedback mechanism	HON
5 August	Dr John Watkins, Portsmouth	Send cover letter, summary and exec summary for info and comment. Offer meeting with David Paynton.	HON
5 August	NESC – director for commissioning, director for GP provision, comms and eng. lead	Send cover letter, summary and exec summary for info and comment	HON
5 August	All PCTs	Development of engagement webpage and survey monkey to link across all orgs	HON, EM, CP, JC
11 August	Southampton Clinical Leadership Board	Attend to discuss strategy	
12 August	IOW PBC Forum	Attend meeting to discuss strategy	RB
17 August	IOW LINk meeting	Attend to discuss strategy if needed.	

18 August	IOW MPC Forum	Attend to discuss strategy if possible.	
18 August	Patient and public	Development of public facing comms and document	HON
19 August	NHS Southampton City board meeting with NEDs	Presentation and discussion of strategy	DP
20 August	CEO, board directors, local authorities, ambulance trust, OSCs, GPs, PBC, LINKs, OOHs providers, pharmacies and LPC, dentists and LDC, LMC, voluntary sector, MPs, councillors, provider trusts (HCHC, SHC), HPFT, SABP, System Reform Boards, neighbouring PCTs, NESC	Letter distributed with link to webpages, full strategy document and summary with reminder that feedback needs to be provided by 24 September.	HON, EM, AH, CP
20 August	Key consultants	Via comms teams at acutes – letter with link to docs on webpage	HON
20 August	Staff (PCTs, acute trusts, HCC, HCHC, SHC)	Article in all staff newsletters/intranets with links to online document and feedback mechanism. Also sent to acute trust comms teams, provider trust comms and local authority comms	HON
20 August	Patients and public: Sign up/members, IOW and Southampton Patient Panel/Council Members, Portsmouth 100	Send public doc and feedback form/email address/weblink to all 'members' i.e. sign up members and NHS Southampton members, IOW patient council and Portsmouth 100	HON, EM, CP, JC
23 August	Wide range of Hampshire, Portsmouth, IOW, Soton – community and voluntary orgs	Letter distributed with link to webpages, full strategy document and summary with reminder that feedback needs to be provided by 24 September.	HON
23 August	Community Development Workers Hampshire	Letter distributed with link to webpages, full strategy document and summary with reminder that feedback needs to be provided by 24	HON

		September.and ask to share with BME groups for review and comment.	
26 August	North & Mid Hants SRB	Updated info sent to directors, chairs and members	HON
7 September	RCGP	Discussions around strategy direction	DP
8 September	LMC Wessex	DP presented to LMC meeting	DP
8 September	GPs	Information sent to be included on primary care website, NHS Hampshire	HON
8 September	NHS IOW Board	Andy/Mark to provide update to Board	
9 September	Southampton Panel B and OSMC	DP presented to OSMC meeting	DP
10 September	North & East SRB	Updated info sent to directors, chairs and members	HON
13 September	MOBBB	Information distributed to MOBBB through comms teams for review and comment	HON
15 September	Hampshire LINk	If required attend LINk steering group meeting to discuss strategy following initial letter	ST
16 September	Hampshire Voluntary Sector Consortium	Attendance at HVSC to answer any questions raised	MM
16 September	All	NHS Hampshire AGM and Let's Talk Health Event	DP
20 September	HPFT, LPC, HCC, SCAS, NESC, CEOs Acutes, Hampshire LINk	Request for formal feedback after reviewing gaps to date with reminder of link to docs and email	HON
22 September	All	NHS Portsmouth AGM – storyboards and feedback forms	
23 September	All	NHS Southampton AGM – storyboards and feedback forms	
23 September	Portsmouth HOSP	Presentation	Jo York
30 September	Portsmouth LINk	Information on LINk website for members and disseminated. If required attend LINk steering group meeting to discuss strategy following initial letter	CP
6 October	Portsmouth patients and public	Stand at Day to Day - Living well with Arthritis and Connective Tissue Diseases	
13 October	North East APAC	DP to attend to present strategy	DP
14 October	SHIP OSC	David to attend to present engagement report and strategy doc	DP

14 October	Portsmouth LINk Steering Group	Provide update on Unscheduled Care strategy	CP
14 October	West APAC	DP to attend to present strategy	DP
20 October	South East APAC	DP to attend to present strategy	DP
Upcoming:			
	Hampshire County Council Adult and Childrens' services	Meeting with David Paynton to discuss social services aspects of proposal	DP

Appendix 3 - Letters from Dr David Paynton to invite review and comment

Unscheduled Care…….a proposal for a remodelled system

Dear Sir/Madam

NHS Southampton, NHS Hampshire, NHS Isle of Wight and NHS Portsmouth, also known as 'SHIP', have worked together to produce a draft strategy for remodelling and improving unscheduled care across Hampshire and the island.

We have produced the strategy using a wealth of information, research and clinical evidence from our locality, south central and nationally. We want to focus on preventative care and planned care while providing a strong, clinically effective model for urgent care when needed.

The aim is to deliver the best quality services for the public through an integrated system that is simple to use, delivers the best outcomes and is financially sustainable.

It is in line with future reorganisation plans for the NHS, to be primary care led and aims to provide a balance between centralised services and local models. Importantly, one strand of this strategy is 'major trauma', which is being led across South Central, to interlink with the overarching unscheduled care proposals.

This initial engagement is about discussing the ideas included in the strategy about what services could look like in the future, not necessarily how it will be delivered in each area at this stage. It is not a formal consultation to determine a specific reconfiguration, it is to discuss the concepts of delivering better unscheduled care services.

We attach an initial summary of the proposals for your consideration before the strategy document is available in early August. We would appreciate your comments and views to incorporate into the draft document. We will also be sending this information out to wider stakeholders, including GPs and PbC leads, for their initial comments.

The draft strategy will be distributed for comment following July 30, 2010, in the meantime we would like to begin discussions. If you would like to provide feedback, ask questions or arrange a meeting or presentation please do contact me at yourviewscount@hampshire.nhs.uk

With best regards

Dr David Paynton FRCGP, DMS, MBE
Director for Unscheduled Care, SHIP

How can we improve ‘Unscheduled Care’?

Dear Sir/Madam

Further to my previous letter, I hope you are now aware that the NHS trusts across Hampshire, Southampton, Portsmouth and the Isle of Wight have been working together with the South Central Strategic Health Authority (SHA) to set out a vision for what unscheduled care services could look like in the future.

We have looked at the current situation, why things need to be improved for patients and developed a proposal for how unscheduled care services could be delivered in the future, based on feedback from patients, doctors, social services and the public.

We have previously distributed a summary of the proposal and the full draft strategy is now available and can be viewed on our website at www.hampshire.nhs.uk/unscheduledcare. A patient and public summary is also attached and available on our website and we would appreciate it if you could distribute this to your contacts for their comments.

This proposal is about what services could look like in the future, not necessarily how it will be delivered in each area at this stage. We are keen to hear your feedback to inform the final version of the draft strategy which can then be taken forward locally.

Please send any comments, views or questions to our dedicated email address: yourviewscount@hampshire.nhs.uk by September 24, 2010.

With best regards

Dr David Paynton FRCGP, DMS, MBE
Director for Unscheduled Care, SHIP

How can we improve ‘Unscheduled Care’?

Dear Colleagues

I hope you are now aware that the NHS trusts across Hampshire, Southampton, Portsmouth and the Isle of Wight have been working together with the South Central Strategic Health Authority (SHA) to set out a vision for what unscheduled care services could look like in the future.

We have looked at the current situation, why things need to be improved for patients and developed a proposal for how unscheduled care services could be delivered in the future, based on feedback from patients, doctors, social services and the public.

As we come close to reaching the end of our initial engagement period on this draft strategy, due to close on Friday, September 24, we have reviewed feedback received so far. To date we have not received a formal response from your organisation and feel your feedback is crucial to ensure this proposed strategy is taken forward successfully.

We therefore hope you will have time to review the draft strategy and provide any comments by the end of the week to enable us to incorporate your feedback into the final plans.

The full draft strategy document and a summary is available on our website at www.hampshire.nhs.uk/unscheduledcare.

This proposal is about what services could look like in the future, not necessarily how it will be delivered in each area at this stage. We are keen to hear your feedback to inform the final version of the draft strategy which can then be taken forward locally.

Please send any comments, views or questions to our dedicated email address yourviewscount@hampshire.nhs.uk .

With best regards

Dr David Paynton FRCGP, DMS, MBE
Director for Unscheduled Care, SHIP

Appendix 4 - Feedback from AGM discussions

Table 1

- **How do we integrate social care into the Unscheduled Care Strategy?**

    - Adult social care workers in GP surgeries and in hospitals
    - Medical and social care assessments in A&E
    - Training in social care needs as well as medical needs
    - Something in strategy needs to address how social care issues affect health – drug, alcohol and mental health problems
    - Providers need better relationships with A&E
    - Providers find it difficult to manage risk – often call ambulance
    - Finance always an issue – must spend it wisely
    - Triage nurses should have social care training – assessment at arrival time
    - GPs will have social care knowledge?
    - Third sector carers have a very important role
    - People have higher regard for medical staff than social workers?
    - Better communication

Table 2

- **What services will make the most impact to help people manage their own health and keep out of hospital?**

    - Clear protocols for ambulance services
    - Aim at chronic frail elderly
    - Signposting to services/information
    - Early interventions
    - Support to remember to take drugs/drink/eat
    - Green Bottle scheme
    - Managed list of patients
    - Carers and information
    - Access to GPs
    - Lack of trust in the system – safer to go to hospital

Table 3

- **How can the voluntary sector assist patients to return and stay in their own home?**

    - Involved at every level including decision making process
    - How to engage with the GPCC
    - Transport within hubs
    - Education of generalists on wards e.g. MS medication
    - Prevention – support mechanisms, overcoming social isolation, beyond older people clubs e.g. gardening clubs
    - Volunteers in hospitals

Table 4

- **What would make patients use local services rather than defaulting to A&E?**

    - Accessibility of GP

- Better information – a quick answer and rapid response
- Telephone advice 24hrs a day with a health professional – has to be trusted and better if local and known to patient
- Simplified and clear system that clinicians and patients understand
- Single point of access
- Consultants in A&E to educate patients and be educated

Table 5

- **If practices offered longer opening hours, what impact will this have on use of other unscheduled care services?**

  - Not about longer hours, about single point of access for triage
  - Need to co-ordinate services, not open longer hours in isolation – need joined up care records
  - Open Sunday night and seven days not just longer hours during the week – about convenience

Table 6

- **What support would clinicians need in order to prepare for this community facing service?**

  - Access to health records by all stakeholders
  - Buy-in from all health professionals and cultural change/understanding of their place in the system
  - Reliable and timely support system e.g. community services – no gaps, streamlined, 24hr

Table 7

- **How would community services need to change to deliver this community facing service?**

  - Transport issues – consider other than ambulance esp. for poor rural infrastructures
  - Patients' relatives getting to centres – public transport
  - Local centres – community hospitals/minor chronic local trauma centre
  - Recruitment of qualified staff
  - Walk in centres will need to include wellbeing/preventative services – but may not be your GP
  - Voluntary services to be used more effectively
  - Education across age ranges about care – take responsibility for own health
  - Issue of dormitory towns

Appendix 5 - Feedback summary of key themes

Theme	Number of related responses
Positive	
Agree with proposals, it will provide a more efficient NHS that concentrates more on the patient, makes a great deal of sense, appropriate way forward, well presented document, creative and imaginative, gives GPs chance to engage constructively with change that is needed, concise and compelling with real benefits for patients, we need more efficient ways of dealing with patients, present system is unsustainable, White Paper supports this, we need to press on and lead the way, good ideas bringing joined up thinking, deserves further development to avoid unnecessary admissions, driven by need rather than supply, sound and well-coordinated, **would make me feel more comfortable as a patient**, community feel can only be beneficial, improvement on current provision, makes a lot of sense, correcting many problems, brilliant in concept but a mountain to climb	35
Isle of Wight already doing a lot of what is suggested e.g. GP at A&E, hub to connect health and social care, IOW ambulance not merely transportation – 30% see and treat. Would be a shame to see this go. Is there a link between IOW existing processes and these proposed processes? 'Beacon' centre should be applied elsewhere, all treatment for islanders should be at hospital on island as far as possible, Helipad is needed at St Mary's however, as the island is smaller this should be an advantage to implementing the proposals	12
Categorisation of three groups brings a helpful clarity – could include more info on non-users and where within segments the greatest inequalities lie, often more complex in practice	5
Most practices will know at risk patients and can plan accordingly, predicting and managing chronic illness is interesting idea, GPs are vital in preventing admissions. Identifying patients at risk is a must to reduce admissions.	4
Would like services to be available 24/7 instead of 10/7, then people will learn to	3

rely on them and use ED less. Would like to see more 24 hour unscheduled care drop in centres to take pressure off GPs.	
Your diagnosis is right, present systems not easily accessible and people are confused	2
If all parties are determined for a successful outcome we can look forward to excellent patient care	1
Sharing IT systems and pooling staff will help cut down on duplication and help cover wider areas	1
Models for chronically unwell and critically injured make a lot of sense	1
Centralisation of services is ideal to provide expert care	1
Solent Healthcare fully support the proposal and are already working with commissioner to drive these agendas forward – welcome a clear strategy to drive the vision. Recognise this will take some mature approaches to deliver in the timescales	1
Eastleigh Borough Council fully support care being delivered closer to home and would welcome more joint work around prevention	1
One Community supports the major thrust of the strategy	1
Portsmouth Hospitals Trust support models for enhanced primary care, especially for patients requiring close monitoring of chronic diseases and patients with minor or self limiting conditions	1
SCAS wholeheartedly supports the proposed direction and has recently developed its own strategy to become more focussed on clinical assessment, treatment and referral rather than conveyance and welcomes the opportunity to work together to make it a practical reality.	1
Frimley Park Hospital is supportive of the intentions and would urge SHIP to communicate more across the boundaries in implementation stage. Support move to planned care and the involvement of a community geriatrician has proved successful.	1
Southampton City Panel B and Overview and Scrutiny Management Committee are supportive of the overall strategic direction – implementation in individual	1

areas will be crucial to success. GPs must be in agreement to allow sufficient capacity for cultural shift.	
Neutral	
Patients need to take responsibility for care and use services appropriately, **education is key** to reduce demand as people learn to cope with their condition, self management is key e.g. expert patients programmes. Must educate re: new set ups and services to use, providing 24hr care is misleading, many patients do not know that GPs are already available for urgent requests, self care in minor illness is non-existent, people seek reassurance, patients brainwashed into thinking they need professional help for everything, (however some people cannot take responsibility for their own health – need to ensure the needs of people with learning difficulties are taken into account e.g. how to access help in a crisis, how to avoid crises) restoring patients confidence in the system will be a key determinant to the success.	21
Need to tackle the problem from top to bottom, contractual level and ambulance service e.g. putting flags on record systems for crews, ensuring Dr's consulted in non-urgent cases by ambulance crews, preventing all 999 calls ending up in hospital, **all professionals need to work more closely together ensuring patients come first.** Opportunities for SCAS to refer back to GPs but little incentive to do so, beware of ambulance service taking on too much as may cause delays elsewhere, requires better liaison between the team and patients GP, like the idea of ambulance crews treating on the spot but worry about litigation if anything goes wrong because of the society we live in	11
Need ability to use alternatives such as nursing homes or residential care, OOH, to keep patients at home, we need much improved community services/fund OOHs more, merge NHS direct and OOHs to improve OOHs services. **Need to mention more about associated services and their coverage** to get	10

model correct e.g. community pharmacies, their delivery systems, medical equipment etc. Would help if **community pharmacies were open for longer hours** to help GP prescribing, especially on Isle of Wight as GPs deliver paracetamol. More integration of social care also. Overall, the role community services already play is muted.	
Need to include more about telecare – independence with support will reduce hospital visits, in hours the telephone is underused, everyone needs access to good advice. Need single point of access for patients with triage, but must result in the correct treatment without delay, may result in erring on the side of safety – NHS Direct had to follow strict protocols which resulted in signposting to A&E, how do we know 111 will be any better? How do we get people to use 111? How will it be resourced?	10
Need more appropriate info from hospitals for GPs and better discharge planning, we will **need to be able to share medical information**	6
The supply of USC services stimulates demand, **be realistic about ability to contain demand with ageing populations**, already seen huge change in use of OOHs for minor ailments and ever increasing walk in numbers, A&E attendance has escalated due to increased access to OOHs, walk-in, NHS direct, lower thresholds, media hype and an aging population	4
Across SHIP there are widely divergent needs and proposals should reflect these complex differences so local detail is not lost, consistency across SHIP may be difficult due to different starting points	3
Interested to see how changes will affect individuals, **at present services work well for me**, ambulance response times quick, Drs visit me at home, very pleased with current excellent service	3
Need to **consider GP training more**, including management of those with learning difficulties	3
Needs more information on the largest and most costly segment - the at risk or chronically unwell, with ambitions around **prevention** more clearly	3

articulated, good model to follow is the Community Innovations Team model	
Want to know **more about 'enhanced primary care'** – what other services are envisaged?	3
Will plans allow patients with chronic conditions (such as ME and rheumatology) to receive services at the nearest location to their home, including pain clinics?	2
In the future is a bit vague can we **include timescales**? Is 3-5 years feasible?	2
OOH should be for urgent care only, base them in ED, newly configured services should prevent need for further extending already stretched GP hours	2
Change is difficult for ill and elderly people to cope with – need great deal of thought to manage this	1
Need to think about the practicalities of implementing the plans such as extra parking, people working more together and being available	1
It should include free swimming	1
Drs should be able to offer prescriptions for practical and emotional support rather than just pills	1
Currently services are scattered and inconsistent	1
Need **more information relating to EOL** care	1
More deprived communities often live near to hospitals and are therefore frequent users	1
Please set up enhanced primary care no more than three miles apart	1
Do graphs of increasing facility usage take into account population growth?	1
Must ensure consideration to our diverse communities including better access to interpreters, more consistent information to prevent visiting wrong places, **consideration of cultural competencies**, services and support for those with mobility issues	1
Centres of excellence is a good idea but can the centres proposed cope when they are already at capacity	1
Will this be inherited by GP commissioning consortia – if so GPs need to veto decisions such as this	1
Needs more information on assessment and referral of people with drug and	1

alcohol problems	
It would be useful to describe clearly clinical boundaries for primary care so when a patient attends another part of the system they can confidently be redirected	1
Negative	
24/7 GP care will overload the system, not enough fully trained professionals to spread through the community, GPs already find it hard to find extra man hours, access will get worse for patients, salaried GPs suffer, unrealistic expectation, should be changed to 'more treatment delivered closer to home by your group of GPs', need compulsory practice provision for man hours per population to be fair, are there enough hungry GPs to run 24/7?, having more OOH centres will necessitate a larger number of GPs or greater delays for patients. **The high standard of current day-time primary care and OOHs must not be lost** – they are the solution not the problem as GPs who know their patients will intrinsically admit less often. GPs being responsible for commissioning is not in the best interest of patients, government seems determined to force plans to make GPs responsible for everything, will GPs be willing to accept changes? There is clearly some way to go until GP practices are committed to this level of service. Lack of continuity if patients seen across GP consortia. Patients need to be seen by their own practice, not another practice, OOHs or NHS Direct. GPs have huge capacity to reduce unnecessary hospital admissions but only if NHS invests in primary care to allow it to save. Low confidence and lack of experience leads to hospital admissions, more experienced GPs can support but only if backfill funded. Document observes a lack of capacity in primary care but does nothing to address it.	26
Costs - Is the money saved in A&E proportional to the costs needed to enhance primary care? It is not clear how much would be saved. **How much will it cost to set up**? This relies on the	17

availability of investment and outcomes from the re-negotiation of the GP contract, great costs involved in providing 24hr care, will current levels of finance allow the implementation?, great idea but needs resources to go with it, mentions sufficient investment but should it say prudent use of available investment? Seriously unwell and major trauma section require serious investment to ensure effective infrastructure and transport services, needs process mapping	
Needs **more reference to working with the voluntary sector**, community care is a significant factor to reducing unscheduled care need, already have bases embedded in the community, can provide direct route for advice, provide equality, preventative care and early intervention. Very disappointing that doc gives little to no reference to sector, confirms suspicion that NHS ranks voluntary sector as a poor-relation, need constructive dialogue to determine future role, can offer efficient, cost effective services.	10
No point asking GPs to sign up to something when they **don't know the outcome of the White Paper**, the size or geography of their new units. Proposals for restructuring OOHs should not be published until planned renegotiations of the GMS contract have taken place. White Paper notes consortia for commissioning but not for providers. Is it against the rules to use GP consortia as providers as well?	9
Categories of users overlap, there is no glue between the segments e.g. urgent care cardiovascular cases are examples of acute chronic illness, some pathways have changed which explain why patients present at acute care, health needs of USC patients are complex and it is difficult to try and quantify them, needs to be a model for communication across three segments as patients switch across the three	5
There appears to be **little evidence to many of the assumptions** made – does not sufficiently explain why there is a need to redesign the system. A large part of the report consisted of subjective	5

opinions. There has been no pilot so a whole scale restructuring is based on un-evidenced assumptions and no evidence to support significant savings	
Systems such as NHS direct play safe and admit more often, including OOHs, management by call centres is always poor	3
NHS direct is part of the strategy but has been scrapped	3
Meant to be patient centred but written from point of view of those trained to make dispassionate judgements – so unfair and unrealistic. Paper seems to be about how services are organised externally rather than how they interact with patients to be swifter, simpler and more effective, local solutions should be worked out by local primary care providers	2
Concerned changes are being put in place to simply save money, model of hospital reorganisation appears to be to save costs rather than improving services for patients	2
Do not want more tiers of advice or care – will cost more and be bad for patients, will there be a risk to accessing A&E if more hoops	2
No models show linkages to how systems currently work and how they are expected to change to make them work better in the future – Lack of any detail on the systems gives no confidence that anything will actually change	2
People with ME are disregarded	1
GPs shouldn't be at the beck and call of patients – patient choice has swung too far – is this the wrong direction when efficiencies are needed	1
Missed **Community Responder Schemes** which are trained to provide24/7 assistance to ambulance services	1
Solution is to provide several smaller centres to take the pressure off A&E but how long until the smaller centres are inadequate too?	1
There may be a temptation to cherry pick elements where most savings can be secured	1
If consortia have to pay for ED attendance everybody is penalised for actions of the few	1

Need to improve triage	1
This proposal seems to be closing windows of opportunity from white paper	1
We should not assume that one size fits all, some areas already doing really well at avoiding admissions	1
Grand schemes don't work – surprised money is being wasted on 'pie in the sky' planning – organisations won't exist in three years time	1
We say patients are confused but what percentage are confused? I have never heard anyone on the Isle of Wight say they are confused	1
GPs do not have the expertise to handle rheumatology, it is impossible out of hours, needs specialist input	1
Centralised model has disadvantages including distance to travel, across health boundaries, difficulties for carers and families	1
Experience of GPs embedded in PHT ED has been disappointing as shifts are unpopular	1
Doesn't address needs of patients who end up in A&E but have predominantly social needs	1