Agenda Item 5

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of meeting:	27 July 2010
Report Title:	Inquiries Received and Action Taken
Report From:	Chief Executive

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1. Summary and Purpose

1.1. This report provides Members with information about the issues brought to the attention of the Committee and the response to these referrals. It sets out the inquiries received, the source of this inquiry and any action taken. Where appropriate comments have been included and copies of briefings or other information attached.

1.2. The approach adopted provides the route through which Local Involvement Networks (LINks) and other partner organisations (Hampshire district councils, NHS organisations, voluntary and independent sector providers and organisations that are representative of social care service users and carers) can raise issues with the Committee.

1.3. Where inquiries raised with the Committee are already subject to monitoring or other performance management activities the action taken will be focused on the local resolution of inquiries through appropriate sign-posting to the agency best placed to respond.

1.4. Where an issue cannot be satisfactorily resolved between the parties concerned then the Committee can consider options for further action.

1.5. New issues raised with the Committee, and those that are subject to on-going reporting are set out in Table One of this report.

1.6. The recommendations included in this report support the Corporate Strategy aim of maximising wellbeing through the overview and scrutiny of health services in the Hampshire County Council area.

Table One: Inquiries Received and Action Taken

Topic/inquiry	Source	Action Taken	Comment
Delivering the 5 year strategy	NHS Hampshire	Appendix One provides members with an overview of the way in which NHS Hampshire is intending to respond to financial pressures, meet targets, reduce health inequalities and secure quality improvements with a specific emphasis on south east Hampshire	
Recommendation: Any additional information requested by members is provided			
Ambulance performance in rural areas	Bucks, Hants, Oxon JHOSC	SCAS have now responded to the issues raised by the Joint Group. This is attached at Appendix Two. Each of the counties involved in the review is now looking at services across its area and identifying the performance information required and priority areas for action. Based on information produced as evidence by SCAS, which identified 'falls' as accounting for 30% of all 999 calls it is recommended that this topic is the focus of the next in-depth review undertaken by the HOSC.	
Recommendations: 1. Members agree the topic of falls as the subject of the next in-depth review undertaken by the HOSC. 2. a small review Panel is agreed to include observer representation from key stakeholders 3. next steps and a project scope is provided for the September meeting			

Topic/inquiry	Source	Action Taken	Comment
Access to health services for people who are homeless	HOSC Members	NHS Hampshire will provide an update on work taking place in relation to these services and Winchester Befrienders will do a short presentation on their work in this area. Background briefing is attached at Appendix Three.	
Recommendation: Any additional information requested by members is provided			
Paediatric Rheumatology	County Councillor	A statement from the lead commissioners confirming the work underway in relation to this service is attached at Appendix Four This confirms action being taken to consolidate and not reduce services.	
Recommendation: NHS Hampshire alerts the HOSC to any plans to change the provision of these services.			
Hythe Hospital	HOSC Chairman	Hythe Hospital has closed to admissions due to clinical risk caused by staff shortages. .	
Recommendation: A verbal update is provided by NHS Hampshire			

Topic/inquiry	Source	Action Taken	Comment
End of Life Care	HOSC Members	This is an update on progress with the implementation of the review of this topic by the HOSC. Keys areas of interest will include: • Demonstrated progress on developing an integrated strategy that addresses access to services through patient pathways, support for family and carers including the bereavement experience. • Demonstrated progress made against a strategy and/or where patient experience has been improved over 2009/10 • Forward plan that sets out the goals and actions for 2010/11 and beyond • Impact of the financial climate on the proposed timetable of improvement • The impact of proposed changes to the NHS	
Recommendation: That a further update is provided to the committee in twelve months time			
Unscheduled and OOH care	HOSC members	Progress with this work was discussed by the HOSC last July. At that time members raised a number of issues and asked for a progress report at this meeting. This should include: • How NHS Hampshire plans to reduce the	

Topic/inquiry	Source	Action Taken	Comment
		variability in performance by OOH providers, and the consequent differences experienced by patients in different parts of Hampshire. • The key developments put in place over 2009/10 • How progress towards greater integration of unscheduled care services and the better management of demand are to be maintained through the evolution of the NHS organisation • How it is planned to progress the development of 24/7 urgent care consistently well in every part of Hampshire A short briefing note on OOH is attached at Appendix Five.	
Recommendation: Members are provided with an update as requested			
Specialist services	Joint HOSC	Members requested an update on progress with the national reviews of paediatric cardiac surgery. The response from the national specialist commissioning team is attached at Appendix Six	
Recommendation: Members are advised when the formal consultation is launched			

Equity and Excellence: Liberating the NHS	HOSC Chairman	A white paper has been published setting out proposals for restructuring and refocusing the NHS. Full details of the document can be found at Liberating the NHS Key points include: – Abolition of PCTs and SHAs – A new Commissioning Board – Local commissioning to be passed to GP consortia – PCT health improvement role to pass to Local Authorities – NHS management costs to reduce by 45% over the next 4 years	This document sets out an ambitious schedule of change for the NHS. Changes relating to local authorities may see the HOSC replaced
Recommendation: Members are apprised of response to consultation on the White Paper			

Section 100 D – Local Government Act 1972 – background papers
The following documents disclose facts or matters on which this report, or an important part of it, is based and has been relied upon to a material extent in the preparation of this report.

NB the list excludes:

1. Published works
2. Documents that disclose exempt or confidential information as defined in the Act.

Appendix One

A New Decade for Local Health

Portsmouth and South East Hampshire Sustainability Plan

1. INTRODUCTION

1.1. A Portsmouth and South East Hampshire Sustainability Plan has been devised in response to the changing world and national financial position, allied to the commitment to implement new ways of working which improve the quality of services for local people; increase productivity and therefore reduce costs across the NHS. This four year plan has been developed by partner NHS organisations, working with social care colleagues, and subsequently reviewed by South Central Strategic Health Authority in May 2010.

1.2. Since it was developed, the focus of planning has moved to the development and delivery of a number of projects, organised into nine work streams.

1.3. The Plan is the collaborative work of NHS Hampshire, NHS Portsmouth, Portsmouth Hospitals NHS Trust, Hampshire Community Health Care, Solent Healthcare, Hampshire Partnership NHS Foundation Trust and NHS South Central. In addition, there has been strong GP leadership in the design and development of the Plan alongside Local Authority partners.

1.4. The nine work streams for the Plan are:

- Transforming unscheduled care;
- Transforming planned care;
- Commissioner (PCT) efficiency;
- Hospital productivity;
- Community and mental health whole systems effectiveness;
- Primary care efficiency;
- Estate reconfiguration;
- Workforce;
- Communications and engagement.

2. BACKGROUND

2.1. In recent years the NHS has delivered major improvements to patient care, reducing waiting times, introducing new drugs and building new facilities. At the same time, the NHS has enjoyed significant increases in funding, helping to keep pace with increases in demand, an ageing population and complexities of care needs. People across the Southampton, Hampshire, Isle of Wight and Portsmouth area now live longer but with more long term

illnesses. Lifestyles are changing giving rise to new problems like obesity. In addition new technologies and treatments mean that care can be offered in new, more convenient ways.

2.2. The use of secondary care services and Emergency Department care is much higher in Portsmouth and south east Hampshire than in other comparable areas across the county and England as a whole. This places great pressure on the secondary care facilities (including the Emergency Department) at Portsmouth Hospitals NHS Trust; it potentially means that patients are not equitably accessing well designed high quality services and places a very significant financial burden on Primary Care Trusts who pay for these unnecessary visits. The Portsmouth and South East Hampshire Sustainability Plan and the projects within it aim to ensure that local people are seen in the right place, by the right person at the right time. Building on the success of service developments in other parts of the county and the wider national NHS will help improve outcomes for local people and ensure NHS services are as efficient as possible.

2.3. For example, traditionally patients with orthopaedic conditions were routinely referred to an orthopaedic consultant. A new musculoskeletal (MSK) service for south east Hampshire, based on existing services elsewhere in the county, has started which assesses and treats patients with MSK conditions. These conditions include lower back pain, joint problems and repetitive strain injuries. Patients are assessed and treated by specialists including GPs with a special interest in orthopaedics, consultant surgeons, physiotherapists and podiatrists. This service brings together these different clinical skills which means patients are seen by the most appropriate person at a venue closer to home, rather then having to go to hospital.

3. CHANGING FINANCIAL CLIMATE

3.1. In the past ten years or so the NHS has seen significant additional investment to fund inflation; increases in population; to drive down waiting times and access to services; address health inequalities and to provide patient choice alongside investment in new technology. Whilst the NHS has been protected from public sector funding cuts so far, it is clear that demand for the NHS services will increase. In order to meet this, the NHS needs to make substantial savings which can be reinvested into patient care. One focus for these savings is reducing management costs and this needs to be done together with making improvements to the quality of patient experiences and outcomes.

3.2. In Portsmouth and south east Hampshire we know that there will be a gap of about £230m over the next four years if spending continues at the current rate. Whilst this presents a huge challenge, there are plans in place to address this in a number of ways:

- Productivity – doing the same but more efficiently – for example, ensuring all our facilities such as hospital theatres and beds are used as efficiently as possible and using staff to maximum effect;

- System transformation – changing the way healthcare is delivered, such as reducing length of stay in hospital to free up resources for other patients, which has been done very effectively, for example, with hip operations over recent years;

- Reviewing clinical evidence – ensuring patients are offered the most clinically appropriate treatment;

- Looking at ways to use buildings and estate more effectively.

4. AIMS AND SCOPE

4.1. The Portsmouth and South East Hampshire Sustainability Plan aims to facilitate and strengthen partnership working so all NHS and social care organisations in the area continue to work together to improve quality and reduce costs.

4.2. All of these local organisations will experience significant financial pressures this year and in years to come. Improving the quality of care so it is more patient focussed will reduce waste and inefficiency and all organisations in Portsmouth and south east Hampshire are committed to working together to make this happen.

4.3. Patients have said consistently that they want care close to where they live, shorter stays in hospital and more efficient administration systems, so that will be the initial focus.

4.4. The types of changes that are being planned are:

- Caring for more people in their own home;

- Supporting more people to care for themselves and keep as much of their independence as possible;

- A greater focus on prevention and helping people to stay healthy;

- Localising health services where possible and centralising where necessary;

- Using new advances in technology to help make services more efficient and easier for patients to access, such as Telehealth;

- Ensuring patients get the most appropriate treatment for their condition, in the most appropriate place.

4.5. In order to do this local community services, hospitals, social services and primary care will be working together to be more effective and make sure that we have:

- More care closer to home;

- Fewer hospital admissions;

- Shorter lengths of stay in hospital.

4.6. Ways of spending public money more efficiently are also being examined:

- Reducing management costs;

- Working more closely with local authorities to buy services more effectively;

- Reviewing the use of agency staff.

4.7. The scope of the Sustainability Plan covers all services commissioned by NHS Hampshire and NHS Portsmouth from both primary, secondary and specialist care providers.

4.8. Individual NHS organisations will be responsible for delivering their part of individual projects included in the scope of the Plan. However, the Plan and its implementation will be reviewed and regularly updated to take account of changing national and local circumstances.

5. WORK STREAMS

5.1. The Portsmouth and South East Hampshire Sustainability Plan consists of nine work streams:

- Transforming unscheduled care
- Transforming planned care
- Commissioner (PCT) efficiency
- Hospital productivity
- Community and mental health whole systems effectiveness
- Primary care efficiency
- Estate reconfiguration
- Workforce
- Communications and engagement.

5.2. The remit and benefits for each of the work streams and the projects that are included in their work are detailed below.

Transforming unscheduled care

5.3. This work stream aims to transform how unscheduled care is provided so local people understand the range of urgent care advice and support available to them and only use the Emergency Department (A&E) when appropriate. Local people need to be seen in the right place, at the right time by the right person. By ensuring the right care and support is provided closer to patients' homes we can avoid people spending time unnecessarily in a hospital bed.

5.4. Projects being carried out by this work stream include:

- Rolling out a programme across the whole of Portsmouth and south east Hampshire so that patients with long term conditions, such as Chronic Obstructive Pulmonary Disease, are given timely and appropriate support that avoids clinical crisis and so avoids unnecessary unplanned admissions to hospital;

- Developing teams of clinicians, social care staff, and voluntary sector partners to work intensively to support people with long term conditions to stay at home with the clinical support they need when they need it: this model is being called a 'virtual ward';

- Working with Adult Social Care and Social Services Departments to develop a reablement service. This service provides intensive support from health and social care staff to both patients in reablement beds and patients in their own home to ensure they return to an agreed level of independence as rapidly as possible;

- Introducing initiatives to reduce the number of alcohol related hospital attendances and admissions;

- Reducing unnecessary spend on very expensive drugs where these are prescribed inappropriately or without evidence;

- Developing a integrated discharge bureau to improve hospital discharges;

- Reviewing all care that is provided for Portsmouth and south east Hampshire residents out of the area work to determine how services need to be changed or developed so these patients can receive the care they need locally;

- Improving the communication and information for service users and carers so that they are clear about the services available to them.

<u>Transforming unscheduled care: Benefits</u>

5.5. The Transforming Unscheduled Care work stream includes a range of programmes and actions to reduce the level of non elective activity at Portsmouth Hospitals and implement planned investment into community services. The various saving schemes are system wide and drawn from the plans of both NHS Hampshire and NHS Portsmouth. In the case of NHS Hampshire the figures reflect the share that is attributable to the south east Hampshire health economy.

5.6. In total, it is anticipated that the schemes will avoid 4,250 patients being unnecessarily admitted to hospital (because of an absence of locally response services) each year. It is also anticipated that the schemes will, in total, realise a £40million benefit over the next four years. In 2010/11 the impact of these schemes is estimated at in excess of £8million.

Transforming planned care

5.7. Hospital consultants and GPs are working together to review the extent to which planned care is used and how this can be made more efficient with improved outcomes for patients. This involves both primary care and hospital based clinicians critically reviewing "patient pathways" in light of new technological advances, guidance from NICE, national and international best practice and changes in treatment to ensure that the best clinical outcomes for patients are delivered as effectively and efficiently as possible. Across Portsmouth and south east Hampshire there are differences in practice that are neither clinically justifiable nor therefore necessarily in the interests of the patient. We are therefore working with clinicians and service users in agreeing clinical guidelines and thresholds that will consistently define when a surgical intervention is clinically appropriate and developing alternative provision for those patients where surgery is not seen as the most clinically appropriate intervention. This provision includes working community service providers and social care colleagues to provide community support and earlier intervention.

5.8. Projects being carried out by this work stream include:

- Working with consultants and GPs and service users during 2010/11 to critically review and develop the patient pathways listed below. This work will be continuously reviewed and further pathways added as appropriate.

    - Trauma and Orthopaedics
    - Gastroenterology
    - Cardiology
    - Vascular
    - Renal
    - Diabetes
    - Gynaecology
    - Rehabilitation
    - Medicine for older People
    - Ear, nose and throat
    - Ophthalmology
    - Rheumatology
    - Oral surgery
    - Pain

- Ensuring all patients are seen within an appropriate timescales and reducing waiting lists that exceed this standard;

- Improving the management of long-term and chronic conditions and support for well being by:

    - Increasing community support for stroke, long-term conditions and palliative care
    - Developing a Chronic Obstructive Pulmonary Disease (COPD) and Community Respiratory Service
    - Developing a Community Diabetes Service.

<u>Transforming planned care: Benefits</u>

5.9. The Planned Care work stream includes a range of programmes and actions to reduce the inappropriately high level of elective and outpatient activity at Portsmouth Hospitals and implement planned investment into community services. The savings shown are system wide and drawn from the plans of both NHS Hampshire and NHS Portsmouth. In the case of NHS Hampshire the figures reflect the share that is attributable to the south east Hampshire health economy.

5.10. In total these schemes aim to realise a benefit of over £27 million over the next four years. In 2010/11 the impact of these schemes is estimated at in excess of £6 million.

Commissioner (PCT) efficiency

5.11. One of the best ways to manage an unaffordable growth in demand for local NHS services, especially secondary care, is by helping local people understand what they can do to live healthy lives and prevent avoidable ill health. By increasing the focus on health promotion, local people can be provided with the information they need to make healthy life choices.

5.12. In addition, the four Primary Care Trusts in Hampshire and the Isle of Wight are looking at how they can increase their efficiency by sharing common functions across the area.

5.13. Projects being carried out by this work stream include:

- Reviewing the quality and value for money received from existing continuing health care spend;
- Reviewing out of area placements to determine if the appropriate care can be provider closer to the patients home;
- Reducing management costs for PCTs (reducing management costs by 33% from a 2008/09 actual spend);
- Identifying opportunities for joint working;
- Implementing a shared Commissioning Enablement Service;
- Reviewing all contracts with private and third sector organisations to ensure the required outcomes and clear and they will deliver quality and value for money;
- Identifying potential 'shared services' to reduce costs.

<u>Commissioner (PCT) efficiency: Benefits</u>

5.14. The Commissioner (PCT) Efficiency work stream involves reducing the cost base of NHS Hampshire and NHS Portsmouth. It targets areas where the PCTs have direct control and does not impact on the acute or community providers in any material way.

5.15. The savings shown are drawn from the plans of both PCTs. It has been assumed that further efficiencies will have to be identified beyond 2010/11 in Head Quarter's costs / back office in line with the requirement to reduce management costs by 30%. In total these schemes aim to save over £11 million over the next four years. In 2010/11 the impact of these schemes is estimated at in excess of £4 million.

Hospital productivity

5.16. This work stream is reviewing how Portsmouth Hospitals NHS Trust carries out some of its core functions and identifying areas where productivity and quality can be increased. This includes ensuring that only beds that have been resourced are open and reducing the number of days a patient spends in hospital before their operation.

5.17. Projects being carried out by this work stream include:

- Reducing the number of temporary staff being used;
- Reducing the number of unresourced beds;
- Introducing theatre, imaging, outpatient and pathology efficiency programmes.

Hospital productivity: benefits

5.18. The Portsmouth Hospitals NHS Trust efficiency work stream involves reducing the cost base at the Trust. It is a combination of the schemes that have been identified through the Turnaround process and the areas identified through national productivity and quality benchmarking. In addition to the significant qualitative benefit associated with these schemes, the system has an ambition to realise over £95 million benefit over the next four years. This is cost that would have been incurred, potentially unnecessarily, without the range of schemes listed above. In 2010/11 the impact of these schemes is estimated at in excess of £31 million.

Community and mental health whole systems effectiveness

5.19. This work stream is reviewing how community and mental health providers are carrying out their core functions and identifying areas where existing models of care can be reviewed and expanded to reduce the number of acute hospital admissions and lengths of stay through whole systems working.

5.20. Projects being carried out by this work stream include:

- Efficiency programmes at both Solent Healthcare and Hampshire Community Health Care to deliver efficiency through productivity gains, economies of scale and transformation plans;

- The mental health work stream is focusing on reviewing existing psychiatric liaison models of care with a view to extend them further;

- Working with Adult Social Care and Social Services Departments to develop reablement beds – patients in these beds will be receive intensive support from health and social care staff to ensure they return to an agreed level of independence as rapidly as possible. There is strong evidence that targeted reablement for those at the point of hospital discharge when the risk of loss of independence and readmission is high can deliver positive outcomes for the individual and reduce the costs of long term health and social care. Evidence from performance monitoring in Hampshire shows that over 50% of people discharged into social care led reablement beds returned to the community, compared with the 5.6% prediction at point of discharge.

- Development of alternative community based services such as ”virtual” wards were people with chronic long-term conditions such as chronic obstructive pulmonary disease and diabetes can be supported in their own homes rather than requiring inpatient treatment in an acute hospital;

- Tactical decommissioning of services that are ineffective or not cost effective, this may also involve the repatriation of work from expensive and distant specialist providers to more local and cost effective local providers, which brings both a financial benefit and more convenience for patients who will no longer have to travel great distances to receive treatment.

Community and mental health whole systems effectiveness: benefits

5.21. The Community and Mental Health Whole Systems Effectiveness work stream involves whole systems working by increasing the scope, productivity and responsiveness of community providers to reduce more costly acute hospitals admissions and reduce acute lengths of staff. It contains the plans that Solent Healthcare and Hampshire Community Health Care have to manage the impact of the tariff changes on their contracts and the additional stretch targets from the Primary Care Trusts.

5.22. In total these schemes aim to realise a financial benefit of over £21 million over the next four years. In 2010/11 the impact of these schemes is estimated at in excess of £4.5 million.

Primary care efficiency

5.23. This work stream covers a number of areas to help primary care clinicians make the best use of NHS resources as they manage the care of local people. This work stream aims to not only work with local primary care contractors so NHS services are used consistently across the area and also aims to support GPs in their role as clinical commissioners through Practice Based Commissioning.

5.24. Projects being carried out by this work stream include:

- Identifying efficiencies in all primary care contracts (GPs, Dentists, Opticians, Pharmacists and Practice Based Commissioning);

- Supporting local practices to commission services for local people through Practice Based Commissioning;

- Reducing the number of referrals made inappropriately to secondary care and managing patients more effectively in the community;

- Reducing the number of inappropriate attendances to the Emergency Department by creating more effective community based service alternatives;

- Working with primary and secondary care clinicians to develop and agree clinical guidelines.

Primary care efficiency: benefits

5.25. The Primary Care Efficiency work stream aims to reduce the cost base of primary care. It mainly targets prescribing costs but increasingly PCTs will need to look to save in areas like enhanced services, primary care premises and primary care contract costs. This work stream will also focus on GP commissioning and plans for this area as developed by the Coalition Government.

5.26. In total these schemes aim to realise a benefit of over £19 million over the next four years. In 2010/11 the impact of these schemes is estimated at in excess of £4 million.

Estate reconfiguration

5.27. There are over 100 NHS sites across Portsmouth and south east Hampshire and this work stream is looking at ways in which the use buildings and estates can be used more effectively.

5.28. Projects being carried out by this work stream include:

- Mapping existing estate including size, location, current services based there and operating hours;

- Identifying opportunities to utilise space to its maximum potential, such as co-locating services in the city centre at the St Mary's Health Campus.

Workforce

5.29. Staff are the biggest asset in the NHS and play a key role in the success of many of these projects.

5.30. Spending on staff accounts for around 70% of total NHS spend so we must ensure that the right people with the right skills are carrying out the right job in the right place.

5.31. Any programme which seeks to reduce spending needs to look critically at the cost of employing staff. As a principle compulsory redundancies will be avoided wherever possible, but have not excluded as a solution. The local NHS will work with staff and their representatives so that these matters are handled sensitively.

5.32. Projects being carried out by this work stream include:

- Reducing the use of temporary/agency staff;
- Ensuring maximum gain from consultancy and other contracted staff so these staff are only used when they provide expertise that is only needed on a short term basis;
- Developing practices that allow the workforce to be as flexible as possible;
- Developing a system wide process for redeploying any displaced staff so their valuable skills are retained within the local area wherever possible and to minimise redundancy costs;
- Developing a system wide workforce plan that covers all NHS organisations in the local area.

6. PATIENT AND PUBLIC INVOLVEMENT

6.1. Communications and engagement plays a fundamental role in the success of all the work streams and their projects. Effective communication of the positive opportunities to improve the quality of care for patients, tackle inefficiency and drive up productivity to local politicians, partners, clinicians, staff, patients and local residents is a key element to the Sustainability Plan. Also all these groups need to be involved in helping to shape a sustainable future.

6.2. Projects being carried out by this work stream include:

- Developing and implementing a Communications and Engagement Strategy that sets out how local people, key stakeholder groups (including the local media), GPs, practice staff, secondary care consultants and clinicians, and NHS staff will be involved and informed;
- Identifying opportunities to work with Local Authority partners in engaging key audiences and sharing existing mechanisms to do this;
- Supporting the development and implementation of Communications and Engagement Plans, as necessary, for individual projects in each work stream.

7. CLINICAL ENGAGEMENT

7.1. Clinical engagement plays a fundamental role in the Plan as consultants and GPs who see and care for local people make many of the decisions about how to treat them most effectively. Working together will helps ensure this reaches its maximum potential by increasing quality and improving patient outcomes.

7.2. The Sustainability Plan is supported by a Clinical Leaders Group which provides clinical input and leadership to the programmes of work. The Group has clinical representatives from all partner NHS organisations to provide the clinical perspective and influence the different work streams.

7.3. This group is also leading the patient pathway review work which is in the Transforming Planned Care work stream.

8. GOVERNANCE

8.1. The governance arrangements are the set of rules by which the organisations in Portsmouth and south east Hampshire will operate under. Each organisation has agreed to the following arrangements.

Portsmouth and south east Hampshire System Steering Board

8.2. This Board carries out the following functions:

- Overseeing the work of the Programme Broad;
- Approving the plan and its subsequent development, seeking formal agreement from statutory Board(s) as appropriate;
- Ensuring decisions are taken in line with strategic objectives;
- Addressing management issues relating to the work programme;
- Overseeing communications and engagement with the public and the Health Overview and Scrutiny Councils;
- Providing assurance to the Boards of the three main organisations that the programme of work is being delivered, including providing reports to the Boards as appropriate;
- Providing assurance and reports where appropriate to the Strategic Health Authority.

8.3. The System Steering Board meets quarterly influencing the strategic direction of the health system focused on the short, medium and long term.

Programme Board

8.4. The Programme Board meets monthly and reports to the System Steering Board. Its overall remit is to shape, assign, direct, monitor and resolve. Specifically the Programme Board is responsible for:

- Developing and refining the plan;
- Developing operational and financial parameters and metrics against which the system should operate;
- Agreeing and overseeing the work of the work streams focussing on development and delivery of the programme;
- Signing off any agreed actions/next steps;
- Directing resources from all partner organisations to ensure delivery of the programme;
- Ensuring appropriate engagement, commitment and involvement of all key stakeholders involved in the commissioning and delivery of health services to the local community;
- Providing assurance to the System Steering Board that the programme of work is being delivered. This will include the production and authorisation of the integrated performance report;
- Providing assurance and reports where appropriate to the Strategic Health Authority.

Delivery Board

8.5. The Delivery Board meets fortnightly and reports to the Programme Board. It is responsible for:

- Developing proposals, terms of reference and delivery goals for work streams that are then agreed by the Programme Board;
- Determining financial and operational targets for individual projects;
- Monitoring the individual and overall progress against delivery milestones of all the work streams;
- Escalating delivery and other issues to the Programme Board.

8.6. The programme team will work with similar programmes across South Central and beyond to seek to share best practice and learning that is relevant to the projects in each work stream.

9. TIMELINE FOR THE CHANGES

9.1. The Portsmouth and South East Sustainability Plan is a four year plan with 2010/11 being a fundamental year to implement new ways of working.

10. WHAT WILL THE NHS IN PORTSMOUTH AND SOUTH EAST HAMPSHIRE LOOK LIKE IN 2013/14?

10.1. The Portsmouth and South East Hampshire Sustainability Plan will ensure the local NHS system is sustainable in the future whilst helping to achieve a break-even position for all NHS partner organisations over the next four years.

10.2. The map of the NHS in Portsmouth and south east Hampshire will look very different in 2013/14 after these changes have been implemented. For example:

Acute Sector

10.3. Providing more community services, ensuring local people are seen in the right place, at the right time by the right person, the use of secondary care services and the Emergency Department would reduce to levels in line with comparable areas in the county and England.

10.4. This could mean that Queen Alexandra Hospital would:

- Need fewer inpatient beds (potentially it will be 15-25% smaller);
- Have a smaller workforce;
- Be used more intensively;
- Devote part of its space for use by other local NHS providers, for example a GP practice.

Other Providers

10.5. By increasing the scope, quality and productivity of services provided by community and other providers more patients will be seen closer to home where appropriate or will need to spend less or no time in an acute hospital.

10.6. This could mean that:

- The number and utilisation of nursed beds in the community (deployed as they currently are in both the private sector and in the community hospitals) will adapt to provide care in new ways;
- The St Mary's Independent Sector Treatment Centre contract is reviewed and re-tendered;
- Community services are provided in a way that focuses on the areas with most need;
- Out of area mental health services are repatriated and provided locally.

Primary Care

10.7. Helping primary care clinicians make the best use of NHS resources will support the local NHS system as GPs manage the care for local people.

10.8. Building on the work already underway, primary care in the future could involve:

- GPs working with hospital consultants to devise more appropriate care pathways and thresholds;
- Some restructuring around GPs as commissioners of services;
- Developing virtual wards in each locality supporting the chronically ill in their own homes;
- Developing large Primary care Centres with co-located with community providers.

Commissioner PCTs

10.9. The organisations are responsible for paying for the healthcare local people need and investing in programmes to help people stay healthy. They also make sure that care is of the right quality and meets all national standards. Working together on these commons functions could mean:

- Lower management costs;
- More shared services with local authorities and with partner PCTs across Southampton, Hampshire, Isle of Wight and Portsmouth;
- Completing the Provider/Commissioner divisions' separation.

11. WHAT WILL THE PORTSMOUTH AND SOUTH EAST HAMPSHIRE SUSTAINABILITY PLAN MEAN FOR PATIENTS?

11.1. The aim is that patients will be affected the least by these changes whilst benefiting the most from improved health outcomes and increased long term benefits. Using staff and facilities more efficiently and effectively whilst cutting out waste will be welcomed by the general public. Similarly ensuring that treatment is given by the right person, in the right place, at the right time will also be welcomed. With more care delivered in the patients' home this will benefit patients, their carers and their families and friends. At the same time the NHS in Portsmouth and south east Hampshire will be responsive to national policy such as Choice.

11.2. The challenges facing the local NHS should not be underestimated. Some hard choices will have to be made and some cherished local facilities may close or have their use changed. But the need to ensure that the services available and the care provided to the population of Portsmouth and south east Hampshire by the NHS is of the highest possible standard, achieves the

best health outcomes and long term benefits for local residents, and meets all national standards is paramount.

11.3. The work included in the Sustainability Plan needs to be carried out with the involvement of local politicians, partners, clinicians, staff, patients and local residents. These groups are key in helping to shape a sustainable future that improves the quality of care for patients, tackles inefficiency and drives up productivity.

12. MONITORING AND EVALUATION PROCESS

12.1. The implementation of the plan will be monitored closely by individual organisations on the delivery of specific organisation focused workstream and by the sustainability Team for system wide workstreams. Progress will be reported to Boards of Directors in each organisation regularly.

Authors: **Elizabeth Harris**
Brian Courtney
Maggie MacIsaac

On behalf of: **The Portsmouth and South East Hampshire System Steering Board**

Date of Issue: July 2010

Appendix Two

Hampshire Primary Care Trust Headquarters
Omega House
112 Southampton Road
Eastleigh
Hampshire
SO50 5PB

Our ref: SJ/CLM

17th June 2010

Dr Peter Skolar
HOSC Chairman
Oxfordshire Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxfordshire, OX1 1ND

Dear Dr Skolar,

Buckinghamshire, Hampshire, Oxfordshire Health Overview and Scrutiny Joint Review Group. South Central Ambulance Service: - Review of Rural Performance

Following on from the very helpful meeting on 26th May 2010, I am writing in response to your letter of 28th May 2010 requesting clarification on a number of areas discussed as part of the joint Health Overview and Scrutiny Committee (HOSC) review outlined above.

Firstly I would like to state how much I welcome the opportunity for Commissioners and South Central Ambulance Service (SCAS) to update on the initiatives to each of the three review Committees on a regular basis. This will enable a more localised approach that will help to ensure a robust and sustainable solution is delivered. I feel this will also help support and develop the relationship between our organisations.

You have confirmed the Joint Committee is happy to be guided on the format and frequency of reporting, I would therefore propose a further communication setting out a timeframe for reporting and by what method, however I would like to schedule an initial meeting with each HOSC to ensure your requirements are fully considered and to work through in more detail, the information provided in my letter of 25th May 2010. A meeting will also be helpful to fully understand how we can best manage and fulfil the expectations of each HOSC locally.

Can I therefore ask that someone from each HOSC is nominated as a lead contact to liaise with Commissioners to progress this programme of work? If you could supply this information to my PA, Sue Wilson, sue.wilson@scscg.nhs.uk, tel: 02380627423, by 25th June 2010 that would be appreciated.

As I discussed recently with Denise Holden, the relevant 2010/2011 contract schedules will be circulated as soon as the detail has been finalised and signed off by all organisations.

On page two of your letter you have outlined in bullet points the issues requiring clarification, please note my response to each point set out below.

- **Progress with identifying a lead NED from PCTs to oversee the performance of SCAS.**

  To encourage representation at locality level it was felt prudent to invite a NED from each HOSC community. I am pleased to inform you that Suzanne Hassleman will represent Hampshire and Mike Williamson will represent Buckinghamshire. I will forward to you shortly the name of the Oxfordshire representative.

- **The timeframe for completing the review of the deployment model**

  The terms of reference for the review have now been agreed (copy embedded) and, once the review is completed, is provisionally due to report in Q3 2010/11 with Implementation in Q4 2010/11. SCAS plan to engage stakeholders in the review process which will be aligned to their clinical strategy that is currently out for consultation. The terms of reference are due to be circulated imminently with a letter to stakeholders inviting them to attend a review panel workshop on 21st July, 2-5pm, in the Newbury area (venue will be confirmed). Stakeholders will be briefed on the current operational deployment model and options for future configuration. Stakeholders will then be able to contribute and feedback to SCAS post workshop to inform the outcome of the review.

  
  100618 Draft SCAS TorS Deploy Rview

- **Confirmation of timeframes for completing unscheduled/urgent care strategies for SHIP and MOBB and proposals for engaging with key stakeholders to inform this work**

  The SHIP Commissioning Cluster Unscheduled Care Board is considering a developing strategy at their next meeting on the 28th June 2010. This strategy will be developed over the summer including an engagement process with HOSCs and all other stakeholders.

  Work continues within the MOBBB Commissioning Cluster to progress the delivery of fully integrated urgent care services for the locality. The cluster have agreed the focus should be on urgent and emergency care pathways and are currently finalising their project initiation document that will drive the delivery of this workstream. It is anticipated this document will be approved when presented to the Urgent and Emergency Care Programme Board by the end of this month. The Cluster is actively working with SCAS as a key stakeholder in the development and delivery of these initiatives.

  The Specialised Commissioning Team are working with both clusters to ensure a robust overarching strategy is developed for the future commissioning of Urgent and Emergency Care services from SCAS.

  I will include an update on these developments as part of the regular briefing to each HOSC.

- **The 'sliding scale' agreed for meeting category B performance standards**

As was discussed at our meeting on 26th May 2010, the achievement of the Category B standard remains a particular challenge for our Health Economy. As part of the 2010/11 contract we have agreed that this standard will be achieved over the next two years. The final two year trajectory will be refreshed next week following the publication of the revised 2010/11 NHS Operating Framework and I will share the trajectories with you as soon as they are completed.

- **The 'floor' agreed for maximum response time and reporting mechanisms**

  The position regarding the proposed floor has been agreed as outlined below:

  We have commenced with a floor of 95% A8 within 15 minutes 12 seconds. SCAS should improve this performance as follows: Q2 1.5%, Q3 2.5%, Q4 2.5% in order to achieve a year end figure of 14 minutes 56 seconds. If there is no improvement from this figure a penalty of £250,000 will be payable. This penalty will not be payable if there is an increase from the 2009/10 outturn number of incidents (400,012). I will obviously share progress against this important local target at each subsequent HOSC meeting.

- **Progress with identifying appropriate metrics (i.e. not call volume) for performance in rural/urban areas, including the work comparing call volume and severity by area.**

  SCAS currently report daily on a number of Primary and Secondary Performance Indicators. These are reported by division, including the demand and performance trends for a number of indicators including all elements of the call connect standard, activity and response information by location, by drive zone area e.g.; Windsor (Urban), Ascot (Semi Rural) and Mortimer West Berks (Rural), Community / Staff responder Activity etc.

  Commissioners are in dialogue with SCAS regarding the development of indicators but feel it would be beneficial to discuss the detail of HOSCs requirements to understand and incorporate these to ensure our expectations are clearly defined and achievable. To progress this issue Carole Le-Marechal will contact Denise Holden in Hampshire HOSC to discuss your requirements. I hope this is acceptable.

- **The report of the results of the audit of calls waiting in excess of 30 minutes and I hour**

  The report on patient safety/delays is going to the SCAS Quality and Safety meeting on 17thJune 2010. The SCAS Executive Director for Patient Safety and Medical Director will then disseminate the findings to the Clinical Directors at PCTs and to the Specialised Commissioning Team before circulating further.

- **The joint action plan covering the recommendations outlined in our report as referred to in your letter of 31st March 2010.**

  As we discussed at the meeting on 26th May 2010, many of the recommendations outlined in your report have been implemented. SCAS and Commissioners are currently using a 100 day planning process to target specific improvement projects. I will ensure that the outstanding recommendations are incorporated into the latest 100 day plan and will share the plan with you shortly.

One final matter that I would like to update you on is that, following contact made at the last review meeting on 26th May 2010, I will be meeting with Anton van Dellen on 25th June 2010 to discuss the development of alternative commissioning models for the provision of ambulance Urgent and Emergency Care services.

You have suggested it would be helpful to attend the South Central HOSC Network meeting on the 16th November 2010 to update on the progress of the initiatives outlined and agreed as a result of the review. Thank you for this invitation; I would welcome the opportunity to attend this meeting.

As ever, if you require any further information to that provided, please do not hesitate to contact me.

Yours sincerely

Simon Jupp
Director, South Central Specialised Commissioning Group

Distribution:

Cllr Mike Appleyard - Buckinghamshire Public Health Overview and Scrutiny Committee
Cllr Peter Skolar - Chairman, Oxfordshire Joint Health Overview and Scrutiny Committee
Andrea Young - Chief Executive, NHS South Central Strategic Health Authority
Bob Deans - Chief Executive, NHS Southampton City
Will Hancock - Chief Executive, South Central Ambulance Service NHS Trust
Ed Macalister-Smith - Chief Executive, NHS Buckinghamshire
Debbie Fleming - Chief Executive, NHS Hampshire
Sonia Mills - Chief Executive, NHS Oxfordshire

Appendix Three

Hampshire Overview and Scrutiny Committee

Provision of primary care services to the Homeless in Hampshire Update July 2010

As previously reported to HOSC work on this project was put on hold as a result of the H1N1 Pandemic Flu pressures and since then the staff member leading the work has left the organisation and has not been replaced. Since the last update however, a number of actions have been taken and progress has been made towards improving services and making them more sustainable.

1. Winchester service

1.1 Several meetings took place at the Trinity Centre in May and June involving NHS Hampshire, the CEO for the centre, the GP and nurse who deliver services to the homeless people and their manager from Hampshire Community Health Care (HCHC). The focus of these discussions was the service model NHS Hampshire would like to continue to commission from this site and the current constraints and limitations in delivering this service.

1.2 An important step forward has been made by developing and signing a lease agreement which sets out the rental terms in regard to the space used for primary care services at the Trinity Centre and secures suitable space for the delivery of clinical services on a regular and planned basis.

1.3 The primary care health service at HMP Winchester have now established contact with the HCHC GP in order to be able to support discharged prisoners who may use the service.

1.4 In conjunction with the centre and HCHC we have identified several limitations and potential risks linked to the current service model and have also established how this could be improved. HCHC has now expressed their wish to terminate their agreement with NSH Hampshire as they have acknowledging that they lack the expertise in upgrading the present model and having HCHC as a provider was, as previously reported to HOSC, not the optimal solution. A versatile future model which would provide clear and robust links with a local GP practice with ability to enhance the service, provide support to the clinicians and their patients is the preferred way forward.

1.5 The move towards a new provider will not affect the present arrangements: location, staff, services provided, etc. The key target is to strengthen the relationship with the Trinity Centre and local primary care services to improve and enhance further the present primary care services offered for the homeless in Winchester.

1.6 The service provided by HCHC will be offered to local primary care providers in a local competitive process. To take this forward NHS Hampshire is in the

process of drafting a new service specification with the aim to have a new provider in place within the next **6 months**.

2. Services in the rest of Hampshire

2.1 Data on patients with no fixed abode who attended the Accident and Emergency departments in Hampshire between 1 April 2009 and 31 March 2010 is now available. The table below highlights the number of patients with no fixed abode attending the A / E departments at Southampton General Hospital (Southampton), Basingstoke and North Hampshire Foundation Trust (Basingstoke), Portsmouth Hospitals Trust (Portsmouth) and Royal Hampshire County Hospital (Winchester) over the year period. These figures include people who have no fixed abode but are based in the cities as well as those based in Hampshire.

A/E departments	Assault	Deliberate self-harm	Other accident	Other than above	Road traffic accident	Grand Total
Basingstoke	2	2	5	6		15
Portsmouth	8	5	10	32	1	56
Southampton		1	2	8		11
Winchester	4	4	14	44		66
Grand Total	14	12	31	90	1	148

2.2 The analysis reveals that the number of attendances at the A/E department at Royal Hampshire County Hospital although the most numerous in the table above is small (less than two per week on average) nevertheless the overall result points to the need to maintain and enhance the primary care services available for the homeless in Winchester.

2.3 In Basingstoke NHS Hampshire commissioned a new GP-led health centre which opened its doors to patients in December 2009 on the Basingstoke and North Hampshire Hospital site, providing medical and dental services to both registered and unregistered patients, with or without an appointment.

2.4 Hampshire Healthcare Centre (Basingstoke) is run by Assura Hampshire Health, a partnership between Assura Medical Ltd, an independent provider of healthcare, and local GPs on behalf of NHS Hampshire and is open from 8am to 8pm, 365 days per year. The Centre benefits from the existing local transport links and patients can now access a wide range of health services including pre-bookable and same day GP appointments. It is expected that the flexible and immediate nature of that service will meet the needs of homeless people in the Basingstoke area and the provider will be encouraged to promote the service to local agencies working with the homeless.

2.5 As previously reported NHS Hampshire continues to commission enhanced primary care services from GPs in Aldershot and GP practices elsewhere in the county provide care to people temporarily living in their area whether homeless or not. Numbers have been shown on audit to be low, mirroring the low reporting by District councils of homeless people.

3. Next steps

3.1 Work will continue with the present provider of services in Winchester and the Trinity Centre and will involve local GP commissioners to ensure that the service provided allows the clinicians to continue delivering care to the homeless population of Winchester in an appropriate setting with a view to consolidation and further development the service once a new provider is identified.

3.2 A Local competitive process will be undertaken over the summer to secure a new provider for the Winchester service which will improve the professional support for the clinicians and reduce the risk of duplication of treatment by aligning recording systems with those in use in general medical practice

3.3 It is expected that the change of provider in Winchester will not affect the front line services and the result will be a more versatile and sustainable model which will deliver improved primary care services for the homeless in Winchester.

3.4 Assura Hampshire Health will be encouraged to promote their service at the Hampshire Healthcare Centre (Basingstoke) to local agencies working with homeless people in the area.

Appendix Four: Paediatric Rheumatology- statement from NHS Hampshire

Juvenile arthritis affects 1/1000 children, and there are currently approx 100 patients being supported by SUHT clinicians.

The service at SUHT, as with many services across the South of England, has been undertaken by adult specialist rheumatologists, in association with paediatricians with interest in rheumatology. There are no plans for immediate closure of this service.

SUHT recognises that the model of care where adult rheumatologists look after children does not adhere to the latest guidelines from a number of different bodies, and adult teams are nervous of continuing in this vein. There appears no succession planning in the form of training for upcoming rheumatologists to cover the paediatric work (no training currently available). Similar delivery model happens at PHT, WEHT, Salisbury and Poole, although the latter two have shared care arrangements with specialists in Bristol. Complex patients are sent to Great Ormond Street, Oxford Radcliffe, Bristol and Birmingham.

There is debate about whether this is a mainstream commissioned service, or a service for specialist commissioning. Interests have fluctuated between Specialist Commissioning and PCTs. South Central Specialist Commissioning group recognised the issue with the current model of care across the South central region and commissioned a report assessing local needs. This was heavily biased towards favouring Oxford Radcliffe as a specialist provider to such an extent that the report was withdrawn, with the intention of the Specialist Commissioning group working with providers to identify an appropriate service model for the region.

The Chief Executive of SUHT has arranged to work with commissioners to discuss SUHT's proposed way forward.

SUHT's clinical strategy is to develop a South of England Children's Hospital, and wish to propose the development of a paediatric rheumatology clinical network for both the South Central and South West SHA regions. Have been progressing discussions with other local Trusts (Poole, WEHT, Portsmouth, Dorchester, and Salisbury) with a view to establishing a south coast network, with leadership from SUHT. SUHT's proposal is that this should be established within the next 5 years.

Appendix Five:

Managing the performance of Out of Hours primary care services in Hampshire
Briefing for Hampshire overview and scrutiny committee July 2010

Summary

NHS Hampshire commissions out of hours services (OOHs) from four providers each serving a geographic area detailed in the table below. Out of hours services are commissioned from the 4 providers by means of 3 year term alternative personal medical services (APMS) contracts. The services are regularly monitored for compliance with the National Quality Requirements which give assurances about appropriate access to services in a timely manner.

Provider	Type of organisation	Geographical area covered	Population covered (size with percentage share)
West Hampshire Out of Hours	Solent Healthcare (formerly Southampton City PCT Provider arm)	New Forest, Test Valley, Winchester and Eastleigh	531,054 (40.54%)
Portsmouth Out of Hours	Solent Healthcare (formerly Portsmouth City PCT Provider arm)	Havant, Fareham, Gosport and southern East Hampshire	347,671 (26.54%)
North Hampshire Urgent Care	A community benefit society, formerly two GP co-ops	Basingstoke, Hart and Rushmoor	344,595 (26.31%)
Thamesdoc Plus Ltd	A limited company formerly a GP co-op	East Hampshire	86,567 (6.61%)

Table 1 Providers of OOHs services to NHS Hampshire

Earlier this year, Dr David Colin-Thomé, (National Director of Primary Care at the Department of Health) and Professor Steve Field (Chairman of the Council of the Royal College of GPs) undertook a study into the local commissioning and provision of out of hours GP services and made a number of recommendations. NHS Hampshire took this opportunity to incorporate these recommendations into Key Performance Indicators for the contracts in place and developed a quality and outcomes framework to further enhance the assurance of quality services which are expected from all our providers for the Hampshire patient population. A detailed and comprehensive assurance plan was developed in response to the recommendations and was shared with the NHS Hampshire board, it is available at http://www.hampshire.nhs.uk/about-us/key-documents/document-a-z-a-categories/doc_details/1061-com10-030-gp-out-of-hours-services.

NHS Hampshire participates in the voluntary national benchmarking programme of OOHs providers, which is supported by the Department of Health, and has shared early outcomes of this work with HOSC. The third report of the benchmarking programme, focussing on service delivery over the Christmas period 2009 is still awaited. The time lag in the production of these benchmarking reports and their separation into individual providers reduces their usefulness as local performance management tools. NHS Hampshire has been active in working with the Primary Care Foundation, who produce these reports, to improve their presentation, their openness and thus their usefulness to commissioners.

This brief paper describes each element of the NHS Hampshire approach to performance management of the services.

National Quality Requirements

The national quality requirements for OOHs services were introduced in 2004, they measure a limited range of factors focussed on the time to answer calls, the time to give advice, the time to a face to face contact and the time to a home visit. In addition complaints handling, referral to 999, and timely transfer to the patient's GP of the contact records are among the standards, previously shared with HOSC, which are reported on a monthly basis.

Overall the providers' performance against the NQRs this financial year has improved on a county wide basis and the table below illustrates the rate of compliance across Hampshire. In order to achieve compliance the services work toward 95% achievement in line with national guidance. Some of our providers continue to experience challenges in a few areas and we are working together to understand and improve their performance in these areas.

Out of Hours Providers National Quality Requirements Summary	Apr-09	Apr-10		May-09	May-10
Outcomes reported to Practices by 0800 next working day	100.0%	100.0%		100.0%	99.6%
Complaints (resolved in line with NHS Complaints (England Regulations 2009)	66.7%	87.5%		100.0%	100.0%
Abandoned Calls	3.0%	2.7%		2.9%	2.8%
Calls Answered within 60 seconds	93.6%	96.3%		93.4%	94.6%
Calls passed to South Central Ambulance Service within 3 minutes	97.0%	98.7%		97.4%	98.9%
Urgent calls clinically triaged within 20 minutes	93.6%	94.7%		94.6%	97.0%
Routine calls clinically triaged within 60 minutes	87.6%	88.4%		91.4%	94.7%
Emergency consultations seen within 1 hour in a Primary Care Centre	100.0%	100.0%		93.3%	100.0%
Emergency home visits seen within 1 hour	100.0%	100.0%		100.0%	100.0%
Urgent consultations seen within 2 hours in a Primary Care Centre	95.9%	97.9%		96.7%	97.5%
Urgent home visits seen within 2 hours	95.1%	95.1%		95.1%	95.8%
Routine consultations seen within 6 hours in a Primary Care Centre	99.4%	99.3%		99.5%	99.3%
Routine home visits seen within 6 hours	98.5%	96.5%		99.3%	97.6%

The NHS Hampshire Primary Care Commissioning Group, a sub committee of the management committee, receives reports on provider performance against NQRs at each of its meetings.

Key Performance Indicators

These indicators have been designed to measure aspects of performance not captured by the NQRs and which were either identified in the recommendations by Dr Colin-Thomé and Prof Field, or they measure impact of the service on other health care sectors.

There is an expectation for the KPIs to be reported by providers on a quarterly basis which will enable NHS Hampshire to monitor:

- the numbers of hospital attendances referred by providers,
- implementation of processes to ensure clinicians are not working excessive hours ,
- specific reports on the bank holiday periods to identify whether sufficient planning is taking place for these particular busy periods of the year
- Detailed activity by practice including conditions and frequent users
- Home visits
- Locum GP agency usage

The KPIs have been incentivised by implementing performance parameters and best practice will be developed over the forthcoming year.

Monthly contract monitoring has been introduced with the 4 providers which promotes a clearer understanding of any issues or concerns which may arise leading to providing solutions by working together.

Quality and Outcomes Framework

This local development builds on the approach in the national quality and outcomes framework (QOF) for GP services and our local developments of QOFs for dental services and prison healthcare services. The range of indicators is informed by the recommendations in Dr Colin-Thomé's report and covers

- National Quality Requirement enhanced information
    - Special notes maintenance by linking with Practices to ensure any vulnerable patient information is current and encouraging practices to regularly update OOHs with vulnerable patient data.
    - Carrying out trend analysis on various aspects of collected data such as complaints and healthcare professional feedback,
    - Engagement with patient groups such as Hampshire LINk
    - Management of telephone clinical assessments delays
- Recruitment Induction and training

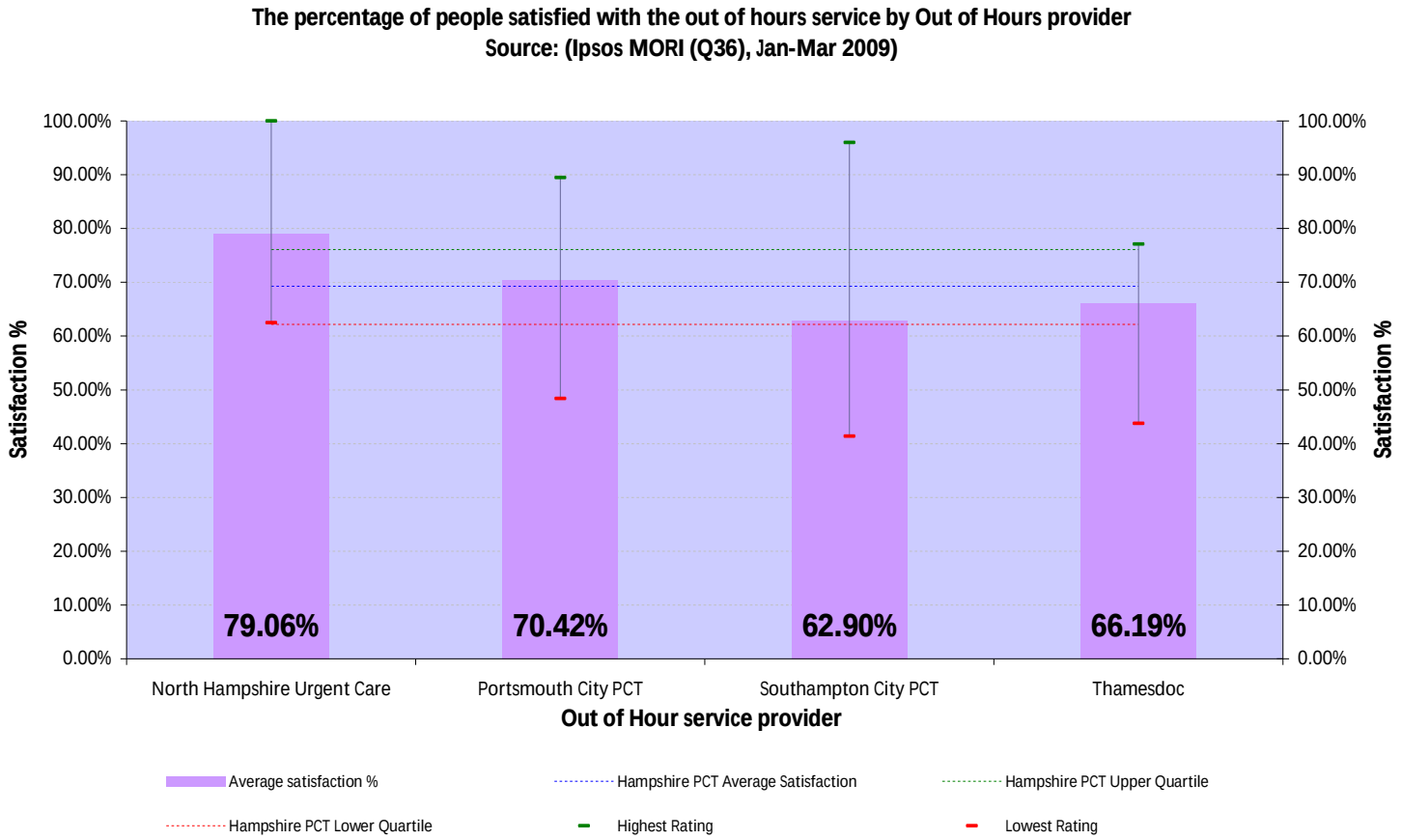
    - Best practice for recruitment and induction
    - Clinical supervision
    - Internal training made available
    - Annual appraisals for all staff
- Management, standards for better health, incidents and serious untoward incidents
    - Range of policies made available to all staff on how to manage or report any areas of concern
    - Robust governance frameworks
- Medicines Management
    - To demonstrate how national and local guidelines around medication are carried out by each service ensuring the safety of both staff and patients.

NHS Hampshire will derive additional assurance on the achievement of the QOF standards by undertaking an annual assurance visits to each provider, in the same way as the GP's QoF is assured, by a team which includes at least a clinician and contract manager. The KPIs and QOF have been introduced to the 4 out of hours providers by means of a Quality and Performance Incentive Scheme (QPIS) for this financial year. The standard of performance required for each KPI and QOF is indicated by 3 bands. Band A represents the desired level of performance, band B the minimum level of performance and band C an unacceptable level of performance. For each performance band there is a corresponding payment/score band and allows the providers to gain a financial incentive dependant on what has been agreed with each provider.

In addition a clinical quality reference group is being established which will bring together clinical commissioners for NHS Hampshire's localities and clinical leaders of the providers to discuss common clinical issues and to propose and agree single solutions which all providers implement to ensure a consistency of approach across the county. These may include, for example, consideration of clinical guidelines and approaches to achieve the QOF requirements.

Patient satisfaction. .

The MORI GP patient survey for 2008-9 (undertaken in January 2009) included for the first time questions about satisfaction with out of hours services. This was reported on a GP practice basis and has been mapped by NHS Hampshire to the out of hours provider covering each practice. The overall satisfaction for Hampshire services is 69.6% which is just above the median for all PCTs and ranks 62 of 152 nationally. The information has been split by each OOHs Provider to give an understanding of the levels of satisfaction in each area. Using this information we are working with the providers to understand how this can be improved further. We have begun working together with patient groups such as Hampshire LINk to understand the patient views on the services provided and work together with stakeholders to improve any deficits.


The percentage of people satisfied with the out of hours service by Out of Hours provider
Source: (Ipsos MORI (Q36), Jan-Mar 2009)
Satisfaction %
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
79.06%
70.42%
62.90%
66.19%
North Hampshire Urgent Care
Portsmouth City PCT
Southampton City PCT
Thamesdoc
Out of Hour service provider
Average satisfaction %
Hampshire PCT Average Satisfaction
Hampshire PCT Upper Quartile
Hampshire PCT Lower Quartile
Highest Rating
Lowest Rating

The future

The recent white paper 'Equity and Excellence: Liberating the NHS' (DH 12th July 2010) indicates that the Government will develop 24/7 urgent care services in every area of England, which will incorporate out of hours services, accessible by a single telephone number. NHS Hampshire will continue to work with our GP commissioners and OOHs providers to improve quality and performance of existing services to ensure patients receive a safe and responsive service for urgent problems during the hours when their GP surgery is closed .

Appendix Six: National Specialist Commissioning Team response to South Central HOSCs.

National review of paediatric cardiac surgery services in England

I write in response to your letter of 15 April to update you on the process for delivering recommendations for reconfiguration, and to respond to the specific points that you raise on behalf of the South Central Health Overview Scrutiny Committees.

As you know, the review has been instigated at the request of NHS clinicians working in the service, their professional associations and parent groups in response to long standing concerns about the sustainability of the current service configuration. Expert advice is that surgical expertise is spread too thinly across eleven surgical centres. The aim of the *Safe and Sustainable* review is to ensure that paediatric cardiac surgery services in England are able to deliver the best possible care in the future.

There remains strong stakeholder support for the review. In April we published a document titled 'The Need for Change' that sets out the clinical case for change and explains the need to concentrate surgical expertise in fewer, larger surgical centres. I am pleased to say that this document was endorsed by the relevant parent and professional associations including the Children's Heart Federation, the Royal College of Surgeons, the Royal College of Paediatrics and Child Health, the Royal College of Nursing and the British Congenital Cardiac Association.

In June and July we held ten public stakeholder events across England, all of which were well attended (including Southampton and Oxford), in order to canvass the views of patients, parents, NHS staff and other stakeholders.

In May and June all eleven centres in England that currently provide children's heart surgery services were assessed against quality standards by an independent expert panel chaired by Sir Ian Kennedy. The quality standards were developed by an expert group of clinicians and lay representatives; they take account of contributions from clinicians and parents from across the country and they include issues such as communication, the role of the cardiac liaison team and the provision of support services for children and their families.

The next stage of the process over the summer will involve the development of options for change taking into consideration factors such as travel for families, impact of any changes for NHS staff and affordability. Once recommendations have been made there will be a 3-month public consultation starting in October.

In response to the specific points that you raise:

1. '*The HOSCs wish to be assured that the full implications for the charities that operate in and around the paediatric cardiac centres are taken into account, especially with regard to the support the charities provide to enable parents to stay close to their children'*

The review has widely canvassed the views of parents, parent groups and charities on issues that need to be taken into account when delivering recommendations for reconfiguration, most recently via the ten public engagement events across England. Parents and charities have very clearly highlighted the importance of accommodation for parents and other family members, as well as other support services for families. Indeed, these issues were given sufficient prominence by the independent expert panel as part of the assessment of each centre.

With regard to the implications for the charities, it is important to appreciate that paediatric cardiac centres will not be closed as an outcome of the *Safe and Sustainable* review. Although recommendations may be made to cease surgery in some centres,

those centres will continue to provide a specialist paediatric cardiac service for their local population.

2. *'It is imperative that the review considers and addresses the cost of travel for families'*

The quality standards that we have developed include specific standards that aim to improve the experience of family members who accompany a child to hospital for heart surgery. We have set out a number of standards that aim to alleviate potential financial pressures relating to access and accommodation (responsibility for reimbursement of travel expenses rests with the Department of Health and we have brought this concern to its attention). One of the criteria that will be taken into account when developing options for change will be the impact on travel times for parents and families.

3. '*The close relationship between paediatric cardiac surgery and paediatric intensive care needs to be articulated in any proposals put forward*'

I completely agree with this statement. Our steering group includes the President of the Paediatric Intensive Care Society, and the consultation document that we will issue in October will cover the provision of paediatric intensive care.

4. *'The idea of a national joint HOSC committee was seen as unworkable'*

Thank you for this feedback. As you know, it is for the HOSCs themselves to establish a scrutiny process that they consider to be optimal for a national review and I look forward to their decision. I am continuing to take advice from the Centre for Public Scrutiny on this issue.

Please let me know of any further concerns or observations.