Public Document Pack

SCRUTINY PANEL B

Thursday, 9th September, 2010
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Council Chamber - Civic Centre

This meeting is open to the public

Members

Councillor Capozzoli (Chair)
Councillor Daunt (Vice-Chair)
Councillor Drake
Councillor Harris
Councillor Marsh-Jenks
Councillor Payne
Councillor Parnell

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PUBLIC INFORMATION

Southampton City Council's Six Priorities

- Providing good value, high quality services
- Getting the City working
- Investing in education and training
- Keeping people safe
- Keeping the City clean and green
- Looking after people

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take.

Access – access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest.

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2010/11

2010	2011
Thurs 10 June	**Thurs 13 Jan**
Thurs 15 July	Thurs 10 Feb
Thurs 9 Sept	Thurs 17 Mar
Thurs 14 Oct	**Thurs 21 Apr**
Thurs 11 Nov	

** **bold** dates are Quarterly Meetings

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the contained in Article 6 and Part 3 (Schedule 2) of the Council's Constitution.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

Disclosure of Interests

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "personal" or "prejudicial" interests they may have in relation to matters for consideration on this Agenda.

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Personal Interests

A Member must regard himself or herself as having a personal interest in any matter

(i) if the matter relates to an interest in the Member's register of interests; or

(ii) if a decision upon a matter might reasonably be regarded as affecting to a greater extent than other Council Tax payers, ratepayers and inhabitants of the District, the wellbeing or financial position of himself or herself, a relative or a friend or:-

  (a) any employment or business carried on by such person;

  (b) any person who employs or has appointed such a person, any firm in which such a person is a partner, or any company of which such a person is a director;

  (c) any corporate body in which such a person has a beneficial interest in a class of securities exceeding the nominal value of £5,000; or

  (d) any body listed in Article 14(a) to (e) in which such a person holds a position of general control or management.

A Member must disclose a personal interest.

Continued/……

Prejudicial Interests

Having identified a personal interest, a Member must consider whether a member of the public with knowledge of the relevant facts would reasonably think that the interest was so significant and particular that it could prejudice that Member's judgement of the public interest. If that is the case, the interest must be regarded as "prejudicial" and the Member must disclose the interest and withdraw from the meeting room during discussion on the item.

It should be noted that a prejudicial interest may apply to part or the whole of an item.

Where there are a series of inter-related financial or resource matters, with a limited resource available, under consideration a prejudicial interest in one matter relating to that resource may lead to a member being excluded from considering the other matters relating to that same limited resource.

There are some limited exceptions.

Note: Members are encouraged to seek advice from the Monitoring Officer or his staff in Democratic Services if they have any problems or concerns in relation to the above.

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

In accordance with the Local Government Act, 2000, and the Council's Code of Conduct adopted on 16th May, 2007, Members to disclose any personal or prejudicial interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Panel Administrator prior to the commencement of this meeting.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the Minutes of the meetings held on 29 July 2010 and to deal with any matters arising, attached.

7 GOVERNMENT HEALTH WHITE PAPER 2010 - "EQUITY AND EXCELLENCE: LIBERATING THE NHS"

Report, of the Head of Policy and Performance, detailing for discussion the current Government White Paper attached.

8 UNSCHEDULED CARE ACROSS SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH

Report, of the Executive Director for Unscheduled Care for Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) outlining the proposals for a model of unscheduled care within the region, attached

9 UNSCHEDULED CARE (EAST SOUTHAMPTON) OPTIONS FOR BITTERNE WALK IN CENTRE

Report, of the Director of Health and Adult Social Care, detailing the work underway in relation to unscheduled care in East Southampton and the options for the future of Bitterne Walk in Centre, attached.

WEDNESDAY, 1 SEPTEMBER 2010 SOLICITOR TO THE COUNCIL

SCRUTINY PANEL B

MINUTES OF THE MEETING HELD ON 29 July 2010

Present: Councillors Capozzoli (Chair), Daunt (Vice-Chair), Drake, Harris, Payne and Parnell

Apologies: Councillor Marsh-Jenks

7. **APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)**

Apologies were received from Councillor Marsh-Jenks.

8. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the minutes for the Scrutiny Panel B Meeting on 10th June 2010 be approved and signed as a correct record. (Copy of the minutes circulated with the agenda and appended to the signed minutes).

9. **PATIENT SAFETY IN ACUTE CARE INQUIRY**

The Panel considered and noted the report of the Executive Director of Health and Adult Social Care detailing the Inquiry's Terms of Reference and Inquiry Plan, (Copy of the report circulated with the agenda and appended to the signed minutes).

RESOLVED that the terms of reference and inquiry plan be approved.

10. **PATIENT SAFETY IN ACUTE CARE INQUIRY – BACKGROUND AND CONTEXT**

The Panel considered the report of the Head of Policy and Improvement for Southampton City Council presenting a paper from the Director of Nursing (at the Southampton University Hospital Trust) and the Associate Director of Performance and Integrated Governance (NHS Southampton City) detailing the quality assurance framework for acute care in Southampton.(Copy of the report circulated with the agenda and appended to the signed minutes). .

The Head of Health and Community Care briefed the Panel on the following matters:

- the National context in relation to the "Equity and excellence: Liberating the NHS" white paper. The briefing indicated the key strategic aims of the Paper, listed below, and briefly indicated how this would affect the provision of acute care in the City:
  - Putting patients and public first;
  - Improving healthcare outcomes;
  - Autonomy, accountability and democratic legitimacy; and
  - Cutting bureaucracy and improving efficiency

- it was explained that the Paper set out the roll that Local Authorities would have responsibility for in the future stating that their responsibilities would now include:
  - promoting joined up commissioning of local NHS Services, social care and health improvement;
  - leading joint strategic needs assessments;
  - supporting the local voice; and

- Leading on health improvement and prevention activity with the Director of Public Health becoming an Local Authority employee; the creation of a National Public Health Service.

- the Panel were informed that the White Paper made specific reference to patient care throughout requiring:
  - "a culture of open information, active responsibility and challenge" ;
  - "increasing amounts of robust information, comparable between similar providers, on……. Safety: for example, about levels of healthcare-associated infections, adverse events and avoidable deaths, broken down by providers and clinical teams" and
  - the Care Quality Commission to be strengthened for its focus on safety and quality of providers;

- the briefing detailed set of national outcome goals that will provide an indication of the overall performance of the NHS emphasising Domain 5 " treating and caring for people in a safe environment and protecting from avoidable harm."

- the five areas for improvement that have been identified in the Paper

- it was explained that General and Acute secondary health care in the City of Southampton costs £128 million which is 32% of the £400m health care spending of the Primary Care Trust;

The Director of Nursing (at the Southampton University Hospital Trust) and the Associate Director of Performance and Integrated Governance (NHS Southampton City) were in attendance and, with the consent of the Chair, addressed the meeting detailing their paper attached to the report.

The Panel noted the procedures, detailed within the paper already in place. across the Southampton's health providers for both the internal and external scrutiny of procedures relating to patient safety and particular events. In particular the specific role of the Care Quality Commission and Monitor were further detailed.

It was explained that the health providers in the City were working together to ensure that quality of care provision remains central to the commissioning of care.

DECISION-MAKER:	PANEL B
SUBJECT:	GOVERNMENT HEALTH WHITE PAPER 2010 - "EQUITY AND EXCELLENCE: LIBERATING THE NHS"
DATE OF DECISION:	9 SEPTEMBER 2010
REPORT OF:	CHIEF EXECUTIVE NHS SOUTHAMPTON CITY AND THE DIRECTOR HEALTH AND ADULT SOCIAL CARE, SOUTHAMPTON CITY COUNCIL

AUTHOR:	Name:	Caronwen Rees	Tel:	023 8083 2524
	E-mail:	Caronwen.rees@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
None

SUMMARY

To inform members of the proposals set out within the White Paper “Equity and excellence: Liberating the NHS” and the implications for Southampton.

RECOMMENDATIONS:

(i) To receive a joint presentation from NHS Southampton City and Southampton City Council on the NHS White Paper.

(ii) To consider the implications for the city of the White Paper and the options for responding to the consultation papers.

REASONS FOR REPORT RECOMMENDATIONS

1. To ensure members are aware for the proposals and have the opportunity to contribute to the consultation.

CONSULTATION

2. The Government are currently consulting on the NHS White Paper.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None.

DETAIL

4. The Department of Health published the White Paper “Equity and excellence: Liberating the NHS”, on 12th July 2010. It sets out proposals for the NHS to become a truly world-class service that is: easy to access, treats people as individuals and offers care that is safe and of the highest quality. The Governments objectives are to reduce mortality and morbidity, increase safety and improve patient experience and outcomes for all. The deadline for responding to the consultation is 5 October 2010.

5. A number of detailed consultation documents have been published to support the White Paper. The consultation period for each of these documents ends on 11 October 2010.

   a) **"Transparency in Outcomes: A Framework for the NHS",** published on 19 July 2010, provides further information on proposals for developing an NHS Outcomes Framework. The framework is intended to identify a focused but balanced set of outcome measures that will act as a catalyst for driving quality across all services and enable the Secretary of State to hold the NHS Commissioning Board to account by providing an indication on the overall progress of the NHS. Transparency In Outcomes

   b) **"Liberating the NHS: Commissioning for Patients",** published on 22nd July 2010, sets out proposals for putting local consortia of GP practices in charge of commissioning services to best meet the needs of local people, supported by an independent NHS Commissioning Board. GP consortia will be established in shadow form from 2011/12. PCT's will be abolished by April 2013. Providers will be freed from government control to shape their services around needs and choices of patients. Liberating the NHS: commissioning for patients

   c) **"Increasing Democratic Legitimacy in Health",** published on 22nd July 2010, builds on the proposals in the White Paper to increase local democratic legitimacy in health. This will be achieved through local authorities: i) being given a stronger role in supporting patient choice and ensuring effective local voice ii) taking on local public health improvement functions, and iii) promoting more effective NHS, social care and public health commissioning arrangements. This document links closely to the consultation on commissioning for patients. Increasing democratic legitimacy

   d) **"Regulating Healthcare Providers",** published on the 26 July sets out proposals to liberate providers from central Government controls and develop Monitor as an independent economic regulator for health and adult social care. Regulating Healthcare Providers

6. Taken together, these documents set out the strategy for commissioning of health, care and wellbeing. They set out how the new system will work together to provide improved outcomes for patients, users and the public. Many of the commitments require primary legislation and are subject to parliamentary approval. 5 further publications are expected by the end of 2010

7. There are several elements where there will be significant change and these are set out below, including some of the implications for Southampton. However, We must not lose sight of our current strategy to improve quality and efficiency. It is just as important, if not more so, as the future governance and delivery arrangements.

Governance and accountability:

8. There will be an enhanced role for elected Local Councillors and Local Authorities(LA's):

- Stronger institutional arrangements, within councils, led by elected members, to support partnership working across health and social care, and public health. The Government prefers for upper tier councils to have a statutory role to support joint working on health and wellbeing.
- Council will have the freedom and flexibility to decide how the health and wellbeing boards would work in practice. Their primary aim would be to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability. The council would bring partners together to agree priorities for the benefit of patients and taxpayers, informed by local people and neighbourhood needs.
- Supporting statutory health and wellbeing boards which would have four main functions:
    a. to assess the needs of the local population and lead the statutory joint strategic needs assessment
    b. to promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health
    c. to support joint commissioning and pooled budget arrangements
    d. to undertake a scrutiny role in relation to major service redesign

9. These new arrangements will replace the current statutory health scrutiny functions. This requires work to be undertaken to strengthen the governance and accountability structures for the local Joint Strategic Board and to review the Health and Well-being Partnership. Membership will include representation from the local HealthWatch and the local GP consortia. A formal health scrutiny function will continue to be important within the local authority, and the local authority will need to assure itself that it has a process in place to adequately scrutinise the functioning of the health and wellbeing board and health improvement policy decisions.

Public Health:

10. Primary Care Trust (PCT) responsibilities for health improvement will transfer to Local Authorities. The aim is to breakdown barriers between health and social care funding to encourage preventative action. Directors of Public Health will be joint appointments between LAs and the new national Public Health Service. Directors of Public Health in councils will become responsible for a newly ring-fenced public health budget allocated according to relative population health need. This will include a health premium designed to reduce health inequalities. There are concerns about availability of adequate funding for any additional managerial costs. Locally the Director of Public Heath is a joint LA/PCT appointment. It is proposed that local neighbourhoods will have freedoms and flexibility to set local priorities, working within a national framework. The programme for Public Health will be outlined in a White Paper in November/ December 2010.

Commissioning:

11. The work on commissioning will have to take on board what personalisation means and how this works in practice. Given the wider personalisation agenda, it is vital for the council to ensure there are links between GP commissioning and the Council.

- Payment system to be altered so that money follows the patient and reflects quality and payment will be on the basis of excellent care rather than average price. We need to consider how this will affect Southampton as it may have a knock on effect both in terms of commissioning and as a provider.
- NHS Commissioning Board will commission general practice, dentistry, community pharmacy and primary ophthalmic services plus national and regional specialised services.
- Power and responsibility for commissioning services will be devolved to local consortia of GPs who will need to work with other health and care professionals, local communities and local authorities. GP consortia may choose to buy in support for this from other organisations including LAs and the private and voluntary sector.
- They will also have a duty to work in partnership with Local Authorities in relation to social care, early years, public health, safeguarding and the older population.

Patient and Public Engagement:

12. LINks will become the local HealthWatch. Like LINks, HealthWatch will continue to promote patient and public involvement, and seek views on local health and social care services which can be fed back into local commissioning. They will have additional responsibilities and the government proposes that local HealthWatch be given additional functions and funding. They will also perform a wider role, so that they become more like a “citizen’s advice bureau” for health and social care - the local consumer champion - providing a signposting function to the range of organisations that exist. They will have additional funding for NHS complaints advocacy services. Councils have a vital role in commissioning HealthWatch arrangements. The local authority will be responsible for holding the local HealthWatch to account for service delivery, and can intervene in cases of under-performance. Increasing choice will be key and increased access to information. This has implications for all advice and information services across the council, health system and other organisations

Performance:

13. This will be more outcomes focused. The separate outcome frameworks for the NHS, public health and social care will provide clear accountability and enable better joint working. The role of the Care Quality Commission will expand to become an effective quality inspectorate across health and social care. Locally there needs to be further integration of performance management systems across health and social care.

Social Care:

14. Expectation that with councils taking a convening role, we will have the opportunity to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and tackling crime and disorder. A document is to be released before the end 2010 on the vision for adult social care with a White Paper in 2011. As part of an increase in personalised care planning, more personal health budget pilots will be developed. There are opportunities for this to be joined up with social care personal budgets and there will need to be consideration of how this process could work.

Funding:

15. Although the government is committed to increasing health spending in real terms in each year of this parliament the NHS will need to achieve unprecedented efficiency gains, especially to meet significant costs of technological and demographic changes. This will have a significant impact on the services and the way they are delivered.

16. New arrangements for joint commissioning and pooled budgets – will need to go beyond specific service areas, such as mental health and learning disabilities. They will seek to secure services that are joined up around the needs of older people or children and families. It is important to engage GPs in the current discussions on joint commissioning approaches within H&ASC and CSL and also funding of appropriate services within Council control.

FINANCIAL/RESOURCE IMPLICATIONS

17. It is not possible to confirm the financial implications at this stage as the proposals are still being consulted upon and further details have yet to emerge.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

18. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

19. None.

POLICY FRAMEWORK IMPLICATIONS

20. The white paper proposals need to be considered in the context of the City's priorities as set out the Southampton City Plan.

SUPPORTING DOCUMENTATION

Appendices

1.	NHS White Paper – Presentation

Documents In Members' Rooms

1.	None

Background Documents

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	Equity and Excellence: Liberating the NHS	

Background documents available for inspection at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

KEY DECISION? **No**

WARDS/COMMUNITIES AFFECTED:	None

NHS
Southampton City
Creating a healthier Southampton

The NHS White Paper

‘Equity and Excellence – Liberating the NHS’

Appendix 1

SOUTHAMPTON CITY COUNCIL

The key aims of the Coalition Government for the NHS are to:

- Uphold the values and principles of the NHS
- Increase health spending in real terms in each year of this Parliament
- Develop an NHS which achieves results amongst the best in the world

NHS
Southampton City
Creating a healthier Southampton

Strategy for the NHS

The NHS White Paper's key strategy points are:

- Putting patients and public first
- Improving healthcare outcomes
- Autonomy, accountability and democratic legitimacy
- Cutting bureaucracy and improving efficiency

As part of the NHS Outcomes Framework, the current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, public health and social care

SOUTHAMPTON CITY COUNCIL

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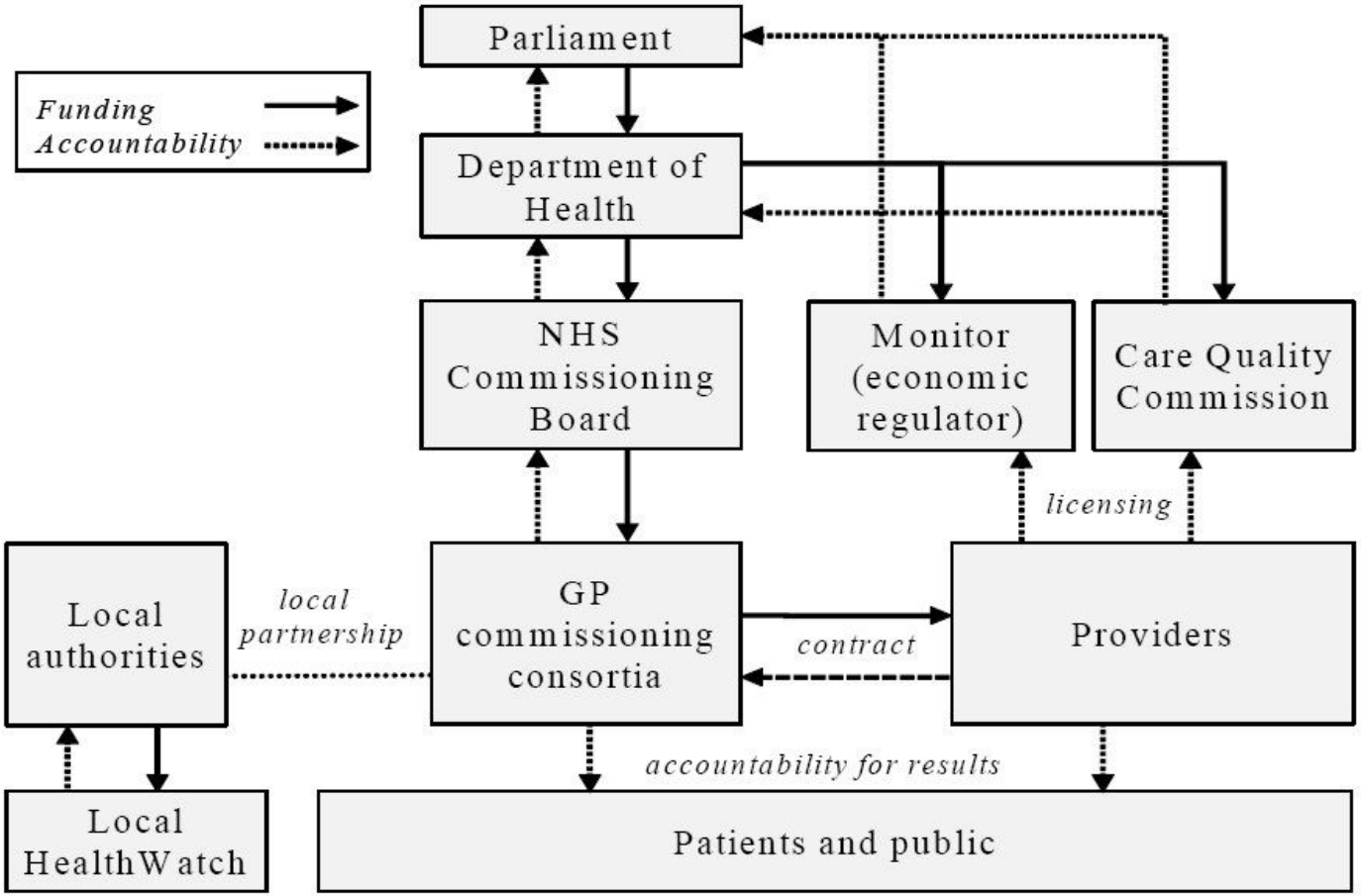
Southampton City
Creating a healthier Southampton

The newly proposed healthcare structure



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GP commissioning consortia

- GP commissioning will be introduced on a statutory basis
- Consortia will work with health professionals, local communities and local authorities to commission the majority of NHS services
- The NHS Commissioning Board will calculate budgets and allocate these to the consortia
- Each will appoint an accountable officer and the Commissioning Board will hold consortia to account

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NHS Commissioning Board

The Board will have five main functions:

- Providing national leadership on commissioning for quality improvement
- Promoting and extending public and patient involvement and choice
- Ensuring the development of GP commissioning consortia
- Commissioning certain services (e.g. Primary Care, national specialised services, maternity)
- Allocating and accounting for NHS resources

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Secretary of State

The key NHS-related functions of the SoS will include:

- Setting a formal mandate for the NHS Commissioning Board
- Holding the NHS Commissioning Board to account
- Arbitration which arises between the NHS and LA
- The legislative and policy framework
- Accountability annually to Parliament

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Local Authorities

As well as taking on the function of joining up the commissioning of local NHS Services, social care and health improvement, LAs will be responsible for:

- Promoting integration and partnership working
- Leading joint strategic needs assessments
- Building partnerships for service changes and priorities

These functions will replace the current Health Overview and Scrutiny Committees (HoSCs)

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Providers

- Providers will be given greater autonomy
- Will form part of plans for “the largest and most vibrant social enterprise sector in the world”
- Within three years, all NHS Trusts will come under the foundation trust regime
- Consultation will take place on increasing foundation trust freedoms

SOUTHAMPTON CITY COUNCIL

Regulators

- Care Quality Commission (CQC) – The CQC will be strengthened for its focus on safety and quality of providers
- HealthWatch (National and Local)
- NICE
- NHS Commissioning Board
- Monitor – Will work with the CQC and be turned into the economic regulator of the health and social care sectors with three key functions:
  - Promoting competition
  - Price regulation
  - Supporting continuity of services

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Key actions for Southampton:

- We must not lose sight of our current strategy to improve quality and efficiency
- Ensuring we have robust commissioning arrangements
- Progressing the provider delivery vehicle –through a NHS FT by April 2011
- Developing strong relationships with GPs and the GP consortium arrangements
- Developing the Health and Well Being Strategic Board
- Developing the HealthWatch arrangements locally
- Modifying and developing the scrutiny arrangements
- Preparations for the transfer of Public Health responsibilities

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The consultation on how to implement the changes is taking place until 5 October 2010 when all comments need to be sent to the DH

SOUTHAMPTON CITY COUNCIL

DECISION-MAKER:	PANEL B
SUBJECT:	UNSCHEDULED CARE ACROSS SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH (SHIP)
DATE OF DECISION:	9 SEPTEMBER 2010
REPORT OF:	EXECUTIVE DIRECTOR FOR UNSCHEDULED CARE FOR SHIP

AUTHOR:	Name:	Dr Paynton	Tel:	02380 296279
	E-mail:	david.paynton@scpct.nhs.uk		

STATEMENT OF CONFIDENTIALITY
Not confidential

SUMMARY

This paper outlines the proposals for a model of unscheduled care within Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP), it does not make any proposals about how it should be delivered.

RECOMMENDATIONS:

(i) To receive a presentation from Executive Director For Unscheduled Care For Ship.

(ii) The note the overall strategic direction for unscheduled care in SHIP and provide comments to be fed into the final document.

REASONS FOR REPORT RECOMMENDATIONS

1. Better patient experience.

2. Improved efficiency and co-ordination between health services and social care across SHIP.

CONSULTATION

3. The proposals are currently being consulted on with all stakeholders in the SHIP area. Feedback can be provided to yourviewscount@hampshire.nhs.uk.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

4. None. The proposal have been developed following a review of the current system including feedback from patients. The proposals are currently being consulted on and are yet to be finalised.

DETAIL

5. The details of the new proposals for the strategic direction for unscheduled care in SHIP are outlined in detail in appendix one. The panel will receive a presentation of the proposals during the panel meeting.

FINANCIAL/RESOURCE IMPLICATIONS

6. Nil at present although the economic modelling will held define financial health and social care cost shifts required to ensure we provide urgent care close to home

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

7. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007

Other Legal Implications:

8. None.

POLICY FRAMEWORK IMPLICATIONS

9. The development of joint commissioning between NHS Southampton City, GP consortium and Local Authorities.

SUPPORTING DOCUMENTATION

Appendices

1.	Unscheduled Care Public Summary
2.	Unscheduled Care Presentation

Documents In Members' Rooms

1.	None

Background Documents

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Background documents available for inspection at: N/A

KEY DECISION? **No**

WARDS/COMMUNITIES AFFECTED:	

How can we improve 'Unscheduled Care'?

Unscheduled care is care that is not planned or pre-booked with your GP or hospital, such as urgent GP appointments, minor injuries or visits to the Emergency Department (A&E).

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.

This vision for unscheduled care has been shaped in recognition of patient needs and to improve services for patients.

This document outlines the current situation, why things need to be improved for patients and 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 are keen to hear your feedback about these initial ideas. This will help to inform our plan to take forward locally.

Please send any comments, views or questions to yourviewscount@hampshire.nhs.uk by September 24, 2010.

A system out of balance

Unscheduled care across Southampton, Hampshire, Isle of Wight and Portsmouth is currently a system out of balance.

Why?

- The numbers of people using unscheduled care services is increasing each year
- Unscheduled care services are delivered differently across Hampshire and the Isle of Wight due to different local developments at different times
- All of this is taking place at a time of financial uncertainty.

What have patients and the public told us?

In our proposal, we have looked at the system from a patient's perspective and have split the population into three main groups:

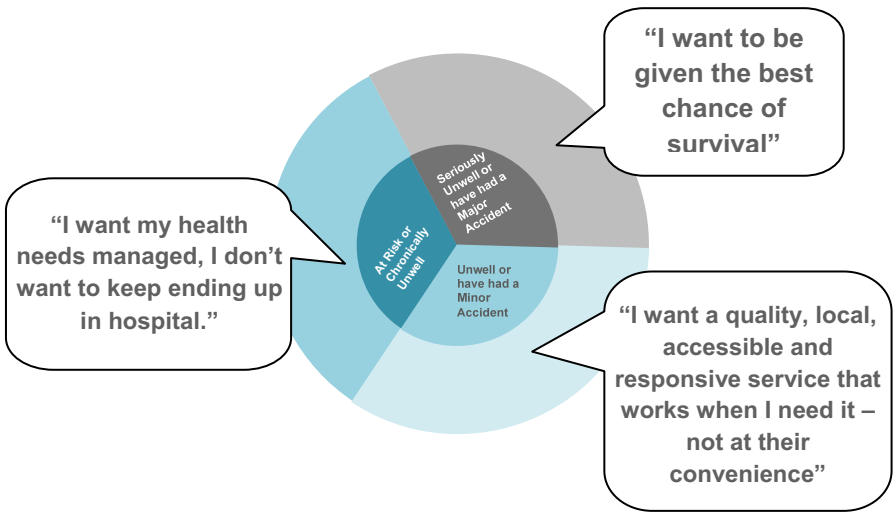
1) Those who are unwell or have had a minor accident, such as a cut hand or a minor illness such as a chest infection

2) Those who are at risk or chronically unwell, such as people with chronic bronchitis, the elderly and those with mental ill health

3) Those who are seriously unwell or have had a major accident, such as people who have had a heart attack or an accident with multiple injuries.

Patients have told us that:

- They are confused and do not know where to go for the right treatment
- They want local, accessible services that open at convenient times so they do not need to travel
- They want their health needs to be managed so they don't end up in hospital if they don't need to and they want to resume normal life as soon as possible.



Principles of the proposed models

This strategy is designed to build on work already taking place to deliver a three to five year plan. The aim is to develop a coherent, co-ordinated system of care that works seven days a week, and where possible 24 hours a day, in line with patient expectations.

Each group of patients deserves the highest quality of care, but their needs are different. This forms the basis for our proposals. The principles are as follows:

- Simpler to use for patients with access to unscheduled care services through the national single access phone number '111' as well as '999'
- Consistency of unscheduled care services within each area
- Ambulance services treating more people at the scene rather then automatically taking everyone to hospital when not necessary
- More treatment closer to home delivered by your GP
- Teams working together to deliver co-ordinated services e.g. GPs, hospitals, social care, pastoral care, befriending and neighbouring schemes all linking together
- Identifying patients who are most at risk, to help avoid repeated unplanned hospital visits by managing their conditions better
- Some centralisation of services to ensure highly skilled, practised teams of consultants are available for patients who need intensive care after a serious accident, including rehabilitation.

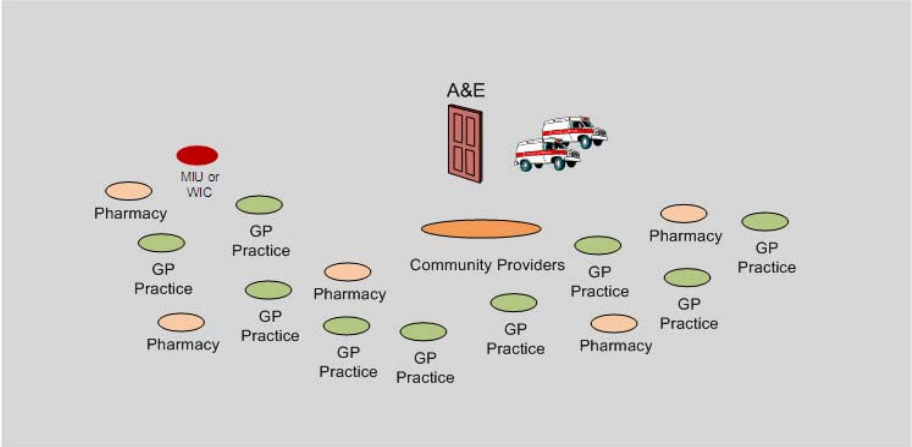
A proposed model for those who are unwell or have minor injuries

This model proposes that services are moved closer to the patient including:

- Access to care closer to home provided by groups of primary care practices working closely with Out of Hours providers
- Greater access to radiology and ultrasound locally to allow diagnoses more quickly
- Primary care services to provide more treatment
- Primary care to be located on the same site as the Emergency Department in some places
- A network of providers for emergency surgery and children's services to ensure consistent high quality care seven days a week.

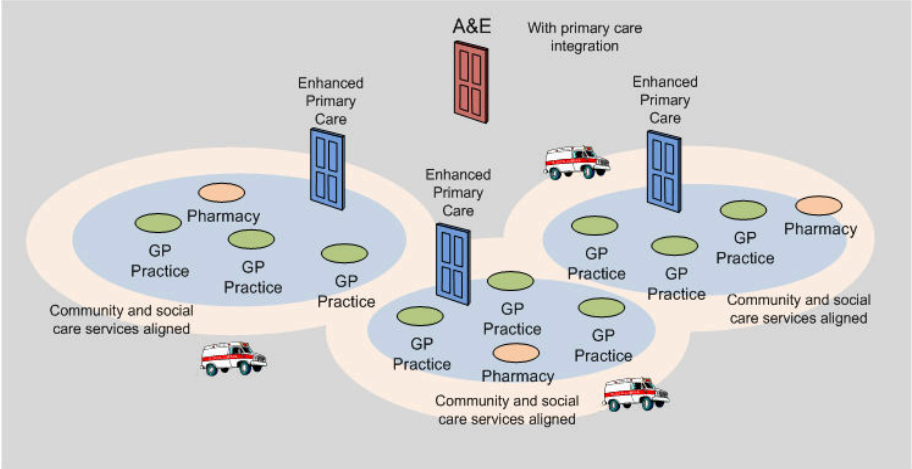
Day Time Models

Current



Currently there are a range of services providing different levels of care that are not necessarily linked up. Different areas will also have different types of services available at different times, causing confusion for patients.

Proposed



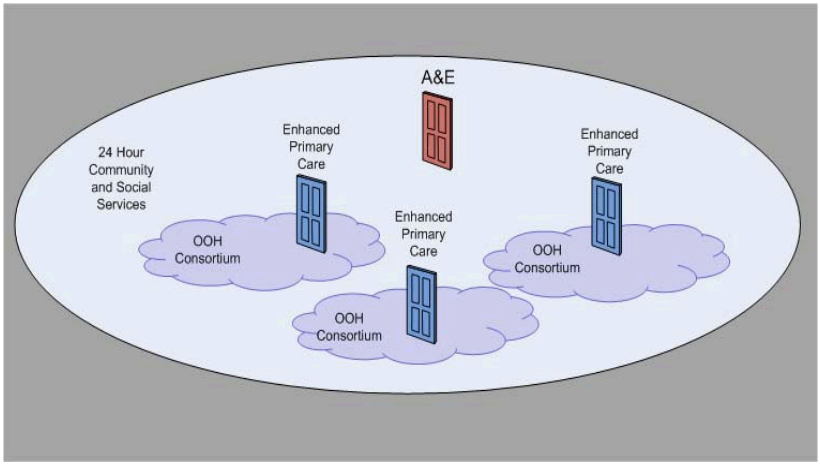
It is therefore proposed that groups of GPs work together with their local pharmacy to provide a similar set of services to patients across Hampshire and the Isle of Wight, with more enhanced services being provided closer to home through primary care. Social and community services will also link in better and primary care will be available at some Emergency Departments to avoid people having to go into hospital unnecessarily.

Night Time Models

Current

There are currently different services available at night, for different levels of care needed. Not all night time services are available 24/7 and they do not necessarily link up with each other, resulting in confusion for people as to where to go. Therefore, many people end up in the Emergency Department.

Proposed



This model proposes groups of providers delivering care 24/7 through enhanced primary care services i.e. GP and pharmacy services. This will also link in with 24 hour services from social care. Although the Emergency Department will always be available people should be able to get treated closer to home to avoid a visit to the Emergency Department unless absolutely necessary.

A proposed model for those at risk or chronically unwell

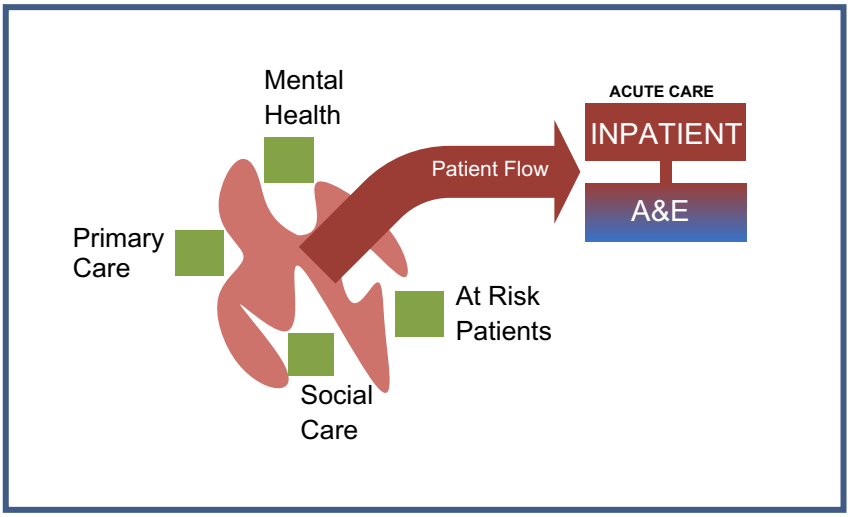
Typically, this group will include:

- Those with chronic conditions (such as chronic obstructive pulmonary disease, coronary heart disease, chronic heart failure, diabetes, asthma etc)
- Those with dementia or other mental health issues
- The frail elderly
- Those people who may be reaching the end of life.

We want to manage more of these patients in the community by co-ordinating services better. This will help ensure their conditions don't progress unnecessarily and should prevent them needing unscheduled care or unnecessary stays in hospital.

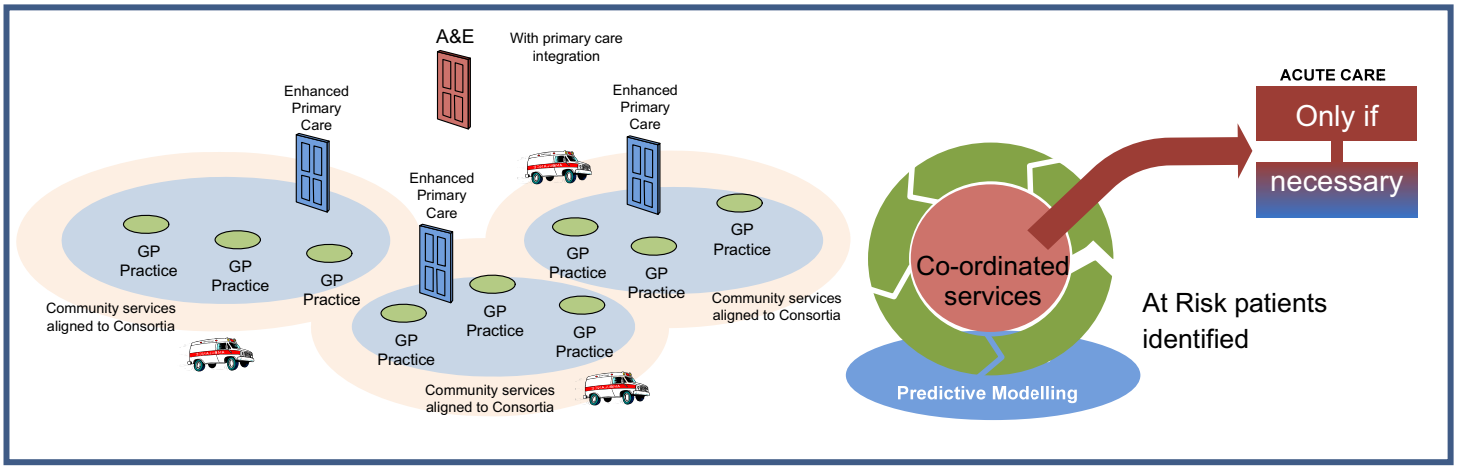
We will also provide the tools to allow GPs to identify and manage patients most at risk before their condition becomes a crisis.

Current model



Currently patients may go through a number of services that are not always aligned to enable conditions to be managed as well as possible. This results in patients needing unscheduled care more often and ending up in hospital.

Proposed model



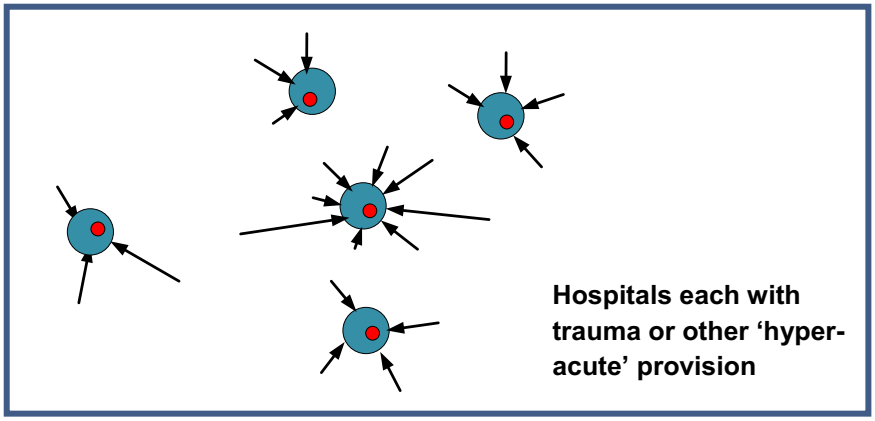
It is therefore proposed that services are developed to be more co-ordinated, tools are provided to identify the most at risk patients and services are delivered closer to home through the enhancement of primary care. This will help avoid unnecessary stays in hospital for those who have long-term conditions or are elderly.

A proposed model for the critically injured and/or ill patient

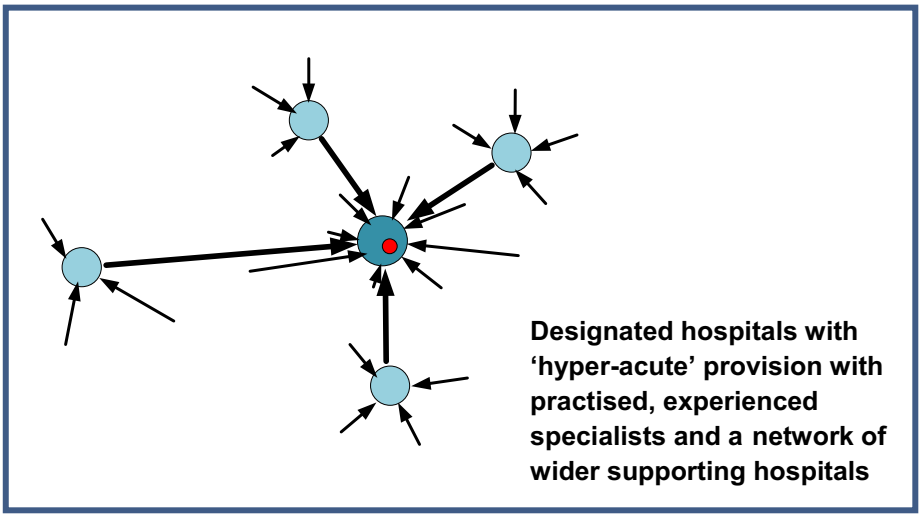
This group represents a small number of patients who require immediate services with a high level of care, such as intensive neuro-surgery or those who have had a major accident.

This work is being led across the south by the South Central SHA. The proposals are for certain hospitals to be chosen as network centres, with a concentration of highly skilled and experienced staff and facilities. Other hospitals will be part of a bigger network concentrating on stabilising/sending and then receiving back local patients when they are out of immediate danger.

Current model



Proposed model – SHA led



In line with future plans for the NHS

The recent NHS White Paper proposes that in the future commissioning will be led by GPs, through GP consortia. Alignment between GP consortia with community and social services will support care in the community especially for those that are considered to be 'at risk'.

These proposals are therefore developed with this in mind and aim to sit within the proposals for how the NHS will be led in the future.

Comments and feedback

We are keen to hear your feedback about these ideas to ensure a final draft of the proposal is developed to reflect local views and comments. This will ensure the best proposal for you.

Please send any comments, views or questions to yourviewscount@hampshire.nhs.uk by September 24, 2010 and we will ensure they are fed back into the final plans.

SHIP

Unscheduled Care

Summary of the strategy for a remodelled system for Southampton, Hampshire, the Isle of Wight and Portsmouth

14 July 2010

Version 0.1

Southampton City NHS Primary Care Trust

NHS Hampshire

NHS Isle of Wight

Portsmouth City NHS Teaching Primary Care Trust

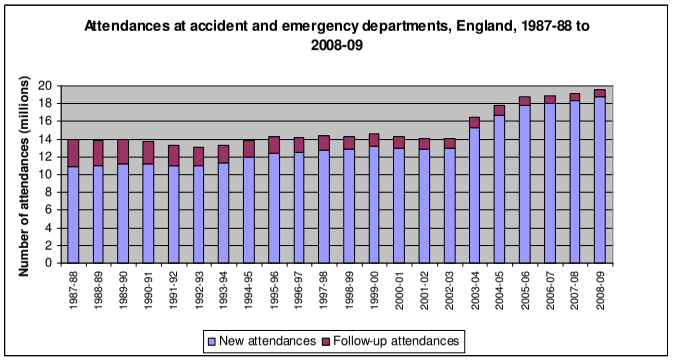
Appendix 2

Introduction

- This document summarises the vision and direction for development of unscheduled care services over the next three years. It describes “what” we propose to see emerge, but is not prescriptive in determining “how” it should be managed.
- The document has been produced in collaboration by NHS Hampshire, NHS Southampton City, NHS Portsmouth City and NHS Isle of Wight (SHIP), working with NHS South Central SHA.
- The strategy segments unscheduled care by three categories of users:
  - Those with **chronic illness** such as mental health, elderly care, end of life and long-term conditions, especially with co-morbidity
  - Those who require **urgent care** such as minor trauma and illnesses needing an experienced primary care response for the initial assessment and treatment
  - Those who require **emergency care** such as major trauma, needing immediate access to fully staffed hospitals with senior clinical capability
- It articulates the underlying problems for each segment and proposes a strategic approach to resolve those problems. With the proposed centralisation of emergency care around major trauma networks, urgent care will become more accessible closer to home, with the responsibility for managing chronic illness based within primary care consortia
- The new models of care summarised here will, over the summer months, be costed and populated with detailed information drawn from initiatives that allow new ways of understanding how the unscheduled care systems work across SHIP. It is then for local communities, clinicians and commissioners to determine how best the model should be co-designed locally

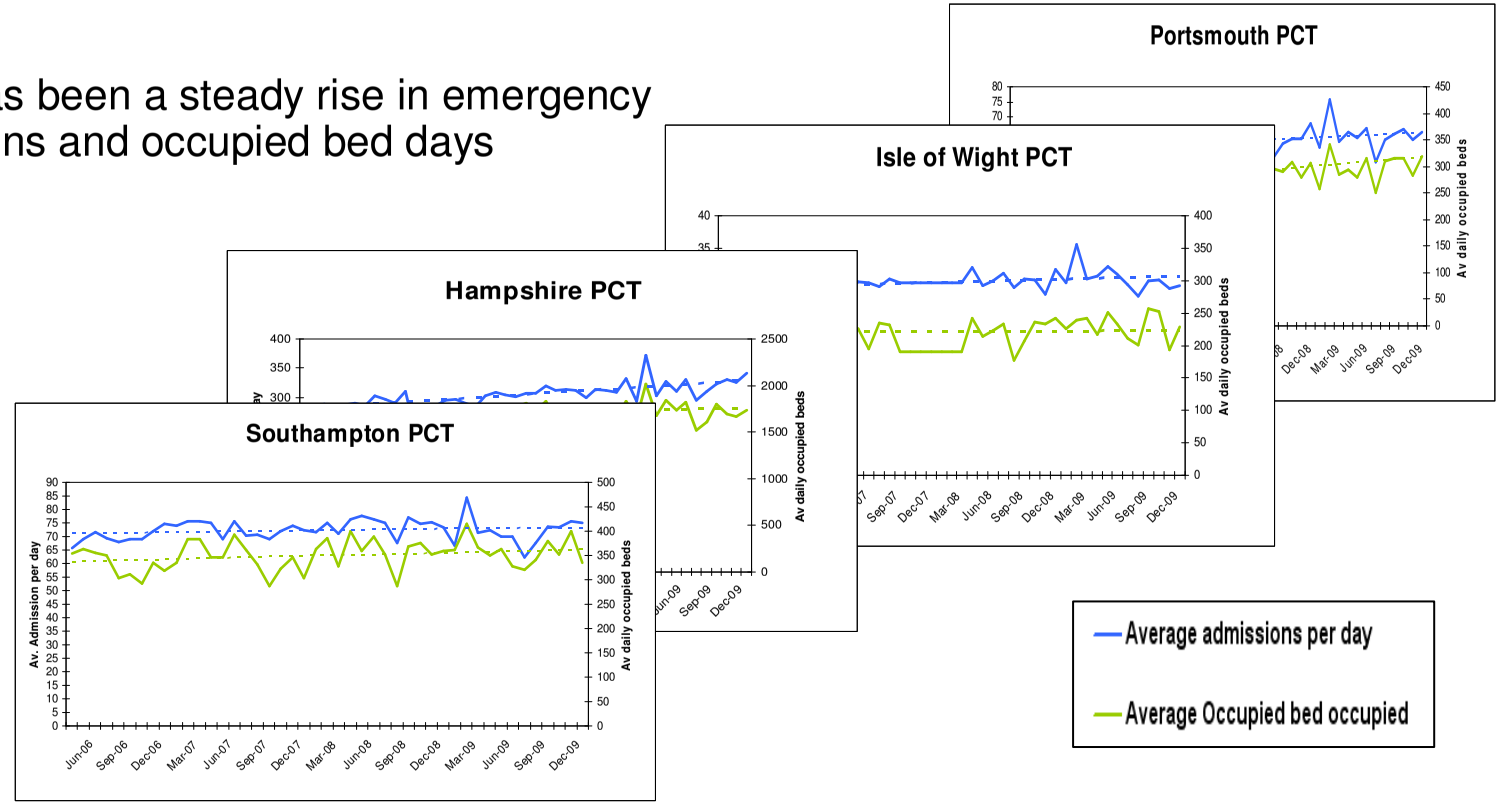
Unscheduled Care – System not in balance

- Attendance at A&E has increased dramatically since 2002



- There is unacceptable variation in trauma care across England (NAO Report, 2010)

- There has been a steady rise in emergency admissions and occupied bed days



The Unscheduled Care Strategy begins by considering the public and patient perspective

Consider three very different perspectives of three typical user groups; 'the unwell', 'the at risk' and the 'critically ill'. Consider each prior to making contact with the health system:

- *What are their differing expectations?*
- *In what way does the current system let them down?*
  (even though in all cases they may not realise it)
- *How we might develop a better model for each?*
- *How in each case that model is better for the patient, whilst making significant productivity improvements.*

In what way do our current services not meet our ‘Unwell or Minor Accident’ patient needs?

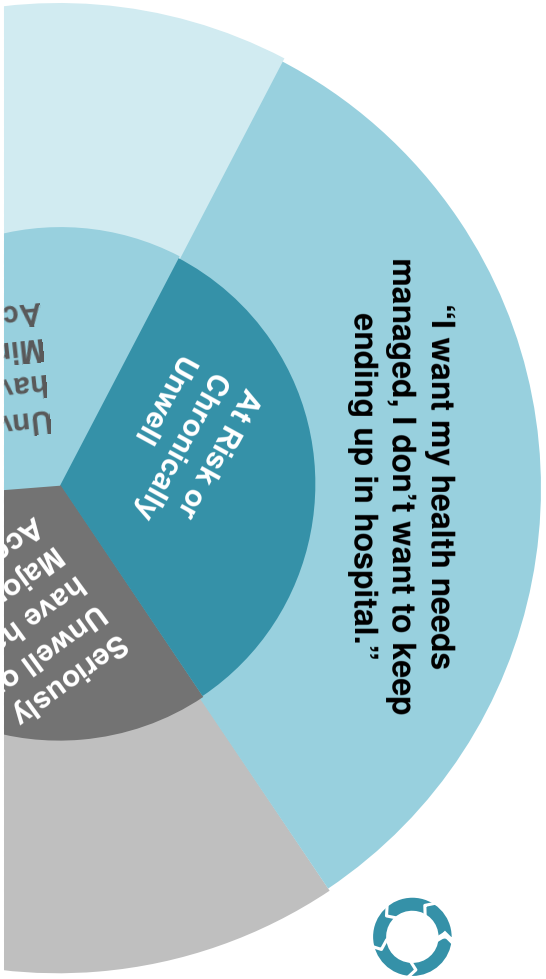
Unwell or minor accident

Our primary care, Out of Hours, A&E and Minor Injuries Units have developed over time in a rather uncoordinated and reactive way, responding more to political imperative than planning based on empirical evidence and patient needs.

The issues are:

- Postcode lottery provision in most primary care services (such as GP availability, accessibility, opening times)
- An inability to see your GP in a timely manner and at a time of your choosing. Primary care receptionists may sign post to A&E if no appointments available
- Variable OOH service which is not integrated with primary care (exacerbated with GP contract change)
- Public confusion as to which is the most appropriate service for what
- An A&E that has to provide a catch all for those areas that do not have adequate GP and OOH services
- High numbers of paediatric admissions without an overnight stay
- High proportion of worried parents/carers :1 in 4 people accessing NHS Direct relate to a sick child between 0-4 years of age
- A system that continues to put in place symptom solutions (GP front ends to A&E and MIUs that very few use) instead of dealing with the underlying issues
- Inefficient use of its resources and inability to embrace alternative approaches that benefit patients. (Surgery opening hours / telephone surgeries etc.)

In what way do our current services not meet our ‘At Risk or Chronically Ill’ patients’ needs?

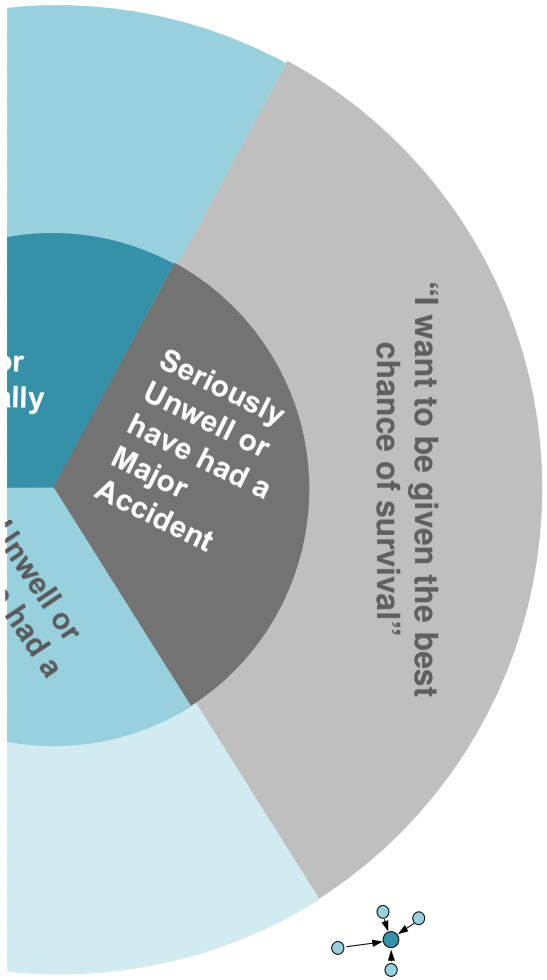


Our Chronically Ill and At Risk patients are normally dealt with either when they turn up at the GP surgery or when they ‘crash’ in some way and end up in hospital. Unless they are being ‘case managed’ (very few, very high risk patients) the systems reacts

The issues are:

- Variable management of patients – need to be more consistently proactive
- The same amount of GP time allocated to a chronic patient as to someone with a minor complaint
- Most patients have co-morbidities, yet services are set up for specific diseases
- Lack of co-ordination of services (intra-health and between Health and Social Services)
- For vulnerable patients a feeling of lack of control
- Lack of skilled staff in primary care and intermediate services; breadth and depth (so hospital or nothing)
- Lack of expert advice in community (eg Community Gerontologist or Paediatrician)
- An endless succession of GP visits, repeat prescriptions, hospital visits with huge waits and emergency crashes in between

In what way do our current services not meet our 'Seriously Unwell or Major Trauma' patient needs?



Seriously Unwell or Major Trauma

In services such as Stroke/Cardiac/Trauma where:

- **The incidence rates are relatively low for a typical hospital catchment, and**
- **Where the skill and resource requirement are high**
  (Consultant, Nurse, and possibly equipment and diagnostics.)

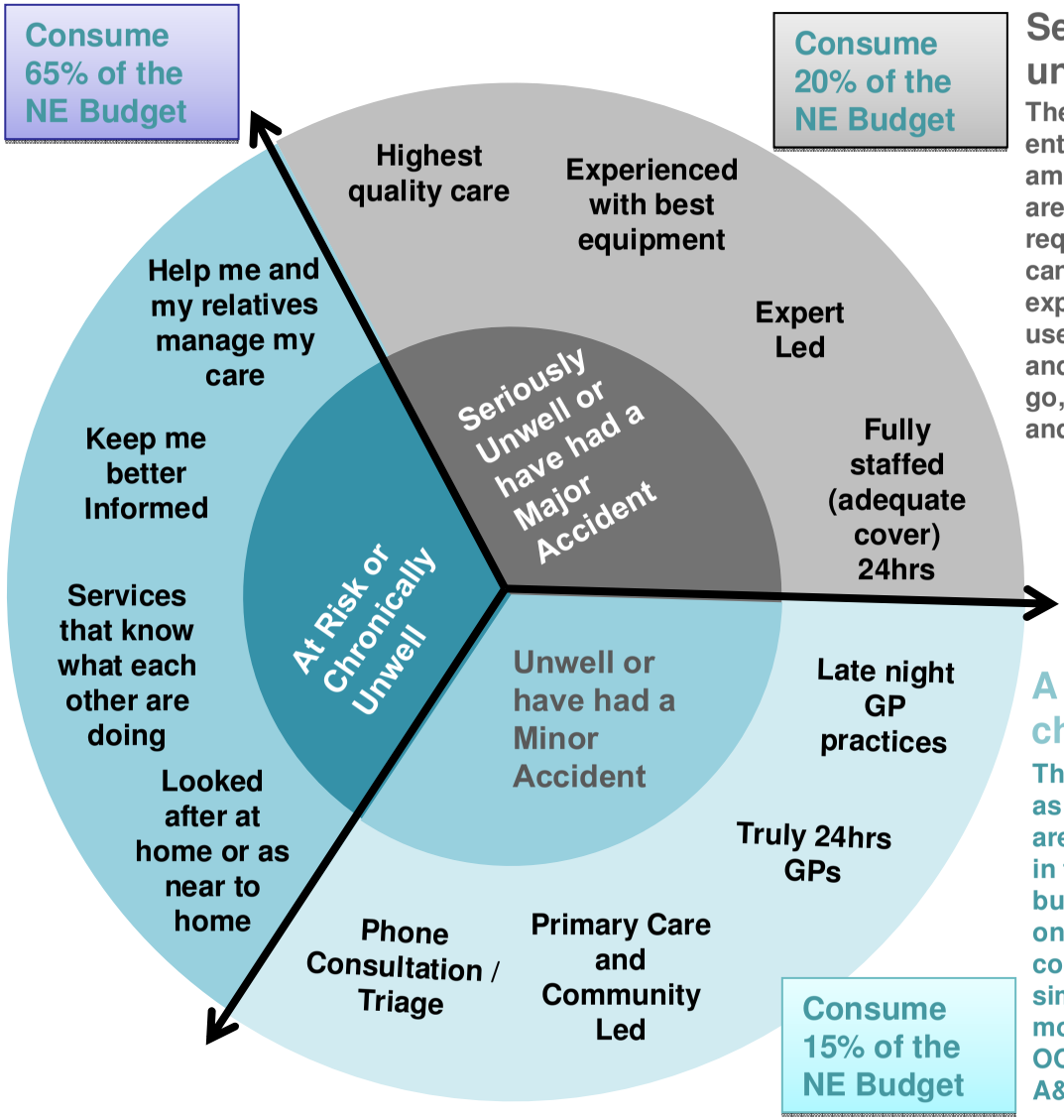
The issues are:

- Insufficient Consultant or nursing cover
  (With an inability to find new staff because of insufficient stock to draw from and because those available are attracted to hospitals with a 'name' in that particular field.)
- Inability within many hospitals to maintain skills (due to relatively low activity)
- Problem exacerbated for paediatrics (which represent a small proportion of this segment)
- Frequent inability to admit patients or inappropriate delay (sometimes necessitating long transfers)
- Outcomes falling or lower than in healthcare systems in equivalent western economies (National Audit Office Report, 2010)
- Inefficient use of clinical resources

This Unscheduled Care strategy addresses the public demand for the highest quality service where and when they need it.

A person with a chronic illness:

These are the patients who are at risk or chronically ill. They manifest in the system as 'frequent fliers'. They frequently use the system for minor things, such as repeat prescriptions and with the day to day issues of dealing with chronic illness, as well as having periods of acute exacerbation or 'falls' often due to poor management of their conditions. These patients currently turn up for treatment in the system as a minor or major incident. The significant difference for this group – is that they can identify themselves, and if we can too – can we better manage their problems to produce better patient outcomes and avoid downstream cost?



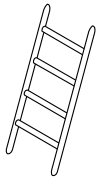
Serious injury or unexpected illness:

These are the patients who will be entering the system through an ambulance, and or via A&E. They are not making choices – they are requiring a responsive service that can ensure they receive the right expert clinical intervention, that are used to dealing with their problem, and that are primed and ready to go, with all the ancillary services and backup needed.

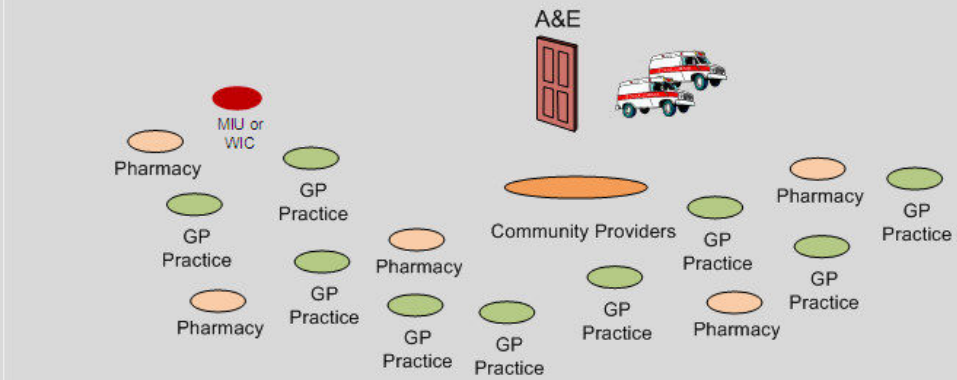
A working family with children:

These are the worried well, as well as the possibly seriously ill! They are a more demanding public than in the past, and just as work and business makes higher demands on them in terms of flexibility and communications, so they expect similar from their health service: a more flexible GP service, a real OOH alternative, an unclogged A&E.

The ‘Unwell or Minor Accident’ patient Segment



Minor Illness and Minor Accident – daytime model



Current Configuration

Predominantly planned GP appointments, typically 8 to 6.30, 5 days a week

A&E and Ambulance is the only unplanned alternative

Proposed Configuration

A 'Practice consortium' approach to Primary Care Provision 12 to 15 hrs a day 7 days a week

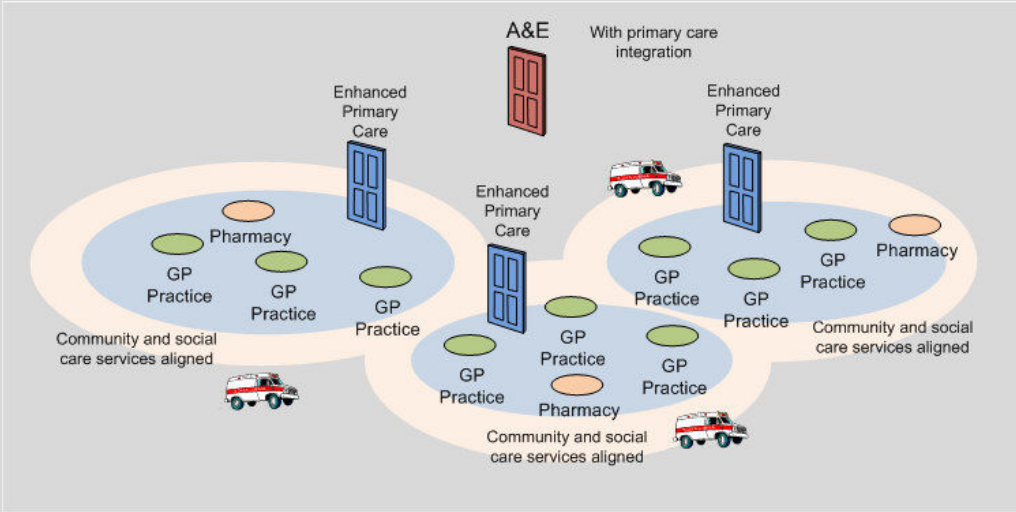
Where Practice consortia are charged with providing:

- **Unscheduled care services / drop in facility**
- **Some early morning & late evening GP surgeries**
- **Usual planned practice surgeries**
- **Smoothed patient flows (waiting times)**

Ambulance see, treat and if necessary refer

A&E still available to patients but consortia charged if used

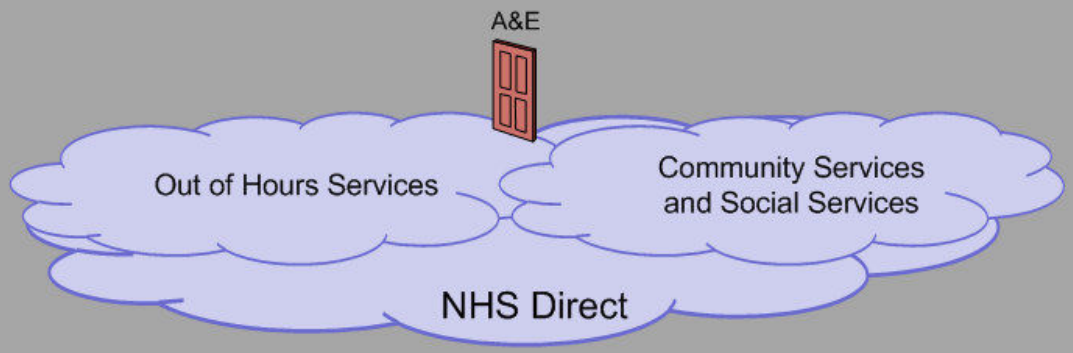
A&E to have integrated primary care team



Minor Illness and Minor Accident – night time model

Current Configuration

Variable OOH service supported by GPs mostly doing phone triage



Proposed Configuration

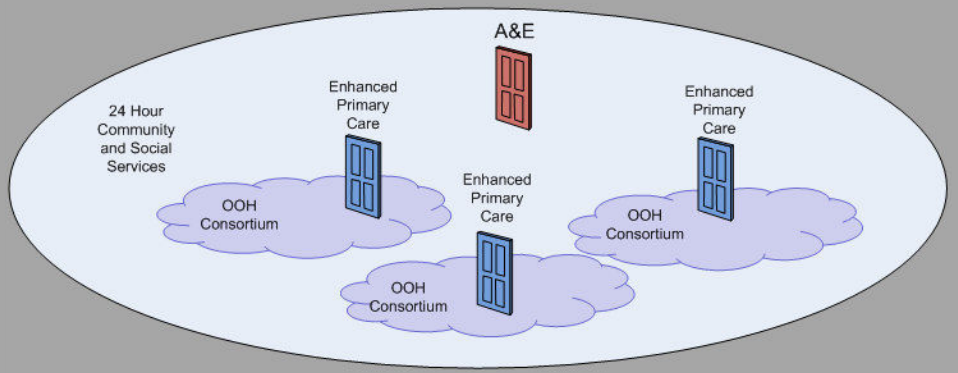
A more 'Practice consortium' approach to Primary Care Provision

Where Practice consortia are charged with providing:
- **Community A&E OOH**
- **Some evening Practice surgeries**

Ambulance see, treat and if necessary refer

A&E still available to patients but consortia charged if used

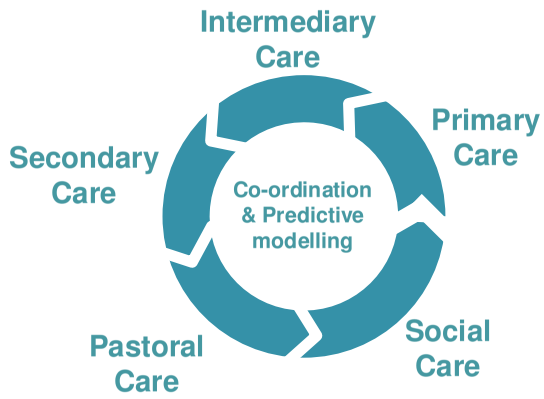
Automatic routing of GP telephone numbers to night time cover



The ‘At Risk or Chronically Ill’ patient’ Segment

A new model to meet our 'At Risk or Chronically Ill' patients' needs:

The broad approach: Pro-active Co-ordination



The premise:

- A relatively small but increasing proportion of patients (the chronically ill and the at risk) drive a significant proportion of the whole Non-elective Secondary care costs
- If we can manage more of these patients we can avoid them using secondary care, and keep their diseases from progressing (outcome and economic gains)
- A significant proportion of these patients that currently occupy secondary care beds actually only need either intermediary care or nurse led home help
- We can find these patients before their condition deteriorates (using GP and secondary care data and predictive modelling techniques) and therefore prioritise our resources around the care of these patients

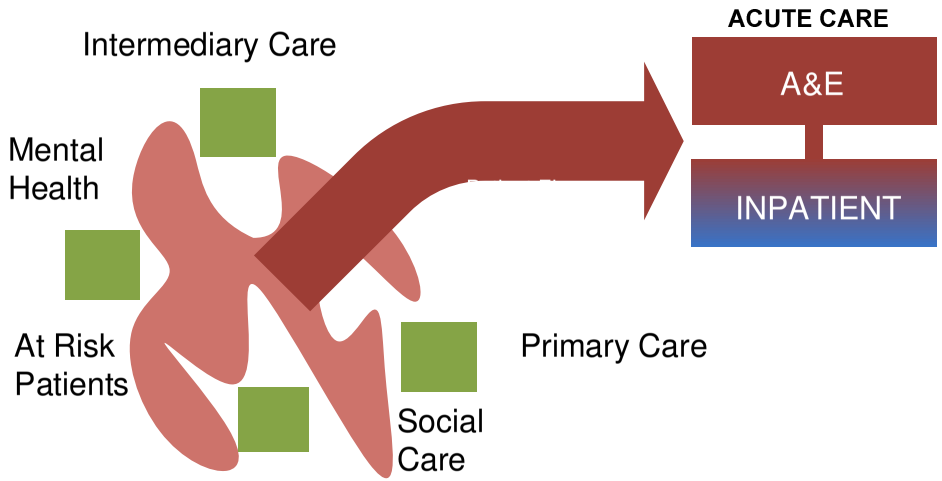
This approach will necessitate a new suite of supporting services. Such as:

- Case Management (probably already exits)
- Virtual Wards
- Expert Patients
- Telephonic Health Coaching

At Risk and Chronically Ill include all those within the public that are at high risk of needing secondary care:

- those with co-morbidities
- those with chronic conditions
  (such COPD, CHD, CHF, Diabetes, Asthma etc)
- those with dementia or other mental health issues
- the frail elderly, or those at EOL

At Risk or Chronically Ill Model

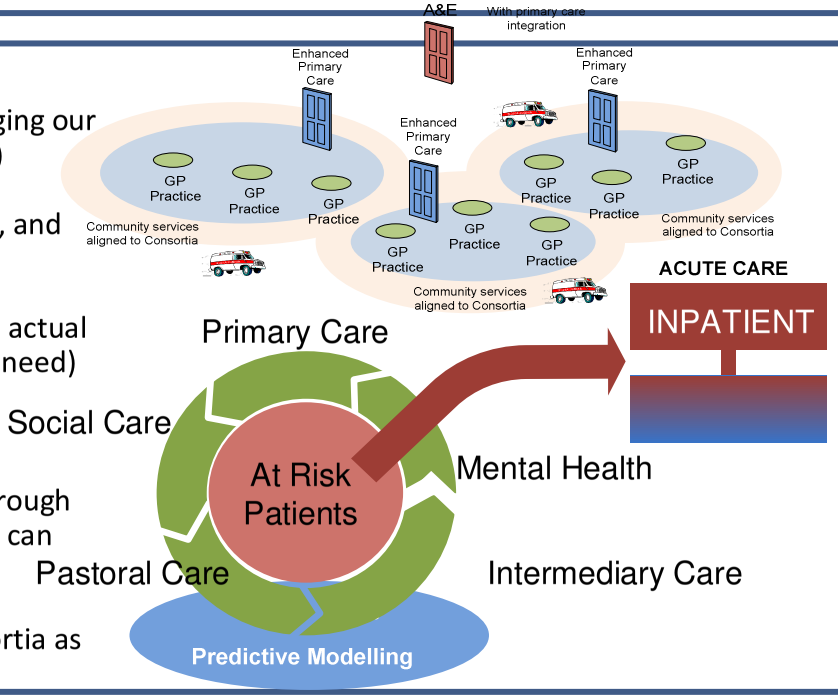


Current Configuration

- Re-active management of patients (A service characterised by an emphasis on secondary care)
- Lack of co-ordination of services (intra-health and between health and Social Services)
- Lack of skilled staff in primary care and intermediate services; breadth and depth (so hospital or nothing)
- Lack of expert advice in community (eg Community Geriatrician)

Proposed Configuration

- Pro-active management of patients (for our 'at risk population: changing our reactive culture to one with an emphasis on 'Planned Primary Care'.)
- Co-ordination of health services (inc. Mental Health) as well as Social, and Pastoral Care
- A better balance between Primary and Secondary provision based on actual need and an avoidance/prevention agenda (reducing secondary care need)
- Some mechanism for sharing budgets and/or aligning incentives
- New services especially telephonic and outreach related, targeted through predictive modelling to find and manage those patients on whom we can have the greatest impact.
- Urgent/emergency care in this segment care handled by same consortia as previously



A strategy that concentrates on initiatives around the high and moderate risk patients (likely to be mainly the chronically ill & elderly) offers the potential to achieve substantial health gains and more effective use of resources.

Characteristic / Approach

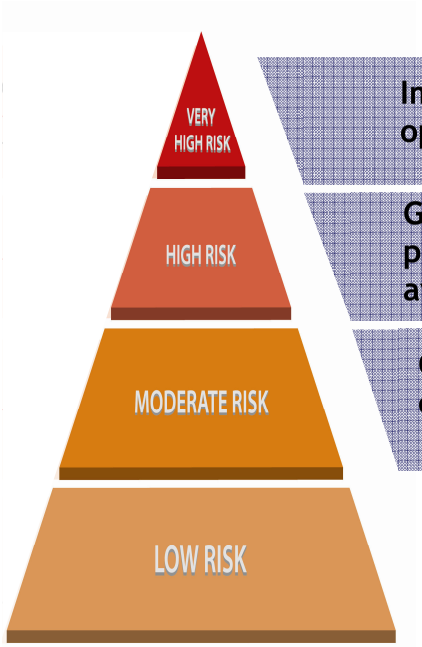
Complex Needs / Co morbidities: Complex Care Management

Established single illness: Disease and care management

Early Onset: Advice and monitoring

Well but at risk pop: Lifestyle change programmes

Well and low risk: Prevention, promotion, screening



Opportunity

Improve quality of care for patients / more limited opportunities for efficiency savings

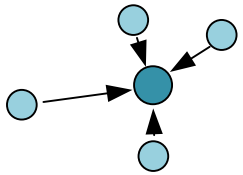
Greatest opportunities for short or medium term productivity efficiencies through alternative provision avoiding inappropriate admissions while improving care

Greatest opportunities for long term productivity efficiencies through preventative care

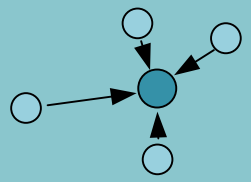
At Risk or Chronically Ill

Predictive modelling to specify high risk population concentrates our efforts where they are likely to have the greatest impact in terms of health improvement and productivity

The ‘Seriously Unwell or Major Trauma’ patient Segment



A different model for our ‘Seriously Unwell or Major Trauma’ patient needs;



The Case for a Network Approach (or Centralisation of service)

For low volume high resource services

Cons

Patient distance from designated network centre

Politically difficult

Public believe they are being exposed to a ‘transfer risk’

Other linked services destabilised

Clinical staff have to travel

Ambulance service requires additional patient transfer skills

Requires active approach to repatriation of patients

Pros

Better Outcomes

Availability (turn-away reduced)

More efficient use of resources
(Current distributed delivery often simply do not have sufficient skilled resources)

Controlled / managed transfer
(risks no greater, probably less, than a distributed service)

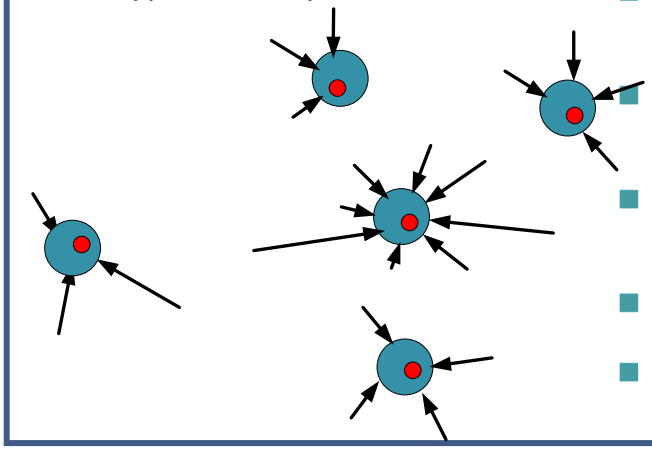
Easier for clinical staff to maintain their skills

Predictable work flow

Better clinical cover and more experienced clinical staff (reduced service risk)

‘Seriously Unwell or Major Trauma’ patient Model

Hospitals each with Major Trauma or other ‘hyper-acute’ provision

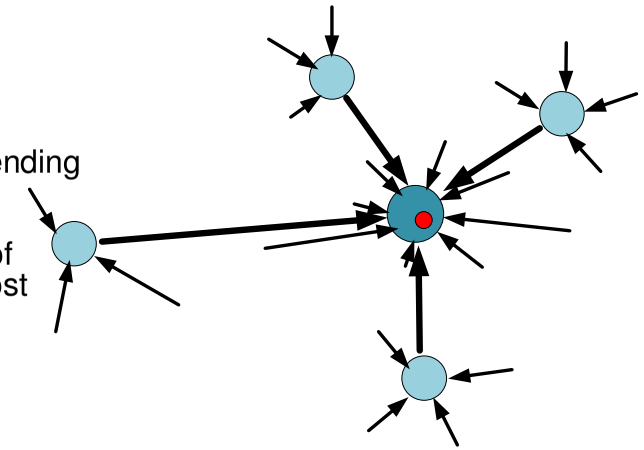


Current Configuration / Issues

- Every hospital in region attempting to provide almost all of the most complex care interventions to its local patients
- Outcomes falling or lower than in healthcare systems in equivalent western economies (National Audit Office Report, 2010)
- Insufficient clinical cover and activity levels that do not allow staff to maintain skill levels
- Frequent inability to admit patients necessitating transfer or inappropriate delay
- Inefficient use of resources

Proposed Configuration – South Central SHA led

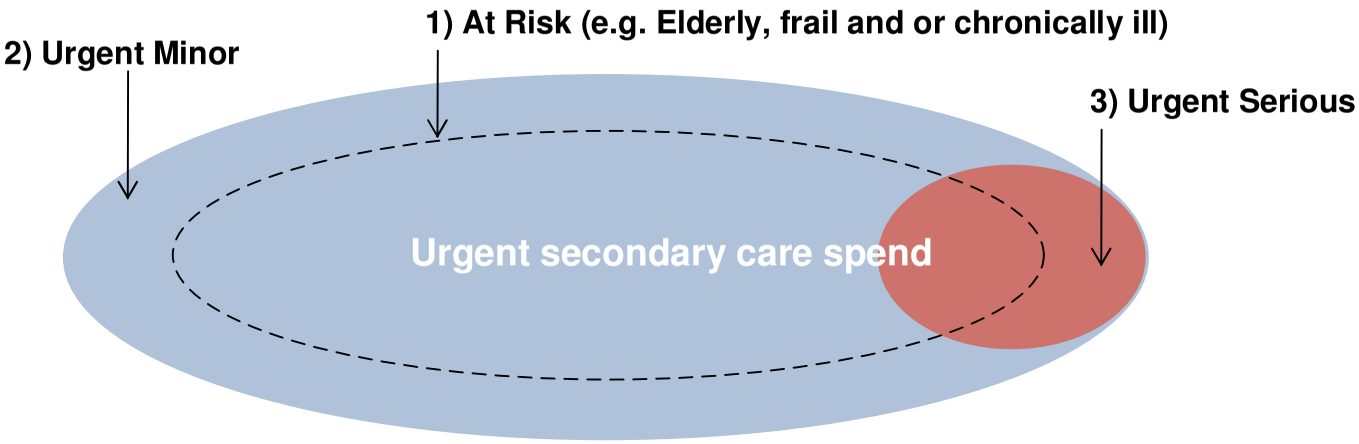
- Designate some hospitals as Network Centres concentrating highly skilled and experienced staff and facilities at those centres
- Designate other hospitals as Network Partners that are geared to stabilising/sending and receiving back local patients
- Ensure networks are optimised with an emphasis on reducing the probability of ‘turn-away’ to an acceptably low level – balanced with efficiency of resource/cost
- Ensure the transportation of patients is anticipated, funded and managed
- Clinical staff that are able to work across multiple sights
- The setting up of Network Boards (with Network Budgets)
- All open to consultation via SHA this year



Only designated Hospitals with ‘hyper-acute’ provision

A summary of the proposed model

Unscheduled Care: Our approach and underlying segmentation involves three groups



Segment	What's the underlying problem	What's our approach	Improving?
1) At Risk (e.g. Elderly, frail and or chronically ill)	These patients dominate unscheduled care (in terms of activity and cost) yet our emphasis to their care has historically been re-active – and secondary care based	Move Upstream: Systematic anticipatory / Care & Support Co-ordination / Close to Home Avoidance / Prevention	Outcomes / Quality of Care / Efficiency
2) Urgent Minor	Primary Care not meeting Patient Needs / Expectations & exacerbating A&E reliance	Greater decentralisation: improved availability of service through Primary Care led Consortia	Quality of Care
3) Urgent Serious	Falling Outcomes (relative to other similar economies)	Greater centralisation: Networking	Outcomes / Efficiency

Unscheduled Care: Strategy on a Page

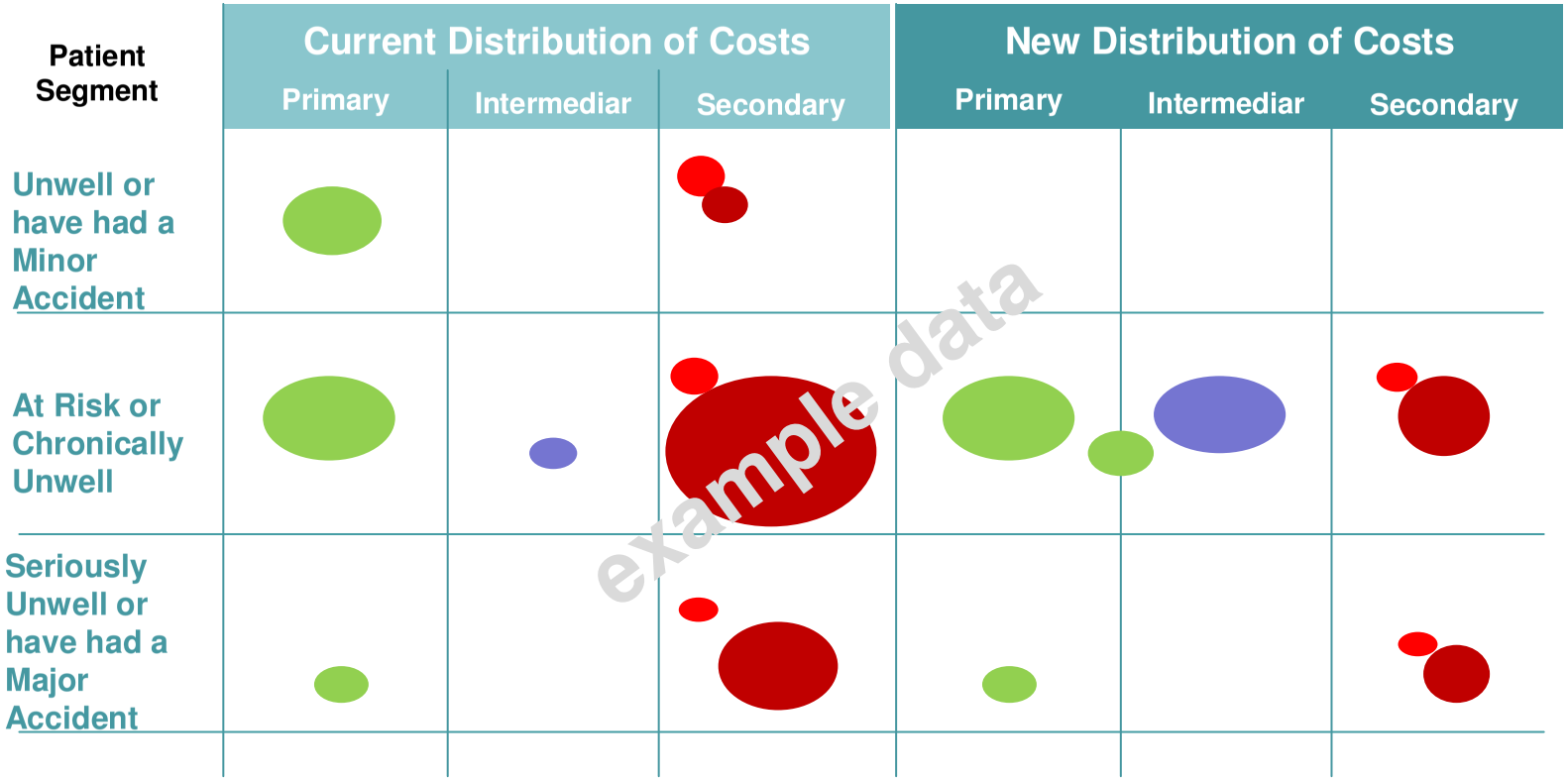
Patient need/ behaviour Segment	At Risk Patients	Urgent Minor Enquiry	Urgent Serious Need
Who	Elderly, Chronic, EOL, 'at risk' (that end up in Urgent Minor or Serious)	Anybody	Anybody
Dominant Driver	Outcome / Quality Care / Greater Efficiency	Quality Care	Outcome
What's the underlying problem	We need to stop waiting for patients to become ill (ending up in the two right hand segments) before we provide care for them, and we need to have more alternatives than just secondary care	Primary Care not meeting Patient Needs / Expectations & exacerbating A&E reliance	The numbers, and our resources do not allow us to be the best clinically at every acute site
Characterization of approach	Systematic anticipatory / Care & Support co-ordination / Close to Home	Primary Care co-ordination	Secondary Care Networking
Change in Approach Description	Whole new areas of service provision: 'pro-active management and co-ordination of services around predicted very high, high and medium risk public' – in the past picked up as a reactive minor or serious need – or in best case small numbers of 'very high risk managed by 'case management'	Much greater emphasis on unplanned Practice based and co-ordinated response (much less reliance on A&E)	Hospitals agreeing network centres and feeder hospitals / transport needs / repatriation policy / and how clinical staff would be shared / rotated
Supporting Technology	Predictive Modelling (ACGs) / Utilisation Management (InterQual). Single point of access for professionals for health and social care	New single point of access (111) GP Dashboard	Network Modelling to support tighter Network specific SLAs
Commissioning Approach	Until this area more mature, decide on range of complementary services (driven by predictive modelling), develop business cases and commission individually from best supplier.	Commission from Consortia of Practices to agree how they address a new minor urgent care SLA	Create Network specific SLA (based on expected clinical experience / transfers / turnaway / repatriation levels

Note: coloured areas provides relative scale of current secondary care cost for this segment (mutually exclusive)

Do the economics work?

System reform will necessitate a redistribution of costs. This is yet to be worked out in detail.

The schematic below reflects how we expect the economics to play out in the new unscheduled care model compared to the current model



- Overall costs will be lower
- There will be a significant shift in spend from secondary care to intermediate care
- Primary Care spend will be broadly constant

Conclusion

- The Unscheduled Care System needs to change:
  - patient experience demands it
  - there is a financial imperative to do things better and cheaper
  - the White Paper sets a direction which this strategy will implement

- The changes proposed in this Unscheduled Care Strategy will deliver:
  - the right care
  - in the right place
  - at the right cost

Next Steps

- We are conducting engagement over the next two months with key stakeholders before developing a final draft of the strategy
- The purpose of the engagement is to discuss 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
- Major trauma - one strand of the unscheduled care plans - is party to a separate consultation led by the SHA
- The focus is to ensure the best services are provided for patients within a sustainable system in line with future plans for the NHS
- Comments should be made to yourviewscount@hampshire.nhs.uk

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DECISION-MAKER:		PANEL B		
SUBJECT:		UNSCHEDULED CARE (EAST SOUTHAMPTON) OPTIONS FOR BITTERNE WALK IN CENTRE		
DATE OF DECISION:		9 SEPTEMBER 2010		
REPORT OF:		DIRECTOR HEALTH AND ADULT SOCIAL CARE		
AUTHOR:	Name:	Caronwen Rees	Tel:	023 8083 2524
	E-mail:	caronwen.rees@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
None

SUMMARY

To inform members of the work underway in relation to unscheduled care in East Southampton and the options for the future of Bitterne Walk in Centre.

RECOMMENDATIONS:

(i) To receive a presentation on unscheduled care (East Southampton) and options for Bitterne Walk in Centre.

(ii) To provide comments on the options which will be fed into the final consultation document.

REASONS FOR REPORT RECOMMENDATIONS

1. To ensure members are aware of the proposals for changes to unscheduled care in East Southampton and have the opportunity to contribute to the consultation.

CONSULTATION

2. There have been a series of engagement events with stakeholders over the last year which have informed the current options. Formal consultation on the options will commence latter this year.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None.

DETAIL

4. The options for changes to unscheduled care in East Southampton are currently being finalised before formal public consultation begins. The panel will receive a presentation (appendix one) on the rational for proposed changes and the options being considered.

FINANCIAL/RESOURCE IMPLICATIONS

5. It is not possible to confirm the financial implications at this stage as the options are still being finalised and are yet to be consulted upon.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

6. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

7. None.

POLICY FRAMEWORK IMPLICATIONS

8. The development of joint commissioning between NHS Southampton City, GP consortium and Local Authorities.

9. Unscheduled Care proposals across Southampton, Hampshire, Isle of Wight and Portsmouth.

SUPPORTING DOCUMENTATION

Appendices

1.	Unscheduled Care (East Southampton) - Options for Bitterne Walk in Centre, Presentation.

Documents In Members' Rooms

1.	None

Background Documents

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Background documents available for inspection at: N/A

KEY DECISION? **No**

WARDS/COMMUNITIES AFFECTED:	All

NHS
Southampton City

Unscheduled Care (East Southampton)
Options for Bitterne Walk in Centre

Sheila Brooke
Associate Director Unscheduled and Primary Care
August 2010

Appendix 1

Creating a healthier Southampton

NHS
Southampton City

Introduction

- **NHS SC Unscheduled Care Strategy**
  - Minimise service duplication
  - Improve access and services to patients who need it most
  - Maximise value for money
  - Support development of integrated care
  - Build on work with patient and public engagement

Sept 2009 Trust Board - Review

- Review progress and impact of service changes
- Review of USC capacity across the urgent care system
- Propose options for future model for consideration
- East Locality GPs work and Practice Based Commissioning project

July 210 Trust Board

- Review, options appraisal
- Agreement to start pre engagement progressing to formal public consultation

NHS
Southampton City

Progress

- Shirley WiC Phased Closure 04-09/09

- Opened APMS GP practice 1/10

- Established MIU

- Primary Care

Phlebotomy commissioned from GPs
Improved access
Complex Care LES

Impact

- 1 concern from public
- Minimised PC duplication
- Financial savings

- 8-8, 7/7 service. Walk in component

- Consistent MIU service with X Ray
- Limited conveyance by SCAS
- Underused
- SCH charging other PCTs for activity

- Patient centred, reduced duplication
- Extended hours and open access
- Improved integration with community

Urgent Care Engagement during past year

- Patients forum
- Links
- Avail stakeholder workshop with key partners e.g. ambulance service, rapid response
- Pensioners forum
- Inform (stakeholders newsletter)
- 2 Workshops last Autumn with key stakeholders e.g. Councillors, Partners etc
- Meet the chief Executive event with voluntary sector
- Briefing to Osc
- Group meeting External Advisory Panel for Equality and Human rights
- Whitehouse pilot
- McKinsey Urgent Care Social marketing project
- Access survey (how far would you travel etc)

What we know

- The public like the walk in element of BWiC service
- 90% of BWiC users have minor illness which GPs are well placed to manage
- 09/10 28% of BWiC activity from Hampshire when GPs surgeries are open
- The service cost £1,645K to commission 09/10
- The public are confused about which service to select

Options Appraisal

1. No Change

2. GP Led PCDC (as discussed at TB)

3. Provide open access walk in service delivered by WHOOHs weekends & BHs and remove Mon to Fri service

4. As Option 3
   with evening opening 18 30 -22.00

5 Full closure of BWiC

6 Service to be defined by East GPs and Solent Healthcare

Potential Risks

Displacement of activity need to consider impact on:

- Users
- Emergency Department
- Minor Injuries Unit
- General Practice

- Public dissatisfaction
- Staff dissatisfaction

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Southampton City

Pre consultation engagement

• Innovation and Investment Group	7th July 2010
• Clinical Leadership Board	14th July 2010
• Unscheduled Care Strategic Commissioning Group	16th July 2010
• BBC Radio Solent Interview	20th July 2010
• East Locality GPs Commissioning Group	21st July 2010
• Trust Board	22nd July 2010
• Health Overview and Scrutiny panel members meeting	29th July 2010
• Patients Forum	9th August 2010
• Staff Meeting BWiC	13th August 2010

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ANY QUESTIONS?

We would welcome your feedback

Creating a healthier Southampton

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