Public Document Pack

Health Overview and Scrutiny Panel

Wednesday, 10th October, 2012
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Claisse
Councillor Jeffery
Councillor Lewzey (Vice-Chair)
Councillor Parnell
Councillor Pope (Chair)
Councillor Tucker
Councillor Morrell

Contacts

Sharon Pearson
Democratic Support Officer
Tel: 023 8083 2302
Email: sharon.pearson@southampton.gov.uk

Caronwen Rees
Policy & Performance Analyst
Tel: 023 8083 2524
Email: Caronwen.rees@southampton.gov.uk

PUBLIC INFORMATION

Southampton City Council's Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

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 the disabled. 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 2012/13

2012	2013
21 June 2012	31 January 2013
15 August	21 March
10 October	
29 November	

CONDUCT OF MEETING

Terms of Reference

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules – paragraph 5) of the 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 INTEREST

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

DISCLOSABLE PERSONAL INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value fo the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having a, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

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 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 PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary 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 Democratic Support Officer 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 SOUTH CENTRAL AMBULANCE SERVICE UPDATE AND CLINICAL QUALITY INDICATORS

Report of the Senior Manager, Customer and Business Improvement for members to note the background to the new ambulance service clinical quality indicators and an update on current developments, attached.

7 DRAFT CARE AND SUPPORT BILL

Report of the Executive Director of Health and Social Care, summarising some of the key issues set out in the draft Care and Support Bill, for the Scrutiny Panel to comment and raise concerns in response to the consultation process being undertaken by the Department of Health, attached.

8 UPDATE ON VASCULAR SERVICES

Report of the Director of Nursing, SHIP PCT Cluster, providing an update on actions taken since the Vascular Services seminar held on 11 June 2012 for the Panel to note the arrangements for monitoring of vascular services and advise when a further update is required, attached.

9 IMPLEMENTING THE NHS REFORMS IN SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH

Report of the Director of Communications and Engagement, SHIP PCT Cluster, providing an update on changes to local NHS commissioning organisations as a result of Government reforms, attached.

TUESDAY, 2 OCTOBER 2012 HEAD OF LEGAL, HR AND DEMOCRATIC SERVICES

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	SOUTH CENTRAL AMBULANCE SERVICE UPDATE AND CLINICAL QUALITY INDICATORS
DATE OF DECISION:	10TH OCTOBER 2012
REPORT OF:	SENIOR MANAGER CUSTOMER AND BUSINESS IMPROVEMENT
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This paper provides members with background to the new ambulance service clinical quality indicators to enable understanding and monitoring in the future. An update on current developments include the 111 service will also be provided.

RECOMMENDATIONS:

(i) To note the paper and receive a presentation from the South Central Ambulance Service (SCAS).

REASONS FOR REPORT RECOMMENDATIONS

1. To ensure members are up to date with ambulance service performance indicators and current developments within SCAS.

DETAIL (Including consultation carried out)

2. Please see the paper provided by the SCAS at appendix 1. A presentation will also be given to the Panel at the meeting.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None

RESOURCE IMPLICATIONS

Capital/Revenue

4. None

Property/Other

5. None

LEGAL IMPLICATIONS

Statutory Power to undertake the 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:

None.

POLICY FRAMEWORK IMPLICATIONS

7. None.

AUTHOR:	Name:	Caronwen Rees	Tel:	023 80832524
	E-mail:	Caronwen.rees@southampton.gov.uk		

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	South Central Ambulance Service Update.

Documents In Members' Rooms

1	N/A

Integrated Impact Assessment

Do the implications/subject/recommendations in the report require an Integrated Impact Assessment to be carried out.	No

Other Background Documents

Title of Background Paper	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

1.	None	

Integrated Impact Assessment and Other Background documents available for inspection at:

WARDS/COMMUNITIES AFFECTED:	All

MISUSE OF AMBULANCE SERVICE COSTS LIVES CAMPAIGN

South Central Ambulance Service (SCAS) launched an innovative media campaign in January 2012 in a bid to stop people calling 999 for non-life threatening reasons. With the service receiving 1,235 hoax calls and many more inappropriate calls from January 2011 to October 2011, this is an increasing problem that is putting people's lives at risk. Inappropriate calls include responding to the emergency of a man in "severe pain" and on arrival he wanted someone to pass him some paracetamol from a table less than two metres away; people calling 999 because they want a lift to visit a relative in hospital; or people injured with say a broken finger, which is not life threatening, but they have no money to get to A&E. There is one ambulance available per 33,000 people across Buckinghamshire, Oxfordshire, Hampshire and Berkshire. Each time an ambulance is used inappropriately it is not available to attend a life-threatening situation.

In a concerted effort to address this issue, SCAS headlined the campaign with a hard-hitting video shot in the style of a movie trailer, which showcases interviews with paramedics, real life emergencies and re-enactments of inappropriate calls and the impact they have. The video is available to view on www.999southcentral.co.uk as well as on YouTube. The video was supported by extensive PR activity and received a considerable amount of local, regional and national media interest including ITV Meridian, BBC Oxford, Berkshire and Solent, The Sun, The Portsmouth News and The Journal of Paramedic Practice. The viral film has had approximately 70,000 views on YouTube and SCAS has attracted 939 new followers on Twitter.

The campaign also comprises a number of educational case study films which are being used to target and engage schools, care homes and GPs to help raise awareness of this increasing problem and encourage appropriate use of the service. Messages from the campaign are also being put on the fleet and as winter approaches the campaign will be re launched with a number of new initiatives including cinema and radio advertising.

Please promote the campaign and post this link on your websites, intranets and newsletters, as well as sharing it with your family and friends:

- http://www.youtube.com/user/999SouthCentral
- Follow SCAS999 on Twitter

Lay Guide to Ambulance Service clinical quality indicators

One of the most common reactions we hear from patients is that in an emergency they want the ambulance to arrive quickly. Delays (perceived or otherwise) in receiving the care they need may also seem worse by the anxiety and stress of the situation. Ambulance trusts recognise this and understand that response time is important, but faster responses to patients are only one part of a process to deliver improved outcomes for patients. Ambulance trusts therefore need to focus on providing the best care at the most appropriate time and, where possible, to resolve issues on the first occasion. We appreciate that sometimes ambulance staff have to focus on the most critically ill patients (i.e. those with life-threatening conditions) but it is important that there are effective systems and the right level of resource to cope with all patients who call 999.

We are publishing a new set of ambulance clinical quality indicators that aim to provide patients with the information they need to be able to see the quality of care being delivered by ambulance services. These indicators will be published regularly and will be made available by each individual ambulance trust. This will mean that there will be information available to allow comparisons between one ambulance service and another. The set of indicators is designed to give a comprehensive picture of the quality of care but importantly also includes the views of service users on the care the ambulance trust has provided. Patient and public feedback is key to facilitating continuous improvement; and trusts will need to take account of this when looking to learn lessons and improve the service they offer. A first-class ambulance service is always keen to hear about suggestions for improvements in care.

The ambulance clinical quality indicators are not just about providing information, they also aim to encourage discussion and debate amongst ambulance staff, NHS managers, commissioners, and the general public about how good the care being provided locally is and how it can be improved.

Eleven clinical quality indicators will be measured from April 2011, and the remainder of this where this document sets out how these specific indicators will improve care.

Service Experience Indicator – most, if not all, ambulance trusts already undertake patient satisfaction surveys. We are now asking them to go beyond simply reporting the results of such surveys, and ambulance trusts will be required to demonstrate and publish how they find out what people think of the service they offer (including the results of focus groups, interviews and patient forums, rather than simply patient surveys) and how they are acting on that information to continuously improve patient care.

Outcome from acute ST-elevation myocardial infarction (STEMI) indicator - STEMI is an acronym meaning "ST segment elevation myocardial infarction," which is a type of heart attack. This is determined by an electrocardiogram (ECG) test. We know that, for many conditions, your recovery will be more likely and quicker if you receive early treatment.
Early access to reperfusion (i.e. where blocked arteries are opened to re-establish blood flow) and other assessment and care interventions are associated with reductions in STEMI mortality and morbidity. Measuring patient outcomes in this way will allow services to place performance in context and stimulate discussion on how to continually improve.

Outcome from cardiac arrest: return of spontaneous circulation indicator – This indicator will measure how many patients who are in cardiac arrest (i.e. no pulse and not breathing) but following resuscitation have a pulse/ heartbeat on arrival at hospital. We recognise that providing resuscitation as early as possible to those in cardiac arrest is likely to improve the chances of recovery. Clearly, the higher the survival rate the better.

Outcome from cardiac arrest to discharge indicator – We know that the ambulance service

play a vital role in saving patient's lives, but it is important to understand the effectiveness of the whole system in managing those patients who are in cardiac arrest. We will know from the indicator above how effective the ambulance service was in responding to and treating patients in cardiac arrest when the ambulance arrives at the hospital – but what about after the patient is in the care of the hospital? That is why this indicator measures the rate of those who recover from cardiac arrest and are subsequently discharged from hospital as a patient outcome.

Outcome following stroke for ambulance patients indicator – The Stroke: Act F.A.S.T campaign has been very successful in raising awareness to the public on the signs of a stroke (as well as TIA's, Transient Ischaemic Attacks (or "mini-strokes")), and we know that prompt emergency treatment can reduce the risk of death and disability. The campaign promotes that when a stroke strikes act F.A.S.T:

- **F**acial weakness - can the person smile? Has their mouth or eye drooped?
- **A**rm weakness - can the person raise both arms?
- **S**peech problems - can the person speak clearly and understand what you say?
- **T**ime to call 999 for an ambulance if you spot any one of these signs.

This indicator will require ambulance services to measure the time it takes from that all important 999 call to the time it takes those F.A.S.T-positive stroke patients to arrive at a specialist stroke centre. We know that patients should be arriving at specialist stroke centres as soon as possible so that they can be rapidly assessed for thrombolysis, delivered following a CT scan in a short but safe time frame; this has been demonstrated to reduce mortality and improve patient recovery.

Proportion of calls closed with telephone advice or managed without transport to A&E indicator - Ambulance trusts are exceptionally good at handling and responding to 999 calls. But calling 999 does not necessarily mean that a 'blue light' emergency response is the best one. Similarly, with ambulance staff becoming increasing skilled in treating patients at the scene even if an ambulance is sent, the front-line crew may be able to treat the patient then and there without the need to take them to an A&E department. On the other hand, alternative healthcare options, other than A&E, may be more appropriate for the patient.
This indicator should reflect how the whole urgent care system is operating, rather than simply the ambulance service or A&E, because it would reflect the availability and provision of alternative urgent care destinations and treatment of patients in the home. Knowing this will help improve urgent and emergency care services so that they offer the right treatment to patients in the right location at the right time.

Re-contact rate following discharge of care Indicator – if patients have to go back and call 999 a second time it is usually because they are anxious about receiving an ambulance response or have not got better as expected. Occasionally it may be due to an unexpected or a new problem. To ensure that ambulance trusts are providing safe and effective care the first time, every time this indicator will measure how many callers or patients call the ambulance service back with 24 hours of the initial call being made.

Call abandonment rate – the vast majority of people who phone 999 do so because they need to access emergency healthcare. If people do not get to speak to the ambulance service quickly they may hang up or try to receive the care they need elsewhere, for example turning up at A&E. This indicator will ensure that ambulance trusts are not having problems with people phoning 999 and not being able to get through so that 999.

Time to answer calls – It equally important that if people/patients dial 999 that they get call answered quickly. This indicator will therefore measure how quickly all 999 calls that are received by the ambulance service get answered. The quicker the ambulance service answer the call, the quicker they can establish what is wrong with the patient so that the best type of response can be given. Answering the call quickly also provides reassurance to often very anxious and scared callers, who have called 999 because it is a real emergency.

Time to treatment by an ambulance-dispatched health professional – it is important that if patients need an emergency ambulance response that the wait from when the 999 call is made

to when an ambulance-trained healthcare professional arrives is as short as possible, because urgent treatment may be needed.

Category A, 8-minute response time – In truly life-threatening situations, the speed of an ambulance arriving could help to make the difference between life and death. This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and importantly measures that those patients who are most in need of an emergency ambulance gets one quickly.

Each ambulance service will be publishing their results against each of these indicators from April 2011, along with an explanation of their local circumstances to place these results in context. This will help to explain any local reasons as to why the results may be different from other ambulance services, but it should also explain how they are working to continuously improve the quality of care they deliver to patients.

Clinical Excellence within South Central Ambulance Service

South Central Ambulance Service (SCAS) continues to remain very focused on achieving excellent clinical outcomes for all of our patients. Over the last few years, we have developed our capability to audit our clinical performance in a number of key areas of our emergency clinical practice. Since the introduction of national Clinical Performance Indicators, which have included clinical care bundles for the management of heart attack, acute asthma, acute stroke, diabetic emergencies, and cardiac arrest, we have maintained an impressive track record of continuous improvement in the standards of care that we deliver to our patients. One of the key areas that we have invested in has been our ability to capture the high quality clinical care that our staff deliver from their clinical records, and for the first time, our staff now have the ability to be able to track and monitor their own clinical performance to inform their own future clinical practice and development.

Within the last twelve months, Ambulance Services in England have for the first time been monitoring the clinical outcomes of patients who have sustained a cardio-respiratory arrest in the community and we have been collecting data on the number of our patients that have arrived at hospital with a restored pulse, and equally as importantly, but more challenging, we have been collecting data on the survival of these patients to hospital discharge. This latter measure is a marker for the quality of care the patient receives from the whole emergency care system, including specialist care delivered in hospitals.

Over the last six months we have recognised that we need to do further work to improve the quality of our clinical data, particularly in the area of survival to hospital discharge data, and we have been working closely with our acute hospital trusts to ensure that SCAS obtains this date in a timely manner. We have also modified the design of our clinical records to facilitate this data capture and have emphasised the importance of staff maintaining high quality clinical records. The position is improving and we are receiving more data, quicker from our acute hospital trust partners.

The latest data we have from the National Department of Health Dashboard, confirms that for the month of April 2012 36.8% of our patients who had sustained a cardiac arrest in the community in whom resuscitation has been attempted had a pulse on arrival at hospital and that 13% of all patients who had survived a cardiac arrest survived to hospital discharge. The proportion of patients who had 'witnessed' cardiac arrests, in which the underlying cardiac arrest rhythm was more favourable (ventricular fibrillation or ventricular tachycardia), is even higher, although the numbers of patients are small. The current overall cardiac survival to discharge rate is reported in the United Kingdom medical literature as approximately 7%.

It is important that the limitations of this data are understood as the absolute numbers of patients who have been treated in cardiac arrest month on month is small, but the data will become more robust with the passage of time as the size of the dataset increases. At this time,

we have good evidence that the quality of care we currently deliver to our patients is good, but we are not complacent. We have had a number of initiatives in place to further improve the clinical care of patients in cardiac arrest, this includes our front line staff using up to date evidenced based cardiac resuscitation algorithms that are approved by the Resuscitation Council UK. All of our staff continues to receive regular refresher update training and performance review.

We are continuing to develop our community first responder's schemes in community areas to enhance the first link of the cardiac chain of survival, namely to try and ensure that basic life support and compressions are initiated as quickly as possible, and to facilitate access to early defibrillation. To complement the growth of our community first responder schemes, we are working with a number of charities to improve the distribution of semi-automatic defibrillators throughout the community at pre-determined locations based on probability of cardiac arrest risk, for example sports centres, shopping centres and railway transport hubs. We are also working on improving the visibility of these assets to our emergency control room staff in the event of reported cardiac arrest, again to improve access to early defibrillation by the public, prior to the arrival of our highly trained and experienced ambulance staff.

We will continue to monitor our clinical performance very closely and we are determined to achieve the best possible outcomes following cardiac arrest, and indeed for all emergencies that we manage in the community.

John Black
Medical Director
SCAS
September 2012

The Ambulance Clinical Quality Indicators in more detail

Providing a fast response in an emergency is vital – but it is only one part of the treatment process. In April 2011, a new method of measuring ambulance service performance was introduced. Ambulance Care Quality Indicators don't just reflect how long it took to travel from "A" to "B" they also show the standard of care delivered from the moment the patient dials 999 so we can better monitor all of the factors which go into providing the best service possible. We know the importance of listening to what people have to say when it comes to identifying possible improvements. That's why we publish the Ambulance Care Quality Indicators each month.

1) Indicator: Outcome from acute ST-elevation myocardial infarction (STEMI)

STEMI is a type of heart attack. This is determined by an electrocardiogram (ECG) test. We know that a patient is more likely to recover if they receive early treatment.

Performance: There is no identified target for this but the desired outcome is for a high proportion of patients to have received early reperfusion (timely thrombolysis and primary angioplasty; delivery of care bundle) and all components of assessment have been consistent during the early months of the financial year. Our performance is 83% for Primary angioplasty and for delivery of the STEMI care bundle 40.64%.

Action: The Trust will continue to scrutinise all cases, and break each incident down into its constituent elements. Staff have been issued with advice to help with keeping on scene times to a minimum. Processes in the Emergency Operations Centre will be reviewed as part of the ongoing improvement in reducing on scene and journey times. SCAS is working closely with the South Central Cardiovascular Network to improve the pathways with the Acute Trusts for direct access to Hyperacute Stroke Units.

Work is currently being undertaken to understand which elements of the patient journey are likely to prevent the patient reaching a hyperacute stroke centre within 60 minutes. This involves looking at each incident to look at the initial call and how the incident has been prioritised within the Emergency Operations Centre (EOC) and then what resource has been sent.

- **STEMI (ST Elevation Myocardial Infarction) Call to Needle**

This clinical practice has been withdrawn with patient receiving primary angioplasty (PPCI), which is more effective for the patient. SCAS does not record data for this measure as the trust no longer undertakes thrombolysis.
All stocks of thrombolytic drugs have now been removed from the trust's vehicles with good access to heart attack centres across South Central the best practice is to deliver the patient direct to the catheter lab with as much pre-alert notice as possible reducing the call to balloon time.

- **STEMI (ST Elevation Myocardial Infarction) Call to Balloon**

The trust has improved its performance against this measure throughout the year. The trust's performance is far exceeding the CQC target and above the national average for all ambulance trusts in England. The trust is now working with acute hospital trusts to reduce the Door to Balloon times.

The trust is currently working towards improving pre-alerts, especially out of hours, so as to help the acute trusts to reduce the door to balloon times. This is a joint target for ambulance and acute trusts to work in seamless partnership to achieve the reduction in call to balloon times. Call to door times has been improved significantly by education and feedback between the ambulance service and acute hospital trusts.

- **STEMI Care Bundle** (Proportion of cardiac patients who received all elements of the optimal care package)

Following analysis of its processes, and delivering improvement in its analgesia (pain relief) administration, SCAS has continued to improve in this area. There are discussions at the National Ambulance Directors of Clinical Care meetings around reviewing the care bundle for STEMI patients, in the light of new evidence which will further enhance the care of this group of patients.
The care bundle focuses on only two forms of analgesia, morphine and Entonox, where as SCAS has a much larger formulary of analgesia. This causes us to have a reduced score for analgesia administration as SCAS staff use a stepwise approach to the management of pain by using more appropriate medicines that reduce risk or by using a combination of analgesics managing pain more effectively.
The use of GTN, which is a vaso-dilator is being reviewed by the national ambulance Medical Directors group as there is evidence that it has no benefit to patients that do not have chest pain, even if they are having a STEMI. The trust is waiting for the evidence to be reviewed and will make any changes to practice if required.

2) Indicator: Outcome from cardiac arrest: return of spontaneous circulation (ROSC)

This indicator will measure how many patients who are in cardiac arrest have been helped to regain a pulse/heartbeat by the time they arrive at hospital. The aim of this indicator is to reduce the proportion of patients who die from out of hospital cardiac arrest. The return of spontaneous circulation is calculated for two patient groups: The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out of hospital cardiac arrest patients; the rate for the Utstein comparator group applies to a subset of all cardiac arrest patients and provides a more comparable measure of management of cardiac arrest for patients where timely and effective clinical care can particularly improve survival.

ROSC for Utstein group (Proportion of patients whose cardiac arrest was witnessed and arrived at hospital with a pulse)

Performance*:* There is no specified target for this indicator but SCAS is continuing work to improve performance in these areas. Our current performance for the Utstein group is 52.54%. Our overall ROSC performance is 31.13%. The higher the ROSC rate the better.

Due to the small sample size involved, SCAS will continue to review its performance. SCAS's overall ROSC rate is consistent with existing published UK survival rates and there are initiatives to improve the early intervention to greatly improve outcomes.

Action: SCAS are increasing the number of community responders that have an important role to improving the outcome for patients that have a cardiac arrest. The success that is seen in London can be attributed to the vast number of defibrillators that are placed in the offices and buildings which give very early access to defibrillation, significantly improving the outcome for the patient. Our Community Responders are trained and live within the community to provide the same such early defibrillation in towns and villages across South

Central, working with the ambulance crew to increase the chance of achieving a Return of Spontaneous Circulation on arrival at hospital.
Defibrillators in the community project is also being expanded, placing defibrillators where large groups of people gather, such as shopping centres, cinemas or village shops, so early defibrillation can be achieved on the spot.

3) Indicator: Outcome from cardiac arrest to discharge indicator –

It is important to understand the effectiveness of the whole system in managing patients who suffer a cardiac arrest. That's why this indicator measures the rate of those who recover from cardiac arrest and are then discharged from hospital alive.

Survival to discharge for Utstein group
(Proportion of patients whose cardiac arrest was witnessed and survived to leave hospital alive)

Performance:
There is no identified target but the desired success is that the higher survival rate the better. SCAS will continue to review and improve its performance in this area, which remain at expected levels from published literature. SCAS is participating in a cluster randomised control trial using a mechanical chest compression device for patients in cardiac arrest that may further improve ROSC and survival to discharge from hospital. Obtaining timely mortality and survival data from acute hospitals continues to be challenging and is contributing to delays in reporting of survival to hospital discharge data.

A patient's survival to discharge from a cardiac arrest is very complex as it has a significant number of factors that need to be taken into account. The most obvious is what has caused the cardiac arrest in the first place. If the arrest is due to a chronic condition such as cancer then the likelihood of a successful resuscitation is very low for instance.

Action: SCAS has made significant effort to build relationships with acute trusts to obtain this information but is reliant on good will at the moment. Steps have been taken at Board level to formalise this process and these are starting to improve the flow of data.

4) Indicator: Outcome following stroke for ambulance patients

We know that prompt emergency treatment can reduce the risk of death and disability from a stroke. This is why people at the scene should act quickly. This indicator will require ambulance services to measure the time it takes from the 999 call to the point where a F.A.S.T-positive stroke patient arrives at a specialist stroke centre.

Stroke care bundle (Proportion of stroke patients who received all elements of the optimal care package)

Performance: There is no identified target but the desired outcome is for the highest percentage of FAST positive stroke patients to arrive at a hyperacute stroke centre within 60 mins. Our current performance is 52.34%. Our current performance for the indicator requiring the highest percentage possible of suspected stroke patients receiving a care bundle, is 60.65%.

SCAS has very good performance in the care of Stroke patients but re-enforces the need to maintain the level of care at any opportunity to avoid any drop in performance.

Action: Training has recently been given to ensure that stroke patients are cared for in line with best practice guidelines.

This page is intentionally left blank

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	DRAFT CARE AND SUPPORT BILL
DATE OF DECISION:	10TH OCTOBER 2012
REPORT OF:	EXECUTIVE DIRECTOR OF HEALTH AND SOCIAL CARE
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This paper summarises some of the key issues set out in the draft Care and Support Bill. It offers the scrutiny panel an opportunity to comment and raise concerns in response to the consultation process being undertaken by the Department of Health.

RECOMMENDATIONS:

(i) That the scrutiny panel identifies any comments it would wish to make in response to the consultation on the draft Care and Support Bill.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the scrutiny panel to respond to the Department of Health consultation on the draft Bill.

DETAIL (Including consultation carried out)

2. Over the years there has been a succession of legislation on adult social care, and some of the changes have resulted in confusion and a number of issues requiring resolution by case law. In an attempt to resolve the confusion the government appointed the Law Commission to undertake a review of the legislation covering adult social care. The Commission published its final report in 2011, and most of its proposals are now set out in a draft Care and Support Bill. The draft Bill proposes a single, modern law for adult care and support that replaces existing outdated and complex legislation. It aims to transform the social care system to focus on prevention and the needs and goals of people requiring care. It also includes a number of health measures, including the law needed to establish Health Education England and the Health Research Authority. This paper does not deal with the issues around Health Education England or the Health research Authority.

A key subject the draft Bill does not address is the future funding of adult social care. The government has accepted principles of the Dilnot report, “Fairer Care Funding”. This is to be reviewed as an element in the next comprehensive spending review.

A number of issues that emerge from the Bill are now briefly commented on.

General responsibilities of local authorities

The draft Bill begins by setting out a series of general duties which local authorities must fulfil when carrying out their social care duties. The first of these is a duty to promote an adult's wellbeing through consideration of:

(a) physical and mental health and emotional well-being;
(b) protection from abuse and neglect;
(c) control by the adult over day-to-day life (including over the care and support provided to the adult and the way in which it is provided);
(d) participation in work, education, training or recreation;
(e) social and economic well-being;
(f) domestic, family and personal relationships;
(g) the adult's contribution to society.

The local authority would be given a duty to provide an information and advice service in relation to care and support. This should be available to everyone, including those who do not met eligibility criteria. There is also a duty to promote diversity and quality in the market of care and support providers, including private sector organisations, not-for profit organisations and social enterprises.

There are several clauses in the draft Bill relating to duties to co-operate. Local authorities would have a duty to co-operate with relevant partners in exercising its social care responsibilities. These include the police, the NHS, the prisons' minister and the probation service. There would a separate duty for local authorities to undertake their social care responsibilities with the aim of integrating services with the NHS or other health-related services (e.g. housing).

The draft Bill creates a legal duty for local authorities to take measures to contribute towards preventing or delaying the development of needs for care and support by adults in its area or reduce the needs for care and support of adults in its area who have such needs. This will link to the work undertaken in producing the joint strategic needs assessment and the joint health and wellbeing strategy.

Assessments and eligibility

Local authority responsibilities for assessments are currently set out in a number of statutes. They tend to focus in identifying a service to be provided rather than the needs of an individual. The draft Bill creates a single duty on local authorities to determine whether an adult has needs for care and support. The assessment:

- Must be of the adult's needs and the outcomes they want to achieve;
- Must be provided to all people who appear to have some need for care and support, and therefore should not consider unrelated factors such as a person's finances;
- Must also not consider whether the local authority thinks a person will be eligible for services;

- Must be carried out with involvement from the adult and where appropriate, their carer or someone else they nominate.

After conducting the needs assessment the local authority will then be required to determine whether the person has eligible needs, using the eligibility framework set out in regulations. These regulations will be a national threshold for eligibility which is to be consistent across all areas in England.

The draft Bill contains a new requirement for local authorities to provide assessments for people intending to move to their area or to continue providing care based on the original care plan in their previous authority's area. This is intended to provide continuity and consistency of care when people move home, and will be of particular benefit to people re-locating to be near families in other local authority areas. In practice this means local authorities to will continue to meet the assessed needs of people who have moved into their area immediately, until they carry out a new assessment of their own. If the outcome of the receiving authority's assessment is different to that from the previous local authority a written explanation will be required.

Charging and Financial Assessments

The draft Bill aims to create a comprehensive and consistent framework for charging. After completing a needs or carer's assessment and deciding whether the person has eligible needs, the local authority will then think about what type of care and support they might benefit from to meet those needs. The draft Bill gives local authorities power to charge for any type of care and support, except for those will regulations say must stay free. If the local authority thinks that an adult's needs might call for a type of care and support for which it charges, it must carry out a financial assessment to determine whether or not the they can afford to pay. The rules on financial assessments, including how to calculate a person's income and capital will be set out in regulations to it is determined in the same way for everyone. The regulations will set a financial limit, and if the adult's total finances are above this limit then the local authority will not be required to contribute towards the cost of their care and support and the person will have to pay the full cost. If they have less than this, then will still have to pay for some of the cost, but the local authority will also contribute.

The draft Bill also provides for deferred payment arrangements. The local authority will pay the adult's care charges on condition they are repaid at a later date, and the local authority secures a charge on the person's interest in their home. New provisions allow local authorities to charge interest on deferred payments for the first time.

Who is entitled to care and support?

The draft Bill aims to create a single, consistent route to establishing an entitlement to care and support for all adults. It also creates entitlement to support for carers. The core entitlement is for an adult's eligible needs to be

met by the local authority, subject to their financial circumstances. Their eligible needs are those which are determined after an assessment. Having an entitlement to "meet needs", rather than in the past to rived a particular service, means there is more flexibility to focus on what that the person needs and what they want to achieve and to design a package of care and support that suits them.

If the person is going to receive one or more types of care and support for which the local authority makes a charge, then one of 3 conditions also needs to be satisfied. Either:

- The person cannot afford to pay any charge for their care and support and this ensures people without the means to pay do not go without care;
- The person does not have the mental capacity and has no-one else to help them and this ensures people who cannot arrange care themselves do not go without; or
- In other cases the person asks the local authority to meet their eligible needs, and this entitles anyone, regardless of their finances, to get the local authority to arrange their care and support for them, and ensure people who are uncertain about the system lack confidence to arrange their care, do not go without.

Personalising care and support planning

The draft Bill proposes a new duty on the local authority to provide a care and support plan (or a support plan in the case of a carer). In providing this plan they must work with the adult to help them decide how to meet their needs and produce a plan which details what was agreed. As part of the planning process, the local authority must tell people about their ability to take a direct payment for some or all of their needs. For the first time the draft Bill creates a legal entitlement to a personal budget. This is to help people to understand the costs of meeting their needs and what public funding is available to help them. This is complemented by a right to request a direct payment to meet some or all of those needs to maximise the control people have over how that money is spent. The draft Bill also requires local authorities to give information to people to help them support themselves. The local authority also has a duty to review the plan ensure the person's needs and outcomes continue to be met over time.

The law for carers

The draft Bill creates a single duty for local authorities to undertake a "carer's assessment". It would remove he existing requirement that the carer must be providing " a substantial amount of care on a regular basis". The stated aim is that more carers would be able to access an assessment. The assessment would aim to consider the impact on the carer and determine whether they have any support needs and what those needs may be. If both the carer and the person they care for agree, a joint assessment of both their needs can be undertaken. When the assessment is complete, the local authority will then

determine what those support needs are and whether those needs are eligible for public support. For the first time carers are entitled to public support on the same footing as the people for whom they care. They key conditions for a carer's entitlement is that they have assessed eligible needs, and that the person for whom they care is ordinarily resident in the local authority area.

Safeguarding

The draft Bill would require the local authority to establish a Safeguarding Adults Board (SAB) to develop shared strategies for safeguarding and report to their local communities on progress. Core membership of the Board is set out in the Bill and includes the local authority, police and the NHS. The Board would publish a safeguarding plan and report annually on its progress against the plan.

The proposed legislation will require local authorities to make enquiries, or to ask others to make enquiries, where they believe an individual with care and support needs is at risk of abuse or neglect. It does not provide power for local authorities to enter a person's property or take other similar action to carry out the enquiry. However, the Department of Health is proposing to undertake a separate consultation exercise to look at whether a specific power of entry is required alongside the duty to make enquiries.

Safeguarding Adults Boards will have to arrange for a safeguarding review to take place in certain circumstances, where an adult dies oe there is concern about how one of the members of the SAB conducted itself in the case. The aim would be to ensure that lessons are learnt, not o allocate blame, but to improve future practice and partnership working to minimise the possibility of it happening again.

Consultation questions posed by the Department of Health

The department of health has posed a number of general questions on the draft Bill, and the scrutiny panel may wish to comment on some or all of them.

The role of the local authority*: Do the opening clauses sufficiently reflect the local authority's broader role and responsibilities towards the local community?*

Individual rights to care and support: *Does the draft Bill clarify individual rights to care and support in a way that is helpful?*

Carers: *The law for carers has always been separate to that for the people they care for. Is it helpful to include carers in all the main provisions of the draft Bill, alongside the people they care for, rather than place them in a separate group?*

The wellbeing principle and care and support planning: *Does the new well-being principle, and the approach to needs and outcomes through care and support planning, create the right focus on the person in the law?*

Portability of care: *Do the "portability" provisions balance correctly the intention to empower the citizen to move between areas with the processes which are necessary to make the system fair and workable?*

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. The scrutiny panel may determine whether or not it would wish to respond to the draft Bill.

RESOURCE IMPLICATIONS

Capital/Revenue

4. There are no financial implications in choosing whether or not to respond to the draft Bill. However, the major issue of the funding for social care will not be changed in the lifetime of the current Parliament.

Property/Other

5. None

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

6. The power to undertake scrutiny activities is set out in the Local Government Act 2000.

Other Legal Implications:

7. None.

POLICY FRAMEWORK IMPLICATIONS

8. None.

AUTHOR:	Name:	Martin Day	Tel:	023 80917831
	E-mail:	Martin.day@southampton.gov.uk		

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	Draft Care and Support Bill http://careandsupportbill.dh.gov.uk/home
2.	White Paper http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper

Integrated Impact Assessment

Do the implications/subject/recommendations in the report require an Integrated Impact Assessment to be carried out.	No

Other 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	

Integrated Impact Assessment and Other Background documents available for inspection at:

WARDS/COMMUNITIES AFFECTED:	All

This page is intentionally left blank

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	UPDATE ON VASCULAR SERVICES
DATE OF DECISION:	15 SEPTEMBER 2011
REPORT OF:	DIRECTOR OF NURSING, SHIP PCT CLUSTER
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

The paper provides an update on actions taken since the Vascular Services seminar held on June 11, 2012.

RECOMMENDATIONS:

(i) The Committee is asked to note the arrangements for monitoring of vascular services and advise when a further update is required.

REASONS FOR REPORT RECOMMENDATIONS

1. Since the seminar the PCT Cluster has continued to impress upon the Chief Executives of University Hospitals NHS Foundation Trust (UHSFT) and Portsmouth Hospitals NHS Trust (PHT) our expectation that a network model will be developed and have agreed and progressed a number of actions as set out in the paper.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. N/A

DETAIL (Including consultation carried out)

3. Please see update attached at appendix one and associated documents.

RESOURCE IMPLICATIONS

Capital/Revenue

4. None

Property/Other

5. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

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:

6. None.

POLICY FRAMEWORK IMPLICATIONS

7. None

AUTHOR:	Name:	Sarah Elliott	Tel:	023 80
	E-mail:	sarah.elliott@hampshire.nhs.uk		

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	Vascular services update September 2012
2.	Clinical Governance Framework to monitor arrangements for the provision of Vascular Surgery
3.	Strategic Planning Group- Vascular Surgical Services

Documents In Members' Rooms

1.	None

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

Integrated Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

This page is intentionally left blank

NHS
Southampton, Hampshire
Isle of Wight & Portsmouth

Vascular services update September 2012

Southampton HOSC

Background

The SHIP PCT Cluster and its component CCGs are fully committed to commissioning a vascular service that offers all local patients the best outcomes.

In order to achieve this a Vascular Review process started in April 2010 when the NHS South Central Cardio Vascular Network prepared a specification for vascular services. In December 2010, proposals were received from Southampton University Hospital NHS Trust (UHS) and Portsmouth Hospitals NHS Trust (PHT) about how they would go about delivering a vascular service in line with the specification. These proposals were reviewed by an expert panel of independent clinicians, GPs and lay members. The panel concluded that Portsmouth Hospitals NHS Trust did not meet the specification at that time and a 'hub and spoke' model between Southampton and Portsmouth vascular services with emergency and planned complex arterial vascular surgery carried out at Southampton was the best model to meet the specification.

The SHIP PCT Cluster Medical Director facilitated some discussions between vascular surgeons and interventional radiologists across UHS and PHT with the aim of developing such a model and at the time these discussions appeared productive.

The Cluster and the Network then arranged a second Expert Panel in October 2011 to consider the output from these discussions and a proposal from PHT to develop a network with St Richards Hospital, Chichester. Having considered the proposal the Panel concluded it was "aspirational" as West Sussex Hospitals NHS Trust had not given their support to the proposal. Again the Panel's recommendation was that a single vascular service offered from the two hospital sites would provide the best chance for long term sustainable vascular services for local people.

Subsequently a third expert panel was held on the 5th January 2012 to consider a "standalone" proposal prepared by PHT which the panel felt could meet the specification if recruitment to planned posts were made and PHT were able to attract patients from West Sussex. However, the panel reinforced the benefit of a network between UHS and PHT to provide a sustainable service for the future.

During January both Trusts worked hard to develop an acceptable network model, and the PCT Cluster have made every effort to facilitate these discussions. Unfortunately the Trusts were unable to reach an agreement.

Recent developments

A vascular seminar was held on June 11th with clinicians and executives from both Trusts, the PCT Cluster and the local CCGs in attendance, together with stakeholders from local HOSCs, LINks and independent clinical expertise. The notes of this seminar have been shared with the Committee.

Since the seminar the PCT Cluster has continued to impress upon the Chief Executives of University Hospitals NHS Foundation Trust (UHSFT) and Portsmouth Hospitals NHS Trust

(PHT) our expectation that a network model will be developed and have agreed and progressed a number of actions as follows:

- Mr Jonathan Earnshaw is going to provide independent clinical facilitation to the two Trusts to discuss the detail of a network model and overcome the historical concerns that have been raised. The first meeting has been arranged for 3rd October 2012.

- The PCT Cluster is establishing a Strategic Planning Group for Vascular Services to develop our commissioning intentions in line with the new national specification. We have confirmed representation from senior executives and clinicians from UHSFT and PHT and expect to hold the first meeting in October. Terms of Reference are attached.

- A clinical governance framework has been developed which will ensure effective monitoring of workforce, activity and clinical outcome requirements. This is attached. The PCT Cluster has been monitoring the workforce and clinical outcomes from the Trusts in line with the Clinical Governance Framework 1st April 2012.

- A vascular patient group has been established and meets bi-monthly. It includes representatives from Portsmouth, Southampton and South Eastern Hampshire. This group is being kept informed of discussions about vascular services between the two Trusts and is providing a service user view to inform future commissioning.

- It has been confirmed that all vascular surgery and vascular interventional radiology services excluding the treatment of varicose veins will be within the scope of national specialised commissioning in future. The service will include out-reach when delivered as part of a provider network. The expected national specification for vascular services has not been published yet.

Decision required

The Committee is asked to note the arrangements for monitoring of vascular services and advise when a further update is required.

Clinical Governance Framework to monitor arrangements for the provision of Vascular Surgery

Background

Following a detailed review of vascular surgical services, the SHIP PCT Cluster and local CCGs recommended that a network arrangement between University Hospital Southampton NHS Foundation Trust and Portsmouth Hospitals NHS Trust would provide the most sustainable service for patients requiring vascular surgery in southern Hampshire. Unfortunately, the 2 trusts were not able to agree on the detail of the network and it has been decided that this cannot proceed at this time and the status quo will be maintained.

Portsmouth Hospitals NHS Trust has historically relied upon St Richards Hospital, Chichester for support with its vascular rota but this arrangement is due to finish at the end of March 2012 when St Richards's consultants join the Brighton vascular network.

In order to ensure that Trusts continue to achieve optimum outcomes for patients accessing vascular surgery, there will be need to be close monitoring of adherence to the Vascular Society of Great Britain guidelines.

Current Vascular Society of Great Britain Guidelines

The current guidelines include:

- need for a 1:8 emergency rota as a large centralised unit (for a population over a million) otherwise 1:6
- *on site* emergency cover
- serving a population of 800,000 which performs at least 32 elective AAAs or 100 over 3 years
- MDT meeting involves vascular surgeons, IR and anaesthetists.
- Mortality only related to elective care: aortic aneurysm mortality of < 6% (open and EVAR).

Proposed Clinical Governance Framework

Workforce Audit

Initial and then 6 monthly analysis of Vascular and Interventional Radiologist Job Plans and Rotas to include

- Provision of 1 in 6 on site, on call rota for both vascular surgeons and vascular interventional radiologists. (currently 3 surgeons and 5 Interventional radiologists)
- Consultant vascular surgeons must be dedicated to vascular surgery rota i.e. no commitments to the general surgery rota.(currently 1 surgeon also covers renal rota)
- Arrangements for MDT involving vascular surgeons, Interventional Radiologists and anaesthetists.

Clinical Activity Audit

Initial and then 3 monthly analysis of:

- Number and outcomes of planned abdominal aortic aneurysm (AAA) procedures per surgeon (needs to be at least 32 annually per vascular centre)
- Number and outcomes of carotid endarterectomise per surgeon (CEA) (needs to be at least 35 annually per vascular centre)
- Number and outcomes for all emergency AAAs per surgeon
- Number and postcode of all patients to determine if Portsmouth Hospital NHS Trust is attracting patients from outside of Portsmouth and South East Hants (current population served 602000)

The information will initially be reviewed by the GP Cardiovascular ,one of the CCG Clinical Governance leads, Medical and Nursing Director and a representative of specialised commissioning for comment and recommendation to the SHIP Cluster Clinical Governance Committee in line with the following timetable. During the latter part of 2012/13, the CCGs and specialised commissioning will assume responsibility for the continued audit of outcomes as preparation for CCG authorisation progresses and CCG clinical governance arrangements are formalised.

Timetable for performance reporting Trusts

Indicator	Performance Reporting	SHIP Cluster Clinical Governance Committee
- Job Plan/Rota/ On Call arrangements of vascular surgeons and interventional radiologists from 1st April 2012	1st March 2012 1st October 2012 1st April 2013	15th March 2012 15th Nov 2012 May 2013
- Baseline information re number of elective procedures per surgeon - Number and outcomes of planned abdominal aortic aneurysm (AAA) procedures per surgeon (needs to be at least 32 annually per vascular centre) - % of Elective AAA cases which are EVAR (should be 50% to 80% of all elective AAA interventions) - Number and outcomes of carotid endarterectomise (CEA) per surgeon (needs to be at least 35 annually per vascular centre) Number and outcomes for all emergency AAAs per surgeon	Already received - 57 planned AAA repairs (24 EVAR) - 88 carotid endarterectomise Q 1 10th July 2012 Q2 10th October 2012 Q3 10th January 2013 Q4 10th April 2013 As above As above	19th July 2012 15th Nov 2012 17th Jan 2013 May 2013 As above As above
- Number and postcode of all patients receiving vascular surgical services	Q 1 10th July 2012 Q2 10th October 2012 Q3 10th January 2013 Q4 10th April 2013	19th July 2012 15th Nov 2012 17th Jan 2013 May 2013

This page is intentionally left blank

DRAFT

Strategic Planning Group- Vascular Surgical Services

Overall aim

To ensure vascular surgical services are commissioned in line with evidence based specification to achieve optimum clinical outcomes for patients across the SHIP PCT Cluster (the group will be extended to the Wessex Area in the coming months)

Terms of Reference

1. To provide a commissioner led forum to bring senior clinicians and managers together to undertake strategic and capacity planning for vascular surgical services.

2. To ensure vascular surgical services are commissioned in line with the evidenced based specification of the National Clinical Reference Group.

3. To facilitate collaboration between vascular centres in order to meet the national specification for services and deliver best outcomes.

4. To contribute to the development of the model of delivery required by commissioners to meet the specification.

5. To undertake strategic planning of the associated infrastructure for vascular surgical services including workforce, estates and equipment.

6. To maintain an overview of national planning of the vascular screening programmes and ensure this is reflected in local arrangements.

7. To agree an appropriate framework to monitor delivery against the specification and ensure this is reflected in contracts.

8. To agree key communications with stakeholders about the future development of vascular surgical services.

9. To make proposals and commission appropriate patient involvement activity relating to vascular surgical services.

10. To ensure there is effective participation in national clinical audits and benchmarking opportunities.

Membership

SHIP PCT Cluster/NHS CB Local Area Team

- Chief Executive/Area Director
- Medical Director
- Director of Nursing
- Specialised Commissioning representative
- Cardio vascular network representative

Clinical Commissioning Groups

- 2 x GP vascular leads (1 from Southampton/West and 1 from Portsmouth/South East
- GP Clinical Governance lead

Frimley Park NHS Foundation Trust

- Chief Executive/Senior Executive
- Vascular Surgeon
- Interventional Radiologist

Portsmouth Hospital NHS Trust

- Chief Executive/Senior Executive
- Vascular Surgeon
- Interventional Radiologist

University Hospital NHS Foundation Trust

- Chief Executive/Senior Executive
- Vascular Surgeon
- Interventional Radiologist

External adviser as appropriate

Frequency of meetings

Quarterly

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	IMPLEMENTING THE NHS REFORMS IN SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH
DATE OF DECISION:	15 SEPTEMBER 2011
REPORT OF:	DIRECTOR OF COMMUNICATIONS AND ENGAGEMENT, SHIP PCT CLUSTER
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

The paper provides an update on changes to local NHS commissioning organisations as a result of the Government reforms.

RECOMMENDATIONS:

(i) The Committee is asked to note the update.

REASONS FOR REPORT RECOMMENDATIONS

1. To ensure members are aware of progress with the changes that are taking place.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. N/A

DETAIL (Including consultation carried out)

3. Please see presentation attached at appendix one.

RESOURCE IMPLICATIONS

Capital/Revenue N/A

4. None

Property/Other N/A

5. None

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.

7. This report is concerned with the implementation of the Health and Social Care Act 2012.

Other Legal Implications:

8. None.

POLICY FRAMEWORK IMPLICATIONS

9. N/A

AUTHOR:	Name:	Sara Tiller	Tel:	023 8062 7444
	E-mail:	sara.tiller@hampshire.nhs.uk		

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	Presentation - Implementing the NHS reforms in Southampton, Hampshire, Isle of Wight and Portsmouth

Documents In Members' Rooms

1.	None

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

Integrated Impact Assessment and Other Background documents available for inspection at:

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	

Implementing the NHS reforms in Southampton, Hampshire, Isle of Wight and Portsmouth

Agenda Item 9
Appendix 1

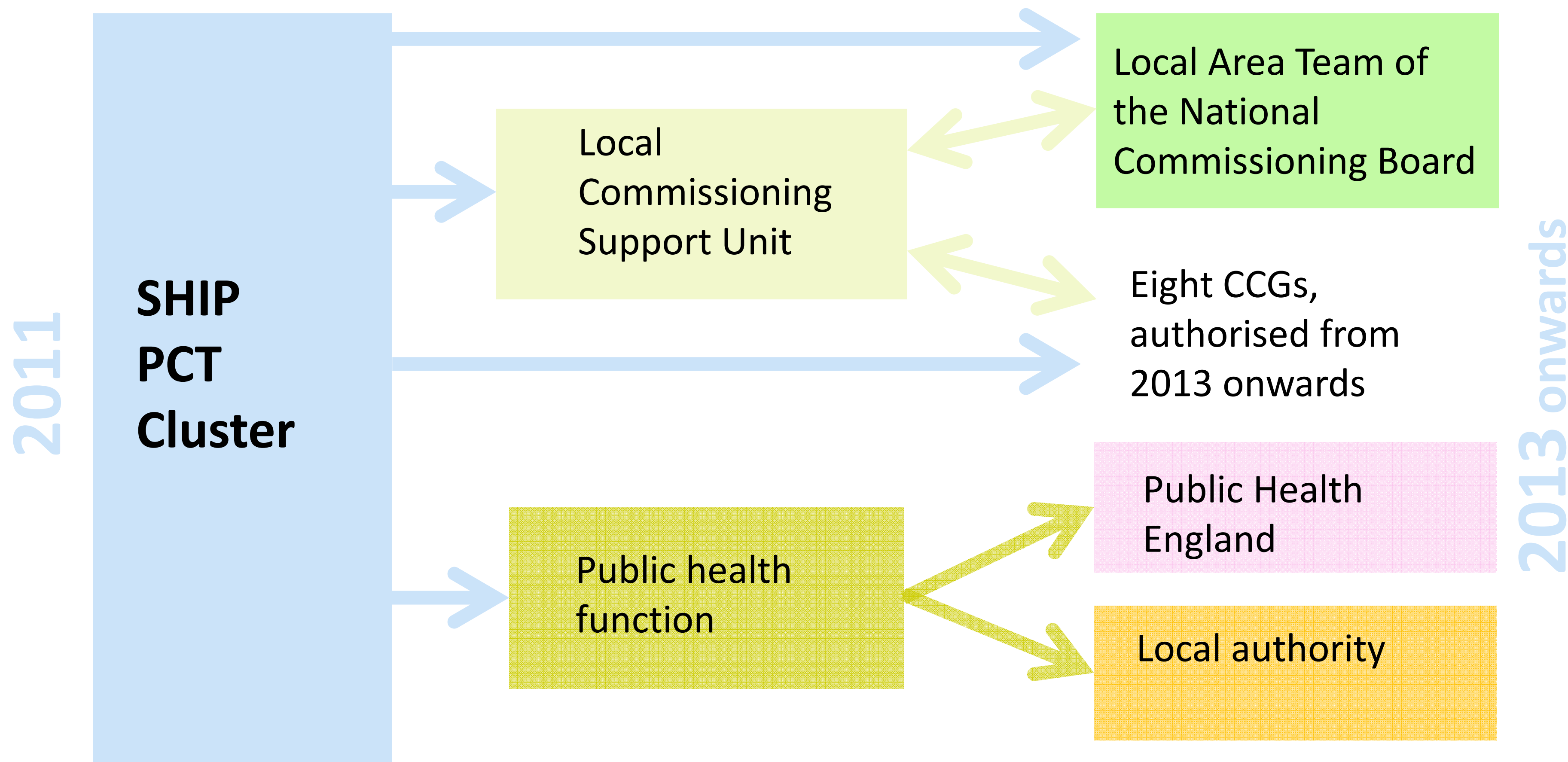
NHS

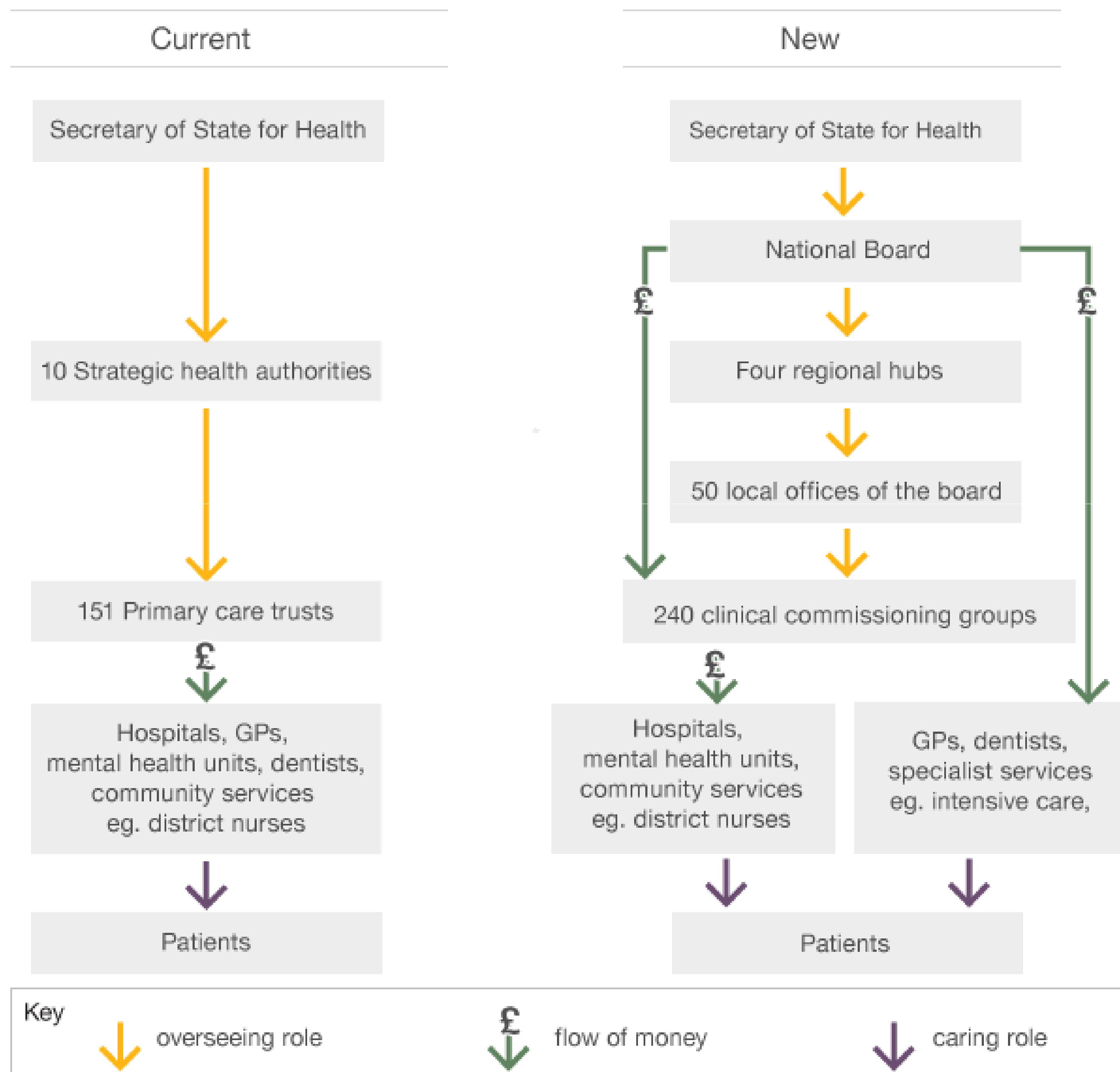
Background

- July 2010 - the Government published its long term vision for the NHS: White Paper, 'Equity and Excellence: Liberating the NHS'
- The three principles at the centre of these reforms are:
  - Giving patients more power
  - Focusing on healthcare and quality standards, and
  - Giving frontline professionals much greater freedom and a strong leadership role.
- Decision making will shift to local groups of clinicians, called Clinical Commissioning Groups (CCGs)
- A new NHS Commissioning Board will be established, responsible for overseeing the CCGs and ensuring that the NHS delivers better outcomes for patients
- Local Authorities will take responsibility for our Public Health teams, and become responsible for public health outcomes
- Action to protect and promote the health of the population will be led nationally by a new public health service - Public Health England

What's happening?

NHS





The structure of the NHS
Current
New
Secretary of State for Health
10 Strategic health authorities
151 Primary care trusts
£
Hospitals, GPs,
mental health units, dentists,
community services
eg. district nurses
Patients
Secretary of State for Health
National Board
£
£
Four regional hubs
50 local offices of the board
240 clinical commissioning groups
£
Hospitals,
mental health units,
community services
eg. district nurses
GPs, dentists,
specialist services
eg. intensive care,
Patients
Key
overseeing role
£
flow of money
caring role

Commissioning Board
A special health authority

National Commissioning Board

Role of the NHS Commissioning Board

NHS
Commissioning Board
A special health authority

- Responsible for ensuring that the NHS delivers better outcomes for patients within its available resources by:
  - providing leadership in the delivery of the NHS Outcomes Framework
  - Holding CCGs to account
  - Supporting choice and competition
  - Ensuring on-going emergency planning and resilience
- Will work with CCGs and other partners to:
  - Improve health outcomes
  - Reduce health inequalities
  - Tackle the QIPP challenges
- Quality and clinical leadership will be central in all it does
- It will be a single, nationwide organisation, with matrix-working at its heart to provide simplicity, aid efficiency and ensure a consistent approach

Functions of the NHSCB

Commissioning Board
A special health authority

Directorate	Functions
Chief of Staff	• Human Resources • Organisation Development
Commissioning Development	• Commissioning support, capacity and capability building • Commissioning guidance and tools • National primary care contracts
Finance and Performance	• Financial strategy • Financial monitoring of CCGs • Planning and accountability
Improvement and Transformation	• Innovation and transformation • Leadership development • Strategy
Medical	• Improving outcomes: Domains 1-3
Nursing	• Improving outcomes: Domains 4-5
Operations	• Oversight of sectors and field force • CCG authorisation • Direct commissioning
Patient and public engagement, insight and informatics	• Information provision • Patient insight • Engagement of public, patient and carers
Policy, corporate development and partnerships	• NHS Mandate • Partnerships • Policy

NHS Commissioning Board
A special health authority

Role of the Operations Directorate

- Directly commission and oversee delivery of:
  - Primary commissioning
  - Specialist commissioning
  - Military health
  - Offender health and
  - Public health (screening)
- Assure, assess and develop CCGs
  - Planning guidance for CCGs to deliver the mandate, NHS Outcomes Framework and the NHS Constitution
  - CCG delivery against planning guidance
  - Ensuring information flows to allow public and parliamentary accountability
- Be responsible for emergency preparedness

NHS
Commissioning Board
A special health authority

Role of the Local Area Team

- 27 Local Area Teams
- Local staff of the Operations Directorate working from a number of office bases across their geographical area
- All will have the same core functions
  - CCG development and assurance
  - Emergency planning, resilience and response
  - Quality and safety
  - Configuration
  - System oversight and partnerships
  - Stakeholder engagement – full partners on HWBBs
- There will be variations in the scope of direct commissioning responsibilities

LAT Commissioning Responsibilities

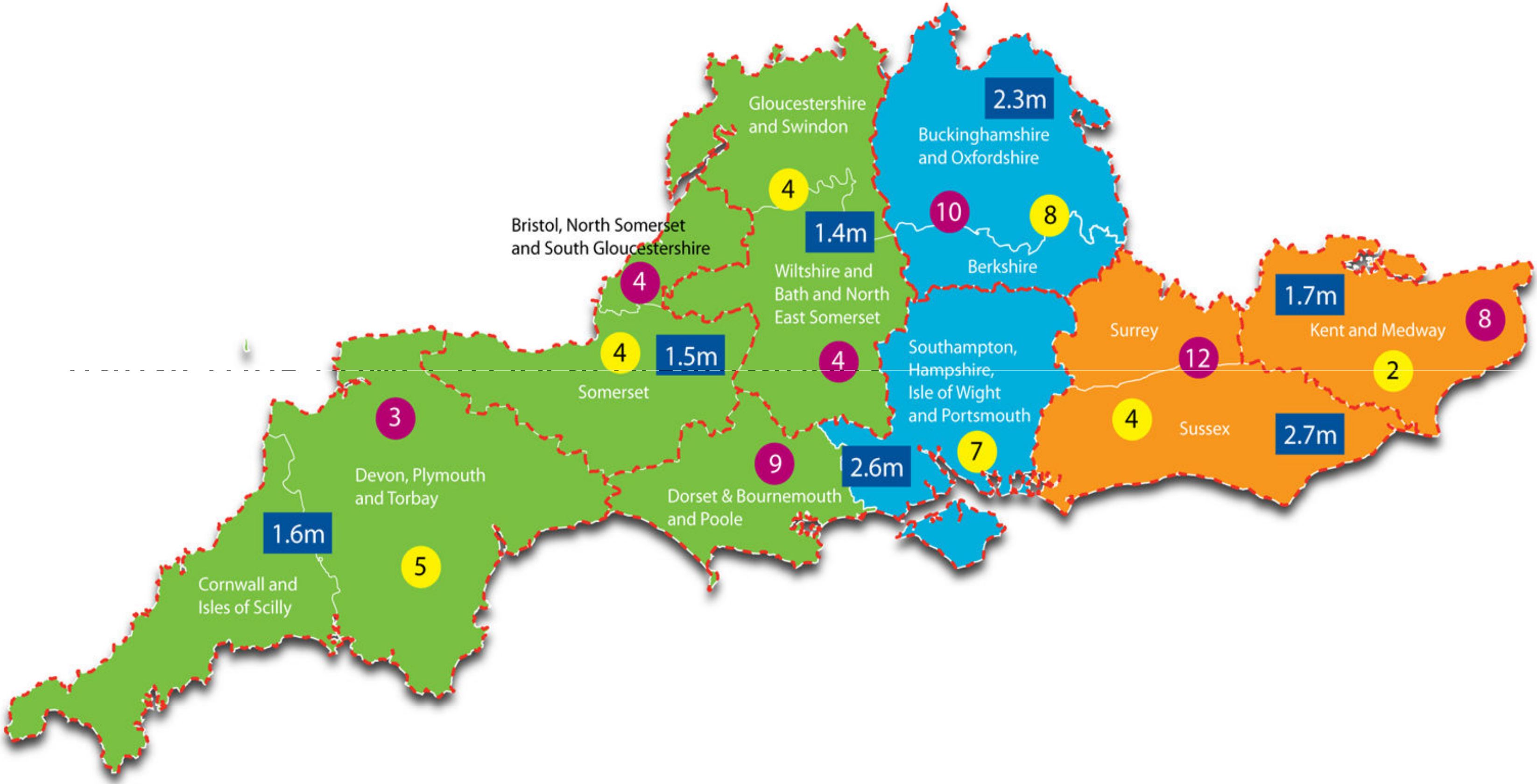
- All LATs will take on direct commissioning of GP services, dental services, pharmacy and certain optical services
- 10 LATs will lead on specialised commissioning across England
- Designated LATs will host the 4 Strategic Clinical Networks
- A smaller number of LATs will carry out the direct commissioning of services such as military and prison health

Regions

Commissioning Board
A special health authority

- 4 Regions (North, Midlands and East, London and South)
- All will operate as part of the central functions of the Operations Directorate
- Provide clinical and professional leadership at a sub-national level
- Co-ordinate planning, operational management and emergency preparedness at sub-national level

Local offices of the NHS Commissioning Board - NHS South of England



Wessex Local Area Team

NHS
Commissioning Board
A special health authority

- Population: 2.6 million people
- Budget: around £2 billion (tbc)
- CCGs: 9
- Local Authorities: 7
- Health and Wellbeing Boards: 6
- Local Resilience Forums:2
- Providers:
  - those providing tertiary services and specialist treatment
  - those providing primary care services
  - those providing screening services
- Relationships:
  - Healthwatch, police, fire, voluntary/third sector organisations
  - all those that are committed to improving services in our area

NHS Commissioning Board
A special health authority

Wessex Local Area Team

Clinical Networks and Professional Development

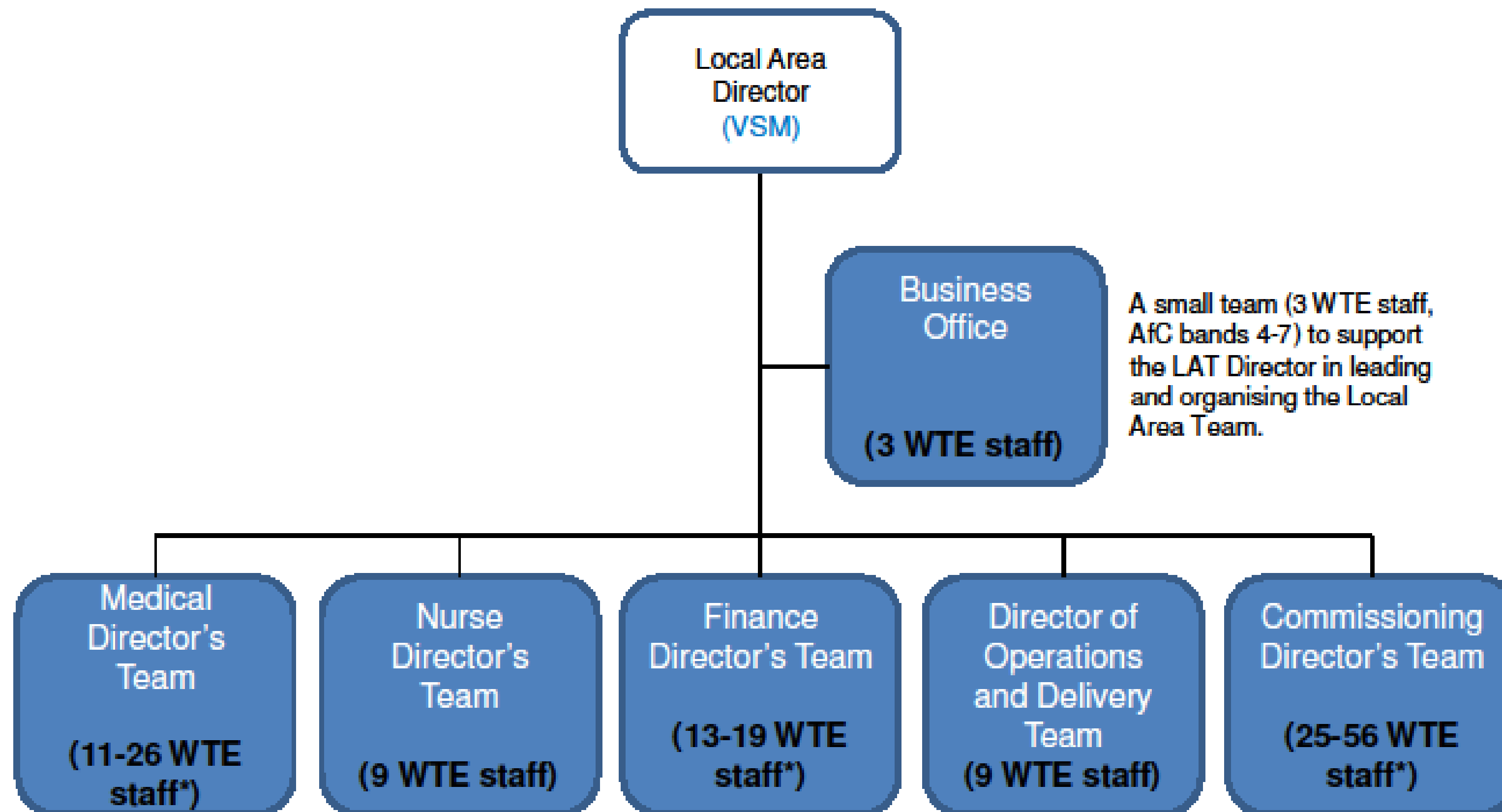
- Strategic Clinical Networks
  - Cancer
  - Cardiovascular disease (including cardiac, stroke, diabetes and renal disease)
  - Maternity and children's services
  - Mental health, dementia and neurological conditions
- Alignment with Wessex Local Medical Committees (LMC)
- Coterminous with Wessex LETB
- Expect to have Wessex Academic Health Science Network (AHSN)

Priorities for Wessex

NHS
Commissioning Board
A special health authority

- Set up a high calibre, top performing Local Area Team
  - Work to engage all LAT staff in developing themselves, restoring morale and building the organisation
- Establish and develop positive local relationships
- Establish robust arrangements for CCG assurance
- Work with CCGs and partners to agree and implement the respective HWB Strategies
- Work with the two LRFs to continue robust local resilience and build for the future
- Ensure that the LAT manages its money within budget
- Develop and implement QIPP plans
- Ensure that there are robust arrangements in place to deliver the Mandate across the system
- Improve outcomes for population

Local Area Team structure (71-123 WTE plus embedded PHE staff)



- Team sizes are dependent on the direct commissioning responsibilities of the Local Area Team and whether they host clinical senates/networks.

Clinical Commissioning Groups

NHS

What are Clinical Commissioning Groups (CCGs)?

- Groups of GPs and other key healthcare professionals that will be responsible for around 80% of the healthcare budget in their area and will plan and pay for services for the local population.
- Clinical Commissioning Groups (CCGs) formerly known as GP Consortia, will buy services from the hospitals, ambulance service and community services providers.
- All GPs will be a member of the CCG in their area.
- Each CCG will have a governing body.
- Governing bodies will include GPs, nurses, hospital doctors, other healthcare professionals and patient/lay representatives.
- The CCGs will also be responsible for engaging with local people to ensure that the services they are paying for meet your needs.

Authorisation

NHS

- **Authorisation is the process by which CCGs will be assessed as ready to take on responsibility for health care budgets for their local communities**
- The authorisation process will be built around six domains – all of which are seen as indicators of success for a CCG and are linked to the legislative requirements that the NHS Commissioning Board must consider when assessing applications

The six domains of authorisation

NHS

- A strong clinical and multi-functional focus which brings real added value
- Meaningful engagement with patients, carers and their communities
- Clear and credible plans (meeting QIPP challenges, national requirements and health & wellbeing strategies)
- Proper constitutional and governance arrangements
- Collaborative commissioning arrangements (with other CCGs, local authorities, NHS Commissioning Board)
- Great leaders who individually and collectively make a difference

The timetable for local CCG authorisation

	CCG	360° stakeholder survey	Application submitted to NHS CB(A)	Authorisation decision returned to CCG
Wave 1	Portsmouth	June 2012	2 July 2012	October 2012
Wave 2	West Hampshire. North East Hampshire & Farnham. South Eastern Hampshire. Fareham & Gosport.	July 2012	3 September 2012	November 2012
Wave 3	North Hampshire	September 2012	1 October 2012	December 2012
Wave 4	Southampton	October 2012	1 November 2012	January 2013

SHIP Area – Shadow Clinical Commissioning Groups

Southampton, Hampshire Isle of Wight & Portsmouth

West Hampshire 536,643

- Barton and Web Peploe Surgeries
- New Forest Central Medical Group
- Twin Oaks Medical Centre
- Ringwood Medical Centre
- Lyndhurst Surgery
- Testvale Surgery
- Cornerways Medical Centre
- Totton Health Centre
- Forestside Medical Centre
- Chawton House Surgery
- Waterfront and Solent Surgery
- The Fordingbridge Surgery
- Forest Gate Surgery
- The Red & Green Practice
- Wistaria Surgery & Milford Medical Centre
- New Milton Health Centre
- The Arnewood Practice
- Abbey Mead Surgery
- Boyatt Wood Surgery
- Hedge End Medical Centre
- Park & St Francis Surgeries
- West End Surgery
- Bursledon Surgery
- Leighside Practice
- Parkside Practice
- St Andrew's Surgery
- Blackthorn Health Centre
- Pine View Practice
- St Luke's Surgery
- Stokewood Surgery
- Alma Road Surgery
- Old Anchor Surgery
- North Baddesley Surgery
- The Fryern Surgery
- Nightingale Surgery
- The Brownhill Surgery
- Twyford Surgery
- Stockbridge Surgery
- The Andover Hc Medical Practice
- Charlton Hill Surgery
- Wickham Group Surgery
- St Clement's Surgery
- West Meon
- St Paul's Surgery
- The Adelaide Medical Centre
- Mansfield Park Surgery
- Bishops Waltham Surgery
- Shepherd Spring Medical Centre
- St Mary's Surgery
- Gratton Surgery
- Alresford Surgery
- The Friarsgate Practice
- Whitchurch Surgery
- Derrydown Clinic

North Hampshire 208,656

- The Beggarwood Surgery
- Kingsclere Health Centre
- Shakespeare House Health Centre
- Chawton Park Surgery
- East Barn Surgery
- Brambys Grange Partnership
- Hampshire Healthcare Centre
- The Wilson Practice
- Chineham Medical Centre
- Bermuda Practice
- Clift Surgery
- Overton and Oakley Practice
- South Ham Practice
- Crown Heights Medical Centre
- Rooksdown Practice
- Tadley Medical Partnership
- Boundaries Surgery
- Gillies Health Centre
- The Hackwood Partnership
- Hook & Hartley Wintney Practice
- Odiham Health Centre

North East Hampshire and Farnham 216,000

- Giffard Drive Surgery
- Victoria Practice
- Hartley Corner Surgery
- The Oaklands Practice
- Southlea Group Practice
- Milestone Surgery
- Richmond Surgery
- Fleet Medical Centre
- Alexander House Surgery
- Jenner House Surgery
- Branksomewood Healthcare Centre
- The Border Practice
- Princes Gardens Surgery
- Mayfield Medical Centre
- Southwood Practice
- The Wellington Practice
- Monteagle Surgery
- Crondall New Surgery
- North Camp Surgery
- Dr O'Donnell & Partners
- The Ferns Medical Practice
- Holly Tree Surgery
- The Farnham Dene Medical Practice
- The Downing Street Surgery

South Eastern Hampshire 211,764

- The Bosmere Medical Centre
- Swan Surgery
- Horndean Health Centre
- Clanfield Surgery
- Riverside Partnership
- The Grange Surgery
- Denmead Health Centre
- The Village Surgery, Cowplain
- Rowlands Castle Surgery
- Middle Park Surgery
- Cowplain Family Practice
- The Homewell Practice
- Havant Surgery
- The Waterside Medical Practice
- Park Lane Medical Centre
- Waterbrook Medical Practice
- Liphook & Liss Surgery
- The Curlew Practice
- Staunton Surgery
- Forest End Surgery
- Queenswood Surgery
- Emsworth Surgery
- The Elms Practice
- Stakes Lodge Surgery
- Greywells Surgery
- Highview Surgery
- Badgerswood Surgery
- Liphook Village Surgery
- Pinehill Surgery
- Bentley Village Surgery

Southampton City 234,600

- Adelaide GP Surgery
- Aldermoor Surgery
- Alma Medical Centre
- Atherley House Surgery
- Bargate Medical Centre
- Bath Lodge Practice
- Bitterne Park Surgery
- Brook House Surgery
- Burgess Road Surgery
- Canute Surgery
- Chessel Practice
- Cheviot Road Surgery
- Grove Medical Practice
- Highfield Health
- Hill Lane Surgery
- Homeless Health Care Team
- Ladies Walk Practice
- Linfield Surgery
- Lordshill Health Centre
- Mulberry House Surgery
- Nichols Town Surgery
- Old Fire Station Surgery
- Portswood Road Surgery
- Raymond Road Surgery
- Regents Park Surgery
- St Denys Surgery
- St Mary's Surgery
- St Peter's Surgery
- Spitfire Court Surgery
- Stoneham Lane Surgery
- Townhill Surgery
- University Health Service
- Victor Street Surgery
- Walnut Tree Surgery
- West End Road Surgery
- Weston Lane Surgery
- Woolston Lodge Surgery

Fareham and Gosport 198,834

- Bridgemary Medical Centre
- Lee-on-Solent Health Centre
- Manor Way Surgery
- Gosport Medical Centre
- Stoke Road Medical Centre
- Lockswood Surgery
- Portchester Health Centre
- Jubilee Surgery
- Brune Medical Centre
- Highlands Medical Centre
- Brockhurst Medical Centre
- Rowner Health Centre
- Brook Lane Surgery
- Stubbington Surgery
- Forton Medical Centre
- Bury Road Surgery
- Westlands Medical Centre
- Waterside Medical Centre
- Centre Practice
- The Whiteley Surgery
- Gudge Heath Lane Surgery

Isle of Wight 140,200

- Medina Healthcare
- East Cowes Health Centre
- Beacon Health Centre
- Ventnor Medical Centre
- Grove House Surgery
- South Wight Surgery
- Esplanade Surgery
- Carisbrooke Health Centre
- Beech Grove Surgery
- Garfield Road Surgery
- Argyll House Surgery
- St. Helen's Medical Centre
- Sandown Health Centre
- Shanklin Medical Centre
- Cowes Medical Centre
- Brookside Health Centre
- The Dower House
- Tower House Surgery

Portsmouth 200,000

- The Health House
- Queens Road Surgery
- Somers Town Health Centre
- John Pounds Medical Centre
- Campbell Road Surgery
- Waverley Road Surgery
- Milton Park Practice
- North Harbour Medical Group
- The Drayton Surgery
- Kirklands Surgery
- Hanway Group Practice
- Northern Road Surgery
- University Surgery
- Guildhall Walk Healthcare Centre
- Crookhorn Surgery
- Kingston Crescent Surgery
- Cosham Park House Surgery
- Paulsgrove Surgery
- The Devonshire Practice
- Ramilies
- Salisbury Road Surgery
- The Osborne Practice
- Sunnyside Medical Centre
- Lake Road Health Centre
- Baffins Surgery
- Heyward Road Surgery
- Southsea Medical Centre
- Eastney Health Centre
- Somers Town Health Centre
- Derby Road Group Practice

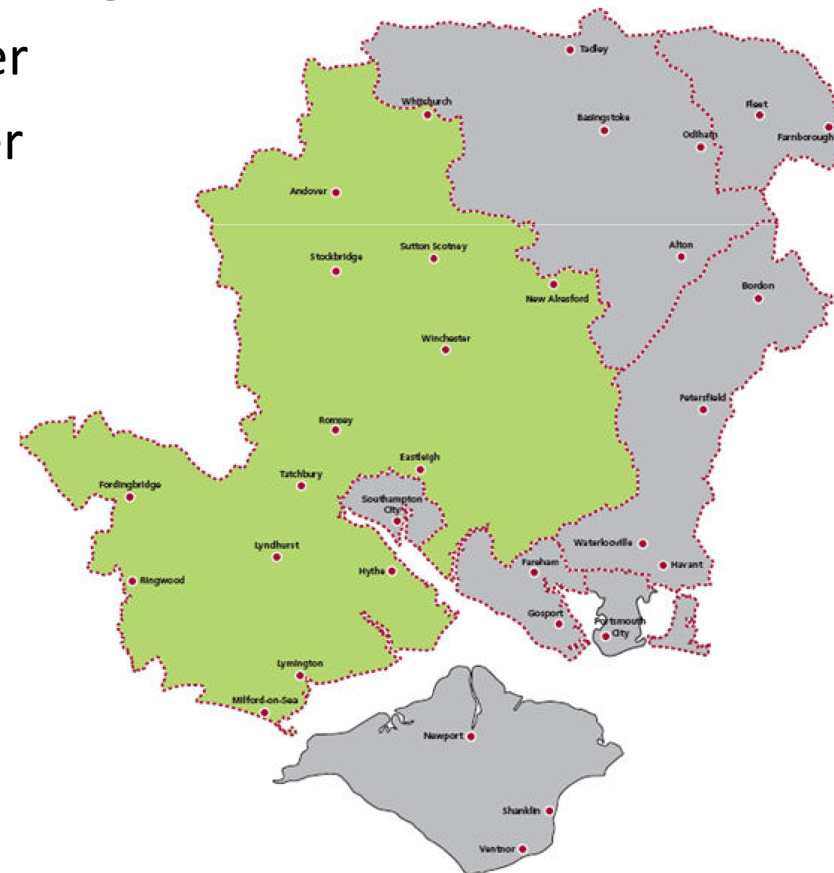
Tadley
Whitchurch
Basingstoke
Fleet
Odiham
Farnborough
Farnham
Andover
Stockbridge
Sutton Scotney
Alton
Bordon
New Alresford
Winchester
Petersfield
Romsey
Eastleigh
Tatchbury
Fordingbridge
Southampton City
Lyndhurst
Waterlooville
Havant
Fareham
Ringwood
Hythe
Gosport
Portsmouth
Lymington
Milford-on-Sea
Newport
Shanklin
Ventnor

SLA33139 – NHS Creative – June 2012

Who's who in West Hampshire CCG

NHS
West Hampshire
Clinical Commissioning Group

- Dr Sarah Schofield, Chair
- Heather Hauschild, Chief Officer (designate)
- Mike Fulford, Chief Finance Officer
- Margaret Wheatcroft, lay member
- Peter Bradshaw, lay member



http://www.westhampshireccg.nhs.uk/

Who's who in North Hampshire CCG

NHS
North Hampshire
Clinical Commissioning Group

- Dr Hugh Freeman, Chair
- Dr Sam Hullah, Chief Officer (designate)
- Lisa Briggs, Chief Operating Officer
- Pam Hobbs, Chief Finance Officer
- Colin Godfrey – patient representative

http://www.northhampshireccg.com/

Who’s who in North East Hampshire and Farnham CCG

North East Hampshire and Farnham
Clinical Commissioning Group

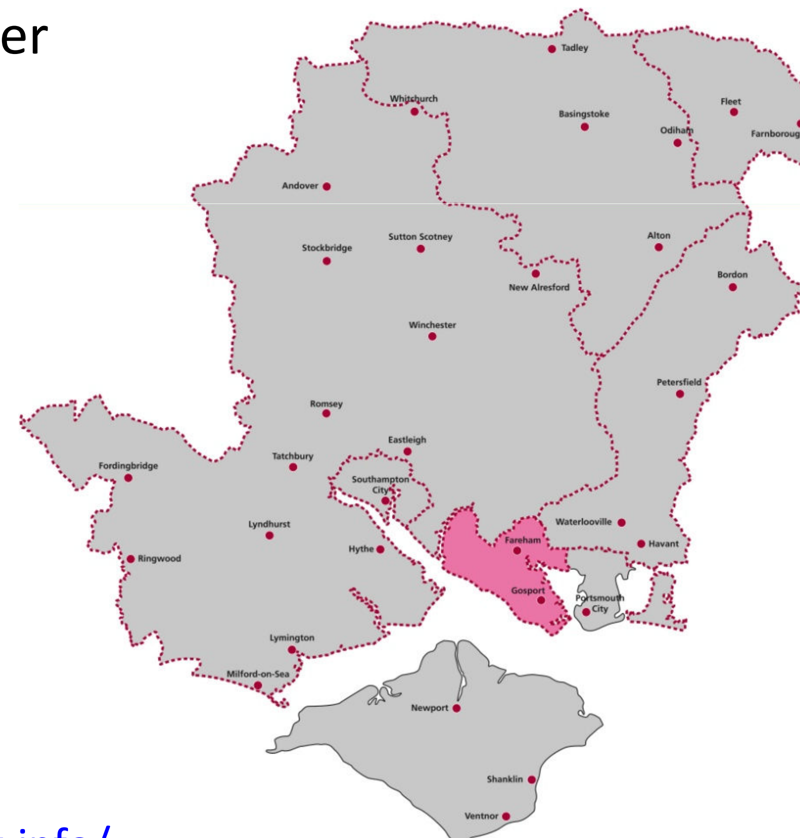
- Dr Andrew Whitfield, Chair
- Maggie MacIsaac, Chief Officer (designate)
- Jonathon Molyneux, Chief Finance Officer
- Frank Rust - Hampshire Local Involvement Network (LINk) Representative
- Donald Hepburn – Patient Participation Representative

http://www.northeasthampshireandfarnhamccg.nhs.uk/

Who’s who in Fareham and Gosport CCG

NHS
Fareham and Gosport
Clinical Commissioning Group

- Dr David Chilvers, Chair
- Richard Samuel, Chief Officer (designate)
- Andrew Wood, Chief Finance Officer
- Dr Keith Barnard, lay member



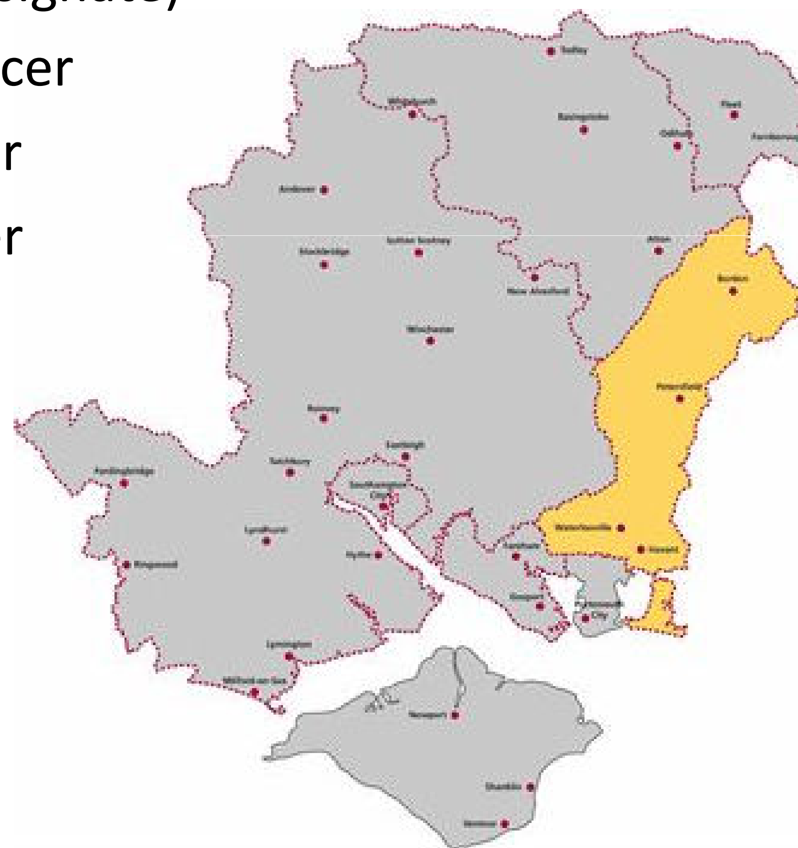
http://www.farehamandgosportcommissioning.info/

Who's who in South Eastern Hampshire CCG

NHS

South Eastern Hampshire
Clinical Commissioning Group

- Dr Barbara Rushton, Chair
- Richard Samuel, Chief Officer (designate)
- Andrew Wood, Chief Finance Officer
- Tracey Faraday Drake, lay member
- Susanne Hasselmann, lay member



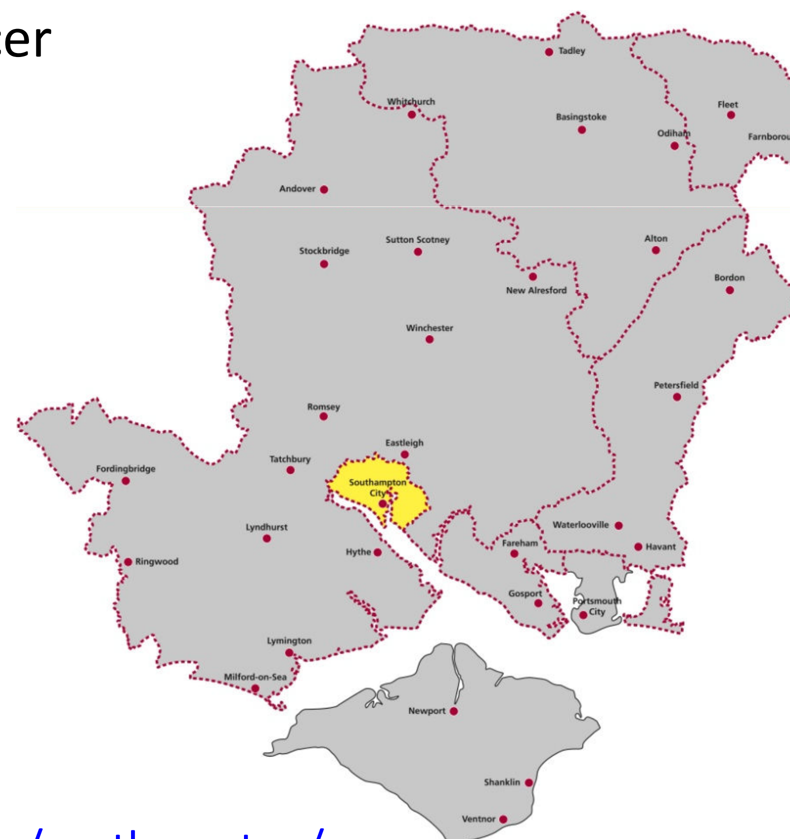
http://www.southamptonhealth.nhs.uk/ship/sehccg/

NHS

Southampton City
Clinical Commissioning Group

Who's who in Southampton CCG

- Dr Steve Townsend, Chair
- John Richards, Chief Officer (designate)
- James Rimmer, Chief Finance Officer



http://www.southamptonhealth.nhs.uk/ship/ccg/southampton/

![NHS]

Who's who in Isle of Wight CCG

Isle of Wight
Clinical Commissioning Group

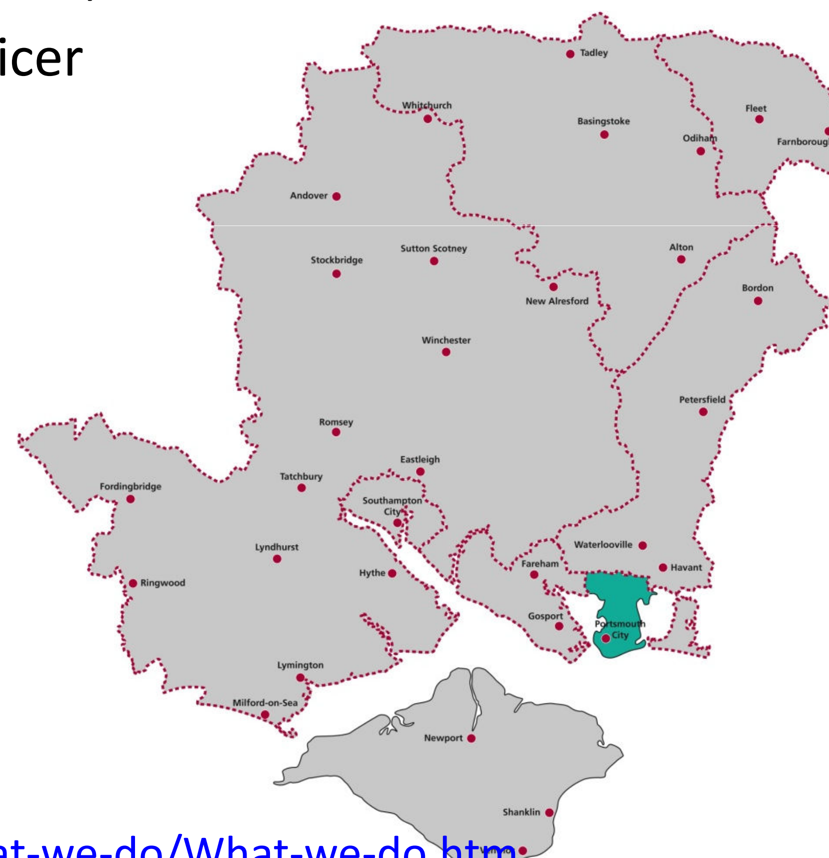
- Dr John Rivers, Chair
- Helen Shields, Chief Officer (designate)
- Loretta Outhwaite, Chief Finance Officer
- Lay members

http://www.isleofwightccg.nhs.uk/

Who's who in Portsmouth CCG

NHS
Portsmouth
Clinical Commissioning Group

- Dr Tim Wilkinson, Chair
- Dr Jim Hogan, Chief Officer (designate)
- Innes Richens, Chief Operating Officer
- Jo Gooch, Chief Finance Officer
- Lay members



http://www.portsmouth.nhs.uk/About-Us/What-we-do/What-we-do.htm

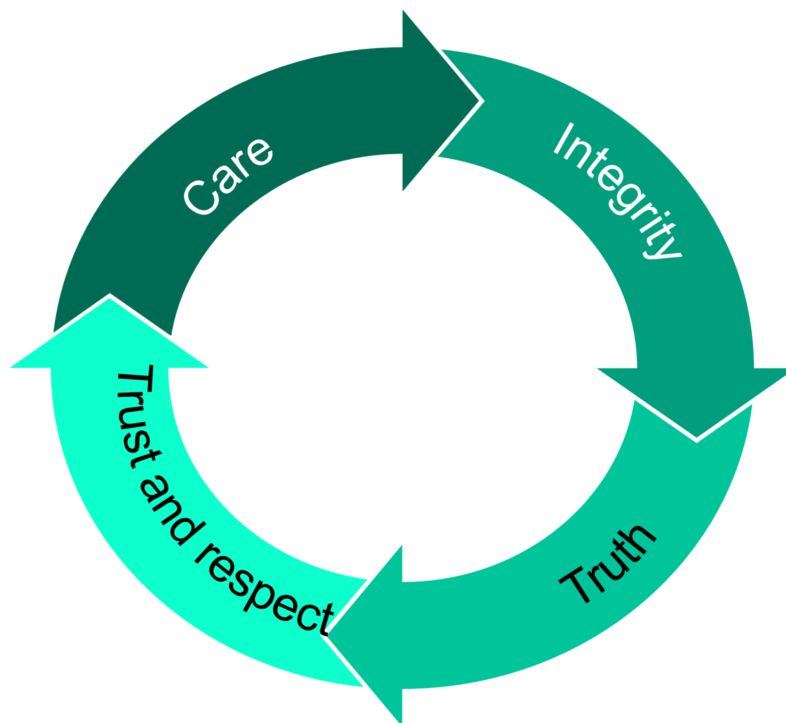
Commissioning Support South

Our Vision and Promise

- Our Vision
  - To be the commissioning support service of choice for local CCGs
- Our promise describes what we will do to support our customers in delivering their goals:
  - To deliver a high quality, cost effective, efficient service that is flexible, agile and responsive and provides customers with the support they need to address their populations needs;
  - To ensure customers get a local, knowledgeable service that can adapt to their needs, and be aligned with their vision for the populations healthcare from one team, dedicated to excellence and customer advocacy; and
  - To be responsive, flexible and innovative in partnership with our customers, and be able to predict their future needs to ensure the effective and efficient implementation of future changes.

Vision

- We are sought after as the commissioning support unit of choice for local clinical commissioning groups: One Team, Many Minds, Best Solutions.
- We deliver our vision and promise through:



Our services

- We provide the services that the CCG wishes to buy
- The following lists the services that we currently hold as part of our core offer
- We are very happy to enter into agreements for services that customers wish to buy that are not listed here
- Our aim is to deliver solutions and outcomes rather than provide just services and as such discussion on the service specifications, outcome required and key performance indicators are as important as the list of services.

-

- Financial services
- Contracting
- Business intelligence
- Planning and performance
- Communications and engagement
- Information Technology for Commissioning and Primary Care
- Human resource management
- Learning and development
- Equality and diversity
- Strategic workforce expertise
- Corporate affairs and governance
- Medicines management
- Quality
- Commissioning for vulnerable adults
- Commissioning for childrens' services
- Clinical and non-clinical procurement
- Project and programme management

Delivery Model

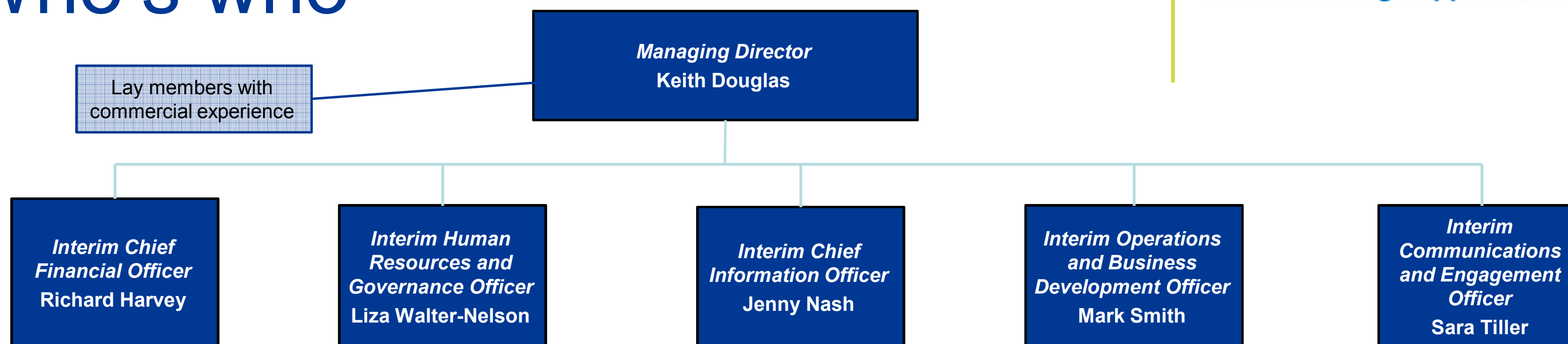
- Customer facing teams
  - working to and for customers
  - embedded with customers
  - possibly serving more than one customer therefore economies of scale
- Back office – do once for many – economies of scale
- Majority of services are directly provided
- A few services provided via sub-contracting or through our associates e.g.
  - Clinical and non-clinical Procurement
  - Project and procurement management
  - These services where joint working with other CSS/Local authorities etc. best meet the local need

Delivery ethos

- Provide the services our customers want
  - based on delivering outcomes as agreed with the customer
  - being customer focussed via local relationship management
- With integration across health systems, providing a local service that is or is based on best practice from elsewhere
  - Horizon scanning – what's good, how can we learn with or work with others to deliver current best practice
- To be a professional advisory service as well as a transactional service
- Acting as an intelligent and informed agent for the customer in relationships with other providers
  - Sub-contract/prime contract status
  - Minimise hand offs/interactions

Who’s who

Commissioning Support South



Questions