Public Document Pack

HEALTH OVERVIEW AND SCRUTINY PANEL

Thursday, 25th August, 2016 at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Rooms 3 and 4 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor P Baillie
Councillor Houghton
Councillor Mintoff
Councillor Noon
Councillor Savage
Councillor White

Contacts

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have six scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the Health Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview and Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

Mobile Telephones: - Please switch your mobile telephones to silent whilst in the meeting.

Use of Social Media: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Public Representations

At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

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

COUNCIL'S PRIORITIES:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

CONDUCT OF MEETING

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 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 INTERESTS

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

DISCLOSABLE PECUNIARY 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 of 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 an, '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.

Dates of Meetings: Municipal Year 2016/2017

2016	2017
30 June	23 February
25 August	27 April
27 October	
22 December	

AGENDA

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.

3 DECLARATIONS OF SCRUTINY INTEREST

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

4 DECLARATION OF PARTY POLITICAL WHIP

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

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

(Pages 1 - 4)

To approve and sign as a correct record the minutes of the meeting held on 30th June 2016 and to deal with any matters arising, attached.

7 TRANSFORMING PRIMARY MEDICAL CARE IN SOUTHAMPTON - DRAFT STRATEGY

(Pages 5 - 32)

Report of the Chair of NHS Southampton Clinical Commissioning Group requesting that the Panel consider and comment on the draft Primary Medical Care Strategy for Southampton.

8 MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE

(Pages 33 - 36)

Report of the Service Director, Legal and Governance detailing the actions of the Executive and monitoring progress of the recommendations of the Panel.

Wednesday, 17 August 2016 SERVICE DIRECTOR, LEGAL AND GOVERNANCE

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL
MINUTES OF THE MEETING HELD ON 30 JUNE 2016

Present: Councillors Bogle (Chair), P Baillie, Houghton, Mintoff, Noon, Savage and White

1. **ELECTION OF VICE-CHAIR**

RESOLVED: that Councillor White be elected as Vice-Chair for the 2016/2017 Municipal Year.

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

RESOLVED: that the minutes for the Panel meeting on 28th April 2016 be approved and signed as a correct record.

3. **UPDATE ON PROGRESS - INDEPENDENT REVIEW OF DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015**

The Panel considered the report of the Chairman of Southern Health NHS Foundation Trust providing the Panel with the requested update on Southern Health's progress implementing the improvement plan and feedback from regulators.

Tim Smart, Interim Chair, and Dr Lesley Stevens, Medical Director, of the Southern Health NHS Foundation Trust were in attendance and, with the consent of the chair, addressed the meeting.

It was noted that the Trust had, earlier that day, released a media statement that day that detailed the Interim Chair's intended course of actions. It was explained that the Board as a whole were currently undergoing a capability review and that the Interim Chair expected that there would be further changes in the near future. It was also explained that the role of the Chief Executive would be shifting toward focusing on the future strategy of the Trust and away from operational matters.

The Interim Chair outlined plans for the learning disability services within Oxfordshire to be transferred to the Oxford Health NHS Foundation Trust. In addition it was noted that, with the development of the multi-speciality community provider vanguard, the future form of Southern Health would significantly change.

The Panel questioned the Interim Chair on how these plans would align with the action plan set by the Care Quality Commission (CQC) and questioned how it was progressing against the targets set. It was explained that the Trust had so far matched the targets and timescales set out within the Action Plan.

The Chair noted correspondence from Councillor Pope seeking the support of the Panel to a motion of no confidence he had circulated. The Panel continued to echo his concerns over the Trust's performance. However, the Panel also noted that measures to improve the performance of the Board, and the Trust overall, were on going and chose not to support the motion at this time, noting instead that the Panel would continue to monitor and challenge the performance of the Trust.

Professor Kingdon, Clinical Services Director for Mental Health in Southampton detailed an urgent briefing that had been circulated to the Panel setting out the Southern Health NHS Foundation Trust's proposed course of action for Antelope House and the Psychiatric Intensive Care Unit (PICU). It was explained that due to severe staffing shortages Southern Health intended to close the Psychiatric Intensive Care Unit (PICU) based in Antelope House for a period of 8 months. It is anticipated that this decision will enable the remaining services operated at Antelope House, and elsewhere in Southampton, to continue to operate safely and allow for recruitment processes to deliver the required level of staffing. The Panel were appraised of the efforts the Trust had taken to work with patients and their families to mitigate the effect of the temporary closure. It was explained that because the Trust had taken to decision to close down the PICU as the temporary measure, the closure would not count as a substantial change in NHS provision.

RESOLVED

(i) That the Panel would continue to monitor the Trust's progress against the Mazars and Care Quality Commission recommendations;

(ii) That the Panel noted the temporary closure of the Psychiatric Intensive Care Unit (PICU) at Antelope House and requested to be kept informed on the progression of plans to reopen the facilities at Antelope House.

4. UPDATE ON 'GETTING THE BALANCE RIGHT IN COMMUNITY-BASED HEALTH SERVICES'

The Panel considered the report of the Director of System Delivery (NHS Southampton City Clinical Commissioning Group) providing the Panel with an assessment of the impact of the closure of the Bitterne Walk-In Service

Peter Horne, Director of System Delivery - Southampton City Clinical Commissioning Group (SCCCG), Sue Atkins, Jane Ward, Nick Chaffey, Barbara Webber and Dee Strutt - local residents, were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of issues arising from the report including:

- The increase in patients attending the Minor Injuries Unit based at the Royal South Hants Hospital and Emergency Depart of the Southampton General Hospital. The Panel were informed that whilst the number of attendees at the Minor Injuries Unit (MIU) was rising there had been a comparative fall in the numbers attending the Emergency department (ED), if you took into consideration national trends.
- The difficulty of getting a GP appointment in the area. The Panel noted that the provision of GP cover had not reduced but that some practices had

amalgamated. It was further explained that the Panel were intending to review the issue of primary care in Southampton at a later date.

- Concerns over the 111 service. It was noted that residents and Councillors had a number of reservations about the service relating to the training of the staff, the length of time it took to get through, and the repetition of information requested by the call operatives.
- Transportation links within the area. Residents noted that there had been no changes to bus services since the closure and that transport to the MIU and the ED was often only possible by taxi. It was noted that the area had high levels of deprivation and that many household did not have access to a car. It was explained that the SCCCG had now set up two hubs within the east where access to an appointment from 8:00 am to 8:00pm 7 days a week.
- A concern that those with health care issues in the east of the City were no longer accessing the correct information or health pathway. Residents stated that the figures indicated that demand for support from health care and or information, previously available at the walk in centre, had substantially reduced. The residents expressed concern that people were no longer bothering to access health care and that this was to the detriment of their wellbeing.

RESOLVED that the Panel:

(i) Noted the progress on decommissioning of the Bitterne Walk in Service (BWIS) and considered the information presented at the meeting and following discussions commented on the report.
(ii) Noted that the recommendations around the closure of the service, that were the responsibility of the CCG to enact, have been completed.
(iii) That the Chair would contact the Cabinet Member for Environment and Transport seeking further information and updates on plans to improve transportation links from the East of the City to health care facilitates;
(iv) Agreed to consider the CCG's emerging Primary Care Strategy at a meeting of the HOSP in 2016/17.That the Panel would look to scrutinise the 111 Service within the City, at a future meeting.

5. **SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY PANELS: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION (REVISED JUNE 2016)**

The Panel considered the report of the Service Director, Legal and Governance, recommending that the Panel agrees the revised arrangements for assessing substantial change in NHS provision

RESOLVED that the Panel agreed the revised arrangements, attached as Appendix 1, for assessing substantial change in NHS provision.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		TRANSFORMING PRIMARY MEDICAL CARE IN SOUTHAMPTON - DRAFT STRATEGY		
DATE OF DECISION:		25 AUGUST 2016		
REPORT OF:		CHAIR - NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Ali Howett**		
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY The draft primary care strategy was developed in response to a number of key challenges including financial and workforce constraints in general practice. It is the result of a prolonged period of information gathering and engagement with patients, General Practitioners (GPs) and other stakeholders.

The purpose of the strategy is two-fold. Firstly, it addresses the expectations of an evolutionary model of service delivery, as outlined in the Five Year Forward View, which meets the needs of patients and supports the delivery of Better Care locally; and secondly, it acknowledges the workforce challenge and recognises the importance of building a strong team of motivated and engaged health and care professionals across a range of disciplines with the GP at the core.

The intention is to produce one document that will appeal to everyone, recognising that individual elements will be of more or less interest to specific audiences. The content and format continues to evolve in response to feedback therefore it remains a work in progress at this time.

RECOMMENDATIONS: That the Panel		
	(i)	Consider the information presented at the meeting and following discussions comment on the draft Primary Care Strategy.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Health Overview and Scrutiny Panel has requested information about the future of local GP practices
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	Not applicable
DETAIL (Including consultation carried out)	
3.	As commissioners, our priority is to commission services that deliver the best quality care to our population within the scope of limited resources. We also need to support the development of the infrastructure that delivers those services.

4.	There is an inherent challenge in combining the different elements of this strategy into one document. It needs to reflect and describe a transformation of service delivery that provides a sustainable operating model whilst also addressing the workforce challenge, which is a key driver for that transformation, and also improving health outcomes and patient experience.
5.	To achieve success, it is important for the GP community to feel engaged and support delivery of the plan. In addition patients have been engaged in the process of strategy development from the outset. A period of formal engagement took place in October and November 2015. Feedback from this has helped to shape the future model and specific feedback is included in the document.
6.	Engagement on the Strategy continues with discussions taking place at the Communications and Engagement Group Reference group, the Consult and Challenge Group and Patients Forum. Further group meetings are planned with, amongst others, Healthwatch and the Pensioners Forum.
RESOURCE IMPLICATIONS	
Capital/Revenue	
7.	Not applicable.
Property/Other	
8.	The draft strategy identifies objectives relating to infrastructure and the standard of general practice premises.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
9.	Not applicable.
Other Legal Implications:	
10.	None.
POLICY FRAMEWORK IMPLICATIONS	
11.	Not applicable.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION		
Appendices		
1.	Draft - Transforming Primary Medical Care in Southampton Strategy	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents **Equality 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	

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DRAFT

Transforming Primary Medical Care in Southampton

5 Year Strategy

2016-2021

Southampton City
Clinical Commissioning Group

"The secret of **change** is to focus all your energy not on fighting the old, but **building the new**"

Socrates

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> "A plan for General Practice needs to ensure that the people of the City have access to high quality, consistent, sustainable Primary Care that meets their needs, whilst being attractive to support recruitment and retention of GPs and their allied staff."

Foreword

We know that General Practice is the foundation upon which effective patient care rests. We also know that there are not enough GPs to provide care in the way it has traditionally been delivered. Indeed, the focus on person-centred, collaborative care means that GPs are increasingly working as part of a team which includes social care and the community. This approach allows GPs to use their skills in co-ordinating and managing the medical care of people with often complex medical and social issues, whilst being supported by a team who can offer very different skills and resources to complement the traditional medically focussed care delivered in Primary Care.

The GP Forward View makes it very clear that, in future, services for people will be developed at a population based level (such as a Locality Cluster, of which we have six in Southampton), rather than at a practice list level.

A plan for General Practice needs to ensure that the people of the City have access to high quality, consistent, sustainable Primary Care that meets their needs, whilst being attractive to support recruitment and retention of GPs and their allied staff. As providers, GP Practices (specifically, the Partners) are responsible for ensuring that their organisation is able to deliver the primary medical services commissioned from them, despite the challenge of recruiting and retaining appropriate staff. The priority for the City is to shape a different model of General Practice which will help GPs to fulfil these responsibilities and mitigate the risks to both services and the practice as a business entity.

This plan has been informed by the views and suggestions of City GPs, as well as other stakeholders, following a number of engagement events across the City. It has a dual purpose in that it sets out the future direction of primary care commissioning whilst also providing a basis for a strategy for sustainability that GP Practices lead and own.

Dr Sue Robinson
Clinical Chair and GP, NHS Southampton City Clinical Commissioning Group (CCG)

Introduction & Context

Purpose of this strategy

The transforming primary medical care strategy was born out of the need to respond to a number of **key challenges**, including financial and workforce constraints in general practice. It has been developed by a working group including five GPs and has been influenced by a prolonged period of information gathering and **engagement** with GPs, practice staff, patients and service users, local providers and other stakeholders via the GP forum, surveys and a stakeholder workshop.

The purpose of the strategy is two-fold. **Firstly**, it addresses the expectations of an evolutionary model of service delivery, as outlined in the *Five Year Forward View* and *GP Forward View*, which meets the needs of people and supports the delivery of Better Care locally; and **secondly**, it acknowledges the workforce challenge and recognises the importance of building a strong team of motivated and engaged health and care professionals across a range of disciplines with the GP at the core.

The intention is to produce one document that will appeal to everyone, recognising that individual elements will be of more or less interest to specific audiences.

How does this strategy align to the CCG's vision and transformation programmes?

Southampton City CCG believes that general practice provides the **foundation** for all other health services and that a strong and sustainable general practice is crucial to securing health care services in the future. Here in Southampton, there are significant programmes of transformation underway. General practice has been identified as one of the key strategic work programmes for Southampton City CCG in 2016/17 and beyond, which will support the delivery of the CCG's overall vision to deliver *"A Healthy Southampton for All".*

Our latest **GP patient experience survey** (July 2016) shows that we have a strong clinical team and are achieving comparable success in some elements of access to appointments;

→ 96% have confidence and trust in their GP *(95% nationally)*
→ 97% have confidence and trust in the nurse they saw *(97% nationally)*
→ 92% were able to get a convenient appointment *(92% nationally)*
→ 63% were able to see their preferred GP always or a lot of the time *(58% nationally)*

However, general practice in Southampton is under the same pressures as observed nationally and is **not sustainable** – **workforce challenges, increasing elderly population, rise in prevalence of long-term conditions, increasing costs and increasing patient expectation** means that general practice needs to change radically if it is to be sustainable and meet the needs of our population.

Case for Change

Case for change

National drivers for change

General Practice is facing significant challenges which, if not resolved, will significantly impact the whole **health and social care system** and our ability to care for people effectively at home and in the community. It is the first port of call for the vast majority of the population, with over **90% of all contacts with the NHS taking place in general practice**, and if it fails the whole NHS will fail.

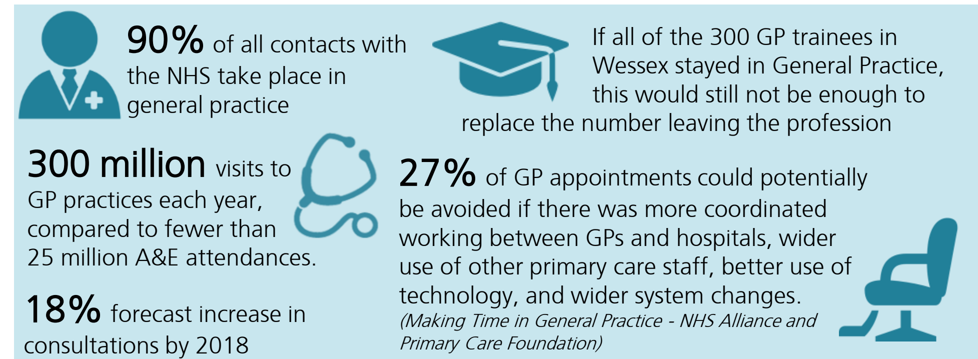
The GP workforce has expanded more slowly than the acute medical workforce and there is national concern around the intensity of workload in primary care. Total direct face-to-face and telephone contacts with patients increased by **15.4%** across all clinical staff groups between 2010/11 and 2014/15. During the same period, the average patient list size increased by **10%**. This is compounded by significant **workforce issues** - over the last 5 years there has been an increasing issue with the recruitment and retention of GPs, practice nurses and practice managers. In addition, there is a national shortage of GPs with many **retiring** early – some in their 50s.

General Practice services also need to meet expectations to be more **accessible** to the population. For example, in a recent survey of patients in Southampton, feedback showed that high numbers of patients would like to see more evening and weekend appointments.

As with the acute sector, the **population is becoming over-reliant** on General Practice and we need to support our population to build independence and self-manage wherever possible. National studies suggest that as many as **27% of face to face GP appointments could be avoided** given appropriate resources (including 7% of people who could be seen to another health professional and 6% who could self-care). A survey of local practice managers suggests that the figure could be even higher.

An effective general practice model is critical to improving the health and wellbeing of our population and enabling people to be cared at home. It is therefore important that the *GP Forward View* is delivered at a local level and resources are made available to support practices. This will require investment in general practice.

To help with the demand in hospitals and to cope with the rising demand in the community, the workforce both in general practice and supporting general practice, must be increased in addition to finding better ways of working that are more efficient. Increasing the number of GPs will only be achieved if general practice becomes a better place to work whereby those who feel they have lost control of their working days regain that control. The workforce must be further expanded by investing in other care professionals such as nurse practitioners, pharmacists, mental health workers. Social workers should also be aligned to general practices and work as members of an integrated health and social care team wrapped around the practice.



The *Five Year Forward View* outlines objectives around focussing on preventative care, empowering patients and puts forward a number of new innovative models of care which encourage integration and a person centred approach to delivery of care. It states that strong general practice and primary care services are essential for a high quality and responsive NHS, fit for the future.

GPs and practice teams provide vital services for people. They are at the heart of our communities, the foundation of the NHS and internationally renowned. However, with limited financial resources and a national workforce recruitment challenge, coupled with unprecedented pressure, it is clear that action is needed.

It has been widely accepted for some years that the NHS is faced with the challenges of an increasingly elderly population with an associated rise in the prevalence of long-term conditions, increasing costs and increasing patient expectation and will need to change radically if it is to be sustainable and meet the needs of the population in the 21st century.

Case for change

Local drivers for change

In Southampton, primary care is under the same pressures as observed nationally. General practice still largely operates in small independent businesses and these have provided good care, particularly holistic and continuing care. However, it increasingly appears that this business model is unsustainable because of our local challenges;

Southampton's workforce challenges:

- **1 in 5** of the Southampton GP workforce is **aged 55+**, with many retiring early
- Ageing practice nurse workforce
- Insufficient numbers of GPs in **training**
- Recruitment is difficult; practices carrying **vacancies**

Our quality and infrastructure challenges:

- Patient experience remains low compared to other city populations
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- Variations in the premises from which primary health care is delivered
- Information sharing across health and social care IT systems is suboptimal

Southampton's demography challenges:

- **15%** increase in **over 65s** (2015-21)
- **20%** increase in **over 85s** (2015-21)
- **12%** of the population is aged **20-24** (Higher than average student/younger population)
- **23%** of the population live in the **most deprived** small geographical areas **in England** (known as LSOAs – Lower Super Output Areas)
- **11,282** (4.6%) forecast increase in **the overall population** (2015-21)
- **22.3%** of the population have a recorded ethnicity of **other than white-British**
- **17.6%** of the population **were born outside the UK**
- **300%** increase in **Europe Migrants** in the last 10 years
- People **die earlier** in the most deprived areas than those in the least deprived:
  - Women **3.2 years** earlier
  - Men **6.7 years** earlier

Southampton's health challenges:

- **20.3%** of **children** in Year 6 are **obese**
- **22%** of **adults** are **smokers**
- **25%** of **adults** are **obese**
- **75%** of the over 65s population is living with **2 or more long term conditions**
- **29,000 adults** are registered with **hypertension**
- **32%** of the population (all ages) **have a long term condition**
- **5,500 adults** are registered with **COPD**
- **490 deaths** from **cancer** (2014)
- **483 deaths** from **respiratory disease** (2014)
- **12,000 adults** are registered with **Diabetes**
- **15,000 adults** are registered with **Depression**

Listening to our GPs and Patients

GP feedback

- In late 2015, we ran a survey and asked Southampton GPs for **their biggest challenges or frustrations in their day-to-day work**.
- These are genuine statements of what they told us and the key themes that came out;

Time with the patient & complexity

"10 minute appointments are **never long enough** for most patients, they either have a list of problems or complex multi-morbidity"

"Over-running on a regular basis due to more and more **complex patients**, and those requiring more time"

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Capacity & workload

"Not enough **time** in the day, too many targets to reach that takes time away from patients"

"So **busy** sorting the day-to-day stuff I can't look forwards"

Patients

"Too many patients seeking medical appointments for social/non health related problems"

"Unrealistic and **unreasonable demands** from the public. General lack of common sense, inability to cope with minor illness."

Integrated working

"**Poor interface** between primary, secondary and community care. Time wasted trying to ring back social workers and members of community psychiatric services."

Staffing

"We are running so tight that any unplanned sick leave or annual leave completely throws the practice"

Satisfaction

"Each day is **14 hours** long with a minimum of 3-4 hours of **administration**."

"It can be an **isolating** job, stuck in your room all day without seeing anyone"

Development

"Lack of **support** for GP's wishing to develop leadership **skills** to fill gaps left as our Senior colleagues retire in next 5 years"

Patient feedback

- We also ran a survey and asked Southampton patients for the **three things they most value about their GP service**.
- The three areas below received the most votes and these are genuine statements of what they told us;

Appointments (Access)

"Get an **urgent**, **same day** appointment when I need one"

"Speaking to a GP on the **phone**"

"Making an appointment for a non-urgent matter in advance, at a **convenient** time"

"**Early** and **late** appointments for workers"

"Having a GP practice **close to my home**"

Service

"Caring and **person-centred** approach"

"**Preventative** measures, such as injections for influenza"

"Personalised services"

"Good organisation and **communication** between staff and patients"

Continuity

"Seeing my **GP who knows me**, or seeing an alternative GP who has enough **information** in front of them to know about me and what's going on with me"

"Records **sharing** between GPs and other health staff"

"My GP reviews the **whole picture** of all of my long term conditions, not just the one thing I'm seeing her about today"

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Our Vision

Our Vision

Building a model of general practice in our city that will be the strong, effective and sustainable foundation of our integrated health and social care system.

Our Objectives

- Primary care services that are responsive to change and working effectively as part of a whole system to meet the needs of the population
- Equitable, person-centred primary care for a registered list of patients benefiting from improved access to services and continuity of care where needed
- Collaborative model that appeals to professionals
- Health and social care based around groups of practices in a neighbourhood
- Primary care system based on quality and reducing health inequalities where possible
- System-wide culture of learning and continuous improvement
- High standards balanced against needs of individuals

Key Areas of Focus

Access

People are provided with access to the level of care that they need at the appropriate time, with same day access and services available in the evenings and at the weekend, 7 days a week.

Quality

People are provided with high quality care which is safe and effective, meeting their needs.

People have a positive experience, which is person-centred, dignified and compassionate.

Workforce

Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers.

Infrastructure (Estates & Technology)

Fit for purpose premises which enable access to clinical services out of hospital, 7 days a week.

Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care.

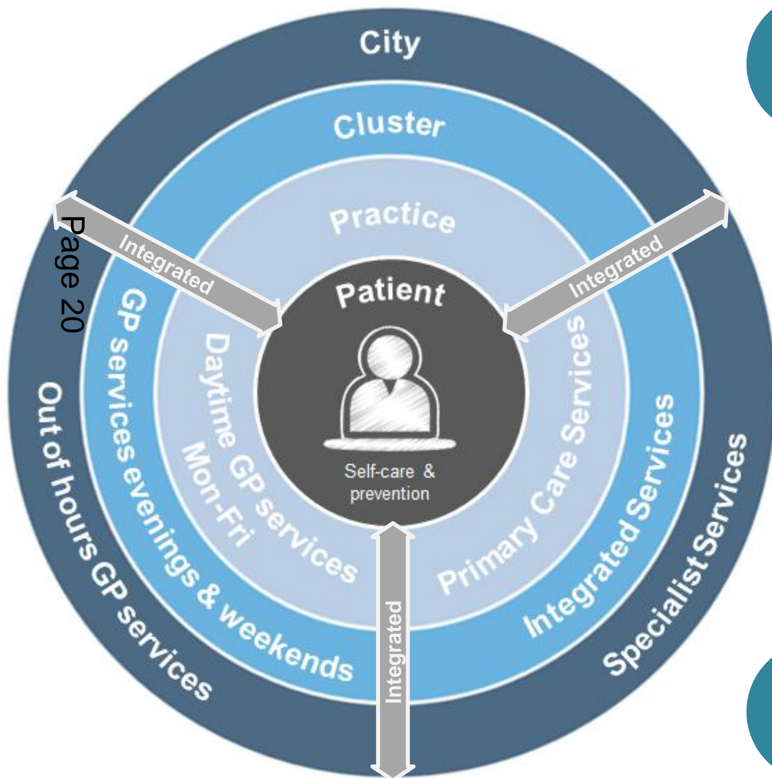
Collaboration

Sustainable and resilient GP services support delivery of integrated care in the city.

The future model of primary medical care

At the centre of this model is the **patient**.

To meet the needs of a changing population and those of an evolving health and social care system, primary care in Southampton must:



1. Generate a **viable, sustainable** service that is, and continues to be, responsive to the needs of all registered patients, recognising the variety and diversity of those needs, and providing them with access to the level of care that they need at the appropriate time.
2. Be creative in the approach to service provision, **working in collaboration** as required to balance same day access for treatment of acute illness with **continuity of care** and **proactive care planning** for those with routine or ongoing health needs, providing services in the **evenings** and at the **weekend**.
3. Take a **multi-disciplinary** approach to the provision of primary care services, with other health professionals such as nurses (including mental health), pharmacists and therapists actively managing patients as part of an **extended practice team** and supporting the delivery of Better Care.
4. Ensure that people have **access in a primary care setting** to the health professional best able to support them, with co-ordination and oversight provided by the GP.
5. Focus on **improving quality and health outcomes**, with particular emphasis on **prevention, safe care, proactive care planning, self-management** and using the principles of **making every contact count**, with the patient firmly at the centre of their care arrangements.
6. Embrace **innovation** and utilise **technology** to provide alternative solutions to traditional methods of delivering care.
7. Create a structure that supports **workforce development** by providing entry points and learning opportunities at all stages in the professional career pathway, supported by flexible contracting arrangements (independent or employed) that meet the needs of individuals.

The future model – key areas of focus

Access

- Patients are still registered with a **local practice** which has its own team of doctors, nurses and other staff.
- Improved access arrangements mean that people can book a planned appointment in their own surgery during normal working hours or they can choose a more **convenient** time in an alternative location within the cluster across **7 days** a week.
- Having an **extended primary care team** to absorb some of the more routine work means that GPs have more time to spend with people with long-term chronic illness or complex health needs who need more support.
- GPs, practice nurses and other practice staff work mainly in their own practice but can also spend time working as part of a **cluster or city-wide arrangement** which provides services seven days per week and out of hours.
- Access to **urgent care** will be simplified and aligned across the system.

Quality

- Consistency of care to **reduce health inequalities** and support patient empowerment for **self-care and self-management** impacting on population health and wellbeing.
- Through clinical and management leadership providing **best care and best experience** for people and carers across all health and social boundaries.
- Practices throughout the city are rated as **good/outstanding by the CQC**.
- Adopting **new technologies** and innovations in healthcare to enhance patient care and quality of life.
- Developing key **skills, knowledge and experience** of all general practice staff to support right care, in the right place by the right person .

Workforce

- Nurses and other health professionals have an **extended role** in the primary care team, including; nurse triage for same day appointment requests; medication reviews and nursing home support from clinical pharmacists; management of musculoskeletal conditions by a physiotherapist or extended scope practitioner; a mental health worker to support people with low-level mental health needs.
- There is plenty of **opportunity** for GPs and practice nurses to develop special interests and work closely with specialists.

Infrastructure

- Practice premises are **modern, accessible and efficiently** run.
- Fully **digital primary care pathways** will be in operation and working effectively as part of the local health system, such as; online assessment and self-help advice; e-consultation; online appointment booking and prescription ordering and tracking; home monitoring and tele-healthcare.
- IT systems are fully **integrated** across primary, community and secondary care services and, with patient consent, clinicians have access to a patient's electronic medical record regardless of which service is being used.

Collaboration

- GPs work **collaboratively** in a new workforce structure that allows them to spend more time with their patients, to meet the growing demands of an aging population and fulfil the expectations of a more accessible service.
- An acute **home visiting service** operates during working hours, so GPs now only visit people who have complex problems or who need end of life care. Housebound people and those in nursing and residential homes are looked after by a special team which includes a GP, a community matron and an elderly care physician.
- All practices are part of a wider cluster network of services, along with other practices in the neighbourhood. This helps to provide access to a broader range of specialist clinical staff and services close to the patient's home.
- An **integrated primary, community and social care team** work together to care for people with long-term chronic conditions. The GP and other health professionals involved in a person's care work together to agree a care plan which is accessible at all times. The plan includes the person's personal health goals, guidance and support on managing their condition themselves and advice on what to do if they become ill.

The future day in the life of a Patient...

I have a new medical problem...

- I need some advice about a new medical problem and I go online to my surgery website and I'm taken through an **online assessment** which gives me some initial advice and guidance on **managing my condition myself** and takes account of my pre-existing conditions.
- If I need support from a health care professional I will be directed to the member of the **primary care team who can best meet my needs**. This may be a GP, nurse, pharmacist or other health or care professional. Today I am advised to see a GP who will be able to see the assessment I have already done.

My consultation options...

- There are a number of consultation options open to me such as **e-consultation, telephone support or surgery appointment**, all of which are bookable online via the surgery website or by telephone.
- I have a **choice of day, evening or weekend** appointments either at my own surgery or at another location in my neighbourhood.

During my consultation...

- There is **sufficient time** given for my consultation to meet my needs. My doctor suggests investigations and discusses **a management plan** with me. I am able to have the **blood tests straight away**, and the physician's assistant is able to organise the **onward referral** for hospital-based investigation with me, rather than the doctor.
- If I have any investigations, I am able to either check that they are all normal by **logging onto the practice App**, or will be contacted by the physicians assistant to explain the issues and arrange any further follow-up needed.

My prescriptions...

- I enquire about a repeat prescription at reception; it has been sent **electronically** to my preferred pharmacy. The surgery pharmacist suggests I book in with her for a **medication review**.

My feedback...

- After my appointment I get an email from the surgery **asking for feedback on my experience** to help them improve their services, which I take a few minutes to complete and send back to them.

Later that evening...

- My condition deteriorates at 9 o'clock that evening. I contact **NHS 111** and after completing an assessment process I am put through to an experienced GP who is able to **access my complete medical records**. I am offered an appointment at my **local cluster hub**, so it is not too far for me to travel.
- The out of hours doctor **updates directly into my own GP's records** and notifies the practice that I have been seen and sends a separate alert of any urgent actions which need to be taken.
- I know that, unless it is a life threatening emergency when I would need to be seen in the emergency department, **all of my care is centred in my GP practice**, which I will contact with any concerns.
- If I need to be seen outside the normal surgery hours of 8am to 6.30pm or I opt for a more convenient evening or weekend appointment, I understand **that I may have to travel a short distance to my locality hub**, of which there are three across the city.

My overall experience...

- My experience of using primary care services today has been **very positive.** I have been able to access both advice and services in a way that not only addresses my needs but also suits my preferences.

The future day in the life of a GP...

Consultations & home visits...

- There is a **designated doctor** available to deal with **urgent** patient enquires, clinical queries and calls from other health professionals. This may be in my practice or provided by a central service in the evenings.
- The people I consult with today will already have been through a **triage process or online assessment**, the details of which are available to me in the clinical record. My consultations are a mix of **surgery visits, telephone calls and e-consultations**.
- The **allied health professionals** who manage the routine care of my housebound patients and nursing or care home residents are a critical part of my practice team. My home visits are now limited to providing end of life care and responding to requests from clinical colleagues.
- Acute home visiting is now managed on a **locality basis** and the GP working in that service can view medical records with patient consent and **update directly into the record**. I am alerted to any follow up actions requiring attention.

Collaboration...

- My primary care team includes **other clinical disciplines** which allows my patients with complex needs to schedule one appointment to review their medical, nursing, pharmaceutical and care planning needs at a single visit.
- I am relieved that I no longer have to spend time trying to sort out system wide problems because there appears to be nobody else willing to take responsibility. The wider integrated primary, community and social care **multidisciplinary team (MDT)** now collectively takes responsibility for each patient and has an **allocated care manager** responsible for coordinating their care.
- I also have meetings about **significant events** with my MDT colleagues.

My time...

- I have more time to spend with more **complex patients** now that people are better supported to **self-manage** and some of my workload has moved over to other practitioners. I also have time for catching up with results, correspondence and emails.
- Any tests or investigations I have ordered today were arranged **electronically** to avoid delay and duplication of effort.
- At the end of the day there is **time to catch up** with colleagues and complete outstanding admin and paperwork.
- My days remain full but they are **manageable** and I am less frustrated as the interface between services is working effectively and demand is controlled.

My development...

- Not only do I provide clinical sessions in my practice but I also work additional sessions from a **menu of options in other areas** that interest me and keep our health system thriving. I am involved in **GP training** and a **mentoring programme** which encourages GP growth and development opportunities.

Key Areas of Focus

Access

Quality

Workforce

Infrastructure (Estates & IT)

Collaboration

Overall Objective: People are provided with access to the level of care that they need at the appropriate time, with same day access and services available in the evenings and at the weekend, 7 days a week.

What will success look like?

People can telephone or visit their surgery any time between **8am and 6.30pm**, Monday to Friday.

Pre-booked and **same day** appointments are structured across **7-days per week** to meet peoples' needs.

Providers of primary and secondary care services work together to co-ordinate a fully integrated primary care pathway for **urgent care 24 hours and 7 days** a week.

Patients are encouraged, educated and empowered to **manage their own health** and understand when clinical intervention is needed.

Innovative and **technological solutions** to support access, for example e-consultations, apps, home monitoring and telemedicine, are embedded as part of core primary care service delivery.

Creating sufficient capacity within primary care will ensure people have a good experience and encourage them to choose primary care as their first point of contact. Whilst patients may continue to access non-urgent or routine care from the surgery where they are registered, they may also choose a more convenient appointment in the evening or at the weekend at a different location.

Professional clinical advice will be available to all patients within Southampton 24 hours a day, 7 days a week to meet urgent medical needs. The challenge moving forward is to integrate and simplify services in a way which enables patients to understand where and how to access care when they need it. This may be at their surgery during the day or at a hub or primary care centre outside of surgery hours.

Prevention, self-management and care planning are key factors in managing demand. People will be supported to manage their own health where possible and to access professional advice when needed. Adoption of digital ways of working will be promoted to support this. This includes digital access to appointment booking, online assessment for acute problems, prescription ordering and medical records, as well as encouraging people to manage their health and wellbeing through easy access to advice and self-care tools. Self-referral routes will be available to support direct access to appropriate specialist services without the need to see a GP first.

Long term conditions will be supported by digitally enabled pathways, for example allowing people to self monitor conditions using their own devices and share data with their NHS record, and enabling online assessments to be completed for long term conditions to streamline the annual review process for both patient and practice.

Overall Objective: People are provided with high quality care which is safe and effective, meeting their needs. People have a positive experience, which is person-centred, dignified and compassionate.

What will success look like?

The quality framework shows evidence of **reduced variation in the quality of care** delivered across all practices

Expected standards for **screening** and **immunisations** are achieved across the whole population, using the principle of making every contact count

Patient reported outcome measures such as the GP Patient Survey and Friends and Family Test demonstrate improved **satisfaction** and **experience**

Health professionals have all the **clinical knowledge and skills** required to deliver safe and effective care to meet the needs of the population

There is evidence that providers are engaged in **incident/event reporting** and peer review to support a culture of ongoing **learning** and **development**

Practices throughout the city are rated **good/outstanding by the CQC**

Some variation is to be expected as a result of individual needs and preferences and the variability of populations; however, it is important to ensure that any unmet needs are addressed. Exploring and understanding variation between practices allows sharing of best practice and helps to narrow the gap.

There are a number of factors that may influence outcomes and create variation including; clinical knowledge and skills, patient preferences and choice, and availability or proximity of services.

A good example of how quality variation is being addressed is through the Diabetes Accreditation Scheme. Diabetes continues to be a priority for the city and work is ongoing to improve outcomes.

The CCG is developing a quality framework model for general practice to identify core standards of quality and provide an opportunity for continuous improvement. The high level Indicators to identify the domains of quality will be;

- Leadership – corporate responsibility and accountability for service delivery and improvement in general practice
- Patient Safety & Experience – ensuring safe and compliant services in a patient focussed system
- Workforce & Workload – supporting the management of service demands, competence and capability of staff and improvement in general practice
- Population Outcomes – responsibility for the health and wellbeing of population
- Performance – accountability for delivery of indicators and targets as agreed

The quality framework model is still in development and is taking account of both national and other CCGs' best practice. A wider discussion with local GPs is planned over the next few months before the model is adopted by the CCG. Once agreed it will be a valuable asset to monitoring progress of transforming General Practice in Southampton.

Workforce

Overall Objective: Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers.

What will success look like?

Practice teams are **motivated** and **engaged**, incorporating a range of **skilled professionals** delivering the appropriate level of care to meet patients' needs.

Professional **development** and succession planning are embedded principles for all providers.

GPs and other health and care professionals working in the city are supported to achieve their preferred **career pathway** and develop special interests, so facilitating recruitment.

25% of the Southampton GP workforce is over 55, with many taking early retirement (GP workforce audit 2015). This coupled with a shrinking GP talent pool at national level, calls for modernisation of the workforce model locally to ensure the city can successfully compete in the skills market.

The future primary care workforce model includes a range of skilled professionals including GPs, nurses, pharmacists and allied health professionals. These will be assisted by trained support staff including health care assistants, mental health workers, clinical support workers and other similar roles. The emergent new model of primary care will help to attract professionals into the area and build resilience into the primary care system. Career development opportunities will be available across all disciplines allowing professionals to build a portfolio career. The workforce structure will allow flexible working arrangements that improve work/life balance.

The plan requires strong leadership for successful implementation and local providers are asked to adapt to meet the changing needs and work to create these new roles.

Infrastructure (Estates & Technology)

Overall Objective: Fit for purpose premises which enable access to clinical services out of hospital, 7 days a week. Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care.

What will success look like?

Completion of a **modernisation programme** ensuring that primary care premises are fit for purpose, provide increased capacity and enable services to be delivered 7 days per week.

Flexible, **multi-use space** is available which is adaptable to service needs and can accommodate innovative and collaborative projects for health and social care provision in partnership with other agencies.

A **resource centre** is located in each of the six clusters across the city providing; a multi-occupancy base for the integrated team supporting all practices in the cluster; multi-use space for training, outreach services and other local initiatives; and information and tools to support people to manage their own health.

Premises and **technology** developments support a culture of learning and education for both staff and patients.

Clinical computer systems are **interoperable**, facilitating communication and information sharing between service interfaces.

Creative and innovative **digital solutions** which support and empower people to manage their own health are embedded.

Across Southampton, there is variation in the standard of general practice premises. Some practices have insufficient space to deliver care that consistently improves outcomes for patients, including meeting regulatory core standards. Premises are also a limiting factor in plans to enable collaborative working, including extended hours and reducing reliance on secondary care services. Delivering the ambitious plans for collaboration and primary care working at scale will be dependent upon having an estates infrastructure that is capable of supporting this new arrangement.

Resource centres will be co-located with a practice in a central location within each cluster and have easy geographical access. The facilities provided will support and empower peoples' self-help, education and prevention with a view to managing their own health and wellbeing. This will include self-monitoring (blood pressure, weight etc.) and also online and printed information and tools to help with self-management of specific conditions. A modernisation programme will ensure that these facilities and the other practices that they support are suitable for delivering primary medical services today and into the future.

The government has made a commitment that all patient and care records will be digitally interoperable and paperless by 2020 and CCGs are required to have a digital roadmap by the summer of 2016 to deliver this. This will reduce risk, waste and inefficiencies within the system, leading to a better experience for people and clinicians alike. Technology is a key enabler to deliver;

- Proactive care, for example through online wellbeing assessments, health improvement resources or support communities;
- Better access, for example with online service portals, telephone triage and email appointment systems;
- Better coordination, with interoperable systems allowing clinicians to share agreed information across organisational boundaries; and
- Modern care, for example, remote monitoring and diagnostic devices.

Collaboration

Overall Objective: Sustainable and resilient GP services support delivery of integrated care in the city.

What will success look like?

GP practices operating within a **business framework** that ensures sustainable primary care.

Practices are **working together** to build a resilient service in the future which operates at scale but remains focused on the registered population.

Primary care is fully engaged with the **local integrated provider group** to deliver true person centred, integrated care.

The **operating model** delivers improvements to health outcomes, patient experience, access and workforce development.

Collaboration is seen as a key enabler to the successful delivery of change initiatives. We are seeing GP practices throughout the country starting to work more closely together in order to maximise the use of their resources, be more innovative with the services they offer patients, and ultimately provide higher quality patient care. It is widely believed that new ways of working across general practice will be a key factor in ensuring a resilient service in the future and we firmly believe the development of collaborative working is essential. This move has been promoted by the NHS Five Year Forward View along with the NHS General Practice Forward View as the way forward for practices at a time when people are living longer and developing more complex health and care needs.

Our vision for primary care will only be possible if the service is supported by a robust and viable business model. In the main, GP practices are separate business entities. Most consist of GPs working in a partnership arrangement and some are run by larger organisations (both NHS organisations and private companies). This independent contractor model is not conducive to meeting the ever-increasing demands and expectations on the service such as extended access in the evenings and at weekends.

In Southampton, primary care is under the same pressures as observed nationally and we are already beginning to see collaboration in action; for example, practice mergers. The numerous benefits include:

- By combining office functions, supplier contracts and administrative and management processes, the practice becomes more financially viable and can redirect resources to improve patient care.
- As a result, smaller practices can benefit from services that have traditionally only been affordable for a larger practice such as nurse practitioners or phlebotomists.
- A larger practice is able to offer a wider range of wellbeing services which support people with complex health and care needs.
- Pooling clinicians means that a wider range of hours can be covered thus offering patients greater convenience of appointments.
- A larger support team can lead to a reduction in administration time for clinicians allowing them to concentrate on patient care.
- There is a bigger support network for new GPs which can make a practice a more attractive prospect in the job market.
- Pooling resources allows creativity and innovation to flourish which leads to a better experience for patients and a better working environment for staff.

Next steps – planning for successful delivery

Next steps – planning for successful delivery

The transforming primary medical care strategy aims to capture the core objectives of what the future model of general practice in Southampton should look like. In starting to explore how we can influence real transformational change in general practice across Southampton, we need to consider funding and workforce requirements, GP ownership and the development of a delivery plan.

Next Steps	
Funding	▪ The *General Practice Forward View* recognises that primary care has been underfunded compared to secondary care over a period of years. ▪ The changes required to deliver this strategy, such as workforce and estates, cannot be made without significant investment. ▪ Financial resources will be available to deliver change programmes, not shore up the existing arrangements ▪ The government has pledged to invest a further £2.4 billion per year into general practice by 2020/21. For Southampton, this means that over the next 5 years the CCG will receive growth in primary care funding of £6.93m. This is, over those 5 years, a 22% increase on 2015/16. This increase assumes a growth of 2.93% in our list size over this period. ▪ In addition to this increase, further funding will be made available to support the development of new models of care as described in the *Five Year Forward View*. Access to this funding will be linked to transformational change programmes designed to deliver general practice at scale. ▪ Capital funding will be available to develop the infrastructure necessary to support these change programmes.
Workforce	▪ A workforce of appropriate number, skills and roles is imperative for transforming care. ▪ In January 2015, a £10m ten point plan was released, focussing on recruitment, retention and supporting those who wish to return to general practice ▪ To compete successfully in the recruitment market, we must create an infrastructure which will support and encourage learning, growth and development of all primary care practitioners and also provide flexibility and career development options to meet the needs of a new generation of health care professionals.
Leadership	▪ Given the national drivers and the impact these are having on practices locally, there is a certain inevitability to change. ▪ Culture and behaviour change is a key factor in success. It requires ownership of both the problems and the solutions by everyone involved including patients, GPs and all other clinicians and staff. ▪ Successful implementation of Transforming Primary Medical Care in Southampton will require the enthusiasm, commitment and support of all GPs and practice staff working in the city. ▪ Engagement of all stakeholders will continue throughout the life of the strategy. ▪ Recognising the need for change is the first step on the transformation journey. Examples of initiatives that are delivering results in other areas are already emerging, for example Making Time in General Practice. There are also a range of organisational development tools available to support practices in identifying areas where change can make a positive difference.
Delivery plan	▪ Development of a detailed delivery plan will form Phase 2 of the change process. ▪ Actions will be identified in each of the five key areas of focus; access, quality, workforce, infrastructure and collaboration. The markers of success identified for each of these areas will be used to map the changes necessary for achievement.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE		
DATE OF DECISION:		25 AUGUST 2016		
REPORT OF:		SERVICE DIRECTOR - LEGAL AND GOVERNANCE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY		
This item enables the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.		
RECOMMENDATIONS:		
	(i)	That the Panel considers the responses to recommendations from previous meetings and provides feedback.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To assist the Panel in assessing the impact and consequence of recommendations made at previous meetings.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
3.	Appendix 1 of the report sets out the recommendations made at previous meetings of the Health Overview and Scrutiny Panel. It also contains summaries of any action taken in response to the recommendations.	
4.	The progress status for each recommendation is indicated and if the Health Overview and Scrutiny Panel confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Panel does not accept the matter has been adequately completed, it will be kept on the list and reported back to the next meeting. It will remain on the list until such time as the Panel accepts the recommendation as completed. Rejected recommendations will only be removed from the list after being reported to the Health Overview and Scrutiny Panel.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
5.	None.	

Property/Other	
6.	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
8.	None
POLICY FRAMEWORK IMPLICATIONS	
9.	None
KEY DECISION	No
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report

SUPPORTING DOCUMENTATION

Appendices	
1.	Monitoring Scrutiny Recommendations – 25th August 2016
Documents In Members' Rooms	
1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	No
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	No
Other Background Documents **Equality 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	

Health Overview and Scrutiny Panel: Monitoring Recommendations

Scrutiny Monitoring – 25th August 2016

Date	Title	Action proposed	Action Taken	Progress Status
30/06/16	Update on 'Getting the Balance Right in Community-Based health services'	1) That, as part of a focus on primary care, the Panel consider the CCG's emerging Primary Care Strategy at a meeting of the HOSP in 2016/17.	Agreed. The Draft Primary Care Strategy is on 25 August HOSP agenda.	
		2) That the Panel review the 111 service at a meeting of the HOSP in 2016/17.	Agreed. To support the discussion it is proposed that the Panel are invited to visit the 111 call centre to see it in operation. If agreed details will be circulated to the Panel.	
		3) That, whilst recognising the emergence of two GP hubs offering extended hours in the east of Southampton, the Council's Executive is requested to respond to the concerns raised about access to urgent care by public transport from the east of Southampton, especially during off peak hours.	Update to be provided at the meeting	

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