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Health Overview and Scrutiny Panel

Thursday, 24th August, 2017
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 and 4 - Civic Centre

This meeting is open to the public

Members

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

Contacts

Ed Grimshaw
Democratic Support Officer
Tel: 023 8083 2390
Email: ed.grimshaw@southampton.gov.uk

Mark Pirnie
Scrutiny Manager
Tel: 023 8083 3886
Email: mark.pirnie@southampton.gov.uk

PUBLIC INFORMATION

ROLE OF HEALTH OVERVIEW SCRUTINY PANEL (TERMS OF REFERENCE)

The Health Overview and Scrutiny Panel's responsibilities and terms of reference are set out within Part 3 of the Council's Constitution: Responsibility for Functions

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.

MOBILE TELEPHONES: - Please switch your mobile telephones to silent whilst in the meeting.

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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.

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent lives
- Southampton is an attractive modern City, where people are proud to live and work

CONDUCT OF MEETING

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 2017/2018

2017	2018
29 June	22 February
24 August	26 April
26 October	
7 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 29 June 2017 and to deal with any matters arising, attached.

7 UPDATE ON DISCHARGES FROM UNIVERSITY HOSPITAL SOUTHAMPTON
(Pages 5 - 12)

Report of the Chief Executive of University Hospital Southampton and the Service Director – Adults, Housing and Communities, providing the Panel with an update on discharges from University Hospital Southampton.

8 EMERGENCY FLOW IN UNIVERSITY HOSPITAL SOUTHAMPTON
(Pages 13 - 16)

Report of the Chief Executive, University Hospital Southampton Foundation Trust, providing the Panel with an update on emergency flow at Southampton General Hospital.

9 UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST - CQC REPORT

(Pages 17 - 40)

Report of the Chair recommending that the Panel note the outcome of the 2017 CQC inspection and discuss the actions that the Trust intend to take in response to the findings.

10 UPDATE ON 'TRANSFORMING PRIMARY MEDICAL CARE IN SOUTHAMPTON 2017-2021 (SOUTHAMPTON

(Pages 41 - 78)

Report of the Director - System Delivery providing an update on the progress and planning for the delivery of Southampton City CCG's strategy – "Transforming Primary Medical Care in Southampton 2017-2021".

11 MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE.

(Pages 79 - 82)

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

Wednesday, 16 August 2017 SERVICE DIRECTOR, LEGAL AND GOVERNANCE

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 29 JUNE 2017

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

Apologies: Councillors Mintoff

Also in attendance Councillor Shields – Cabinet Member for Health and Sustainable Living

1. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

It was noted that following receipt of the temporary resignation of Councillor Mintoff from the Panel the Service Director, Legal and Governance, acting under delegated powers, had appointed Councillor McEwing to replace them for the purposes of this meeting.

2. **ELECTION OF VICE-CHAIR**

RESOLVED: that Councillor White be appointed as Vice-Chair for the 2017/2018 Municipal Year.

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

RESOLVED: that the minutes for the Panel meeting on 27 April 2017 be approved and signed as a correct record.

4. **HAMPSHIRE AND ISLE OF WIGHT SUSTAINABILITY AND TRANSFORMATION PLAN: DELIVERY PLAN**

The Panel considered the report of the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) Lead detailing progress made to date on the core delivery programmes.

Richard Samuel (Hampshire and Isle of Wight – Sustainability and Transformation Plan Lead) and John Richards (Chief Officer NHS Southampton City Clinical Commissioning Group) and Dr Sue Robinson (Clinical Chair of the Southampton City Clinical Commissioning Group) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel were presented with an overview of how the regional STP was progressing and developing its core delivery programmes. It was noted that these had been broadened to include services for the treatment of children and cancer. It was noted that the STP was building on local plans such as the Better Care programme in the

City. It was explained that local ownership of the programme was a key aspect of the STP.

The Panel questioned how IT issues were being managed noting that the Hampshire Health Records System had provided a platform that enabled the differing health organisations to share information electronically.

It was explained that the City's Better Care Programme had been used to help draw together the draft Southampton City Local Delivery System Plan. The Chief Officer NHS Southampton City Clinical Commissioning Group explained that it would be possible to share this draft plan with the Panel in order for Members to understand the detail of how the local plan was feeding into the core programmes of the STP.

The Panel questioned how the system was adapting to the use of modern technology especially around the potential scope of text messaging. The Panel were keen to see the local system taking advantage of the opportunities such as these to drive forward savings, greater efficiency and an enhanced patient experience. The Panel discussed the 111 service and in particular reflected on the pilot that was introducing a greater level of clinical input into the service with the aim of making it more effective and increasing patient satisfaction.

The Panel questioned how both local and regional plans would impact on dental health outcomes within the City. The recommendation of the former Southampton Public Health Director which set out their considerations relating to the addition of fluoride to the water supply in Southampton was noted and the Panel requested clarification on the decision making process and on the role of the Health and Wellbeing Board in this matter.

The Panel questioned how the STP would include considerations around adults with learning disabilities. The Panel were particularly concerned that delays on health care plans for children would have a knock on effect in establishing the correct levels of funding.

RESOLVED that the Panel requested:

- (i) that clarification is provided to the Panel of the decision making process required to introduce fluoride into the water supply and the role that the Health and Wellbeing Board would play in this decision;
- (ii) that the draft Southampton City Local Delivery System Plan is circulated to the Panel;
- (iii) that the Panel would review the impact of, and the potential for technology at a future meeting.

5. MAKING BETTER USE OF OUR COMMUNITY HOSPITALS IN SOUTHAMPTON

The Panel considered the report of the Director, System Delivery - NHS Southampton Clinical Commissioning Group, informing the Panel of proposals to make better use of the land and buildings at the Royal South Hants Hospital and at the Western Community Hospital.

Peter Horne (Director of System Delivery, Southampton City Clinical Commissioning Group), Paul Benson (Senior Commissioner, Southampton City Clinical Commissioning Group) and Harry Dymond (Chair of Healthwatch Southampton) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel noted the key drivers and intentions of the proposals to rationalise the use of land at the two sites. It was explained that the project was essentially an exercise to consolidate and tidy up the estate of the local health service in order to:

- Make better use of sites within the City;
- Draw together key departments; and
- Improve customer experience and clinical efficiency.

The process undertaken to develop the proposal to its current state was explained to the Panel. It was noted that there were a number of factors that had been taken into consideration including:

- a clinical need for an extra care facility and improve the efficiency of services offered by facilitating the movement of patients through to key departments;
- a desire to enhance the potential offer to employees through the construction of key worker housing;
- community concerns that would need to be overcome including parking difficulties and the public impression/perception of the disused and vacant Department of Psychiatry. It was noted that a community use could be found for the Chapel building at the Royal South Hants site; and
- the financial concerns. It was noted that the proposals needed to be both practical and affordable.

It was noted that Healthwatch had been engaged within the early discussions and that at this stage the plans to reconfigure the clinical configuration of the two sites were being supported.

RESOLVED that the Panel noted the report and broadly supported the CCG's direction of travel for the two sites. It was recognised that this would be a challenging programme and requested that the Panel be kept informed as the programme develops.

6. SOUTHAMPTON SUICIDE PREVENTION PLAN

The Panel considered the report of the Chair of the Health Overview and Scrutiny Panel requesting that the Panel consider the quality of the Southampton Suicide Prevention plan and how effectively it is being implemented.

Dr Jason Horsley (Director of Public Health) and Sally Denley (Public Health Development Manager) were in attendance and, with the consent of the Chair, addressed the meeting.

It was explained that this item had come forward at the direct request of the House of Commons Health Committee who had recommended that there should be scrutiny of the implementation of the local suicide prevention plans.

It was noted that Southampton's figures were a cause for concern. The Panel explored the potential reasons for the records showing a higher than average rate locally. Officers stated that the reason for the high figures were unclear but, there did seem to

be a correlation between the increase in suicides, both nationally and locally, and the performance of the economy. Officers stated that figures also indicated that the biggest increase in numbers had been seen within the middle aged, white, male sector of society.

It was explained that the figures reflected concerns and issues across Southampton but, noted that there were sections of society which tended to show higher rates of both suicide and attempted suicide and that work was being undertaken to support individuals within these groups through community engagement and a variety of methods.

It was explained that whilst the amount of finance allocated by the Council to this issue was small it was being used as effectively as possible. Officers identified that some of the funding had been used to support communities and the families of those who had committed suicide. The Panel explored how additional support could be given through programmes of education in schools and sports clubs.

RESOLVED that the report be noted and that further updates be brought to the Panel in due course.

Agenda Item 7

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL			
SUBJECT:	UPDATE ON DISCHARGES FROM UNIVERSITY HOSPITAL SOUTHAMPTON			
DATE OF DECISION:	24 AUGUST 2017			
REPORT OF:	CHIEF EXECUTIVE, UNIVERSITY HOSPITAL SOUTHAMPTON AND THE SERVICE DIRECTOR, ADULTS, HOUSING AND COMMUNITIES, SOUTHAMPTON CITY COUNCIL			

CONTACT DETAILS				
AUTHOR:	**Name:**	**Jane Hayward** **Sharon Stewart**	**Tel:**	**023 8120 6060** **023 8083 2660**
	E-mail:	Jane.Hayward@uhs.nhs.uk sharon.stewart@southampton.gov.uk		
Director	**Name:**	**Fiona Dalton, Chief Executive, UHS** **Paul Juan, Service Director – Adults, Housing and Communities, SCC**	**Tel:**	**023 8120 6060** **023 8083 2530**
	E-mail:	fiona.dalton@uhs.nhs.uk paul.juan@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

The University Hospital Southampton NHS Foundation Trust and representatives from Adult Social Care at Southampton City Council will update the committee on progress being made reducing complex discharges in the Hospital.

RECOMMENDATIONS:

	(i)	The Panel is asked to note the work which has been undertaken across the system since HOSP last considered this matter and the improvements which have been made.

REASONS FOR REPORT RECOMMENDATIONS

1.	At the request of the Chair of the Panel.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)

3.	Following discussion at the February 2017 meeting of the HOSP the Panel requested an update on discharges from University Hospital Southampton at the August 2017 meeting.
4.	Attached as Appendix 1 is an update on discharges from University Hospital

	Southampton that identifies the current position and the steps that are being taken to improve performance across the system.
RESOURCE IMPLICATIONS	
Capital/Revenue	
5.	N/A
Property/Other	
6.	N/A
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.
Other Legal Implications:	
8.	N/A
RISK MANAGEMENT IMPLICATIONS	
9.	N/A
POLICY FRAMEWORK IMPLICATIONS	
10.	N/A

KEY DECISION	N/A
WARDS/COMMUNITIES AFFECTED:	N/A

SUPPORTING DOCUMENTATION	
Appendices	
1.	Update on discharges from University Hospital Southampton
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	

Update on Discharges from University Hospital Southampton – August 2017

Southampton City Council Health Overview and Scrutiny Panel

Introduction

Our last update in February 2017 discussed a considerable body of work that had been undertaken internally within the Trust and externally in collaboration with commissioners, community providers and the councils in relation to discharge and centred around the three pathways outlined in *Figure 1*. This work has continued and the pathways are now well bedded.

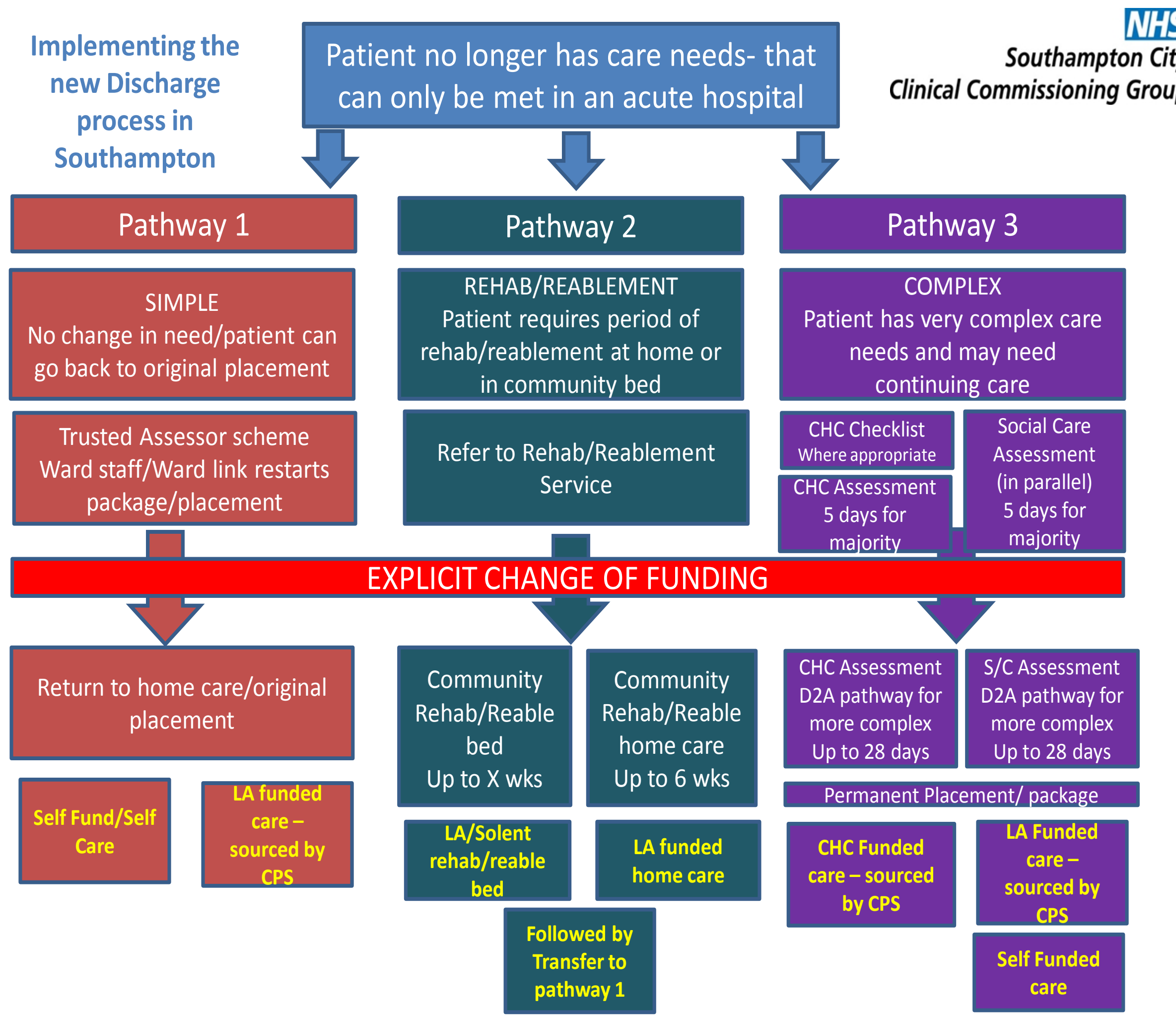


Figure 1: discharge pathways out of hospital

Details of work undertaken / ongoing

a) Agreed recovery trajectories with Southampton and West Hampshire Clinical Commissioning Groups and the relevant Councils for Delayed Transfer of Care

- Reduce the system Delayed Transfers of Care rate to 3.5% by March 2018
- Allocate specific performance targets to each delay reason cited within the Care Act reporting metrics

b) Ongoing development of the UHS discharge team and Integrated Discharge Bureau

- Development of Discharge Officer team to co-ordinate and case manage the discharge of complex patients in clinical ward areas, competency based
- UHS Complex Discharge manager recruited and started in post March 2017
- IT systems and new Social care act compliant system well embedded
- Ongoing trust wide education
- 7 day working consultation for UHS IDB staff commencing August 15th 2017

c) Development of processes within the Emergency Department and Acute Medical Unit

- Plan discharge from admission
- Investment in resource and Frailty service
- Consultant geriatrician in Emergency Department and Acute Medical Unit between hours of 8-8 will be in place from October
- Work with Solent Urgent Response Service (URS) and SCC to embed pathways to more effectively pull patients out and better link with RSH

d) Development of systems within the hospital to support flow

- Electronic Patient Status At a Glance (ward white) boards – launch due Oct/Nov 2017
- Introduction of effective board round project successful within MOP and medicine wards, to roll out across Trust this Autumn, includes red and green days
- 'Eat Sleep Move' (Previously 'Stay Active' campaign) remains trust priority for 2017/18. Launched Summer 2017 and is ongoing

e) Development of processes to enable UHS staff to discharge patients down pathway 1 / simple pathway without the involvement of social care

- Trusted professional contract with HCC in place, SCC to follow shortly
- Training complete on HCC systems, training on SCC IT systems will be required once contract in place
- UHS Trusted professionals working through competencies and shadowing HCC staff
- Process will be same for SCC once agreement in place
- Data collection and impact assessment underway

f) Successful roll out of Supported pathway in conjunction with Solent NHS trust

- Discharge to assess scheme increased capacity to 22 patients per week
- Reconfiguration of Royal South Hants to support better flow into non-acute step down beds – demonstrable improvement in RSH flow

- Further investment from Southampton City Clinical Commissioning Group in year 2017/18 and national recognition from NHS England - Cited in annual NHS-E report as best practice D2A scheme nationally.

Continuing healthcare (CHC) processes

A combination of increased admissions, increased complexity and unexpected staff shortages has resulted in deterioration in performance. In the immediate term UHS has used internal staff to increase capacity and are actively recruiting. However, with the large restructure within WHCCG CHC teams there is a high risk that the current and future staff vacancies within UHS will remain unfilled. In the longer term the health system plans to perform a higher number of CHC assessments in the community: either prior to admission or on a discharge to assess basis. This is increasingly mandated by NHS-England. Determining a model and funding this continues to provide challenge to the system.

Time to wait for domiciliary care

This remains the major issue for the national and local system. Delay in sourcing packages of care has increased, currently due to summer school holidays but anticipated also in the coming winter months. This impacts patients leaving the General Hospital and also those in the RSH and the effectiveness of the supported discharge to assess pathway. This is the major priority for the Southampton Health and Social care system and as such the organisations are working collaboratively to source dom care solutions. The situation is considerably better in the City than in Hampshire – to try and alleviate the situation UHS are working with HCC to recruit HCA's to provide dom care in hard to source areas in Hampshire, secondment and permanent recruitment is currently underway. Following a pilot, use of Care Home Select is underway to help source home care to support under pressure brokerage systems.

Time to wait for rehabilitation beds

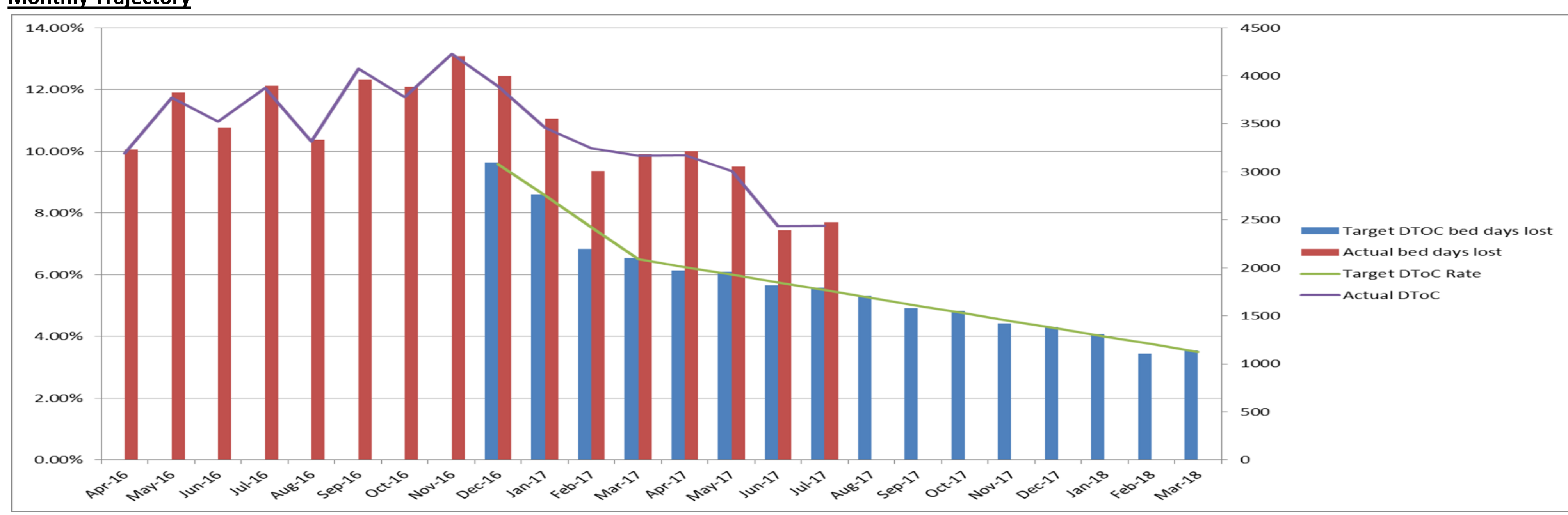
Flow into rehabilitation beds at the Royal South Hants has improved considerably and associated waits are usually no more than a few days, this is mostly due to a well embedded 'pull' model from RSH staff based within the IDB, as well as initiatives detailed above.

Conclusion

Good progress has been made in many areas towards improving safe and timely discharge from hospital. The joint work we have put in is well embedded and continues to show its results in terms of the increasing numbers of discharges and operational position at the hospital relative to the regional and national picture. Whilst there has been an improvement in the performance since the last report, maintaining a steadily improving picture remains a challenge for the system and heading into the winter months will require additional focus.

The Panel should be aware that there are still significant risks and challenges as we move forward. Major pressures are a consequence of increased admission rates, increased frailty within the population and ongoing recruitment issues within the domiciliary care market.

Monthly Trajectory



Improvement against trajectory, UHS, Southampton and Hampshire

Weekly Trajectory	06-Apr-17	13-Apr-17	20-Apr-17	27-Apr-17	04-May-17	11-May-17	18-May-17	25-May-17	01-Jun-17	08-Jun-17	15-Jun-17	22-Jun-17	29-Jun-17
UHS													
Total - Target	63	62	62	62	62	60	60	60	60	57	57	57	57
Total - Actual	103	105	126	124	103	112	110	95	82	88	85	89	92
Variance	40	43	64	62	41	52	50	35	22	31	28	32	35
Target DToC Rate	6.25%	6.25%	6.25%	6.25%	6.00%	6.00%	6.00%	6.00%	5.75%	5.75%	5.75%	5.75%	5.75%
Actual DToC Rate	9.88%	10.07%	12.08%	11.89%	9.88%	10.74%	10.55%	9.11%	7.86%	8.44%	8.15%	8.53%	8.82%
Southampton	06-Apr-17	13-Apr-17	20-Apr-17	27-Apr-17	04-May-17	11-May-17	18-May-17	25-May-17	01-Jun-17	08-Jun-17	15-Jun-17	22-Jun-17	29-Jun-17
Total - Target (30%)	19	19	19	19	19	18	18	18	18	17	17	17	17
Total - Actual	32	35	35	35	27	32	31	33	27	35	31	26	28
Variance	13	16	16	16	8	14	13	15	9	18	14	9	11
Health & Social Target (46%)	9	9	9	9	9	8	8	8	8	8	8	8	8
Health - Actual	12	16	22	19	15	15	16	16	16	13	17	9	14
Social - Actual	13	9	9	11	7	13	10	12	10	21	14	15	12
Both Target (7%)	1	1	1	1	1	1	1	1	1	1	1	1	1
Both - Actual	7	10	4	5	5	4	5	5	1	1	0	2	2
Hampshire	06-Apr-17	13-Apr-17	20-Apr-17	27-Apr-17	04-May-17	11-May-17	18-May-17	25-May-17	01-Jun-17	08-Jun-17	15-Jun-17	22-Jun-17	29-Jun-17
Total - Target (70%)	44	43	43	43	43	42	42	42	42	40	40	40	40
Total - Actual	71	70	91	89	76	80	79	62	55	53	54	63	64
Variance	27	27	48	46	33	38	37	20	13	13	14	23	24
Health & Social Target (46%)	20	20	20	20	20	19	19	19	19	18	18	18	18
Health - Actual	37	27	48	37	22	33	36	28	31	37	29	29	33
Social - Actual	33	40	40	49	49	39	38	30	22	15	24	33	31
Both Target (7%)	3	3	3	3	3	3	3	3	3	3	3	3	3
Both - Actual	1	3	3	3	5	8	5	4	2	1	1	1	0

Weekly Trajectory	06-Jul-17	13-Jul-17	20-Jul-17	27-Jul-17	03-Aug-17	10-Aug-17	17-Aug-17	24-Aug-17	31-Aug-17	07-Sep-17	14-Sep-17	21-Sep-17	28-Sep-17
UHS													
Total - Target	57	54	54	54	54	52	52	52	52	52	49	49	49
Total - Actual	78	80	78	83	90	92	0	0	0	0	0	0	0
Variance	21	26	24	29	36	40	-52	-52	-52	-52	-49	-49	-49
Target DToC Rate	5.50%	5.50%	5.50%	5.50%	5.25%	5.25%	5.25%	5.25%	5.25%	5.00%	5.00%	5.00%	5.00%
Actual DToC Rate	7.48%	7.67%	7.48%	7.96%	8.63%	8.82%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Southampton	06-Jul-17	13-Jul-17	20-Jul-17	27-Jul-17	03-Aug-17	10-Aug-17	17-Aug-17	24-Aug-17	31-Aug-17	07-Sep-17	14-Sep-17	21-Sep-17	28-Sep-17
Total - Target (50%)	29	27	27	27	27	26	26	26	26	26	25	25	25
Total - Actual	28	20	21	17	25	31	0	0	0	0	0	0	0
Variance	-1	-7	-6	-10	-2	5	-26	-26	-26	-26	-25	-25	-25
Health & Social Target (46%)	13	12	12	12	12	12	12	12	12	12	11	11	11
Health - Actual	10	11	11	8	12	19	0	0					
Social - Actual	16	8	8	6	11	7	0	0					
Both Target (7%)	2	2	2	2	2	2	2	2	2	2	2	2	2
Both - Actual	2	1	2	3	2	5	0	0					

Hampshire	06-Jul-17	13-Jul-17	20-Jul-17	27-Jul-17	03-Aug-17	10-Aug-17	17-Aug-17	24-Aug-17	31-Aug-17	07-Sep-17	14-Sep-17	21-Sep-17	28-Sep-17
Total - Target (50%)	29	27	27	27	27	26	26	26	26	26	25	25	25
Total - Actual	50	60	57	66	65	61	0	0	0	0	0	0	0
Variance	22	33	30	39	38	35	-26	-26	-26	-26	-25	-25	-25
Health & Social Target (46%)	13	12	12	12	12	12	12	12	12	12	11	11	11
Health - Actual	22	25	25	27	29	26	0	0					
Social - Actual	27	33	31	37	35	34	0	0					
Both Target (7%)	2	2	2	2	2	2	2	2	2	2	2	2	2
Both - Actual	1	2	1	2	1	1	0	0					

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	EMERGENCY FLOW IN UNIVERSITY HOSPITAL SOUTHAMPTON
DATE OF DECISION:	24 AUGUST 2017
REPORT OF:	CHIEF EXECUTIVE, UNIVERSITY HOSPITAL SOUTHAMPTON

CONTACT DETAILS

AUTHOR:	**Name:**	**Jane Hayward**	**Tel:**	**023 8120 6060**
	E-mail:	**Jane.Hayward@uhs.nhs.uk**		
Director	**Name:**	**Fiona Dalton,** **Chief Executive UHS**	**Tel:**	**023 8120 6060**
	E-mail:	**fiona.dalton@uhs.nhs.uk**		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

The University Hospital Southampton Foundation Trust and system partners will update the Panel on the latest Emergency Department performance.

RECOMMENDATIONS:

	(i)	That the Panel notes the performance information within Appendix 1 and, following discussions, agrees any issues that may need to be brought forward to a future HOSP meeting.

REASONS FOR REPORT RECOMMENDATIONS

1.	At the request of the Chair of the Panel.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)

3.	Attached as Appendix 1 is an update on emergency flow within University Hospital Southampton. The Panel are requested to note the most recent increase in attendances and the consequential performance. The Trust is yet to meet the target of 95%.

RESOURCE IMPLICATIONS

Capital/Revenue

4.	N/A

Property/Other

5.	N/A

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

6.	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:	
7.	N/A
RISK MANAGEMENT IMPLICATIONS	
8.	N/A
POLICY FRAMEWORK IMPLICATIONS	
9.	N/A

KEY DECISION	N/A
WARDS/COMMUNITIES AFFECTED:	N/A

SUPPORTING DOCUMENTATION

Appendices	
1.	Update on Emergency Flow in University Hospital Southampton
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

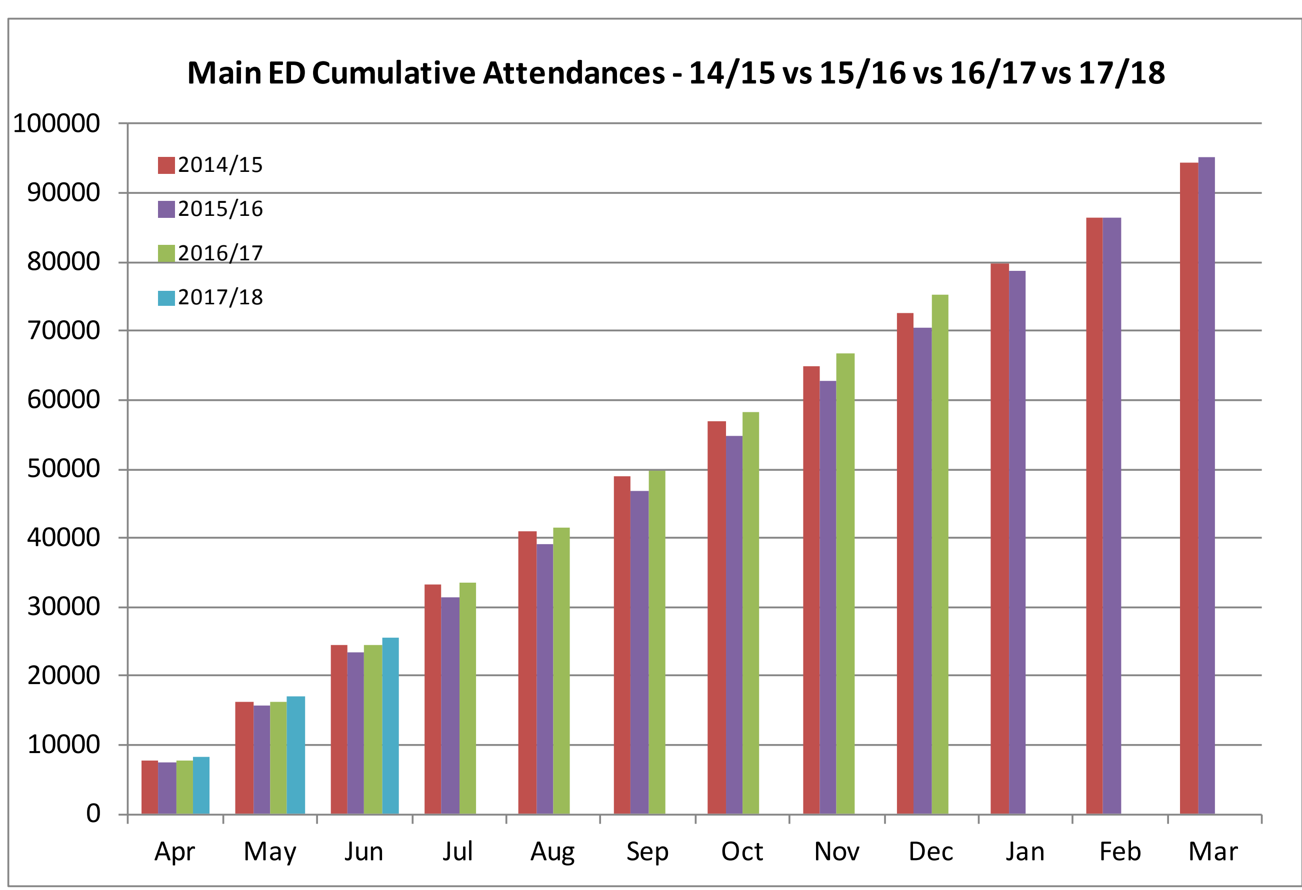
Equality Impact Assessment and Other Background documents available for inspection at:

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	

Update on Emergency Flow in University Hospital Southampton

Activity

The table below shows the demand for Main ED (ie excluding Minor Injuries Unit and Eye Casualty) over the current and previous 3 financial years:



Year-on-year monthly Emergency Department attendances are up for each month in 2017/18 when compared to previous years. The increase in demand is not equal and we are seeing a reduction in minor attendances (small injuries/minor illnesses) and an increase in patients arriving by ambulance to our majors department (severe trauma/major illness). This increase in the complexity of the patients is having a detrimental impact on performance.

Performance

The four-hour Emergency Department target states that at least 95% of patients attending the department must be **seen, treated, and admitted or discharged** in under four hours. It is recognised that this is not being achieved across the County and Trusts have been asked to deliver at least 90% for the first three quarters of the year and 95% by March 2018.

The performance by Main ED (excludes eye casualty) against the 95% target for can be seen in Table 1, along with the 95th centile, mean and median treatment times.

Table 1:

		April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance: Main ED	2016/17	85.5 %	91.4 %	92.9 %	91.2 %	93.6 %	93.1 %	86.9 %	83.8 %	84.9 %	82.1 %	79.2 %	88.3 %
	2017/18	87.9 %	85.5 %	84.7 %									
Performance: Main & Eye ED Combined	2016/17	87.8 %	92.7 %	94.0 %	92.5 %	94.6 %	94.1 %	88.8 %	85.9 %	86.9 %	84.4 %	82.1 %	89.7 %
	2017/18	89.5 %	87.4 %	86.7 %									
Wait: 95th Centile (Main ED)	2016/17	07:15	05:20	05:13	05:34	05:03	05:02	06:54	07:09	06:34	08:04	08:22	06:04
	2017/18	06:25	06:05	06:18									
Wait: Mean (Main ED)	2016/17	03:21	03:07	03:04	03:11	02:41	02:26	03:20	03:30	03:26	03:39	03:46	03:16
	2017/18	03:27	03:22	03:22									
Wait: Median (Main ED)	2016/17	03:15	03:15	03:10	03:18	03:07	03:12	03:15	03:18	03:21	03:26	03:29	03:20
	2017/18	03:17	03:21	03:04									

In the first quarter the Trust has not delivered the performance it planned but did meet the 90% target once the performance in the MIU at the RSH and the MIU at Lymington are taken into account, this is allowed within the national rules.

Next Steps

The Trust has an agreed action plan in place. A monthly monitoring meeting is in place with the CCGs and a fortnightly internal meeting chaired by Fiona Dalton.

The action plan focuses on 5 key areas:

- Create new services within or near ED, this includes a new GP led service, a new 'on the day' service for patients who do not require a bed overnight for treatment and a new service for elderly care patients.
- Reduce length of stay in hospital to ensure there is always a bed for admission.
- Create new facilities in ED including the new GP hub, specialist beds for mental health patients and start the build of the children's ED (subject to charitable funding).
- Implement a new IT system to collect more detailed data on the types of patients presenting to ED and the treatment given.
- Ensuring there is robust special event planning throughout the year.

Conclusions

The ED continues to see a sustained and unprecedented rise in attendance levels. The Trust must improve performance in the remaining 7 months of the year to ensure the 95% target is delivered in March 2018.

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST – CQC REPORT
DATE OF DECISION:	24 AUGUST 2017
REPORT OF:	CHAIR OF THE HEALTH OVERVIEW AND SCRUTINY PANEL

CONTACT DETAILS

AUTHOR:	Name:	Mark Pirnie	Tel:	023 8083 3886
	E-mail:	Mark.pirnie@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

This item enables the Health Overview and Scrutiny Panel to discuss with representatives from University Hospital Southampton NHS Foundation Trust (UHS) the key findings from the January 2017 Care Quality Commission (CQC) inspection.

RECOMMENDATIONS:

	(i)	That the Panel note the outcome of the inspection and discuss the actions that the Trust intend to take in response to the CQC findings.

REASONS FOR REPORT RECOMMENDATIONS

1.	To enable the Panel to discuss the CQC Inspection findings with representatives from University Hospital Southampton NHS Foundation Trust.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)

3.	The CQC carried out a follow up inspection of the Southampton General Hospital site, part of the University Hospital Southampton NHS Foundation Trust, between 25 and 27 January 2017 with an unannounced inspection on 7 February 2017. This inspection was to follow up the CQC's comprehensive inspection in 2015 where some services had required improvement.
4.	The CQC Provider Report which provides a summary of the full inspection report is attached as Appendix 1. UHS received an overall rating of Good. The Panel are requested to note the report and discuss the actions that the Trust intend to take in response to the CQC findings.

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
RISK MANAGEMENT IMPLICATIONS	
9.	None.
POLICY FRAMEWORK IMPLICATIONS	
10.	None

KEY DECISION	No
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report

SUPPORTING DOCUMENTATION	
Appendices	
1.	University Hospital Southampton NHS Foundation Trust – CQC report
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	

RHM

University Hospitals Southampton NHS Foundation Trust

Quality report

Trust Headquarters
Tremona Road
Southampton
SO16 6YD

Tel: 023 8077 7222
Website: www.uhs.nhs.uk.

Date of inspection visit:
25-26 January, and 7 February 2017

Date of publication:
<xxxx> 2017

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected and information given to us from patients, the public and other organisations.

Overall rating for this trust	**Good**
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Outstanding

Letter from the Chief Inspector of Hospitals

We carried out a follow up inspection of the Southampton General Hospital site, part of the University Hospitals Southampton NHS Foundation Trust, between 25 and 27 January 2017 with an unannounced inspection on 7 February 2017. This inspection was to follow up our comprehensive inspection in 2015 where some services had required improvement.

University Hospital Southampton NHS Foundation Trust is one of the country's largest university hospitals, with around 1390 beds. The trust provides a major trauma centre and wide range and complexity of general services Southampton and south Hampshire. The trust also provides specialist services such as neurosciences, cardiac services and children's intensive care to over 3.7 million people in central southern England and the Channel Islands.

During this inspection, we inspected all key questions in four of the eight core services of surgery, critical care, end of life care and outpatient and diagnostic imaging. The trust had a stable

leadership team in place since our last inspection.

At this inspection we saw significant improvement across the areas we inspected. There were improvements in surgery, critical care, end of life care and outpatients. Critical care is rated overall as ‘Outstanding’, with surgery, end of life care, and outpatients and diagnostic imaging as ‘Good’ overall. These services had been rated requires improvement in 2015. The improvements were in line with the trust’s improvement plan and had been assisted by the trust board and executive leadership team.

Previous inspection in 2015 had found safety of medicine and maternity services, along with responsiveness of urgent and emergency care and children’s services required improvement. The improvements found at this inspection in 2017 has led to overall rating of outstanding for caring and well led. The trust has improved overall to a rating of Good.

The Trustwide ‘Well Led’ inspection is rated as outstanding.

Our key findings were as follows:

- Patients were at the heart of all major trust decisions, and this was clearly evidenced by the Executive team and board’s adherence to the trust values.
- There were many examples where the staff interactions with patients, and often relatives, had exceeded, or far exceeded, expectations. These comments related not only to clinical staff, but to domestic, portering, catering and clerical staff.
- The leadership strategy and the trust culture were successfully entwined, and the resultant cohesive purpose drove continuous improvement to patients, staff and external stakeholders.
- The board were fully sighted on strategic issues and future planning, and provided supportive challenge.
- The non-executive directors displayed knowledge and clear understanding of complex issues.
- External partners described the trust as progressive, transparent, forward-looking and providing a measurably-positive impact on the local health economy.
- The trust had significant engagement with partners and stakeholders in the planning and delivery of care at all levels throughout the trust and beyond its internal footprint. This included participation in the Hampshire and Isle of Wight Sustainability and Transformation plan (STP).
- There was a healthy impatience to improve. Open and honest conversations were held, to enable learning from lessons and shaping of future care and management.
- Collaboration, support and constructive challenge was evident across the core services management and delivered by the Trust Board and Executive team.
- The Council of Governors were highly engaged with the Board, the Executive team and the hospital staff as a whole, and undertook many activities and engagements to support the hospital.
- The trust has a large body of over 1000 volunteers, being used in many roles around the hospital including signposting, general enquiries and nutrition assistants. The dedication and kindness of these volunteers and their willingness to help their local populations was outstanding.
- Relatives told us they were recognised as partners in the care of their family, their interactions were recognised and valued, and they were included in team discussions about further care and treatment.
- The trust had specific, detailed and effective strategies for people living with dementia or a cognitive disability.

- Services were held to account, and there was an integral drive for continuous innovation.
- Teams and individuals spoke with clarity, enthusiasm and commitment about their “desire to make every day better than the one before”, even though this could be challenging.
- The comprehensive governance systems ensured the executive team had recent verifiable date which informed further planning and decision making.
- In the recent Friends and Family test, 97% of respondents said they were “likely or “very likely” to recommend the hospital
- The trust demonstrated significant improvements since the 2014 inspection, and the comprehensive action plan had been met in full.
- There was a significant reduction of hospital acquired pressure ulcers, and falls resulting in harm to the patient.
- The antibiotic stewardship CQUIN presented a significant challenge to the Trust, however, performance remained on track to deliver in full by year end.
- The trust was a high reporter of incidents, and learning from these continued to be positive.
- The Trust vacancy rate overall is currently on trajectory at 13%, the aim is to reduce the vacancy rate to 10% by December 2017.
- The trust monitored patient acuity at bed meetings held several times each day, to ensure senior managers had oversight of patient acuity, bed numbers and staffing flexibility.
- There were ongoing capacity demands and the trust had an occupancy rate of 93%. Patients could be moved four times during their stay.
- There were some mixed sex breaches in surgery, and critical care against best practice recommendations.

Importantly, the trust must :

- Reduce the number of mixed sex accommodations across the trust to improve privacy and dignity for patients.
- Ensure medicines are always stored at temperatures that ensure their effectiveness.

We saw areas of outstanding practice including:

- The integrated medical examiners group (IMEG) reviewed all deaths twice each day and approved the death certificate before it was signed, including contact with the coroner if needed. This had proven benefit to an improved accuracy of mortality data, opportunity to reflect upon practice, an improved understanding of correct death certification, consistency amongst reviewing staff, and an overall improvement to patient safety after learning.
- The Chief Executive Officer (CEO) held patient lunches, and staff and patients regarded these as unique and most welcome. Teams received feedback on any issues raised.
- There were focus groups within specific cancers for patient involvement although no patients took part in the governance groups yet. The trust used representatives from the local ‘health watch’ when planning major redevelopments.
- The trust had a culture of innovation and research, and staff were encouraged to participate. There were examples of research that were nationally and internationally recognised. Staff were supported to lead innovation projects in their work environment.
- The trust had implemented a new tool called the favourable event reporting form (FERF). Anyone who sees an incident or an event which had gone particularly well was invited to document this. Everyone mentioned in a FERF received a personal letter, thanking them for their contribution, and the positive practice was cascaded throughout the trust.
- The trust made regular and concerted efforts to reach out to connect with hard to reach

communities, such as the traveller community.

- The trust had established engagement links with young people and children within the community, and many diverse activities were set up on and off site for these groups. recent ‘Lifelabs’ at Open Days gave local children the opportunity to try experiments and learn about personal health. Opportunities such as this encouraged children of every socio-economic background to attend and to view healthcare as a potential career option.
- Hospital teams, supported by hospital volunteers and emergency services, ran 'family road safety days' in central Southampton. Local children and their parents learned about road signs and had opportunities to practise resuscitation techniques.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Background to University Hospitals Southampton NHS Foundation Trust

Sites and locations:

University Hospitals Southampton NHS Foundation Trust comprises two hospitals and one hospice, and is one of the largest NHS trusts in the country. It is an acute teaching trust and became a foundation trust in October 2011. It has five registered locations: Southampton General Hospital, Countess Mountbatten House, Princess Anne Hospital, New Forest Birthing Centre, and runs some clinics out of the Royal South Hants Hospital.

Population served:

University Hospital Southampton NHS Foundation Trust provides services to some 1.9 million people living in Southampton and south Hampshire, plus specialist services such as neurosciences, cardiac services and children's intensive care to more than 3.7 million people in central southern England and the Channel Islands.

Our inspection team

The team included two CQC inspection managers, ten inspectors and two support staff, and a variety of specialist advisors including: surgical consultant; surgical nurse team leader; critical care consultant, critical care specialist nurse, end of life care consultant and specialist nurse, outpatients nurse team leader; diagnostic consultant, radiographer; and two board level directors.

How we carried out this inspection

Prior to the inspection we reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust. We requested and obtained feedback and overviews of the trust performance from local Clinical Commissioning Groups and NHS Improvement, and this provided information to further inform the inspection planning. We also held a focus group to meet with staff and managers at this time.

We carried out the first part of our inspection between 25 and 27 January 2017 and returned to visit some wards, units and departments unannounced on 7 February 2017.

We spoke with 219 staff across the services. We reviewed 24 patient records as part of this inspection. We observed how people were cared for, talked with carers and family members, and reviewed care and treatment records. We also spoke with the executive team, non executive staff and senior managers.

What people who use the trust’s services say

We spoke with 40 patients, carers and relatives in the wards, units and departments. The experience of patients using the Southampton General Hospital was mainly highly positive about the care and treatment they had received.

Patients told us they had received compassionate and often highly-personalised treatment and

care were given sufficient time to ask questions and were given choices. They said staff responded to patients, and their relatives with support and compassion, needs were mostly responded to quickly, and to the patients' satisfaction.

Relatives told us they were partners in care, with equal voices, and felt enabled to ask probing questions to ensure the care and treatment was best for their family member.

External partners described the trust as progressive, transparent, forward-looking and providing a measurably-positive impact on the local health economy.

Facts and data about this trust

Beds: 1372

- 1394 General and acute
- 92 Maternity

Staff: 8890

- 1350 Medical
- 2816 Nursing
- 4724 Other

Activity type (April 2015- March 2016):

- 123,231 inpatient admissions (a rise of 3%),
- 483,119 bed days, (a rise of 1%).
- 616,712 first and follow up outpatient appointments and
- 36,907 surgical patient spells, of which 36.3% were day cases, 28.2 elective or booked admissions and 35.5% emergency patients.
- From January 2016-December 2016, the total number of adult deaths in the hospital was 1948, approximately 1.5% of admissions.
- The standardised hospital mortality indicator (SHMI) between October 2015 and September 2016 was 95.13. This was within the expected range for patient mortality.

- **Revenue**: £556,500,000
- **Full Cost:** £557,300,000
- **Surplus (deficit**): £(9,800,000)

The trust had a stable board, with the most recent executive appointments being the chief financial officer in 2016. The Chief Executive Officer (CEO) had been in post since 2013. At the time of our inspection the Chief Executive Officer (CEO) was leading the work for the South Hampshire Sustainability and Transformation Plan.

Inspection History:
The trust has had four inspections since its registration in April 2012. In December 2014 and January 2015, we carried out an announced comprehensive review of the trust and all locations. We rated the trust at that time as requires improvement overall. Surgery, critical care, end of life care and outpatient and diagnostic images were rated as requires improvement.

Previously Southampton General Hospital was inspected in October 2012 and April 2013. The Princess Anne Hospital was inspected in December 2012.

Summary of findings

Are services at this trust safe?	Requires improvement ●

Safe is rated as requires improvement trust wide because safety in medicine and maternity services required improvement in 2015.

These services were not re-inspected in 2017, as were overall Good in 2015.

Summary of findings for services inspected in January 2017:

- Safety and quality of service were a high priority for the trust, and staff at all levels and across the four core services, could demonstrate their focus to constantly improve safety.
- There were well-defined and embedded systems, processes and standards operating procedures in place to keep people safe.
- There was a positive incident reporting culture in the trust. They declared themselves high reporters, and viewed this as positive.
- Investigations were thorough and opportunities for learning from safety incidents were shared locally to improve practice.
- The board displayed a high awareness of the level, number and severity of incidents, and these were routinely discussed to support learning.
- Duty of candour awareness was prominent in all areas visited, and well embedded at board. The trust monitored this through their online incident reporting system.
- The hospital wards, departments, and all open areas were visibly clean. Staff complied with infection prevention and control practices.
- Effective systems ensured patients were safeguarded from abuse.
- Staffing levels were regularly planned, implemented and reviewed to keep patients safe, and cared for according to their specific needs. However, in critical care services, staffing experienced frequent challenges, which meant there were occasions when staffing levels did not meet best practice guidelines.

However:

- Patient records were not always stored securely.
- Some medicines were not always stored securely.
- There were some delays in obtaining pressure-relieving mattresses.
- There were delays in ward repairs resulting in some facilities being out of use for months.
- Palliative care medical staff levels were below the expected range.
- Mandatory training and appraisal rates were low in some services.

Incidents

- There was an effective system for the recording and reporting of incidents. Risk was identified and mitigated, and staff were high reporters of incidents.
- There were polices and processes to report serious incidents. Staff understood what these were, and were actively supported to report these. The policies had standard operating procedures to enable and facilitate the ongoing management of serious incidents.
- All staff understood their individual and professional responsibilities to report incidents.
- Managers and local leads ensured that learning from incidents was cascaded locally, and where necessary or of use, wider within the trust.

- Incidents were investigated, reviewed and actions taken. Actions were taken to promote learning and prevent recurrence.
- Staff received feedback about incidents although the feedback was not always more widely disseminated beyond the immediate team.
- A new reporting tool had been implemented recently, called the favourable event reporting form (FERF). Anyone who saw an incident or an event which had gone particularly well was invited to fill out a form. These forms were reviewed on a monthly basis by a multi-disciplinary team within the department. Everyone mentioned in a FERF received a personal letter, thanking them for their contribution. The multi-disciplinary team discussed the FERF, and analysed what was positive about the incident. The summary of these reflections were fed back to the whole department as part of the mortality and morbidity meeting along with lessons learnt from adverse events. Good practice was then disseminated throughout the trust.

Mortality and Morbidity

- There were embedded processes for the review of mortality and morbidity within each division in the trust. Mortality was discussed at regular meetings throughout the year and information shared with colleagues and the board.
- The standardised hospital mortality indicator (SHMI) was 95.3 between October 2015 and September 2016. This was within the expected range.
- Mortality was regularly discussed at executive and board level meetings, enabling a clear process for monitoring any trends or concerns.
- The integrated medical examiners group (IMEG) reviewed all deaths twice each day and approved the death certificate before it was signed, including contact with the coroner if needed.

Duty of Candour

- There was a good understanding of the duty of candour requirements throughout the trust. Training was provided which enhanced staff knowledge and awareness.
- Duty of Candour was monitored through incident reporting at board level. The trust board ensured that all incidents where significant harm had occurred had the duty of candour undertaken.

Safeguarding

- The trust had a safeguarding strategy, policies and training to protect vulnerable adults, children and young people. These policies were accessible on the trusts' intranet pages with further information about local contact details
- Safeguarding was overseen by a specialist group, which implemented new policies, overview of these, and ensured that training was appropriate to the individual's roles.
- There was generally good compliance with level one and level two safeguarding training. Where there was non-compliance with safeguarding training, this was predominantly with medical staff.
- Safeguarding was well understood by most staff in the divisions, with the exception of outpatients where there was a lack of clarity about the role of the departmental safeguarding lead.

Staffing

- The trust previously had substantial challenges in 2015 to recruit and retain sufficient numbers of registered nursing staff but had made significant progress with this in 2016. The trust is currently on its' proposed trajectory at 13% vacancy, and the aim is to reduce the vacancy rate to 10% by December 2017.
- The trust had recruited 143 WTE nursing staff from overseas. The trust supported and developed them with language skills and a comprehensive induction. The trust created an internal rotation scheme to maintain their interest and further develop their skills.
- Ward establishments were reviewed six monthly, against the funded and agreed establishment. The board papers provided by the trust demonstrated frequent discussion about nursing establishment and safer staffing levels.
- Agency spend remained within the agreed ranges for funding. Where there was agency and locum use, staff were properly inducted to the area they were working in and had their competencies checked before starting work.
- In some areas staffing did not meet national guidance. This included in the consultant hours in palliative care, and nursing and medical staffing in critical care.

Are services at this trust effective?	Good

Effective is rated as Good trust wide based on inspection in 2015 and 2017.

Summary of findings for services inspected in January 2017:

- Care pathways followed national guidance across clinical services.
- There was an audit plan for all services, and action plan results were re-audited to further embed new practices. The trusts took part in all required national audits and conducted further local audits to benchmark and improve outcomes.
- Improvement and innovation was actively encouraged and facilitated, with examples such as the Integrated Medical Examiner Group, (IMEG), and the 'PRESS' pressure ulcer tool.
- The trust had a clinical effectiveness and outcomes steering group which monitored the compliance of National Institute for Health and Clinical Excellence guidance, and quality standards.
- Patient outcomes were regularly reviewed by the quality committee and within the clinical work streams report.
- There was effective multi-disciplinary working within teams in all the cores services we inspected, and with external healthcare partners.
- Consent to care and treatment was sought and documented before care or treatment was given. There was evidence that capacity assessments and best interests decisions took place in most cases.
- Staff demonstrated understanding of the Mental Capacity Act 2005

However;

- Not all the DNACPR forms we reviewed were completed in line with national guidance.

Evidence-based care and treatment

- The trust had a clinical effectiveness and outcomes steering group (CEOSG) which monitored compliance of National Institute for Health and Clinical Excellence (NICE)

guidance and quality standards.

- Monthly spreadsheets of new NICE guidance and quality standards were sent to the CEOSG. Any new guidance was raised at the CEOSG meetings and leads were identified. Some examples of the NICE guidance and quality standards used were Glaucoma in adults QS7, in ophthalmology, and head injury: assessment and early management Clinical guideline 176 in radiology.
- Care within the intensive care units was being provided in line with best practice guidelines.
- There was an audit plan in place for most services across the trust with named clinicians leading. Audit results had action plans created in response to findings and areas of concern were re-audited following action plan.

Patient outcomes

- The outcomes of patients' care were routinely collected and monitored to measure the effectiveness of care and treatment. The trust took part in national audit programmes and also established local audits.
- The trust performed well in the national critical care audits (ICNARC) as well as for a number of measures in the emergency department.
- Audit meetings were held to discuss the progress of audits and present audit results and recommendations once completed. These meetings were recorded and minutes were circulated to staff.
- Pressure ulcer management was audited regularly and actions produced as a result. The data showed a substantial decrease in Grade 3 and 4 pressure ulcers over the last year.

Multidisciplinary working

- There was positive multidisciplinary working across the trust both within and between services. We observed that professionals respected each other's roles which contributed to the care of patients.
- Effective multidisciplinary care also occurred with other care providers. We saw staff working to ensure that patients were transferred successfully to other units. The trust was working with other organisations in southern England to effectively provide cross service care and ensure repatriation.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Most staff had a good knowledge and received training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- There were a number of occasions, particularly in end of life care, where documentation was not clear that the Mental Capacity Act had been properly considered. This was the case in 10 out of 14 'Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR's).

Are services at this trust caring?	Outstanding

Caring is rated as **outstanding** trust wide based on ratings from inspections in 2015 and 2017. Children and young people's services were outstanding for caring in 2015, and critical care was rated outstanding in 2017.

Summary of findings from inspection of services in January 2017:

- We heard of many examples where the staff interactions with patients, and often relatives, had exceeded, or far exceeded, expectations. These comments related not only to clinical staff, but to domestic, portering, catering and clerical staff.
- In the recent Friends and Family test, 97% of respondents said they were 'likely' or 'very likely' to recommend the hospital.
- Care for patients across critical care was outstanding. Patients' needs were considered at all times, and a high level of support was provided for the emotional and spiritual needs of family members and patients.
- Patients told us that staff, no matter how busy, went to "extraordinary lengths" to deliver compassionate and highly personalised care.
- Patients, relatives and carers told us how much they appreciated a new initiative at the hospital. It was called "eyes up" and recommended that all members of staff make eye contact appropriately when meeting, greeting or treating patients.
- On wards and areas we visited, we noted that privacy and dignity was respected.
- Relatives and carers were supported by a 'Carer's Café' held every week to provide advice and support.

Compassionate care

- The feedback from patients, carers and relatives was consistently positive, and many people contacted us before, during and after the inspection to tell us this.
- Patients in a waiting area told us how the consultant for the clinic took time to ask them about their life and their family before discussing the care and treatment. They told us that level of personalised interaction meant a lot to them.
- Care for patients across critical care was outstanding. Patients' needs were considered at all times, and a high level of support was provided for the emotional and spiritual needs of family members and patients.
- On the neurosurgical unit, relatives told us how the staff managed to calm their family member down by taking time to understand what he was trying to say, and by reassuring him when his behaviour presented challenges. They took time to ensure he understood the care and treatment they would receive.
- Patients said they were always treated with kindness, compassion and dignity.
- Staff took time to wholly interact with patients. Where extra time was necessary to facilitate full understanding, it was given.
- Patients were addressed by the name they preferred, and staff used the "Hello my name is" introduction.

Understanding and involvement of patients and those close to them

- Relatives told us they were recognised as partners in the care of their family, their interactions were recognised and valued, and they were included in team discussions about further care and treatment.
- Patients and their carers and relatives, were actively supported in their decision making, to ensure they had the correct information prior to making any important decisions.
- Staff ensured patients and their relatives understood diagnoses and treatment and were given the opportunity to ask questions.

Emotional support

- In End of Life Care, single rooms were, as often as possible, given to these patients. In these circumstances, patients and relatives were specifically asked how much privacy they wished, or did they prefer to have the ongoing support of staff entering the room regularly to check on their welfare.
- Emotional support was consistently provided to patients and their families throughout the trust.
- Organ donation nurses supported families and staff though the organ donation process, which included completing last offices, and following up with families once the retrieval had been completed.
- There was a trust wide chaplaincy team supporting patients, relative carers and staff from different religions and denominations.
- There was access to a range of counselling and psychology services for patients and staff.

Are services at this trust responsive?

Requires improvement

Responsive is rated as requires improvement trust wide, because responsiveness of urgent and emergency care and children's services required improvement in 2015.

The services were not re inspected in 2017as were overall Good in 2015.

Summary of findings for services inspected in January 2017:

- Senior staff worked effectively with commissioners and partners to address system-wide flow issues. Patient flow was proactively monitored throughout the trust.
- Patient transfers did happen between wards, but were usually avoided after the early evening unless for clinical need.
- We saw patients living with dementia or with learning disabilities had their individual needs assessed and met.
- The trust had taken part in the 'Tools to Care' initiative and was now an 'exemplar site'. There was excellent mental health support for patients who needed it.
- The trusts performance in referral to treatment times was better than the England average.
- Patients attending day surgery were given pagers so they did not have to wait in a crowded waiting room.
- The trust monitored and audited prolonged stays in recovery; recovery staff were able to give patients food and drink and had developed a system to discharge patients straight from recovery to improve flow.
- Recovery were able to discharge low risk patients direct from recovery to maintain patient flow.
- The trust's referral to treatment time (RTT) for admitted pathways for Surgery has been better than the England overall performance since November 2015.
- There was an effective complaints service, integrated with the patient experience group.
- The trust has a large body of over 1000 volunteers, being used in many roles around

the hospital including signposting, general enquiries and nutrition assistants.

Service planning and delivery to meet the needs of local people

- The trust had demonstrably good relationships and substantial engagement with their local commissioning bodies. Services were planned and delivered, using choice and flexibility, to the trust's local and wider populations.
- The CEO described the progressive concept of "A Hospital without walls" where patients will come in, be treated for acute episodes and be transferred out to the community for the continuation of their care, under the care of the same consultant.
- The trust had significant engagement with partners and stakeholders in the planning and delivery of care at all levels throughout the trust. This included participation in the Hampshire and Isle of Wight Sustainability and Transformation plan (STP), where each local region of the NHS plans how health and social care will work together in the future.
- The CEO also leads on a local 'Acute Alliance' with other local hospitals and trusts. This has enabled sharing of good practice, agreeing better communication and transfer mechanisms, and organisational consideration of services across the footprint.
- The trusts performance in referral to treatment times was better than the England average, and consistently achieved the two week wait for urgent cancer referrals.
- Parking facilities were not always sufficient to enable patients and visitors to easily find a car parking space. Sometimes this had impacted upon the time patients arrived for appointments, and had caused anxiety.
- Since the previous inspection the trust now had four specialist palliative care beds on the oncology ward. The palliative care beds were prioritised for symptom control and step down from critical care.

Meeting people's individual needs

- The trust has a large body of over 1000 volunteers, being used in many roles around the hospital including signposting, general enquiries and nutrition assistants. The dedication and kindness of these volunteers and their willingness to help their local populations was outstanding.
- The trust had specific, detailed and effective strategies for people living with dementia or a cognitive disability. Individual needs were considered and where appropriate, reasonable adjustments were made to deliver a more responsive and personalised service to patients with complex or additional needs.
- The surgical preoperative assessment process included capacity questions relating to dementia. If the patient was living with dementia, their relatives or carers were encouraged to stay with the patient whenever possible. The information was shared, and if the preoperative assessment team were already aware of the dementia prior to the appointment, a double slot would be booked to allow more time.
- There was a dementia strategy implementation group who formulated an action plan to develop the dementia provision. Two wards had taken part in the 'Tools to Care' initiative and were now trust exemplar sites.
- Patients with learning disabilities (LD) who were booked or elective admissions were also flagged at preoperative assessment, the LD team liaised with the patients at home or at school to find out their background and if they had a 'patient passport'. The team carried out the patient's capacity assessment and best interests meeting before the patient was admitted. Theatres were notified in advance. The theatre team told us that the anaesthetist highlighted patients with learning disabilities at the team brief stage of the safety checklist, though we were not able to observe this practice.

Access and flow

- The trust bed occupancy figures between April 2016 to December 2016 were slightly higher than the England average; 93% compared to 90%.
- Access and flow remained a challenge within the trust. However, there were proactive arrangements and processes to minimise the impact of this on patients, clinicians and occupancy figures.
- Meetings occurred throughout the day within the trust to monitor and manage bed capacity and flow. Escalation procedures were in place to provide high level (senior) intervention and assurance of the ongoing patient flow, and effectiveness of the care pathways.
- Patient discharge data was monitored to focus and track any interventions where discharge and transfer could be made more efficient.
- The trust monitored the number of times a patient moved ward and actions were implemented to try to reduce the number of moves made.
- Late transfers and discharges did take place, and these were actively tracked between 20:30 and 08:00 if they were for non clinical reasons.
- Where medical patients (outliers) were cared for on non-medical wards, there were effective systems to ensure they received regular review by their consultant team.
- For the period July 2016 to October 2016, the national standards for cancer wait times were being met and the trust was consistently above the standard with 94% of people on average see within two weeks of referral, and 97% of people waited one month from a decision to treatment.
- Work had been completed in a number of specialities, including ophthalmology, to help achieve the referral to treatment time targets. The trust offered a number of one-stop clinics to reduce patient visits.

Learning from complaints and concerns

- The trust had an effective system to handle, monitor and subsequently learn from complaints. The number of complaints has dropped year on year, for the last three years.
- All complaints were talked about in ward meetings and in clinical governance meetings, so learning and any changes in practice were shared.
- The complaints department had a new Head of Service just appointed and this was to ensure the integration of patient experience with complaints, to give a further developed, supportive and cohesive service.

Are services at this trust well-led?	Outstanding

We rated well-led as outstanding because:

- Patients were at the heart of all major trust decisions, which was evident through the senior team's adherence to the trust values, a pro-active learning culture, and consistent support of staff to deliver 'ever better' care.
- There was a strong and inspirational executive team, with the necessary experience, knowledge, strategic vision and capability to function effectively while leading supportively.
- The aim of the trust is to become a world class health organisation, where the best people come to work, and to stay, to deliver the best possible research-based care and outcomes to patients.
- The trust strategy 'Ever better' whilst challenging was achievable financially and operationally.

- Leaders, at senior and executive level, had a shared purpose and strategy which encompassed the desire to be a learning organisation.
- The structure was flat and non-hierarchical, with supportive challenge encouraged.
- External partners described the trust as progressive, transparent, forward-looking and providing a measurably-positive impact on the local health economy.
- There was a healthy impatience to improve. Open and honest conversations were held, to enable learning from lessons and shaping of future care and management.
- The governance arrangements were established at local, divisional and executive level, and actions were cascaded for maximal effect. However, some concerns identified by the inspection were not highlighted through the governance processes.
- There was an effective risk management action plan. Risk identification and risk management was appropriately recorded and supervised.
- Staff morale was generally very high. Staff felt able to raise concerns and said they felt they would be listened to. Many staff told us this internal supportive culture was one of the reasons they felt proud to work for the trust. A small number of people did not agree with this.
- There was an improved focus on both transformation and organisational development.
- The trust fulfilled its responsibilities in respect of equality and diversity.
- The trust met the requirements of the Fit and Proper Persons Regulation.
- There was evidence of positive and regular engagement with people who use services, and with staff.

Leadership and culture

- The executive team was stable, high-calibre, cohesive, competent and highly visible.
- The Chief Executive Officer (CEO) had been in post since November 2013. The Medical Director was appointed in September 2012, and the Director of Nursing and Quality was appointed in October 2015.
- The Chief Executive Officer (CEO) was consistently described as “inspirational” “facilitative” and “an outstanding change agent” by internal staff and external stakeholders. They had been in post since November 2013. The Chief Executive Officer (CEO) was said to be substantially responsible for the positive culture change noted by staff of all grades and across many professions and services.
- The Chief Operating Officer, Medical Director and Director of Nursing were also widely acknowledged as providing a high level of support, knowledge and participative leadership to the staff they led, and the CEO they supported.
- The board were fully sighted on strategic issues and future planning, and provided supportive challenge. Board study days created time to work together, and staff now had someone beyond the executive team to talk with.
- The non-executive directors displayed knowledge and clear understanding of complex issues.
- The council of governors were highly engaged with the trust and there was evidence that executives and their decisions could be easily challenged or held to account.
- Collaboration, support and constructive challenge was evident across the core services management and delivered by the Trust Board and Executive team.
- There was a strategic nursing plan, which detailed the workforce priorities and the impact of the nursing workforce on other priorities for the coming year.
- The NHS Staff Survey 2016 identified the trust was similar compared to other trusts for staff reporting good communication between senior management and staff, however this was not consistent across all services.
- There was executive support for the palliative care team and across all divisions to raise

the profile of palliative care. The end of life care steering group was chaired by the trust director of nursing, who was the trust lead for end of life care. The group reported to the trust executive committee.

- The staff described the executive team as visible and approachable, with regular planned and unplanned walkabouts taking place. The non-executive directors also visited with the chairman and board members, both in and out of hours.
- Collaboration, support and constructive challenge was evident across the core services management and delivered by the Trust Board and Executive team.
- There was a significant and notable culture of continuous improvement. This evolved through acknowledging that sometimes mistakes were made or processes weren't always correct, then an organisational shift and commitment to becoming an "always improving" organisation.
- Staff we spoke with demonstrated the trust values of, 'Putting patients first, working together and always improving'.
- We observed continuous mutual respect and professionalism between professional groups.
- There were high levels of staff satisfaction across the trust. Staff were proud to work for the organisation and spoke highly of the culture.
- There was a whistleblowing policy in place for the trust. We reviewed the concerns raised by the trust and these were investigated appropriately.
- We received whistleblowing concerns about a service which cited bullying and concerns regarding leadership of the trust. We reviewed the trust's investigation and response, and although they did not class the concerns as whistleblowing they had fully investigated the concerns and were addressing any issues with the service identified. However, the time taken to progress and conclude the investigation was longer than expected and could have been concluded sooner.
- The trust valued and encouraged staff to raise concerns. Many staff reported they could give open and honest feedback to managers and said that ideas and concerns were listened to and actions taken to progress where that was possible or could provide improvement to patients or staff.

Vision and strategy

- The trust values were 'Working together, Putting patients first, and Always improving' some key statements underpinned these in a 'constant drive to improve quality safety and efficiency'.
- Trust values were patient focused, agreed by all staff, and well-embedded. Staff were working on a description of the behaviours which would align to these values so that demonstrable improvement could be seen, assessed and acted upon where necessary to ensure that values were acted upon.
- There were eight top priorities for improvements, which were the guiding principle framework for any developments to be linked to. The vision and strategy with the detailed priorities was available for staff and for patients and relatives via the trust website.
- The trust ambition was to become a "Hospital without walls". The trust actively worked in partnership with other organisations, enabling and encouraging each to provide the services where they added most value to provide a comprehensive health package for patients within their local communities.
- The Chief Executive Officer (CEO) was the lead for the local acute alliance and Sustainability and Transformation Plan (STP) within the local health economy.

Governance, risk management and quality measurement

- There were clearly defined governance arrangements and effective risk management procedures to support the safety and quality of care and treatment.
- Governance was reviewed through a comprehensive integrated performance report, and executive and non-executive directors understood and could discuss current issues of concern.
- Care Group governance reports were reported into the divisional governance. These groups reported to the trust quality governance steering group (QGSG) and ultimately to the trust board.
- We reviewed the action plan following the internal quality review in June 2016. It contained 19 actions across six areas including medication and end of life care. All actions was rated according to priority from red to green (RAG) with red being the highest risk, and green the lowest. The items included progress, review and completion date for each action.
- All care groups had local risk registers; risk coordinators managed these, and ensured that all risks had been assessed accurately before they were added to the register. Senior staff we spoke with could access their risk registers, and were aware of their highest risks and shared them with us. One example of actions following a risk being escalated, was a shortage of theatre trolleys which impacted on theatre lists. 48 hours after the risk being raised the theatre senior team obtained ten additional trolleys to alleviate the risk.
- Effective ward to board assurance processes were in place to ensure that processes were effective and in line with national guidance. Challenge was provided to the executive team by non-executive directors, both at the quality and outcomes committee, and at trust board meetings.
- There was evidence that any significant risk was noted, escalated and action taken at various levels of the organisation until resolved.
- Quality dashboards were used for every division and this linked into the trust wide assurance framework where oversight and scrutiny took place.
- The patient safety group, incorporating the IMEG, collated safety data, incidents and learning, so these could be cascaded, using a multiplicity of methods, to all departments and divisions.
- Complaints actions and outcomes were signed off by the CEO, noted by board, and visualised by the regular use of 'patient stories' to demonstrate real issues and activated learning.

Equalities and Diversity – including Workforce Race Equality Standard

- The board was sighted on the equality, diversity, and Black, Minority and Ethnic (BME) group agenda. The trust produced the required data for reporting under their legal and regulatory obligations in line with the Equalities Act 2010 and the Workforce Race Equality Standard. The board members spoken to understood the responsibilities and had recently undertaken equality and diversity training.
- There was an Equality Diversity and Inclusivity (EDI) Committee reported directly into the trust Board. The governance to support EDI was an 0.8 post of Head of EDI working closely with HR.
- The EDI steering group had effective representation from across the organisation and was able to influence the EDI agenda.
- The 'Annual Celebrating Diversity' conference was held in September 2016. Feedback from the conference was highly positive and included the suggestion to hold additional lunch time events / workshops across the organisation throughout the year.
- Workforce Race Equality Standards (WRES) data presentation was presented at divisional and departmental training.

- Organisational and cultural development within the trust included supporting events. The trust attended the local Black History month celebrations, sharing information about services and work opportunities at the trust.
- A poster and photograph displayed at main entrance of Southampton General Hospital commemorates Black History month, and Interfaith week celebrations held in chaplaincy, as well as Celebrating Diversity at Christmas.
- The trust were organising a joint lecture panel discussion event with Southampton University for Lesbian Gay Bisexual and Transgender (LGBT) month focussing on mental health issues in the LGBT community.
- The trust were also working with community partners to participate in Southampton city wide celebrations for 'International Women's Day'.
- An EDI newsletter had been created and circulated amongst all staff. This newsletter with information and success stories will continue to be circulated quarterly.
- Three staff with disability have been sponsored and recruited to leadership programme jointly run by Disability rights UK and Leadership Academy.
- BME staff have been actively encouraged to attend different national leadership programmes for band 5, 6, 7.
- The board and executive team composition of the trust board does not reflect the staff mix or local community mix and there is not an even spread of BME staff across the staff bands within the trust.
- The majority of BME staff within the trust were employed in low band positions with few at a senior management level. Of clinical staff, 21.7 % were employed at Band 5, with decreasing percentages after that. There were 4.33% employed at Band 8a and above and 0.00% at VSM level.

Fit and Proper Persons

- The trust had a policy which complied with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Person's Requirement.
- We reviewed five files of senior executives and found these complied with the information required under the regulation.

Public engagement

- The trust actively sought the engagement of their local communities in developing and improving the services it offered.
- Public engagement was very high on the trust agenda and this was notable with the range and diversity of activities regularly undertaken for a wide range of patient groups and local communities.
- The Chief Executive Officer (CEO) held patient lunches, staff and patients regarded these as unique and most welcome. This included bereaved relatives to hear about their experiences. Teams received feedback on any issues raised.
- There were focus groups within specific cancers for patient involvement although no patients took part in the governance groups yet. The trust used representatives from the local 'health watch' when planning major redevelopments.
- The trust made regular and concerted efforts to reach out to connect with hard to reach communities, such as the traveller community.
- The trust had established engagement links with young people and children within the community and many diverse activities were set up on and off site for these groups. A recent 'Lifelab' at an Open Day gave local children the opportunity to try experiments and learn about personal health. Opportunities such as this encouraged children of every socio-

economic background to attend and to view healthcare as a potential career option.

- There were opportunities for members of the public to become involved with the trust by becoming a foundation trust member, opting to support the hospital charity, becoming a volunteer or registering for 'my medical record.'
- Hospital teams, supported by hospital volunteers and emergency services, ran a 'family road safety day' in central Southampton. Local children and their parents learned about road signs and had the opportunity to practise resuscitation techniques.
- The trust charity has raised over £18 Million for the benefit of patients over the last nine years.

Staff engagement

- Non executive and executive members undertook site walk arounds to understand the issues they were being asked to engage with.
- Staff engagement took place across local and divisional team meetings, research groups, governance and leadership groups, and disease-specific interest groups.
- Each professional group had their own engagement strategy and were enabled to engage with the executive team.
- Staff attended Hospital-open days to support these. These were often attended in staff's own time.
- The trust was named as one of the best nationally for staff engagement. The hospital scored 3.95 out of 5 against a national average of 3.81 for similar trusts and was ranked the fifth best in the country.
- Two teams have been nominated for team of the year at the British Medical Journal (BMJ) awards.
- A cancer team won the commercial research category at the Wessex Awards.
- Staff were consulted about a new behavioural strategy to ensure the values were well embedded within the trust culture.

Innovation, improvement and sustainability

- Improvement and innovation was actively encouraged and facilitated.
- The integrated medical examiners group (IMEG) reviewed all deaths twice each day and approved the death certificate before it was signed, including contact with the coroner if needed.
- There had been a sustained reduction in hospital acquired pressure ulcers through the local pressure risk evaluation and skin screening tool (PRESS) initiative.
- The trust had appointed a consultant pharmacist in diabetes to support patient care.
- Ideas were trialled and successful ones shared across divisions. There was a very accessible 'improvement team' to support new ideas and developments.
- The introduction of the rapid access multidisciplinary palliative assessment and radiotherapy treatment (RAMPART) clinic was a 'one stop' clinic for cancer-induced bone pain. This service was supported by palliative care and through assessment and meant patients could have delivery of 'one fraction palliative radiotherapy' in a single hospital visit.
- The mortuary commissioned the design of a new specification and type of viewing bier (trolley) to be used in the viewing area or if required within ward areas without causing unnecessary distress.
- A new reporting tool had been implemented recently, called the favourable event reporting form (FERF). Anyone who saw an incident or an event which had gone particularly well was invited to fill out a form. These were reviewed on a monthly basis by a multi-

disciplinary team within the department. Everyone mentioned in a FERF received a personal letter, thanking them for their contribution. The multi-disciplinary team discussed the FERF, and analysed what was positive about the incident. The summary of these reflections were fed back to the whole department as part of the mortality and morbidity meeting along with lessons learnt from adverse events. Good practice was then further disseminated throughout the trust.

Overview of ratings

Our ratings for Southampton General Hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Critical Care	Good	Good	Outstanding	Good	Outstanding	Outstanding
End of Life Care	Good	Good	Good	Good	Good	Good
Outpatients & diagnostic imaging	Good	Inspected but not rated[1]	Good	Good	Good	Good
Overall	Good	Good	Outstanding	Requires improvement	Good	Good

Notes:

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. Responsive is rated as requires improvement overall because responsiveness of urgent and emergency care and children's services required improvement in 2015. The services were not re inspected in 2017 as were overall Good in 2015.
3. Caring is rated as outstanding trust wide based on ratings from inspections in 2015 and 2017. Children and young people's services were outstanding for caring in 2015, and critical care in 2017.

Our ratings for University Hospitals Southampton NHS Foundation Trust are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Our ratings for the well led function	Requires improvement	Good	Outstanding	Requires improvement	Outstanding	Good

Outstanding practice

We saw several areas of outstanding practice including:

- The integrated medical examiners group (IMEG) reviewed all deaths twice each day and approved the death certificate before it was signed, including contact with the coroner if needed. This had proven benefit to an improved accuracy of mortality data, opportunity to reflect upon practice, an improved understanding of correct death certification, consistency amongst reviewing staff and an overall improvement to patient safety after learning.
- The Chief Executive Officer (CEO) held patient lunches, staff and patients regarded these as unique and most welcome. Teams received feedback on any issues raised.
- There were focus groups within specific cancers for patient involvement although no patients took part in the governance groups yet. The trust used representatives from the local 'health watch' when planning major redevelopments.
- The trust made regular and concerted efforts to reach out to connect with hard to reach communities, such as the traveller community.
- The trust had established engagement links with young people and children within the community and many diverse activities were set up on and off site for these groups. A recent 'Lifelab' at an Open Day gave local children the opportunity to try experiments and learn about personal health. Opportunities such as this encouraged children of every socio-economic background to attend and to view healthcare as a potential career option.
- Hospital teams, supported by hospital volunteers and emergency services, ran a 'family road safety day' in central Southampton. Local children and their parents learned about road signs and had the opportunity to practise resuscitation techniques.
- The trust had a culture of innovation and research, and staff were encouraged to participate. There were examples of research that were nationally and internationally recognised. Staff were supported to lead innovation projects in their work environment.
- The trust had implemented a new tool called the favourable event reporting form (FERF). Anyone who sees an incident or an event which had gone particularly well was invited to fill out a form. Everyone mentioned in a FERF received a personal letter, thanking them for their contribution.

Areas for improvement

Action the trust MUST take to improve

- Reduce the number of mixed sex accommodations across the trust to improve privacy and dignity for patients.
- The trust must ensure medicines are always stored at temperatures that ensure their effectiveness.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury Accommodation for persons who require nursing or personal care	Health and Social Care Act 2008 (Regulated activities) Regulations 2014 Regulation 10: Dignity and respect (10)(2)(a) How this was not being met 1. Patients were not able to consistently access clearly labelled gender- specific toilet and bathroom facilities as arrangements were not consistently implemented. 2. Patients were sometimes sleeping in mixed sex bays in the acute surgical unit.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON "TRANSFORMING PRIMARY MEDICAL CARE IN SOUTHAMPTON 2017-2021"		
DATE OF DECISION:		24 AUGUST 2017		
REPORT OF:		DIRECTOR, SYSTEM DELIVERY - NHS SOUTHAMPTON CITY CCG		
CONTACT DETAILS				
AUTHOR:	**Name:**	Phil Aubrey-Harris	**Tel:**	07971 690626
	E-mail:	Phil.aubrey-harris@nhs.net		
Director	**Name:**	Peter Horne	**Tel:**	07768 926487
	E-mail:	Phorne@nhs.net		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY This report provides an update on the progress and planning for the delivery of Southampton City CCG's strategy – "Transforming Primary Medical Care in Southampton 2017-2021".		
RECOMMENDATIONS: That the Panel		
	(i)	Note the progress on the CCGs delivery of its strategy "Transforming Primary Medical Care in Southampton 2017-21".
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Health Overview and Scrutiny Panel has requested an update on the development of primary care services in Southampton.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not applicable.	
DETAIL (Including consultation carried out)		
	Introduction and context	
3.	General Practice is a cornerstone of any future model of healthcare. Recent estimates suggest that GP practices in the UK deliver around 340 million urgent and routine appointments per year and between 2011 and 2015 there was a 15% increase in demand on GP services (BMA 2016). Demographic changes, changing need and public expectation, market forces and other factors make current models of primary care unsustainable in their current form. It is inevitable that these services change significantly over the coming years in order to ensure high quality healthcare for future generations.	
4.	In April 2016 NHS England published the "GP Forward View" to announce national directives intended to improve quality and sustainability of general practice. The GP Forward View 2016 recognises primary care services as a	

	fundamental component of the NHS and that there has been a history of relative underinvestment that must be rectified. The GP Forward View sets out a range of investments and other support for Primary Medical Care to be implemented by NHS England, CCGs and other partners.
5.	Currently in the city there are 29 GP partnerships delivering care to approximately 280,000 people living in the city and its immediate environs. These are made up of around 180 GPs (of which around 110 are partners) as well as nurses, other healthcare professionals and administrative staff. The practices operate from around 40 sites across the city.
6.	In April 2016 the CCG was granted delegated responsibilities for the commissioning of primary care. Since then the CCG has developed its expertise and confidence as a primary care commissioner. During 2016/17 the CCG worked in partnership with local communities, GPs and other relevant stakeholders to develop a five year primary care strategy, "Transforming Primary Medical Care in Southampton" (see Appendix 1). This paper will cover the following: • Overview of 7 key elements of the strategy • Summary of progress against these 7 key elements • Overview of management of delivery.
	Commissioning Plan
7.	In December 2016 the CCG developed its two year delivery plan, setting out its detailed work programme to implement the strategy. The plan is divided into the following areas and is supported with investments: • 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 weekend. • Quality – People are provided with high quality care with is safe and effective, meeting their needs. People have a positive experience, which is person centred, dignified and compassionate. • Workforce – A motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers. • Estates – Fit for purpose premises which enable access to clinical services outside of hospital 7 days per week • Technology – Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care • Collaboration – Sustainable and resilient GP services supporting the delivery of integrated care across the city • Communications & engagement – Practices are engaged in transforming the way they deliver care and have support of the public, who understand the variety of resources available to help them to manage their health.

	Access
8.	Over the last two years the city has had the benefit of primary care "hubs" that offer additional choice and capacity for patients – including appointments at evenings and weekends. This service is delivered by Southampton Primary Care Limited (SPCL) and was initially funded by NHS England with the Prime Minister's Access Fund. In April 2017 the contract for the service novated to the CCG and the service now forms a key component of the city's primary care services, offering around an additional 40,000 appointments per year for city residents.
9.	These services will be developed to have better integration with regular GP services, GP Out-of-Hours, Minor Injuries Unit, Emergency Department, NHS 111 and other community services to provide a more seamless model of care.
10.	In some cases around 30% of GP workload relates to musculo-skeletal complaints. During 2017 the CCG has commissioned new direct access physiotherapy pilots where patients with musculo-skeletal complaints are able to book appointments with a physio via their GP reception or on a direct access basis. This improved access to physiotherapy without the need for an initial GP appointment has been well received by patients and GPs alike.
	Quality
11.	Since acquiring delegated commissioning responsibilities, the CCG has sought to work with local practices to promote better quality care. In January 2017 the CCG appointed a new Primary Care Quality Lead to support the progression of a range of initiatives including but not limited to: • Supporting practices with reporting, investigation and subsequent learning associated with incidents and complaints • Establishing support for nurses and other healthcare professionals working in general practice • Providing supportive review and challenge for practices around their Care Quality Commission (CQC) standards – including attending mock CQC inspections.
12.	Practice resilience is a key priority for the CCG. The majority of the city's practices have viable operating models and good future plans, but there have been a small number who require additional support.
13.	During 2016/17 the CCG worked with NHS England to implement a practice resilience programme, focusing support into key areas around practice planning and efficiency and targeting practices that were most vulnerable. Last winter the CCG provided funding for additional GP and nursing appointments across the east of the city in order to support access at a time when local practices were struggling to meet demand. This was a time limited initiative in response to significant changes in practice partnerships and patient registrations in the area.
14.	Taking the learning from these workstreams, the CCG has refined its approach and is currently developing a "menu of support" for practices along with

	contingencies through working with more stable local partners.
	Workforce
15.	Constraints around workforce supply represent a significant risk to the sustainability of primary care in Southampton. The CCG has commenced a range of initiatives along with other partners such as Health Education Wessex, that will: • Consider innovative ways to promote the recruitment and retention of GPs and other healthcare professionals in primary care in Southampton • Consider and promote the deployment of alternative healthcare professionals (e.g. nurse practitioners or physiotherapists) • Support practices to develop more efficient operational processes to ensure that the right part of the workforce is doing the right work.
16.	Over coming months the CCG Primary Care team will be assessing the baseline of primary care workforce across the city, taking into account a range of factors including potential GP retirement ages. From this the CCG will work with GP practices and our partners to establish likely workforce needs over coming years that take into account the impact of practice business plans, further integration and supply factors (i.e. numbers of GPs in training).
17.	The CCG is currently consulting practices on our potential involvement in an initiative to recruit GPs from overseas. The initiative, supported by NHS England and Health Education Wessex, will attract additional funding to support GP relocation.
18.	During 2016/17 the CCG commissioned training for practices to consider the more efficient use of the practice team, thereby enabling clinicians to devote more time to clinical care. This successful programme will be repeated and refined in 2017/18.
	Estates and Information Technology Infrastructure
19.	The CCG recognises that good primary care services are predicated on their ease of access and relative position within local neighbourhoods. The CCG is currently undertaking a baseline audit of primary care premises, including consideration of position, condition, occupancy, and tenancy status. This will further inform our plans for primary care estate and drive investment through programmes such as the Premises Improvement Grants.
20.	During 2016/17 the CCG undertook a feasibility study to establish preferred locations for Better Care "Cluster Resource Centres" that would be accessibly located within each of the city's clusters and include a range of additional services, including extended hours and out-of-hours primary care and other community services. During 2017/18 we will continue to progress this workstream with Southampton City Council and other local partners with a view to establishing more tangible plans for the delivery of the centres.
21.	Developments in information technology will play a vital role in the delivery of more integrated services in the future and the CCG continues to play a key leadership role in the Hampshire-wide Digital Roadmap programme.

22.	More locally and as part of the GP Forward View commitments the CCG is working with local practices and Southampton Primary Care Limited (SPCL) to promote the uptake of on-line consultations, offering patients alternative means of access to GP services. Currently there are five practices in the city offering on-line consultations and this number is set to grow significantly over coming months – supported through CCG investments.
	Collaboration
23.	There is a history of collaboration between GP practices in the city. In 2015 SPCL was formed as a company limited by shares, owned by 28 of the local practices. The CCG will continue to work with SPCL and other similar local primary care organisations as these organisations have a key role in new models of primary medical care in the city.
24.	The Southampton Better Care Programme has adopted a strong focus on neighbourhoods centred on the six Better Care clusters. GPs and primary care teams are key to the success of Better Care, both in terms of their roles within local leadership and in the delivery of new care models. Since 2015/16 the CCG has continued to work hard to support primary care engagement in Better Care with significant progress in some areas, including but not limited to: • In June 2017 the CCG invested in a new Local Improvement Scheme with to further support and encourage GP engagement in Better Care and to improve services for people with long term conditions and cancer. • In recent months the CCG has been working in partnership with SPCL to pilot a new Acute Visiting Service which will commence in September 17 and will further strengthen the primary and community care response to urgent patient need. • The CCG is currently procuring a new community care navigator service that will provide support for people in accessing health and care services to ensure that they are matched to the right choices to best meet their needs. • The CCG will be funding training during 2017/18 for practice reception staff to help sign-post people to local health and community service. • In line with national requirements, the CCG is working in partnership with West Hampshire CCG and University Hospital Southampton NHS Foundation Trust to develop and deliver a pilot “Clinical streaming” service for the Emergency Department (ED) of Southampton General Hospital. The service will involve the streaming of appropriate patients attending the ED to a closely located GP service. The pilot service will go live from 30th September 2017.
	Communications and engagement
25.	We use information provided to us by patients to help us shape the healthcare

	in the city.
26.	***Existing survey results*** Most recently, the GP Patient Survey results show that overall experience in the city was as follows: **Rating** / **%** Very good / 36 Fairly good / 44 Neither good nor poor / 12 Fairly poor / 5 Very poor / 3
27.	These results show a slight decline of 5% in satisfaction since 2013. Further highlights can be found in Appendix 2. As part of our regular engagement throughout the city, we have also received feedback from patients about difficulties in accessing GP services and concerns about the future of services when GP practices are struggling to recruit staff. We also receive concerns about the availability of non-urgent appointments.
28.	***CCG engagement on the primary care strategy – 2016/17*** To help us create and implement our primary care strategy, we engaged directly with a significant and diverse range people of people across Southampton. Throughout this process we have been guided by our own internal patient groups on how best to engage with the local population, such as our Communications and Engagement Group, Patient Forum and our Equality and Diversity Reference Group. Consequently we worked with Carers in Southampton, Sure Start families, the Pensioners Forum, and our urgent care providers.
29.	In addition, we surveyed over a thousand people about their preferences for primary care, with a response rate of almost 50%, through the City Council's People Panel. These results can be found in Appendix 2. Throughout Spring 2017 we held our most ambitious engagement project to date, with a bus roadshow travelling across the city. Locations can also be found in Appendix 2. The key points we learnt through our engagement to date are: • We should prioritise urgent, same day appointments for those times a patient needs one • Patients would like the ability to book an appointment outside of normal working hours for people who cannot attend the practice during the day. • We were also told about the importance of continuity in service, with patients being able to see a GP who is fully aware of their health situation and who has enough information to make decisions about their health. This feedback has helped to shape the delivery plan and confirmed that we are focussing in the right areas.

30.	***Future events*** Our model for the future of primary care will be discussed at a stakeholder event taking place at The Spark, Southampton Solent University, in October. We will be inviting community groups from across Southampton to share their thoughts and experiences on current services, what will change in primary care, and ways in which we can work together.
	Oversight and management of delivery
31.	Since being delegated responsibilities from NHS England in April 2016, the CCG has been developing its capacity as a commissioner of primary care services. During 2016-17 the CCG invested in strengthening our primary care commissioning team in order to support the implementation of our primary care strategy.
32.	The CCG is currently establishing a more structured contractual relationship with practices and primary care organisations.
33.	The CCG is currently developing practice profiles. These bring together a range of key information relating to how practices are performing across a range of domains (e.g. complaints, list movements, vaccination rates, vacancies, patients use of other services such as A&E). We will use these profiles in our dialogue with practices in order to promote quality and provide better "early warning" arrangements to identify practices in need of support.
34.	To supplement these two developments, the Primary Care team has recently implemented a new "link role" arrangement that will seek to further build trust and dialogue with local practices. These arrangements will include a more proactive schedule of meetings in order to raise concerns, identify support and hold practices to account for the quality of services.
35.	The CCGs Primary Medical Care Committee (PMCC) provides the main formal governance gateway for decisions relating to delivery of the CCGs commissioning of primary care and delivery of our strategy. Terms of Reference for the committee have recently been refined to allow the delegation of further appropriate decision making relating to primary care matters. The Primary Care Operating Group (PCOG) operates as a subcommittee of the PMCC, acting as the main forum for developing proposals for PMCC approval. The CCG has recently extended the membership of the PCOG to include a representative from a local Practice Patient Participation Group.
36.	Members are asked to consider the information presented at the meeting and following discussions comment on the report.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
37.	None
<u>Property/Other</u>	
38.	None
LEGAL IMPLICATIONS	

Statutory power to undertake proposals in the report:	
39.	Not applicable.
Other Legal Implications:	
40.	None.
RISK MANAGEMENT IMPLICATIONS	
41.	None.
POLICY FRAMEWORK IMPLICATIONS	
42.	Not applicable.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	ALL

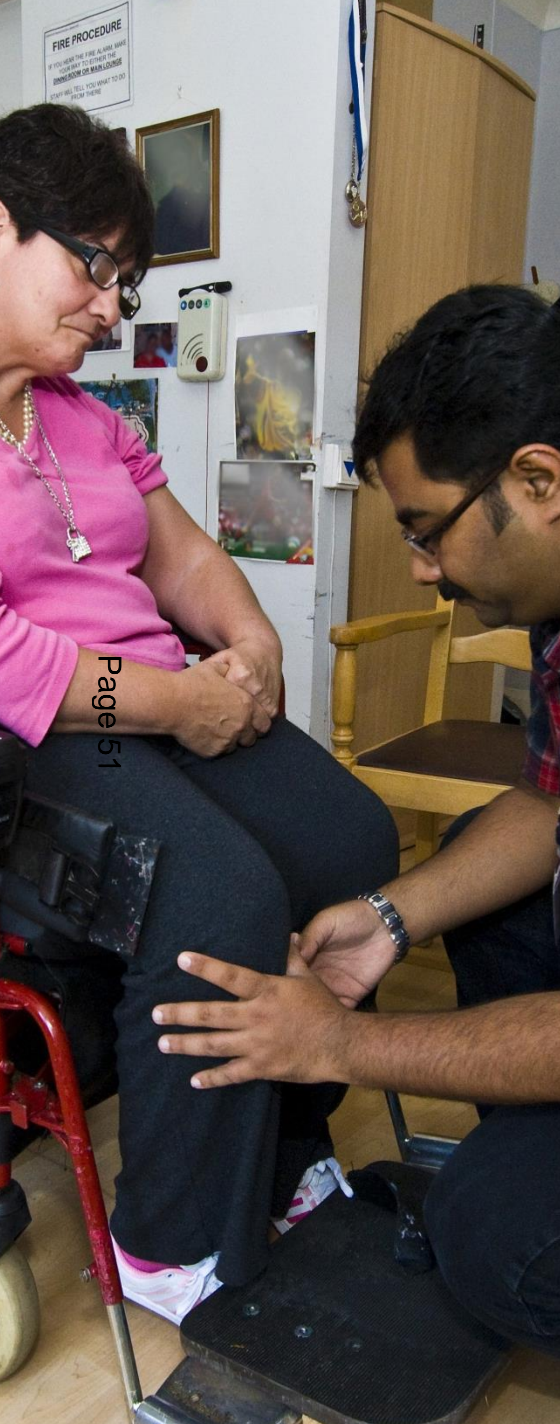
SUPPORTING DOCUMENTATION		
Appendices		
1.	Transforming Primary Medical Care in Southampton – 5 Year Strategy	
2.	Summary of national patient survey July 2017 for Southampton practices	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require 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)		
1.	NHS England GP Forward View – April 2016 https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf	

Transforming Primary Medical Care in Southampton

Our Five Year Strategy to Deliver the General Practice Forward View in Southampton (2017-2021)

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

Socrates



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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 – it will need to be GP led rather than always GP 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. We want to build on the fundamental strengths of general practice, such as the ongoing relationship with patients, continuity of care and the GP role as a trusted professional with an overview of patient care.

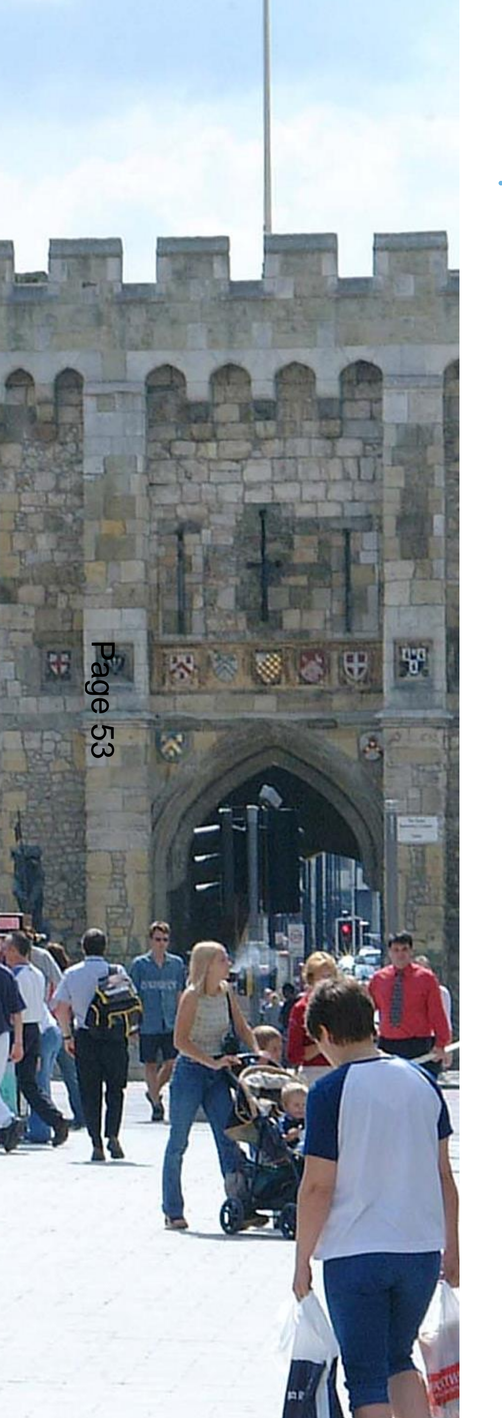
The GP Forward View, NHS England's five year plan for primary care, makes it very clear that, in future, services for people will be developed at a neighbourhood population level (such as a Locality Cluster, of which we have six in Southampton), rather than at a practice level. Where the partnership model is working well, this will be supported to continue, recognising the value of the this and the continuity that it provides. However, we do need to develop alternative models for those people and practices for whom the traditional model of general practice partnership is not attractive or sustainable.

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, e.g. nurses or therapists. GP Practices (specifically, the partners) are responsible for ensuring that their organisation is able to deliver the primary medical services for which they are paid, 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 manage the risks to both services and the practice as a business entity.

This plan has been developed following contributions from city GPs, as well as other interested groups and organisations during a number of engagement events across the city. It has a dual purpose in that it sets out the future direction of primary care planning and delivery 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)

> "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."



Introduction and 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 health and care providers including the voluntary sector, and other interested groups and organisations, via the GP Forum, surveys and a workshop.

The purpose of the strategy is two-fold. **Firstly**, it addresses the expectations that the way in which care is delivered will change, as outlined in NHS England's *Five Year Forward View* and *GP Forward View*, in order to meet the needs of people and support the delivery of Better Care and the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) 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.

What is the primary care strategy not?

The future model of Primary Care will integrate the roles of other professional groups such as clinical pharmacists, dentists and ophthalmologists. This will form the basis of further strategic development following the adoption of this strategy. This strategy is presented as a key building block for wider system reform recognising general practice is at the heart of the health system.

The primary care strategy aims to capture the core objectives of what the future model of general practice in Southampton should look like but is not an implementation plan – a delivery plan will form Phase 2 of the change process and actions will be developed across access, quality, workforce, infrastructure and collaboration. This strategy recognises the value of the traditional partnership model of General Practice, and seeks to build upon those strengths, whilst offering an alternative option. No practice will be compelled to enter into any new contract against their wishes.

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 is one of the key strategic work programmes for Southampton City CCG in 2016/17 and beyond and 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 strong local practices 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 will need to work differently in order to remain 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

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, hospital-based 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 five 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 also seen in the acute sector, the **population is becoming over-reliant** on general practice and we need to support our population to build independence and take responsibility for managing their own health 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 by another health professional and 6% who could self-care, i.e. manage their illness themselves). 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 for 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.

90% of all contacts with the NHS take place in general practice

If all of the 300 GP trainees in Wessex stayed in general practice, this would still not be enough to replace the number leaving the profession

300 million visits to GP practices each year, compared to fewer than 25 million A&E attendances

27% of GP appointments could potentially be avoided if there was more coordinated working between GPs and hospitals, wider use of other primary care staff, better use of technology, and wider system changes.
(Making Time in General Practice - NHS Alliance and Primary Care Foundation)

18% forecast increase in consultations by 2018

8.3 average number of GP consultations per year, per person (Nuffield Health) compared to 3.9 in 1995 (RCGP)

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 whole person 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

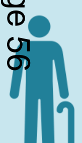
Insufficient numbers of GPs in **training**

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:



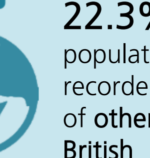
15% increase in **over 65s** (2015-21)

20% increase in **over 85s** (2015-21)

12% of the population is aged **20-24** (Higher than average student/younger population)

11,282 (4.6%) forecast increase in **the overall population** (2015-21)

23% of the population live in the **most deprived** small geographical areas **in England** (known as LSOAs – Lower Super Output Areas)



22.3% of the population have a recorded ethnicity of **other than white-British**

People **die earlier** in the most deprived areas than those in the least deprived:

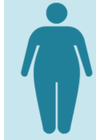
Women **3.2 years earlier**

Men **6.7 years earlier**

17.6% of the population **were born outside the UK**

300% increase in the population recorded in **the other white** ethnic group in the last 10 years

Southampton's health challenges:



20.3% of **children** in Year 6 are **obese**

25% of **adults** are **obese**

22% of **adults** are **smokers**

75% of the over 65s population is living with **2 or more long term conditions**

29,000 adults are registered with **hypertension**

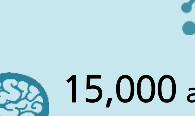
32% of the population (all ages) **have a long term condition**

5,500 adults are registered with **COPD**

483 deaths from **respiratory disease** (2014)

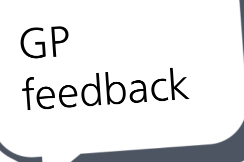
490 deaths from **cancer** (2014)

12,000 adults are registered with **diabetes**



15,000 adults are registered with **depression**

Listening to our GPs and patients



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

TIME WITH THE PATIENT AND 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"

CAPACITY AND 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**"

"Having to spend so much time dealing with minor problems by telephone triage and proportionally less time dealing with medical problems that use my experience"

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 this is 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"

Our vision

Our vision on a page

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;
- System-wide culture of **learning** and **continuous improvement**;
- People are educated and empowered to take responsibility for **managing their own health,** with a particular focus on **prevention;**
- Health and social care based around **clusters of practices** in a neighbourhood;
- Primary care system based on **quality** and reducing health inequalities where possible;
- **Technology** options are readily available to support the care of those people who prefer that option.

Our key areas of focus and outcomes

Access

- ✓ People can access their surgery **8am to 6.30pm**, Monday to Friday
- ✓ Pre-booked and same day appointments, **7 days** a week
- ✓ Integrated community based primary care pathway for **urgent care** 24 hours and 7 days a week
- ✓ Patients are encouraged, educated and empowered to **manage their own health**
- ✓ Innovative **technological solutions** to support access are embedded

Quality

- ✓ Reduced **variation** in the quality of care delivered across all practices
- ✓ Standards for **screening** and **immunisations** are achieved
- ✓ Improved patient **satisfaction** and **experience**
- ✓ Health professionals have all the **clinical knowledge and skills** required to deliver safe and effective care
- ✓ Practices are engaged in **incident/event reporting**
- ✓ Practices are **rated good/outstanding** by the CQC

Workforce

- ✓ Practice teams are **motivated and engaged**, incorporating a range of skilled professionals
- ✓ Professional **development** and **succession** planning are embedded principles
- ✓ 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

Infrastructure

(Estates and technology)

- ✓ Modern premises that are **fit for purpose**
- ✓ Flexible, **multi-use space** is available which is adaptable to service needs
- ✓ A **resource centre** is located in each of the six clusters across the city
- ✓ Clinical **computer systems** are **interoperable**, i.e. provider systems are connected, facilitating communication and information sharing
- ✓ Innovative **technological solutions** which empower people to manage their health

Collaboration

- ✓ GP practices operating within a business framework that ensures **sustainable** primary care
- ✓ Practices are **working together** to build a resilient service which operates **at scale** but remains focused on the registered population
- ✓ Primary care is fully engaged with the local **integrated provider** group, i.e. the cluster.
- ✓ The **operating model** delivers improvements to health outcomes, patient experience, access and workforce

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:

City
Cluster
Practice
Patient
Self-care & prevention
Integrated
Integrated
Integrated
GP services evenings & weekends
Daytime GP services Mon-Fri
Primary Care Services
Integrated Services
Specialist Services
Out of hours GP services

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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 communities and their 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** in a way which is simpler to access and navigate.
3. Take a **multi-disciplinary** approach to the provision of primary care services, with other health professionals such as nurses (including mental health), clinical pharmacists and therapists actively caring for patients as part of an **extended practice team** and supporting the delivery of Better Care and the STP.
4. Ensure that people have **access in a primary care setting,** such as a GP surgery or health centre, to the health professional best able to support them, with co-ordination and oversight provided by the GP, recognising the health benefits to be gained by **working more closely with other primary care services**, such as optometrists, dentists and community pharmacists.
5. Focus on **improving quality and health outcomes**, with particular emphasis on **preventing illness, 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 (GP led rather than GP delivered).
- GPs, practice nurses and other practice staff work mainly in their own practice but may also spend time working as part of a **cluster or city-wide arrangement** which provides services 7 days per week and out of hours.
- Access to **urgent primary care** will be simplified across the system.

Quality

- Consistency of care to **reduce health inequalities** and support patient empowerment for **self-care** 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; online consultation; online appointment booking and prescription ordering and tracking; home monitoring and tele-healthcare. Patients and staff will be supported to make best use of these options.
- 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 a physician for older people.
- 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. 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 **online 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...

- If 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 around 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 local 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 and 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 online consultations**.
- The **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 focused on 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 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 **patients with more complex needs** 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 reviewing test 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 more reasonable.

My development...

- Not only do I provide clinical sessions in my practice but I also work additional sessions **in other specialist 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 and IT)

Collaboration

Access

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 community based primary care pathway for **urgent care 24 hours a day, 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 online 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 illnesses will be supported by digitally enabled pathways of care, for example allowing people to self monitor conditions using their own devices (such as phone, computer or medical device) and share data with their NHS record. This will enable online assessments to be completed 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 dignified, compassionate and focused on them as a person.

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 practices 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 and experience – ensuring safe and compliant services in a patient focussed system
- Workforce and 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.

20% 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, gaining experience in other specialist areas. 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 and 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 either established or planned 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 all parts of the health and care system.

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 hospital 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 healthy lifestyle 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 (local technology plan) 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 assessment and email appointment systems,
- better coordination, with interoperable systems allowing clinicians to share agreed information across organisational boundaries,
- 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 for 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, i.e. practices working together, 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. It will also facilitate the delivery of services that may not be easily delivered by an individual practice, such as such as appointments in the evening and at weekends, integration of extended access with out of hours and urgent care services, and other services developed at a population based level.

The move for new ways of working 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. Where the partnership model is working well, this will be supported to continue. However, we do need to develop alternative models for those people and practices for whom the traditional model of general practice partnership is not attractive or sustainable. The voluntary multispecialty community provider contract is one option and will be available from April 2017. Practices can opt to remain outside this alternative contract. All changes to practice service delivery are subject to NHS policy and require approval from the CCG.

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.
- 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 choice.
- 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 to support 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 five years the CCG will receive growth in primary care funding of £6.93m. This is, over those five 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 national £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. ▪ There will be continuous engagement with patients and other stakeholders throughout the life of the strategy, to ensure a co-productive, i.e. joint, approach and to influence behaviours, perceptions, expectations and cultures to support the new model. ▪ 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 is in progress and will form phase two of the change process. The delivery plan will be submitted to NHS England on 23rd December to demonstrate the CCG's plan to implement the General Practice Forward View (GPFV). ▪ 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. ▪ Communications and engagement will be an integral part of every element of the delivery plan.

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Who’s who?

Who's who?

NHS Southampton City Clinical Commissioning Group (CCG)

Our purpose as a CCG is to help meet the health and care needs of local people. Southampton City CCG is allocated a budget of around £350 million a year to achieve this and use it to plan and pay for (or 'commission') health and care services from a number of service providers (such as hospital, mental health and community trusts). CCGs were established in April 2013 with a clear remit to ensure that family doctors and other clinicians play a leading role in deciding and directing how local NHS resources should be used.

Southampton City Council and other health and care partners

The CCG works closely with the Council and other partners to ensure the right services are in place for the community. The CCG pools £68 million of their budget with £28 million from the Council in order to progress the vision for Better Care in Southampton, to integrate health and care services in order to improve people's quality of life.

Southampton Primary Care Limited

Southampton Primary Care Limited was formed as a legal entity in November 2014. It is a federation of 29 of the 31 city GP practices; the member practices are the shareholders with voting rights linked to the practice population (1 per 1,000 registered patients with a maximum of 10 votes per practice).

NHS England

NHS England sets the priorities and direction of the NHS, shares out more than £100 billion in funds and holds organisations to account for spending this money effectively for patients and efficiently for the tax payer. This includes the commissioning of contracts for GPs, pharmacists, and dentists and they support local health services that are led by CCGs.

STP

Every health and care system in England has produced a Sustainability and Transformation Plan, showing how local services will evolve and become sustainable over the next five years. Southampton is part of the STP being developed for the whole of Hampshire and the Isle of Wight.

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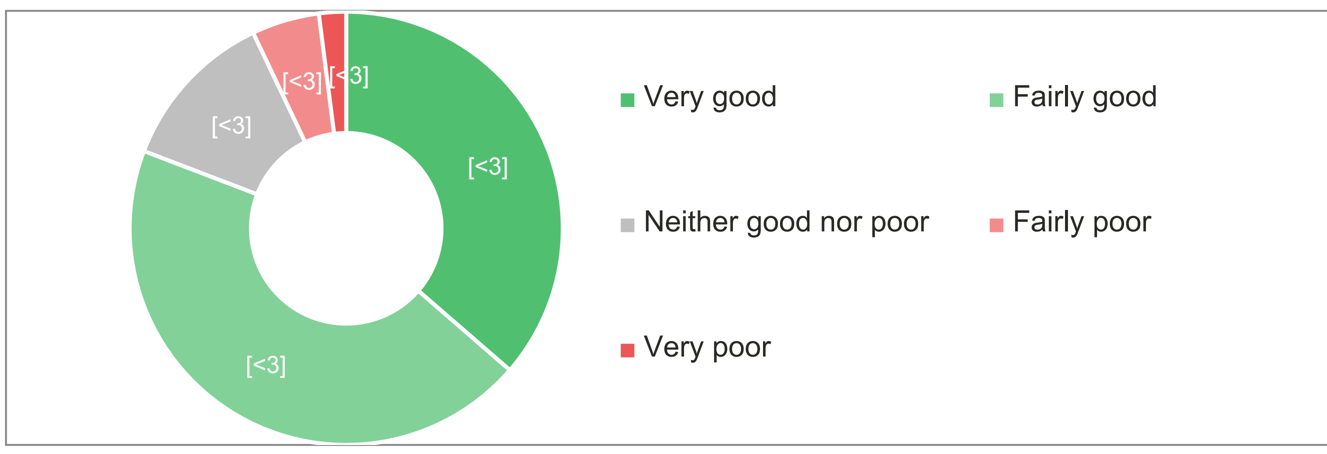
GP PATIENT SURVEY RESULTS, JULY 2017

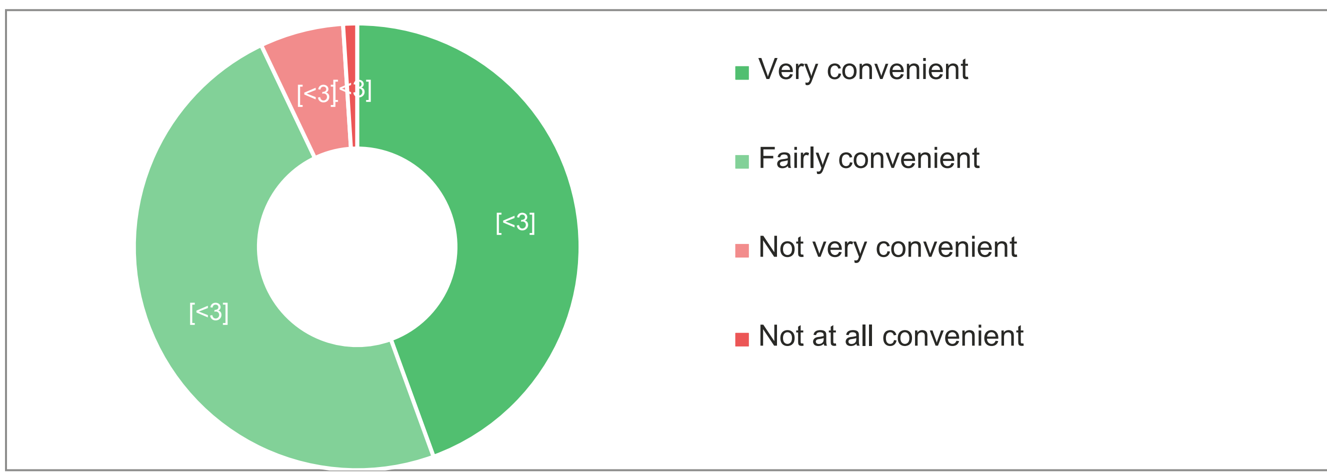
The GP Patient Survey is an England-wide survey, providing practice-level data about patients' experiences of their GP practices. Ipsos MORI administers the survey on behalf of NHS England.

Fieldwork took place from January to March 2017. In NHS Southampton CCG, 9,704 questionnaires were sent out, and 3,279 were returned completed. This represents a response rate of 34%. Full results can be found here: https://www.gp-patient.co.uk/downloads/slidepacks/2017/10X%20-%20NHS%20SOUTHAMPTON%20CCG.pptx

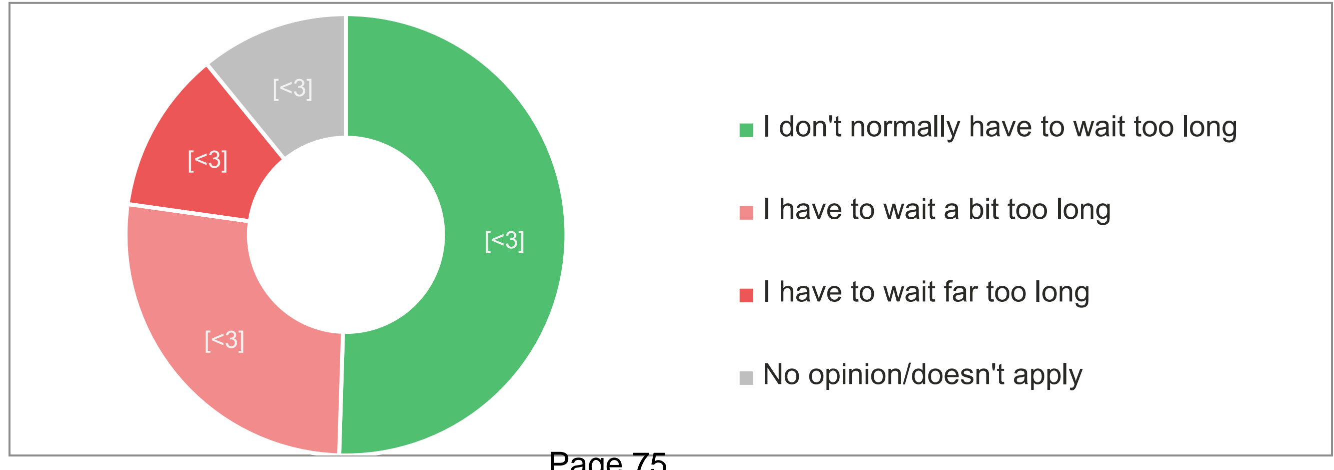
Overall, how would you describe your experience of your GP surgery?



How convenient was the appointment you were able to get?



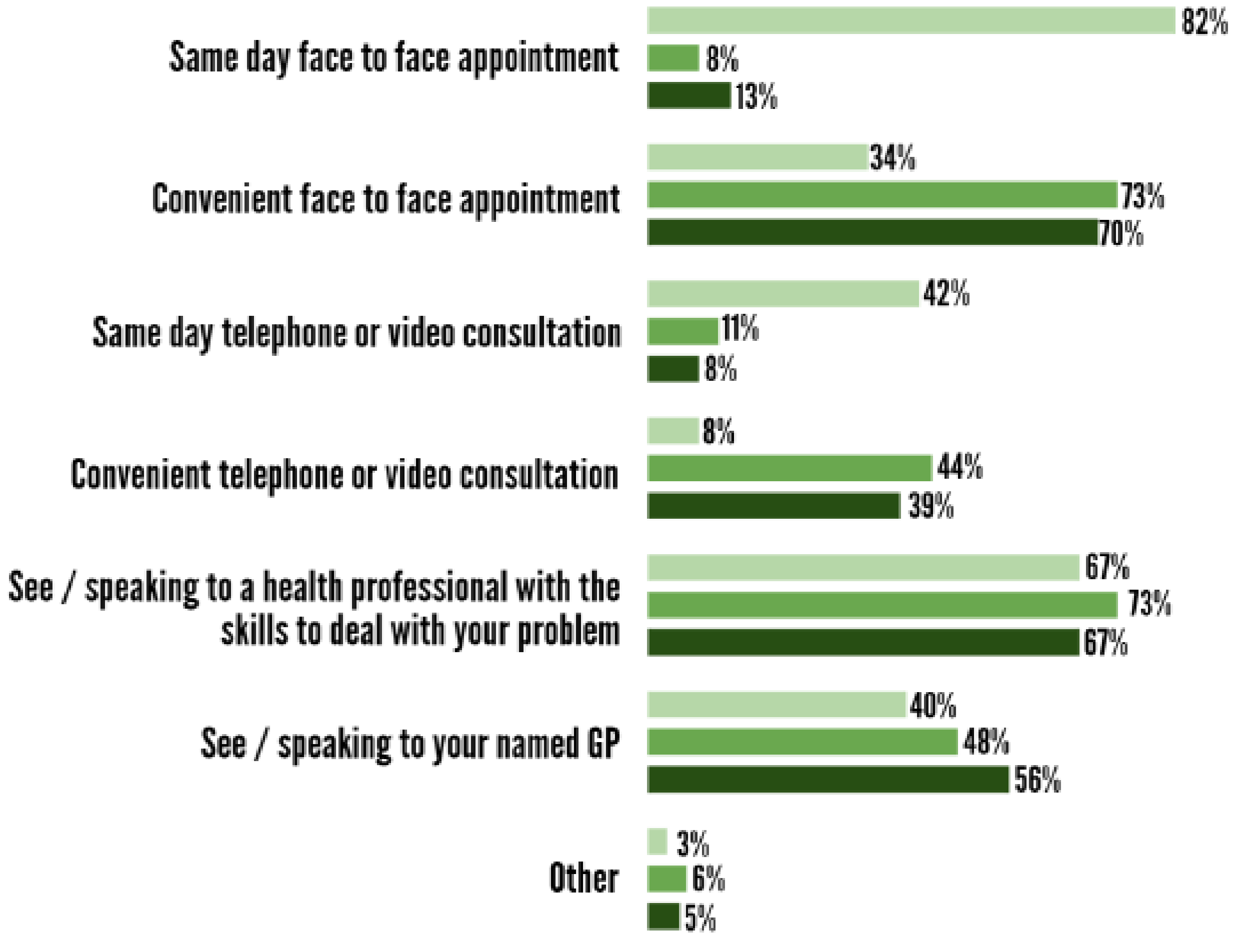
How do you feel about how long you normally have to wait to be seen?



Accessing GP Services

people's panel poll

- You are seeking help with a problem that you feel needs urgent or immediate attention from your GP surgery.
- You want to make a routine appointment at your surgery for a new problem that does not need immediate attention.
- You need an appointment for a regular review of a long term condition such as diabetes or a heart / respiratory disease.



Would you be willing to see someone specially trained to deal with the problem you have rather than a GP?

Yes - 96%

No - 4%

What times in the evening would you consider booking a non-urgent appointment at your doctors surgery?

6pm	7pm	8pm	9pm	10pm
99%	70%	47%	22%	10%

You ring your GP practice on a Friday afternoon for a non-urgent appointment. The next available appointment is on Sunday afternoon. What would you prefer to do?

70% would attend the appointment on Sunday

30% would prefer to attend an appointment on Monday

We are planning to have evening and weekend GP appointments available in centres around the city. When deciding upon the locations of each of these, is there anything that you think we should consider? (Themes of comments)

Theme	%
Public transport availability	55%
Availability of parking	33%
Distance to travel/area demographics	28%
Accessibility	15%
Safety (late at night / lighting)	14%
Access to pharmacy	5%
Other	24%

From the following list of alternative technologies to support your health needs, please select the ones you would be open to using.

61% - Mobile phone apps

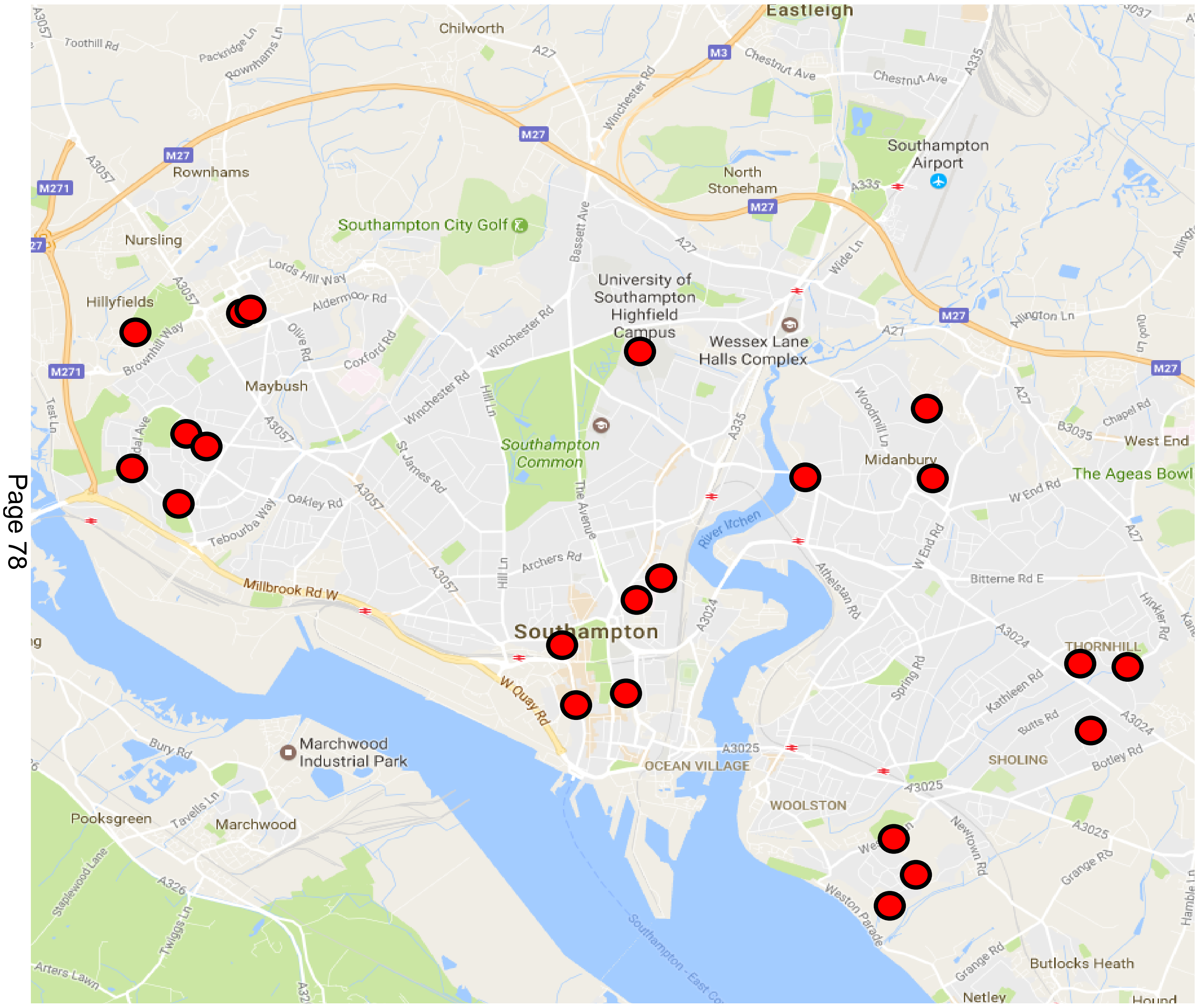
73% - Email

53% - Online / video consultation

Source: Southampton People's Panel 29th Poll - 558 respondents (48% response rate)

You can always contact us with ideas and suggestions at peoples.panel@southampton.gov.uk

LOCATIONS OF NHS SOUTHAMPTON CITY CCG BUS ROADSHOWS (SPRING 2017)



Lordshill Library

All Saints Church, Sedbergh Road

Newlands Primary School

Sure Start, Pickles Coppice

Millbrook Christian Centre

David Lloyd Gym, Frogmore Lane

Maytree Nursery and Infant School

Montague Avenue, Sholing

University of Southampton campus

Hinkler Road, Thornhill

Chamberlayne Leisure Centre

Weston Shore Infant School

Antelope Park

Meggeson Avenue, Townhill Park

Guildhall Square

Royal South Hants Hospital

Drayton Close, Weston

The Bargate

Bitterne Park Triangle

Vanguard Road, Bitterne

Mela Festival, Hoglands Park

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE		
DATE OF DECISION:		24 AUGUST 2017		
REPORT OF:		SERVICE DIRECTOR - LEGAL AND GOVERNANCE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**Mark.pirnie@southampton.gov.uk**		
Director	**Name:**	**Richard Ivory**	**Tel:**	**023 8083 2794**
	E-mail:	**Richard.ivory@southampton.gov.uk**		

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
RISK MANAGEMENT IMPLICATIONS	
9.	None.
POLICY FRAMEWORK IMPLICATIONS	
10.	None

KEY DECISION	No
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report

SUPPORTING DOCUMENTATION	
Appendices	
1.	Monitoring Scrutiny Recommendations – 24th August 2017
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 – 24th August 2017

Date	Title	Action proposed	Action Taken	Progress Status
29/06/17	Hampshire and IOW STP: Delivery Plan	1) That clarification is provided to the Panel of the decision making process required to introduce fluoride into the water supply and the role that the Health and Wellbeing Board would play in this decision.	• A decision to introduce fluoride into the water supply in Southampton and some neighbouring areas would ultimately need to be taken by Full Council following wide consultation with residents. The law has changed in recent years and when last considered the Council was a consultee NOT decision maker. • Fluoridation proposals were last considered and rejected by Full Council in September 2011. http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=122&MId=2029&Ver=4 • The current law requires ALL the authorities whose residents would be affected to take the decision so the decision would also need to be taken with neighbouring authorities who share the same water supply as Southampton and would not be effective unless by weighted voting 67% of those in favour do so. It is a complex legal process and a joint committee is required to be set up to oversee the project. • A very comprehensive consultation programme is required, based by supporting professional evidence prior to any proposal being considered by those Councils affected. • When the matter was last considered neither HOSP nor the HWBB were in	

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Agenda Item 11

Appendix 1

			place, Council was the consultee. The Health and Wellbeing Board has responsibility for developing the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy. The Health and Wellbeing Strategy 2017-2025 was agreed by the Board, and by Full Council in March 2017. This strategy does not recommend fluoridation or any other specific actions in relation to dental health in the period 2017-2025. The Health and Wellbeing Board receive regular updates on the JSNA which provides evidence to support any actions of the Board. • Any Member of the Health and Wellbeing Board can, in agreement with the Chair, put forward a paper for discussion for discussion by the Board. All papers must be published one week before the meeting. • The Health and Wellbeing Board can, in agreement with the Chair, agree to make a recommendation on fluoridation based on their evidence, which would be put forward to Full Council for consideration.	
		2) That the draft Southampton City Local Delivery System Plan is circulated to the HOSP	Circulated to the Panel on 14th July 2017	Completed