Outline Programme for Unscheduled Care Deep Dive for

Portsmouth and South East Hampshire System

13 November 2013

Venue: Meeting Room, Trust Headquarters, F Level

Queen Alexandra Hospital, Portsmouth Hospitals NHS Trust

8.15 – 8.30	Arrival at PHT Trust Headquarters Office, F Level QAH
8.30 – 8.45	**Welcome** from Dr Jim Hogan (Chief Clinical Leader for Portsmouth CCG and Chair of System Sustainability Board) and Ursula Ward (Chief Executive Portsmouth Hospitals Trust)
8.45 – 9. 30	**CCGs/Urgent Care and System Sustainability Board** Dr Jim Hogan (Chief Clinical Leader Portsmouth CCG), Dr Barbara Rushton (Clinical Chair of South East Hampshire CCG and Chair of Urgent Care Design Board), Alex Berry (Chief Commissioning Officer Portsmouth, South East Hampshire and Fareham and Gosport CCGs)
9.30 – 10.15	**Portsmouth Hospitals Trust** Ursula Ward (Chief Executive Portsmouth Hospitals NHS Trust), Ben Lloyd (Director of Finance and Deputy Chief Executive), Cherry West (Chief Operating Officer)
10.15- 10.30	Coffee
10.30 – 12.00	**Visit ED, integrated Urgent Care Centre, Medical Assessment Unit and Ambulatory Care Unit** – Rick Strang PHT
12.00 – 12.30	Lunch
12.30 – 1.15	**Ambulance and 111 provider** Sue Byrne (Chief Operating Officer South Central Ambulance Service), Neil Cook (Area Manager, South Central Ambulance Service) Linda Lambourne (Assistant Director for 111)
1.15 – 1.45	**Care UK provider of OOHs and Minor Injuries/Illness**

	Penny Daniels, (Hospital Director Care UK –ISTC St Mary's), Tim Wright (Medical Director) and Andrew Russell (OOH/PHL)
1.45 – 2.00	Break
2.00 - 2.45	**Southern and Solent Community Providers** Sue Harriman (Acting Chief Executive), Gethin Hughes (Integrated Services Divisional Director), Southern Health Community Foundation Trust Alex Whitfield (Chief Operating Officer, Solent NHS Trust)
2.45 – 3.15	**Portsmouth City Council and Hampshire County Council** Gill Duncan (Director of Adult Services HCC) and Karen Ashton (Strategic Commissioning Director – Joint Commissioning HCC) Julian Wooster (Strategic Director & Director of Children's Services, Portsmouth City Council), Rob Watt (Head of Adult Social Care) and Angela Dryer (Asst Head of Adult Social Care) (Portsmouth Social Services)
3.15 – 3.45	**CCGs Clinical lead and Chief Officer** Dr Jim Hogan , Innes Richens (Chief Operating Officer Portsmouth CCG), Dr Barbara Rushton, (Chair of South Eastern CCG) Alex Berry and Jacqueline Cotgrove (Director of Operations Wessex Area Team)
3.45	Coffee and close

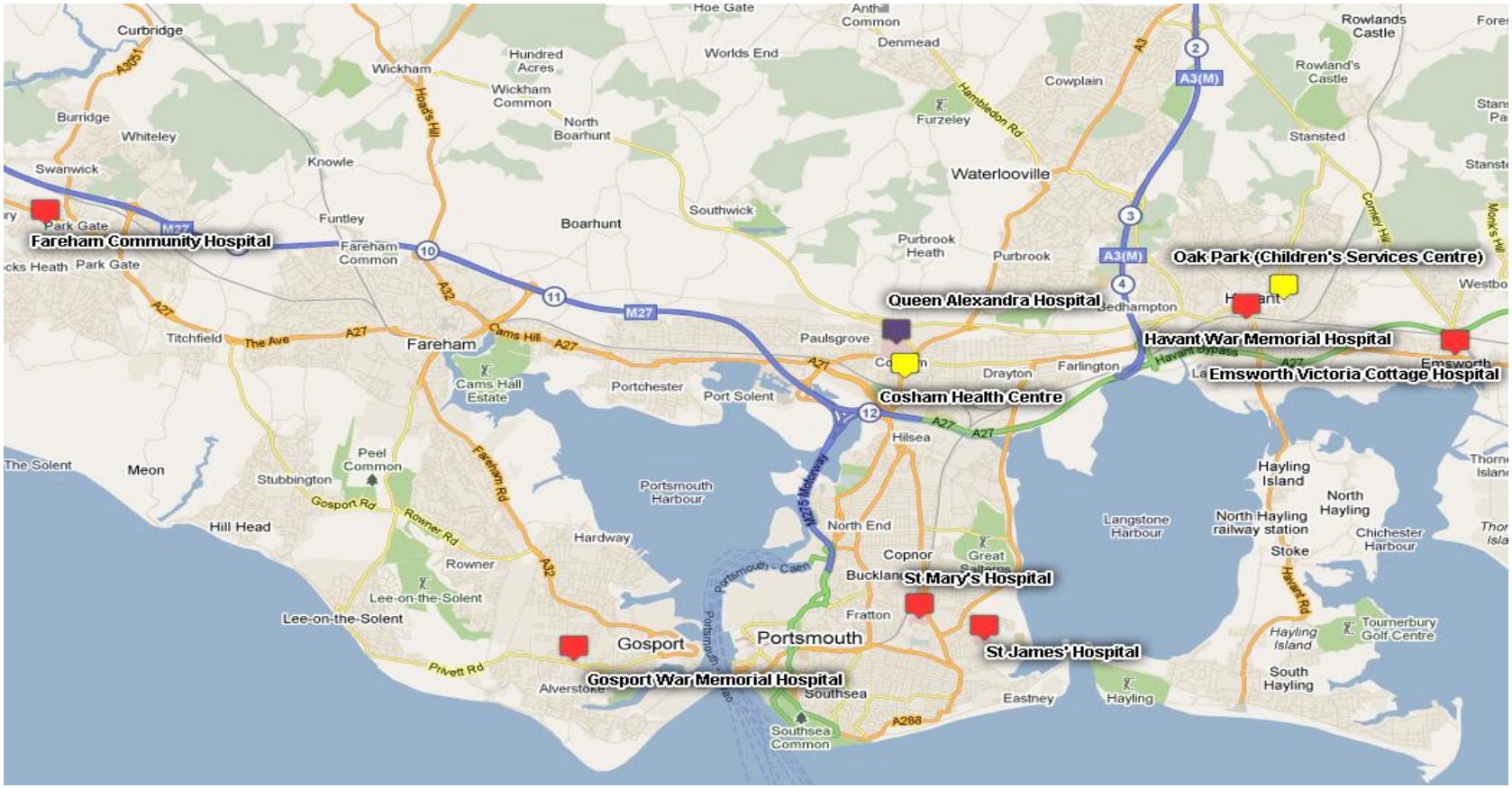
Briefing note: 13 November 2013

Managing unscheduled care across Portsmouth & South East Hampshire

Contents

Background information.

Portsmouth & South East Hampshire health and social care system serves more than 650,000 people and covers the area shown below:



Key organisations in the health and social care system are:

- NHS Fareham & Gosport Clinical Commissioning Group (F&G CCG)
- NHS South Eastern Clinical Commissioning Group (SHE CCG)
- NHS Portsmouth Clinical Commissioning Group (P CCG)
- Portsmouth Hospitals NHS Trust (PHT)
- South Central Ambulance NHS Foundation Trust: Ambulance and 111 (SCAS)
- Solent NHS Trust (ST)
- Southern Health NHS Foundation Trust (SHFT)
- Care UK [Out of Hours and St Mary's Minor Injuries service] (CUK)
- Portsmouth City Council (PCC)
- Hampshire County Council (HCC)
- South Eastern Hampshire Primary Care Alliance (SEHGPA)
- Fareham and Gosport Primary Care Alliance (FGGPA)
- 73 GP Practices

The major acute hospital for the area is the Queen Alexandra Hospital at Cosham.

Details of local facilities include:

Facility	Location	Available Overnight beds	Other facilities	Provider(s)
Queen Alexandra Hospital	Cosham	874 general and acute (includes 17 ITU and 52 Paeds)	Full range of DGH services	PHT
Gosport War Memorial Hospital	Gosport	39 general and acute	Accident Treatment Centre Rapid Assessment	PHT SHFT

			Unit/community/rehab	
Oak Park Community Clinic	Havant	None	Rapid Assessment Unit	SHFT
Petersfield Hospital	Petersfield	42 general and acute	Rapid Assessment Unit/community/rehab beds	PHT & SHFT
St Mary's Hospital	Milton	16 general and acute	Community beds	Solent
Guildhall Walk Healthcare Centre	Portsea Island	None		CUK

Another 25 beds (including Continuing Health Care and end of life care beds) are available in Jubilee House together with 10 rehabilitation/reablement beds at The Grove Unit. Both units serve Portsmouth City and are managed by Solent NHS Trust. There are also 30 places in total at Harry Sotnik House, Cams Ridge Care Home, Edenvale Nursing Home and Wenham Holt Nursing Home.

In addition to these physical facilities the system has many health and social care staff working in the community.

These community services include three Integrated Care Teams: a long-running and very successful scheme in Central Portsmouth plus two new pathfinder schemes in Bordon and Hayling Island.

Integrated Care Teams typically include local GPs/Practice teams, community geriatricians, community nurses, social care staff, occupational therapists and physiotherapists, older people's community mental health teams, care co-ordinators and healthcare assistants

2. Executive Summary

2.1 Portsmouth & South East Hampshire health and social care system has devoted significant effort and resource in recent times to developing a coherent, system-wide strategy and model for out-of-hospital care. The result is that the system operates extremely efficiently in comparison to other local and national systems.

2.2 The health and care system successfully supports more individuals safely in their normal place of residence (and hence admits significantly fewer non-elective patients than other systems) and has managed to reduce the number of such admissions over the course of the last five years when systems across the south of England have seen increases averaging 21%.

2.3 Indeed the local health system can demonstrate very strong performance across a range of indicators from the effectiveness of 111 and the ambulance service to the effectiveness of community and local authority partners in limiting delayed transfers of care.

2.4 The system has achieved this level of performance by working in partnership, through a focus on patient experience and quality, and through investment in both out-of-hospital and in-hospital systems. A new COMPACT between the 3 local CCGs has enabled a systematic review and alignment of out-of-hospital and in-hospital services across the patch, reducing duplication and complexity. Many of the improvements flow from a Whole System Unscheduled Care Plan underpinned by a detailed action plan developed with ECIST.

2.5 Despite its many successes the system has, over the course of the last 18 months, consistently failed to deliver the ED four hour wait. With support from ECIST the system has identified four key reasons for this:

- rising attendances at the ED;
- the need for greater flexibility in the acute trust clinical workforce;
- the need for improved patient flow within the acute hospital;
- the need to accelerate safe patient discharge into the community.

2.6 During the past six months the health and care system has focused on improving each of these areas so that ED 4 hour performance improves to match other elements of local unscheduled care performance. The Trust failed to meet the 95% target for four hour waits for most of the past six months but at the time of writing has achieved it for the month of October and is currently among the top 10% of NHS Trusts in England for performance against this indicator. Whilst this achievement deserves to be celebrated, all system partners wish to ensure that this performance level is sustained over the long term.

3. Introduction/overview

3.1 Portsmouth & South East Hampshire health and social care system has devoted significant effort and resource in recent times to developing a coherent, system-wide strategy and model for out-of-hospital care.

3.2 Its approach is performance-focused and data-driven, with strong CCG leadership allied to clear lines of accountability and good governance. Investments are designed to deliver maximum impact and a better patient experience.

3.3 As a result the health system admits relatively few patients unnecessarily in comparison to other areas.

- Non-elective admissions at Portsmouth Hospitals NHS Trust are currently 3.8% lower than last year, against 0.5% growth nationally. [1]
- Emergency admissions between 2007 and 2012 grew by just 3%, compared to 21% across the South of England. [2]
- The admission rate for assessed patients with a high risk condition (e.g. heart failure, respiratory disease, dementia) is 20% compared to a national rate of around 30%.
- The three local CCGs are in the top 5% nationally for unplanned admissions for conditions that should not need hospitalisation.[3]

[1] SUS data
[2] Kings Fund review of urgent and emergency care

Developing out-of-hospital care

- Despite this good benchmarked performance, there is scope for further improvement. Audits and other studies have indicated that 15% of current non-elective admissions to Portsmouth Hospitals NHS Trust could be managed more appropriately in other settings. As an example, root cause analysis and a recent patient survey highlighted that nearly half of all attendees do not consider calling 111 or their GP before they attend A&E

CCG strategic commissioning plans therefore emphasise the need to provide as much care as possible outside hospital, and to reduce unnecessary hospital attendances and admissions. Recent initiatives include:

Integrated Community care teams. Two pathfinder schemes for integrated health and social care teams, each covering around 30,000 people, started in August 2013. Common assessments, a single patient record, and multi-disciplinary care planning across primary, community and social care provide seamless access to a range of services on an individualised pathway.

Re-ablement and rehabilitation service. The Portsmouth service provides seven day coverage. A range of health and social care professionals are accessible through the team which also has access to community geriatrician support and links to the emergency department and community in-reach team in PHT.

Primary care. A new DES scheme for 2013/14 (delegated to CCGs to manage on behalf of the NHS England Area Team) encourages GPs to increase efforts to identify high risk patients with complex co-morbidities. Community teams then monitor these patients regularly and intervene as appropriate.

Virtual wards. A multidisciplinary team chaired by a community geriatrician meets weekly to discuss priority cases (typically the highest-risk 1% of a practice's population) and agree appropriate case management with the aim of maintaining patients in their own home. This arrangement is known as a 'virtual ward'.

[3] CCG outcomes data pack

A study of 'virtual wards' for Portsmouth Health & Social Partnership found that over the life of the scheme outcomes improved and hospital admissions fell slightly. People tended to require fewer residential care packages, less domiciliary care, and less intensive support and treatment.

Improved care pathways. New care pathways have been developed and introduced for high risk conditions such as heart failure, respiratory disease and dementia. These enable earlier identification and better community management, resulting in fewer assessed patients being admitted to hospital.

Care Closer to Home. Most consultant-led outpatient services still occur in acute settings. The CCGs are redesigning outpatient services and/or re-commissioning them in community settings. This will take services closer to patients and make savings by paying practitioners a sessional rate rather than a PbR tariff.

Long Term Conditions. CCGs are proposing that the model of care for all long term conditions should mirror the 'super six' model developed for diabetes care across South East Hampshire. The model defines six services that need to be provided in an acute setting because of their multi-disciplinary nature or the specialist skills required. Other patients can be managed in the community through a combination of telephone and/or email contact and GP surgery visits. In 2011 this resulted in:

- 656 patients discharged from secondary care, saving £65,000 a year in secondary care follow up appointments;
- 57 patients transferred to "super six" clinics and 15 needing a clinic review pending discharge; and
- the general diabetes referral time reducing from 15 months to 2 months.

3.5 The three Clinical Commissioning Groups also support a number of pre-existing schemes that minimise acute hospital admissions. These include ***rapid assessment units*** and ***step-up beds*** in local community hospitals and nursing homes, and the innovative ***Children's Outreach Assessment and Support Team*** (COAST) managed by Solent NHS Trust.

COAST has been operating its community-based assessment service for five years. Only 360 (9%) of the 4,000 children seen during that time have been referred to the acute children's ward.

NHS 111 and related issues

3.6 The introduction of NHS 111 and the re-procurement of out-of-hours services has created some local demand for unscheduled care but benchmarking indicates that the impact is significantly lower here than elsewhere.

- 6% of 111 calls in Portsmouth and South East Hampshire were transferred to 999 compared to 10% nationally
- 10% of 111 calls in Portsmouth and South East Hampshire were transferred to 999 or the Emergency Department compared to 15% nationally
- 37% of weekday calls and 66% of weekend calls in Portsmouth and South East Hampshire are referred to GP out-of-hours services
- The local 'see and treat' rate for South Central Ambulance Service is 47.6% compared to 36.9% nationally

4. Emergency department attendances and related issues

4.1 Whilst the local health and care system has successfully managed pressure in non-elective admissions, Emergency Department attendances at Queen Alexandra Hospital have grown in line with national trends. There has been 4.5% growth year on year for the past 3 years with 132,244 attendances in 2012/13.

4.2 The Trust failed to meet the 95% target for maximum four hour waits for most of the past six months but at the time of writing had achieved it for the month of October and is currently among the top 10% of NHS Trusts in England for performance against this indicator.

% Attendances within 4 hours	13/10/2013	20/10/2013	27/10/2013	03/11/2013
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	92.14%	94.97%	93.85%	94.51%
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	96.22%	91.70%	93.25%	95.35%
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	95.35%	95.96%	96.67%	97.52%
FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	93.54%	95.02%	94.80%	97.31%
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	99.03%	98.27%	96.53%	98.32%
ISLE OF WIGHT NHS TRUST	92.73%	94.79%	95.44%	97.89%
KINGSTON HOSPITAL NHS FOUNDATION TRUST	95.37%	94.09%	95.64%	96.72%
POOLE HOSPITAL NHS FOUNDATION TRUST	94.27%	95.87%	96.80%	95.09%
PORTSMOUTH HOSPITALS NHS TRUST	97.03%	96.87%	95.11%	96.19%
ROYAL SURREY COUNTY NHS FOUNDATION TRUST	87.16%	88.10%	93.68%	96.71%
SALISBURY NHS FOUNDATION TRUST	97.13%	97.43%	93.28%	98.65%
ST GEORGE'S HEALTHCARE NHS TRUST	95.81%	93.97%	89.57%	95.90%
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	95.29%	94.79%	93.48%	94.59%
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	95.81%	96.55%	94.32%	94.62%
WESTERN SUSSEX HOSPITALS NHS TRUST	94.92%	95.36%	97.15%	97.84%

4.3 Whilst the achievement deserves to be celebrated, system partners wish to ensure that this performance level is sustained over the long term and are tackling the issues through the measures described below.

Managing the rise in attendances

4.4 One of the key reasons for this consistent failure to achieve the ED performance target has been the rise in ED attendances, predominately in individuals presenting with primary health care needs. Evidence states that 1 in 6 patients

require primary care treatment and redirection. A root cause analysis and a recent patient survey has highlighted that nearly half of all attendees do not consider calling 111 or their GP before they attend A&E. By freeing up A&E time by offering alternative provision for these groups of patients will support the attainment of the 4 hour target

4.5 The CCGs have therefore commissioned an **Urgent Care Centre** at the Emergency Department to operate throughout peak attendance hours (08.00 – 18.30hrs).

4.6 There is now a single front door for all walk-in patients requiring urgent care. An Emergency Nurse Practitioner triages all walk-in patients on arrival and directs them to the most appropriate service.

4.7 Some continue on to treatment in the Emergency Department. Others may be treated by a nurse or GP in the urgent care centre, referred to a local minor injuries unit, re-directed to their GP or community services, or given advice on self-care.

4.8 The triage nurse also uses the contact as an opportunity to inform people about their treatment choices. Some studies have indicated that public awareness of minor injury units is as low as 10% despite regular publicity.

4.9 The Urgent Care Centre is a proof of concept model running from November 2013 until the end of March 2014. If it proves successful it may be re-commissioned as part of a wider procurement exercise that integrates it with other walk-in services and out-of-hours provision.

4.10 Whilst ambulance non-conveyance rates for Portsmouth and South East Hampshire are good and above the national average at 47%, we recognise that more could be done. We are working with primary care to investigate how we can strengthen links between the ambulance service and locality integrated community teams.

4.11 Additionally, we also know that since the primary care access DES (which required practices to profile the demand of their face to face appointments, identify and implement approaches to shape demand, match the demand with capacity, collect data to demonstrate improvement and develop contingency plans for staff sickness) ceased in 2006 there has been little incentive for practices to continue this work, and consequently even if practices continued to manage their capacity and demand; the knowledge and evidence base in CCGs) regarding primary care access is poor.

4.12 As an immediate action the CCGs are analysing existing MORI poll data to better understand the demand for urgent primary care appointments, and undertaking a telephone interview to every practice to gather soft intelligence about access systems. In 2014/15 Fareham and Gosport and South East Hampshire CCGs will ask practices to report on primary care access on a regular basis, review capacity and demand year on year, and develop a plan to respond to the anticipated demand. Portsmouth City GPs have also signed up to a Primary Care CQUIN programme to reduce primary care admissions, Practices will:

- review messages given out by reception staff and other practice staff regarding the availability of urgent appointments;
- reinforce messages (in practice waiting rooms, on repeat prescriptions etc) about practice opening hours and remind people to use the practice (or the 111 service out of hours) if it is not a medical emergency;
- review frequent ED/OOH attenders to identify whether they are coming to the practice first and if not, ask why not;
- review use of AACPs in conjunction with the community nursing team and actively contribute to plans; and
- share AACP or other care plans with SCAS, OOH, PRRT etc.

4.13 Further work includes:

- a review of walk in centres to reduce waiting times, and investigate whether review clinics could be stopped.
- collecting primary care data to better understand the pressures in primary care and any correlation between these and ED attendances, and develop support for GP practices to offer access to urgent advice and treatment
- reducing unnecessary admissions from nursing homes by improving linkages with community and primary care
- increasing the number of GP triage systems so that more same day advice and/or appointments can be offered.

Increasing clinical workforce flexibility

4.14 ECIST identified a need to reduce the variation associated with weekend working patterns.

4.15 In response PHT is renegotiating contracts to provide **additional weekend consultant cover** in the Emergency Department, has appointed an interim **Deputy Chief Operating Officer** for the Emergency Department to lead cultural change and has appointed an operational Centre Manager and the Managing Director is now full time in ED.

4.16 Further work includes scoping current services provision across the week and across all providers (including primary care) and using gap analysis to identify where services need to expand to cover the weekend.

Improving patient flows

4.17 Research findings tell us that:

- more than half of local inpatient beds are occupied by the 10% of patients who stay in hospital for more than 2 weeks;
- 3 out of every 5 admissions are for patients who have been admitted before within 12 months;
- frail elderly patients and those with long term conditions often experience poorly coordinated care and poor customer service;
- many of these patients could have been better supported at home or in the community; and
- many patients being admitted from nursing homes could have been managed in the community with a different model of care.

4.18 Further work which is being taken forward includes:

- The introduction of five new **ambulatory care pathways** and an extension of the service from 5 to 7 days (from November 2013) will reduce the conversion rate from attendance to admission
- Increased speciality consultant cover at the weekend (discharge shift)
- developing in-house standards which specify the expected timescales for therapy assessments and monitor them regularly; and
- implementing a weekly multi-disciplinary' long length of stay' meeting to review all patients waiting over 14 days and take action to facilitate discharge where appropriate.

4.19 The local health and social care system is also working on a longer term project to fundamentally redesign service for frail elderly people and those with long term conditions.

4.20 Although a lot has been done to improve systems and processes, a more coordinated approach is needed. The three CCGs have agreed a three year strategy for delivering a new clinical model for integrated and urgent care.

Accelerating safe patient discharge

4.21 Discharge arrangements at Portsmouth Hospitals NHS Trust perform well. The Trust loses just 1.02% of bed days to delayed transfers of care compared to an average 2.51% across the whole of Hampshire, Dorset, Surrey and Sussex. [4] Portsmouth City Council was ranked 7th in the country for the number of DTOCs per 100,000 in 2012/13. [5]

4.22 The health and social care system covering Portsmouth and South East Hampshire has access to a good range of community bed capacity. Admissions are managed across the whole seven day week when clinically safe to do so, and there is seven days a week access to therapy and social care support.

4.23 ECIST noted that whilst a large amount of work has been and continues to done, there was still significant potential to improve discharge processes. It found that there was no single discharge process, and the multiple forms and pathways had the potential to confuse ward staff when discharging patients to community services.

4.24 In response a **Community Assessment Lounge/team (CAxL)** has been established specifically to target admission avoidance within the Emergency Department at Queen Alexandra Hospital. The Community Assessment Lounge provides a clinician led specialist community assessment service so that patients who do not require hospital admission can be returned safely and promptly to the community with an appropriate support plan for their immediate and longer term health and social care needs. This service helps avoid short stay admissions that can result from the need to deliver the four hour A&E target.

4.25 Additional **therapy services** and **weekend consultant cover** are in place on inpatient wards to support timely discharge; and **community in-reach teams** (working 7 days a week from October 2013) identify medically fit, clinically stable dementia patients in acute beds and provide community-based alternatives for their care.

[4] SUS data
[5] ACOF Comparator Report from Health and Social Care Information Centre 12/13

4.26 All five local providers work together to manage the patient pathway smoothly, with an integrated multi-disciplinary team working on ward rounds to ensure information is available at the right time, allowing for better patient transfer out of PHT.

4.27 The acute hospitals have a discharge pathway covering the entirety of their work, with an extended Integrated Discharge Bureau coordinating the most complex patients.

4.28 Cross-working between community provider clinicians allows them to offer a 365 day service with enhancements from adult social care.

4.29 Additional **Continuing Health Care (CHC) nurse input** at the hospital has been introduced in November to raise staff awareness and improve patient flows (e.g. by transferring potential CHC patients from acute wards to community hospital or nursing home beds where their assessment can be completed).

4.30 Portsmouth has a single point of contact for Continuing Health Care services which improves the quality of assessment, and reduces delays and potential disputes in the pathway between health and social care. It has led to an improved understanding of third sector and voluntary services with an emphasis on well being. Improved commissioning of the service has helped reduce costs and increase equality for individuals.

Community in-reach teams aim to halve the number of medically fit and clinically stable dementia patients in acute beds from 60 to 30 during Q3 2013/14

4.31 Local authorities are supporting these initiatives, e.g. through the **enhanced domiciliary care packages** provided by Hampshire County Council Adult Services. Portsmouth City Council have developed in collaboration with the CCG PRRT, Grove, Victory, GP Cluster MDT working, 7 day working from PRRT and hospital team, and the lowest figure for delayed transfer of care attributable to adult social care of all its comparator authorities in the country.

4.32 A system wide snapshot review of social care at the hospital / community / social care interface was recently undertaken. The snapshot review took a pathway approach and through observation and documentary evidence intended to identify what currently works well and areas where improvement would be beneficial. The review aimed to assess the current operating model against the following outcomes:

- Consistent high quality and safe discharge for people, and where appropriate their carers and relatives;
- Affirming the importance of joint (inter-agency) and multidisciplinary (intra-agency) team working, and meet legal, national standards;
- Providing a consistent, coordinated approach with multidisciplinary, multi-agency input while maintaining the individual's interests as central to the discharge planning process;
- Ensure adherence to national and local quality standards
  The findings from the review are now being worked through and implemented.

4.33 Further work is now in train to:

- standardise processes as far as possible;
- review training given to ward staff about discharge planning;
- review the effectiveness of in-house standards for ward discharges, and review performance against them;
- conduct a series of "ward conversations" to understand the reasons for discharge delays and the improvements that staff feel could be made;
- focus on weekend discharge arrangements, e.g. daily ward rounds led by senior staff, weekend social services cover (not just on-call), weekend pharmacy services, weekend therapy cover, and use of a specialist discharge team

5. Winter planning 2013/14

5.1 Our winter plan is designed specifically to minimise the impact of any seasonal rise in unscheduled care.

5.2 Portsmouth and South East Hampshire received a £1.4 million allocation for winter planning. This money has been invested in:

- additional Emergency Department staffing at Portsmouth Hospitals NHS Trust, particularly at weekends;

- additional therapy support to facilitate prompt discharge from acute wards and improve patient flow; and
- an additional 16 community beds to boost capacity and enhance patient flow across the system.

5.3 Regular desktop exercises will ensure that each local health and social care organisation clearly understands system capacity, trigger points; escalation plans etc so that we can respond swiftly to any issues that arise.

5.4 In previous years we had no means of objectively quantifying system demand and pressure. For 2013/14 system partners have invested in '**Kitbag**', a management tool which takes operational data from all partners and enables earlier forecasting of pressure and hence earlier response and system escalation. This is a web based tool and enables the system to review all partners' data on a daily basis.

5.5 A Primary Care Surge and Escalation plan has been drafted with input from CCGs and involvement from Public Health and the Local Medical Committee. Useful discussion has taken place at the regular Wessex Primary Care and CCG forum helping to identify where the greatest impact would be felt from seasonal pressures. Triggers whereby GP providers will report agreed levels of capacity challenge have been identified. The escalation process was reviewed and the agreement clarified whereby CCGs, practices and NHS England Primary Care Commissioner will come together on "summit" calls when an issue is identified and agree remedial action. The productive Primary Care forum also informed the development of the "Top Ten Tips" checklist against which business continuity plans and business practices may be reviewed to flex primary care capacity to better meet seasonal pressures on clinical services. Practices have been asked to nominate one or more 'buddy practices' with which a formal or informal agreement has been reached for mutual support in the event of a serious event. Most also provide extended hours and will keep the balance of appointments flexible. A list of the named practice lead and named deputy with 24 hours contact will be maintained by NHS England (Wessex).

6. Governance

6.1 Organisations in the local health and social care system work collaboratively through a well-defined governance structure:

- The **Sustainability Board** provides leadership, direction and oversees the agreed work programme of *Building a Sustainable NHS in Portsmouth and South East Hampshire*. This work programme includes a Whole System

Unscheduled Care Plan underpinned by the ECIST action plan which was developed for Portsmouth and South East Hampshire.

- The **Unscheduled Care Design Group** meets monthly. It is commissioning-led and is responsible for identifying the strategic commissioning landscape for the next 3-5 years, scoping commissioning priorities and managing the design process prior to delivery & implementation.

- The **Integrated & Urgent Care Board** is provider-led and is responsible for the delivery of the Portsmouth, Fareham & Gosport & South Eastern system Integrated & Urgent Care Programme. It is responsible for schemes/projects that will improve quality and outcomes for the frail & elderly and/or people with long term conditions, and holds all system partners to account for their delivery.

6.2 An integrated Programme Management office meets and reports weekly. There are also weekly meetings between the provider organisations' executive sponsors of the programme, and monthly meetings between provider organisation chief executives.

6.3 In addition to the governance arrangements there are good working relationship with and between organisations at a senior and operational level. The Kings Fund have been working with the system leaders over the last year around the unscheduled care agenda which has helped improve and strengthen relationships. In addition at an operational level there are regular operational calls and meetings with key managers to address surge and escalation issues.

7. Outstanding issues

7.1 We believe that the actions and plans we have in place will strengthen the local model of out-of-hospital care still further and support the national drive to reduce unscheduled admissions.

7.2 We recognise, though, that there are areas which require more work such as our 0-1 day emergency admission rate (currently above the South of England average) and the high proportion of inappropriate Emergency Department attendees

who are either unaware of or do not consider alternative. This latter issue may be linked to the high proportion of parents with unwell young children who are referred there by NHS 111.

7.3 We also intend to focus on strengthening the operational interface between our community hospital wards and the main acute site at QAH.