Public Document Pack

Health and Wellbeing Board

Wednesday, 27th July, 2016 at 5.30 pm

Council Chamber - Civic Centre

This meeting is open to the public

Members

Councillor Lewzey
Councillor Payne
Councillor Paffey
Councillor Shields
Councillor Taggart

Rob Kurn – Healthwatch
Kim Drake – Service Director, Children and Families Services
Derek Law – Interim Director, Housing Adults and Communities
Dr B Coates – Acting Director of Public Health
Dr S Robinson – Clinical Commissioning Group
Dr E Mearns – NHS England Wessex Local Area Team

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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities;
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

Responsibilities

The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
    - Health care
    - Social care
    - Public health services
    - Ensuring safety in improving health and wellbeing outcomes

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

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

Southampton City Council's Priorities:

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

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

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

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

Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.

Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Dates of Meetings: Municipal Year 2016/17

2016	**2017**
27 July	25 January
28 September	29 March
30 November	

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

PROCEDURE / 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.

RULES OF PROCEDURE
The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

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.

AGENDA

Agendas and papers are now available via the Council's Website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 ELECTION OF CHAIR AND VICE-CHAIR

To elect a Chair and Vice-Chair to the Health and Wellbeing Board for the 2016-2017 municipal year.

3 STATEMENT FROM THE CHAIR

4 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.

5 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 23rd March 2016 and to deal with any matters arising, attached.

KEY ISSUES

6 MENTAL HEALTH AND SUICIDE PREVENTION UPDATE

To receive a verbal update at the meeting.

7 PREVENTION AND MANAGEMENT OF CHILDHOOD OBESITY

Report of the Interim Public Health Director detailing a proposal to develop a Childhood Obesity Prevention Plan, attached.

MANAGING THE BUSINESS

8 PUBLIC HEALTH ANNUAL REPORT 2015 HEALTH AND WELLBEING BOARD RESPONSE

Report of the Chair of Health and Wellbeing Board detailing the Health and Wellbeing Board's response to the Public Health Annual Report 2015 recommendations, attached.

9 FAIRNESS COMMISSION: HEALTH AND WELLBEING BOARD RESPONSE

Report of the Chair of Health and Wellbeing Board detailing the Health and Wellbeing Board's response to the Fairness Commission recommendations, attached.

10 SUSTAINABILITY AND TRANSFORMATION PLAN 2016: UPDATE

Report of the Chief Executive Officer, Southampton City Clinical Commissioning Group seeking an agreed response to the draft Plan, attached.

Tuesday, 19 July 2016 Service Director, Legal and Governance

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 23 MARCH 2016

Present: Councillors Shields (Chair), Lewzey and White
Dr Sue Robinson (Vice-Chair), Dr Elizabeth Mearns, Rob Kurn, Kim Drake and Bob Coates

Apologies: Councillors Chamberlain and Jeffery

34. DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

Councillor Shields declared a personal interest in that he was a Council appointed representative of Solent NHS Trust and remained in the meeting and took part in the consideration and determinations of items on the agenda.

Councillor Lewzey declared a personal interest in that he was a Council appointed representative of Southern Health NHS Foundation Trust and remained in the meeting and took part in the consideration and determinations of items on the agenda.

35. MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

RESOLVED: that the minutes of the Board meeting held on 27th January, 2016 be approved and signed as a correct record.

36. EXCLUSION OF THE PRESS AND PUBLIC - CONFIDENTIAL PAPERS INCLUDED IN THE FOLLOWING ITEM

RESOLVED that in accordance with the Council's Constitution, specifically the Access to Information Procedure Rules contained within the Constitution, the press and public be excluded from the meeting in respect of minute 39 below based on category 3 paragraph 10.4 of the Access to Information Procedure Rules. The appendix includes information relating to financial or business affairs which, if disclosed prior to the entering into a legal contract, could put the Council at a commercial disadvantage.

37. HEADSTART STRATEGY

The Board considered the report of the Cabinet Member for Education and Children's Social Care, providing assessment of the performance and effectiveness of local safeguarding services as detailed in the Annual report of the Independent Chair of the Local Safeguarding Children's Board (LSCB).

The Board acknowledged and noted the updated information as follows:

- The Strategy had become a recognised City wide 5 year vision;
- Four schools had fully engaged with the process;

- All Secondary Heads were considering how the Strategy would work for their own schools;
- A total of 3 Headstart teams were engaged with all secondary schools, Compass and Polygon schools as well as transition pupils from year 6 to 7, local communities and families;
- Big Lottery funding decision expected in June;
- Children and young people had involved themselves in the process;
- Following a successful Red Funnel Event last year a second event was being planned for 2016;
- The Board's role was to receive the learning experience and challenge the conclusions;
- The Board expect the Strategy to evolve as schools become involved, the strongest impact likely to come from schools;
- Discussions take place intergenerational, within the community, in social networks and interactions with friends, family and online.
- Headstart looking at attendance, tracking pupils over year groups city wide using a variety of tools and data available both locally and nationally; and
- Strength would come from an integrated approach in Southampton.

RESOLVED:

(i) To endorse the HeadStart Strategy;
(ii) Subject to approval by Council, to accept the funding in advance, and subject to approval by Cabinet to delegate authority to the Director of Quality and Integration following consultation with the relevant Cabinet Member to decide on the final model of commissioned services and all decision making in relation to this programme, to carry out a procurement process for the provision of HeadStart Phase 3 as set out in this report and to enter into contracts in accordance with Contract Procedure Rules.

38. PUBLIC HEALTH ANNUAL REPORTS (PHAR) FROM 2014 AND 2015

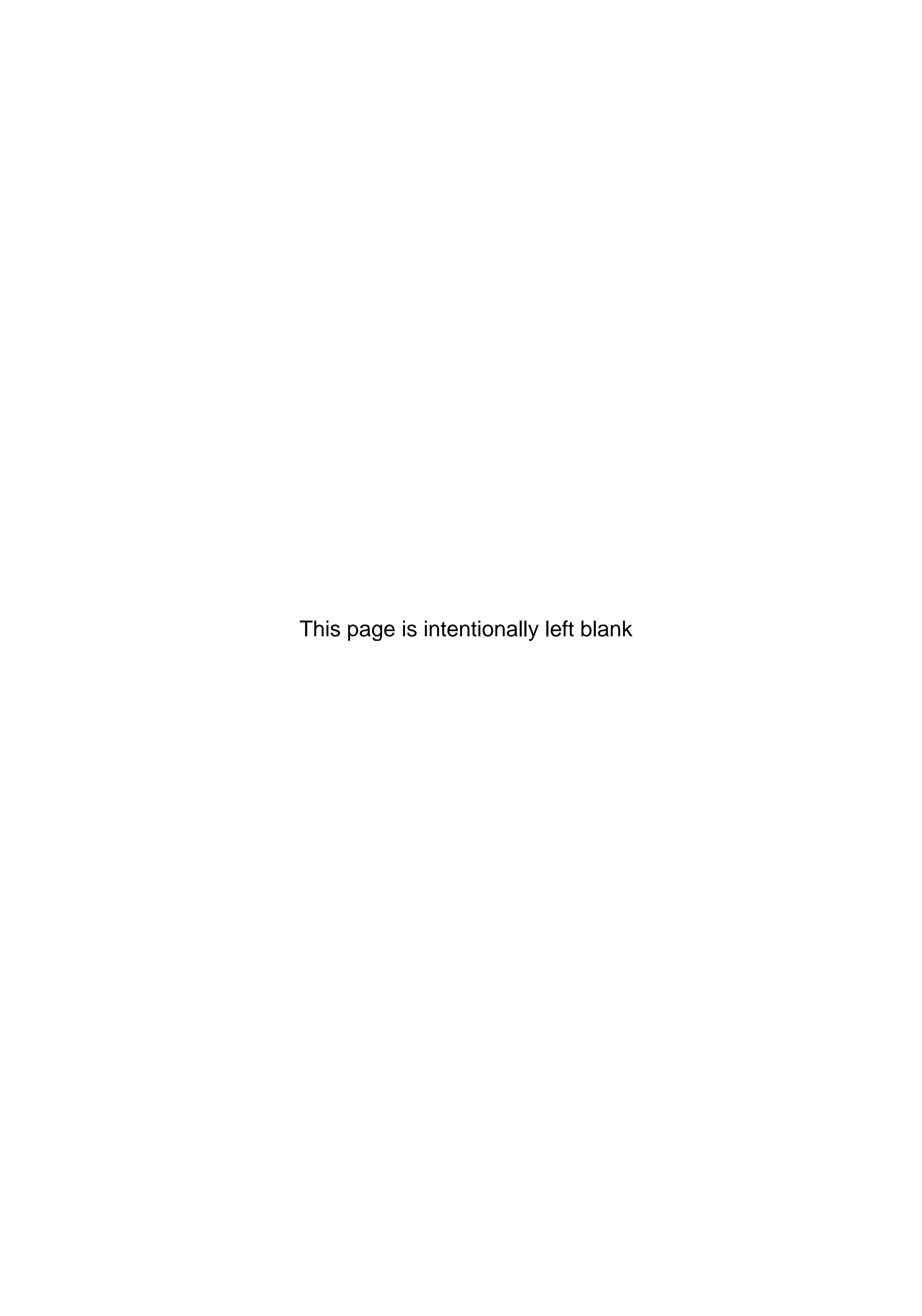
The Board considered the report of the Interim Director of Public Health detailing Public Health Annual Reports from 2014 and 2015.

The Board acknowledged and noted the following:

- the theme of the 2014 report covered fitness in young people, building mental resilience in young people, Southampton child health profile, air quality, dementia in long term illness, high blood pressure and tackling health inequalities;
- recommendations were in general on target and those showing as amber were progressing;
- concerns highlighted for wider improvement were child injuries associated with social class, the lack of uptake of cancer screening in Southampton, mortality data produced 18 months in arrears and with an ageing population attention was required to add life to years.

RESOLVED:

(i) To note progress in delivering the recommendations from the Public Health Annual Report 2014 and to advise on areas where more actions needs to be taken;
(ii) To defer consideration of the recommendations in the Public Health Annual Report 2015 to the next meeting of the Board.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Agenda Item 7

DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		PREVENTION AND MANAGEMENT OF CHILDHOOD OBESITY		
DATE OF DECISION:		27 JULY 2016		
REPORT OF:		INTERIM PUBLIC HEALTH DIRECTOR		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Ravita Taheem**	**Tel:**	**023 8083 3020**
	E-mail:	**Ravita.taheem@southampton.gov.uk**		
Director	**Name:**	**Bob Coates**	**Tel:**	**023 8083 3537**
	E-mail:	**Bob.coates@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY

In Southampton 24.5% of children in year R (5 year olds) are either overweight or obese (England average 22.5%). Among year 6 pupils (11 year olds) levels of overweight and obesity increase to 36.8% (England average 33.5%,data from the National Child Measurement Programme for 2013/14). Levels of overweight and obesity among year R pupils have remained stable over time but for year 6 pupils levels have steadily increased. Among adults in Southampton 64.8% are either overweight or obese (Southampton Health Profile, 2015). Obesity in childhood is associated with reduced academic performance, low self-esteem, school absence, bone and joint problems, high cholesterol and type 2 diabetes, as well as obesity and premature mortality in adulthood. Since Public Health transferred to Local Authority in April 2013, Southampton City Council has had the responsibility for the prevention and management of obesity in the city. The council has a significant role to play in influencing whether the environment in the city is obesogenic (encourages behaviors towards developing obesity) and can encourage partnerships and new ways of working to tackle the issue.This paper outlines a proposal to develop a childhood obesity prevention plan and requests collaboration across council departments in the development and implementation of the plan.

RECOMMENDATIONS:

(i) To endorse the development of a city wide plan for the prevention and management of childhood obesity. Action taken should seek to achieve a reduction in health inequalities by targeting the most deprived communities.

(ii) To endorse and drive a city wide approach across a range of sectors to address wider determinants for childhood obesity.

(iii) To agree a target to tackle childhood obesity as recommended by the workshop, to increase the proportion of healthy weight children in the city and reduce excess weight among children by 5% in 5 years.

REASONS FOR REPORT RECOMMENDATIONS

1. Childhood obesity is increasing in Southampton and Southampton City Council has responsibility for the prevention and management of childhood obesity.

2. Obesity affects disadvantaged communities most, action is required across organisations and systems to effectively address the issue

3. The previous strategy developed by the PCT has expired and there is a need to develop a new plan to drive action for children and young people in the city.
   This work aligns with the behaviour change themed priority in the draft HWB Strategy: **People in Southampton live active, safe and independent lives**.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

4. Do nothing (no change)
   Current trends indicate that childhood obesity especially among year 6 pupils will continue to rise. Childhood obesity is associated with low academic attainment, poorer employment outcomes and an increased likelihood of being in receipt of welfare in adulthood.

5. Those obese in childhood are likely to remain obese as adults and obesity in adulthood increases the risk of cardiovascular disease, cancer and type 2 diabetes, resulting in increased costs for health and social care.

6. In view of the upward trend in childhood obesity and given that the prevention and management of childhood obesity is now the responsibility of the local authority under the Health and Social Care Act 2012, this alternative option is not recommended.

DETAIL (Including consultation carried out)

Level of Childhood obesity in Southampton

7. Obesity prevalence increases with age, and is higher among those on the lowest incomes, those with no qualifications and those living the most deprived areas. Amongst men, those who are skilled manual workers and among women those who are unskilled manual workers have consistently higher obesity prevalence compared to other social classes. In ethnic minority groups the prevalence of obesity is higher among Pakistani women, Black African women and Black Caribbean men and women.

8. In Southampton 8.6% 5 year olds (year R) are obese (not including overweight), levels double for 11 year olds (year 6) to 20.8% (2014/15). A crude estimate suggests that there are approximately 19,500 obese or overweight 0-19 year olds in the city. Those who are obese in childhood are likely to remain obese as adults. Data indicates that obesity prevalence in children has increased steadily over the last 10 years.

9. Obesity is associated with lower academic attainment compared to healthy weight individuals. In addition research shows that obese individuals are less likely to pursue further education, are more likely to be in receipt of welfare support and have poorer employment and relationship outcomes.

10. **National and local Insights**

The national family food survey indicate that low income households consistently purchase less fruit and vegetables, more pork, eggs, sweets and chocolates. A poor quality diet, low in fruit and vegetables, high in fat, saturated fat, sugar and salt is linked to a number of diet-related diseases including diabetes, cardiovascular disease and certain cancers. Those on the lowest incomes are at greater risk of having a poor quality diet.

11. Insights from local families suggest that parents understand the healthy eating messages and would like to eat more healthily but there are often barriers to putting them into action. The key barriers are; mixed messages in the media, the higher cost of healthier food options, opposition from family members and lack of confidence about their cooking skills. Increasingly local families are shopping for food more often but buy a smaller number of items with a reliance on bargains, indicating that there was less planning involved in family meals.

12. Insights gathered from agencies that support local families generally reported trends towards unhealthier food choices and missed meals. The agencies also reported that after school sports and activity clubs were well attended but fundamental physical skills such as catching, throwing jumping are lacking.

13. Action taken to tackle obesity should seek to achieve a reduction in health inequalities and target the most deprived communities.

14. **What Action is Required**

In recent months Southampton participated in a pilot of the Childhood Obesity Prioritisation tool, (commissioned by Public Health England) which highlighted that tackling childhood obesity was not a strategic priority. Public interest in reducing childhood obesity is increasing, and it was recognised by the HWB that the City could and should do more and ensure that tackling childhood obesity is a strategic priority.

15. The national childhood obesity strategy is due to be published later in 2016. A local prevention plan should be developed for Southampton to provide a

strong, local vision outlining how the council and partners can tackle the issue. The plan should be regularly reviewed to enable the Health and Wellbeing Board to be a critical friend for delivery teams and partners.

16. Public Health have lead an initial stakeholder workshop this included representatives from Health, Leisure, planning academia and Public Health England. A key recommendation of the workshop was that the plan should outline clear aims to reduce childhood obesity by 5% in 5 years and detail the actions that will be taken.

17. The causes of obesity are complex and a single intervention or programme will not address the issue. Action needs to be taken at all levels using a "whole systems approach", across all sectors, organisations and communities. The current approach points the responsibility to the individual and focusses on encouraging individual behaviour change. However, habits, the environment, limited choice and other constraints can thwart efforts made at an individual level. The approach should go beyond health education/behaviour change and include environmental changes to improve the lifestyle choices and behaviours of a population.

18. The Childhood Obesity Prioritisation tool exercise identified an imbalance between opportunities for physical activity and improving diet & nutrition. There were a range of opportunities for children and young people to increase their physical activity levels (it was not clear if these activities engaged the communities most at risk). However, little is offered to improve food choices, both in terms of targeted interventions and universal interventions, such as restrictions on the concentration of takeaways in areas in close proximity to schools.

19 Schools are well placed and already do much to encourage healthy lifestyle choices. More targeted work is required to improve food choice among families with primary school aged children, as the prevalence of childhood obesity doubles during this period. Families should be supported to improve food shopping and cooking skills. The Youth Health Champion model could be rolled out in secondary schools, so more young people can promote healthy lifestyle choices among their peers. For children and young people who have been identified as having excess weight the plan will ensure there is a clear pathway of self- help and support available.

20. The prioritisation process also identified the need for a more robust system for monitoring and evaluation of existing services. This would provide useful data to improve service provision and development. The service provided by Public Health School Nursing was identified as a key provision particularly the initial contact and support provided to children identified as having excess weight through the National Child Measurement Programme.

21. The strategic approach should address healthy food choices across the system including the concentration of hot food takeaways in the city, healthier vending machines and adopting national UK guidance on Healthier More Sustainable Catering.

22. Central to all action undertaken, children, young people and their families must be engaged throughout the development of a childhood obesity prevention and management plan, to ensure that actions taken address the priorities reported by the target groups.

RESOURCE IMPLICATIONS

Given the extent of childhood overweight and obesity in the city and the cuts to the public health grant, tackling the issue requires collaboration across the city to make the best use of existing resources. The council has identified resources in the public health team to develop a city wide plan.

Capital/Revenue

N/A

Property/Other

N/A

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

Health and Social Care Act 2012 section 2B subsection 3

Functions of local authorities and Secretary of State as to improvement of public health

(3) The steps that may be taken under subsection (1) or (2) include—

(a) providing information and advice;

(b) providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way);

(c) providing services or facilities for the prevention, diagnosis or treatment of illness;

(d) providing financial incentives to encourage individuals to adopt healthier lifestyles;

(e) providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment;

(f) providing or participating in the provision of training for persons working or seeking to work in the field of health improvement;

(g) making available the services of any person or any facilities.

Other Legal Implications:

POLICY FRAMEWORK IMPLICATIONS

The proposals are in accordance with the council's Health and Wellbeing Strategy

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	None.
2.	

Documents In Members' Rooms

1.	
2.	

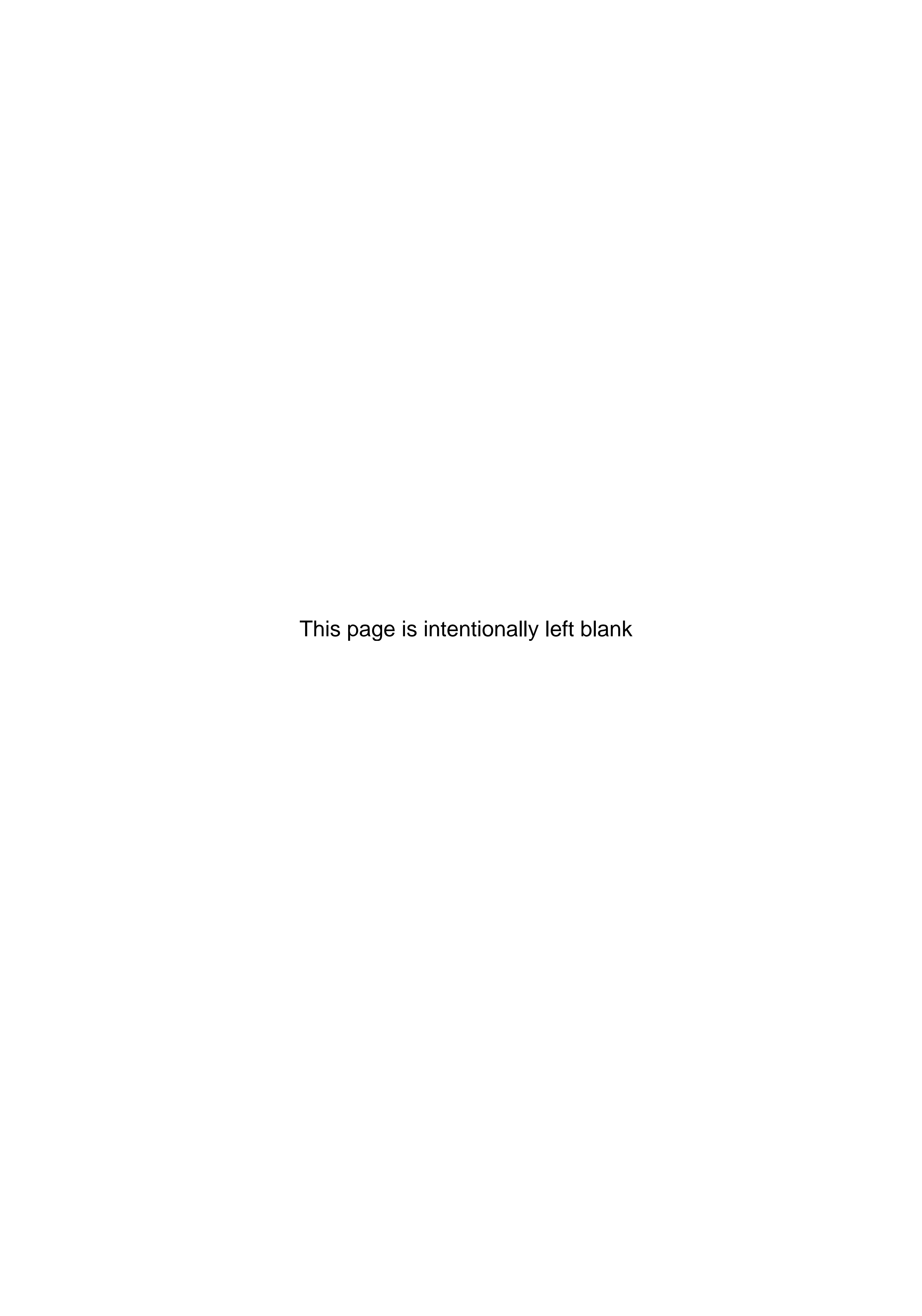
Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) 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)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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		PUBLIC HEALTH ANNUAL REPORT 2015: HEALTH AND WELLBEING BOARD RESPONSE		
DATE OF DECISION:		27 JULY 2016		
REPORT OF:		THE CHAIR OF HEALTH AND WELLBEING BOARD		
CONTACT DETAILS				
AUTHOR:	Name:	Katy Anastasi	Tel:	023 8083 2994
	E-mail:	katy.anastasi@southampton.gov.uk		
Director	Name:	Emma Lewis	Tel:	023 8091 7984
	E-mail:	emma.lewis@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

Each year the Director of Public Health published an independent report on the health and wellbeing of the local area. The Public Health Annual Report is a statutory duty and intended to inform local strategies, policy and practice. The 2015 report was considered by the Health and Wellbeing Board in March 2016. This report outlines the Health and Wellbeing Board's response to the recommendations in the report.

RECOMMENDATIONS:

The Health and Wellbeing Board:

(i) Note and agree response.

(ii) Decide how to monitor and report on the actions agreed to.

REASONS FOR REPORT RECOMMENDATIONS

1. The Health and Wellbeing Board is a statutory body with responsibility for health. The Board need to consider if it will accept and take any actions against each recommendation.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3 The recommendations from the Public Health Annual Report challenge the Council, NHS, and partner agencies to make improvements in services and other interventions in the crucial first 1,000 days of life among city residents. The report structures its recommendations under 6 key areas: Social Factors, Emotional and Mental Health, Diet and Nutrition, Substance Misuse in Pregnancy, Infections and Screening.

4 The 2015 Public Health Annual Report was formally presented to the Health and Wellbeing Board in March 2016. The board agreed to respond to each of the 31 recommendations by July 2016 providing updates on any existing or planned activity.

5 The draft responses can be found in Appendix 1 'Health and Wellbeing Board response to Public Health Annual Report 2015 Recommendations.'

6 The board are required to agree their response to each recommendation and decide how to monitor the progress of the agreed recommendations.

RESOURCE IMPLICATIONS

Capital/Revenue

7 The responses provided by members of the Health and Wellbeing Board detail existing or planned actions related to the recommendations and so not represent activities requiring additional resources beyond that already agreed.

Property/Other

8 None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

Other Legal Implications:

9 None

POLICY FRAMEWORK IMPLICATIONS

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Health and Wellbeing Board response to Public Health Annual Report 2015 Recommendations

Documents In Members' Rooms

1.	None.

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

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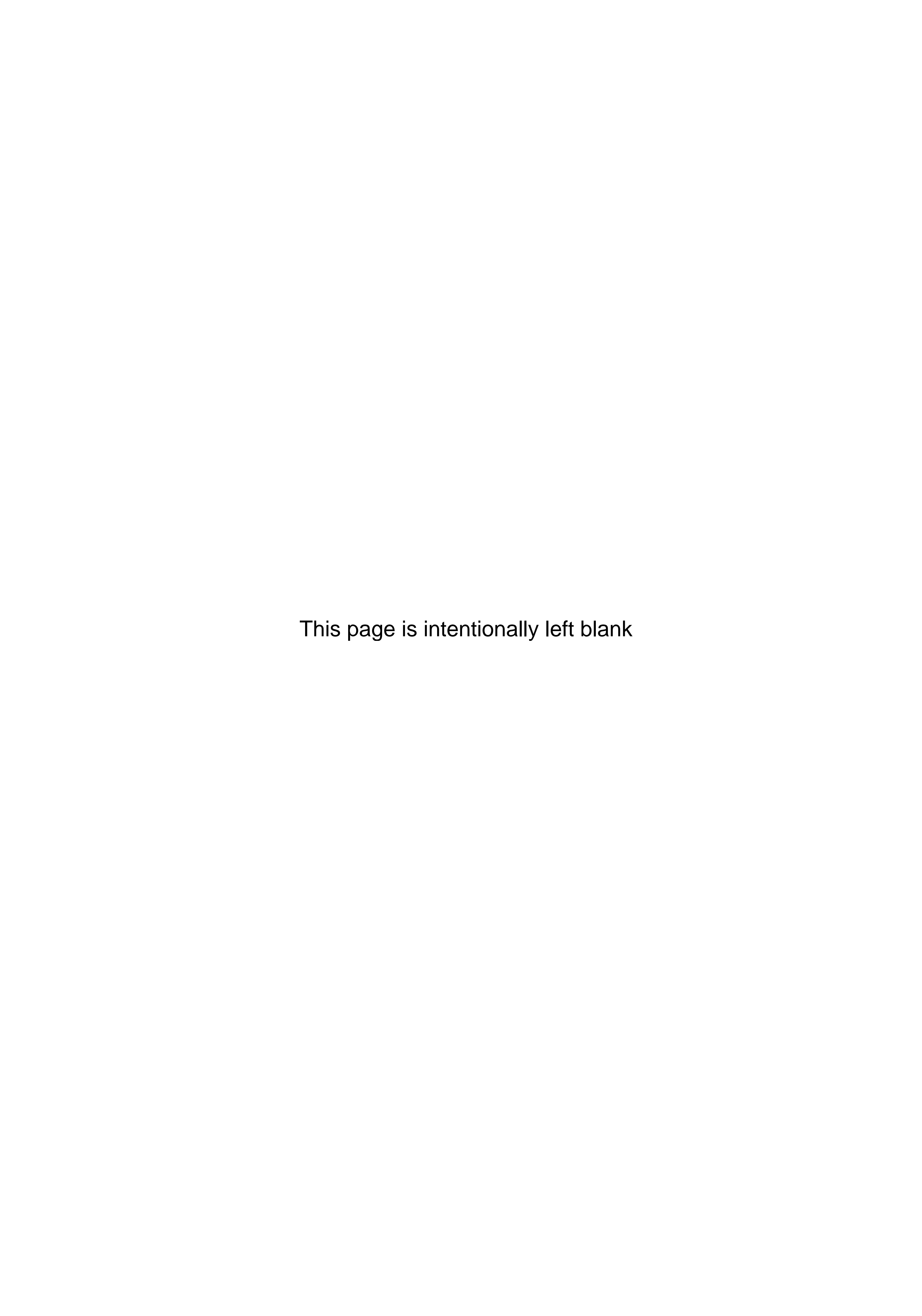

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Public Health Annual Report 2015: List of recommendations

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
A	**SOCIAL FACTORS**		
A1	The Health and Wellbeing Board should promote the development of a child poverty strategy for Southampton (as recommended by the Children's Commissioner).	Southampton City Council is developing a new Children and Young People's Strategy. The strategy will include actions to address Child Poverty in the city. Child Poverty is not a standalone issue and should be addressed as an integral part of the city's vision for Children and Young People, rather than creating a separate strategy.	Southampton Connect
A2	Service providers should identify new ways of engaging with disadvantaged groups of women pre-conceptually and during pregnancy to support them to make healthy choices in recognition of their social circumstances	Some work is already underway within Southampton's Maternity Services regarding smoking and obesity during pregnancy. A briefing paper on Public Health opportunities in Maternity Services is to be presented to University Hospitals Southampton in July. However, this work does not cover women's pre-conceptual health, as they would not become known to the service until they book. Support to women pre-conceptually needs to be an integral part of wider Public Health programmes, including Behaviour Change. The Southampton Public Health team's role will be to identify need and evidence opportunities to engage with young women pre-conceptually via LifeLab.	SCC/CCG

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
A3	Locality based children's health and social care teams should be formally integrated to deliver shared outcomes, and seek opportunities to "make every contact count" (MECC)	Integration is a key theme with Better Care Southampton and national set direction of travel. Integration of children's health and care is a current work programme being led by the Director of Children's Services. Locality teams for early help have been established and we are developing our early help offer, which incorporates the families matter programme. The ICU is working closely with Children and Families and Public Health to put in place the required commissioning arrangements for this integration. MECC is broadly consistent with delivery of the Healthy Child Programme, and links and pathways to new behaviour change services will be developed for parents seeking support in making lifestyle changes where the support needed is beyond brief interventions. MECC is a priority within the Behaviour Change Service recommissioning project.	SCC / CCG
A4	Reducing health and developmental inequalities must be a priority for those young children identified as vulnerable, ensuring the approach supports "proportionate universalism"	The principle of the approach is adopted in the Public Health Nursing Service. Public Health is currently aligning universal, universal partnership and universal partnership plus (and specialist) offers for health and care provision. Commissioning priorities for the 5-19 Public Health Nursing model already support proportionate universalism in seeking to prioritise reducing avoidable health and developmental inequalities in vulnerable children. This approach has also been a guiding design principle for the ICU in the design and development of 0-19 prevention and early help service integration proposals.	HWBB

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
A5	The Health and Wellbeing Board should consider the poor dental health in children that has persisted for over two decades and make a recommendation on the implementation of Southampton's water fluoridation scheme	A technical briefing was delivered to the CCG Clinical Executive Group in June 2016 and a position statement is being drafted by the CCG executive leads for the Health and Wellbeing Board. The Cabinet Member for Health and Sustainability is also planning engagement events and dialogue with other council members throughout summer and autumn to clarify the Council Members' position on water fluoridation. Dialogue continues between the Cabinet and Public Health England about options for resourcing any further public consultation and engagement needed on this important issue.	HWBB
B	**EMOTIONAL AND MENTAL HEALTH**		
B1	Evidence based approaches should be embedded within services (and innovative approaches assessed) to improve mental health during pregnancy.	The Health Wellbeing Board recognise the importance of improving mental health during pregnancy, and consider that this should be extended to include perinatal health. Pre and peri-natal mental health are Public Health priorities for Maternity Services. A paper on this issue will be presented at the Maternity Board meeting in July. It is also is a key work stream for Wessex Clinical Senate (WCS) for Maternal and Child Health. Southampton has among the best perinatal specialist (acute) mental health facilities in Wessex. Preventative perinatal mental health services is a higher priority for development.	SCC / CCG

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
B2	Health professionals should take every opportunity to prevent and identify mental health issues at the earliest stage, pre-pregnancy, during pregnancy and in the early years of life	This links with '5 ways to wellbeing' and 'Mentally Healthy Southampton' ambitions. The Mental Health Matters review aims to achieve a shift to prevention and early intervention, and to ensuring the needs of young people whose parents have mental health problems are addressed. This is a priority for Mental Health and Child and Family commissioning leads in the ICU. It is a key part of the 0-19 integrated offer. It is not just an issue for health services, but for universal services, employers and other services.	CCG/SCC
B3	The Health and Wellbeing Board should ensure that community resourcefulness is promoted and is a key principle in future strategies	This is a key principle in the Prevention and Early Intervention work, and developing community capacity is a core part of the Behaviour Change Service recommissioning. Developing community resourcefulness is a key element of Better Care Southampton and an agreed principle across health and care providers. Significant programmes of Public Mental Health work are already underway making use of community resources.	HWBB
B4	All pregnant mothers and their partners should be able to access antenatal and postnatal support with a strong focus on the quality of the interaction between the parent/s and the child	Southampton City Council and the CCG will ensure that this is a requirement in future Maternity Service specifications and ensure strong links with the health visiting service.	CCG/SCC
B5	Recording of mental health and attachment should be included as indicators of the quality of maternity and health visiting services.	The CCG will ensure this is a requirement incorporated within service specifications. Commissioners will need to work with Mental Health Services and Public Health to define appropriate, robust and objective measure.	CCG
C	**DIET AND NUTRITION**		

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
C1	More settings should be supported to achieve quality standards in terms of food and nutrition provision, with training provided for staff and volunteers in these settings on nutrition in the early years	Work is underway to review and improve practical skills development for healthy eating on a budget via Healthy Early Years Award (Early years staff, volunteers, children and their families are supported to adopt a more healthy lifestyle) as part of Behaviour Change Service recommissioning: http://sid.southampton.gov.uk/kb5/southampton/directory/advice.page?id=mL6L_cWinF4	SCC
C2	Targeted promotion, and opportunities for practical skills development is required for at risk families, especially those affected by the welfare reforms, through both health and community services. This should include promotion of breastfeeding, Healthy Start, weaning and practical skills development for healthy eating on a budget.	Services have already been commissioned to support these recommendations. Other support is available via the Families Matter (FM) programme which offers employment coaching, access to the City Deal key work programme and other local provisions such as 'adult learning'. Priority families who are most at risk can be identified for inclusion on FM and/or sign posted to support through Welfare Rights. A large programme of work is offered through Sure Start Children's Centres offering language support, adult learning and volunteer opportunities for families. Work is also underway to review and improve practical skills development for healthy eating on a budget via Healthy Early Years Award as part of Behaviour Change Service recommissioning.	SCC
C3	To make healthier food choices easier for people in Southampton, the public health impact should feature in decisions by various sectors which shape and influence food choices including planning, licencing, economic development, transport and leisure.	Partnerships between Planning and Public Health are developing. A new childhood obesity action plan will inform future work. We should work collectively harder as a national system (up to and including PHE) to develop the stylish and appealing development of the messages we want parents, children and young people to take on board. We should do more to create an appetite and interest in doing the right thing with healthy, fresh ingredients to counter the efforts of those selling convenience foods packed with sugars, fats and preservatives.	SCC

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
C4	Commissioners and maternity services should support the extension of CO screening across the whole antenatal pathway including health visitors, and all agencies working with young families, to ensure this is systematically and sustainably implemented across the system in a joined up approach by end of 2016.	Smoking in pregnancy is a priority within the 'Quitters' contract for this year and has been highlighted across HIOW as a priority within the Sustainable Transformation Plan. Some work is already underway with Maternity Services. A briefing paper on Public Health opportunities in Maternity Services will be presented to University Hospitals Southampton in July which will re-emphasise this priority. Work is underway to include CO screening within the Health Visitors service specification. However this needs to be balanced against priorities in delivering core Health Care Professional and safeguarding responsibilities within a reducing financial envelope Procurement of Behaviour Change Services to improve confidence in the accessibility of smoking cessation support will also help in the longer term. Pregnant women will be a target area in the new Behaviour Change Service	CCG/SCC
C5	Commissioners and maternity services should review the outcomes of the Family Nurse Partnership (FNP) work to consider longer term investment to reduce smoking in young pregnant women, with particular focus on areas of deprivation	A pilot programme is being developed to test the use of incentives for giving up smoking during pregnancy. The Southampton FNP team are working with Public Health and commissioners to explore and pilot approaches to improving smoking cessation and reduction, especially in areas of deprivation.	CCG/SCC
C6	Local agencies should work together to support the delivery of a Smoke Free Homes campaign by Children's Centres/FNPs and Health visitors during 2016.	Leadership of this campaign should come from Southampton's Public Health team. Enthusiastic support for the campaign should be expected from all the named providers and others (maternity, schools, early years settings, GPs, pharmacies etc.) and pushed by commissioners and other service and system leaders. Shifting ownership of the campaign itself to others risks falling at the first hurdle to get the core message right, and negates the impact of others in then pushing a sub-optimal message.	HWBB

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
D	**SUBSTANCE MISUSE IN PREGNANCY**		
D1	The data collection methods and referral pathways for maternity and substance misuse services should be reviewed to understand the scale of the problem posed by substance misuse in pregnancy and identify ways to improve outcomes.	This is already part of the action plan within Maternity Services, working with substance misuse providers. This issue will be explored by new the Public Health Consultant lead for substance misuse.	ICU/ Public Health
D2	The training of healthcare staff involved in the clinical management of women who misuse substances during pregnancy should be reviewed to ensure appropriate health knowledge is available for prevention and management.	The Health and Wellbeing Board recommends that this should be extended to include Mental Health and Domestic Abuse. The review would then incorporate all of the issues relating to substance misuse in pregnancy. CCG will ensure that this is a requirement incorporated within service specifications. These issues will be explored by the new Public Health Consultant lead for substance misuse.	CCG
D3	Midwives should extend questions about alcohol use in pregnancy to a modified version of the AUDIT tool and be trained in brief advice or extended brief interventions.	These issues will be explored by the new Public Health Consultant lead for substance misuse. Brief intervention training is currently being reviewed as part of Behaviour Change Service recommissioning. This will need negotiating with Maternity Services as it is not currently included in the specification. These issues will be explored by the new Public Health Consultant lead for substance misuse.	CCG

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
D4	Alcohol's harmful effects in pregnancy should be emphasised more in schools delivering sexual health education.	Delivery of the Youth Health Champion programme is currently being developed for 2016-17. This includes some content on alcohol and sexual health. Information provided should include Foetal Alcohol Spectrum Disorder. Public Health will take a lead in developing high quality teaching resources that convey this information persuasively and lastingly to pupils, and in engaging schools in the adoption of these materials into their curriculum.	SCC
D5	Women of reproductive age who are consuming risky levels of alcohol should be signposted to contraceptive services by drug and alcohol services.	These issues will be picked up in the regular substance misuse Contract Review and Clinical Quality Review Meetings. A Public Health consultant is involved in the governance of Sexual Health services, and will explore options to include information in the literature about "you and your drinking".	Public Health/ICU
D6	Women using sexual health services who are found to be consuming high levels of alcohol are warned about the risks of Foetal Alcohol Spectrum Disorder and should be signposted to the appropriate drug and alcohol services.	An Alcohol Campaign is planned for 2016-17. This issue is to be included in the Alcohol Strategy which is being developed.	ICU
D7	The new guidance on alcohol should be widely promoted, emphasising the important change to advice during pregnancy.	An Alcohol Campaign is planned for 2016-17. This issue is to be included in the Alcohol Strategy which is being developed. Midwifery services are aware of new alcohol consumption guidelines.	HWBB
E	**INFECTIONS**		
E1	The awareness by clinical staff of the risk factors for serious infection, including maternal obesity and following caesarean section, should be increased to improve recognition.	This should be part of first appointment with either their lead midwife, GP or obstetrician. Currently ensuring this is part of care pathways and training in recognition of risks – e.g. Sepsis 6.	NHS England

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
E2	The local translation of the NICE "febrile" guideline into care pathways across the Wessex area should be supported and widely promoted by service providers.	Wessex Healthier Together pilot offers opportunity to provide clear consistent advice for practitioners and parents on managing febrile conditions for 0-5 year olds. It includes a care pathway and guidelines for practitioners. This is embedding within clinical pathway around Sepsis 6 pathways. An example would be the learning from PAH following a Serious Incident – non-ED admission routes of a deteriorating patient (foetal loss).	NHS England
E3	The risk of chicken pox infection during pregnancy is higher in women from other countries, and local obstetric protocols need to raise awareness of this greater risk and encourage proactive diagnosis and advice	This should be part of first appointment with either their lead midwife; GP or obstetrician. It could be flagged at a Maternity Contract meeting – Public Health and NHS England attend.	NHS England
E4	BCG "catch-up" immunisation must be ensured locally, especially given the recent increase in TB notifications in the Southampton area	BCG immunisation is within the Maternity Service specification. The service is also commissioned to deliver the following screening and immunisation programmes by NHS England, the payment for which is covered by the maternity PBR tariff. NHS England is the responsible commissioner for these services and accountability for delivery of quality and performance will be to NHS England. The detailed specifications can be found in the NHS England contract with UHS. TB service specification will be revised in preparation for service change in April 2017.	NHS England/ CCG

	PHAR 2015 Recommendation	Comments	Lead Partnership / Organisation
E5	New schedules of immunisation need to be promoted actively to ensure the highest level of protection for mothers and babies, as immunisation among pregnant mothers remains the most important strategy to reduce harm to mother and baby	There have been 7 changes to immunisation schedule for 2016. The updated schedule is available on the NHS England website. Information is cascaded to all practice nurses, midwives and health visitors. In addition, training is provided across Wessex via Health Education England to strengthen skills. The Wessex Healthier Together pilot in Southampton (starting September 2016) offers an opportunity to strengthen understanding and communication on the current schedule to both practitioners and parents. Further opportunities to engage with parents via health visiting and children's centres will be explored.	NHS England/CCG
F	**SCREENING**		
F1	Service providers should maintain the high coverage of antenatal and new-born screening in line with the targets of the five main national screening programmes.	Verbal update at HWB meeting on 27th July.	NHS England
F2	The new-born and infant examination screening programme coverage should be reviewed by public health when the data becomes available in 2015/16.	Verbal update at HWB meeting on 27th July.	NHS England
F3	The outcome data from the various programmes should be reviewed to better understand the burden of disease affecting Southampton and the relative benefits of the screening programmes.	Verbal update at HWB meeting on 27th July.	NHS England

DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		FAIRNESS COMMISSION: HEALTH AND WELLBEING BOARD RESPONSE		
DATE OF DECISION:		27 JULY 2016		
REPORT OF:		THE CHAIR OF HEALTH AND WELLBEING BOARD		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Katy Anastasi, Senior Partnership Officer**	**Tel:**	**023 8083 2994**
	E-mail:	**katy.anastasi@southampton.gov.uk**		
Director	**Name:**	**Emma Lewis, Service Director – Intelligence, Insight and Communications.**	**Tel:**	**023 8091 7984**
	E-mail:	**emma.lewis@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

In December 2015 the Southampton Fairness Commission published an independent review seeking to enable a fairer Southampton where everyone, irrespective of social or financial status can reach their full potential, live in good quality, affordable homes, and lead healthy, active and independent lives. As part of the Health and Wellbeing Board's duty to promote health and wellbeing and reduce health inequalities in the local population, the Board agreed to respond to the Fairness Commission's recommendations, following a discussion at the September 2015 formal Health and Wellbeing Board. This report outlines the Health and Wellbeing Board's response to the recommendations.

RECOMMENDATIONS:

That the Health and Wellbeing Board:

(i) Notes and agrees response

(ii) Decide how they will monitor and report the actions they have agreed to.

REASONS FOR REPORT RECOMMENDATIONS

1. The Health and Wellbeing Board needs to consider if they will take any actions in response to the health related recommendations made by the Fairness Commission. The Health and Wellbeing Board agreed to respond to these recommendations by July 2016.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3 The Southampton Fairness Commission has considered a range of evidence and developed a set of recommendations aimed at making Southampton a fairer city. The report urges key partners, including the Health and Wellbeing Board, to work together in affirming commitments to the delivery of the recommendations. The full Fairness Commission report can be found online: Fairness Commission Report.

4 In September 2015 the Fairness Commission formally presented their report and 13 recommendations to the Board. Two of which the Health and Wellbeing Board were asked to respond to:

i. Encourage our citizens to take individual responsibility for healthier lifestyles and all agencies to take collective action to support this through citywide campaigns to reduce smoking, drinking and obesity.

ii. All health and social care commissioners should ensure that contracts with providers require them to demonstrate that they have taken action to achieve equity of outcomes. The Health and Wellbeing Board must monitor inequalities and take actions to address them.

5 The first recommendation relates mainly to the Better Care Plan and is reflected in the draft Health and Wellbeing Board Strategy. The second recommendation can be supported by the work of the Integrated Commissioning Unit. The full response can be found in Appendix 1: Health and Wellbeing Board response to Fairness Commission Recommendations.

6 The board are asked to agree the response set out and decide how to monitor and report on the agreed recommendations.

RESOURCE IMPLICATIONS

Capital/Revenue

None

Property/Other

None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

None

Other Legal Implications:

None

POLICY FRAMEWORK IMPLICATIONS

None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Health and Wellbeing Board response to Fairness Commission Recommendations
2.	

Documents In Members' Rooms

1.	None.
2.	

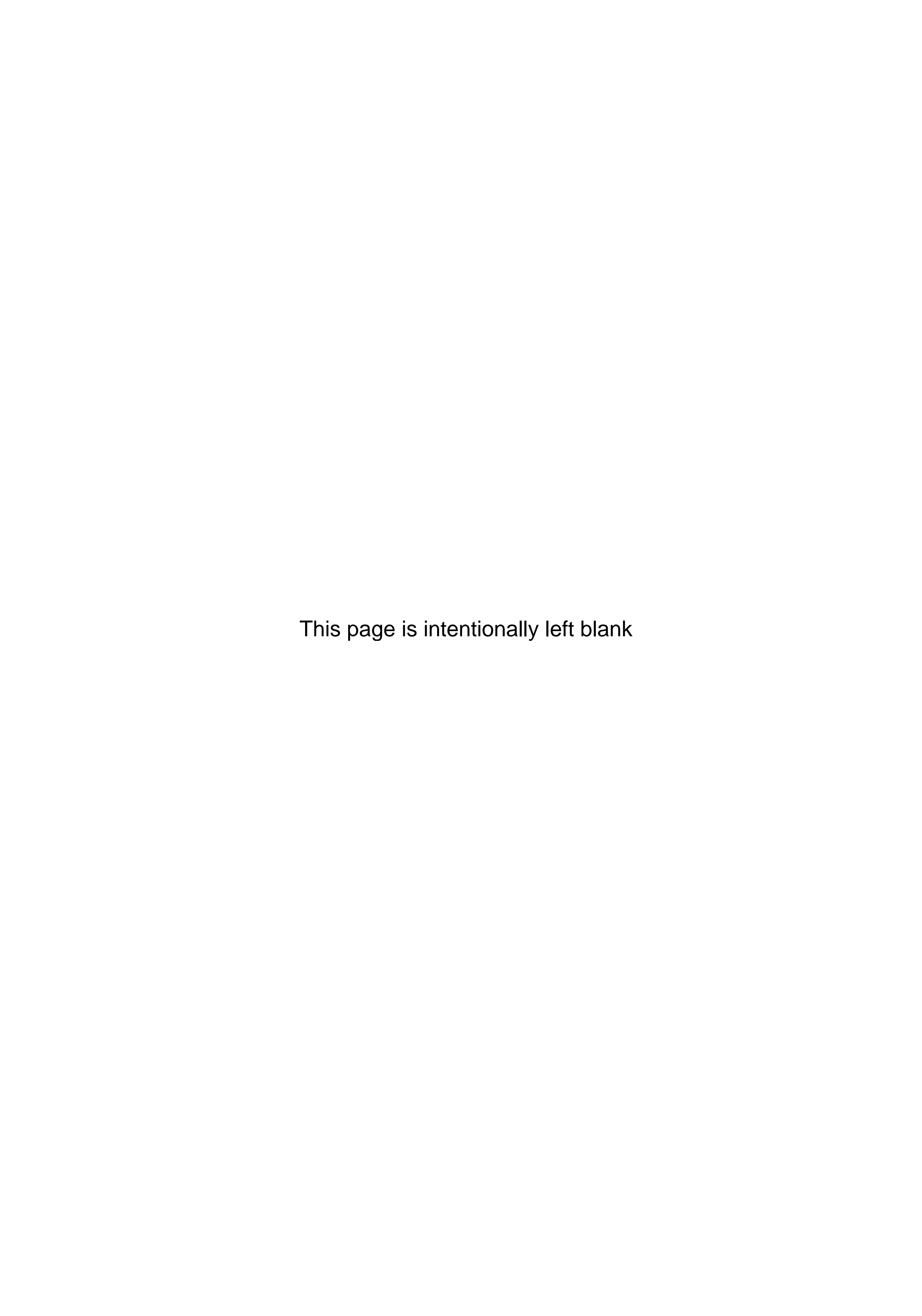
Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/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.		
2.		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Recommendation	Actions taken	Actions to take
Encourage our citizens to take individual responsibility for healthier lifestyles and all agencies to take collective action to support this through citywide campaigns to reduce smoking, drinking and obesity.	• One You campaign led by Public Health started in May 2016. • Public health communications campaigns for 16/17. • Core basis of Better Care Southampton Model. This includes priority on Make Every Contact Count (MECC) to develop a workforce with the skills, knowledge and confidence to talk to people about their health. • Behaviour Change Service recommissioning intentions. Series of engagement events held to inform the development of a new Behaviour Change model. • Alcohol needs assessment completed. • All GP practices in Southampton are signed-up to delivering Health Checks and over 4,000 people in 2014/15 who meet the current criteria have had a check. • The CCG will focus on increasing the use of person-centred planning, in which patient activation and self-care forms an important element by including provider quality schedules as part of business as usual. This has taken place across the NHS landscape, incorporating 3 key NHS providers (Solent, Southern, UHS).	• Communications campaign led by SCC Communications in conjunction with Public Health for 16/17. • Behaviour Change Service in place for April 2017 led by Public Health and ICU. • Plans for a workplace wellbeing offer to support the Workplace Wellbeing Charter is being developed by Public Health Communications and Campaigns group. • Training underway on MECC within the city for health and care providers (ICU – ongoing). • Alcohol Harm Reduction Strategy for the city to be developed by November 2016. • SCCCG in collaboration with Hampshire CCG's are redesigning the current Tier 3 and Tier 4 weight management pathway following the novation from local authorities and Specialist Commissioning. A new service will be in place from April 2018. • Continued focus on uptake of Health checks.
All health and social care commissioners should ensure that contracts with providers require them to demonstrate that they have taken action to achieve equity of outcomes. The Health and Wellbeing Board to monitor inequalities and take actions to address them.	• Joint Strategic Needs Assessment process used to identify inequalities and groups to target in order to inform commissioning, further work taking place. • RightCare programme being implemented by CGG will aim to see the quality of services improve reducing unwarranted variation. • Equality Impact assessments undertaken in advance of any Procurement/service change. • Emphasis within new specification for Behaviour Change to develop a partnership ethos to encourage behaviour change across all sectors; plus a prominence to reduce the health inequalities gap within the city. • The CCG aims to ensure all contracts	• Addressing health inequalities will be included as one of the 4 key outcomes in the new Health and Wellbeing Strategy. • ICU in conjunction with Public Health will work to ensure recommissioned services are proportionate to level of need for Public Health contracts. • Work to improve the use of existing performance data disaggregated by age, sex, race, disability and pregnancy and maternity.

	and Service Level Agreements contain clauses and performance measures around duties and responsibilities under equality and diversity legislation (including access to services and information in appropriate formats). • SCCCG uses the NHS Standard Contract which includes a mandated set of Service Conditions, one of which covers equality and diversity. • During 2013 - 2015 SCCCG has included a requirement to collect equality data on patients using services for all of our major providers with the aim of including this requirement in all our service contracts over the next year. • Additionally, providers tendering for new contracts now have to demonstrate how they are addressing equality issues throughout the tender process. A good example of this was the procurement of the minor injuries service in Southampton. • Performance managers and quality team monitor performance of commissioned providers against the agreed contract schedules and service specifications, including around equality and diversity requirements.	

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		SUSTAINABILITY AND TRANSFORMATION PLAN 2016: UPDATE		
DATE OF DECISION:		27 JULY 2016		
REPORT OF:		CHIEF EXECUTIVE OFFICER, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
Author	**Name:**	**John Richards, Chief Executive Officer for CCG**	**Tel:**	**02380 296923**
	E-mail:	**john.richards@southamptoncityccg.nhs.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

The aim of the Hampshire and Isle Of Wight (H&IOW) Sustainability and Transformation Plan (STP) is to enable local health and care partners across H&IOW to work at scale to realise solutions that can transform the health and wellbeing of our population. The purpose of this report is for the Health and Wellbeing Board to note submission of the draft H&IOW STP. A verbal report will be made at the meeting as regards national feedback and next steps. The Chair has written a letter of support on behalf of the HWBB.

RECOMMENDATIONS:

(i) Note submission of the draft plan and agree response.

(ii) Consider the governance role of the Health and Wellbeing Board (HWB) going forward.

REASONS FOR REPORT RECOMMENDATIONS

1. The HWB is a statutory body with responsibility for health. Because of the tiered approach described in the plan (page 4) and the importance of the subsidiarity principle that has been agreed with partners, the HWB will play an important role in defining local priorities and overseeing delivery of the plan, especially as regards prevention and early intervention, personalisation and integration There is also an emerging proposal to secure overall political (elected member) and clinical (CCG) leadership and governance of the H&IOW STP by means of a coalition of the four HWBs it encompasses.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3 In December 2015, the NHS shared planning guidance 16/17 – 20/21

outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

4 The full report was submitted to NHS England on 30th June 2016. A response from NHS England is expected on 15th July with a view to start implementation on agreed plans in Autumn 2016, with the most compelling and credible STPs securing the earliest additional funding from April 2017 onwards.

5 STP guidance encourages STPs to build on the work of Health and Wellbeing Boards, including local needs assessments, and health and wellbeing strategies. HWB boards must be central to the development of STPs, as a system-wide forum with a democratic mandate from local communities. It is currently being proposed that the four HWBs across the area covered by the STP should create a new joint HWB to oversee the STP development and delivery, comprised of HWB chairs and vice chairs.

RESOURCE IMPLICATIONS

Capital/Revenue

Property/Other

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

Other Legal Implications:

POLICY FRAMEWORK IMPLICATIONS

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	STP HIOW submission
2.	STP App 4 Workforce Strategy
3.	STP App 5 Digital Roadmap
4.	STP App 6 Estates Enabling Plan
5.	STP HWB Chair's letter of support

Documents In Members' Rooms

1.	
2.	

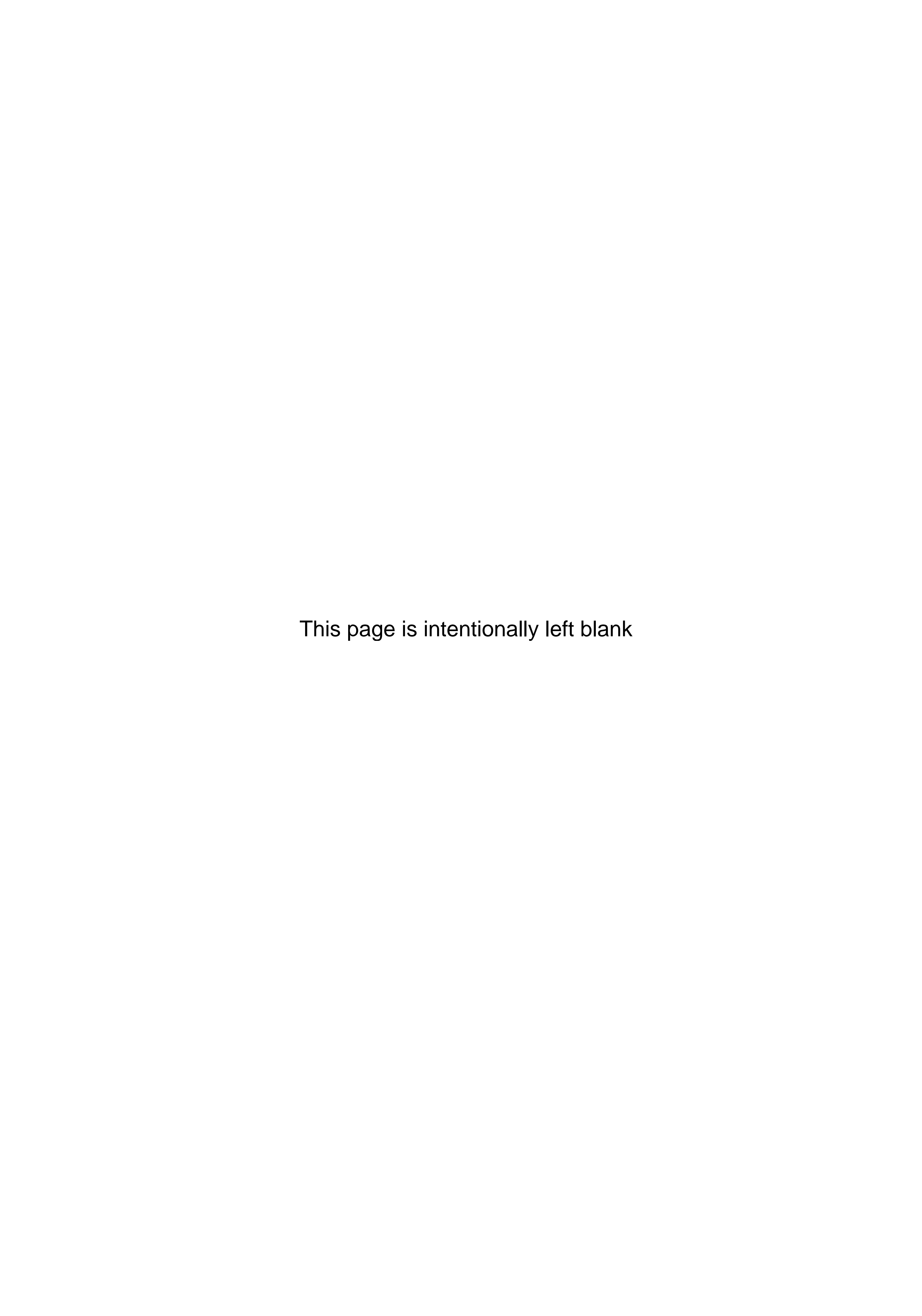
Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) 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.		
2.		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Hampshire and Isle of Wight Sustainability and Transformation Plan

Footprint no. 44

Version: FINAL

30 June 2016

This information is intended for future publication, but at present would be the subject of an exemption under Section 22 of the Freedom of Information Act.

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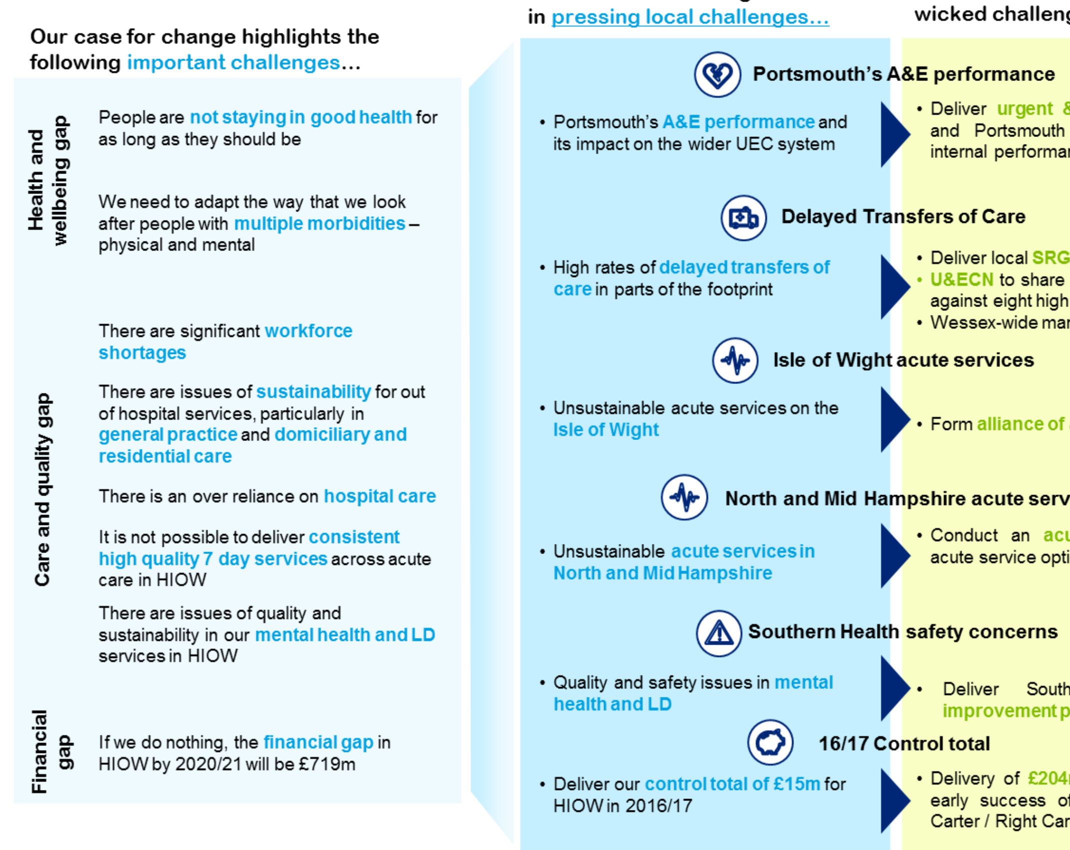
1

2 EXECUTIVE SUMMARY

As leaders of the health and care system in Hampshire and the Isle of Wight (HIOW), we are resolved to work together to transform outcomes and improve the satisfaction of local people who use our services. The STP offers us an opportunity to come together to address our pressing local issues and deliver longer term sustainability by working at scale.



We have plans to tackle these wicked challenges…

- Deliver urgent & emergency care plan and Portsmouth Hospitals NHS Trust's internal performance improvement plan
- Deliver local SRG improvement plans
- U&ECN to share best practice and monitor against eight high impact areas
- Wessex-wide management of care market
- Form alliance of acute providers
- Conduct an acute services review of acute service options in North/ Mid Hants
- Deliver Southern Health's quality improvement plan
- Delivery of £204m cost savings through early success of new care models and Carter / Right Care savings

As well as a set of longer term priorities to deliver sustainability for the citizens of HIOW…

Radically upgrade prevention and intervention
Promoting self-management by developing the technology and workforce to support people to stay well for longer

New models of care
Delivering care around the person, as close to home as possible, including shifting 30% of activity out of general practice to allow GPs to focus on high impact activity and helping to address DToCs

Delayering services
Reducing the non beneficial steps that people go through in acute and community settings

Developing an acute alliance
Priorities will include cancer, maternity and paediatrics. We will share clinical support and back office services

Working at scale in mental health
Pooling resource and delivering high quality mental health at a HIOW level for secondary care services, and on a bigger scale for tertiary mental health services

Transforming learning disabilities
Improving health &care services, empowering people to live fulfilled lives in the most independent setting possible

Financial balance
Delivering savings across our footprint through prevention, new models of care, reconfiguring our services, and generating provider and CCG efficiencies

All supported by a common set of capabilities

1. Ensuring we have the right people, skills and capabilities
2. Developing a simplified access point to health and care services
3. Developing a single digital infrastructure that will connect people and places
4. Transforming commissioning, incentives and contracting

CHALLENGES — SOLUTIONS

3 VISION FOR HEALTH AND CARE IN HIOW

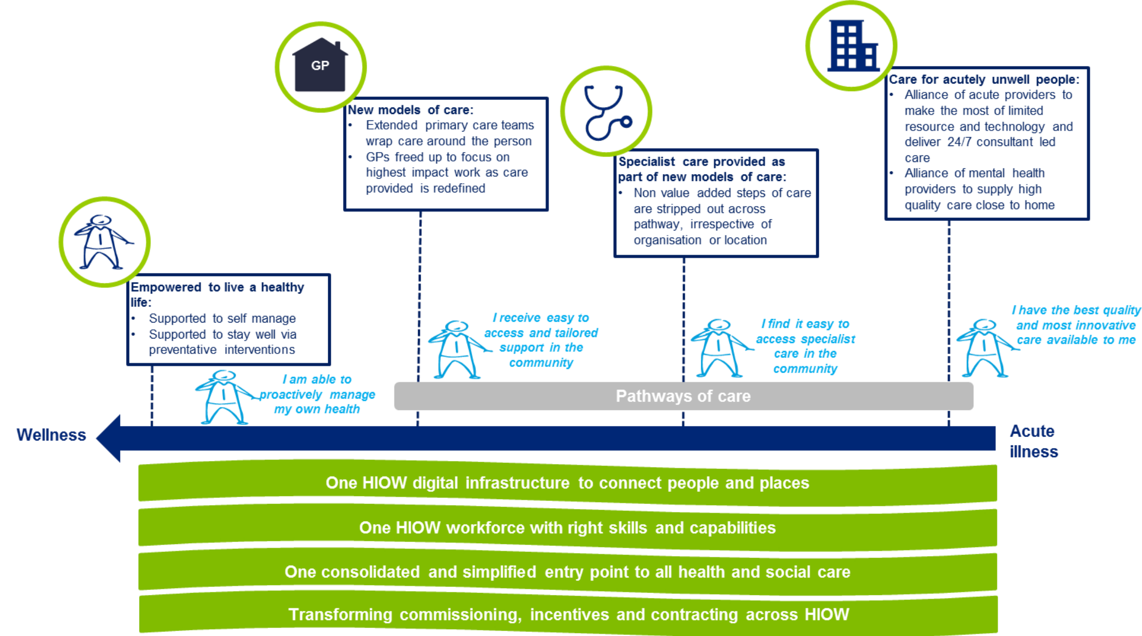
As leaders of the health and care system in Hampshire and the Isle of Wight (HIOW), we are resolved to work together to transform outcomes and improve the satisfaction of local people who use our services, and we are committed to pooling our sovereignty and resources in order to maximise the impact of the resources available to us.

Our ambition is to help HIOW citizens to lead healthier lives, by promoting wellbeing in addition to treating illness, and supporting people to take responsibility for their own health. We will ensure that HIOW citizens have access to high quality consistent care 24/7, as close to home as possible.

We have developed a set of principles that address the challenges of our current system, which inform how we want to change for the better.

Current system	New system
Reactive and focussed on treating illness	Proactive, designed to support wellness at every step
Emphasis is on the care professional	People are empowered and encouraged to take responsibility for their own health and wellness
A lot of care is delivered in hospital	An avoidable hospital admission is considered a failure
Services are variable in availability and quality	Removal of unwarranted variation and access to care 7 days a week where there is need
Focussed on organisations	New models of care based around the person

Our local place based services in Southampton, Isle of Wight, Portsmouth and Hampshire will be the bedrock of our plan, empowering people to stay well and independent at home and caring for the whole person's needs (mental, physical and social). They will be supported by an upgraded and systematic approach to prevention, early identification and self-care. Together, this will enable a shift of care from hospital to community, and from primary care to self-care. For more specialised services, across both physical and mental health, our providers will work collaboratively to ensure that all people across HIOW have access to high quality consistent acute care and mental health services.



To do this we will focus on the following priorities over the next 5 years in HIOW:

1. We will improve the health and wellbeing of our population through developing our infrastructure and workforce, and by focusing on targeted interventions to deliver **prevention, early intervention** and **self-management**.
2. We are accelerating the development of **new models of care** that are already being established in our communities to deliver care around the needs of the person as close to home as possible, and ensure the sustainability of general practice.
3. We will **simplify services**, working across pathways to reduce the non beneficial steps that people go through to access the right care in both community and hospital settings.
4. We will address the sustainability issues of our acute services by working collaboratively in an **alliance model** across acute care, and we will resolve the issue of sustainable services on the Island and in North and Mid Hampshire.
5. We will improve the quality of mental health services being delivered across HIOW by **working at scale** to deliver secondary and tertiary mental health services.
6. We will **improve health and care services for people with learning disabilities**, empowering people to live fulfilling lives in the most independent setting possible.

We will ensure that we establish the **core capabilities** that we need to sustain change. As such we have a number of additional priorities that will be crucial to making a lasting change:

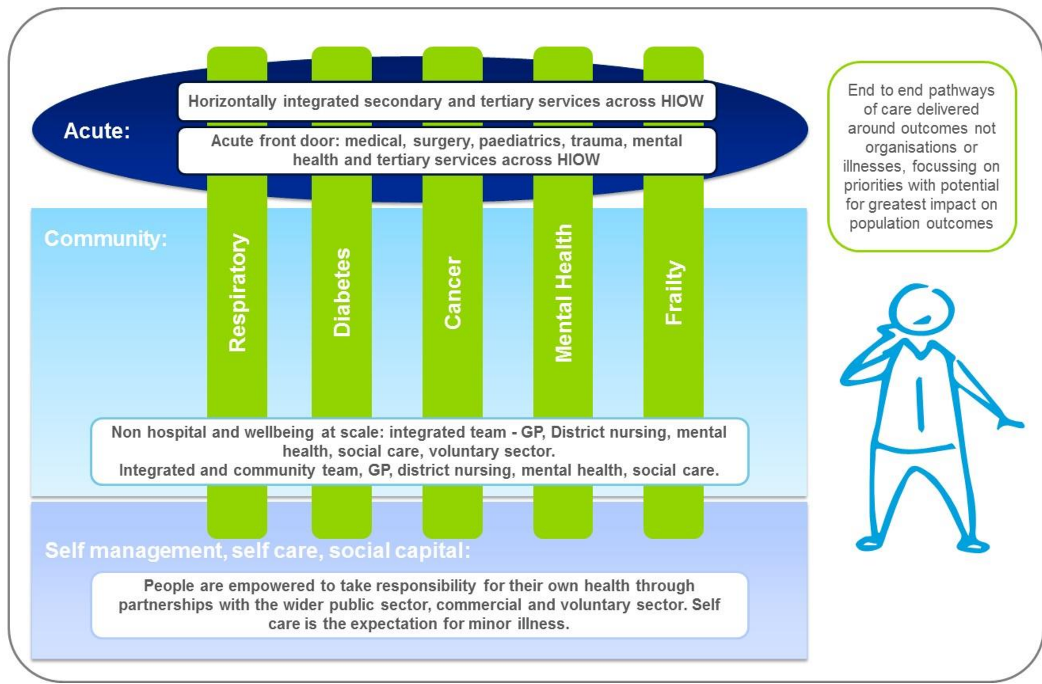
i. We will work as one HIOW to manage our **staff, recruitment and retention**, and to develop one **HIOW workforce strategy** to ensure that we have the skills and capabilities necessary to support our goals.

ii. We will develop a **simplified access point** to health and care services to support citizens and professionals to get the information they need and to navigate the care system.

iii. We will build a strong **digital infrastructure** underpin the successful delivery of our priorities in prevention, new models of acute and acute physical and mental health services.

iv. We will adapt **commissioning** to create the right environment for transformational change across HIOW.

The diagram below illustrates how our transformed system of care may look:



We recognise that there are different tiers of planning and delivery to be considered in implementing our changes – with certain services requiring a local, place based approach and other services requiring a much larger footprint. In defining how care is delivered across HIOW, we are considering the most appropriate scale of delivery, which in turn will have an impact on how services are commissioned.

Footprint	Population	Example of care delivery planning
Individuals and families	1	Self-care, self- management
Natural Communities of Care	30-50k	Local integrated teams
Health and wellbeing boards	250k	Place based models of integrated care in the community
Acute catchment population	500k	Referral systems & operational resilience
HIOW wide	1 - 2m	Safe & sustainable 24-7 acute services, supporting infrastructure
Beyond HIOW	2m +	Highly specialised services such as tertiary mental health services

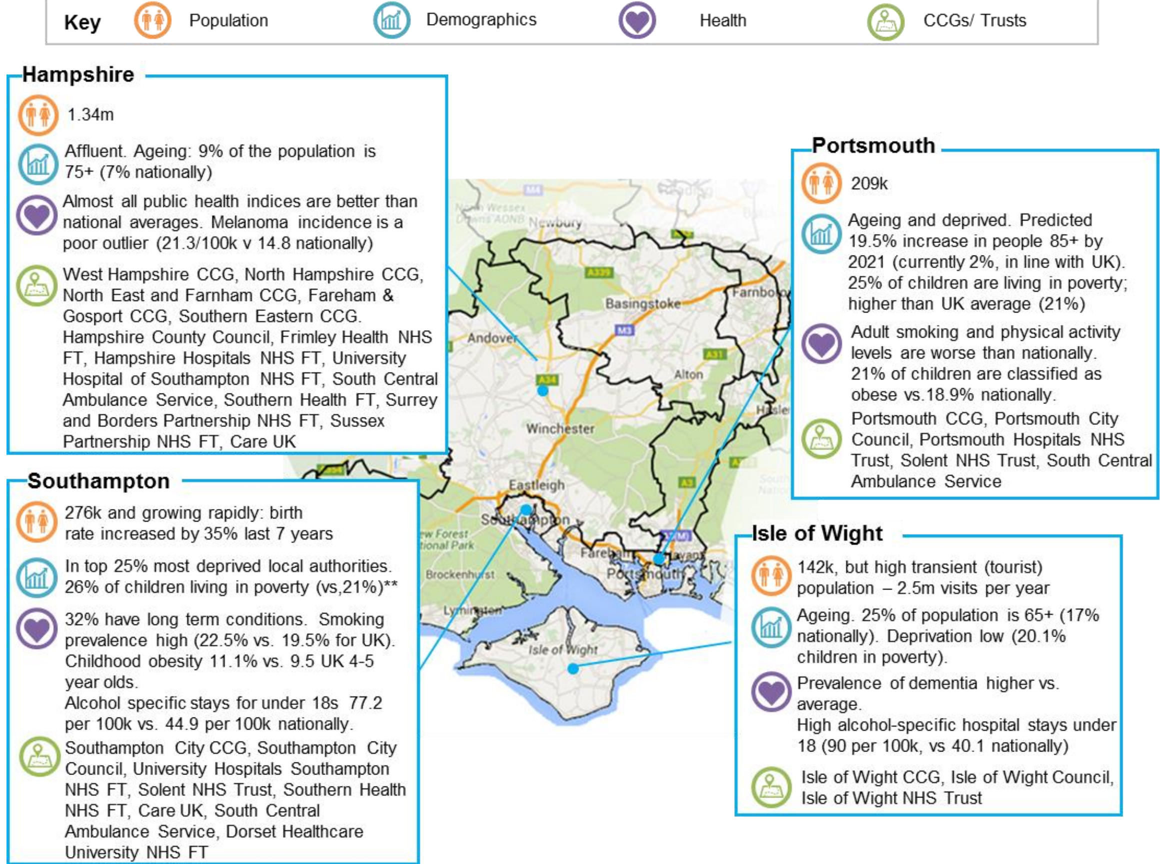
The tiers of planning are flexible, and are intended to be compatible with other initiatives such as the Solent devolution deal and other similar types of collaboration. These conversations are ongoing and will continue to shape the future form of services across HIOW.

We recognise that where we have tried to make transformational change before, a number of barriers have impeded our success. This time will be different - the STP represents the first time that our organisations have come together to work collaboratively to address the challenges facing the health and social care system. As such the system recognises it is on a journey to deliver transformational change. On a personal or individual organisational level, this may mean giving up some authority or areas of responsibility, or taking on more. These changes will require honesty and trust and the STP is already being used as a platform to achieve this, by forging collaborative relationships to change and sustain the way the patch will operate for the future.

4 CONTEXT

4.1 Our STP footprint

Hampshire and Isle of Wight (HIOW) has a population of over 2 million people, with a complex geography: substantial urban settlements primarily in the south and north contrast the large open areas interspersed with market towns and villages. This diversity gives our area great strength, but also means there are variations in deprivation, housing and health which will require slightly different solutions.

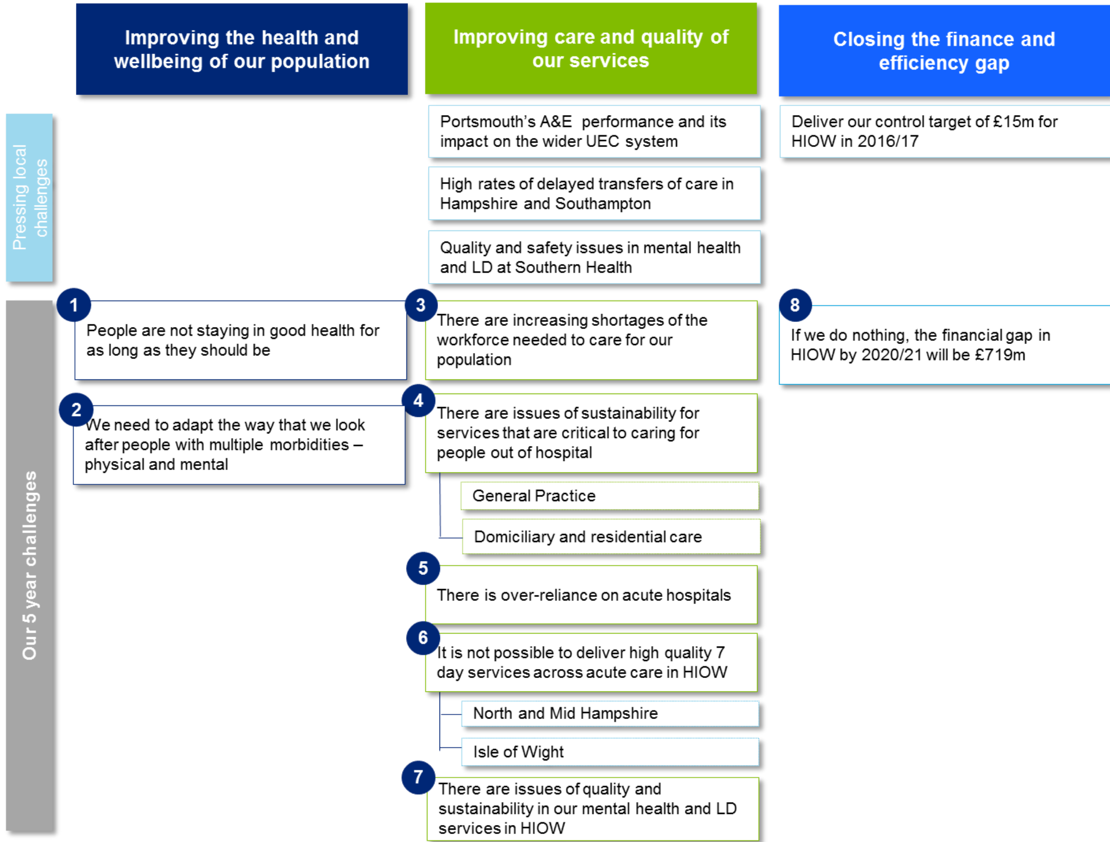


Our HIOW footprint is made up of the following organisations:

- 8 clinical commissioning groups: Fareham & Gosport CCG, Isle of Wight CCG, North Hampshire CCG, North East Hampshire and Farnham CCG, Portsmouth CCG, Southampton City CCG, South Eastern Hampshire CCG and West Hampshire CCG.
- 1 county council and 3 unitary authorities: Hampshire County Council, Portsmouth City Council, Southampton City Council and Isle of Wight Council.
- NHS England is also a major commissioner in the area and is responsible for commissioning all specialised care, screening and military health.
- 226 GP surgeries
- Hampshire Hospitals NHS Foundation Trust, Isle of Wight NHS Trust, Portsmouth Hospitals NHS Trust, University Hospitals of Southampton NHS Foundation Trust and Frimley NHS Foundation Trust all provide acute secondary care.
- Southern Health NHS Foundation Trust and Solent NHS Trust provide the majority of mental health and community services on our footprint.
- South Central Ambulance Service and the Isle of Wight NHS Trust provide ambulance and NHS 111 services.
- Other organisations providing care in the footprint include: Salisbury NHS Foundation Trust, Care UK, Sussex Partnership Foundation Trust, Surrey and Borders Partnership NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust.

5 CASE FOR CHANGE

HIOW is facing a number of challenges across both health and social care around the need to empower people to stay well; provide high quality, sustainable health and care to everyone who needs it; and deliver consistent and affordable care to all of our population.



Although our challenges are substantial, there are many examples of transformation that are already underway in HIOW, which demonstrate our ability as a system to lead change and foster innovation, including three vanguard sites operating within the footprint and other new models of integration.

5.1 Our providers are facing operational challenges, which is impacting on the quality of care

There are considerable operational challenges in a number of our providers. This is impacting on the quality of care that our people receive, leading to differences in care and quality across our footprint. With the exception of Frimley Health NHS FT and Hampshire Hospitals NHS FT (HHFT), all of our providers have been classed as requiring improvement by the Care Quality Commission. There is also longstanding recognition that change is required to ensure that sustainable services are provided in HHFT in the future.

Provider	CQC Rating	Rating Description	Date of last CQC Inspection
Frimley Health NHS Foundation Trust	★	Outstanding	September 2014
Hampshire Hospitals Foundation Trust	●	Good	November 2015
Isle of Wight NHS Trust	●	Requires Improvement	September 2014
Portsmouth Hospitals NHS Trust	●	Requires Improvement	June 2015
Solent Health NHS Trust		Not yet rated	N/A
South Central Ambulance Service		Not yet rated	N/A
Southern Health Foundation Trust	●	Requires Improvement	April 2016
University Hospitals Southampton	●	Requires Improvement	April 2015

The most pressing challenges for the HIOW system which are impacting the quality, safety and cost of care that people receive are listed below. These challenges require us to work together to use our collective capabilities to address the issues.

5.1.1 Portsmouth Hospital NHS Trust's A&E performance

All of the acute hospitals within the footprint are failing to meet the 4 hour A&E target, with the trusts within our footprint ranging from seeing 72.9% - 92% of patients within 4 hours.

Portsmouth Hospitals NHS Trust (PHT) is one of the top 10 worst performing A&E units in England, with a performance of 72.9% delivered in February 2016. Following an inspection in February 2016, the CQC rated PHT's urgent and emergency services inadequate citing that the emergency department was overcrowded with patients not being assessed or treated in a timely way, and highlighting that the trusts inability to deal with emergency admissions was impacting on partner organisations.

5.1.2 Delays in getting people out of hospital

As in the rest of the country, delays in discharging people from acute hospital are a significant issue across HIOW. We know that longer hospital stays, particularly for older people, leads to poorer health outcomes and increased care needs on discharge. This includes a reduction in an older person's muscle strength of up to 5% every day in hospital; a permanent reduction in their ability to perform everyday activities (bathing, eating and dressing) and a significantly greater (574 times) risk of acquiring hospital infections in comparison to younger patients.

Across our acute hospital settings there are approximately 8,000 reported delayed bed days every month. This equates to about 260 beds occupied by people who would have been better supported in a different setting. These are, however, only the reported delays. We know that the actual number of people in hospital no longer benefiting from acute care is approximately 2.7 times the figure officially reported. This extrapolates to 700 acute beds across HIOW (or 20% of our total acute bed stock).

Whilst there have been localised improvements over the past 12 months (in Southampton City there was a 14% reduction in bed days lost due to delays) across the breadth of the HIOW, the situation has continued to deteriorate. Notwithstanding variation in recording, three of the four health and care systems in HIOW are above the national average for delayed days per 100,000 population.

One of the root causes of the delays is a lack of availability of the right type of support – both in terms of care packages and residential care provision. These issues are faced whether the person's care is being funded by the NHS, social care, or by themselves or their family. A recent study by the National Audit Office showed that the cost of delivering hospital care is five times that of the onward care in the community.

Furthermore, there are operational issues in our hospitals, particularly in terms of the timeliness of making and processing referrals and assessments where onward care is likely to be needed by a person in hospital, and ensuring that the care that a person needs is not 'over prescribed'. In addition to this delays are also caused by patient or family choice , people need to be supported with the right information early on where it is likely care will be needed.

5.1.3 Southern Health NHS Foundation Trust secondary Mental Health and Learning Disabilities services

Serious concerns have been raised over the quality and safety of mental health and learning disabilities services at Southern Health NHS Foundation Trust, following concerns that were raised about mortality reporting and investigation processes in a report published by Mazars in December 2015. In a subsequent investigation, the CQC reported that "overall, the Trust's governance arrangements did not facilitate effective, proactive, timely management of risk." It found that the Trust had not put in place robust governance arrangements to investigate incidents, including deaths, and found that as a result, opportunities had been missed to learn from these incidents and to take action to reduce the likelihood of similar events happening again. In addition it reported that effective arrangements had not been put in place to identify record or respond to concerns about patient safety raised by patients, carers and staff or by the

CQC. Significant action is being taken by the trust and across the system to strengthen these processes.

5.1.4 Delivering our control target in 2016/17

Alongside these challenges, we also need to deliver our control total in 2016/17 of £15m surplus (which includes our share of specialised commissioning). In 2015/16 all of our provider trusts and 3 out of our 8 CCGs ended the year in deficit, totalling circa £75m. The surpluses in CCGs only amounted to £3m which is far short of achieving a 1% surplus target of c. £23m.

Our forecasted out-turn at 2016/17 of £15m surplus is heavily contingent on £43m of non-recurrent STF funding being received by some providers this year, along with achieving £204m of cost efficiencies.

The health and wellbeing gap:

5.2 People are not staying in good health for as long as they could be

Whilst most people are living longer, they are increasingly spending longer in poor health, and in some areas healthy life expectancy is starting to decline. In addition, we have seen an increase in suicide rates in recent years, after many years of decline. Only 28% of people who die by suicide are already in contact with mental health services, and a quarter have had contact with a health professional in the week before they die, indicating that our population is not receiving the preventative care they need.

To date our funding and approach to prevention, early intervention and self-management in health has been fragmented, and underfunded. In addition there have been significant cuts to local authority budgets which have also impacted our ability to drive the prevention agenda. Whilst as a whole, our outcomes are generally in line with the national average, it is our aspiration to do better, and to reduce inequalities. We have identified four priority areas – **cancer, diabetes, respiratory and mental health**, where focus on prevention will demonstrably improve outcomes and healthy life expectancy. If these areas are not addressed in HIOW over the next 5 years, this will result in an additional cost of an estimated £138m to the NHS (excluding social care) between now and 2020/21.[1]

Disease	Improvement area	Metric	HIOW STP	HIOW worst performance	England average	Top decile
Cancer	Screening uptake and diagnosis	% cancers detected at stage 1 and 2	41.1%	32%	54.7%	52.5%
		1 year mortality from cancer per 100k popuation	113	123.8	121	102
Diabetes	Self management	% people with good control of blood sugar levels	58.3%	53.7%	60.4%	
		Complications from diabetes per 100k population	85	105.7	100	77
Respiratory	Diagnosis & outcomes	1 year mortality from respiratory per 100k	25.1	35.6	27.6	19
		Admission rates per 100k for children with respiratory	400	527	372	232
Mental health	Access to support	% of seriously mentally ill people with crisis plan	6.7%	0.6%	13.3%	
		Quarterly referrals to psychological therapies per 100k	418	248	535	

To improve the quality of life and healthy life expectancy of our population, interventions, improvements and motivational behavioural change is needed to move to a focus on promoting wellness, amongst those who may not have yet presented with illness, in addition to helping those who already have chronic disease stay well.

[1] Public health gap analysis

5.3 The health and care system needs to be further adapted to address multiple morbidities

People in HIOW are living longer, with increasing numbers of long term chronic conditions. Our system needs to develop to treat the whole person and the multiple illnesses that they have, rather than being focused on individual problems. This also extends to mental health, which needs to be given the same focus and priority as physical health.

Previous models of care based on episodic or single morbidity have resulted in disjointed, inflexible care. People find themselves having to repeat themselves many times over to different professionals, who are accessing different systems with different information. This is reflected by the fact that currently 2 in 5 people living in our area do not feel supported to manage their long term condition, and further evidenced by the health reported quality of life for people with long term conditions, which is in the bottom national quartile for 5 out of our 8 CCGs.[2]

Mental and physical health need to be considered together, of equal priority, as they are highly interlinked. People with long term physical health conditions are 2-3 times more likely to develop mental health problems, and those who have a long term condition and a mental health condition increase the cost of care by 45%. Similarly, the life expectancy of people with serious mental illness is 15-20 years less than the average life expectancy, and two thirds of these deaths are due to avoidable causes – the number of health checks for people with Serious Mental Illness in HIOW is below the national average (30.3%, compared to 34.8%). There are also ongoing challenges with the transition of care to adult services for young people who require ongoing health and care in adult life.

Care and quality gap:

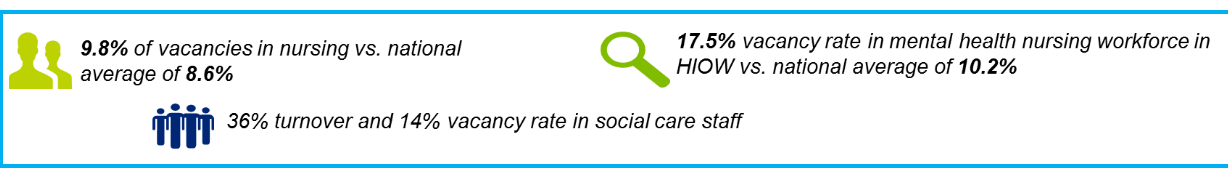
5.4 There are increasing gaps in the workforce required to care for our population

Workforce is the single largest cost and asset in delivering health and social care in HIOW. There are currently significant challenges in HIOW in recruiting and retaining staff across most sectors of health and social care.

In parts of our region, unemployment rates are some of the lowest in the South East of England. In Hampshire the unemployment rate is 3.6% which is 30% lower than the national average of 5.1%. Both the high employment rates and the relatively high cost of housing act as barriers to recruiting lower paid workers particularly support workers and nurses (vacancies for adult nursing and for care workers in social care settings are higher than nationally).

The shortages in workforce are making our services unsustainable, and in addition expenditure on agency staff in our local hospitals has been growing over the last few years. As well as being more expensive than permanent staff, high use of agency staff can impact the quality and continuity of care that people receive.

We need to rethink the skills, roles and workforce market required to deliver the care that we require, especially given that there is an opportunity to rethink the care that we provide and how we deploy our resource.



These gaps in the workforce are leading to broader sustainability issues as described below.

[2] CCG outcomes tool

5.5 There are significant issues of sustainability in services that are critical to caring for people in their community

5.5.1 General practice

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 take place in general practice,[3] and if it fails the whole NHS will fail.

Locally the GP workforce has expanded more slowly than the acute medical workforce and there is national concern around the intensity of workload in primary care. Since 2008, consultations have increased by over 10%, and by 2018, it is forecast there will be a further increase of c. 18%.[4] This is compounded by significant workforce issues - over the last 5 years there has been an increasing issue with the recruitment and retention of GPs, practice nurses and practice managers.

Primary care services across HIOW also need to meet expectations to be more accessible to the population. In a survey of 1,400 people across GP practices in Gosport, 71% said they would like GP practices to provide services earlier in the day and 93% said they would like them provided later.[5]

*c. **14%** of GPs plan to retire in next two years, with a fifth retiring earlier than planned*

***2/3** of practices had a GP vacancy yet **28%** of them failed to recruit to vacant positions*

*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*

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

An effective general practice model is critical to improving the health and wellbeing of our population and enabling people to be cared at home. It is therefore important that the GP Forward View[6] 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.

5.5.2 Domiciliary and care home sectors

As in primary care, there are a number of challenges facing social care which constrain our capacity to look after people in the community. It is increasingly challenging to source the right care home and domiciliary care provision in parts of HIOW. Historically market management of care home and domiciliary care across social care and the NHS has been uncoordinated, and this is exacerbated by insufficient workforce capacity to deliver domiciliary care, which is linked to the relatively low unemployment and high cost of living in Hampshire. In Southampton there has been some recent success as domiciliary care was recommissioned under a new framework in

[3] "Transforming Primary Care in London", NHS England.

[4] NHS England's Call for Action (General Practice) 2013: http://www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf

[5] Healthwatch 2015: http://www.healthwatchhampshire.co.uk/sites/default/files/gosport_primary_care_report_june_2015.pdf

[6] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

2015 which has enabled the Council and CCG to develop a much stronger relationship with a smaller number of framework providers.

In the nursing care home sector, demand appears to be exceeding supply which is resulting in the inability to accept people with more challenging needs such as severe dementia and bariatric care; higher care costs and people being offered places out of area which they and their families are unable to accept. This also means that people are often in settings which are not appropriate for their conditions.

Additionally, the private funded market in Hampshire is strong, meaning that providers of nursing and domiciliary care have been able to position themselves to support this market, rather than the publicly funded sector.

5.6 There is an over reliance on acute hospital care

There are too many people in hospital beds who don't need to be there; and people stay in hospital for a long time even though many are medically fit to leave hospital. The longer people stay in hospital, the more likely they are to develop complications and reduced independence; and it is also expensive to keep someone in hospital unnecessarily, with the average excess bed day costing £273.

Non elective admissions require a different approach, particularly for people who are frail and at the end of life. Although HIOW performs better than average for emergency admissions for acute conditions that should not usually require hospital admission, we want to strive beyond the average and ensure that there is the infrastructure in the community to ensure that no one is admitted in to a setting which is not best for their needs. Many conditions and pathways can be managed effectively in the community, combining the expertise of specialist consultants and GPs, but this is not happening routinely.

In addition, Right Care analysis reveals a total savings opportunity of between £17.9m and £36.8m based on reducing the length of stay of non-elective admissions to mean or top 5 CCG peers, and between £17.9m and £35.2m based on reducing elective admissions.[7] The areas with the biggest savings potential are neurological disorders, gastrointestinal and trauma and injuries for non-elective and musculoskeletal and gastro intestinal for elective.

If this balance is not addressed, the expenditure on acute care, which is already the lion's share of commissioning spend, will continue to rise and be unaffordable. Not only is this financially unsustainable, but there is not the workforce available to support this continued trend, and it would not be in the best interests for our population.

5.7 Sustainability of delivering high quality acute services across HIOW

Our future vision for HIOW is predicated on reducing the amount of people in hospital beds who don't need to be there. However, there will always be a need to deliver acute services to some of the most seriously ill people, and when this occurs, access to specialist staff, specialist tests and equipment should be available 24/7 for our population.

The national 7 day services policy that states that safe acute care needs to be available 24/7, (which includes the 7 day service standard for consultant presence), necessitates significant change in our acute hospitals. Even our largest acute trust, University Hospitals of Southampton NHS Foundation Trust (UHS), which is one of the designated national leaders for 7 day services, does not yet meet the standards. To achieve these standards across all of our acute hospitals will require fundamental changes to how our services are planned and delivered, involving much closer working between trusts, and the centralisation of some services.

This is compounded by the fact that as medicine has advanced and techniques have developed, there has been a continuous move towards subspecialisation, which means that our hospitals have to provide an ever increasing number of sustainable clinical rotas. Advances in medical technology can dramatically improve survival rates and outcomes, but are costly, particularly if provided across all hospitals in HIOW.

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[7] Right care packs, January 2016

Within HIOW, 3 of our 6 acute hospital sites are unsustainable in their current form. In each case the relevant Trust has been trying to design a sustainable future but has recognised that a radical solution is now required. Below we summarise the key sustainability issues for these sites.

5.7.1 Sustainability of services on an island

The Isle of Wight is small and geographically remote, and has significant demographic challenges. 25% of the population is over 65, and by 2030, the number of over 85s will have doubled. In addition, the island's population markedly increases over summer with 2.5m visitors per year.

The island faces unique challenges due to low volumes of some activities, and the costs of providing some services are often higher than on the mainland where resources can be shared. In order to maintain a range of cost effective services in a district general hospital of this size, a population would generally need to be over twice the size of that of the Isle of Wight. Some services and don't see sufficient numbers to allow the workforce to maintain and build their skills, leading to concerns about quality.

Added to this, the health and social care workforce needs to expand and grow, but the Island is currently struggling to recruit and retain people across general practice, nursing, therapies, consultants and care workers, with gaps in specialties such as emergency medicine, paediatrics and urology. These challenges will only get worse due to the age profile of our workforce - there are 19 consultants who are likely to retire in the next 5-10 years and in General Practice there are 34 GPs in the 50-60 age band, likely to retire in the next 10 years.

These challenges are set against a backdrop of unprecedented financial pressures across both health and social care.

In order to address these challenges and start to achieve best-in-class outcomes, we need to transform how services are provided for the island population to meet future demand with a reducing financial allocation. Inevitably some services that are currently provided on the island on an ad-hoc or 5 day per week basis will need to be transferred to the mainland to achieve a full 7 day per week service.

5.7.2 Sustainability of services for the most seriously ill people in North and Mid Hampshire

Hampshire Hospitals NHS Foundation Trust (HHFT) was established in 2012 with a view to ultimately centralise the most-acute services to ensure clinical and financial sustainability for a population over 500,000. HHFT has been working closely with commissioners on plans to ensure the delivery of better acute and emergency care. However recent performance target failures and feedback from the CQC Inspection reaffirmed issues with clinical workforce unsustainability. The status quo cannot be maintained, and the need for change is urgent. HHFT has been working to address this since it was established.

HHFT is still running two sets of acute services and believes that centralising the most acute elements (namely critical care, emergency care, obstetric deliveries and acute paediatrics) will improve 24/7 coverage for consultant-delivered treatment for the most unwell patients. In response to this issue, the trust has developed a proposal that includes the development of a 320 bedded critical treatment hospital, maintaining 220 beds at the two hospitals in Basingstoke and Winchester to provide elective and ambulatory care plus step-down from the critical treatment hospital. This is a reduction of 160 beds on current numbers, and assumes in the future that there will be no delayed discharges. Whilst commissioners support the principle of centralisation (if necessary on a service by service basis) they still have questions about the clinical model, impact on other STP partners and are concerned the proposal may increase the cost to the system.

5.8 Sustainability and quality issues of secondary mental health care and learning disabilities services

There are a number of challenges in mental health and learning disabilities services that are impacting our ability to deliver high quality services for people with mental illness and for those with learning disabilities. As outlined already, the CQC has raised concerns about the quality and

safety of mental health and learning disabilities services delivered by one of our main providers, Southern Health.

In addition to this there are challenges with people with mental illness having to be cared for out of area due to mismatches of demand and capacity in both community and inpatient services. This is exacerbated by significant workforce challenges across psychiatric nursing (c. 18% vacancy) and amongst the medical workforce – in Wessex only 10 out of 34 training posts were filled.

We are committed to improving the experience of individuals in mental health crisis, ensuring there is consistent, timely and effective co-ordination of agencies involved (including primary care, mental health providers, local authorities, emergency departments, ambulance services, and police) to ensure people receive care in the most appropriate and independent environment.

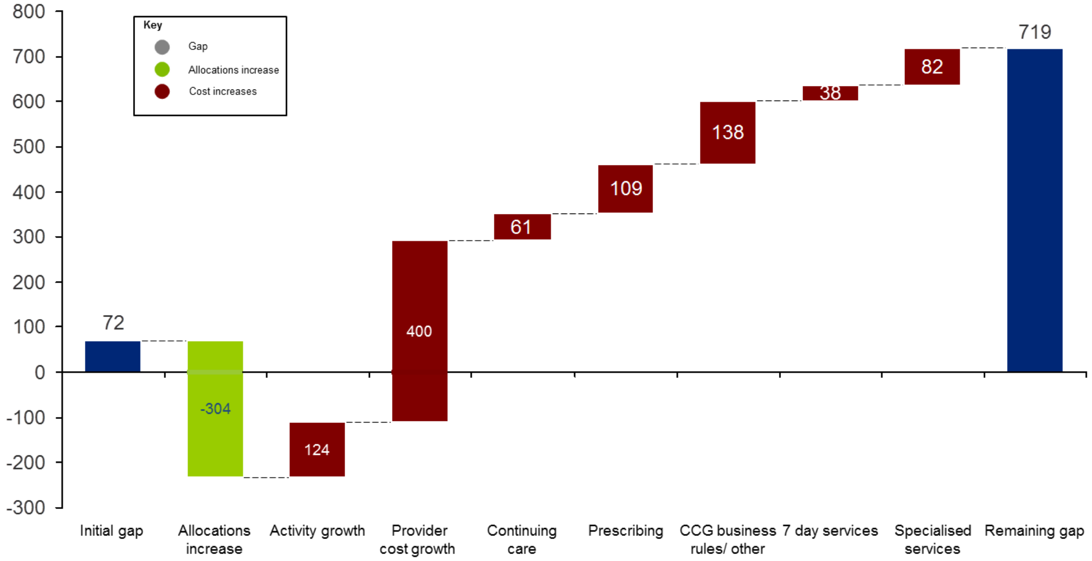
There are also opportunities to improve the experience and outcomes of people living in HIOW with learning disabilities, which include ensuring that they are able to live in the most independent setting possible, and making sure that people with a learning disability receive parity of esteem in terms of their physical health. In HIOW the number of people with learning disabilities who had a health check in the last 12 months was 29% versus the national average of 40%.

Finance and Efficiency

5.9 Finance and Efficiency Gap

The system in HIOW is facing increasing financial challenges as increases in funding are outstripped by demand growth due to a growing and ageing population, and cost inflation. Furthermore new technologies, 7 day services, mental health, cancer, maternity and other improvement policy requirements are difficult to deliver in the context of our financial challenges.

Based on current services, and using the national do nothing assumptions, by 2020/21, if we do nothing as a system, there will be a financial gap of £719m in health alone:



This gap does not reflect the financial challenge in social care. The social care & public health cost efficiency challenge for HIOW is estimated to be at least £350m by 2019/20. Although this is not reflected in our numbers, the interdependencies between health and social care are significant, and our challenges cannot be considered in isolation of one another.

Other than the diseconomies of scale of maintaining island services, national benchmarking suggests that the system in HIOW is relatively efficient - the analysis conducted as part of the Carter Review and Right Care benchmarking indicates that the opportunity for savings in the areas reviewed are not as high as in some other health systems, indicating an already comparatively lower cost system. This means we need to work even harder to fundamentally

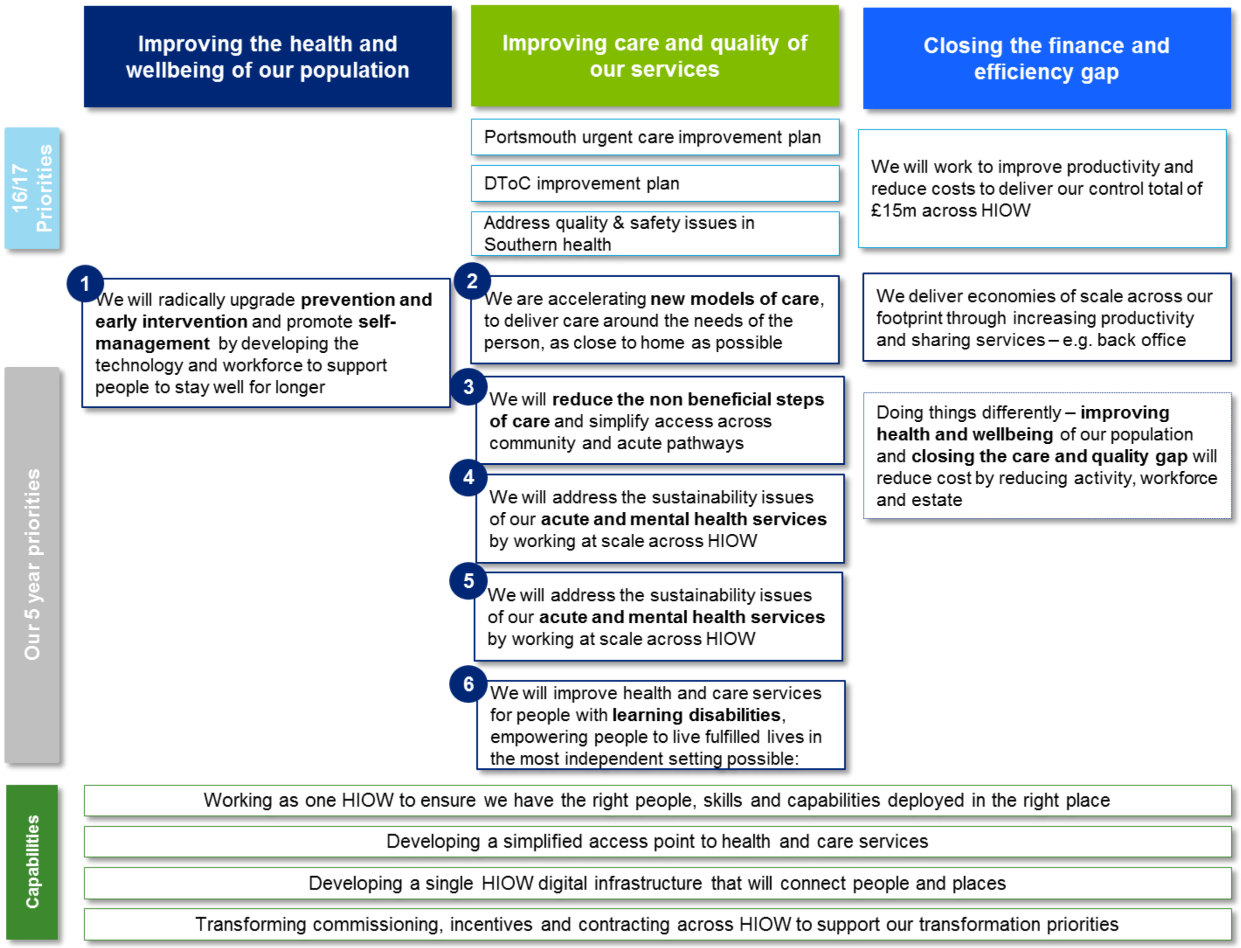
transform care for our population as “doing things better” alone will not be sufficient to address our challenges. This will include building resilience and improving health and wellbeing to reduce reliance on services, transforming community care via new models of care that wrap around the person and delivering acute care and mental health care to our most unwell as efficiently as possible.

6 OUR PRIORITIES AND TRANSFORMATION SCHEMES

It is clear that to address the challenges we are facing in HIOW, we need to do things differently - to empower people to take responsibility for their health; change the way that we deliver services and work smarter to deliver high quality, cost effective care.

Our ambition is to help HIOW citizens to lead healthier lives, by promoting wellbeing in addition to treating illness, and supporting people to take responsibility for their own health. We will ensure that HIOW citizens have access to consistent high quality care 24/7, as close to home as possible.

Our priorities over the next five years are summarised below. Underpinning our priorities is a number of key capabilities that are critical to delivering sustainability:



6.1 Local pressing priorities for 2016/17

Our immediate priorities for 2016/17 are to address the most pressing operational and quality challenges that our system is seeing. These are:

6.1.1 Addressing Urgent and Emergency Care performance in Portsmouth Hospitals NHS Trust

A programme is in place to address the issues in Urgent & Emergency Care at Portsmouth Hospitals NHS Trust (PHT), which is being overseen by the Portsmouth and South East Hampshire System Resilience Group. This will improve PHT's A&E performance to 90% by March 2017 and features the following key programmes of work:

- We are **improving front door processes** in our Emergency Department and Acute Medical unit, reducing handoffs and through changing the model so that all expected admissions go directly to

admission units/wards. We will also use clinical leadership to drive decision making and through the implementation of an unselected medical take model that will ensure that all people who are admitted are seen by a consultant within 8 hours (when admitted during the day) and 14 hours (when admitted at night) of admission.

- We are **improving patient flow** throughout the hospital by placing specialities in charge of agreed targets on their own wards; using the SAFER patient flow bundle; and an integrated pathway from front to back door supported by an **integrated discharge service** delivered by **trusted assessors.**
- This will be underpinned by a single **discharge to assess model** that supports people to maintain and maximise their independence, reduces emergency admissions length of stay and the need for long term care.
- We are developing a **frailty pathway** to prevent admission and reduce length of stay where an admission is necessary and includes frailty assessment, multidisciplinary and specialist support.
- We are improving our **ED escalation processes** to ensure the Trust returns to 'normal' working as quickly and safely as possible and limits the impact on other HIOW hospital at times of high demand. This includes a process of risk sharing across the Trust when the ED has more patients than it can safely care for.

6.1.2 Reducing delays to people being discharged from hospital in Southampton and Hampshire:

We are working at both a local and HIOW-wide level to address the quality and cost challenges associated with both the length of stay and delays associated with discharging people from hospital. Four local and HIOW-wide programmes will form the basis of the overarching transformation.

- Across HIOW, each of the local new care models' transformation programmes are ensuring a common focus on the following points of impact: intensive case management for citizens with long term health conditions reducing the need for non-beneficial acute admissions; provision of community-based treatments for people presenting with urgent ambulatory care sensitive conditions and so reducing admissions; creation of strong community based teams focused and incentivised to 'pull' patients out of hospital; and the development of a consistent approach to person-centred end of life planning.
- We are driving local improvement programmes through our established **System Resilience Groups** (SRGs) in Southampton and South West Hampshire; South East and Portsmouth; North and Mid Hampshire; Isle of Wight and Frimley, focused on enhancing operational resilience and developing capacity plans.
- The Wessex **Urgent and Emergency Care Network** (U&ECN) will support and coordinate the SRGs in standardising practice, and monitoring and managing performance across the system. This network supported by the U&ECN will build an understanding of where each SRG is against the eight high impact areas of improvement and support the development of local action plans.
- The **multi-agency HIOW Frailty Forum** will take the lead as a professionally and clinically-led task force to focus on scaling and spreading best practice and innovation. This will include developing a common approach to quality and defining outcomes and process for potential inclusion either in common system CQUINs or in the emerging MCP / PACS contracts.
- We are also undertaking a **multi-agency review** of the collective gaps in the residential and domiciliary care markets. On 27th July 2016, HIOW local authority and health partners will meet to discuss joint commissioning approaches and develop a memorandum of understanding between partners to help us manage the care market more effectively.

6.1.3 Addressing the concerns raised in CQC inspections over the quality and safety of mental health and learning disabilities services:

Southern Health NHS Foundation Trust (SHFT) has developed an action plan that addresses the concerns raised by Mazars and the CQC, and is in the process of implementing this plan:

- SHFT have undertaken a **Board capability review** following a review by the Interim Chair, and the findings of this will be implemented, including a further strengthening of the Board to ensure the best balance of skills and expertise.
- The **leadership and executive** team will be adapted to allow a more concentrated effort on the day to day delivery of high quality, safe services for our patients. Executive leadership of the quality governance function has transferred to the **newly appointed Director of Nursing** and a number of actions are underway to strengthen the link between the corporate and divisional teams to improve the assurance on quality improvement that is provided to the Board, including a restructure of the Quality Governance team. In addition to this, an interim appointee to a new role of Deputy Director of Nursing for Mental Health and Learning Disabilities is in place whilst substantive recruitment takes place.
- Dashboards have been developed to **report progress** against each action and their sub-actions and these are monitored by a weekly CQC Delivery Group and presented to Trust Board and Quality & Safety Committee as well as to external stakeholders.
- Immediate action has been taken to **address patient safety risk** in inpatient facilities, and to strengthen executive and Board oversight of the improvement programme. Intensive support and additional leadership presence is in place at Evenlode, estates work has been completed and increased staffing in place at Kingsley ward.
- The trust needs to change the way it delivers services because currently it operates across too broad a spectrum of clinical services, and too wide a geography. The plan is for **learning disabilities services** provided by SHFT in Oxfordshire to be **transferred to Oxford Health NHS Foundation Trust**, as soon as agreement is reached. Other changes will also occur.
- The Chair of SHFT is setting up a steering group to further accelerate the **strategic vision** for SHFT, alongside the longer term priorities for mental health and learning disabilities in HIOW outlined in the STP. This will involve a review of how services are organised and delivered led by clinicians and commissioners.

6.1.4 Delivering the improvements required to hit our forecast £15m surplus across HIOW in 2016/17

We have ambitious targets in place across both commissioners and providers to deliver our forecast surplus of £15m at the end of 2016/17. This includes £43m of STF funding in 16/17 and will require us to realise £204m in CIP and QIPPs savings. Delivery of our forecast relies on the early success and impact of our new models of care and vanguard sites that will result in reduced admissions, appropriate treatment, and streamlined access and pathways. This will be in addition to traditional improvement in workforce costs, procurement, medicines management and estates reconfiguration, in line with recommendations from the Carter Review.

Given the level of savings required, this presents a high level of risk to the overall STP, as any lag in the delivery of savings would impact on the financial profile of future years. To manage this risk, we are committed to working collectively to reduce overall cost, and we will undertake a HIOW view of risk management, investment and decision making during 2016/17, governed through our HIOW-wide Finance Directors Group. We are also exploring the benefits of operating a shadow control total.

Our five year priorities

Closing the health and wellbeing gap:

6.2 We will improve the health and wellbeing of our population by investing in the technology and people development to deliver prevention, early intervention and promote self-management across the life-course:

Effective prevention, early intervention and self-care are fundamental to improving the health and wellbeing of the people of HIOW which in turn will reduce demand and ensure the sustainability of our health and care services.

Our ambition is to move to a proactive system that supports and empowers people to take responsibility for their health, remaining in good health for all of their life or preventing those with long term conditions deteriorating, by making sure that our citizens have access to high quality support as quickly and as close to home as possible.

My life a Full Life: Prevention and early intervention on the Isle of Wight working with the council and voluntary sector, the programme has developed a number of initiatives to help empower people to look after their health and care needs.

Café Clinics have been set up for people with long term conditions and their carers, where people can access a range of health professionals who can monitor their health conditions locally and provide advice and support for carers. Local Area Coordinators also work at a neighbourhood level with 50-65 people and their families to help individual and communities at risk build resilience and prevent crisis.

This is one of the many initiatives designed to reduce reliance on statutory services, towards a model whereby people will have greater involvement in their treatment.

Advice on prescription

We are working with Citizens Advice Hampshire to co-design a 'practical advice' package of interventions which our health professionals would be able to refer into to ensure that people get the most appropriate form of care that addresses the whole person.

At a HIOW level we will develop the **capabilities** that will support us to deliver prevention and early intervention at scale, to reduce demand on services, by investing in organisational behaviour change and technological infrastructure:

- We will build on the Hampshire Health Record, using linked primary care data to target and personalise primary and secondary prevention, developing the **data analytics** that allow us to effectively analyse, identify and target people to support them to maintain good health, and ensuring that insights are readily available to our care professionals at the point of care. We will need to consider the mechanisms by which these insights are made available to our population.
- We will use **supportive technology** to help people to care for themselves and reduce demand on the system, We are committed to delivering cost effective solutions to our population to help people look after themselves. The vast majority of people now have smart phones; we aim to utilise this by piloting a new infrastructure that supports prevention and early intervention, directing people to opportunities and interventions that are available in their area, systematically co-ordinating what they need to help them stay well. We recognise that this won't suit everyone so our approach will use a variety of methodologies; apps, internet, telephone, face to face, co-ordinated on the basis of individual need. As part of this we will look to provide solutions that enable people to link into social activities and peer support, such as the GENIE tool that is in place on the Island.

There are over 40,000 health apps available on iTunes, equipping people with tools so they can manage aspects of their own health, such as their heart rate and blood pressure.

- We will develop our **workforce** to be at the forefront of promoting wellness and resilience. We will equip them with the skills and capabilities necessary to have put 'healthy conversations' (including motivational interviewing and health coaching) at the heart of every consultation. This may lead to new roles as part of our extended primary care teams that will work intensively with people to improve outcomes. We recognise that these changes will not be solved by training alone but will be underpinned by a HIOW organisational development programme.
- We will support organisations improve the **wellbeing of our staff**. As the employer of over 40,000 HIOW residents, improving the health and wellbeing of our own staff is key. By improving the health and wellbeing of our own workforce, they will in turn become ambassadors for healthy lifestyles. We will implement the workforce wellbeing charter in all our organisations. As part of this we will observe the national pilot work on NHS staff health and wellbeing that UHS is piloting, with a view to roll it out across all organisations in HIOW.

Whilst it will take time to embed the infrastructure and change required to deliver prevention at scale, there is much we can do to improve existing services. In the immediate future we will embed prevention into all areas of work with a particular focus on those lifestyle behaviours that have the biggest negative impact on health:

Alcohol

We will support people to drink responsibly by

- upscaling alcohol care teams in acute hospitals
- ensuring alcohol identification and brief advice is delivered in all primary and secondary care settings
- establishing Alcohol Assertive Outreach Teams (AAOT) to reduce repeat users of hospital and other services such as police and social services
- reducing relative risk of alcohol-related conditions by 14%, supporting research via My*MedicalRecord*

Smoking

We will support smokers to give up smoking by:

- identifying and targeting the 37% of people who smoke and have a LTC and ensure that they enabled to give up with the right support
- delivering the 'stop before your op' programme in all our surgical pathways to improve outcomes
- assessing all pregnant women for carbon monoxide and refer to specialist support

Healthy diet

We will support people to achieve and maintain a healthy weight by

- ensuring there is adequate capacity in the evidence based weight management services
- working with academic partners to develop an evidence based approach to treating and preventing childhood obesity

We will also focus on prevention and early intervention particular areas, where investment in may have the largest impact on health outcomes:

We will support improved outcomes for ***people with mental health conditions*** *by*

- increasing the number of people with serious mental illness who have a health check and follow-up intervention from 30% to 50%
- increasing the number of people with a LTC having a psychological intervention via our new models of care
- reducing suicide by 10% through improving 24/7 care for people in mental health crisis, and delivery of the suicide prevention plans

We will improve ***the health and wellbeing of children*** *by*

- expanding the number of health visitors and the development of the family nurse partnership to enable early identification of support to vulnerable families
- working collaboratively across health, education and local authorities to address behaviours which impact adversely on health and wellbeing such as Public Nursing Service

*We will support **early intervention for priority conditions** by*

- improving early diagnosis of cancer to increase the proportion of cancers detected at stages 1 and 2 to increase screening attendance by 13,000 in line with our comparators, through targeted reminders for screening and testing a programme of direct access to cancer 2 week wait services for people with red flag symptoms.
- working to reduce diabetes by 26%, by implementing the diabetes prevention programme
- improving the blood sugar control of 4,500 more people who are suffering from diabetes by supporting better management in primary care and providing more effective lifestyle support.

Closing the care and quality gap:

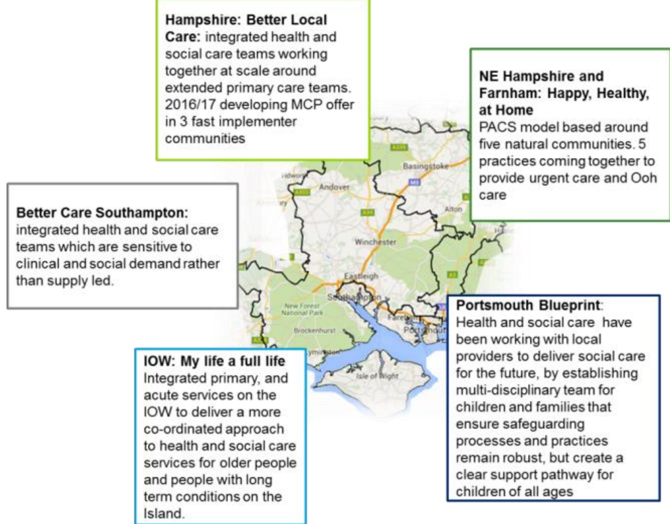
6.3 We will accelerate the implementation of new models of care (NMC) so care is centred on the holistic needs of the person as close to their home as possible

We know that people want to be cared for by professionals that they trust in a way maximises their independence and minimises impact on their lives and disruption to those around them. We need to make sure that primary and community based care in HIOW can be sustained beyond 2020/21 which requires a fundamental shift in thinking about how care is provided. We are developing a series of new models of integrated care across HIOW that will:

Approximately t**wo-thirds** of people would prefer to die at home. If recent trends continue, by 2030 **fewer than 1 in 10** people will die at home

- Improve outcomes for people with, long term conditions and multiple co-morbidities.
- Reduce non-elective hospital admissions and A&E attendances associated with chronic and urgent ambulatory care.
- Enable more people to maintain independent home living.
- Enable more people to be able to interact with, and take care of, their health and wellbeing needs digitally.
- Deliver sustainability in primary care across HIOW.

Integrated local systems of care will be the bedrock of care in HIOW, delivered locally by five emerging new models of care which include the cities of Portsmouth and Southampton plus three existing MCP / PACS vanguards. Further detail on each of these models can be found in appendix 3. Each one will bring together primary, community, social, learning disability, mental health, and voluntary sector services into a multi-disciplinary team offering providing extended access and simplified care across 14 natural communities of care (NCC).



Whilst the NMCs are all locally owned and different according to the needs of the populations that they serve, they all share the same core principles:

Improving the sustainability and availability of General Practice:

80% said they would be happy to be seen somewhere other than their own practice if they needed a routine appointment

- By 2020/21 **all GP practices** across HIOW will be part of a NMC with **extended primary care** teams working at populations between 30,000 and 50,000 providing joined up primary, community, mental health and social care both in, and out of hours. Pooling these resources will allow us to manage the highest risk people in the community proactively and effectively.
- By delivering general practice at greater scale, we will be able to provide **extended access to our primary care services** to all people living in HIOW. Collective primary care working will ensure that citizens will have **access to on-the-day support** and advice, and 40% of primary care issues will be resolved remotely. As part of this work we will explore how we offer **on-the-day / urgent care facilities** across HIOW in a more streamlined and efficient manner to better manage short term issues that should not require an admission (such as urinary tract infections, blocked feeding tube or exacerbation of COPD). This will respond to what our communities want from primary care services, which is more specialist and timely care in the community.
- We will **reduce 30% of the activity** that is currently done in general practice to free up GPs to focus on the highest impact interventions, such as upskilling GPs with new specialist skills to better manage care in the community. We will do this by:
    - Learning from the commercial sector, we will **identify and stop processes** and activities that do not add value to the citizen instead **providing alternative digital solutions** (largely self-service) to enable people to self-manage and self-care.
    - We will **redefine the work** that is typically done in general practice and undertaken by GPs including better utilising **other professions** more suited to handle citizens' presenting issues. We will also reduce steps in the pathways where we know that seeing a specialist (e.g. physiotherapy /mental health practitioner) in the first instance leads to a quicker and/or better recovery.

Need based offering to citizens:

- We will develop **targeted, integrated case management** of long term conditions via multidisciplinary team input and provide crisis intervention for exacerbations and complex care needs, providing alternative treatment locations in the community.
- We will design **personalised and detailed care programmes** for our citizens with the most complex needs potentially optimising the clinical extensivist model with a senior clinician providing overarching navigation on behalf of, and decision making with, the citizen.
- We will create strong community based teams (with the support of local authorities) designed to "pull" patients out of hospitals and support them in their own homes, which in turn will reduce **delayed transfers of care**.

Physical health checks for citizens with learning disabilities or mental illness:

- Our new models of care will ensure that all citizens with a mental illness or learning disability have timely physical health checks to improve their overall health and wellbeing.

Medicines optimisation:

- **Evidence based medicines optimisation** actions will be systematised across new models of care to allow for more efficient and effective prescribing of medication. We will utilise community pharmacists to conduct systematic drug reviews to ensure that people are on appropriate medication. This will include medication review of people living in a care home environment, and ensuring that all hospitals have systems in place to refer people to community pharmacy on discharge for support with medicines. Our NMC will also ensure the

wholesale adoption of repeat dispensing by general practice, to release time to deliver medicines optimisation at scale.

Outcomes based pathways:

- We will **standardise care pathways, protocols and standards** for priority long term conditions and end of life care. Along with reducing variation we are committed to ensuring that these pathways are streamlined to ensure that people can access the right steps of care as quickly as possible. These standardised best practice pathways will be **co-designed by our user community** and our primary and acute professionals in conjunction with specialist input on social issues such as housing and employment.
- To facilitate an improvement in population health and to ensure services meet the population's expectations, we will move to commissioning **outcomes based pathways.** The Hampshire Better Local Care programme is part of **a national contracting pilot**; we will spread this learning to develop a scaled up offering across HIOW**.**

Shared digital infrastructure:

- Using information from a HIOW-wide **population health data infrastructure** that gives granular level information about our population, citizens of HIOW will be **proactively risk stratified** based on their current and future prognosis and needs. Our extended primary care teams will **target interventions** towards cohorts of people that evidence tells us would benefit from support, treatment or modifications to existing care plans. This will allow us to drive up diagnosis rates, reduce practice level variation and cease interventions where the evidence base is non-existent or poor.
- We are committed to deploying **one care record** across HIOW to ensure that everyone has access to a full set of information spanning all settings of care. This will provide the population with easy access to their health and care record, irrespective of the setting they are attending. We will explore other shared capabilities that could be supported by a common infrastructure such as estates, workforce and back office services.
- We will ensure that our **digital interaction** responds to how the population wants to engage with health and care (e.g. 24/7 access to advice, web-based solutions, video-conferencing versus face-to-face clinics.

6.4 We will reduce the non beneficial steps of care across community and acute services.

We will examine the flow of patients into our services, and to take a radical approach to 'delayer' and simplify these processes, taking out non-beneficial or unhelpful steps, wherever they sit in the pathway.

Our citizens tell us that they find it difficult to access the right service first time, and often have to go through unnecessary steps to access specialist care or test they need first time.

As a result of this, by 2020/21 we would envisage that:

- There will be a reduction in first outpatient appointments of between 20% and 50%.
- There will be an infrastructure which supports remote consultation; which will include people requiring long term follow up who will be managed through digital patient triggered follow up programmes with primary, community and acute clinicians all having a shared role.
- There will be an increase in direct access to protocol driven diagnostics.

These pathways, which will be symptom based rather than diagnosis based will be used by all those referring in to our services in HIOW. For example, our hypothesis is that a very significant number of first outpatient appointments and follow-up appointments would not be required and that earlier access to diagnostics will allow treatment decisions to be made more quickly. We will also explore the innovative use of technology to support our care professionals and to develop the virtual outpatient consultation. This will provide the population with more timely and accessible services, closer to their home. This will be facilitated by simplified access and navigation around the health and care system for professionals (as well as citizens).

6.5 We will address the sustainability and quality issues of our acute physical health services by working at scale across HIOW

Whilst prevention, early intervention and new models of care will mean that more people are cared for in their community, when people in HIOW are acutely unwell, we are committed to ensuring they have fast access to specialist care 24/7. We will improve the quality, outcomes and consistency of care for people who are acutely unwell in HIOW, through a collaboration of our providers.

86% of patients surveyed were prepared to travel further away from home for specialist and complex care, and **42%** for A&E services.

By 2020/21:

- We will work to evidence based guidance to standardise care and remove variation in physical and mental health across HIOW. Clinical outcomes, patient reported outcomes and patient experience will improve as a result.
- When people are admitted they rapidly receive the diagnosis and treatment they need from the relevant specialist, whatever the time of day, or day of the week, in a setting which is most appropriate for the population.
- All pathways into acute care will have been reviewed against LEAN principles, using quality improvement methodology, and delayered by removing non-beneficial steps regardless of whether these are steps are currently in the community or acute sector.
- There will be a coordinated, timely and effective multi agency response to people in mental health crisis.
- People will have improved choices around how they are cared for towards the end of life.
- Specialist care will be provided from fewer sites.
- Tariffs and incentives will have been designed to support high quality outcomes for patients.
- Providers will be more efficient and this will mean the overall cost of acute physical and mental health services will be lower.

6.5.1 Acute services alliance

UHS, Isle of Wight NHS Trust, PHT and Lymington Hospital will form an alliance that will improve outcomes and reduce cost by removing variation between hospitals, via multi professional networks planning and delivering care for people regardless of which organisation is treating them. This will provide the local population with access to the best available acute and specialist care.

Services will be centralised where appropriate, and back office and clinical support functions will be shared between organisations. Ideally this alliance would include Andover, Winchester and Basingstoke sites as well, but this is not agreed by HHFT who run these sites.

This will require us to define what should be done, where and by whom for the population of HIOW. We will work through every secondary care service to assess what the model of delivery should be for the alliance, each with a clinical lead. Our clinical leaders will review this on a speciality by specialty basis, building on strategies developed by the Wessex Clinical Networks, and co-designed with our population to redesign and reconfigure our services to ensure the best care can be delivered 24/7 across HIOW.

Individual Trusts will remain sovereign organisations and retain responsibility for finance, performance and quality but will work together to agree common approaches to improvement, operational management, IT, quality and strategy, and a joined up clinical strategy that delivers seven day services; specialist services to the right critical mass; and sustainable services on the Isle of Wight.

We are in the process of setting up a management group of the Chairs and Chief Executives of each of the relevant providers that will meet monthly to oversee the transformation programme. Our key initial priorities are cancer, maternity services, paediatrics and urgent & emergency care.

We will also start by collaborating on areas where there are specific pressures such as Urology, where integrated services are needed as a matter of urgency to manage the IOW patients.

The alliance model will be critical to delivering high quality urgent and emergency care, and the 4 hour A&E target across HIOW. This will involve adopting a consistent approach to patient flow from admission to discharge, along with developing transparent sharing of data that allows patients to be tracked in real time across the system. This will allow us to better manage our capacity and improve service user experience.

We will look to make the configuration of paediatric services across HIOW more sustainable in the future including increasing the number of paediatric consultants and reviewing the configuration of paediatrics sites across the footprint – paediatric services in Southampton and Portsmouth already work closely together and will continue to build on this collaborative working.

The alliance model will also build on the work of the strategic clinical networks that is already in progress in the system such as the maternity network:

Standardisation of maternity care

We have been collaborating on maternity services for the past two years. HIOW is one of the **Maternity Choice and Personalisation Pioneers**, following the national review of maternity services.

We will create a **single point of access for women, including providing a named midwife to help navigate through the pathway** and will develop a set of guidelines across the STP so that whenever a woman enters the system, she receives a **standardised model of care, building on best practice, shared learning, skills and expertise.**

Specialised Commissioning will be heavily involved in this process, and this work is in line with the opportunities identified including integrating pathways, developing local service alternatives and helping to crystallise opportunities for consolidation as part of reconfiguration plans.

4.5.2 Resolving sustainability issues in North and Mid Hampshire

An important step in defining the scope of the alliance will require a resolution on how we address the sustainability issues in North and Mid Hampshire. The relevant commissioners – West Hampshire CCG, North Hampshire CCG and NHS England (in their role as specialised commissioners) and HHFT are agreed that centralisation and rationalisation of services is necessary in order to improve patient outcomes, provide 24/7 consultant delivered care, and ensure that services are sustainable in the long term. However, the Commissioners do not support the model proposed by HHFT for a new build critical treatment hospital for reasons of affordability given the scale of the financial challenge for the whole STP footprint, the clinical model incorporating the three existing sites, the impact on other providers, and the incomplete evaluation of options. HHFT have evaluated other options and believe this is the optimal solution. NHS Improvement is reviewing the business case, including a review of the clinical and financial model, but is yet to report back.

A series of review meetings have taken place under the auspices of the STP, as this issue has an impact on the wider system. STP partners at this stage remain unclear about the integrity of the clinical model and are concerned about the impact on other stakeholders in the STP (including acute, community and ambulance providers and commissioners). The STP is not in a position to support the proposal in its current form, and there is broad consensus across the STP that at least one alternative model exists which should be evaluated in detail.

HHFT believe that the concerns and questions raised by commissioners have been addressed already and are concerned that further delays in the resolution of this issue will result in growing risk. However given that commissioners still have concerns about the clinical model and affordability of the plan, West Hampshire CCG and North Hampshire CCG are commissioning a full review of the options identified on behalf of the wider STP, which will commence in July, with the expectation that it will be a fully inclusive process with the involvement of all key stakeholders. These options will need to be considered in the light of the STP clinical model proposed to deliver high quality 24/7 care, new models of care and the level of investment (and consequent revenue requirement) that the system can support.

4.5.3 Addressing the sustainability issues on the Island

In developing the alliance model at a specialty level, we will in turn resolve the sustainability issues on the Isle of Wight. To do this we will review all clinical services on the island and identify what can safely be delivered there and what can't, and we will work with local people to co-design acute services. This will involve some patient care being repatriated to the island but other specialties being delivered on the mainland. One of the first priorities for resolution by the alliance will be to resolve Urology services, where integrated services are needed as a matter of urgency on the Island. Over the next 3 months, the alliance will plan the overall work programme, which will be informed by the pressing issues that require a resolution.

6.6 We will improve the quality of mental health services being delivered across HIOW by working at scale

6.6.1 HIOW mental health alliance

As in our acute trusts, there are significant sustainability issues in mental health, both for the Isle of Wight NHS Trust and for our two mainland providers – Southern Health NHS FT and Solent NHS Trust. There are currently 4 providers of secondary mental health care across HIOW, with child and adolescent mental health services (CAMHS) being delivered in Hampshire by Sussex Partnership NHS Trust, all with different pathways and protocols.

We will create an alliance across HIOW to improve quality and access to mental health services in HIOW through recovery approaches. This will involve developing networked services, arriving at a single model of care, and standardising pathways and protocols, using evidence based practice. We envisage that this will work across community and inpatient care pathways for a needs led adult mental health service, and for community CAMHS to ensure there is a consistent pathway through which people can move as their needs change. However, the precise scope of services included will be tested as part of the process of defining how the alliance will work in practice.

By working at a larger scale we will improve outcomes through optimised and standardised processes, and we will be able to deploy the resource that we have more effectively. An example of this will be the management of psychiatric intensive care beds, whereby an alliance will allow us to share best practice, and better manage our bed capacity at scale.

> People in crisis need to know which options are available to them, both formal and informal, and should expect that services are tailored to their needs

In addition to improving our mental health pathways we will work with our acute providers to develop a HIOW wide approach to what is provided in physical health settings for those in crisis. Our citizens have asked for somewhere they are able to go when feeling isolated or at risk of a crisis so this new approach will ensure that people in mental health crisis are able to have rapid access to appropriate and high quality services, and that there is effective collaborative working between the many agencies involved. The HIOW crisis concordat steering group monitors action of this plan, and this will be standardised across all providers. We will also explore the roll out of the Crisis Café model. Liaison services will be standardised and evidence based across HIOW

as currently provision is variable across trusts, these services will also address Medically Unexplained Symptoms.

It is envisaged that the organisational form for mental health may change as a result of these changes; however our initial focus is to define the function of the alliance and the standardised services that sit within it.

Safe Haven Café in Aldershot, North East Hampshire

A Safe Haven café in Aldershot has helped reduce mental health hospital admissions by a third in seven months between 2014 and 2015. It provides an evening drop in where people can go if they need support, helping to provide support for those at risk of a crisis. NHS workers and third sector partners provide informal support to anyone suffering from a mental health problem, diagnosed or not.

6.6.2 Delivering tertiary mental health services on a greater scale

For tertiary mental health services (starting with secure mental health services and tertiary CAMHS) we will work at a greater scale – across HIOW, Dorset, Berkshire, Oxfordshire and Buckinghamshire. By working at a larger footprint our population will be able to access the care they require within a reasonable distance, allowing the system to manage flow, assure quality and standardise practice. This will require robust governance arrangements between HIOW and its neighbouring STPs. The exact footprint for this is not yet determined, however we have applied to be part of the NHS England Tertiary Mental Health new care models pilot, the outcome of which is still to be confirmed.

6.7 We will improve health and care services for people with learning disabilities, empowering people to live fulfilled lives in the most independent setting possible:

The HIOW Transforming Care Partnership Programme has been established and will improve the health and care that people with a learning disability and/or autism receive, by building on a person's unique strengths and abilities and ensuring there is the care in the right place at the right time and is consistent across the footprint. To achieve this we will:

- Keep people well through **early intervention and planned prevention strategies** for individuals. This will involve reconfiguring our Community Learning Disability Health and Social Care Teams to support early intervention and prevention. We will also ensure that healthcare is better equipped to give people with a learning disability the best care by developing 'Learning Disability Friendly GP Practices' and Learning Disabilities liaison services across all acute trusts.
- Care for people in the **least restrictive setting that drives the best quality and outcomes** for the individual, reducing our bed base by 20% by 2019. By the end of 2016 we aim to have repatriated all patients who have been in hospital for more than 3 years to local community services. To do this we are developing our community services to enable people to be discharged into the community, and establishing a Community Forensic Rehabilitation Service in 2016/17 to allow people to receive care and treatment in the community where appropriate.
- Support more people to live in the community, we are **developing a greater range of options for housing.** We are working with the Housing and Support Alliance, commissioners and providers to develop a Regional approach to Housing Development, which will increase the range of housing available providing housing options that meets people's needs.
- Give people more choice in how they are supported by **increasing the uptake of personal budgets**, by 20% by March 2019. We will do this by offering personal budgets to more people, including children and young adults, pooling budgets across health and social care, and decommissioning elements of block contracts such as speech and language therapy.

Capabilities to deliver our vision

6.8 We will work as one HIOW to manage our staffing, recruitment and retention to ensure that we have the skills and capabilities necessary to support our transformed health and care system.

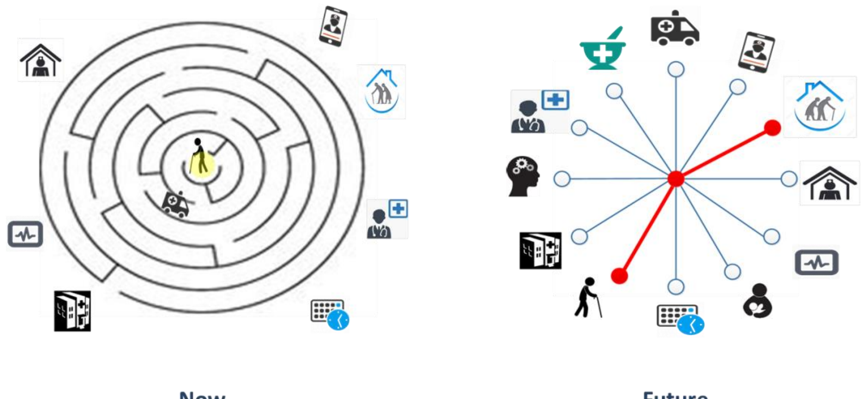
Our workforce is our greatest asset to deliver safe, high-quality services to our population. We will help our providers and commissioners establish the partnership and shared principles to develop a workforce that will deliver better care across HIOW by focusing on the following areas:

- We will develop our people to support our new models of care and ensure that our workforce is fit for purpose in a transformed system, this will involve:
  - Rolling out **prevention and early intervention skills training** at scale across the system. We will implement a behaviour change framework, to enable the system to recognise the training needs of each workforce group to create a fit for purpose behaviour change development programme across HIOW.
  - Using our workforce more efficiently through **agreement of protocols and pathways by networked staff** to avoid duplication of assessments/diagnostics, with 'one trusted professional' at the forefront of an integrated, patient-centred service.
  - **Widening the breadth and type of staff working in community and primary care** through new models of care. The newly established Wessex Primary and Community Learning and Development Hubs will ensure a supply of qualified staff, equipped with the skills and experience to work in primary care teams by extending the breadth of training in primary care.
  - **Increasing the support available to our carers and volunteers**, by identifying the 10% that deliver unpaid care, so we can provide them with education and training, and support through schemes such as Shared Lives and drive closer collaboration between community services and voluntary services to improve the quality of our carers' lives and their capacity to continue to deliver care.
- We recognise that we need to make **health and care careers more attractive** to address the shortages in workforce. We will bridge the information gap so that young people are aware and enthused about the job opportunities health and social care has to offer. We will continue to build and improve on the work experience offered in our organisations and look to widen the scope of those considering a role in health and social care by working with communities to support those currently farthest from the labour market. We will develop a clear career pathway which enables people to fully develop and work to their potential from apprenticeships through to consultant practitioners, which will also be strengthened through new and extended roles. We will also ensure the whole system works more efficiently by developing new public/private partnerships for employment and career development across health and social care.
- We will take a more consolidated approach to staffing, by developing **one HIOW approach to staffing** by developing a flexible workforce which works across geographical boundaries enabled through standardised employment contracts, which will enable the rationalisation and effective deployment of specialist skills across current organisations and decrease the use of agency workers through the creation of HIOW concordat.

6.9 Simplified access point to health and care services

- Through an **enhanced telephony and digital infrastructure,** we will enable people to obtain the information and support that they need and provide simpler access to our health and care system. This approach will be critical in helping local care systems rise to the challenge of growing numbers of residents who are frail or living with multiple co-morbidities, helping people to self-manage.

- We will offer the equivalent of a '**satnav**' for local care systems that will enable people to identify and access the care that they need via simplified access to 111, digital applications and websites. This will involve using expertise of other teams to provide enhanced assessment to help people to navigate the care system and access the relevant services.



- Initially, we will focus on **streamlining access to urgent and emergency care services**. One of the first steps will be to create an integrated service model between the NHS111 and GP out of hours services on the mainland, in line with the Keogh recommendations. On the island, we already have an integrated clinical hub which enables a multi-disciplinary assessment and response to 999, 111 and out of hours GP calls.

56% of people said they knew who to contact when they required out-of-hours care

- We will improve the interface with the local hubs, provider alliances and other sectors, enabling access to a wider range of experts and **senior decision makers.** Some will be **co-located with 999 and 111 services** (such as GPs, midwives and mental health advisors), whilst others will be **accessed remotely via telephone or video links**. This will enable us to draw upon a range of expertise when assessing someone's needs and to directly access relevant services (rather than having to refer to primary care for onward referral), which will ensure that the system is more streamlined for people to navigate.

Providing tailored support for children needing to access health services

Children make up over 25% of emergency attendances, and parents tell us that they are unsure how to navigate the urgent and emergency care system. By providing more seamless and person-centred care for children at the point they need to access 999 and 111 services, we may be able to prevent unnecessary emergency attendances for children, and ensure that children are treated in the most appropriate setting.

- We will also continue to build links with a wide range of other **agencies**, including third sector as well as public sector partners such as Social Services, Police, Citizens Advice Bureau and Samaritans.
- In future, we may explore extending this integrated model to **all health and social care** in response to any physical, mental health and social care need.

6.10 We will build a strong digital infrastructure to underpin the successful delivery of our priorities in prevention, new models of care and acute physical and mental health services

In order to deliver the scale of transformation set out in this STP, we will need to invest in digital and technology across the footprint, along with the associated change management required to fully embed new systems, processes and ways of working. Whilst the HIOW system has some notable achievements in the digital and technology domain, not least the establishment of the Hampshire Health Record, we must go further and faster in our digital transformation, in order to realise the anticipated benefits of:

- Reduced routine and unplanned demand on clinical time, freeing resource for pro-active population and risked based care.
- Better integrated services around the person.
- Reduced demand for the estate and physical assets which in combination with other efficiency initiatives will lead to a reduction in the size and cost of the portfolio.
- Enablement of patients and service users to take ownership of their own care.

This will require investment from the system to create:

- A way of developing and managing integrated records and interoperability.
- The means of analysing and making data available at the point of care using linked primary care data.
- A telephony and web based solution to simplify access to care and foster a culture of self-management.
- The systems required to deliver our new models of care and the acute priorities outlined above.

Our digital roadmap is outlined in appendix 5.

6.11 We will adapt commissioning to create the right environment for transformational change across HIOW:

Commissioners are committed to creating the environment and ensuring the delivery of the transformation priorities set out in the STP.

- We will orientate our commissioning activities according to the tier model set out on page 4 within our vision.
- An immediate priority is the closer integration of health and care commissioning around place, and the alignment of local commissioning pounds accelerating place based solutions for the local population. This is already well developed across the Isle of Wight, Portsmouth and Southampton. The five CCGs in Hampshire have committed to work together in a single and consistent approach with Hampshire County Council. An outcome of this work will be the achievement of the significant growth in personal health budgets as set out in the individual organisations' planning frameworks.
- The five Hampshire CCGs have also agreed that they will work together to make a step change in prevention across Hampshire, developing a shared financial strategy and developing a shared view and plan for strategic commissioning to reflect the changing role of CCGs as we pursue new care models such as MCPs and PACs. The immediate next step is to determine how CCG leaders should re-align themselves and their organisations to lead this work as more business is undertaken together over summer 2016.

At an STP level we will:

- Develop a common approach to competition and collaboration including a framework for determining the benefits of market procurement.
- Work together systematically to better plan and commission acute secondary and tertiary care (for physical and mental health) for the whole HIOW population. The focus of this work will include setting common quality and outcomes standards and creating the environment through which alliances of providers can work collaboratively to reduce cost, improve outcomes and address sustainability. There will be a single set of commissioning intentions for acute physical and mental health services for 2017/18.
- Have far greater involvement in specialised commissioning with a view to move to a system of joint commissioning. Delivering change and savings in specialised services is a critical part of our STP. As a first step we have agreed with NHS England to appoint a Director of Specialised Commissioning who will work between NHS, HIOW and the BOB footprint.
- The commissioning system will collectively draw in the strategic clinical networks and emerging clinical fora (including the cancer network, the HIOW frailty forum, the urgent and

emergency care network), and use these as the clinically led vehicles for establishing quality and outcomes standards for the HIOW population.

- All commissioners are intent on developing outcome based contracts with scaled new models of care. At an STP we will share learning of the back of piloting the new MCP contract for Better Local Care MCP in 17/18, and the PACS contract in NE Hampshire.
- We will collectively review our commissioning support requirements in the light of the move towards outcome based contracts and the partnership with local authorities.

6.12 Estates

Partners across the STP have come together to develop an Estates Enabling Plan (EEP), a draft of which is included at Appendix 6. The main impetus and focus for estates work will be at a local, place based level where much is already happening to optimise and develop assets. There is a strong consensus across organisations that flexible use of the NHS and wider public sector estate is a central enabler to establishing new models of care while delivering operational efficiencies and reduced costs. The estates work is initially being driven by the model of integration and will subsequently be refined to reflect the clinical needs that will emerge from the acute workstream.

One issue that we will seek to address are the challenges with NHS Property Services, who lack the incentive and alignment to the local transformation plan, and as a result we want see the return of key assets to ensure delivery of our transformation priorities.

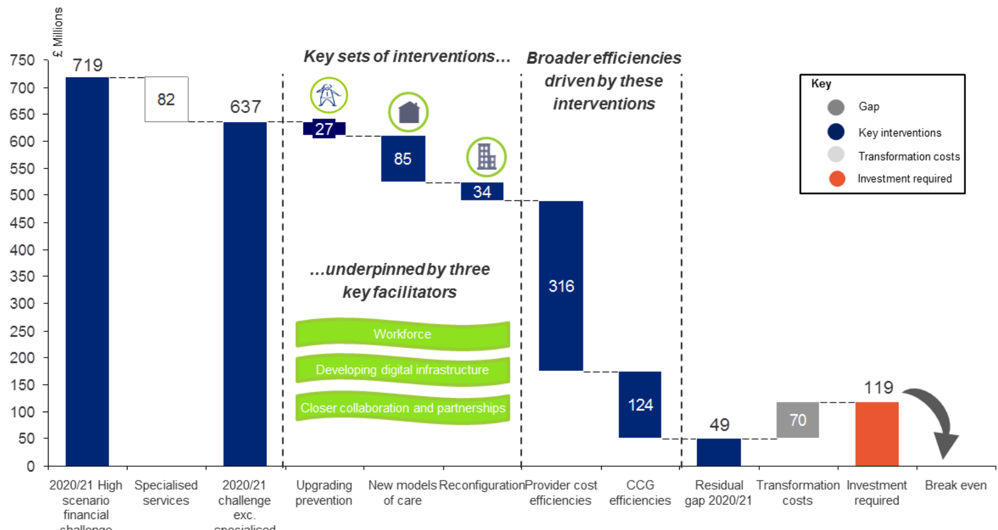
7 FINANCIAL PLAN

7.1 HIOW solutions to address the challenges

The scale of the financial gap by 2020/21 in a do nothing scenario, (£719m) means that it will not be possible to close the forecast financial gap through marginal improvements. This is why the interventions identified are radical and ambitious – because only by tackling these will we unlock further efficiencies.

Collectively HIOW will focus on cost reduction and targeting resource where we will get best value. This means that we will strive for top quartile efficiency and productivity, and as a minimum we will contain existing acute spend. However, our ambition is to reduce this to allow us to shift investment into primary care and prevention. This will be supported by acute reconfiguration, streamlined commissioning and working collectively on cost reduction and risk management, supported by an improved alignment of incentives across the system. Through this strategy we anticipate we will improve our financial position, meet the required national standards and address deliver clinical and financial sustainability.

Through radical ways of working we have modelled a scenario that closes our financial gap by 2020/21. Fundamental to this is that large scale commissioner and provider efficiency can only be unlocked if we transform our health and care services to work differently. Even with this programme of radical transformation, it is estimated that the investment required to break even in 2020/21 is £119m – comprising £69m to cover the cost of transformation and £50m for a residual gap in funding. The chart below summarises the impact of the projected savings as a proportion of the forecast financial challenge in 2020/21:

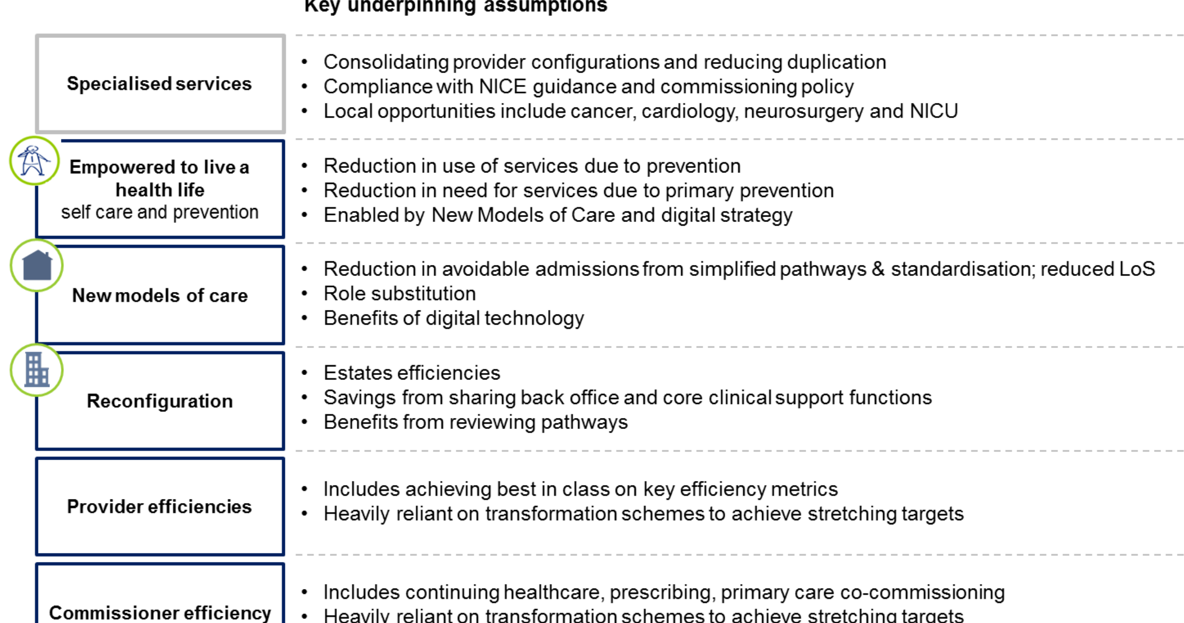


Whilst the largest savings are in provider and CCG cost efficiencies, the delivery of these savings is dependent on the transformation priorities that we have identified. Using information from organisational plans that are already underway in the system, benchmarking and national case studies, the financial impact of each of our priorities has been assessed to provide a 'top down' view of the potential impact of our plans. Whilst some of these plans are already underway, such as Vanguards, in other areas, more detailed implementation plans are required. The table below outlines the activity assumptions that underpin our strategy:

5 – year activity growth

	AE	NEL-IP	NEL-DC	EL-IP	EL-DC	OPFA	OPFU	OPROC	MH-IP	CHS-IP
Activity growth	11.8%	11.7%	11.7%	10.7%	10.7%	20.5%	20.5%	20.5%	9.9%	18.0%
Less activity reduction from actions										
Net growth	***-2.5%***	***-7.3%***	***-7.3%***	***-2.1%***	***-2.1%***	***4.3%***	***4.8%***	***6.1%***	***1.9%***	***9.4%***

The table below outlines the key assumptions that have been modelled as our solutions:



7.2 Investment and support required

These plans require significant capital and revenue support, as well as funding to cover the cost of transformation. As set out above, it is estimated that £119m additional funding would allow us to activate our transformation priorities and close the financial gap (excluding capital investments). There are four forms of financial investment that HIOW will require to successfully deliver the interventions set out above:

1. **Delivering local and national priorities:** a significant proportion of the investment we require will be to support local and national priorities such as the delivery of A&E standards, 7 day services, the GP 5 year forward view, Mental Health taskforce, Cancer taskforce, local digital roadmap, tackling childhood obesity and improving diabetes diagnosis.
2. **Capital investment requirements**. The operating model we are planning to move to requires capital investment in certain assets – and there is a possibility that access to capital funding, or lack thereof, could be a limiting factor on the transformation plans. The options for change will continue to take this into account. More detailed work is required to understand the capital implications, but capital investment requirements could include (but are not limited to):
    a. Investment to support new models of care.
    b. Investment to enable acute reconfiguration and in particular now we see the scale of ambition over sharing back-office / clinical support functions. Each one of these will need significant investment to make it work (e.g. common IT systems, estates changes).
    c. Investment in technological capital assets, to support the use of digital channels as a means of empowering patients and reducing primary care activity.
3. **Transitional costs.** Our transformation will require investment upfront to fund double running costs during transition (on staff and estates), and implementation support to ensure that the changes are properly managed. Early investment in transformation schemes is required to enable the system to fundamentally redesign care with the emphasis on patient activation, intelligence driven care and early intervention with less reliance on secondary care.
4. **Additional revenue investment**. Change cannot be delivered, and delivered well, overnight – but needs to be phased in over time to be properly embedded, and ensure effective implementation. Support is required to manage the continued deficit over the period between now and 2020/21, as the gap is gradually closed. To deliver financial balance by 20/21, funding from the STF will be required to achieve financial balance. By 2020/21 we estimate that £50m of the STF will be required to close a residual financial gap. Each intervening year will also require

funding to achieve in year balance for HIOW. The in year support required number will be dependent on achieving the savings profile, but is currently estimated as:

	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m
STP funding to deliver local and national priorities:					
Non Recurrent	9.4	5.8	5.1	4.2	
Recurrent investment		36.5	49.5	69.3	70.0
Additional revenue investment (sustainability)	43.2	30.8	51.2	44.3	49.0
Total STP Funding required	**£52.6**	**£73.1**	**£105.8**	**£117.8**	**£119.0**

7.3 Increased collaboration to deliver transformational change

Further to the specific interventions which will help to close the financial gap, our future financial sustainability will only be a reality by working together collaboratively, with a relentless focus on overall cost reduction across HIOW. This will require a commitment to work together in the overall interest of financial sustainability rather than in organisational silos or shunting cost across the system, and to develop aligned planning processes and investment decisions. In light of this we are exploring the benefits of a system control total. We will also need to strengthen links with social care and improve our joint planning processes with our local authorities.

As part of this we will review and implement current contracting and payment mechanisms to align outcomes, metrics and financial incentives to support optimum patient outcomes and financial stability.

7.4 Finance delivery risks

The interventions will be phased over five years, taking us gradually to a sustainable financial position by 2020/21; however it should be noted that there are considerable delivery risks associated with this, as outlined below

Risk	Risk	Potential Mitigation
2016/17 has challenging efficiency and QIPP plans, if these aren't delivered this will undermine the delivery of future plan.		Individual organisation focus on delivering schemes, supported by a new approach to working collectively
The complexity and extent of transformation may not be quick or radical enough to address the financial challenge or deliver the level of savings expected		We will develop more detailed plans which are proactively managed with senior leadership through to delivery.
Capital funding constraints may compromise the deliverability of digital technology and estates plans and ability to release savings		Bid for capital funding, liaise with NHSI regarding capital opportunities and explore other financing options
In the short term, increases in capacity may be required which have a step cost change not reflected in the financial plan		Develop more detailed activity and capacity plans for H&IOW to highlight pressure points and explore more cost effective solutions.
Challenges of cost effective service configuration on an island within current resources		Acute alliance will maximise use of resources, reduce duplication & costs
Acute trust configuration still to be agreed, which could have a significant impact on financial modelling and future financial position.		Ensure future acute configuration plans to only be agreed if they are affordable within the STP.
Joint planning with specialised is not strong enough to address the specialised financial gap		Formalise engagement and planning process
Centrally mandated cost pressure assumptions do not reflect true increases in cost over the term of the plan		Frequent review of assumptions early planning to address any differences
System infrastructure, including alignment of outcomes and financial incentives, does not match needs of STP in short term		Urgent review and agreement of support required

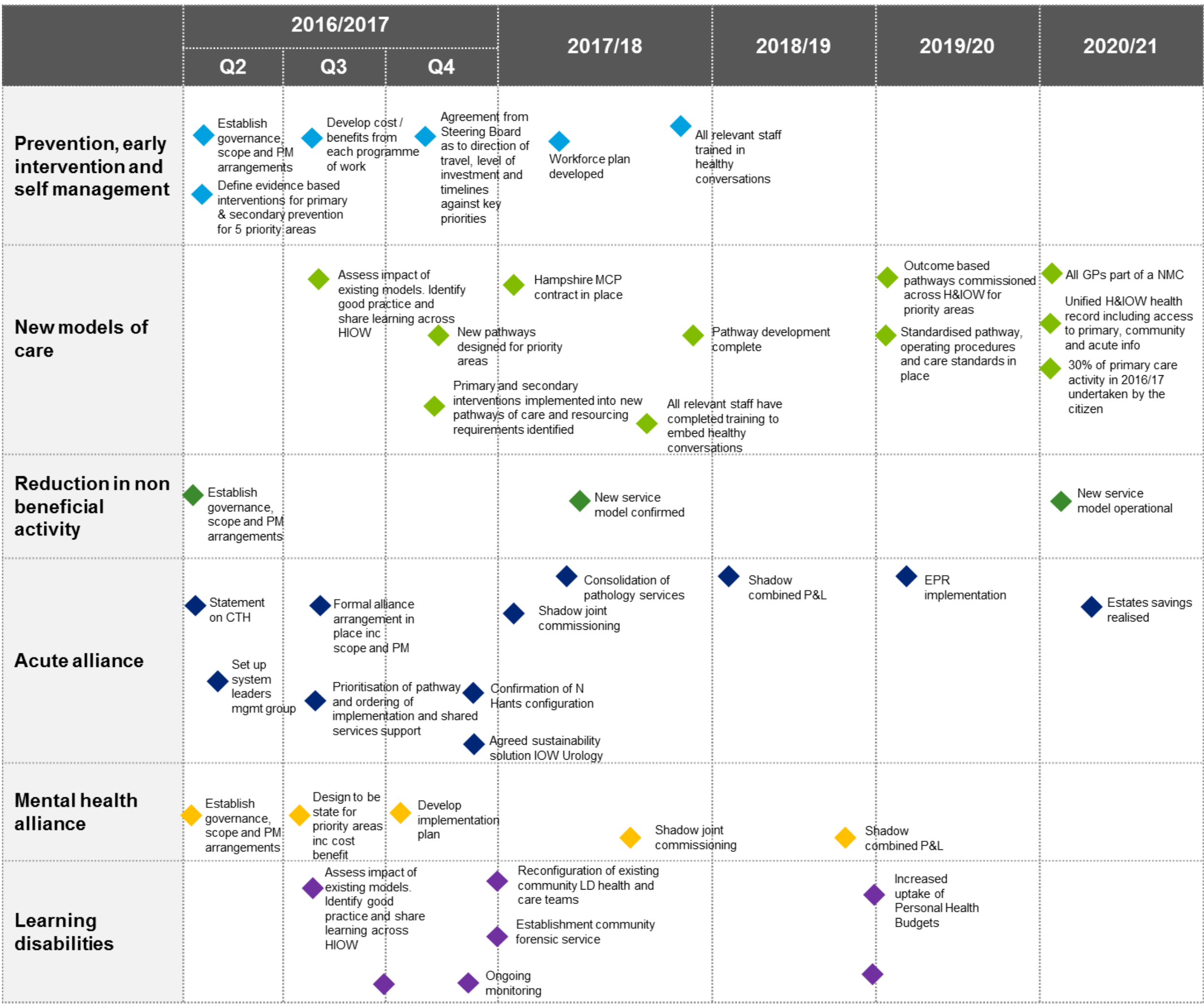
8 IMPLEMENTATION ROADMAP

8.1 How the STP partnership will work in practice

We recognise that we are on a transformation journey, and given the timescales of the STP, although we have a collective vision for health and care in HIOW, our plan is still in development. We have some tough decisions to make in HIOW. Before we address these decisions, more work is required to scope the opportunities we have identified. As a result we acknowledge that over the next 3-6 months we will need to establish the ongoing role and governance of the STP and further refine and develop our priorities.

The milestones below set out indicative timings for each of our priority areas. Whilst these are likely to change as the work streams are further developed and refined, these milestones demonstrate what our plan is predicated on at present. As we refine our plan between July and September this year, this will be a key area of focus, to further refine and agree the end state for each of our transformation priorities.

Whilst we have arranged our milestones into work streams, we acknowledge the interdependencies between them and also with the capabilities and as such there will be regular checkpoints between work streams.



Between July and September 2016 we will continue with our existing governance structure which is based on a model of collective leadership by the accountable leaders. The STP Steering Board includes all the health and care organisations across HIOW, with both clinical and managerial representation, and has been the key forum through which the content of the plan has been refined. This forum will continue whilst we explore the most appropriate leadership and

governance arrangements that will support both local and HIOW wide delivery at scale. Our key next steps for defining the ongoing governance of the STP are outlined below:

STP Chair – Karen Baker (CEO, Isle of Wight NHS Trust), STP Programme Director – Richard Samuel (CEO, Fareham and Gosport CCG, NHS South Eastern Hampshire CCG)

Workstream	Next Steps	By when
Governance and leadership of the STP	**System Development**	
	Implement system leadership development days to focus on building relationships, discussing key issues and developing and agreeing future leadership and governance arrangements	July – September 2016
	Governance and Leadership	
	1. Use development days to determine system leadership, STP delivery model arrangements and resource requirements	June – September 2016
	2. Agree future governance, leadership arrangements and delivery model arrangements at STP Steering Board	By end September 2016
	3. New STP governance arrangements live	1 October 2016
	Resourcing	
	Agree and implement resourcing plan & model to support delivery	By end July 2016

We expect significant clinical and management resource to be required to deliver our priorities, and we acknowledge this cannot be done within existing roles. All Chief Executives in our STP have committed to giving at least 1 day per fortnight to the STP. For the transition period between July through to October, the HIOW leadership community have supported the leadership arrangements outlined below. Each priority area has been assigned a Chief Officer Sponsor and a Senior Responsible Officer (clinical where appropriate), who will oversee the delivery of our change programme.

Below we list the leadership arrangements and immediate actions for each priority area that will allow us to firm up our plan, and move into implementation planning. This will include ensuring the governance for each area is robust including the refinement of subgroups, agreeing the precise scope and focus areas of work, doing a detailed cost benefit analysis of all interventions, and where possible defining an operational blueprint for the changes we are proposing. Our work stream structure at present follows our key priorities:

Chief Officer Sponsor – Richard Samuel (HIOW STP Leader), Senior Responsible Officer - Janet Maxwell (Director of Public Health, Portsmouth City Council)

Workstream	Next Steps	Due by:
Prevention, early intervention, self-management	Confirm governance for the prevention workstream and agree required resources	July 2016
	Building on the current vision define scope of prevention programme	August 2016
	Develop cost benefits for each programme of work	September 2016
	Agree quick wins and develop plans to enact these	October 2016

Chief Officer Sponsor - Katrina Percy (CEO, Southern Health NHS Foundation Trust), Senior Responsible Officer – Interim arrangements whilst GP appointed

Workstream	Next Steps	By when
New models of care	1. Confirm governance arrangements including updating the scope, defining membership and authority, and depict clear governance structure (including any sub groups), with the aim of design the roadmap for delivering the STP priorities and implementing NMC at scale across HIOW	July 2016

	2. Continue deploying place based care models already in existence and report back on impact to the Task and Finish Programme Group. Identify good practice and share learning across HIOW	September 2016
	3. Create clinical working groups to standardised pathways and create common care standards for priority areas (cancer, respiratory, mental health, diabetes, frailty, and end of life care) to include prevention (primary and secondary), primary, community and acute	September 2016
	4. Initiate pathway development and start to define future state	September 2016
	5. Map current state/pathways for priority areas	December 2016
	6. Define costing and contracting framework options (outline the current cost and money flows, options to achieve required money flexibility, develop cost model, calculate ROI, outcomes based contracting models)	December 2016
	7. Develop outline implementation plan	October 2016
	8. Develop options for risk sharing frameworks	December 2016
	9. Identify benefits and cost analysis to support verification of top-down STP financial assumptions	December 2016
	10. Sign off from STP steering board	December 2016

Chief Officer Sponsor – John Richards (Chief Officer Southampton City CCG), Senior Responsible Officer – SROs from prevention, community and acute work streams

Workstream	Next Steps	By when
Reduction of non beneficial steps of care	1. Convene task and finish group to specify what is meant by 'delayering' and to propose a simple governance structure (acute, community and primary care) and agree resourcing the programme	August 2016
	2. Agree priority specialties/pathways	September 2016
	3. Map the 'as is' state identifying key inefficiencies, barriers, non-beneficial activity	October 2016 – March 2017 sequentially
	4. Design the 'to be' state	November 2016 – April 2017 sequentially

Chief Officer Sponsor – Karen Baker (CEO, Isle of Wight NHS Trust), Senior Responsible Officer – Derek Sandeman (Medical Director, University Hospitals Southampton NHS Foundation Trust)

Workstream	Next Steps	By when
Alliance of acute providers	1. Confirm initial membership of the alliance (excludes HHFT at this stage – and will remain on hold until Dec 2016 – see above)	December 2016
	2. Design and approve Alliance governance arrangements and agree required resources	June 2016
	3. Opportunity assessment to understand which pathways/specialties have the greatest opportunities to reduce unwarranted variation	August 2016
	4. Initiate work streams Clinical strategy, IT strategy, IOW integration – U&E care, Elective care, Pathology, Radiology, Pharmacy, Back office functions	September 2016
	5. Strategic outline business case for financial and clinical benefits	September 2016
	6. Determine whether there is a requirement for formal consultation (esp. with regard to IOW)	December 2016
	7. Develop a detailed implementation plan	December 2016

The resolution of the CTH will progress in parallel with an acute services review that will be commissioned by West Hampshire CCG and North Hampshire CCG with a separate governance structure.

Chief Officer Sponsor – Sue Harriman (CEO Solent NHS Trust), Senior Responsible Officer – Lesley Stevens, (Medical Director, Southern Health NHS FT)

Workstream	Next Steps	By when
Alliance of mental health providers	1. Confirm governance for the mental health alliance work stream including how tertiary mental health will be managed vs. the broader alliance, and which services will be included in the tertiary work stream	July 2016
	2. Opportunity assessment to identify key focus areas, including whether CMHTs are in scope of this programme of work and how this will interact with new models of care	September 2016
	3. Develop implementation plan	December 2016

Chief Officer Sponsor – Heather Hauschild (Chief Officer, West Hampshire CCG), Senior Responsible Officer – Lesley Stevens (Medical Director Southern Health NHS FT)

Workstream	Next Steps	By when
Learning disabilities	1. Review the impact of the Transforming Care Partnership Programme	September 2016
	2. Refine model accordingly and continue to track progress	December 2016

Chief Office Sponsor – Sue Harriman (CEO, Solent NHS Trust), Senior Responsible Officer – Ruth Monger (Health Education England)

Workstream	Next Steps	By when
Workforce	1. The newly established HIOW Local Workforce Action Board (LWAB) will be formally established as part of the HIOW STP and Health Education England – Wessex structures and will be the vehicle through which local health and social care partners are brought together to discuss and action workforce issues facing the health and social care system.	September 2016
	2. Primary Care Learning Environment Leads will be recruited to the newly established Wessex Primary and Community Learning and Development Hubs. These appointments will be critical extending the breadth of training in primary care settings.	October 2016

Chief Officer Sponsor – Richard Samuel (STP leader), Senior Responsible Officer – Isabel Wroe

The plan for a simplified access point to health and care will be developed after review in July of whether a competitive procurement or collaborative partnership is the better way forward".

Chief Officer Sponsor – Roshan Patel (Chief Finance Officer North East Hampshire & Farnham CCG), Senior Responsible Officer – Mark Smith

Workstream	Next Steps	By when
Digital infrastructure	1. Confirm governance to deliver on the digital roadmap	July 2016
	2. Strategic Outline Case for digital investment plans	September 2016
	3. Secure investment funding and implement as appropriate	December 2016

Chief Officer Sponsor – Jim Hogan (Chief Officer Portsmouth CCG)

Workstream	Next Steps	By when

Commissioning		
Commissioning	1. Confirm governance arrangements, scope of commissioning work stream	July 2016
	2. Appoint a Director of Specialised Commissioning (HIOW, BOB)	July 2016
	3. Review current MCP / PACS models and define principles for outcomes based contracts	October 2016
	4. Develop a common set of commissioning intentions for acute physical and mental health services for 2017/18	October 2016
	5. Sign off commissioning strategies	December 2016

8.2 Implementation Risks

Category	Description	Consequence	Risk	Mitigation
Governance	There is a risk that lack of formal decision making powers at the Steering Board may limit the ability to progress at pace	It will not be possible to deliver transformation at the pace required		Agree Steering Board reporting lines to constituent statutory bodies and process for Steering Board members to take decisions back through their boards
Delivery	There is a risk that operational pressures mean that partners are not able to devote time, attention and energy to transformation	Requirements of the STP are not met and financial problem worsens		SROs have been appointed for each workstream and management time will be released for the STP
Finance	There is a risk that we will not deliver 16/17 cost efficiencies	It will not be possible to deliver what is set out in the STP		Individual organisation focus on delivering schemes, supported by a new approach to working collectively
Stakeholders	Organisations are not in agreement regarding the scope of collaboration / pooling resources across the STP	It is not possible to deliver the transformation set out in the STP		Leadership community development programme to agree a robust governance structure for the STP
Delivery	There is a risk that the vision is too ambitious	It is not possible to deliver what is set out in the STP		Between July and September, we will continue to scope and prioritise our ambition
Digital	There is risk that we will not achieve the data integration required to deliver these changes	It is not possible to deliver what is set out in the STP		The Digital workstream will work at an STP wide level to support this
Finance	There is a risk that we will not get access to STF quickly enough to deliver to STP timelines	It will not be possible to deliver transformation at the pace required		Finance workstream is working to plan investment across the system
Delivery	There is a risk that we do not get engagement and co-production right and fail to design services around people's needs	The transformation programme will be unsuccessful		Public and patient engagement plan being developed – all proposals to be coproduced
Delivery	There is a risk that we fail to change the relationship between the public sector and the public	It will not be possible to deliver the ambition set out in the STP		Public and patient engagement plan being developed – all proposals to be coproduced

8.3 National support required

As a health and care leadership community we have a clear vision of what we want to achieve at both a local and pan-HIOW level and we have most of the tools to realise this vision. There are, however, six 'asks' of the Tri-partite and arm's length bodies:

1. **Estates:** We would like to explore options around the use of a Special Purpose Vehicle structure to maximise value from public estate, which could, where appropriate build on existing mechanisms within the system (e.g. Hampshire LIFT). This may include:
    - Gain share arrangements and ways to increase Trusts' incentives to dispose of unused or derive value from underused assets.
    - Review of the shareholding in Hampshire LIFT with a view to increasing the local stake and alignment with transformation drivers.
    - The managed transition of the current non-surplus primary and community care estate currently owned by NHS Property Services into the vehicle.
2. **Pharma:** We would like to explore with the centre how we develop a new shared approach to care of people with long term conditions where the STP and the pharmaceutical industry operate as health and care partners. This would include moving from a cost per item based payment structure to one of working together to support our people to get more from their medicines, sharing risks and outcome-based rewards.
3. **Competition and Collaboration:** We intend to build a more developed model of competition and collaboration, and we would ask that a common national view is taken about how our providers can form more integrated partnerships and new care models without falling foul of the competition regulators. For example, national advice on developments such as prime contractor models or federations in primary care would be beneficial.
4. **Digital and Intelligence:** We need the centre to develop an effective information governance framework that fosters an innovative and agile approach to shared integrated data, supporting all the partner organisations. A shared view of the end user is fundamental pre-requisite to transforming the outcomes for citizens at scale. Without this integrated person centred approach to data sharing, effective care cannot be realised.
5. **Changing pathways:** We have some bold ambitions to simplify our current approach to care and remove unnecessary steps in care pathways. We would ask that we are supported with adaptions to national counting and monitoring arrangements when we propose making changes to national mandates, such as the 14 day cancer waits target. For example, if we want to enable citizens to self-refer to a secondary care one stop clinic without a GP referral to trigger the clock start, then we would need to work with NHS England to find a way to measure and monitor standards appropriately.
6. **Clinical Education and Training:** To support closer integration of long-term condition management within multi- disciplinary teams by bringing specialist and generalist clinicians together, we would welcome national bodies' support in exploring how the training requirements for doctors' could be better aligned to emerging models of care.
7. **Financial:** In order to deliver our STP and achieve financial balance by 2020/21, we have provided an initial assessment of the financial support required. This includes non-recurrent support of £5m per year from STP funding to cover double-running costs, staff training, travel and pay protection and implementation support such as a programme management function. We also require recurrent STP funding to implement local and national priorities – building up from £37m in 2017/18 to £70m by 2020/21. This includes areas to improve care and quality such as 7-day services, extending GP access, investing in the prevention programme, supporting the Local Digital Roadmap and investments linked to national Cancer and Mental Health taskforces. In addition we require system sustainability funding, utilising STP funding to support the overall financial position each year and totalling £49m by 2020/21. Capital investment will inevitably be required to deliver our work programmes around estates, acute reconfiguration and GP extended hours. We will require a level of support from the centre in addition to capital sourced by provider finance initiatives.

9 APPENDIX 1: GOVERNANCE

9.1 Governance arrangements

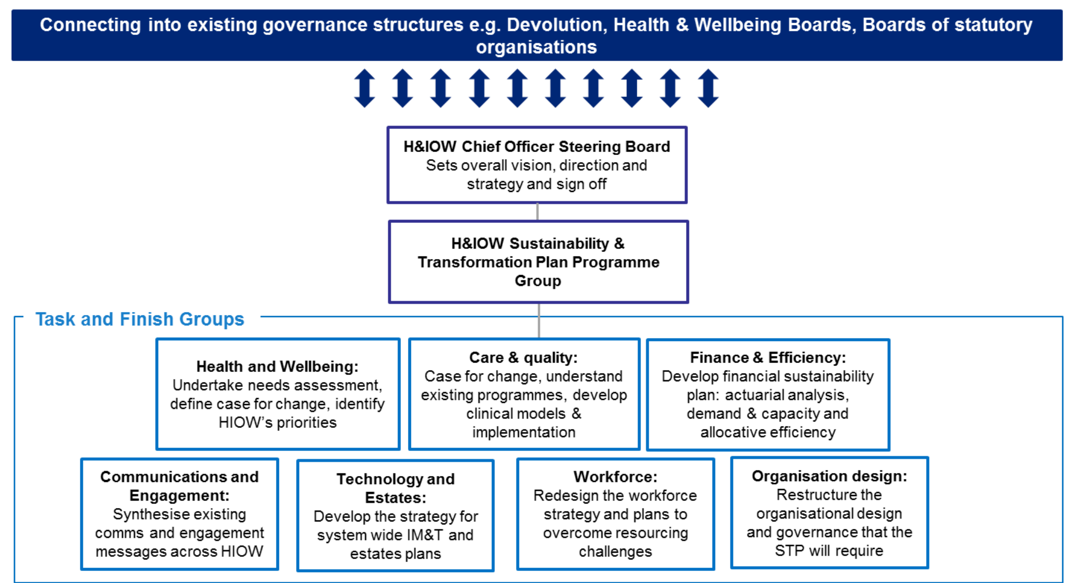
Structure, effective decision making, system leadership

There are good examples of effective collaborative working between health and care organisations within the HIOW STP footprint on which to build.

Arrangements January – June 2016

Over the last few months, leaders across the system have worked hard to quickly build and develop strong relationships with partners across the whole STP footprint to support the development of an ambitious transformational plan for the population that goes beyond local geographies.

A model of collective leadership has been implemented (see below) by the accountable leaders. The STP Steering Board includes all the health and care organisations across HIOW, with both clinical and managerial representation, and has been the key forum through which the content of the plan has been discussed and refined and the challenge given to increase the level of ambition of for the future of the health and care system. The members of the Steering Board have responsibility for constructively challenging each other to ensure each partner plays their part. Richard Samuel, Accountable Officer for South Eastern Hampshire and Fareham and Gosport CCGs has been seconded as the STP Leader to drive the development of the plan.



During the last few months a series of 'hot house' events have been held with the system leaders to discuss the 'wicked' issues and to create a plan which has a high level of ambition and will transform the system in a way not yet achieved for the population of HIOW.

Interim arrangements June – October 2016

These are the early stages of a journey which the leadership are committed to implementing and recognise that the next phase of the STP needs a robust arrangement to ensure delivery at pace of both local and larger scale plans. This will take continued building of high levels of trust and challenge to address complex issues and break down organisational boundaries both at a strategic leadership and operational level. A programme of development support is being rapidly designed to strengthen the leadership team. As part of this programme, there is agreement to explore the most appropriate leadership and governance arrangements that will support both local and delivery at scale and will harness the skills and experience of the leaders and workforce across the system to lead, enable and deliver the changes set out in the plan. A programme of development support is being rapidly designed to strengthen the leadership team. As part of this

programme, there is agreement to explore the most appropriate leadership and governance arrangements that will support both local and delivery at scale and will harness the skills and experience of the leaders and workforce across the system to lead, enable and deliver the changes set out in the plan.

To do this effectively will take time and therefore to create the time and space required, the interim arrangements set out above will continue until September 2016. A plan is in place to ensure that leadership and governance arrangements are in place beyond this to support delivery over the medium term.

In order to deliver, effective leadership and empowerment of staff and clinicians from across organisations is essential. All need to be able to look outwards to places and partners rather than internally only.

As shown throughout this submission we are committed to a collective leadership approach and development As part of our enabling programme and our on-going commitment to leadership and organisational development - the NHS Thames Valley and Leadership Academy will lead this work steam to enable ongoing leadership development support and work with us to further develop our leadership and OD plan over the coming months.

The STP steering board members have committed to giving one day per fortnight to meet as a leadership group from the end of June to end of September 2016. This will provide sufficient resource to ensure that collective leadership and governance arrangements are ready to be implemented from 1 October 2016.

Work streams and delivery structure

Through the development of the STP, eight key works streams have been developed (see below). These will be used flexibly to change, remove or add work streams as the plan is implemented. For example, an HR work stream may need to be added as the work progresses and the impact on staff roles needs to be better defined and a change process implemented.

The work streams are being led by experienced clinical leaders and supported by appropriate management and admin resource, with a CEO sponsor. The Clinical SRO will provide visible leadership on their respective work stream, and will undertake a 1-2 day per week commitment.

In addition to our priorities, we have developed a separate quality group that will be responsible for ensuring aligned, efficient and robust quality clinical governance arrangements to be embedded in transformation programmes.

Workstream	CEO sponsor	Clinical SRO
Prevention	Richard Samuel	Dr Janet Maxwell
New models of care	Katrina Percy	To be appointed
Reducing non beneficial steps of care	John Richards	All C&Q SROs
Provider acute alliance	Karen Baker	Dr Derek Sandeman
Mental Health alliance	Sue Harriman	Dr Lesley Stevens
Transforming Care	Heather Hauschild	Dr Lesley Stevens
Simplified access to health and care	Richard Samuel	Isabel Wroe
Commissioning	Dr Jim Hogan	
Finance and efficiency	Jo Gooch	Ian Howard
Quality		Julia Barton
Estates	Roshan Patel	Mark Smith
Technology	Roshan Patel	Mark Smith

The clinical SROs will come together to form a Clinical Reference Group which will meet regularly to ensure that the interdependencies and connectivity of the individual work streams are discussed.

A central admin office will continue to provide support to the Steering Board Chair, STP lead and Programme Director and will be responsible for arranging and servicing STP meetings and events.

Wherever possible, roles will be filled as secondments from partner organisations. Each organisation has commitment to providing resources to support the STP, and if not able to contribute in people, organisations will provide financial resource so that the cost of resource is shared across organisations.

10 APPENDIX 2: ENGAGEMENT

We have carried out considerable engagement on health and social care matters across HIOW and we will continue to use these channels to engage and consult with our people at a local level in order to deliver care that incorporates the changes they want to see.

We have undertaken engagement with stakeholders and key organisations by building a database of over 380 stakeholders and key organisations to ensure our regular updates are sent to providers, commissioners, lay members, local authorities, trust board representatives, local politicians, MPs, voluntary sector organisations, health networks and Healthwatch, along with more formal updates at Board meetings.

We have also hosted a series of engagement events across a variety of audiences:

Event	Date	Content	Attendees
Socialising the gap – the challenges	29 April	Informing people about the STP and what it is designed to do, and sharing and getting feedback on our key challenges and possible solutions Outcomes: ▪ 75% felt their knowledge level had increased by at least 20% ▪ 100% understood the purpose of the HIOW STP ▪ 100% thought the emerging priorities presented were correct	75 attendees Full Board invites (including executives and NEDS, Lay members, council officers and members, clinical network representatives etc.)
Leadership hot house 1	5-6 May	Bringing together of HIOW system leaders (Chairs, Chief Executives, Medical Directors) to seek to establish consensus about the vision and the priorities for HIOW	CEOs, Medical Directors and Chairs
Leadership hot house 2	7 June	Receiving and refining the emerging vision and priorities developed through the first Hot House and building a collective and common understanding of the way forward	CEOs, Chairs, Medical Directors, Directors of Finance

Engaging our Boards and partners

- Over the past few months we have kept Boards up to date with the progress of the STP via providing materials for and attended Board meetings and through the events we have held. We also send a newsletter to a mailing list of 360 people.
- We will engage more formally with boards and partners after the July conversations, by continuing to provide update materials with Governing Bodies, Trust Boards, Health and Wellbeing Boards, HOSP Select Committees, Healthwatch, Boards and Voluntary Sector Consortia in September and October.
- We are developing the next phase of our engagement plan for Boards and governing bodies to ensure that our partners and stakeholders are informed of our engagement process and messaging approach for communities and individuals.
- We are also holding a follow up event for our key partners including executives, NEDs lay members and council leaders that was originally planned for June but delayed due to Purdah restrictions.

Co-designing our plans with local people

- We will continue to use our existing channels within HIOW to engage and consult with local people to coproduce our plans. For example, we engaged extensively with the public in the development of West Hampshire's acute strategy through public events, focus groups and online questionnaire and involved the local population on the Isle of Wight to develop the new vision for My Life a Full Life, and all of us have been using our existing patient and public involvement networks to seek local views and input to our proposals.
- We will work with Healthwatch and other channels to **gather opinions and views on health and care services** through events, roadshows, focus groups, e-surveys and citizen panels which will **help us to identify groups and individuals with whom we will co-design and co-produce** our services across the footprint. We will build on the engagement already in place to support the Vanguard projects, but this will be widened to all areas of the footprint and scope of services of the STP.
- We are currently developing a plan for footprint-wide patient and public engagement, and will share these with our Health and Wellbeing Boards in the autumn.
- We will also **build on** already existing **local examples of co-production** that have developed new services within our communities – such as **the mental health drop-in café in North East Hampshire** and ensure learning around co-production is shared, with a view to establishing co-production principles and guidance for the HIOW STP area.
- We will develop a patient guide that clearly outlines the changes that we are proposing to health and care in HIOW.

Engaging our staff

- We will work with organisations to **engage staff in the STP process by developing staff engagement principles and materials** for our partners to deliver to their workforce teams. Regular STP updates for staff will be delivered through presentations and video updates on their intranets. It will be the responsibility of the member organisations to ensure that staff are kept up to date.
- We are also keen to engage GPs and will be holding **a GP event** in early Autumn to share the STP contents, programme of activity and five-year plan, focussing on the specific changes to their ways of working.
- In addition, we will continue to work with **our established Strategic Clinical Networks** around cancer, maternity, cardiovascular, diabetes, mental health, dementia trauma and paediatrics to share information and shape the implementation of our STP plan, to ensure the changes are reflecting demands in the health and care service.

9 APPENDIX 3: New Care Models

Better Local Care

Southern Hampshire Vanguard Multi-Specialty Community Provider

The multi-speciality community provider (MCP) programme involves 16 local NHS, local government and voluntary organisations to extend and redesign primary and community care across most of Hampshire. The MCP began with three early adopters – Gosport, South West New Forest and East Hampshire. Many of care models developed in the initial pilots are now being spread across Hampshire.

New model of care

1. **Extended Primary Care Teams.** Extended Primary Care Teams (EPCTs) are multi-disciplinary teams led by local GPs to proactively manage the population health of their community. Across all of our communities, clinicians from Southern Health NHS FT work together with primary care colleagues to provide support for patients in the community. For example, integrating practice and community teams means that patients with mild to moderate mental health can be supported directly in the community.

2. **Redesigning access to primary care.** Primary care 'hubs' will bring together GPs and other care professionals to provide extended access to primary care seven days a week. This could move up to 40% of individual patient contracts out of individual practices in to more comprehensive and multi-disciplinary hubs. A Same Day Access Service has already been developed at Gosport War Memorial Hospital to provide more extensive primary care services for patients. Building on this, GP practices are also coming together across the locality to provide primary care services with extended hours, including the Practice at Lymington Hosptial, providing 7 day access to primary care.

3. **Specialist support closer to home.** The programme aims to change the way consultants and GPs work together, enabling hospital clinicians to support plans for patients in the community and to enable primary care professionals to develop appropriate specialist skills and services locally. For example, GPs in Bordon New Town have been working with hospital consultants to bring services for diabetes and respiratory conditions closer to patients and into local surgeries. Better Local Care has also been working on a pilot with South Central Ambulance Service and care home staff to focus on the top 20 care homes in Hampshire who were high users of 999, to more effectively manage patients in the community.

4. **Prevention and self-management.** Enabling patients to be more in control of their own health will enable earlier diagnosis and treatment of any long-term conditions earlier. The vanguard programme also prioritises 'social prescribing' – using non-medical sources of support, usually delivered by local or voluntary services, for example volunteer 'surgery signposters' in Gosport, working with Gosport Voluntary Action.

Next steps

The organisations involved in the vanguard are currently exploring an accountable provider model, which would allow the organisations involved to remain independent but to be collectively accountable for the health and care outcomes of the population. The programme is also looking at new employment models for GPs, with the possibility of Southern Health NHS FT directly employing GPs in some areas in the future. The vanguard is also part of the national contracting pilot looking at outcomes based commissioning, which should be in place for the 2017/18 contracting round.

Better Care Southampton

Integrating health and care with the person in the centre

Initially developed under the Better Care Fund initiative, organisations in Southampton have come together to join up the way services are delivered across health and social care. The model is part of a collaboration between Southampton City Council, Southampton CCG, Solent NHS Trust, Southern Health Foundation Trust, University Hospitals Southampton and community and voluntary organisations, under the oversight of the Health and Wellbeing Board.

The Better Care strategy is currently being refreshed through the development of a whole system Blueprint and plans for 16/17 have been agreed.

New model of care

1. **Person centred coordinated care.** Six multi-disciplinary cluster teams have been set up to work on a seven day basis, providing proactive assessment and early intervention for patients most at risk of hospitalisation. These cluster teams are made up of healthcare professionals across both primary and secondary care, social care staff, housing workers and the voluntary sector.

2. **Integrated discharge, reablement and rehabilitation services.** Existing teams involved in rehabilitation/reablement across the city have been brought together to form an integrated service under a single management structure to provide a streamlined response to crisis and support timely discharge, with a greater focus on promoting and maintaining independence in people's own homes. Discharge planning will start at the point of admission or as soon as possible after stabilisation of a crisis and there will be a focus on reablement earlier in the patient's pathway to support speedier recovery. With a particular focus on addressing delayed transfers of care, organisations are also working to strengthen the interface between hospital and discharge teams with the community clusters to strengthen the "community pull" approach.

3. **Community solutions.** This work is aimed at developing local community assets and supporting people and families to find their solutions. Models are currently being piloted across the city, including falls exercise classes delivered by a consortium of voluntary sector partners and delivery of community navigation within clusters.

4. **Better supporting carers.** A carer's assessment and support services have been commissioned, with the aim of better supporting those who look after relatives/friends with long term conditions.

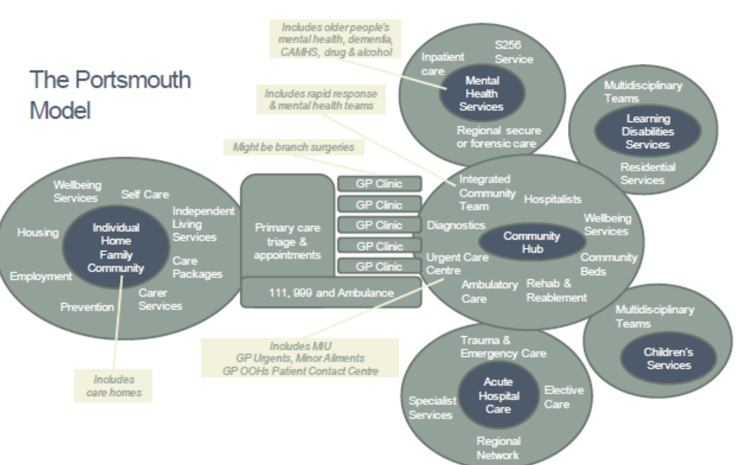
Next steps

Southampton is looking to build on the successes of the Better Care Fund and will be pooling over £100m of health and social care resource in 2016/17, going well above the minimum national requirement. Schemes for 2016/17 will focus on the extension of the Better Care Model to the working age adult client group (particularly targeting high/frequent users of health and social care)), further development of services to facilitate timely discharge, commissioning of prevention and early intervention activity and redesign of the care market, increasing the use and availability of extra care housing and developing the use of telehealth care.

Portsmouth Blueprint

A strategy for reconfiguring services in Portsmouth

During 2015, representatives from Portsmouth CCG, Portsmouth Council, Solent NHS Trust, Portsmouth NHS Trust and Portsmouth GP Alliance to developed a blueprint for collectively responding to the challenges facing health and care in the city.



New model of care

1. **Single Point of Access and Triage.** This will bring together 111 and out-of-hours services into a single point of access to ensure patients receive timely and appropriate care. The single point of access will also act as a triage service, pointing people in the direction of the most suitable health service available. This will move the 111 service away from a primary triage service based on clinical pathways to one which provides a person with the same level of service, regardless of whether it is by walking in or by telephone or online.

2. **Creating services to support independence.** Community hubs will be created, bringing together multi-disciplinary teams within the Single Point of Access and Triage to provide services for patients most at risk of hospitalisation. More specialist services will also be placed within the same localities as the community teams so that professionals have direct access to the services patients might need within the community, including ambulatory care, reablement, rehabilitation and diagnostic services.

3. **Reconfiguration of urgent and emergency care services.** Urgent care services will be based next to the locality community services and within community hubs, making it clearer for people were services can be accessed. Hospitals providing trauma and emergency medicine may also need to start working as networks so that local people can access the best of specialist hospital care elsewhere in the region to improve their outcomes, based on best available clinical evidence.

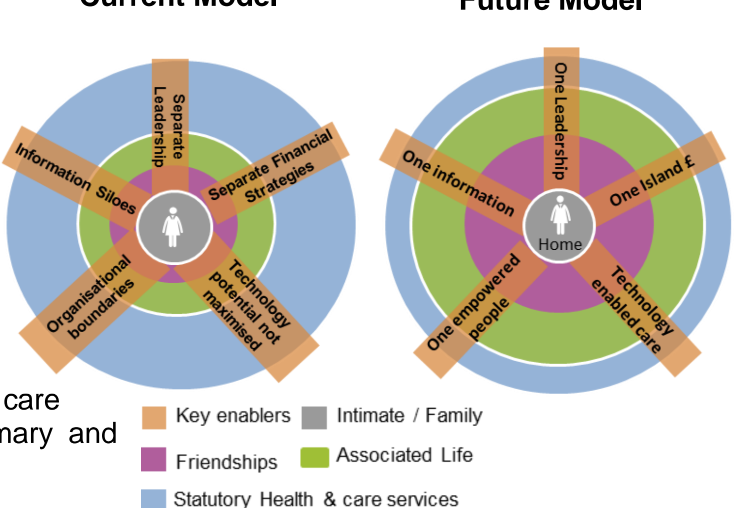
4. **Creating a different primary care service.** The GP will still be at the heart of primary care provision, but where possible practices will be integrated within the community hubs to provide comprehensive services, such as diagnostic tests, within the community. A ‘specialist primary care’ workforce will also be developed, enabling GP and other primary care staff to specialise in areas of interest and making more specialist skills available in the community.

Next steps

The scale and scope of change of this kind will require integrated working with Portsmouth’s wider STP footprint in Hampshire and the Isle of Wight. The Portsmouth Health and Care Executive, made up of key organisations within the city, are currently reviewing and agreeing the top level milestones for the first 18 month period, and specific priorities for the Executive will include pooled finances, risk shares, organisational forms and individual roles

My Life a Full Life

A primary and acute care systems vanguard for the Isle of Wight



Covering a population of 142,000, My Life a Full Life is a model of care for the Isle of Wight which brings together providers, commissioners and the voluntary sector in a more integrated and sustainable model. The programme has been accelerated under the Five Year Forward View new models of care initiative, and has been designated as a Primary and Acute Care Systems (PACS) vanguard.

New care model

The programme works to move away from the existing model, largely reliant on statutory services, and which provides unintegrated and disjointed care, towards a new model in which people will have greater involvement with their associate life. The new model will created by implementing:

- One leadership and one empowered workforce
- One information and technology enabled care, infrastructure and estates
- Strategic commissioning, contracting and shared financial strategies across the island
- Organisational integration and form
- Evaluation and measurement to facilitate wider roll out
- Communication, engagement and PMO to support implementation

The new model will focus on prevention and early intervention, integrated access, integrated localities and a whole system redesign, and includes a number of specific initiatives such as:

Integrated Hub and Crisis Response Team: This deploys resources in a targeted way for the individual following a 999 or 111 call instead a separate dispatch of an ambulance, social care and/or mental health professional to deal with different aspects of the emergency. Since April 2015, the crisis team has seen 922 patients, of which only 87 were admitted in to hospital.

Care navigators: The model has set up three integrated locality teams, made up of individuals from across health and social care organisations who are jointly responsible for care in the community, focusing on residential and nursing homes and general practices. The programme has developed the role of Care Navigators, supported by vanguard funding, to support the population over 50+ navigate the health and social care system - each Care Navigator should save up to £500 compared to the existing delivery model.

Next steps

Alongside these specific initiatives, the Isle of Wight is also engaged in a whole integrated system redesign throughout 2016/17 to understand how current services are delivered, the impact of redesigning services and how they should be delivered in future.

The programme is also looking at the future of strategic commissioning and contracting, and is currently exploring new contracting and organisational forms which might support whole system integration.

Happy, Healthy, at Home

North East Hampshire and Farnham vanguard programme

The Primary and Acute Care System (PACS) vanguard covers all primary care, hospital, community, mental health and social care for 220,000 people living in North East Hampshire and Farnham. It aims to both **change the way services are delivered** by integrating services and creates a new way for commissioners and providers to work together in an **accountable care system**, via a capitated budget.

New model of care

1. **A strengthened focus on self-care and prevention to support people to stay healthy**. The vanguard model focuses on expanding social prescribing within the community, developing recovery college courses to support those with long term conditions and providing support for carers. Since April 2016, 39 recovery colleges have been set up to deliver educational courses for those with long term conditions and the first of nine Healthy Living Pharmacies has been established, which will support pharmacies reduce inequalities within the local community.

2. **Enhanced primary and community care.** Patients will be able to benefit from extended access to urgent primary care, together with integrated multi-disciplinary teams of health and social care professionals. New primary care hubs will open in September in Farnham and Yateley, intended to provide tailored support those at greatest risk.

3. **Improved local access to specialist expertise and care.** The programme aims to redesign the interface between hospital and primary care so that patients with complex needs have better access to specialist services in the community. Alongside this, the programme has expanded its rapid community response service to increase capacity and reduce avoidable admissions. A pilot of GPs working in Frimley Park hospital is also working to help minimise delays in discharge.

4. **Investing in a shared care record across primary and social care.** This will provide GPs with access to the Hampshire health Record (HHR) by the end of summer 2016, and already provides clinicians in A&E and in the out of hours primary care service with real time information.

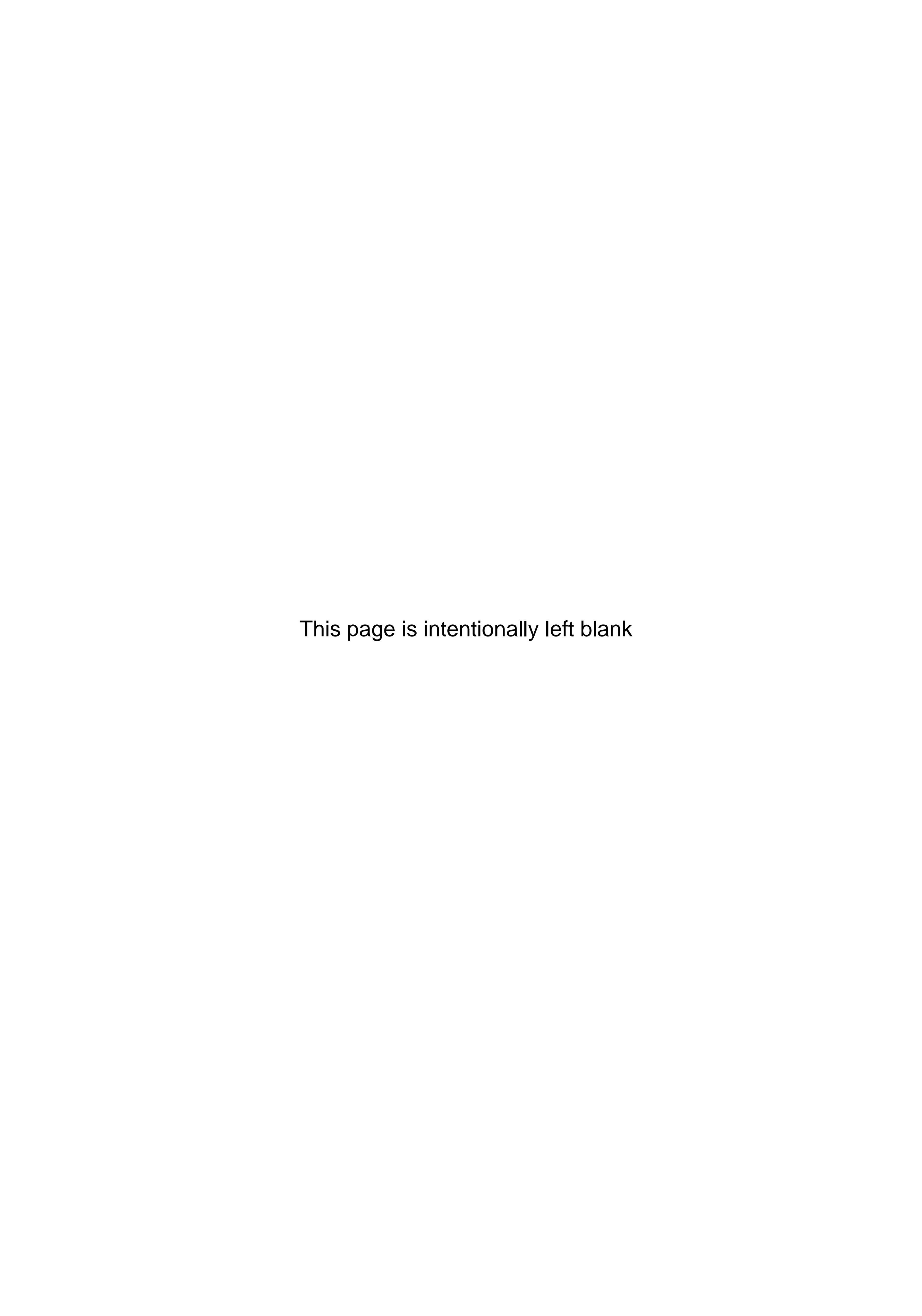
Underpinning the vanguard programme is the involvement of local people in the design of their services. 80 community ambassadors have been recruited, with plans to increase this number to 200 by March 2017.

Accountable care system

Commissioners and providers across NE Hampshire and Farnham are also coming together to create an accountable care system, which will be responsible for collectively delivering health and care across the community.

Next steps

The shadow board of the Accountable Care System will be meeting for the first time in September 2016. Work will also focus on extending the new model of enhanced primary and community care to all five localities in North East Hampshire and Farnham, appointing single team leaders for each Integrated Care Team, redesigning provision of specialist support to locality teams, and extending the scope of the shared care record.



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Hampshire & Isle of Wight Workforce Strategy

Workforce Strategy - Developing the Workforce of the Future

Our workforce is our greatest asset to deliver safe high-quality services to our population. This strategy sets out the overarching workforce framework to help partners establish the partnership and principles to develop the workforce that will deliver better care across Hampshire and the Isle of Wight (HIOW).

The strategy focusses on;

- The One Hampshire and Isle of Wight Workforce
- A Workforce Focussed on Prevention
- A Clear Career Framework – From the Support Workforce to Consultant Practitioner
- A General Practice Workforce for the Future
- Workforce Productivity
- The Impact of Technology

The 'One Hampshire & Isle of Wight Workforce'

The underpinning principle of the strategy is a fundamental change from regarding the workforce solely at an organisational level to viewing the workforce across the entire footprint to enable optimal health and care outcomes to the whole population, with a particular focus on our shared values, integration, prevention and patient activation.

This strategy therefore includes not just employed staff in the NHS, general practice and social care settings but also the recognition that unpaid carers, care workers in the independent care sector and our enormous wealth of volunteers are also key to the improving the life of our population. By integrating and working together effectively, staff from all agencies can more easily identify which people are most at risk - for example, of going into hospital - and then assemble a combined package of care, support and lifestyle advice to keep them healthier and independent for longer. Older people and people with long-term health conditions will be the first to benefit from this.

To unpin this development system leaders have agreed to adopt the principles developed by the 'My Life a Full Life' Vanguard initiative to underpin our developing partnership. The framework describes the collective ambition and shared values for the health and care workforce in HIOW, and the commitments and actions of the partners to develop and implement a workforce that will transform and integrate services. A key principle of this approach is "One Trusted Professional' at the forefront of an integrated, patient-centred service. We will further develop our workforce to have a breadth of knowledge and competences to provide more streamlined care for those with multi-morbidities. Our networked clinical staff will agree protocols and pathways to avoid duplication of assessments/diagnostics as patients move through the system. This approach is being developed in the SHIP pioneer maternity network. This project embodies our aspiration for a high quality responsive service focused on patient need. The aim is to further embed our current informal partnership, breaking down the barriers and boundaries across 4 NHS maternity providers and 8 CCGs. This will create a more 'family focussed' maternity service that offers women a clear, consistent menu of informed choice. Each woman will have a named midwife who works across boundaries utilising an agreed set of clinical guidelines. The named midwife can navigate

women through pathways into any maternity facility. This will enable the wider service to responds to peaks and troughs of activity in individual centres. This will require developing a flexible workforce which works across current geographical boundaries. This network will also standardise competence, skills, training and practices and support and promote multi-disciplinary education and training through a virtual maternity academy to ensure the consistent provision of training for all provider of care on the maternity pathway including GPs. This will be achieved by remodelling funding arrangements and developing and implementing supportive IT systems.

In addition we will;

- Work in partnership across the system to improve recruitment and address skills shortages and ensure no one organisation is left with a staffing shortfall.
- Manage the workforce market more effectively and decrease reliance on agency workers by creating a HIOW concordat and a county-wide bank system.
- Further facilitate the reconfiguring and networking of services and specialist skills across organisations which is essential to achieve the ambitions outlined in this plan.
- Develop a HIOW wide recruitment and retention strategy which values and acknowledges the contribution of the whole workforce including carers and volunteers.
- Address the significant gap in our domiciliary workforce and paid carers, as part of our plan to address delayed transfers of care and ensuring the whole system works more efficiently by developing new public/private partnerships for employment and career development across health and social care.
- Develop agreements between employers on training and development.
- Undertake joint workforce planning across organisations and sectors to enable delivery of care in the most appropriate setting to ensure optimal outcomes.

Supporting our Hidden Workforce – Carers and Volunteers

While considering the One Hampshire and IOW workforce we need to be aware of the huge contribution made by the unpaid carers and volunteers in our society.

Approximately 10% of our population provide unpaid care to family members or others because of long-term physical or mental ill health or disability, or old age. Of these approximately 39,437 people (40% of whom are over 65) provide over 50 hours of unpaid care, and 21,513 people provide between 20 and 49 hours of care. Our ageing population and increases in long-term, degenerative conditions, such as dementia means there is growing pressure on care systems and carers. Carers UK estimate that there will need to be a 40% increase in the number of carers required by 2037 and highlight the importance of bringing about a step change in the way that carers are recognised, identified and supported systematically throughout the HIOW health and social care system.

It is vital that unpaid carers have access to the appropriate support. Under the new Care Act, carers have the right to request advice and information about services from local authorities. In HIOW, support is provided by a range of providers. Adult services in Hampshire provides access to the Take a Break service and Shared Lives scheme for carers that are eligible based on completion of a carer's assessment. Respite care and other support is also provided by various charities, including the Princess Royal Trust in Hampshire and Carers IW on the Isle of Wight. Carers UK is a national charity that aims to improve carer's lives by providing direct support, as well as representing carers by working with carers' groups and volunteers in local communities and with local authorities to improve services. Early identification of carers will help to avoid or reduce any detrimental effect on the health and wellbeing of carers themselves and therefore their capacity to provide care. Portsmouth NHS Trust is introducing Carer Passports to help staff in the planning of care and appropriate support. As part of the 15 year

Strategic Framework Health Education England are working with partners to develop an education and training strategy to include patients and carers[1].

The drive to integrate care will require closer collaboration between services and the increased involvement of the voluntary sector. Charities are key to this and it is vital that they are involved in strategic decisions around service transformation. The National Council for Palliative Care is one of the Department of Health's Third Sector Strategic Partners and works closely with the DH and partner charities to assist strategic work with the voluntary sector to improve health and social care in all settings. The engagement of this sector will be increasingly important in future models of care.

A Workforce Focussed on Prevention

It is clear that we must transform our system from one that treats people when they are ill to one that empowers our population stay healthy for as long as possible. Transformation of the workforce will be a key aspect in achieving this significant step-change.

To support and upskill our workforce to enable a person-centred approach to prevention and public health we will utilise the UK Public Health Skills and Knowledge Framework (PHSKF) and extend and build on the innovative work already being undertaken in our system;

- **Making Every Contact Count (MECC)** is a behaviour change intervention whereby health and social care staff are trained to recognise and seize opportunities to provide brief advice to patients on healthy living. This initiative empowers patients and aims to reduce morbidity and mortality risk factors for local populations and provide cost savings through prevention, as well as empower both staff through skills development. It is currently being implemented across HIOW, not only in NHS trusts but also in local authorities and fire and rescue services.
- **Public Health Practitioner Development** increases capacity in our system by enabling non-specialist staff in public health to become registered practitioners.
- **Youth Health Champions** supports young people to be trained in health and wellbeing in order to become a Youth Health Champion. Once trained they can support their peers through health advice and promotion within their settings (i.e. School; Youth Club).
- **Reducing Obesity By Education (ROBE)** is an educational app for health professionals which focuses on childhood obesity. The app (currently in development with an expected prototype to be available for testing by the end of 2016) will enable health professionals to gain core knowledge around childhood obesity along with practical skills and tools to support them in practice.
- **Public Health Apprenticeship** is a new standard being developed. The role will work as part of a team, providing high quality advice and support on healthy lifestyles, facilitate behaviour change and deliver health promotion campaigns. This will provide opportunities for organisations to recruit apprentices into this role to support local prevention and public health. This programme is in the early development phase and we would look to implement this as soon as it is available.

In addition to these existing programmes we need to ensure that the development of behaviour change interventions, including health coaching and motivational interviewing are being delivered within an effective person centred approach. Developing a behaviour change framework or model which enables the system to recognise which workforces need which type/level of training would allow for a fit for purpose behaviour change development programme across HIOW.

We also need greater recognition of the assets which exist within our communities which can support the health and wellbeing of our population. Social capital can have a significant impact on the health and

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mental wellbeing of an individual where they feel connected and a part of a community. These assets can be used to support individuals who access health and social care services to be better supported within their communities. A systematic approach to training primary and community professionals on asset based approaches when developing/providing/commissioning services is needed in order to ensure a holistic approach is taken to addressing prevention.

The workforce transformation required to embed these changes needs to be progressive and challenge traditional ways of working. This could be achieved through more multi-disciplinary and multi-level training and education between sectors. This will enable the development of a shared sense of the system, reduce silo mentality and encourage partnership working. System leadership will be key to driving these changes and in recognising how the system can work collaboratively in order to achieve improved outcomes and reduce inequalities.

A Clear Career Framework – From the Support Workforce to Consultant Practitioner

To deliver high-quality sustainable services to the citizens of HIOW we need a well-trained, highly valued workforce. The health and social care sector is one of the largest employers in the region and it is essential that we attract the best people to work across the 300+ different job roles. We will develop a clear career pathway which enables people to fully develop and work to their potential from apprenticeships through to consultant practitioners. The opportunity for career progression through new and extended roles may lead to improved job satisfaction and increase the retention of the current workforce, which is the biggest opportunity for reshaping the workforce and redesigning service delivery.

Attracting the Best People

Across HIOW the potential available population for education and training or work (e.g. number of people aged between 16 and 65) is 881,412 – around 45% of the population[1].

Studies have found that the career aspirations of young people do not reflect the reality of labour market demand. One survey concluded that 36.3% of teenagers are interested in just 10 occupations, only one, a doctor, was a healthcare profession. The studies conclude that there is good reason to believe that the gap between career ambition and labour market demand is a significant problem for young people and employers.

As a health and social care system we will bridge the information gap so that young people are aware and enthused about the job opportunities health and social care has to offer and are well prepared when faced with educational choices.

As a system we will continue to build and improve on what we are currently offering, including;

Improving the Quality of Work Experience - At least 1,000 young people a year undertake work experience in NHS Trusts in HIOW. All our Trusts are committed to signing up to the Work Experience Quality Standards supported by the UK Commission for Employment and Skills and we need to ensure that each placement is a positive experience. We will also look to widen the scope of those considering a role in health and social care by working with communities to support those currently furthest from the labour market into meaningful work experience.

Ambassador Programmes - Ambassador programmes match NHS volunteers with schools requiring speakers. Inspiring the Future[9] has been adopted as one of the key programmes which ask volunteers to pledge one hour a year.

Promoting Medical Careers - The Isle of Wight NHS Trust has launched a 'Careers in Medicine Training Day' for A-Level students. During the day 30 students from school years 11 and 12 take part in a number of interactive sessions ending with practice on interview skills. The programme complements outreach work to careers fairs and observation days in the Trust. Students from IOW have already successfully applied to medical school. For those students who have decided not to pursue a career in medicine, it is hoped that they have been inspired to explore other opportunities in health and care.

National Step into the NHS Competition - The annual Step in the NHS competition is promoted through the national health careers website[10] (formerly NHS Careers). It asks students in years 8 and 9 (aged 13-15) to create a job description and advertisement for a career in the NHS. In 2015/16 across Thames Valley and Wessex there were 186 entries from 403 pupils across seven schools.

Apprenticeships

The development of a joint HIOW apprenticeship strategy will ensure that the opportunities presented by the apprentice levy are optimised across the system.

The introduction of the apprenticeship levy in April 2017 will be used as a vehicle to deliver new apprenticeships. The levy will apply to both public and private UK employers across all sectors with a PAYE bill in excess of £3m a year. Levy funds can be used towards the cost of apprenticeship training and end-point assessment. They can be used to fund existing employees and in this way can be used to upskill the workforce. This is particularly relevant to the NHS where approximately 80% of apprenticeships are undertaken by existing staff.

By developing rotational roles working across organisations and sectors we will develop a more flexible workforce that can improve patient care and workforce productivity by working across the health and care interface. Offering exposure to different employers and working environments may also help to address some of the recruitment difficulties experienced by the care sector, particularly around domiciliary care. We will also build on initiatives currently being piloted in Hampshire and Isle of Wight, for example, students from local colleges and sixth forms who are completing the Advanced or A Level BTEC in Health and Social Care this summer are being recruited on the National Skills Academy for Health (NSAH) Apprenticeship Training Agency (ATA) to undertake the Foundation Degree in Health and Social care (Higher Apprenticeship) at Southampton Solent University. These students will be hosted by one of the acute hospitals to enable them to gain the clinical competence required for the FD. Upon completion of the programme they will be in a position to apply for Assistant Practitioner roles in the local area or progress onto undergraduate professional registration training.

Developing and Utilising the Skills of the Support Workforce

One of the key recommendations of the Reshaping the Workforce report (Nuffield Trust, 2016) is the expansion of the support workforce. With short training times, there is an opportunity to mobilise this large and highly flexible workforce to reduce the workload of more senior staff. Current support staff can be upskilled and redeployed, with the possibility of professional registration for those without academic qualifications, which also supports the widening participation agenda.

Support workers comprise 38% of the whole NHS non-medical workforce in HIOW and an even larger proportion of the workforce in social care.

The high cost of living and high employment levels in most of HIOW causes particular issues recruiting lower paid support staff in social care. The vacancy rate and the staff turnover rate in HIOW is greater than the national average.

We will look to increase the retention of this important workforce by increasing the standardisation of training and offering individuals the opportunity to deliver care in a variety of settings. Pilot schemes have demonstrated the opportunities to provide integrated training, for example by offering BTEC students placements within a nursing home, reablement service and an acute hospital. Developing these opportunities underpinned by the recently introduced Care Certificate which standardises the initial training required will be key to developing a high quality and engaged support workforce in HIOW.

We will also give clear opportunities for support staff to further develop their careers, should they wish to do so. To enable progression into more senior roles the HIOW NHS workforce is currently able to access a foundation degree which is delivered in partnership between trusts and Southampton Solent University. We will evaluate the options to develop this to create a holistic training community, covering both health and social care that learns from and about each other's practice, thereby impacting positively on the patient journey.

We will also implement the new 'nursing associate' role as this develops. International evidence and practice in the United States, Canada and Australia shows beneficial impacts to service and patient care where generalist support roles are part of a team and supervised by nurses. This new role will have a clear training pathway and distinct qualification and will allow registered nurses to be confident in delegating and patients confident in receiving care. It should also provide further development opportunities for those in support roles and help to develop a local 'home-grown' workforce. Health Education England - Wessex are currently working with Southampton Solent University who are interested in delivering a pilot module of the potential course and we are expecting this to be ready for delivery in January 2017.

For those support workers who wish to progress onto a pre-registration degree to become a qualified health professional, a 3 month academic 'bridging' programme has been developed that help to prepare for entry to programmes leading to professional registration.

Advanced Practice and Consultant Practitioners

In the future care will increasingly be delivered by non-medical staff. It is therefore vital that the skills of registered non-medical healthcare professionals, such as nurses, pharmacists, physiotherapists and paramedics, are expanded, enabling long-term conditions to be managed more effectively, with increased continuity of care, and gaps in the medical workforce to be alleviated. Advanced practice roles provide opportunities for the development of existing non-medical staff, particularly nurses, as recommended in the Reshaping the Workforce report (Nuffield Trust, 2016).

Advanced Practitioners in specialist areas e.g. neonatal, oncology and emergency care are able to take on some of the tasks traditionally undertaken by junior doctors. They make clinical decisions and order further investigations. In addition many will be independent prescribers and so are able to review and make decisions about medications.

All of our Trusts are currently undertaking in-house developments for advanced practice and we will share the outcomes across our footprint, these include the 'Hospital at Night' project at PHT which will develop an Advanced Clinical Practitioner (ACP) service to work across the Trust as part of the Hospital at Night service. The inclusion of an ACP role in the service aims to provide critical interventions and senior clinical decision making for inpatients that become acutely or critically unwell during out of hours

Consultant Practitioners operate at doctoral level and are expert clinicians in their field e.g. Stroke and Neuro Rehab, Emergency Care etc. They have clear management responsibilities for their team and clinical practice it provides as well as responsibilities for education and training leading

improvements/innovations. Health Education England – Wessex run formal development programmes to prepare Nurses, Midwives and AHPs for Consultant roles. The programmes are work-place based, with participants studying at doctoral level alongside their development in the other domains. There are pathways in;

- emergency care,
- midwifery,
- mental health,
- learning disabilities,
- cardiovascular (neurological rehabilitation and heart disease).

A Primary Care Workforce for the Future

Primary care is an essential element of the health and social care system. We will take forward the actions outlined in the General Practice Forward View (DH, 2016) to implement a greater skill-mix and multi-disciplinary team approach. This along with new employment models will lead to fulfilling roles and will stabilise and transform primary care into a service which is both effective and sustainable in the future.

General Practitioners

General Practitioners remain at the heart of the workforce and the HIOW system will continue to extend the support it provides to improve the recruitment and retention of this workforce.

Recruitment

Health Education England – Wessex has increased the number of general practice training places from 130 in 2010 to 150 in 2016 and will continue to promote general practice as a career of choice at a range of levels. This includes the use of GP ambassadors who visit local schools to enthuse 6th form students about a career in general practice. In addition we will also continue to build links with the medical school at University of Southampton to emphasise general practice to undergraduate medical students.

To ensure full recruitment to all GP training opportunities further efforts will be undertaken to promote general practice as a career path of choice to post-graduate medical trainees. This will build on initiatives including;

- The development of innovative ‘extensivist’ training posts at Lymington hospital which allows trainees the opportunity to broaden their experience by working in multi-disciplinary teams in primary care, secondary care and specialist clinics during their training programme.
- The opportunity to do 6-12 months ‘out of programme experience’ (OOPE) in with partner organisations in New Zealand, South Africa, Cambodia or Kenya
- The incentive scheme to provide additional support to ‘hard to recruit to’ areas. In 2015/16 this has resulted in the full recruitment of 10 GP trainees to the IOW.
- Taster sessions for FY1 trainees to shadow an ST3 in GP for a week to gain further exposure of the specialty

Retention

While the recruitment of new GPs is important there are particular concerns in HIOW about the numbers of GPs who are signalling their intention either to reduce their working hours or even to take early retirement. Therefore it is essential that the HIOW system provides a supportive professional environment to retain the current workforce.

We will improve retention of the general practitioner workforce through;

- The development of new models of care, currently being explored by our Vanguard sites, which will enable GPs to experience a greater breadth of clinical work and employment models more aligned to their aspirations and lifestyle.
- Promoting the RCGP First5 scheme to support new GPs through the first five years in practice up to the first point of revalidation.
- Ensure GPs are aware of The Retained Doctor Scheme. This is a package of support to help GPs who might otherwise leave the profession to stay in clinical general practice work. The scheme enables Retained GPs to keep up to date, develop their careers, supports portfolio careers and supports revalidation. This is particularly effective at supporting GPs who may be lost due to caring responsibilities.
- Promote and support Wessex Insight. This is a service run by the Wessex Local Medical Committee which offers professional support for practitioners who may be struggling with challenges which are causing a negative impact on their performance.
- Practice Based Small Group Learning is an innovative approach to CPD for GP's. GPs from a single or several practices voluntarily work in small groups of 5-12. This approach closes the gap between current practice and "best practice" by discussing real patient problems and the evidence to solve these cases.

Return

- Fully support the Return to Practice scheme which provides an opportunity for GPs who have previously been on the GMC Register and on the NHS England National Performers List (NPL), to safely return to General Practice after a career break, raising a family or time spent working abroad. This can also support the safe introduction of overseas GPs who have qualified outside the UK and have no previous NHS experience.

Wessex Primary and Community Learning and Development Hubs

To meet the needs of our population and to ensure the sustainability of services it will be essential to develop a non-medical workforce in general practice in addition to GPs. The GP Forward View, published by NHS England and the Royal College of General Practice, restates the commitment to invest in 13 multidisciplinary training hubs (Community Provider Education Networks) across the country to support the development of the wider workforce within general practice. This will include developing new undergraduate placements in general practices for a range of pre-registration students including physiotherapists and pharmacists, extending the proportion of pre-registration nursing students who are offered a primary care placement, development for current staff and aligned workforce planning.

The Wessex Primary and Community Learning and Development hubs will create the infrastructure needed to deliver a highly skilled multi-professional workforce to work alongside our GPs. This is being delivered in partnership with the Wessex AHSN via the Wessex Primary Care Project, the Wessex School of General Practice and CCG and Vanguard workforce leads. It will ensure a supply of qualified nurses, allied health professionals and pharmacists, who are equipped with the skills and experience to work in primary care teams. Key deliverables include:

- Facilitating the development of new roles in primary care
- Improved HIOW primary care workforce supply and demand information
- Additional clinical and non-clinical apprenticeship opportunities
- Improved education capability and capacity in primary care to enable the development of innovative practice experiences for a range of pre-registration health professionals who are not currently reflected in the primary care workforce.
- An expansion in pre-registration adult nurse placements in primary care settings and support to the development of the associate nurse role

- The development of training for the whole primary care workforce in line with the GP stepping forward document, (including Making Every Contact Count, coaching and motivational techniques across a spectrum of levels of intervention).

Practice Nurses

By fully utilising the advanced role of the practice nurse it will enable an increased number of appointments to be seen by the non-medical workforce thus releasing more GP time to deliver more complex patient care.

We will offer opportunities to develop our practice nurses in line with the Practice Nurse Career Framework HEE (Wessex), including;

- Support workers to be offered the opportunity of an apprenticeship in primary care and a career progression to become an assistant practitioner or registered nurse
- Supporting the workforce by increasing the number of places commissioned on the Foundation in Practice Nursing course to provide accredited training with provision of the key clinical skills for this new role.
- Providing Non-Medical Prescribing places for the advancing role of the practice nurse and providing a continuing pathway to become an advanced nurse practitioner.

Pharmacists

A number of general practices have started to include clinical pharmacists in their multi-disciplinary teams. The experience from these sites suggests that there have been significant benefits for both patients and for practice teams.

This extended pharmacist role could include independent prescribing as well as supporting patients to self-manage their long term conditions, through optimising medicines, and improving medicine-related communication between general practice, hospital and community pharmacy e.g. on admission and discharge.

The HIOW system has two sites in the current NHS England pilot scheme covering 63 practices in North East Hants and in South East Hants and pending the evaluation of the pilot we will look to increase the utilisation of pharmacists in extended roles across general practice.

We will also further utilise the pharmacy workforce in other settings, as recommended in The Carter Report (2016) which emphasises the key role of clinical pharmacy staff in securing better value in medicines use, driving better patient outcomes, and contributing to the delivery of 7 day health and care services.

The supply of pharmacy graduates is increasing as a result of the number of pharmacy undergraduate places in England has increased year on year. In 1999 there were 12 schools of pharmacy training around 4,200 students. By 2011 there were 24 schools of pharmacy training around 10,950 students (CFWI 2014).

Allied Health Professionals

AHPs have expertise in a range of assessment, diagnosis, treatment and rehabilitation interventions that we could more fully utilised in a range of settings.

Within HIOW, developmental work is already underway to explore new roles for AHPs in primary care. To date, these roles have been profession and/or care pathway specific, for example, frailty clinics lead

by physiotherapists, same day access services involving physiotherapists and paramedics and the training of advanced musculoskeletal physiotherapists so they can be 'first contact practitioners' in primary care for those with musculoskeletal problems.

The AvOCET project (Non-Medical Community Workforce Development Project) in Gosport promotes the use of specialist practitioners, such as advanced AHP practitioners, to undertake roles that have historically fallen under the remit of the GP. Further scoping work is required around the potential of each AHP profession within primary care. With the development of an AHP leadership role in the HEE Wessex Primary and Community Learning and Development Hubs further intelligence in this area will be gathered and will inform future steps. A local governance framework for advanced practice is also being developed. This will include an 'a-z' of the Advanced Practitioner to highlight capabilities, skills, competencies and 'added value' that advanced practitioners can bring to clinical settings to improve healthcare delivery.

Paramedics

Paramedics are increasingly becoming employed in the primary care sector and the traditional role of the paramedic is evolving in line with the move towards more community-based work. The development of new and enhanced skillsets is key to enabling paramedics to adapt to new ways of working in reconfigured health economies.

However it is important to recognise that there are currently significant shortages in the paramedic workforce both in HIOW and nationally, which has resulted in paramedics being added to the National Shortage Occupation List in April 2015.

It is essential that the system works collaboratively to ensure that we recognise the impacts for education and training on this increased service demand and that the recruitment of staff to one sector does not result in staff shortages in another.

Workforce Productivity

Our system faces a significant financial challenge over the next five years. Workforce costs account for approximately 70% of all NHS expenditure. The Carter Report (Crown Copyright, 2016) emphasises the key role of workforce productivity in delivering financial savings. It argues for a change of mindset from viewing workforce as a creative and productive asset to be harnessed, rather than a cost to be controlled.

The report compares a number of workforce metrics across NHS trusts to identify variation in practice. Addressing this variation offers the potential to achieve both efficiency savings and deliver improved clinical outcomes for HIOW. Key workforce actions are:

- Increasing the level of staff engagement: There is a variation in levels of staff engagement between HIOW NHS trusts across the region. Carter highlights the link between improved clinical outcomes and engaged staff. This will require continued focus as organisations move towards new ways of working requiring increased workforce flexibility and multi professional teams
- Addressing turnover: NHS turnover rates in HIOW are higher than the average for England and have shown a small year on year rise. Turnover in the social care workforce is also higher than national averages and considerably higher than the NHS with particularly high rates for care workers. Developing a 'One Hampshire and Isle of Wight' approach to recruitment and retention could be key in helping to address this issue.

The Impact of Technology

Technological advances, including genomics, tele-medicine and tele-health will be implemented more widely in patient care and will result in changing the way we work. Communication technology will enhance mobile working and communication between professionals working in care pathways, and social networking will provide access to information for staff and the public. Tele-medicine and tele-health will potentially improve efficiency in assessment, diagnostics, monitoring and self-management. Patients will be empowered through new health technology, whether offering self-service (ranging from making an appointment or requesting repeat medication to remote monitoring of blood pressure or home test kits for medical screening) or encouraging self-care, resulting in a shift of activity from providers to patients. It will be critical to quantify the impact that these developments will mean for workforce levels recognising that previous technological developments have not necessarily led to a reduction in workforce numbers, and indeed it can lead to increased demand due to improved diagnosis and patient expectations.

Organisations need to develop a culture of innovation – developing both capacity and capability. An innovative culture starts with basic training, education and induction and continues through lifelong learning. The workforce also needs to be ready for new advances in healthcare as these are developed, and training of new and existing staff needs to reflect this.

A key priority across Wessex is to build a competent and capable workforce that uses technology and is receptive to new opportunities and innovations. This will be facilitated by the support and promotion of clinical academic careers and placements, the increased use of technology in staff training through e-learning and simulation, and the development of education and training programmes that reflect changing technologies, delivery systems and disease management. Will ensure staff are confident, both to use technology themselves, and to support patients and carers to use technology effectively, particularly in the management of long term conditions. This will lead to new ways of working and needs to be supported by a more innovative approach to care pathway planning and workforce design.

Next Steps

Developing the health and social care workforce is a continuous process. This strategy sets out the overarching workforce framework to help partners develop the workforce that will deliver better care across Hampshire and the Isle of Wight (HIOW).

Health and care providers need to consider their workforce plans and ensure that plans will deliver not only for their organisation but address the workforce development challenges of the HIOW system.

The newly established HIOW Local Workforce Action Board (LWAB) has developed this strategy and will be the vehicle through which local health and social care partners are brought together to discuss and action workforce issues facing the health and social care system. The regional HR Directors Network will also be critical to develop system-wide HR solutions. By each fulfilling our shared responsibilities, and by holding each other to account, we will improve health outcomes for the citizens of Hampshire and Isle of Wight.

Hampshire and Isle of Wight Digital Roadmap 2016 - 2021

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Preface

I am delighted to be introducing the Local Digital Roadmap (LDR) for Hampshire and the Isle of Wight (HIOW). It represents almost a year of hard work from a dedicated portfolio team and over 40 partner organisations who have given their time, resource and ideas. I am proud to be associated with such a large and complex footprint that has come together in this way.

The origins of the digital aspiration of HIOW go back much further than 12 months however. For over a decade we have developed the Hampshire Health Record which holds 20 million documents and makes them available for the care of nearly 2 million people.

This capability has allowed our clinicians to do some really exciting things which we now want to do at scale. It puts us in an excellent starting position for cross system interoperability, for exploiting data further and for citing digital at the centre of our Sustainability & Transformation Plan (STP) transformation.

I have been a relatively recent convert to the digital cause. My time as Senior Responsible Owner (SRO) and Chair of the Digital Transformation Portfolio Board has opened my eyes to the potential but also the hard work we have in front of us to achieve our goals. As the lead for the HIOW STP I hope I have been successful in ensuring that digital is 'baked in' to our future direction of travel as a system.

Consequentially this LDR is not really about Information Sharing and Information Governance (IG) – although we do need to improve that. Neither is it about technology per se.

Instead its main focus is addressing our digital maturity so that we can implement integrated team working, population health, care coordination and decision support at the point of care and make a real impact on the wellbeing of our citizens.

Richard Samuel

Programme Lead for STP & Chair of Digital Transformation Portfolio Board

June 2016

A Executive summary

Introduction

A1.1 NHS England's Five Year Forward View (5YFV) sets the context for the transformation of health and care service delivery in England. In response, local commissioning footprints have been asked to develop five-year Sustainability & Transformation Plans (STPs) to describe how they will deliver the required transformation across local systems. Many of the changes envisaged in the 5YFV and local STPs are critically dependent on the transformative power of information and technology.

A1.2 In addition, the National Information Board (NIB) has identified a set of national 'Paper Free at the Point of Care' (PF@POC) targets for uplifting the digital maturity of local heath and care systems by 2020.

A1.3 To support the delivery of local STPs, and to set out local plans for achieving PF@POC targets, local commissioning footprints have been asked to develop Local Digital Roadmaps (LDRs) which map out the requirements, priorities and timeline for digital transformation across each footprint.

A1.4 LDRs will support local access to national investment funding for technology-enabled transformation. Progress in delivering the commitments and aspirations set out in these LDRs is expected to become part of commissioner and provider assurance, assessment and inspection regimes.

A1.5 The health and care system covering Hampshire and the Isle of Wight (HIOW), comprising of eight CCGs, four Local Authorities and a range of provider organisations, has come together to develop both an STP and LDR for this geographical footprint. This represents one of the largest systems in the country.

A1.6 The HIOW LDR partners have established a joint Digital Transformation Portfolio Board to bring together thinking from across the footprint and provide collaborative leadership for developing and agreeing the local digital ambitions and roadmap for delivery.

A1.7 This is the first LDR for HIOW. As such, it is not necessarily comprehensive and will need to be refined and expanded in subsequent iterations. Further iterations will go through a governance and sign off process through the Digital Transformation Portfolio Board

A1.8 The Portfolio Board is supported by a Design Authority, a Procurement Sub-group and five locality-based Sub-portfolio Boards responsible for developing local plans for digital transformation and co-ordinating inputs to the LDR across the five localities.

A1.9 This process has involved significant stakeholder engagement, and during the LDR development process we have held 6 Portfolio Board sessions, 26 Sub Portfolio Board sessions and over 100 one on one stakeholder interviews.

A1.10 In May 2016 including a Digital Transformation event with over 170 clinical, patient representatives, provider and commissioning staff invited representing over 40 organisations. This was the first time all stakeholders from HIOW had come together to discuss digital transformation and was their opportunity to review and provide further input into the roadmap.

Strategic context

A1.11 The draft STP for the HIOW footprint sets out an ambition to help HIOW citizens to lead healthier lives, by promoting wellness in addition to treating illness, and supporting people to take responsibility for their own health. It aims to ensure that HIOW citizens have access to high quality care 24/7, as close to home as possible.

A1.12 The STP recognises that significant investment in digital services and technology infrastructure is critical to successful delivery of the future health and care system and new ways of working.

A1.13 Linked to local transformation requirements are the national ambitions for PF@POC by 2020. NHS England has identified seven capability areas and ten universal capabilities (see Figure 8) for which local health and care systems are expected to make early progress on, demonstrating clear momentum in 16/17 and 17/18.

Our ambition and priorities

A1.14 In response to these strategic drivers, our ambition is to ***empower the public, patients, care providers and commissioners to improve the health and care of people in the HIOW region through digital transformation***.

A1.15 We will achieve this by delivering five digital transformation priorities over the next five years. We will:

1. Provide an integrated digital health & care record;
2. Unlock the power of data to inform decision making at point of care;
3. Deliver the technology to shift care closer to home;
4. Establish a platform to manage population health; and
5. Drive up digital participation of service users.

A1.16 Our LDR ambition and priorities underpin delivery of both the HIOW STP transformation priorities and the national PF@POC ambitions, which both ultimately contribute to local delivery of the national vision set out in the 5YFV.

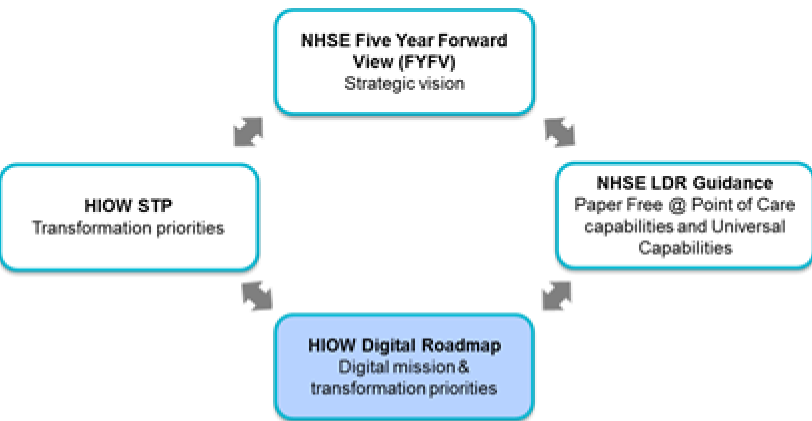


Figure 1: HIOW LDR Strategic Alignment

Current situation

A1.17 As a local health and care system, HIOW is recognised nationally as one of the more digitally developed footprints, with significant system level achievements such as the Hampshire Health Record, as well as many local achievements. This gives us a great platform for which to build upon and maximise future investments faster and easier.

A1.18 Across primary care, all the local CCGs are promoting take-up and utilisation of national strategic systems, and there are established protocols for sharing digital patient information (point-to-point).

A1.19 For social care, all four Local Authority partners have IM&T strategies and programmes of work underway to improve digital maturity.

A1.20 According to the recent digital maturity assessment, digital maturity for secondary care across the HIOW footprint is broadly in line with the national average, and better than average in four of the seven PF@POC capability areas.

A1.21 Progress to date has been constrained locally by a number of factors, such as investment funding, capacity and capability.

A1.22 The LDR must have a dual focus on putting in place strategic system-wide building blocks and enablers, and supporting different localities and providers to deliver their local requirements for improving digital maturity.

Delivery roadmap

A1.23 Development and deployment of digital and technology infrastructure capabilities will be achieved through a combination of strategic system-wide initiatives, such as the HIOW Interoperability Programme, and locality-based or organisational change projects and programmes.

A1.24 Building on the identified digital transformation priorities, a roadmap for the delivery of system-wide transformation has been developed.

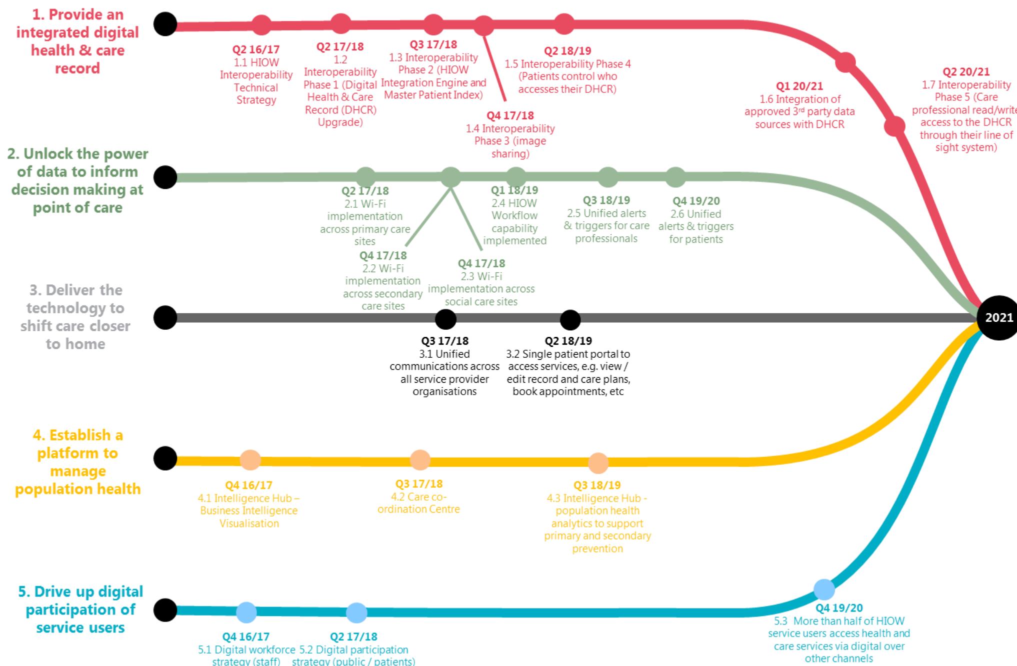


Figure 2: System-wide delivery priorities and milestones

A1.25 This system level roadmap is underpinned by local delivery plans for achieving identified digital maturity trajectories and enabling infrastructure requirements and plans.

Organising to deliver

A1.26 At a HIOW level, central shared resources will be required to co-ordinate delivery of the LDR, develop, deliver and drive adoption of HIOW-level strategy, and provide the governance and portfolio management support function to the HIOW Digital Transformation Portfolio Board.

A1.27 Locally, resource will be required to lead local implementation of HIOW-wide programmes, as well as developing and delivering local change projects and programmes to uplift digital maturity.

A1.28 To deliver the transformation defined in the STP and LDR, we must ensure adequate time and resource is invested in embedding the changes at the frontline of service delivery. For change to be effective, it requires a balance of leadership and change management techniques and we will use a framework for change that is based on best practice methodologies.

A1.29 For us to achieve the vision set out in STP and LDR, we will establish a robust benefits identification and management approach to ensure the investments we are making are the right ones and will achieve real value. Realisation of benefits will be pro-actively managed at the change delivery level where the benefits are expected to accrue.

A1.30 The scale and complexity of the HIOW footprint together with the size of the ambition and required pace of transformation means that significant investment in digital and technology will be required to achieve the desired outcomes and benefits.

A1.31 Early analysis indicated capital investment of c.£35M and revenue implications of c.£10M per annum would be required to achieve our digital ambition. Focus on this analysis was on the system wide initiatives such as the interoperability and population health programmes with limited funds assigned to individual organisations maturity ambitions.

A1.32 Without further work to assess detailed bids the total value of additional investment to achieve partner trajectories for digital maturity is in excess of £100m.

A1.33 Given the level of maturity across the HIOW system around digital information sharing, co-ordinated investment in digital and technology is expected to see rapid advances in capability deployment and the associated benefits' realisation.

A1.34 As the HIOW STP leadership team determines how best to organise to deliver system-wide transformation, the LDR arrangements, some of which are already in place, will be revisited to ensure full alignment with the overall STP delivery approach.

A1.35 Funding sources have yet to be confirmed, but we anticipate these will be a combination of local and national sources including local IM&T budgets, local Vanguard programme budgets, the national Sustainability & Transformation Fund, the national Estates and Technology Transformation Fund (ETTF), and the national Driving Digital Maturity Investment Fund (as referenced in the LDR guidance).

B Introduction

B1 Background

B1.1 NHS England's Five Year Forward View (5YFV, October 2014) sets the context for transformation of healthcare delivery. Many of the changes envisaged are critically dependent on the transformative power of information and technology (summarised as information management and technology (IM&T) throughout this document). One key commitment is that, by 2020, there will be "fully interoperable electronic health records so that patient's records are largely paperless".

B1.2 In response to the 5YFV, the National Information Board (NIB) has identified a set of IM&T priorities for delivery (in Personalised Health and Care 2020. Using Data and Technology to Transform Outcomes for Patients and Citizens. A Framework for Action, (November 2014)). Amongst its recommendation, the NIB identified the need for "development of local roadmaps for digital interoperability to be published in 2016". Commissioners have been tasked with coordinating the development of LDRs, which form a core component of local STPs.

B1.3 The health and care system covering Hampshire and Isle of Wight (HIOW) has come together to develop both an STP and LDR for this geographical footprint, representing one of the largest systems in the country – this LDR therefore covers a population of over 2 million people, which equates to c. 3% of the national footprint.

B1.4 A signed-off LDR is a requirement for accessing national investment funding for technology-enabled transformation. Progress in delivering the commitments and aspirations set out in LDRs will become part of commissioner and provider assurance, assessment and inspection regimes.

B2 Purpose of this document

B2.1 The purpose of the LDR is to set out the strategic roadmap for digital transformation across HIOW.

B2.2 Successful delivery of the HIOW STP is critically dependent on the design, implementation and wide-scale adoption of digital and technology solutions for health and care services, and therefore the LDR must align with and be central to the overarching STP.

B2.3 The LDR is also the vehicle for driving co-ordinated improvement in digital maturity at a local level, so that the HIOW health and care system becomes 'paper-free at the point of care' and achieves the delivery ambitions set out by NHS England.

B2.4 The LDR focuses on the common themes across the footprint where collaboration is either desirable (e.g. to achieve economies of scale, to share scarce resources, to share best practice) or essential (e.g. cross-organisational data sharing and interoperability), and provides a framework for prioritising investment at a footprint level to maximise the benefits of technology-enabled transformation, whilst also supporting the delivery of existing organisational IM&T strategies and plans.

B3 LDR Scope

B3.1 The HIOW LDR footprint includes the following partner organisations:

Local Authorities

Trusts

Portsmouth Hospitals NHS Trust

Hampshire Hospitals NHS Foundation Trust

University Hospital Southampton NHS Foundation Trust

South Central Ambulance Service NHS Foundation Trust

Solent NHS Trust

Southern Health NHS Foundation Trust

Frimley Health NHS Foundation Trust

Isle of Wight NHS Trust

CCGs

NHS North East Hampshire and Farnham Clinical Commissioning Group

NHS North Hampshire Clinical Commissioning Group

NHS West Hampshire Clinical Commissioning Group

NHS South Eastern Hampshire Clinical Commissioning Group

NHS Isle of Wight Clinical Commissioning Group

NHS Southampton City Clinical Commissioning Group

NHS Fareham and Gosport Clinical Commissioning Group

NHS Portsmouth Clinical Commissioning Group

Figure 3: HIOW Partner Organisations

B3.2 These partner organisations have come together to provide collective leadership for digital transformation across HIOW, achieved through a joint HIOW Digital Transformation Portfolio Board. Representatives of partner organisations on the Portfolio Board are detailed in Annex 9.

B3.3 In addition to the partner organisations, a wide range of stakeholder groups and representatives have been engaged and provided inputs to the development of this LDR, including voluntary organisations and other service providers, amongst others.

B3.4 It should be noted that, whilst building on pre-existing IM&T strategies and plans, this is the first LDR for HIOW. As such, it is not necessarily comprehensive and will need to refined and expanded in subsequent iterations.

B4 Our approach to developing the LDR

B4.1 The HIOW Digital Transformation Portfolio Board have been responsible for bringing together thinking from across the footprint and provide collaborative leadership for developing and agreeing the local digital ambitions and roadmap for delivery.

B4.2 The Portfolio Board is supported by a Design Authority, a Procurement Sub-group and five Sub-portfolio Boards responsible for developing locality plans for digital transformation and co-ordinating inputs to the LDR across five localities:

- Isle of Wight
- North Hampshire

- North East Hampshire & Farnham
- South East Hampshire
- West / South West Hampshire

B4.3 Figure 4 shows the high level process we have been through to develop the LDR.

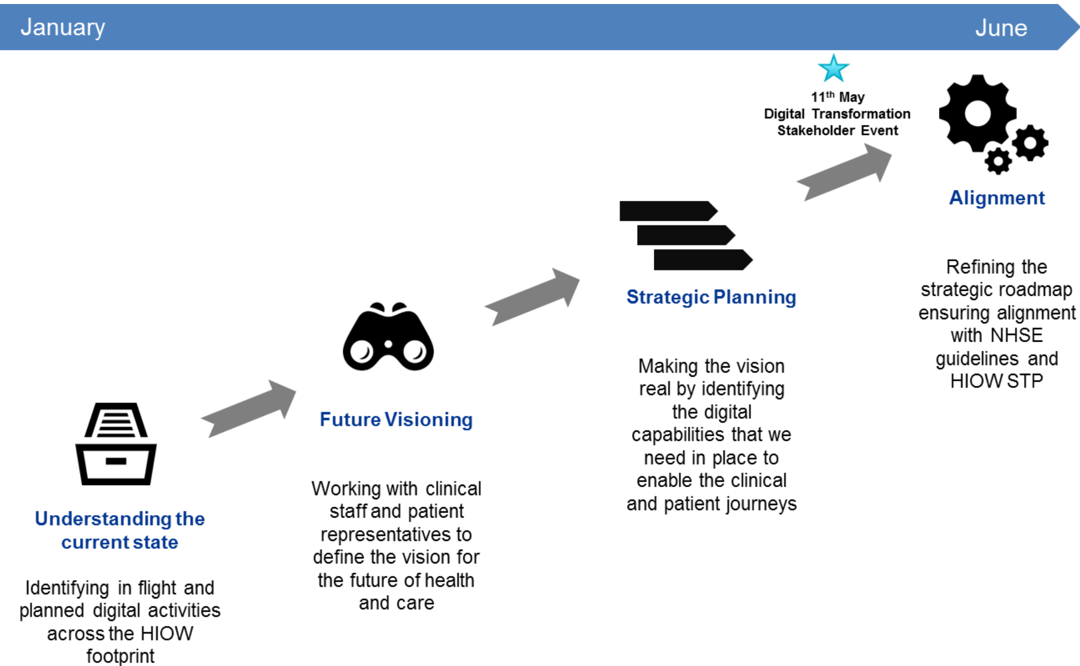


Figure 4: LDR Development Process

B4.4 We have followed a four stage process:

1. **Understanding the current state:** through engaging with sub portfolios, we have established a view of where organisations are on their digital journey, their current priorities and aspirations for change;

2. **Future visioning:** we have worked with our stakeholders to identify and agree our 5 year ambition for digital within HIOW including, at a high level, our priorities for delivering this;

3. **Strategic planning:** through the use of workshops and meetings with our stakeholders we defined a strategic roadmap detailing the key digital capabilities required over the five year period to achieve our vision; and

4. **Alignment:** throughout the development of the LDR we were engaged with the STP team and NHSE to ensure alignment of key priorities. Time was also spent pre final submission to ensure key points had been captured.

B4.5 This process has involved significant stakeholder engagement, and during the LDR development process we have held six Portfolio Board sessions, 26 Sub Portfolio Board sessions and over 100 one on one stakeholder interviews.

B4.6 In May 2016 we held a Digital Transformation event with over 170 clinical, patient representatives, provider and commissioning staff invited representing over 40 organisations. This was the first time all stakeholders from HIOW had come together to discuss digital transformation and was their opportunity to review and provide further input into the roadmap.

C Strategic Context

C1 LDR Strategic Alignment

C1.1 The HIOW LDR brings together the emerging thinking from the STP as well as the capabilities that have been prioritised within the national guidelines.

C1.2 Figure 5 shows how the LDR links into the transformation priorities coming out of the STP as well as the PF@POC capabilities, both of which align to the NHSE FYFV.

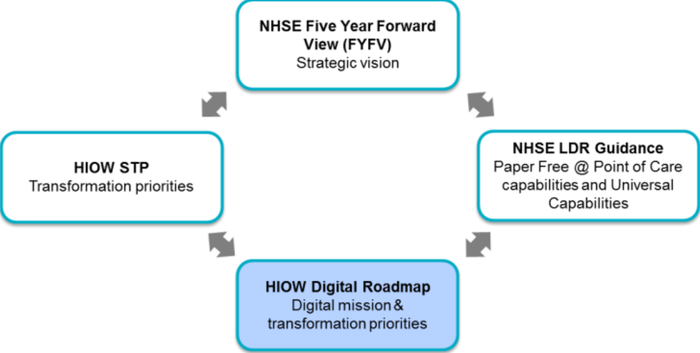


Figure 5: LDR Strategic Alignment

C2 HIOW Sustainability & Transformation Plan (STP)

C2.1 All local health and care systems in England are required to produce a strategic Sustainability & Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the 5YFV vision and addressing the identified gaps in care and quality, finance and efficiency, and health and wellbeing.

C2.2 The draft STP for the HIOW footprint sets out an ambition to help HIOW citizens to lead healthier lives, by promoting wellness in addition to treating illness, and supporting people to take responsibility for their own health. It aims to ensure that HIOW citizens have access to high quality care 24/7, as close to home as possible.

The draft STP has identified key challenges that need to be addressed locally over the next five years. For detail, please see Figure 6.

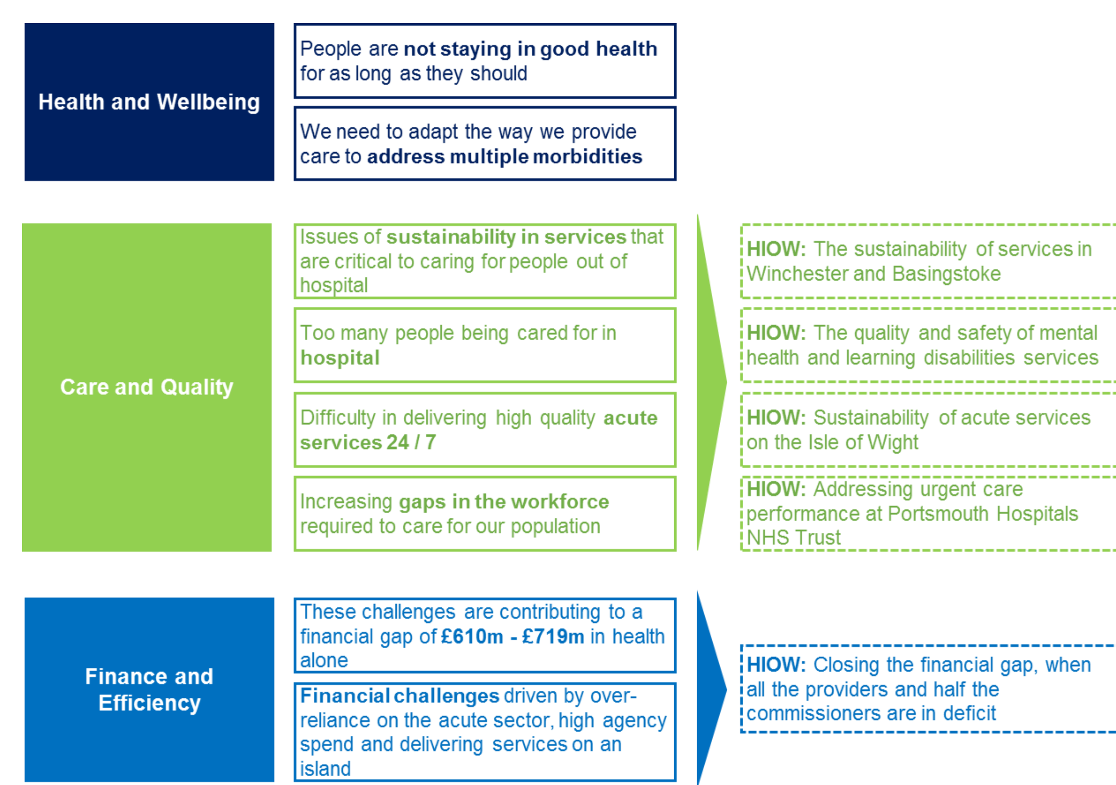


Figure 6: HIOW Health & Care system challenges

C2.3 In response to these challenges the draft STP identifies five transformation priorities that the HIOW system will focus on over the next five years. These are summarised in Figure 7.

1. We will improve the health and wellbeing of our population by investing in infrastructure and people development, and focusing on targeted interventions to deliver **prevention** and **early identification** and to promote **self-management**.
2. We are accelerating the development of **new models of care** that are already being established in our communities to deliver care around the needs of the person as close to home as possible, and ensure the sustainability of primary care.
3. We will **simplify our acute services**, pulling specialists into our new models of care; reducing the unnecessary steps that people go through to access the right care in both community and hospital settings.
4. We will address the sustainability and quality issues of our secondary physical and mental health services by working collaboratively in an **alliance model** across acute care and mental health providers in HIOW.
5. We will **improve health and care services for people with learning disabilities**, empowering people to live fulfilling lives in the most independent setting possible.

Figure 7: STP transformation priorities

C2.4 The STP proposes fundamental changes to the way the HIOW health and care system operates, including organisational changes. The business and operational landscape in five years' time will look very different, and will require different digital capabilities to support and enable this future vision.

C2.5 The STP identifies four additional priorities for developing the core system-wide capabilities required to deliver and sustain these transformational changes:

i. We will work as one HIOW system to manage our staffing, recruitment and retention, and to develop a one HIOW workforce strategy to ensure that we have the skills and capabilities necessary to support our goals;

ii. We will redesign the access points to health and care into a consolidated "front door" and care coordination centre that simplifies access to care and fosters a culture of self-management and self-care;

iii. We will invest in the digital services and technology infrastructure required to support our future health and care system and new ways of working; and

iv. We will transform commissioning to support our new models of care and reduce the complexity and cost of the way we currently commission services.

C2.6 The STP therefore recognises that significant investment in digital and technology is critical to its successful delivery.

C2.7 Section C4 sets out the HIOW digital ambition and strategic priorities that will underpin delivery of the STP transformation priorities.

C2.8 Every effort has been made to align the digital ambition and strategic priorities with the current thinking emerging from the STP. As this thinking develops and the implications are further understood, the priorities and plans to achieve them will need to be revisited. As new models of care emerge, individual organisation digital ambitions may change and this will need to flow back through the LDR. As a specific example, early thinking around an acute alliance has prompted a commitment to work towards a common acute IM&T strategy.

C3 Paper Free at Point of Care (PF@PoC) Capabilities

C3.1 NHS England has outlined an ambition to achieve Paper-free at Point of Care by 2020 and identified seven capabilities to deliver this:

- Records, Assessments and Plans
- Transfers of Care
- Decision Support
- Orders and Results Management
- Medicines Management and Optimisation
- Remote Care
- Asset and Resource Optimisation

C3.2 Within these capability areas, NHS England has identified 10 universal capabilities, for which local health and care systems are expected to make early progress on, demonstrating clear momentum in 16/17 and 17/18.

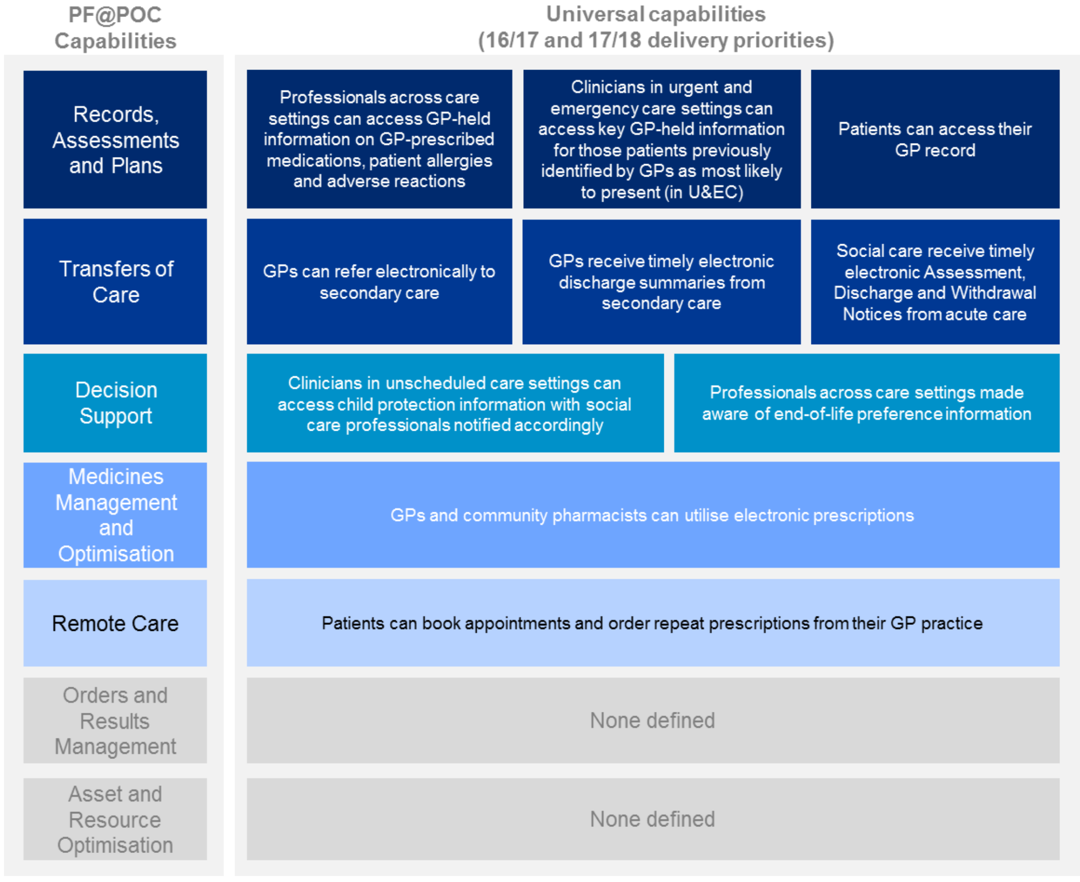


Figure 8: Alignment of PF@POC Capabilities and Universal Capabilities

C3.3 These universal capabilities form a core component of the digital transformation priorities and, in most cases, align with and underpin the delivery of the system-wide digital and technology requirements needed to deliver the HIOW STP transformation priorities.

C3.4 Development and deployment of each capability across the HIOW health and care system will be achieved through a combination of strategic system-wide initiatives, such as the HIOW Interoperability Programme, and locality-based or organisational change projects and programmes.

C3.5 Different localities and organisations within the HIOW health and care system are at different stages of digital maturity in terms of deployment of these capabilities (see Section D).

C3.6 Therefore, local delivery plans that feed into the overall LDR will vary in scope and sequence depending on baseline maturity positions and the scale and pace of change required to achieve national and local ambitions (see Section E).

C4 Our LDR ambition and digital transformation priorities

C4.1 The HIOW digital ambition is to ***empower the public, patients, care providers and commissioners to improve the health and care of people in the HIOW region through digital transformation***

C4.2 We will achieve this by delivering five digital transformation priorities over the next five years:

Provide an integrated digital health & care record	• An integrated health and care record for all GP-registered citizens in HIOW • Including care history, current medications, appointments, care plans and preferences • Supported by a patient consent model that enables appropriate access by health and care professionals
Unlock the power of data to inform decision making at point of care	• Flexible systems access for care professionals enabling them to work from any location, including web-based access to integrated health and care records • Cross-organisation, cross-specialty workflow, triggers and alerts to support decision making at the point of care
Deliver the technology to shift care closer to home	• Citizens enabled to self-manage their health and care plans, e.g. appointments, update details, log symptoms / observations of own health, etc. • Mobile ways of working and telehealth capabilities established across health and care services to deliver care provision closer to home
Establish a platform to manage population health	• HIOW-wide population health analytics capability established and made available to all relevant commissioners and clinical surveillance and research organisations • Real-time data analytics tools used to inform clinical decisions / patient choice at the point of care for particular population cohorts, such as diabetes, frail & elderly and mental health patients
Drive up digital participation of service users	• Workforce strategy to ensure staff have the skills to work in new ways and can advise and support the public and patients on use of digital service channels • Co-ordinated communications, engagement, training and education across HIOW footprint to equip the public and patients with the information and tools to drive uptake of digital services

Figure 9: HIOW LDR digital transformation priorities

C4.3 By delivering these digital transformation priorities we will support and enable delivery of the HIOW STP, underpinned by the development and deployment of the PF@POC capabilities at a local level across the HIOW footprint.

D Current situation

D1 Digital maturity

D1.1 Over the past 6 months, there has been a national drive to better understand the digital maturity of health and care systems in England across a range of digital and technology capabilities.

D1.2 There is a direct correlation between digital maturity and the performance of organisations. A boost in digital maturity will inevitably increase organisations' ability to deliver better health and care.

D1.3 This section summarises the key findings of the digital maturity assessments (DMA) completed for primary, secondary and social care across the HIOW footprint.

<u>Primary Care</u>

D1.4 All of the CCGs within our footprint are promoting the take up and utilisation of national strategic systems such as Summary Care Record (SCR), e-Referrals, GP2GP, Electronic Prescription Service (EPS2) and Patient Online, to enable more integrated care across all care settings and achieve operational benefits for patients and clinicians.

D1.5 The Wi-Fi network currently deployed is limited and not connected to the practice network. It is our ambition to upgrade this network to enable Wi-Fi access for patients and NHS staff (visiting and non-visiting) and safe connectivity of third party systems.

D1.6 All national systems (EMIS, TPP, EPS, GP2GP) are hosted in TIER3 data centres and some central services have been hosted from facilities at St James Hospital and the Royal South Hants Hospital. However, local files are still hosted at the surgeries for personal and practice shared folders.

D1.7 All local GPs and providers of health & social care sharing patient digital information have agreed to a consistent information sharing model (including common consent protocols).

Social Care

D1.8 All four of the local authorities within the HIOW footprint completed and submitted a response to the digital maturity assessment (DMA). There is a large amount of work underway within the authorities, with digital strategies being established and implemented. Our ambition within HIOW is to increase collaboration with the Local Authorities and deliver health and care initiatives together. Early DMA results have provided us with the following information:

D1.9 Within Hampshire County Council (HCC), significant work has been done to move adult and children's social care records online. However, more work needs to be done to allow care professionals to access and update the record at point of care. A digital strategy has been developed and a programme is underway to build on the information they have already and enable easy access to the information care professionals need at point of care. The NHS number is already used within Adult Social Care, however, further work is required to establish how the NHS number can be used in Children's Social Care as this is currently a blocker for integrating records.

D1.10 Capabilities delivered by HCC so far have enabled integrated working between teams. With a strong foundation built, the focus of the digital strategy moves towards online access and electronic updating of information. Examples include:

- Notifications and alerts to specific client risks for alerting professionals outside the organisation.
- The use of assistive and new technologies to enable self-care including the ability to write back to the personal record.
- Sharing of child protection information to be with unscheduled care settings.

D1.11 Portsmouth City Council are currently developing their blueprint for health and care and are looking at information sharing between adult and children's social care with other providers.

D1.12 Similarly, Southampton City Council's digital strategy focuses on enabling more self-service to shift care closer to home.

Secondary Care

D1.13 According to the Digital Maturity Assessment (DMA) results, digital maturity for secondary care across the HIOW footprint is broadly in line with national average scores, and in four of the seven PF@POC capability areas are slightly better than average see figure 10.[1]

[1] It should be noted that there has been no read-across of DMA scores and therefore direct comparison of scores may be misleading.

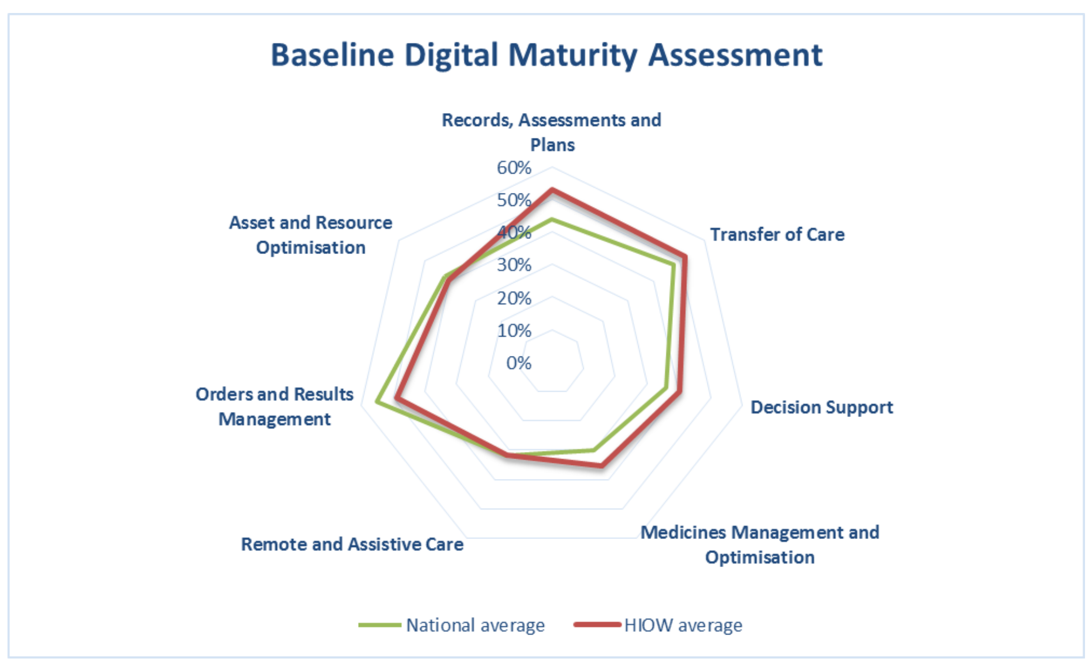


Figure 10: Comparison between national and HIOW digital maturity baselines

D1.14 Whilst this indicates the HIOW footprint is one of the more digitally mature footprints in England, average scores across the capabilities are in the range of 40 – 55%, showing there remains significant room for improvement.

D1.15 These variations indicate different starting positions in different localities and organisations in terms of the scale and pace of change required to uplift digital maturity across the footprint to enable us to achieve our strategic priorities at a HIOW level.

D1.16 The LDR must therefore have a dual focus on putting in place strategic system-wide building blocks and enablers, and supporting different localities and providers to deliver their local requirements for improving digital maturity.

Secondary Care - Acute Trusts

D1.17 When compared with national baseline digital maturity against the seven PF@POC capabilities, acute trusts in the HIOW footprint[2] exceed the national average for two domains; orders and results management, and medicines management and optimisation (see figure 11).

D1.18 The footprint is broadly in line within national averages (within 5%) for records, assessments and plans and decision support. However, there remains a gap to be filled across the three remaining capabilities: asset and resource optimisation; remote and assistive care and transfer of care. Further detail of projects planned to achieve these capabilities are outlined in Annex 7 Master Portfolio List.

[2] Isle of Wight NHS Trust has been included as an acute provider, however it should be noted that this trust is unique in England, combining acute, community, mental health and ambulance health care

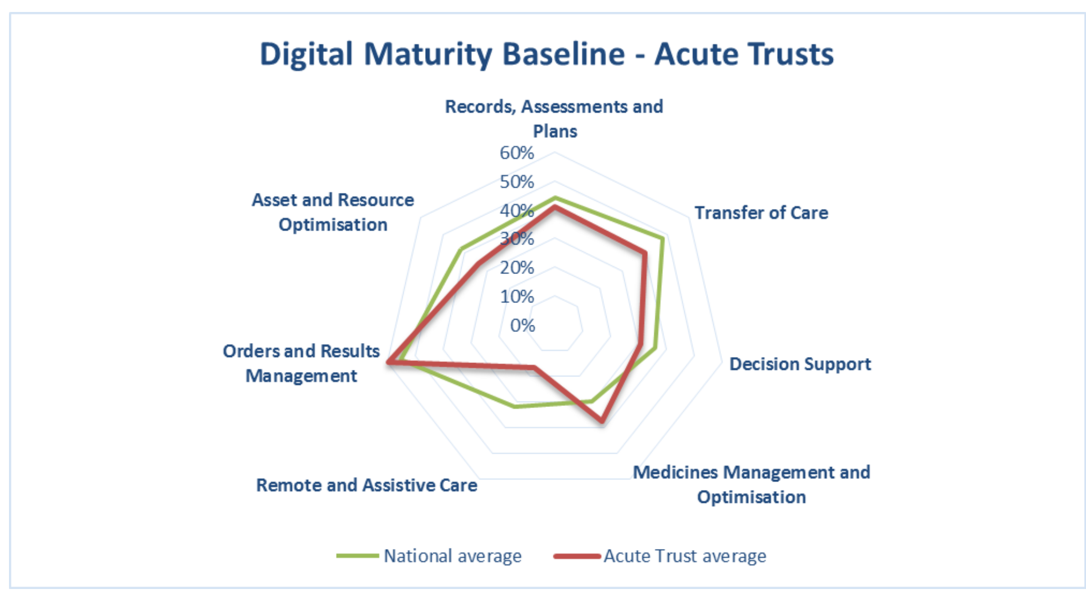


Figure 11: Comparison between national digital maturity baseline and HIOW acute trusts

D1.19 There is substantial variation in baseline digital maturity between the acute providers in the HIOW footprint across all seven PF@POC capabilities (figure 12).

D1.20 Records, assessments and plans and orders and results management are the most well developed capabilities across all acute providers in HIOW, whilst transfer of care and remote and assistive care show significant variation in maturity between providers.

Trust Name	Records, Assessments and Plans	Transfer of Care	Decision Support	Medicines Management and Optimisation	Remote and Assistive Care	Orders and Results Management	Asset and Resource Optimisation
Frimley Health NHS Foundation Trust	27%	36%	33%	3%	17%	84%	80%
Hampshire Hospitals NHS Foundation Trust	52%	70%	30%	63%	0%	69%	30%
Isle of Wight NHS Trust	48%	0%	46%	50%	0%	28%	0%
Portsmouth Hospitals NHS Trust	24%	16%	8%	0%	8%	34%	10%
University Hospitals Southampton NHS FT	54%	79%	36%	72%	58%	83%	50%
Acute Trust average	41%	40%	31%	38%	17%	60%	34%
HIOW average	53%	52%	40%	35%	32%	49%	40%
National average	44%	48%	36%	30%	32%	55%	42%

Figure 12: Digital maturity baselines of HIOW acute trusts against seven PF@POC capabilities

Secondary Care - Ambulance Trusts

D1.21 South Central Ambulance Service (SCAS) is the provider of ambulance services across Hampshire, whereas these services on the Isle of Wight are provided by the combined IOW NHS Trust (see acute trust analysis).

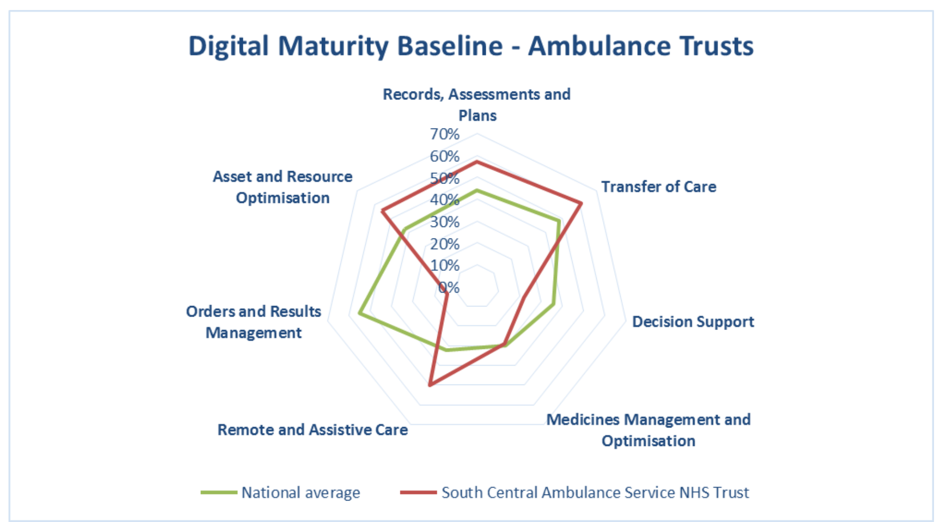


Figure 13: Comparison between national digital maturity baseline and HIOW ambulance trusts

Trust Name	Records, Assessments and Plans	Transfer of Care	Decision Support	Medicines Management and Optimisation	Remote and Assistive Care	Orders and Results Management	Asset and Resource Optimisation
South Central Ambulance Service NHS Trust	57%	61%	22%	29%	50%	14%	56%
HIOW average	53%	52%	40%	35%	32%	49%	40%
National average	44%	48%	36%	30%	32%	55%	42%

Figure 14: Digital maturity baselines of HIOW ambulance trusts against seven PF@POC capabilities

Secondary Care - Community and Mental Health Trusts

D1.22 There are four community and mental health trusts[3] in the HIOW footprint. On average, these trusts exceed the national average across all PF@POC capabilities with the exception of orders and results management (see figure 15).

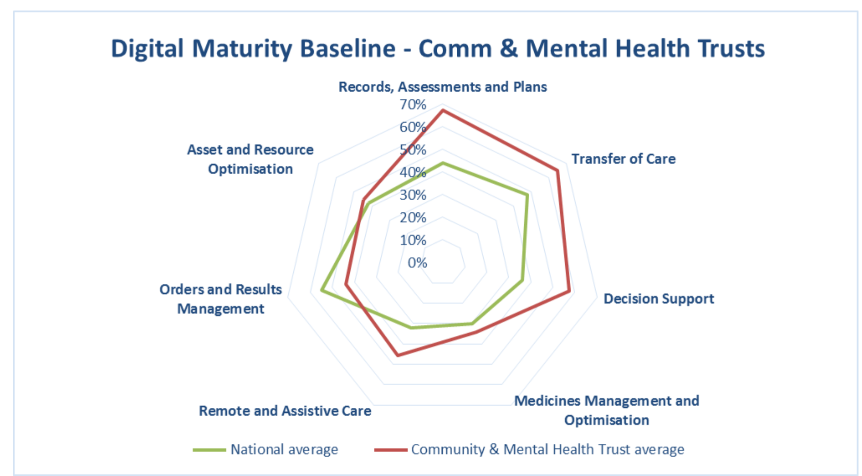


Figure 15: Comparison between national digital maturity baseline and HIOW community and mental health trusts

[3] Isle of Wight NHS Trust has been included as an acute provider, however it should be noted that this trust is unique in England, combining acute, community, mental health and ambulance health care

Trust Name	Records, Assessments and Plans	Transfer of Care	Decision Support	Medicines Management and Optimisation	Remote and Assistive Care	Orders and Results Management	Asset and Resource Optimisation
Care UK	81%	88%	100%	88%	58%	75%	63%
Solent NHS Trust	58%	65%	68%	34%	33%	63%	35%
Surrey and Borders Partnership NHS FT	45%	58%	43%	8%	42%	0%	45%
Southern Health NHS Foundation Trust	84%	49%	18%	6%	50%	38%	35%
Community & Mental Health Trust average	67%	65%	57%	34%	46%	44%	45%
HIOW average	53%	52%	40%	35%	32%	49%	40%
National average	44%	48%	36%	30%	32%	55%	42%

Figure 16: Digital maturity baselines of HIOW community and mental health trusts against seven PF@POC capabilities

D1.23 There are substantial variations in baseline positions across organisations and capabilities in the footprint. It is necessary therefore to focus simultaneously on ensuring the building blocks to develop digital maturity are in place for individual organisations whilst focusing on the strategic priorities at a HIOW level to achieve digital transformation.

D2 Recent achievements

HIOW Footprint level

D2.1 At a system level, the Hampshire Health Record (HHR) provides a well-established shared care record and data repository, which we continue to develop. One of the UK's longest running shared care records, the HHR provides a single source of information from a multitude of different health and care systems across the county.

D2.2 The HHR currently enables 172 GP practices, three acute hospitals, two community and mental health Trusts, South Central Ambulance Service and adult social care to share information for 1.9M patients in Hampshire.

D2.3 Critical to the HHR's success has been the integration with emergency and out of hours services ensuring that key information to support clinical decisions is always available:

- Patients are supported to receive the right treatment, in the right place by the right health care professional. Emergency services can then ensure care is managed in accordance with each patient's care plan.
- By providing better information at the point of care, HHR has enabled improvement in the speed and quality of care delivered, a reduction of unnecessary referrals and admissions and a reduction in the number of repeat tests carried out. It has also reduced the length of stay for patients that are admitted to hospital.

D2.4 Building on the successes of the HHR, Providers, Local Authorities and CCGs across the footprint have come together to form a collaboration group to ensure strategic alignment and provide collective leadership for digital transformation across HIOW. Refer to Section F for more details.

D2.5 In addition to the HHR, there have been a number of projects delivered that have had a significant impact across a large section of the HIOW footprint:

- A project for South Central Ambulance Service (SCAS) to enable access to the HHR via single sign on is also nearing completion. This will allow 999 and 111 call handlers to directly access HHR data, including real time searching and customised 'flags'. The scope of this extends across SCAS' extensive coverage within HIOW.
- In April 2016, Southern Health (SHFT) implemented single sign on from their EPR systems to the SCR. Since go live in April, the SCR has been accessed nearly 2,500 times by 1,000 members of staff, with the functionality being used extensively by the pharmacy team.

- 110 GP practices have been activated to receive electronic correspondence (Electronic Discharge summaries) across North and West Hampshire, Fareham and Gosport, South East and Southampton areas from SHFT. Adult mental health inpatient wards / units have all been set up on the system. The functionality is being rolled out to community and older persons mental health wards.

- SHFT has delivered instant/video messaging software to staff across the organisations extensive geography. The reduction in travel and improvement in communication has been widely recognised by the organisation.

- SHFT completed a successful merge of the three versions of RiO in 2015, resulting in a single clinical record across the Trust used by Adult Nursing and Therapies, Mental Health and Learning Disabilities. Over 850,000 patients now have their record within the system.

- HCC have developed a digital strategy to articulate the Council's ambition, vision, and objectives. It identified an agile Council in the future that works across the organisation using digital tools and insightful information to deliver user centric services, wherever possible through self-service.

- An App for young people to hold their health information and manage their on-going health and social care contacts and appointments has been developed. The app was developed with the Children In Care team and young people.

- SHFT has delivered business intelligence software for data visualisation which has enabled a suite of tools to be provided to front line services. Examples of use include unscheduled care dashboards bringing together patient level acute and community information to enable integrated primary and community teams to effectively manage patients that intensively use services across care settings.

- Mobile working has been delivered to over 3,000 SHFT staff who routinely access information and records at the point of care. The mobility programme is actively pursuing the replacement of some laptop devices with tablet technologies

North East Hampshire and Farnham

D2.6 Recent achievements include the rationalisation of all GP systems across the NEH&F locality, with majority of the GP practices now using the EMIS system and the remainder to be migrated by Q3 16/17.

D2.7 The implementation of EMIS GP data viewer at Frimley Park Hospital has meant that nurses and consultants within A&E are able to view GP-held patient data. Anticipated benefits include admission avoidance and providing allergy information.

D2.8 GP practices are now uploading GP-held patient data into the HHR and viewing records via single sign on within EMIS. North Hampshire Urgent Care are also now able to view this data through the implementation of GP data viewer via Adastra (also by single sign on).

D2.9 The rollout of DXS Point of Care to all practices provides supporting clinical information about care pathways in our CCG triggered from within EMIS during relevant consultations.

D2.10 The procurement of EMIS Enterprise to enable remote analysis of member practices' performance in agreed areas (e.g. Local Service Contract (LSC) reporting, medicines management)

North Hampshire

D2.11 Successful trial of a flexible systems access solution which has allowed teams from Hampshire County Council (HCC), Southern Health and GPs within North Hampshire to work across the different sites in the region.

D2.12 The development of a primary care information hub under the "North Hampshire Clinical System Umbrella service" centred on EMIS and the HHR to connect GPs with the Integrated Care teams, Out of Hours service and GP led ED Front-Door service.

D2.13 HHFT has taken an innovative approach to achieving a high level of digital maturity. The latest development is to allow clinical staff to capture vitals information and flag when patients are at risk so that they can receive appropriate care. This has been done at significantly lower cost to similar systems. A pilot project is planned to test the rollout within a community hospital to help eliminate unnecessary admissions.

D2.14 HHFT has developed a contact form which allows Clinical Nurse Specialists to record all contacts with patients, including where patients have open access arrangements. The form can be electronically sent to the GP automatically and will put an alert on the ePR. The development has significantly reduced admissions and has been short listed for a 2016 Nursing Times Award for technology innovation.

D2.15 Following the SHFT Lync rollout, the use of Lync has been extended to GP practices in the North of Hampshire to enable MDT meetings to take place remotely. Pilots are currently underway to support electronic consultations with patients within the perinatal and diabetes services.

Isle of Wight

D2.16 The Isle of Wight is unique in England in that is operates a combined NHS Trust providing acute, community, mental health and ambulance Services. Through the Vanguard programme, My Life a Full Life, the island has a well-developed digital health and care environment involving the Isle of Wight Council, Clinical Commissioning Group, NHS Trust and GPs.

D2.17 The Acute Trust is now paperless in several outpatient areas. The Wards have adopted an electronic observation system and nurses are using tablets and touch screen laptops to capture observations and other information using the E-form capability within the ePR. The E-forms have been utilised to send Social Care referrals and Community nursing referrals and these are picked up by the receiving staff who access the ePR.

D2.18 As part of My Life a Full Life, a full requirement scoping exercise has taken place to capture the integration needs between NHS IOW and IOW Council and the Voluntary Sector. The solution proposed enables a shared record for health and social care via an Information Sharing Platform and links the main three ePRs used on the Island across Health and Social Care enabling a seamless approach to delivery of care.

D2.19 In January 2016, IOW CCG launched an International Normalised Ratio (INR) self-monitoring service pilot for patients on warfarin. Patients on long term treatment can self-test at home, and receive the appropriate dose via anticoagulation dosing software.

West/South West Hampshire

D2.20 The University Hospital Southampton (UHS) development of My Medical Record has been a significant achievement in this region. UHS patients are able to access their record, cancel and rebook appointments and share information with the clinician online. The software uses a cloud based architecture and is not bound solely to UHS. My Medical Record is already deployed across multiple trusts through relationships with Prostate Cancer UK (Movember) and Macmillan which is a joint development with Liverpool. The business case shows a number of win-win benefits including demand management (reduction in activity).

D2.21 Under the Integrated Digital Care (IDCR) technology fund and Safer Wards fund, UHS is rolling out a patient observations monitoring system where vital signs data for any level of acuity reside in a single platform, including Level 3 intensive Care. This demonstrates a high level of integration and an innovative approach to deliver total continuity of data through any hospital spell.

D2.22 South West Hampshire has for many years shared a single patient record through the same Patient Administration System (PAS) and still runs a combined library for paper notes. The IDCR tech fund II has enabled this approach to be taken forward into electronic records with a project for an area wide Electronic Document Management System (EDMS).

D2.23 UHS is highly integrated, and is one of few acute hospitals to have delivered full order communications and electronic prescribing. It uses integration engine technology extensively, and has application single sign-on which is regularly quoted as best practice for access to shared records with the connection to the Hampshire Health Record.

D2.24 Adult nursing and therapies team within the New Milton Area have migrated to TPP SystmOne to enable a fully integrated read write record with primary care.

D2.25 Solent has rolled out a trust wide ePR (TPP's SystmOne) to all services barring Dental and Sexual Health. This has included all services that were on the legacy Rio platform as well as any remaining services that were operating outside of the previous clinical systems.

D2.26 Solent has rolled out new IT infrastructure to support mobile working, including the pilot for the use of TPP mobile to support disconnected working.

D2.27 Solent is nearing the completion of the handover of its IT services and support to CGi, this has involved a complete refresh of all server and user devices and a complete network redesign. Work is now underway to agree how Solent will work with partner organisations across the network.

<u>South East Hampshire</u>

D2.28 Portsmouth Hospitals has worked with a supplier to develop a chronic obstructive pulmonary disease (COPD) app, delivering pulmonary rehabilitation in patients' homes and allowing patients to monitor their symptoms, learn inhaler technique, review and update their management plan. It enables hospital-based clinicians to view real-time patient symptom data and to intervene if necessary.

D2.29 Portsmouth Hospitals has conducted a pilot of the use of Skype for patient consultations to enable remote care.

D2.30 Portsmouth Hospitals has supported commercial supplier The Learning Clinic in developing their VitalPAC applications to enable vital signs monitoring of hospital inpatients with automated alerts and to support multiple nursing assessments.

D2.31 Portsmouth Hospitals has initiated the eHospital Portsmouth programme to define, procure and implement an integrated electronic medical record (EMR) solution across all its hospital services. As well as reducing risks for patients and increasing the efficiency of the hospital, this will enable it to play a full part in planned interoperability initiatives to support patient-centric care.

D2.32 Portsmouth Hospitals has an innovative approach to infrastructure renewal and is at the vanguard of NHS organisations in its development of both virtual server and virtual desktop environments. The latter, which benefitted from national Technology Fund monies, enables clinicians to tap-and-go with smart-cards, so they can switch between desktop devices without long log-in waits.

D2.33 Solent's work across West/South West Hampshire also covers South East Hampshire.

D3 Rate limiting factors

D3.1 As described in section D1, the current digital maturity across the footprint is variable and shows that different localities and provider organisations have progressed at different rates.

D3.2 There are a range of factors that will affect the rate of progress across the system:

Funding

D3.3 To date, there has been relatively little funding available to support digital transformation, and uncertainty about availability of future funding as a system has hindered the prioritisation of large system-wide transformational initiatives.

D3.4 In addition, providers are faced with a significant challenge around allocating capital funding to boosting digital maturity. For example, Portsmouth Hospitals is a private finance initiative (PFI) trust and under its contract must pass most of its annual capital funding to its PFI provider.

D3.5 Solent has made significant investment in both effort and budgetary terms to support the modernisation and stabilising its IT infrastructure. Funding to support future change is limited and the managed service arrangement with CGi will have to be taken into consideration when supporting any future work.

Information Governance

D3.6 Through use of the HHR, there has been good progress with tackling information governance challenges. However, there are still further challenges that need to be overcome in order to improve the way that we share information between different health and care professionals.

D3.7 In addition, there will be future challenges around the ambition to use information to drive population health management and decision support for front line care.

Geographical challenges

D3.8 The wide geographical spread and sheer number of stakeholders across our footprint causes challenges in developing a common vision and strategy which all parties can agree to. Achieving a consistent level of engagement and keeping all organisations updated will remain a challenge.

D3.9 In addition, achieving communication and alignment (where appropriate) across footprint borders will remain a challenge (e.g. Dorset, Surrey and Sussex). In particular the link with the Frimley footprint is key with the population of North East Hampshire and Farnham CCG utilising services across this border.

D3.10 The nature of the geographical spread and variety of organisations means that there may be technical (i.e. different Wide Access Networks (WANs)) and security issues hindering cross organisational working.

D3.11 HIOW has a mix of rural and urban areas with varying levels of connectivity and access to public services and/or transport. Reaching all parts of the population geographically and demographically, particularly ensuring engagement with harder to reach communities, will be both a challenge to overcome and an opportunity to exploit for digital.

D3.12 In order to achieve the ambition set out in this LDR, the system has already started by adopting a portfolio approach and putting in place a system wide governance group, see section F.

Capacity and expertise to deliver

D3.13 We have a significant challenge across the system in resource and capacity to deliver digital transformation, with an increasing resource gap causing a stretch on the demands of health and care professionals. To date this has meant that focus has been on providing the best care possible and deprioritising the boost of digital maturity and transformation. In order to accelerate digital transformation, the system will need to significantly increase its capacity to deliver.

D3.14 Although the footprint boasts significant digital leadership and expertise it recognises that additional specialist expertise will need to be sought. For example external expertise to support the development of the technical strategy and architecture is required immediately.

E Delivery Roadmap

E0 System-wide transformation

E0.1 Building on the identified digital transformation priorities (see Section C), a roadmap for the delivery of system-wide transformation has been developed.

E0.2 Figure 17 sets out the key delivery milestones we aim to deliver at a HIOW system level over the next five years.

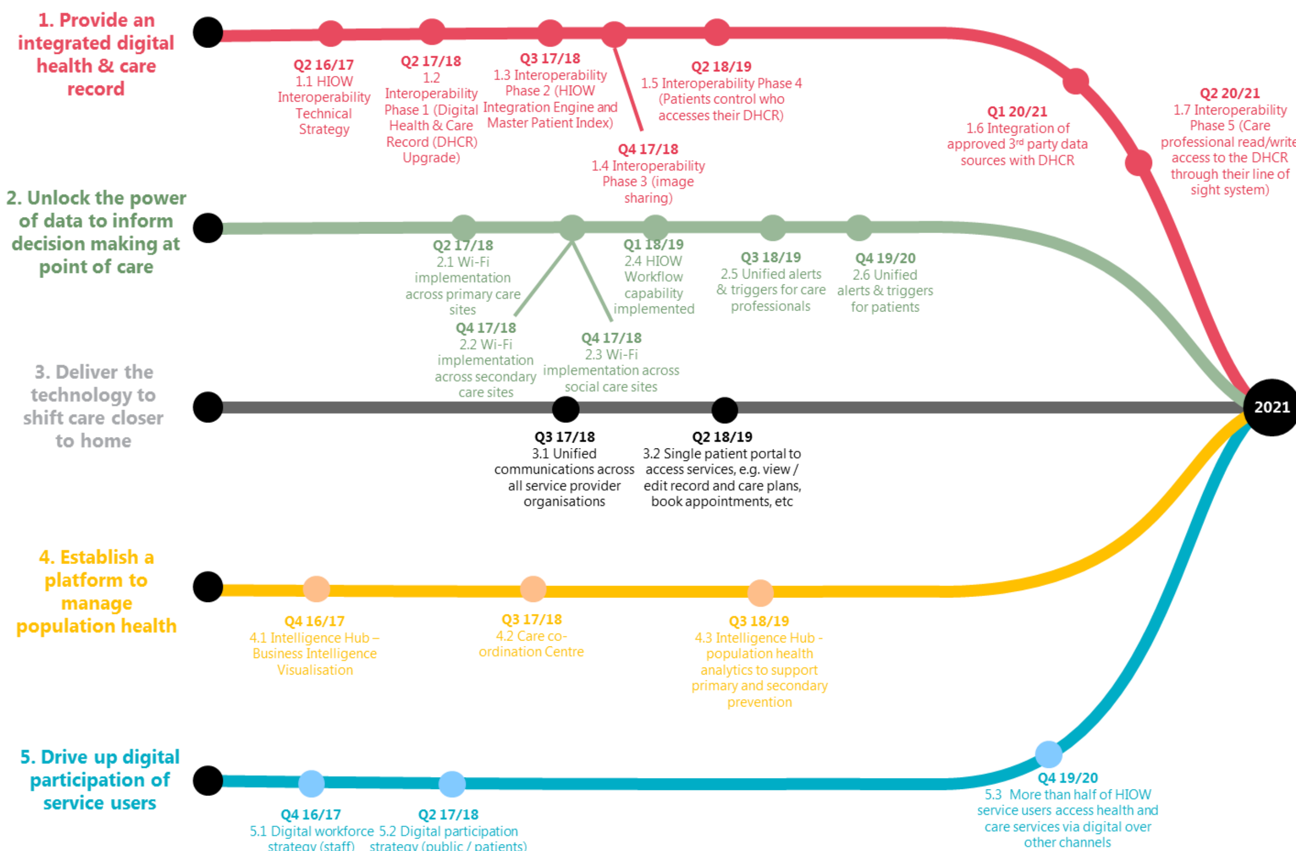


Figure 17: System-wide priorities and milestones

E0.3 This system level roadmap is underpinned by local delivery plans for achieving identified digital maturity trajectories, as set out in Section E2, and enabling infrastructure requirements and plans, which are outlined in Section E6.

E0.4 Together, these co-ordinated system and local level delivery plans will enable and support delivery of the HIOW STP.

E0.5 Sections E1 to E5 describe each digital transformation priority and the associated system level delivery milestones.

E1 Provide an integrated digital health & care record (DHCR)

E1.1 Over the past few years in HIOW, we have made significant steps in moving towards having an integrated digital health & care record. Through the HHR, we have an existing data repository of patient information which is currently being used by multiple organisations involved in the health and care of the patient.

E1.2 However, much work needs to be done in order to move towards our ambition of having a truly integrated digital health and care record and we need to take advantage of the investment that we have already made in the HHR.

E1.3 In addition, we will review the feasibility of implementing the HHR on the Isle of Wight. Rolling out HHR across the island will result in the entire footprint having access.

E1.4 Providing an integrated digital health & care record will be key to achieving our ambition as it will provide the backbone for our new models of care. It will improve cross discipline working and collaboration, ensure every health and care professional is talking the same language and improve data accuracy.

E1.5 Our ambition for an integrated digital health and care record is:

- For all GP-registered citizens in HIOW to have a digital health and care record;
- For health and care providers to be able to easily view the appropriate information, such as care history, current medications, appointments, care plans and preferences;
- For the record to be consistently used across the footprint and across our borders; and
- For the patient to be in control of their record. This includes being able to view and update their record, as well as grant access to those involved in their care.

E1.6 *Table 1* outlines the system level milestones for delivering this priority.

Milestone	Summary description
1.1 HIOW Interoperability Technical Strategy	A detailed technical blueprint for how we convert our high level ambition into deliverable components and standards. The strategy will document our existing infrastructure and integrations and then define a series of standards and steps to achieve a fully interoperable solution for HIOW.
1.2 Interoperability Phase 1 (Digital Health & Care Record (DHCR) Upgrade)	As part of the forward view for the HHR, a new enhanced version of the underlying software, CareCentric Plus will enable support for mobile working and customisable dataset interfaces for clinical staff.
1.3 Interoperability Phase 2 (HIOW Integration Engine and Master Patient Index)	The integration engine and master patient index are key components of our HIOW interoperability platform. The integration engine will act as a central point of orchestration for information flowing between specialities and organisations. The master patient index will act as the single version of the truth for identifying and authenticating patients and care professionals across the HIOW health and care system.
1.4 Interoperability Phase 3 (image sharing)	This project aims to join up the existing PACS radiology image sharing network with the main interoperability programme and to wider domains. The current consortium covers South Hampshire including Southampton, Portsmouth and Isle of Wight plus Salisbury. The project will connect the new Master Patient Index through the new Integration Engine and use the IHE standard XDS/XDSi protocol using XCA extension to connect to other XCA capable domains. Currently this includes Hampshire Hospitals and Sussex but there are future plans for Bournemouth and others.
1.5 Interoperability Phase 4 (Patient control who accesses to their DHCR)	Patients will have greater control over who accesses their record through granting permissions on the patient portal.

1.6 Integration of approved 3rd party data sources (e.g. health & wellbeing monitoring apps) with patient health and care record	Data that is relevant from 3rd parties is collected and integrated with the DHCR, updating the relevant part of the patient record. Scope includes health monitoring apps, both for patients with known conditions and for tracking activity (e.g. fitness/diet) and the ability for patients to input information based on their wellbeing.
1.7 Interoperability Phase 5 (Care professional read/write access to the DHCR through their line of sight system)	The DHCR will interface with all health and care provider systems meaning all health and care professionals across HIOW will be able to access a comprehensive integrated digital health and care record in real time. Following their provision of care, information inputted will update the DHCR in real time through the interface with their system.

Table 1. Milestone Summary Descriptions

E1.7 In order to fully realise the benefits of an integrated health and care record, local plans for improving digital maturity must be delivered in alignment with system level transformation – refer to Section E6.

E2 Unlock the power of data to inform decision making at the point of care

E2.1 To date, much of the work within HIOW has been focused on creating the means to capture and store information. Now that we have that information, our focus must shift towards realising the potential of this data for improving outcomes and productivity.

E2.2 With rapid advances in technology over the past few years, the collection, analysis and use of data has become increasingly fundamental to the way organisations are run, and this is no different for health and care organisations. The vast majority of individuals use online services and mobile devices, which makes capture of data more feasible, and with greater data capture there is much more we can achieve. In particular:

- Real-time access to information and tools to support decision making at the point of care; and
- Data driven alerts and triggers to notify care professionals when there is a situation they need to action.

E2.3

E2.4

E2.5 Table 2 outlines the system level milestones for delivering this priority.

Milestone	Summary description

2.1 Wi-Fi implementation across primary care sites	The proposed solution would be capable of presenting patients with Wi-Fi internet access, the practice with Wi-Fi access to their practice LAN and other health and social care professionals (e.g. community staff and social workers) access to their own web-based systems. The solution would utilise the current internet connections at the practices in Hampshire and the Isle of Wight (HIOW), and intelligently route traffic to NHS or internet resources efficiently.
2.2 Wi-Fi implementation across secondary care sites	The proposed solution would be capable of presenting patients with Wi-Fi internet access, clinical staff at the trust with Wi-Fi access and other health and social care professionals (e.g. community staff and social workers) access to their own web-based systems.
2.3 Wi-Fi implementation across social care sites	The proposed solution would be capable of presenting patients with Wi-Fi internet access and other health and social care professionals (e.g. community staff and social workers) access to their own web-based systems. The solution would utilise the current internet connections in Hampshire and the Isle of Wight (HIOW), and intelligently route traffic to NHS or internet resources efficiently.
2.4 HIOW Workflow capability implemented	New models of care and pathways require a joined up approach to providing services. This requires not only information to be shared but also the transfer of care. The workflow tool will facilitate the creation of cross organisational workflows by orchestrating a set of linked tasks, decision points and hand offs. This includes joining up with adult and children's social care. The workflow capability will also facilitate the creation of lists of patient/population cohorts for the focus of targeted interventions.
2.5 Unified alerts & triggers for care professionals	Providing health and care professionals across HIOW with notifications when their attention is required to help their decision making at the point of care. Alerts and triggers are provided in the form of metadata, pointing them towards the information that they need to access in order to understand full detail. Examples here include DNR, vital signs.
2.6 Unified alerts & triggers for patients	This will be provide patients across Hampshire and Isle of Wight with alerts and triggers that are relevant to their health and care. This should be joined up across the entire pathway. Examples of alerts and triggers include appointments, medication reminders.

Table 2: Milestone summary descriptions

E2.6 In order to fully realise the benefits of these system level initiatives, local plans for improving digital maturity must be delivered in alignment with system level transformation – refer to Section E6.

E3 Deliver the technology to shift care closer to home

E3.1 Advances in technology have resulted in an increase in the number of people using mobile devices to help them perform day to day activities such as shopping and banking, as these new digital services become available.

E3.2 Personal attitudes towards healthcare are also changing. The use of health apps in the UK more than doubled between 2014 and 2016; for wearables, usage tripled.[4] Technology is moving faster

A1.1 [4] Accenture, Digital Consumer Health Engagement 2016 – Global Report, 2016.

than ever and this presents significant opportunities for the health and care system. For example, utilising wearables to monitor the vitals of a patient or using home technology such a smart scales to monitor the weight of a patient with heart disease.

E3.3 Within HIOW, we are seeking to leverage these changes to promote health and wellbeing, prevent illness, shift demand towards digital self-service, and deliver care services closer to patients' homes.

E3.4

E3.5

E3.6 Table *3* outlines the system level milestones for delivering this priority.

Milestone	Summary description
3.1 Unified communications across all service provider organisations	Unified communications will deliver technology that makes use of new and current systems and technologies adopted by individual organisations and enable them to work together. This includes staff from all partner organisations being able to video conference and work collaboratively regardless of organisation or location. Unified communications will also provide video or telepresence capabilities to enable professional to interact with the public or patients. The platform will bridge or replace existing localised solutions and will support secure collaboration across Health (N3) and Care (PSN) networks. This activity is dependent on the completion of the HIOW Interoperability Technical Strategy.
3.2 Single patient portal to access services, e.g. view / edit record and care plans, book appointments, etc.	A portal that is accessible by the patient on multiple devices and is their main route in to the HIOW health and care system. The portal should allow the patient to access services such as; view their DHCR, view their pathway (breadcrumb trail), manage their appointments, order repeat prescriptions and interact with health and care professionals.

Table 3: Milestone summary descriptions

E3.7 In order to fully realise the benefits of these system level initiatives, local plans for improving digital maturity must be delivered in alignment with system level transformation – refer to Section E6.

E4 Establish a platform to manage population health

E4.1 As set out in the HIOW STP, the HIOW footprint partners have identified the need to move towards a population health approach to service delivery as a key ambition for addressing local health and care challenges.

E4.2 Population health management can be described as the ability to assess the health needs of a specific population; implement and evaluate interventions to improve the health of that population; and provide care for individual patients in the context of the culture, health status, and health needs of the population of which that patient is a member.[5]

E4.3 A population health approach offers a number of significant benefits relative to more traditional service delivery approaches, including:

- Population health applies to an overall population or subpopulation, rather than only for patients of a specific hospital or provider.
- Illness or risk is traditionally the "trigger" for receiving clinical care. In population health, the trigger for inclusion is not related to specific diseases or conditions, but to any opportunity to prevent illness from occurring in the first place.
- Healthcare system activities occur in settings such as hospitals and nursing homes. By contrast, population health activities are implemented in the community or involve some kind of partnership between a healthcare provider and a community-based organisation or social service provider.
- While healthcare providers typically address medical problems and symptoms such as pain or loss of function, population health strategies address the wider range of needs that are influencing the health problems, including housing, food access, and safety from violence.
- Population health strategies aim to improve outcomes, such as morbidity and mortality, rather than focusing on process, output or quality measures.
- Traditional healthcare performance data are often reported as an average, rate or percent for an overall group of patients. This type of reporting can sometimes mask health disparities. The population health approach emphasises the importance of using data to identify health disparities and inequities and selecting strategies that will improve health for all groups.
- Population health strategies provide opportunities for individuals to improve their own health and wellbeing in ways that are meaningful to them. Population health strategies also attribute accountability to both healthcare and public health organisations, and to policy decisions that impact the social, economic and physical environment.

E4.4 Figure 18 below sets out a high level ambition and data flows for patient centred population health that will enable HIOW to leverage the data we already have and enable transformational change to services.

[5] Definition provided by the Association of American Medical Colleges (AAMC)

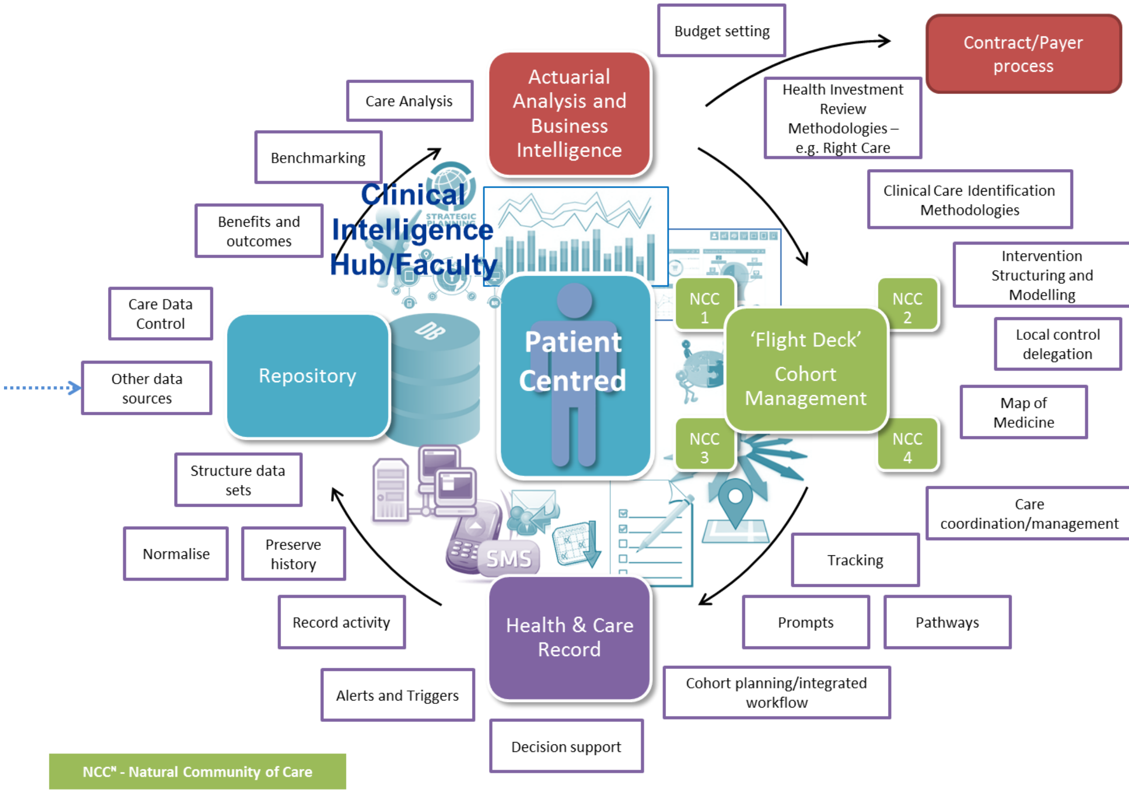


Figure 18: Patient-centred population health data flows

E4.5 Taking a population health approach entails a number of significant requirements for change to existing IM&T capabilities and the development of new capabilities across the HIOW service delivery landscape. These IM&T requirements include:

- Risk stratification and associated tools will be a key driver of the system and the associated information requirements must become integral to the health and care record;
- Capitation-based payment mechanisms will be a key component of pricing, and therefore financial systems must reflect new ways of working;
- A HIOW-wide data repository is required to enable data analysis and improvement opportunity identification, which will also drive pricing;
- Incentives will become better aligned so Provider CSFs are driven by prevention, non-escalation, appropriate settings and wellness – business systems will need to change to support this;
- Learning/ feedback mechanisms are required such that current commissioning/payor activity becomes better informed by success (and failures) of past;
- Cohort management strategies, standards and guidance, e.g. top three interventions will need to be linked to health and care records; and
- Patient activation and behaviour change will be facilitated through open access to records, care plans and services.

E4.6 *Table 4* outlines the system level milestones for delivering this priority.

Milestone	Summary description
4.1 Intelligence Hub - Business Intelligence Visualisation	A layer of business intelligence will be enabled over the current DHCR solution the Hampshire Health Record (HHR). This will be done by utilising local data and business intelligence expertise and experience to develop a series of dashboards answering business and operational needs. Dashboards will be linked to appropriate data systems supporting direct patient care and integrated working to inform decisions at a local (practice based/NCC) and Hampshire and Isle of Wight strategic level.
4.2 Care Co-ordination Centre	As part of the future digital landscape, the STP requires establishment of **Care Co-ordination Centre. This will provide a**HIOW level 'flight deck' for co-ordinating health and care service delivery, including managing 999 and 111 calls, providing routing for primary care appointments, referring to clinical triage hubs, and maintaining a live directory of services.
4.3 Intelligence Hub – Full lifecycle Population Health Analytics to support prevention & improve intervention	BI / analytics capability sitting across key HIOW health and care data repositories, enabling the Intelligence Hub, Care Co-ordination Centre, commissioners and providers to derive population health insights and apply these to commissioning and service delivery. **The Intelligence Hub** will provide a centre of excellence for making best use of health and care data sources, risk stratification, data mining, generating population health insights, and supporting clinicians to leverage data-driven insights.

Table 4: Milestone summary descriptions

E4.7 In order to fully realise the benefits of these system level initiatives, local plans for improving digital maturity must be delivered in alignment with system level transformation – refer to Section E6.

E5 Drive up digital participation of service users

E5.1 If we are serious about shifting health and care services towards a more digital-based provision model with all the benefits that entails, the associated transformation must drive up digital participation by patients and the public.

E5.2 Three quarters of UK adults now own a smartphone, however those most likely to gain from health interventions – low income earners and older people – are least likely to own a device.[6] Engaging cohorts of the population that are at greater risk of poor health and helping them to become digital participants in their own health and care has multiple potential benefits, including improving health and wellbeing outcomes, increasing patient self-care, improving patient experience, and achieving cost savings for health and care service provision systems.

E5.3 Digital participation requires, on the part of the service user, both motivation and digital literacy. By improving digital literacy through appropriate training and education, and influencing motivation by raising awareness of the benefits of digital services, the health and care system can drive up digital participation of both patients, population cohorts and the wider public.

[6] Deloitte, Mobile Consumer 2015: The UK cut: Game of Phones, 2015; We are Apps, UK Mobile Devices Usage and Demographic Roundup, 2013.

E5.4 In addition, we must also ensure that our care professionals are trained in delivering digital services and in encouraging and supporting their patients and population cohorts in using these services.

E5.5 These changes will be delivered through a range of initiatives at different tiers of the system. This includes: leveraging nationally funded, locally delivered programmes such as the Widening Digital Participation programme[7], engagement and communications campaigns, and local change projects and programme for particular population cohorts and services.

E5.6 *Table 5* outlines the system level milestones for delivering this priority.

Table 5. Milestone summary descriptions

Milestone	Summary description
5.1 Digital workforce strategy	A shared HIOW system workforce strategy to make best use of the digital capabilities that will be delivered through LDR in supporting new models of care and address the significant workforce implications, such as: • Training in how to use technology (e.g. virtual consultations, remote monitoring, alerting) and new ways of working (e.g. shared decision-making, customisation of services); and • New roles and skill mix, e.g. lower skilled workforce enabled with decision support systems.
5.2 Digital participation strategy	It is viewed that the necessary change will be delivered through a suite of initiatives at different tiers of the system. This includes a mix of: leveraging nationally funded, locally delivered programmes such as the Widening Digital Participation programme, regional engagement and communications campaigns, and local change projects and programme for particular population cohorts and services.
5.3 More than half of HIOW service users access health and care services via digital over other channels	Usage of implemented technology needs to be high in order to maximise the return on investment and realisation of benefits. Through implementation of the participation strategy and continued service user engagement and involvement we will maximise usage.

E6 Capability improvement plans

E6.1 Following on from the national Digital Maturity Assessment (DMA), an exercise has been conducted with key providers across HIOW to define the maturity trajectory against the seven PF@PoC capabilities between now and 2018/19. The following sections outline local ambitions and plans for improving capability maturity across HIOW. The seven PF@POC capabilities are:

- Records, Assessments and Plans
- Transfers of Care
- Orders and Results Management
- Medicines Management and Optimisation
- Decision Support
- Remote Care

[7] https://www.england.nhs.uk/ourwork/tsd/wdp/

- Asset and Resource Optimisation

E6.2 Figure 19 displays an aggregated view of the capability deployment trajectory across all of the secondary care providers in HIOW. For a detailed breakdown, please see Annex 3.

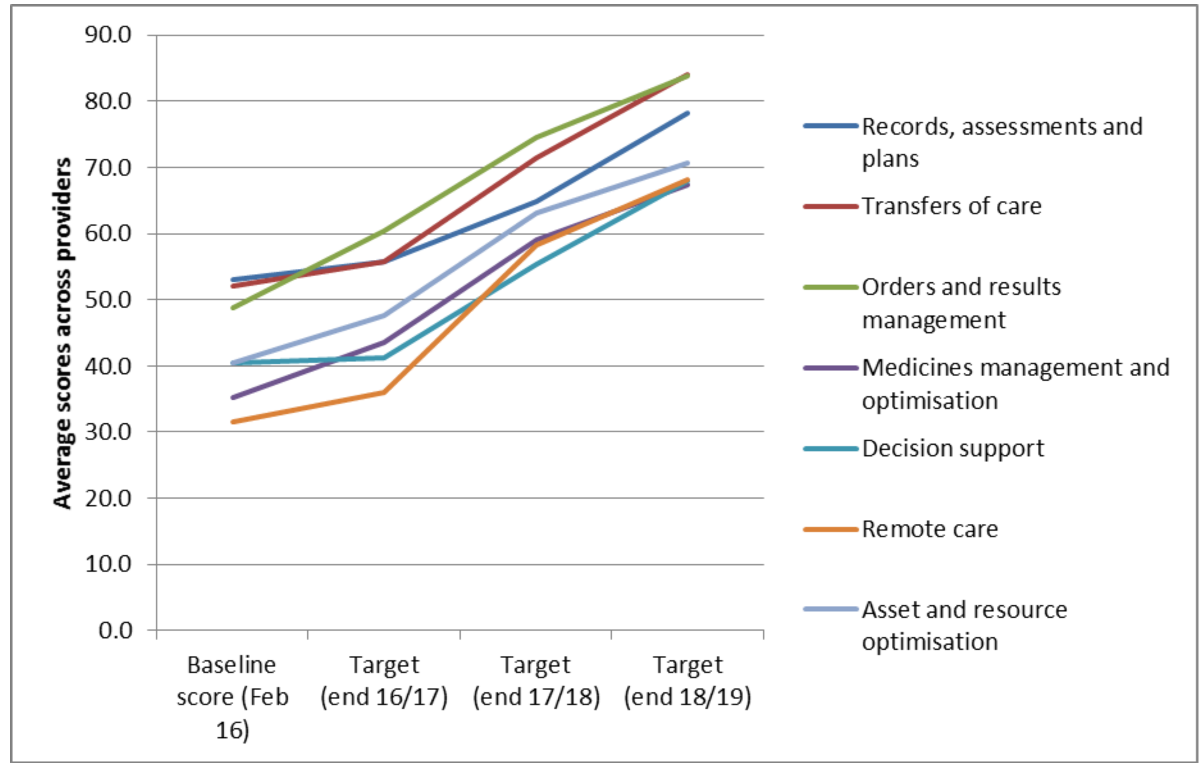


Figure 19: HIOW Secondary Care Capability Deployment Trajectory

Records, Assessments & Plans

Universal capabilities and aims

E6.3 Table 6 summarises the universal capabilities and aims for the Records, Assessments & Plans capability.

Delivery priorities	Aims
Professionals across care settings can access GP held information on GP prescribed medications, patient allergies and adverse reactions	• Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients) • Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions

Clinicians in urgent and emergency care settings care access key GP held information for those patients previously identified by GPs as most likely to present (in U&EC)	• Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations • Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients)
Patient access to their GP record	• Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition • Patients who request it are given access to their detailed coded GP record

Table 6: National delivery priorities for Records, Assessments & Plans

Local capability maturity ambitions

E6.4 Figure 19 highlights the ambition for the secondary care providers across HIOW within the Records, Assessments and Plans capability. The ambition is to move from the current average of 53% to 79% by the end of 2018/19.

Local delivery plans

E6.5 In order to achieve these trajectories, there is a wide range of change initiatives underway or planned across the footprint, at both HIOW and locality levels of the system.

E6.6 Table 7 sets out a sample of initiatives that will contribute to meeting the ambitions set out in the universal capabilities as well as delivering improvements in the Records, Assessments & Plans capability area.

Summary of initiative	Coverage	Delivery date
Interoperability Phase 1 (Digital Health & Care Record (DHCR) upgrade): See Section E1	Hampshire-wide	16/17 – 17/18
Single patient portal to access services: See Section E3	HIOW-wide	18/19
Interoperability - Access to Special Patient Notes: provide SCAS with automated access to the Special Patient Notes information held within the Hampshire Health Record (See Annex 10)	SCAS	In flight
Interoperability - Access to Integrated Patient Record: provide SCAS with real-time GP Patient Records as part of the each regional group's Programmes of Interoperability (See Annex 10)	SCAS	Planning
Interoperability - End of Life - DNR - Paper Form Removal: utilising electronic Do Not Resuscitate instructions to replace the master paper record currently being used across all regions (See Annex 10)	SCAS	Concept
UHS My Medical Record: UHS patients are able to access their record, cancel and rebook appointments and manage their care with the clinician online.	UHS (with further support to additional locations in UK)	TBC

UHS EMR/EPR: Implementation of an integrated EMR solution to enable digital recording of structured notes, assessments, observations and care plans shared across the hospital and the interfacing to support sharing of these by care partners and access by patients	UHS	TBC
eHospital Portsmouth programme: Implementation of an integrated EMR solution to enable digital recording of structured notes, assessments, observations and care plans shared across the hospital and the interfacing to support sharing of these by care partners and access by patients	Portsmouth Hospitals	Q3 18/19
Rollout of electronic clinical noting for nursing and AHPs: Clinical notes to be captured and reviewed electronically, significantly reducing paper usage.	HHFT	June 2017
Fundamentals of Care programme to provide electronic assessment, capture and recording of care plans: programme to fully replace all assessments and care plans with structured electronic data capture. Developed internally on top of existing clinical ePR.	HHFT	June 2018
Vital signs monitoring: to capture observations electronically: Cost effective solution to capture vital signs electronically, automatic alerting of deteriorating patients and remote monitoring. Fully integrated into ePR.	HHFT	Mar 2017
Electronic document management solution: Fully integrated solution to ensure capture and retrieval of all medical record data electronically.	HHFT	Mar 2020
South East EMIS Common Care Record Pilot	SHFT	Q4 16/17
The Isle of Wight ePR includes functionality to build assessments and care plans integration enabled with Social Care and Community teams . The functionality forms part of the workflow within the ePR. The next development phase is to include drawings and patient signatures to ensure complete data capture for Care Pathways within the Trust.	Isle of Wight	Underway
Solent TPP Viewer giving patient centric view of full patient record as appropriate for clinical staff	Solent Wide	March 17
TPP uploads to Hampshire Health Record and summary care record integration to TPP	Solent Wide	Underway
Customisation of TPP Clinical Build by Service Line	Solent Wide	March 17
GP MIG for Solent Practices	Solent Wide	17/18
TPP Mobile deployment which will ensure the accurate and timely availability and updates of records	Solent Wide	16/17 -17/18

Table 7: Initiatives for improving maturity in Records, Assessments & Plans

E6.7 The full list of local change initiatives that are underway or planned to develop these capability areas is set out in the Master Portfolio List in Annex 7.

Transfers of Care

Universal capabilities and aims

E6.8 Table 8 summarises universal capabilities and aims for the Transfers of Care capability.

Delivery priorities	Aims
GPs can refer electronically to secondary care	• Every referral created and transferred electronically (By Sep 17 – 80% of first outpatient elective referrals made electronically) • Every patient presented with information to support their choice of provider • Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability).
GPs receive timely electronic discharge summaries from secondary care	• All discharge summaries sent electronically from all acute providers to the GP within 24 hours • All discharge summaries shared in the form of structured electronic documents • All discharge documentation aligned with Academy of Medical Royal Colleges headings
Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care	• All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act

Table 8: National delivery priorities for Transfers of Care

Local capability maturity ambitions

E6.9 Figure 19 highlights the ambition for the secondary care providers across HIOW within the Transfers of Care capability. The ambition is to move from the current average of 52% to 85% by the end of 2018/19.

Local delivery plans

E6.10 In order to achieve these trajectories, there are a wide range of change initiatives underway or planned across the footprint, at both HIOW and locality levels of the system.

E6.11 Table 9 sets out a sample of the initiatives that will contribute to meeting the ambitions set out in the universal capabilities as well as delivering improvements in the Transfers of Care capability area.

Summary of initiative	Coverage	Delivery date
eReferrals (National): from HIOW GPs to secondary care	National	

Sharing SCAS Discharge Summary: to provide a summary of SCAS clinical activity for a patient and confirmation of discharge / handover from the Trust (See Annex 10)	SCAS	Concept
Bookings for Emergency GP Appointments: to enable SCAS to have the capability of providing Emergency GP Appointment Booking for selected GP surgeries. (See Annex 10)	SCAS	Concept
Bookings for Minor Injuries Unit Appointments: to enable SCAS to have the capability of providing Minor Injuries Unit Appointment Booking for selected facilities (See Annex 10)	SCAS	Concept
Inbound Patient Condition Sharing: to share earlier vital signs information from the frontline Ortivus system with the receiving Emergency Departments. (See Annex 10)	SCAS	Concept
Transformation - Mental Health Pathway: to facilitate the automated transfer of care / patient alert from the SCAS clinical service to the Mental Health Social Care Pathway (See Annex 10)	SCAS	Concept
Non-Emergency Patient Transport: to share patient information with the Programmes of Interoperability and Transfer of Care capability alerting (See Annex 10)	SCAS	Concept
HHFT eCorrespondence: E-discharges and Clinical Contact Notes to improve use of e-discharges throughout the trust, including providing clinic letters in an electronic version.	HHFT	16/17
SHFT eCorrespondence: a project is currently in flight to support clinical correspondence and e-discharges for mental health and paediatric patients, with plans to roll this out further.	Southern Health	16/17
Instant/video messaging software to support Multi Disciplinary meetings (NH CCG): to enable health and social care professionals (primary, community and acute), to work collaboratively to provide patient centric care. Working with HHFT to federate with their solution.	NH CCG/SHFT	Mar 2017
UHS EMR/EPR: Implementation of an integrated EMR solution to enable digital recording of structured notes, assessments, observations and care plans shared across the hospital and the interfacing to support sharing of these by care partners and access by patients	UHS	TBC
eHospital Portsmouth programme: Implementation of an integrated EMR solution to support clinical workflows across the hospital and the interfacing to enable electronic transfers of data both for patients transferring into the hospital's care and those transferring out to that of care partners.	Portsmouth Hospitals	Q3 18/19
SW Hants EDM Implementation: EDM solution linking into referrals management	SW Hants	

e-correspondence (Solent): Currently working to support use of electronic communications with other providers, primary care and the patient	Solent	16/17 – 17/18
e-referrals (Solent): Capability to send e-referrals both internally and externally through TPP	Solent	17/18
Delayed Transfer of Care App (allows the organisation to monitor and proactively managed delayed discharges)	Solent	Underway

Table 9: Initiatives for improving maturity in Transfers of Care

E6.12 The full list of local change initiatives that are underway or planned to develop these capability areas is set out in the Master Portfolio List in Annex 7.

Decision Support

Universal capabilities and aims

E6.13 Table 10 summarises the universal capabilities and aims for the Decision Support capability.

Delivery priorities	Aims
Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly	• Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children) • Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details • The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record
Professionals across care settings made aware of end-of-life preference information	• All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care • All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected

Table 10: National delivery priorities for Decision Support

Local capability maturity ambitions

E6.14 Figure 19 highlights the ambition for the secondary care providers across HIOW within the Decision Support capability. The ambition is to move from the current average of 40% to 71% by the end of 2018/19.

Local delivery plans

E6.15 In order to achieve these trajectories, there are a wide range of change initiatives underway or planned across the footprint, at both HIOW and locality levels of the system.

E6.16 Table 11 sets out a sample of the initiatives that will contribute to meeting the ambitions set out in the universal capabilities as well as delivering improvements in the Decision Support capability area.

Summary of initiative	Coverage	Delivery date
Interoperability Phase 1 (Digital Health & Care Record (DHCR) upgrade): See Section E1 (Note: HHR holds end of life preference information)	Hampshire-wide	Q4 16/17
Intelligence Hub – Business Intelligence Visualisation: See Section E4	Hampshire-wide	Q4 16/17
HIOW Workflow capability implemented: See Section E3	HIOW-wide	Q1 18/19
Unified alerts & triggers for care professionals: See Section E2	HIOW-wide	Q3 18/19
Online Triage System	FG CCG, Solent, W Hants, N Hants	March 2017
HHFT clinical electronic observation system: Calculates NEWS (National Early Warning Scores) values to inform clinical decision making. These scores are electronically available to clinical staff throughout HHFT and integrated with the HHFT ePR.	HHFT	2016/17
UHS EMR/EPR: Implementation of an integrated EMR solution to enable digital recording of structured notes, assessments, observations and care plans shared across the hospital and the interfacing to support sharing of these by care partners and access by patients	UHS	TBC
eHospital Portsmouth programme: Implementation of an integrated EMR solution to support clinical workflows across the hospital, including decision support, automatic prompting, alerting, monitoring of over-rides and links to evidence-based reference material.	Portsmouth Hospitals	Q3 18/19
Fundamentals of care programme will alert Nursing staff of overdue care needs	HHFT	17/18
Real time integration of pathology results into Local ePR and HHR.	HHFT	Mar 17
Full use of Barcode technology for patient identification	HHFT	2019
Child Protection Information System Access for MIUs and Children's services	SHFT	Q4 16/17
Business Intelligence: Southern Health to provide access to health professionals from the wider multi-disciplinary team with external, secured, access to the Trust's Business Intelligence Tool, Tableau, to support population health management and proactive case management	SHFT	Q3 16/17

SCAS LiveLink for Front Line: Project that has been scoped to deliver the capability of visual communications between clinicians to support clinical decision making and provide eyes on the ground visibility.	SCAS	Concept
SCAS LiveLink for Patient: Project that has been scoped to provide visual communications with the public that contact the service which will support the decision of what course of action needs to be taken (See Annex 10)	SCAS	Underway
Business Intelligence - Auto Reporting & Alerting: Project that has been scoped to enhance the capabilities of real-time data capture from the Programme of Interoperability and existing SCAS systems to enable full automation of reports & dashboards and facilitate new patient alerts	SCAS	Concept

Table 11: Initiatives for improving maturity in Decision Support

E6.17 The full list of local change initiatives that are underway or planned to develop these capability areas is set out in the Master Portfolio List in Annex 7.

Medicines Management and Optimisation

Universal capabilities and aims

E6.18 Table 12 summarises the universal capabilities and aims for the Medicines Management and Optimisation capability.

Delivery priorities	Aims
GPs and community pharmacists can utilise electronic prescriptions	• All permitted prescriptions electronic (By end 16/17 – 80% of repeat prescriptions to be transmitted electronically) • All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic rather than paper • Repeat dispensing done electronically for all appropriate patients

Table 12: National delivery priorities for Medicines Management and Optimisation

Local capability maturity ambitions

E6.19 Figure 19 highlights the ambition for the secondary care providers across HIOW within the Medicines Management and Optimisation capability. The ambition is to move from the current average of 35% to 67% by the end of 2018/19.

Local delivery plans

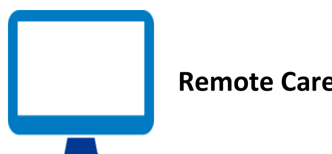
E6.20 In order to achieve these trajectories, there is a wide range of change initiatives underway or planned across the footprint, at both HIOW and locality levels of the system.

E6.21 Table 13 sets out some of the sample initiatives that will contribute to meeting the ambitions set out in the universal capabilities as well as delivering improvements in the Medicines Management and Optimisation capability area.

Summary of initiative	Coverage	Delivery date
Interoperability Phase 1 (Digital Health & Care Record (DHCR) upgrade): See Section E1 (Note: HHR holds information on prescribed medications, patient allergies and adverse reactions)	Hampshire-wide	Q4 16/17
Electronic prescription capabilities: in place across all CCGs within the HIOW footprint, with further developments and expansions planned to increase uptake and usage.	HIOW-wide	TBC
Online long term condition toolkit (FG CCG):	TBC	TBC
Healthy living pharmacies (NEHF CCG):	TBC	TBC
UHS EMR/EPR: Implementation of an integrated EMR solution to enable digital recording of structured notes, assessments, observations and care plans shared across the hospital and the interfacing to support sharing of these by care partners and access by patients	UHS	TBC
eHospital Portsmouth programme: Implementation of an integrated EMR solution including pharmacy stock control and ePMA module to support electronic prescribing and medicines administration across the hospital and utilisation of GS1-standard bar codes to prevent incorrect drugs administration	Portsmouth Hospitals	Q3 19/20
Rollout of ePrescribing and medicines administration (EPMA) to outpatient settings: Pilot, followed by full rollout to ensure sufficient hardware and software to allow EPMA in all outpatient areas.	HHFT	2019
Electronic Prescribing Pilot	Solent	Q4 16/17
Electronic Prescribing roll out	Solent	17/18-18/19
Electronic Prescribing	SHFT	17/18 – 18/19

Table 13: Key initiatives for improving maturity in Medicines Management and Optimisation

E6.22 The full list of local change initiatives that are underway or planned to develop these capability areas is set out in the Master Portfolio List in Annex 7.



Remote Care

Universal capabilities and aims

E6.23 Table 14 summarises the universal capabilities and aims for the Remote Care capability.

Delivery priorities	Aims
Patients can book appointments and order repeat prescriptions from their GP practice	• By end 16/17 – 10% of patients registered for one or more online services (repeat prescriptions, appointment booking or access to record) • All patients registered for these online services use them above alternative channels

Table 14: National delivery priorities for Remote Care

Local capability maturity ambitions

E6.24 Figure 19 highlights the ambition for the secondary care providers across HIOW within the Remote Care capability. The ambition is to move from the current average of 32% to 67% by the end of 2018/19.

Local delivery plans

E6.25 In order to achieve these trajectories, there are a wide range of change initiatives underway or planned across the footprint, at both HIOW and locality levels of the system.

E6.26 Table 15 sets out some a sample of the initiatives that will contribute to meeting the ambitions set out in the universal capabilities as well as delivering improvements in the Remote Care capability area.

Summary of initiative	Coverage	Delivery date
Unified communications across all service provider organisations: See Section E3	HIOW-wide	Q3 17/18
Single patient portal to access digital services: See Section E3	HIOW-wide	18/19
Solutions to support video consultations: Virtual clinics are planned across a number of HIOW health and care providers (IOW, Southern, etc.) with a Skype pilot in flight for Solent.	HIOW-wide	TBC
Wi-Fi implementation across primary care sites – see section E2	HIOW-wide	Q2 17/18
Wi-Fi implementation across secondary care sites – see section E2	HIOW-wide	Q4 17/18
Wi-Fi implementation across social care sites – see section E2	HIOW-wide	Q4 17/18
Mobile working solutions and remote workforce enablement being rolled out (UHS, Solent, IOW, Portsmouth) solution for social care (HCC)	HIOW-wide	TBC
HantsWeb2: Re-platforming the Council website to support and promote the concept of self-service and self-fulfilment. It will enable online resolution of the most popular enquiries, will have optimised end to end processes and provide new transactional services.	HCC	Underway

Tele-monitoring in the home (NH CCG) and nursing homes (NEHF CCG)	TBC	Concept
Wearable patient monitoring proof of concept (UHS)	TBC	Dec 18 (Concept)
UHS EMR/EPR: Implementation of an integrated EMR solution to enable digital recording of structured notes, assessments, observations and care plans shared across the hospital and the interfacing to support sharing of these by care partners and access by patients	UHS	TBC
eHospital Portsmouth programme: Implementation of an integrated EMR solution that supports home care monitoring and teleconferencing both amongst HCPs and for remote patient consultations	Portsmouth Hospitals	Q3 20/21
Unified Comms and Guest WiFi access: at all inpatient sites	SHFT	Q4 16/17
Unified Comms roll out (Solent): to include federation of Skype for Business to support e-consultation pilot	Solent	March 17 - ongoing
Collaborative work with Social Services on use of Telecare alerts	Solent	17/18
Trials of Tele-health/Telemedicine	Solent	17/18 -18/19
SCAS LiveLink to Care Homes: Project that is scoped to deliver the capability for SCAS to provide the service of virtual see and treat between the Clinical Contact Centre and the participating Care Homes.	SCAS	Currently in pilot

Table 15: Initiatives for improving maturity in Remote Care

E6.27 The full list of local change initiatives that are underway or planned to develop these capability areas is set out in the Master Portfolio List in Annex 7.

Orders and Results Management

E6.28 Whilst NHS England has not specified particular delivery priorities for 16/17 and 17/18 in this capability area, Orders and Results Management remains a key capability that must be developed to achieve the Paper Free at the Point of Care vision for 2020.

Local capability maturity ambitions

E6.29 Figure 19 highlights the ambition for the secondary care providers across HIOW within the Orders and Results Management capability. The ambition is to move from the current average of 49% to 82% by the end of 2018/19.

Local delivery plans

E6.30 In order to achieve these trajectories, there are a wide range of change initiatives underway or planned across the footprint, at both HIOW and locality levels of the system.

E6.31 Table 16 sets out a sample of the initiatives that will contribute to delivering improvements in the Orders and Results Management capability area.

Summary of initiative	Coverage	Delivery date
HIOW Workflow capability implemented: See Section E2	HIOW-wide	Q1 18/19
Unified alerts & triggers for care professionals: See Section E2	HIOW-wide	Q3 18/19
UHS EMR/EPR: Implementation of an integrated EMR solution to enable digital recording of structured notes, assessments, observations and care plans shared across the hospital and the interfacing to support sharing of these by care partners and access by patients	UHS	TBC
Electronic Order Communications (Solent)	W/SW Hampshire (PH)	March 17
Internal referrals (Solent) – supporting requests for assessment between health care professionals	Solent	17/18
Information sharing platform: system wide integrated diagnostics - ordering and results	IOW	Dec 2018
Portsmouth Hospitals ICE For Radiology roll-out - Implementation of interim electronic order communications system to enable electronic requesting of Radiology imaging in ED, inpatient wards and outpatient clinics	Portsmouth Hospitals	Q4 16/17
eHospital Portsmouth programme: Implementation of an integrated EMR solution including electronic requesting, results reporting, alerting, audit trails and integration with legacy PACS/CRIS solutions	Portsmouth Hospitals	Q3 18/19
Internal referrals integrated into ePR: Programme to remove paper based speciality to speciality referrals. Integrated into work lists.	HHFT	June 2018
Cross community access integration to allow pull of imaging data from other providers: implementation of XCA IHE standards compliant gateway to allow efficient image and report sharing with other providers. Substantial benefits in reducing both work load and patient treatment times.	HHFT	Mar 18

Table 16: Initiatives for improving maturity in Orders and Results Management

E6.32 The full list of local change initiatives that are underway or planned to develop these capability areas is set out in the Master Portfolio List in Annex 7.

Asset and Resource Optimisation

E6.33 Whilst NHS England has not specified particular delivery priorities for 16/17 and 17/18 in this capability area, Asset and Resource Optimisation remains a key capability that must be developed to achieve the Paper Free at the Point of Care vision for 2020.

Local capability maturity ambitions

E6.34 Figure 19 highlights the ambition for the secondary care providers across HIOW within the Asset and Resource Optimisation capability. The ambition is to move from the current average of 40% to 69% by the end of 2018/19.

Local delivery plans

E6.35 In order to achieve these trajectories, there are a wide range of change initiatives underway or planned across the footprint, at both HIOW and locality levels of the system.

E6.36 Table 17 sets out a sample of the initiatives that will deliver improvements in the Asset and Resource Optimisation capability area.

Summary of initiative	Coverage	Delivery date
HIOW Integration Engine and Master Patient Index implemented: See Section E1.	HIOW-wide	Q3 17/18
Wi-Fi implementation across primary care sites – see section E2	HIOW-wide	Q2 17/18
Wi-Fi implementation across secondary care sites – see section E2	HIOW-wide	Q4 17/18
Wi-Fi implementation across social care sites – see section E2	HIOW-wide	Q4 17/18
Solutions to support patient contact centres: Providing interoperability solutions across practice appointment systems, including 111, to enable practices to directly book appointments at another practice	HIOW-wide	TBC
NHS Mail2	National	Dec 2016
Portsmouth Hospitals Asset Management: Procurement & implementation of an asset management system to enable tracking of medical equipment, devices & prostheses	Portsmouth Hospitals	Q2 17/18
Extend Mobile Working to Tablets Pilot	SHFT	Q4 16/17
Real time electronic bed management solution	HHFT	Dec 2018
Single Point of access view of TPP enabling cross organisation view and booking of appointments	Solent	17/18
Enterprise Data Warehouse project to assist with resource optimisation	Solent	17/18
Staff e-Rostering: to integrated e-Rostering with allocation of assets / equipment to efficiently utilise collectively	SCAS	Concept

Table 17: Initiatives for improving maturity in Asset and Resource Optimisation

E6.37 The full list of local change initiatives that are underway or planned to develop this capability areas is set out in the Master Portfolio List in Annex 7.

E7 Information Sharing

E7.1 Information sharing underpins everything that has been set out in this roadmap. Across HIOW we have already made significant progress into sharing health and care information and making it available across organisations through the use of the Hampshire Health Record (HHR).

E7.2 Our ambition going forward is to build on these foundations to ensure health and care services across HIOW provide the right information, at the right time, to the right people in the right way.

E7.3 This will result in the provision of better care and more informed decision making, whilst also improving the experience of service users.

E7.4 Information sharing will ensure we are able to leverage population health analytics and modelling through front line service delivery and decision support, shifting care closer to home and enabling citizen-activated health and care focussed on prevention, self-care and holistic wellbeing.

E7.5 We have identified the following requirements to enable effective information sharing across the HIOW footprint and help to achieve our overall vision:

- **A single information sharing agreement:** Facilitating better sharing of information between health and care organisations.
- **A single shared consent model:** A central shared citizen/patient consent model which all delivery partners commit to and utilise.
- **Online tool for partners to specify information sharing preferences:** Giving greater control to partners to specify whom they share with and what is shared. Also allowing new entrants and organisations to quickly integrate with existing partners under the single information sharing agreement.
- **Online tool to enable citizens to control and share access to their information:** Giving greater control to the citizen/patient to share their information with partners of their choice. Enabling them to update consent preferences and specify people within their wider circle of care to whom wish to give access to their information.
- **Open API adoption adhering to national standards:** Using the HIOW integration engine to provide a platform of open interfaces to minimise the technical barriers to sharing information between systems, partners and applications. Adoption will be phased and culminate in a public facing set of Open APIs that facilitate integration with public apps and wearables.

E7.6 Further detail on the information sharing ambition is included within Annex 5.

E7.7 In all instances we will look to leverage national solutions, standards and communication campaigns including Verify, Summary Care Record and Patient Online.

E8 Information Sharing Agreements

E8.1 We have already undertaken work across the footprint to identify and assess existing information sharing agreements and consent models between partner organisations. The key findings are that there are many sharing arrangements in place already and there's a high level of maturity amongst partners in this regard. Going forward we need to simplify these arrangements and ensure consistency across the footprint to achieve our five year roadmap through single reusable models where possible.

E8.2 Governance for information sharing will be provided by strengthening an established forum consisting of Information Governance and Caldicott Guardian representatives from each partner organisation. This group will report into the Digital Transformation Portfolio Board, providing specialist advice, assurance and resource.

E8.3 The proposed HIOW Digital Health and Care collaborative team, working on behalf of all partners within the footprint could manage and co-ordinate a HIOW level information sharing agreement (ISA), which has already been developed in draft. This ISA will provide assurance in respect of the standards that each party to the agreement must adopt.

E8.4 The draft ISA covers:

- Purpose and Objectives for Sharing Information
- Principles for Sharing
- Datasets and Data flows
- Consent Arrangements for Sharing Personal Confidential Data
- The Legal Framework
- Legal Basis for Sharing
- Legal Justification for Sharing
- Disclosure and Access to the Integrated Digital Care Record
- Data Accuracy
- Data Retention Schedule
- Procedure for dealing with Subject Access Request (SAR) and Access to Health Records
- Procedure for dealing with Complaint and Breaches
- Audit and Review Arrangement
- Role Based Access Control (RBAC).

E8.5 As part of the mandatory compliance with information governance the proposed health and care entity will complete the Health and Social Care Information Centre (HSCIC) Information Governance Toolkit (IG Toolkit) assessments up to level 2 standard and apply the information security management and, quality assurance standards (ISO 27001 and 9001).

E8.6 To ensure we engage consistently with the public an “Active Communications Campaign” will be established developing a single and clear messages for partners, staff and the public about the intentions and methods by which information will be shared and utilised.

E9 Adoption of the NHS number

E9.1 We will set up and support all our partners to achieve the minimum requirement of using the NHS number as the key identifier for identifying, communicating and sharing information.

E10 Infrastructure

HIOW Footprint Level

E10.1 Infrastructure maturity across HIOW is inconsistent and requires investment. Only two providers' maturity for providing Wi-Fi to care professionals is above the national average with three out of the 10 providers at 50% or lower. Where there is a lack of provision amongst provider organisations there is acknowledgement of the requirement and plans to improve the provision, however these are subject to identifying funding.

E10.2 Public Wi-Fi access varies significantly with three secondary care providers not offering a service while some have rolled out public access across their sites. In order to achieve our STP vision we will need to secure funding to roll out a programme giving consistent public Wi-Fi access across all our provider's publically accessible sites.

E10.3 With regards to infrastructure to support collaboration there has been a successful pilot of providing flexible access to partners' systems from multiple sites. Hampshire County Council, Hampshire Fire and Rescue, Southern Health Foundation Trust, Hampshire Hospitals Trusts, Portsmouth Hospital Trust, local schools and GP practices have successfully implemented a new approach to creating links between secure networks enabling staff from any organisation to touch-down at partner's desks and access their systems.

E10.4 This approach has helped staff from community health and social care co-locate in three hubs across Hampshire, social care staff access their systems from ward PCs, school nurses access their provider systems from a school terminal, GPs access an acute EPR and GPs access the Hampshire Health Record from Local authority care homes.

E10.5 A number of existing initiatives across our footprint are exploring using video and web conferencing to support greater collaboration and reduce the impact of traveling. Several partners are establishing mobile working practices, including holding multi-disciplinary team meetings using Skype for Business and have successfully federated access across two separate domains. There are several projects across our footprint also looking at providing remote access to care and nursing homes via video link supported by shared vital signs monitoring. As part of our system wide maturity we plan to review existing capabilities with an objective to provide a consistent or single method of connecting with people across all partner organisations.

E10.6 There are existing relationships and shared hosting arrangement across our footprint. Local providers are encouraged to explore partners' infrastructure hosting options when reviewing or setting up new technical solutions. Through the HIOW digital Design Authority we plan to explore further opportunities for maximising our local assets where there is existing capital investment that can be used or exploiting cloud hosting when it is appropriate.

HCC

E10.7 HCC and an increasing number of health providers also purchase and share their network infrastructure from the Hampshire Public Services Network (HPSN2). The shared partnership run infrastructure across the public sector partners driving a lower cost of ownership and increased performance. HPSN2 is linked to N3 and offers the ability for partners to rationalise local N3 connections.

PHT

E10.8 Portsmouth Hospitals has a comprehensive Wi-Fi network throughout its Queen Alexandra Hospital site. This currently supports bedside monitoring and gathering of vital signs data. Limited patients' access to Wi-Fi is provided in areas where patients have to spend long periods of time (e.g. Renal dialysis) though this currently excludes streaming services due to bandwidth limitations.

SHFT

E10.9 SHFT's WAN backbone is HPSN2 with the majority of SHFT sites connected directly; the organisation has two N3 points of presence one at each of the two data centres which provide for Disaster Recovery in an active passive arrangement. The majority of SHFT sites have a level Wi-Fi capacity/capability and a programme of work is underway to increase coverage at all sites.

E10.10 SHFT is planning for the implementation of guest Wi-Fi at all sites which will provide secure patient and visitor Wi-Fi access, the design will utilise existing infrastructure

E10.11 A Unified Communications project is currently underway to deliver a consolidated communications platform across SHFT sites. This is being implemented in a phased approach with 15 sites due to complete in 2016/17.

E10.12 Quality of Service (QoS) is being delivered across Southern Health sites to address bandwidth constraints and to provide low latency for relevant network services ensuring that traffic is appropriately prioritised.

E10.13 Services are hosted on a virtual environment and delivered to a 50/50 mix of mobile and static staff/devices, utilising virtual private network (VPN) technology over Wi-Fi / 3G. Work is underway to consider extending this to a virtual desktop infrastructure (VDI) solution that will deliver a consistent desktop environment on lower cost endpoints.

HHFT

E10.14 End user computing: the existing end PC and laptop estate's lifetime is being extended by rolling out of a virtual desk top environment based on Citrix. This allows fast login times and session persistence. Options to looks at cheap end user Citrix devices (e.g. Blackberry PI) are being reviewed. All Windows PCs have been upgraded to Windows 7. Bedside devices are being installed for use both as patient entertainment systems as well as clinical applications. PC refresh is an ongoing issue due to funding, with too many devices being over 10 years old and a struggle to cope with current operating systems and applications. Mobile devices remain a stretch target if funding can be found.

E10.15 Network: the core network has recently been replaced along with Wi-Fi access. The edge network replacement is due to complete in March 2017. Free Wi-Fi is available for both clinician and patient access. Access from home / home working has limited support at present, plans are in place to rollout more extensively pending funding.

E10.16 Fixed telephony: due to be upgraded starting in March 2017 with full digital capabilities. Significant amounts of analogue telephony will remain due to the cost of replacing handsets.

E10.17 Servers and Storage: a new virtual server and storage solution is in the process of being rolled out. Following this the rationalisation of datacentres on the two main sites is planned for 2018/2020. This includes the use of generic cloud and will allow for a full disaster recovery environment to be supported.

E10.18 Security: there is an ongoing programme to ensure that all software is running on supported platforms and is patched on a suitable schedule.

Solent

E10.19 Solent NHS are currently working with CGi on the migration of all end user devices, server and network infrastructure to a fully managed service. As part of this migration one of the key components is the roll out of mobile working across all areas of the organisation. Key to this work is the adoption of 4G enabled laptops with VPN functionality as the default device for users and a move away from shared fixed assets in locality based offices. To date more than 50% of the community based staff in Solent have been issues with mobile equipment and the roll out is due to complete by September 2016. Work is also underway with local partners to provide Wi-Fi access

from as many locations as possible to streamline access and provide options for areas with poor 4G coverage.

UHS

E10.20 End user computing: The existing end PC and laptop estate lifetime is an issue with more than 1,000 devices more than six years old. It is hoped that if investment can be maintained to get the maximum age down to around six years within the 2016/17 period. Maintaining this state will require replacement at around 700-800 per annum ongoing. Mobile devices remain a stretch target if funding can be found.

E10.21 Networking: The core network is being replaced by a 10Gb backbone, which has dual core. This highlights a significant problem in the estate with asbestos and the need to survey anything before any works, a factor of the age of the buildings.

E10.22 NHS Network: The existing <100Mb is challenged. Given the trend towards cloud computing this will become more of an issue, unless there is a move to send more data over cheaper internet links.

E10.23 Wi-Fi: Access is generally good but there are areas of non-coverage. This is difficult to correct partly due to age of buildings but also as a heavy user of the wireless network, planning is becoming an issue. Flooding areas with access points is counter-productive, and as an ePrescribing and mobile medical notes user the existing local wireless bandwidth is challenged. There is limited patient access upon request.

E10.24 The fixed telephony is being upgraded during 2016 but is still largely analogue, with more than 6,000 bell wire extensions. This will not alter during the five year planning period, and this may affect ambitions around unified communications.

E10.25 Data centre and Servers: The estate is largely virtualised over two data centres for disaster recovery and resilience purposes. There is a mixture of dedicated application servers for things such as Pathology, and general virtual storage and smaller servers. At some point the estate will become an issue (space) and there is a view that applications will start to move to the cloud.

E10.26 Security: There is a patching schedule but it becomes out of date as servers cannot be taken down. The perimeter is managed by firewalls.

SCAS

E10.27 SCAS have an aspiration to commence two projects to further develop their infrastructure and enable mobile working:

- NHS Mail 2: project that has been scoped to introduce the secured NHS Mail solution and bring in Skype for Business which both will introduce cost savings relating to cost and time of off-site meetings.
- SCAS Clinical cloud: project that has been scoped to introduce Cloud hosting technologies that will improve remote system access for off-site working and reduce capital expenditure on hardware.

FHFT

E10.28 FHFT have Wi-Fi infrastructure in all of their buildings. In addition, a network upgrade project is due to start in the next month.

E10.29 Mobile devices have been piloted and a Mobile Device Management (MDM) strategy needs to be finalised and the policy written.

E10.30 Single Sign on is used and smartcards for access are in clinical areas. At this time there are smartcards at Frimley/and small number at Wexham. SSO is in place at Frimley and not at Wexham but part of the plan is to roll it across the Trust in the next year.

Isle of Wight

E10.31 The Trust has a need to update an ageing network and server infrastructure which will be key to enabling further progression towards paperless at point of care. This is an essential piece of work and needs to take place before any transformational change

E11 Adoption of GS1 standards

E11.1 Within the HIOW footprint, we recognise that the use of GS1 standards will enable, through standard identifiers and bar codes, the local health and care system to identify, capture, and share information on medicine, medical devices, consumables, assets and returnable equipment automatically.

E11.2 The standards will help identify patients and staff as well as delivery and requisition locations to improve patient safety and supply chain efficiency, whilst saving on costs and enable the recording of the full service line costing of procedures and patient care.

E11.3 Across the HIOW footprint there is a named GS1 lead for each NHS Trust and NHS South of England Procurement Services are on the Department of Health's national group for GS1 implementation.

E11.4 By December 2020, HIOW NHS Trusts are working to have implemented the following against the national standards and five-year plan:

- Single logistics function and inventory management
- Single Procure2Pay process (for supplies, pharmacy etc.)
- Single product recall procedure
- Utilisation of the GS1 barcodes
- Point of care scanning for patient identification in place in 100% of the Trusts
- 90% of products purchased are on a catalogue system.

E11.5 The HIOW CCGs only require limited application of the GS1 standards, when relevant to patients being seen by GP's and the medicine and products they order directly for patient use. In this instance there will be a drive to ensure a consistent approach across the healthcare system, which will be led by the acute service provider organisations.

F Organising to deliver

F1 Governance

F1.1 This LDR has been developed with oversight from a collaborative governance group representing all the HIOW footprint partners, referred to as the HIOW Digital Transformation Board.

F1.2 This group now reports into the HIOW STP Board, which provides overall leadership for transformation across the HIOW health and care system. Partner organisation representatives are responsible for reporting back to their respective Executive Boards.

F1.3 As the STP process gains momentum current digital transformation governance arrangements may need to change to align with that of the STP.

F1.4 Figure 20 sets out the governance structure for digital transformation across HIOW in the context of the broader transformation governance arrangements.

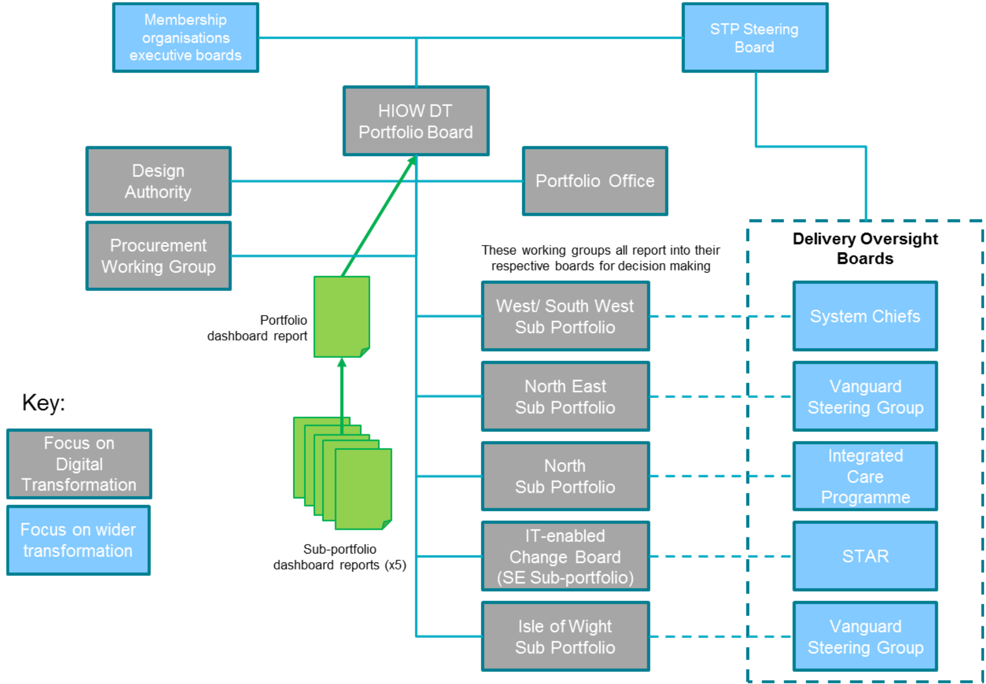


Figure 20: HIOW Digital Roadmap Governance Structure

F1.5 A portfolio management based approach has been used to support the HIOW Digital Transformation Board to establish visibility and portfolio level controls to enable collaborative decision making in relation to investment priorities and delivery oversight.

F1.6 Five sub-portfolios have been established to provide locality-based collaborative governance groups, which report into the HIOW Digital Transformation Portfolio Board, and local transformation leadership groups.

F1.7 A dedicated Design Authority, comprising of CIOs, CCIOs, GP IT Leads and local stakeholder technology leads has been established to provide collaborative technical leadership and to ensure partner organisations work towards shared objectives and outcomes in terms of the approach and design of technology solutions.

F2 Organisation and resource

F2.1 Delivery of the roadmap will require co-ordinated efforts at all levels of the HIOW health and care system.

F2.2 Going forward it is expected that the HIOW health and care system will establish a collaborative team, which will:

- Develop and assure delivery of the Local Digital Roadmap for the HIOW footprint;
- Develop and deliver HIOW-wide digital transformation programmes, including the strategic interoperability platform;
- Drive adoption and use of HIOW-level strategic solutions by health and care organisations across HIOW;

- Facilitate digital innovation through partnerships, stakeholder engagement, adopting an agile approach to delivery, and supporting proof of concept projects that benefit the whole footprint; and
- Provide the governance and portfolio management support function to the HIOW Digital Transformation Board.

F2.3 This collaborative will operate on behalf of the partner organisations that comprise the HIOW Digital Transformation Portfolio Board, and will operate under the terms of a HIOW Digital Transformation Collaboration Agreement, which is under development.

F2.4 It is envisaged that instead of setting up a standalone entity to provide these functions, individual organisations will lead on and resource specific elements, such as procurement, as agreed by the partnership, and will be funded appropriately.

F2.5 Further work is required to define and agree the scope, priorities and resource requirements of the collaborative.

F2.6 In addition to HIOW-level resources, resource will be required locally to lead implementation of HIOW-wide programmes, as well as developing and delivering local change projects and programmes to uplift digital maturity.

F3 Change Management

F3.1 To reap the benefits of the significant transformation set out in the HIOW STP and LDR, we must ensure adequate time and resource is invested in embedding the changes at the frontline of service delivery.

F3.2 For change to be effective, it requires a balance of leadership and change management techniques and we will use a framework for change that is based on best practice methodologies.

Leading change:

F3.3 The HIOW footprint is already well established in terms of leadership for digital transformation, with both system-wide and locality based collaboration groups in place.

F3.4 This vision, and the associated changes required to deliver it, will be championed at a senior level across the system, with appropriate investment in communications and engagement to validate the vision and changes, and gain buy-in from relevant stakeholder groups.

Managing change:

F3.5 In addition to effective leadership, change management capabilities must be embedded within the portfolio, programme and project teams responsible for delivering change across the HIOW health and care system, whether that is part of a HIOW-wide strategic programme, or a project within or between individual provider organisations.

F3.6 In delivering the agreed digital transformation across HIOW footprint, we will use a consistent framework to prepare, deliver and sustain the identified changes, which is summarised in Figure 21.

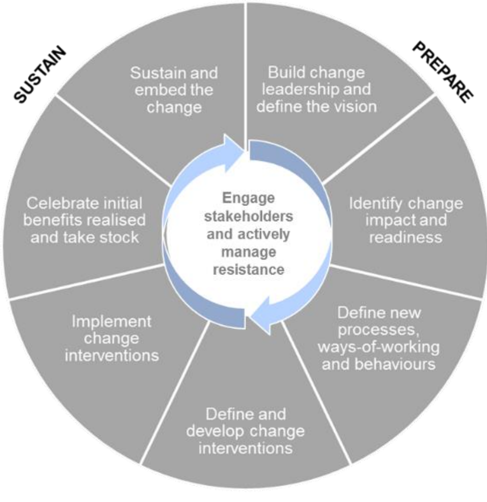


Figure 21: Change management framework

- Engaging all stakeholder groups with the change is key to its success – without the involvement and buy-in of the end users and those enabling the change, it will inevitably fail. Engaging stakeholders, and managing resistance to change, are critical activities to realising the anticipated benefits of change.

F4 Benefits Management

F4.1 For us to achieve our ambition within HIOW, we are going to need a robust benefits identification and management approach to ensure the investments we are making are the right ones and will achieve real value.

F4.2 If value is to be created and sustained, it is important to manage the benefits through the entire investment lifecycle; from describing and selecting the investment, through programme scoping and design, programme delivery and operation of the assets to release the identified benefits.

F4.3 Benefits will accrue at different levels of the system, e.g. to patients, staff, provider organisations, commissioners and the system as a whole, e.g. aggregate savings from cost improvement. In order to have a single view of the benefits being realised through delivering of the HIOW STP and LDR, benefits must be pro-actively managed at the change delivery level.

Benefits management process

F4.4 The figure below shows a high level overview of the benefits management process which will be used to define and track benefits at a programme and project level across the digital transformation portfolio.

Figure 20: Benefits management process

F4.5 Summary of each process step:

- **Define benefits management plan:** This will describe the policies and procedures, roles and responsibilities for benefits management of a project or programme.
- **Identify and structure benefits:** Captures required benefits from key stakeholders. The interrelationships between delivery outputs and achieving associated outcomes will be understood through benefits modelling and mapping. Each benefit (and dis-benefit) will be documented in the project / programme business case in terms of value, timescales, ownership and dependencies.
- **Plan benefits realisation:** This step involves capturing baseline measurements and agreeing targets for metrics that will represent each benefit to be delivered by a project / programme. Baseline measurements will identify the current performance of an operation so that improvements can be measured.
- **Implement change:** This is about implementing the changes required to deliver the identified benefit, including changes to processes, systems and behaviours.
- **Realise benefits:** Following completion of the project / programme, the business-as-usual operational teams must be clear on roles and responsibilities for embedding the changes and ensuring maximum benefits are realised.

F4.6 Projects and programmes will go through appropriate prioritisation based on the benefits they deliver and the return on investment. Prioritisation and go/no go decisions will be decided by the relevant governance group, e.g. organisational board, locality sub-portfolio board or the HIOW Digital Transformation Portfolio Board.

Anticipated benefits

F4.7 Delivery of the HIOW LDR is expected to realise a broad range of benefits to different stakeholders in the health and care system.

F4.8 Whilst specific benefits will be identified and managed at project and programme level, it is important to ensure these are understood and reported on at a system level to ensure appropriate prioritisation of investment and resources to optimise the digital transformation portfolio.

F4.9 Table 1 sets out a high level benefits model, identifying the desired benefits that the HIOW STP and LDR are seeking to achieve, and mapping these to the outcomes and capabilities that must be delivered in order to realise them.

Benefit	Achieved through (outcomes)	Enabled / delivered by
Improve the health of the citizens of the HIOW footprint and prevent ill health	• Better informed health and wellbeing decisions by citizens	• Patient (citizen) portal • Integrated health and care record • BI / analytics
Improve care outcomes for patients	• Better informed clinical decision making • Faster / better co-ordinated delivery of care pathways, including across care setting and organisational boundaries • Better informed commissioning / demand and capacity planning	• Integrated health and care record • Interoperability • Workflow, triggers and alerts • BI / analytics
Improve public / patient experience of health and care services	• Delivery of care closer to home • Better access to services • Better informed choices about care services • More self-service options • Greater control of personal care plans • Better informed commissioning / demand and capacity planning	• Patient portal • Integrated health and care record • Wi-Fi Infrastructure • Interoperability • Workflow, triggers and alerts • BI / analytics
Improve the productivity of care professionals	• Better access to information by care professionals • Better informed clinical decision making • Faster transfer of information between care professionals to enable faster delivery of care pathways • Avoid repeat entry of health and care information (paperless, single shared electronic repository)	• Integrated health and care record • Mobile working • Wi-Fi Infrastructure • Interoperability • Workflow, triggers and alerts • BI / analytics
Reduce overall demand from the public and patients on provider	• Better informed health and wellbeing decisions by citizens • Better informed choices about care services	• Patient (citizen) portal • Integrated health and care record

organisations / the health and care system	• More self-service options	• BI / analytics
Shift demand to more efficient channels / settings, increasing productivity of provider organisations / the system	• Delivery of care closer to home • Better access to services • More self-service options • Better access to information by care professionals • Better informed clinical decision making • Better informed commissioning / demand and capacity planning	• Patient portal • Integrated health and care record • Wi-Fi Infrastructure • Mobile working • Interoperability • Workflow, triggers and alerts • BI / analytics

Table 19: High level benefits model

F4.10 Further work is required across the HIOW digital transformation portfolio to ensure that benefits are clearly defined and plans put in place to manage and realise them at the appropriate level of the system.

F5 Risk Management

F5.1 Management of risks to the successful delivery of the HIOW LDR will be led by the HIOW Digital Transformation Board, with support from the portfolio management team, who will pro-actively monitor, review and manage identified risks.

F5.2 An appropriate portfolio risk management framework will be established to ensure the Board has visibility and management control of HIOW level risks.

F5.3 Please see Annex 6 for details of the key identified risks to successful delivery of the HIOW digital ambition and roadmap.

F6 Investment Profile Summary

F6.1 The scale and complexity of the HIOW footprint together with the ambition for strategic transformation means that significant digital investment will be required to achieve our outcomes. The high level of investment reflects the need for all organisations to reach a threshold of maturity acting as a technical foundation and the need to invest in top down strategic interoperability and population health analytics to deliver holistic citizen centric services.

F6.2 Throughout the digital roadmap process a portfolio approach has been used to collect and share an increasing level of detail surrounding our existing maturity, current and planned projects and individual trajectories to achieve the national capabilities. While the information has provided a unique insight into the work being undertaken, there is now a requirement evaluate and align, at scale, to ensure we are making the best use of resources, maximising collaboration opportunities and everything is contributing to our strategic 5 year ambition. Utilising the governance structures, including the digital design authority, future digital projects and their corresponding business cases will be evaluated to ensure they are fit for purpose and strategically aligned.

F6.3 The HIOW footprint is a multi-billion pound health and care system supporting approximately 50,000 staff supporting over 2 million citizens. Every aspect of our future transformation is underpinned by digital from our estates strategy, customer access and new models of care. We recognise investment in digital as the key driver for change and releasing the ongoing efficiencies to maximise the health and wellbeing of our population.

F6.4 Funding required to deliver the roadmap is split between investment to support local digital maturity and HIOW wide strategic investment. Without identifying the detailed design requirements and

overall technical strategy estimating the split between capital and revenue required, particularly with IT and digital solutions being increasing hosted on the cloud, is difficult to predict.

F6.5 Early analysis indicated capital investment of c.£35M and revenue implications of c.£10M per annum would be required to achieve our digital ambition. Focus on this analysis was on the system wide initiatives such as the interoperability and population health programmes with limited funds assigned to individual organisations maturity ambitions. Finance Directors have been consulted in the development of these estimates through the STP process. Further engagement with local providers has also identified key shortfalls in local digital maturity (covered in section D1) that require significant investment to align over the next 5 years.

F6.6 Estimates for this include:

- £4m to support a local provider to transition to electronic document management.
- £10m to support a £50m project to overhaul and modernise a hospital's core technology platform.
- £20m to support an ePR replacement.
- >£5m to support local Wi-Fi initiatives.
- >£5m as 1/3 funding to support systems rationalisation as part of an acute trust merger.

F6.7 Without further work to assess detailed bids the total value of additional investment to achieve partner trajectories for digital maturity is in excess of £100m.

F6.8 HIOW strategic investment covers both short and long term investment projects. The interoperability strategy builds on existing capabilities and technology to provide early benefits as well as recognising the need to invest in new shared technology to support future integration work. Shorter term the priority is to harness the investment and asset we have in our existing integrated digital care record the HHR. Work includes an upgrade to the latest version, rollout of single sign-on, mobile working and creating a decision support dashboard utilising a business intelligence visualisation tool.

F6.9 To support our workforce to work flexibly, co-locate, and enable public access to services and to underpin our future systems it is vital we invest in our infrastructure. Short term will be look to build on existing work to ensure staff from any partner organisation can work across all location flexibly and ensuring there is Wi-Fi access across our shared estate. Longer term, and in light of national programmes, we investigate opportunities to exploit shared networks and services such as unified or federated communications platforms (for example the Health and Care network and extended NHSmail2 services).

F6.10 Longer term strategic investment includes:

- Shared Infrastructure
- Strategic Interoperability
- Population health/Intelligence hub
- Support to integrate with local system and APIs
- Technology to support care coordination and patient activation
- Capability and capacity to implement, integrate, train and manage the future ambitions

F6.11 We have detailed estimates for initial investment required to support strategic interoperability and have already started to engage with the market to identify potential solutions. We are looking to secure funding for short term strategic solutions through the ETTF, Vanguard and local CCG funding.

F6.12 Investment in technology will require identifying funding sources and where appropriate pooling resources to benefit from our footprints ability to deliver economies of scale.

F6.13 Our target sources of investment include:

- ETTF
- Vanguard funding
- STP funding
- Digital maturity investment fund
- Local IM&T funding
- Cash releasing efficiencies

F6.14 There will be a significant gap between the investment needed and identified. The gap will ultimately limit our ability to deliver the transformation and therefore it is vital we can measure outcomes and release cashable benefits early from our digital investment. Securing a level of early momentum, working with our pioneering business areas will help secure the confidence and business justification to unlock future funding streams.

F6.15 While it would not be feasible to restrict all local funding applications for small initiatives to support local sustainability, any future large or strategic requirement will be channel through the Digital and STP governance. Evolving a process that will ensure we align to our transformation objectives is critical in order to achieve the efficiencies needed to deliver modern health and wellbeing solutions meeting our future population and organisational needs.

F6.16 Our LDR recognises that funding may come in tranches and our approach to delivery will be aligned to reflect this.

G Annexes

Annex 1.	NHSE Checklist Mapping Tool	Annex 1 - NHSE checklist mapping t
Annex 2.	HIOW Capability Deployment Schedule	Annex 2 - HIOW Capability Deployme
Annex 3.	HIOW Capability Deployment Trajectories	Annex 3 - HIOW capability trajectorie
Annex 4.	HIOW Universal Capability Delivery Plan	Annex 4 - HIOW Universal Capability
Annex 5.	HIOW Information Sharing	Annex 5 - Information Sharing
Annex 6.	HIOW LDR Risk Log	Annex 6 - HIOW Digital Roadmap Ris
Annex 7.	HIOW Master Portfolio List	Annex 7 - HIOW_Master_Portf
Annex 8.	HIOW LDR Glossary	Annex 8 - HIOW LDR Glossary v03.do
Annex 9.	HIOW LDR Governance Group	Annex 9 - HIOW LDR Governance Gr
Annex 10.	SCAS LDR Vision	Annex 10 -SCAS Vision of the Local [

Hampshire & Isle of Wight STP estates enabling plan

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EXECUTIVE SUMMARY

Over the past two months, partners have been meeting as a workstream forum to compile the Estates section of the STP.

This builds on individual work through the Local Estates Forums (LEFs) to produce Strategic Estates Plans (SEPs) and Providers' own work to deliver cost improvement and innovation.

This document is an Estates Enabling Plan (EEP) and sets out the interim conclusions of the workstream, but more importantly points to an ongoing process whereby the partners will move towards a more robust Estates Strategy reflecting the full transformation implications of the STP.

The partners agree:

1. That the main impetus and focus for Estate Rationalisation will be at a local, place-based level where much is already happening to optimise and develop assets
2. That they will work together to pursue the five opportunity areas identified in this report:
    a. Reducing demand for the Estate
    b. Increasing asset utilisation
    c. Introducing or enhancing flexible working
    d. Reducing operating costs
    e. Enhancing "One Public Estate" ethos through shared service initiatives
3. That the current planning assumption for a potential £35m revenue savings (net of investment) is a stretching but achievable target over 5 years but needs more review and refinement and site based testing in the light of the STP Transformation proposals
4. There are strong interdependencies between Digital and Channel Shift, New Models of Care and Alliances/Collaboration within other STP workstreams and estates efficiencies cannot be delivered independently.
5. Across HIOW there is value in considering a forum - building on the work of this workstream – to oversee, share, optimise and learn from others and to undertake a periodic stocktake.
6. That there remains more work to be done in describing hub facilities within New Models of Care in a way that maximises standardisation, flexibility, cost efficiency and re-use of existing facilities
7. That partners will strive collectively to improve the information held and exchanged about the Estate and exploit data to improve performance including fitness for purpose reviews, condition assessments and compliance audits
8. That there may be value in exploring non-capital and other innovative financing mechanisms including asset-backed or special purpose vehicles
9. That more work is required to explore revenue generation opportunities including void management, temporary uses and generally more active Estate Management
10. That the connection of Health and Care to the wider economic development, regeneration, and inward investment and innovation agenda need to be emphasised and improved. This includes exploring site assembly to facilitate housing such as staff accommodation.

PURPOSE OF THIS DOCUMENT

This document is an Estates Enabling Plan (EEP) designed to begin to develop an estate response to the main STP transformation themes. It is the intention that, with more work, it will sit with the SEPs to be an estates strategy for HIOW.

The EEP does not intend to replace or replicate existing organisations' estates strategies/plans across the footprint. Rather, the EEP focuses on the common themes across the footprint where collaboration is either desirable (e.g. to achieve economies of scale, to share scarce resources, to share best practice) or essential (e.g. cross-organisational data sharing and co-location), and provides a framework for prioritising investment at a footprint level to maximise the benefits of estate-enabled transformation.

CONTEXT

The Sustainability and Transformation Plan (STP) has been developed in order for the NHS to deliver the Five Year Forward View (5YFV) published on 23 October 2014.

It is clear that patient needs are changing and we are facing a particular challenge in the NHS from increasing demand on services. The current method and growth of service delivery is unsustainable and so the NHS will need to contemplate significant change. The 5YFV contains a vision of how the NHS needs to change over the next five years in the areas of:

- Health and Wellbeing
- Care and Quality
- Finance and Efficiency

Nationally, STPs are a key vehicle for realising this vision. They address both Health and Care and are divided into 44 geographical footprints. Hampshire and the Isle of Wight (HIOW) is one of the larger footprints.

In HIOW we are facing a financial gap of £719m by 2020/21. The STP will look to optimise our estate portfolio in order to contribute to closing this financial gap and to better support our New Models of Care and other key transformation themes. The estates workstream of the STP links closely with technology and channel shift, and so have been grouped together under 'Technology and Estates'. This is because the initiatives coming from these workstreams will have a material impact on the demand for the Estate.

PARTNERS

Since work on the estates STP began in mid-April, we have had four team meetings and four stakeholder meetings. Our team meetings have guided the methodology of the work which has been presented for review in our stakeholder meetings.

Partners from CCGs, local authorities and trusts, as well as CHP and NHSPS, have been invited from all over HIOW to partake in the wider stakeholder meetings for their feedback and input around the

Estates STP. The process has been iterative and centred on an approach that has been captured in this document.

APPROACH

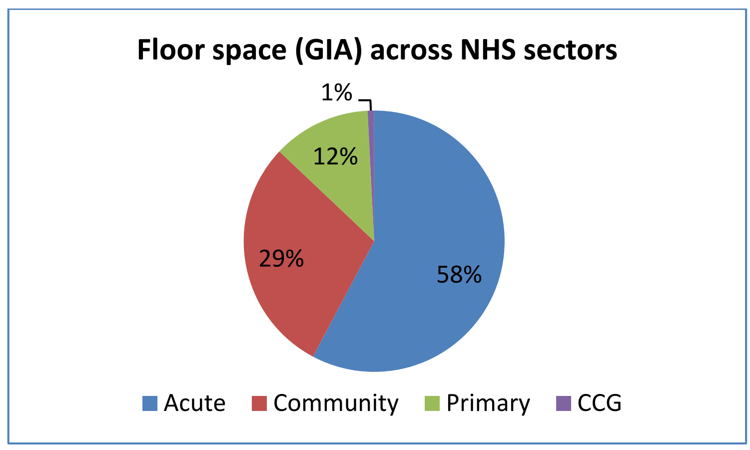
The approach to the Estates workstream over the last few months has involved research and analysis prepared by the core team and validated with stakeholders. The core team has researched at a national level to understand what monetary and non-monetary opportunities can be realised in transforming estate. The Strategic Estate Plans (SEPs) have given an overview of the estate portfolio in HIOW which has allowed the workstream to see how these opportunities can applied to the local estate. The areas of focus have been filtered through the course of dialogue between the core team and stakeholders to arrive at five key opportunity areas. Hypotheses around these opportunity areas were created based on case studies and stress-tested where possible in order to help understand the revenue savings potential in the HIOW Estate. Estimates around the savings potential were then formalised and proposed to the stakeholder group for review. A bottom-up analysis has given baseline estimates of revenue savings based on our current actions and a top-down analysis has given targets based on what can potentially be saved by implementing the five opportunity areas. This has been an iterative process: proposed savings estimates, discussion around these estimates, potential risks raised, further feedback from stakeholders, and then revisiting estimates.

CURRENT PORTFOLIO

By extracting data from the Strategic Estate Plans* (SEPs), prepared earlier this year, we see that the NHS Estate in HIOW covers a Gross Internal Area (GIA) of **916k m^2**. This amounts to an annual running cost of **£258m**. The estate can be split into 4 sectors: acute, community, primary, CCGs, which comprise 58%, 29%, 12%, and 1% of the GIA respectively.

Acute sites cost the most to run, averaging at **£306/m^2**, compared to £255/m^2 for community and £251/m^2 for primary care. As the acute sector has the highest running costs and comprises the largest GIA, and the STP makes reference to an Acute Alliance and an overall transfer of resource to other sectors, we envisage that it will ultimately provide the most opportunity for estates savings, however, the community and primary sectors are the areas of greatest initial opportunity. We also expect most of the investment to be in the community sector to facilitate new models of care.

The graph below displays the Gross Internal Area (GIA) across NHS sectors.



The table below displays the running costs on the GIA of HIOW estate.

Type	Floor Area/GIA (m2)	Annual Cost	Annual Cost (%)	Cost per sq. m
Acute	529,085	£161,800,000	63%	£306
Community	268,286	£68,400,000	27%	£255
Primary	111,182	£27,900,000	11%	£251
Total	**908,553**	**£258,100,000**	**100%**	**£284**

*Note: It has been highlighted that the SEPs include some inaccuracies

LOCAL INITIATIVES

The Hampshire and Isle of Wight Footprint covers eight CCGs. The system wide-strategies contained within the STP aim to build on and complement the commissioners' local initiatives. This is reflected in the Estate approach also. A summary of local estates strategy for the eight CCGs are as follows. More details can be found in *Appendix 1*.

NHS North Hampshire CCG

NHS North Hampshire CCG is working with the North Hampshire MCP and the North Hampshire Alliance Estates Strategy Group to assess potential to exit, increase, or optimise estates to deliver clinical and financial benefits, and to deal with the challenges of a growing population.

- The CCG are seeking to **reduce and/or exit estates** in primary care through re-provision, by 'working at scale' and co-location of services, and in the community by disposal of certain portions of the community estate (pending option appraisals in certain areas).
- The CCG will **increase estates** by developing primary care facilities based on increased population (delivering improved premises in line with NHS England strategic objectives), and by increasing the community estate in line with population growth which the existing system is unable to absorb.
- The CCG is undertaking option appraisals of its community and primary care sites, to determine how best to **optimise their estates**.
- Secondary Care estates programmes are currently subject to ongoing work to resolve proposals for a new Critical Treatment Hospital.

NHS South Eastern Hampshire CCG

NHS South Eastern Hampshire CCG is working with the Portsmouth and South East Hampshire System Transformation and Resilience Board to assess potential either to exit, increase, or optimise estates to deliver clinical and financial benefits, and to deal with the challenges of a growing population.

- The CCG are seeking to **reduce and/or exit estates** in primary care through re-provision, by 'working at scale' and co-location of services, and in the community by disposal of certain portions of the community estate.
- The CCG will **increase estates** by developing primary care facilities based on increased population (delivering improved premises in line with NHS England strategic objectives), and by increasing the community estate in line with population growth which the existing system is unable to absorb.
- The CCG has highlighted specific sites for **estates optimisation.**
- The CCG has no plans to reconfigure the Secondary Care estate

NHS Fareham and Gosport CCG

NHS Fareham and Gosport CCG is working with the Portsmouth and South East Hampshire System Transformation and Resilience Board to assess potential either to exit, increase, or optimise estates to deliver clinical and financial benefits, and to deal with the challenges of a growing population.

- The CCG are seeking to **reduce and/or exit estates** in primary care through re-provision, by 'working at scale' and co-location of services, and in the community by disposal of certain portions of the community estate.
- The CCG will **increase estates** by developing primary care facilities based on increased population (delivering improved premises in line with NHS England strategic objectives), and by increasing the community estate in line with population growth which the existing system is unable to absorb.

- The CCG has highlighted specific sites for **estates optimisation** in the Community, and will be undertaking options appraisals for optimisation of the Primary Care estate**.**
- The CCG has no plans to reconfigure the Secondary Care estate

NHS Southampton City CCG

NHS Southampton City CCG is working with the South West Hampshire Estates Group to assess potential to exit, increase, or optimise estates to deliver clinical and financial benefits, and to deal with the twin challenges of shifting balance between Acute and Out of Hospital Care and 25% Social Care efficiency

- The CCG are seeking to **reduce and/or exit estates** in primary care through re-disposal of certain CAMHS facilities, and in the community by disposal of certain portions of the Community Estate.
- The CCG is looking to **increase estates** in the community through a new joint facility with Southampton City Council, and is in discussion with its acute providers regarding new facilities. Increases in the primary care estate are to be determined following completion of Primary Care strategy
- The CCG has highlighted specific sites for **estates optimisation** which will be achieved by shifting services from acute providers and back-filling services across the community estate**.** Optimisation of the primary care estate is to be determined following completion of primary care strategy.

NHS West Hampshire CCG

NHS West Hampshire CCG is working with the West Hampshire Strategic Estates Group to assess potential to exit, increase, or optimise estates to deliver clinical and financial benefits.

- The CCG are seeking to **reduce and/or exit estates** in the community through the rationalisation of smaller occupations and leases, and consolidation of community hospital sites into modern, compact facilities.
- The CCG is looking to **increase estates** in the community through by developing existing community sites in the next five years.
- The CCG has highlighted specific community sites for **estates optimisation**.
- Secondary Care estates programmes are currently subject to ongoing work to resolve proposals for a new Critical Treatment Hospital.

NHS Isle of Wight CCG

NHS Isle of Wight CCG is working within its local Strategic Estates Group (firmly linked into the Island’s New Care Model’s ‘My Life a Full Life’ programme) to assess potential to exit, increase, or optimise estates to deliver clinical and financial benefits.

- The CCG are seeking to **reduce and/or exit estates** in secondary care by reducing their hospital footprint at Newport, in the community by relocating community services other centres and in primary care by consolidating practices.
- The CCG will **increase estates** for "out of hospital" services by increasing technologically enabled rooms across the island, in the community estate by increasing step down facilities and sessional rooms across the island through care home / Dementia and Extra Care sites, and in Primary care through consolidated facilities
- The CCG's plans for **estates optimisation** include, re-letting space to third party providers, optimising expensive long-lease community property (including releasing cheaper space), and disposing of outdated primary care property

NHS North East Hampshire Farnham CCG

NHS North East Hampshire and Farnham CCG is working through a North East Hampshire and Farnham Estates Workstream to assess potential to exit, increase, or optimise estates to deliver clinical and financial benefits.

- The CCG are seeking to **reduce and/or exit estates** by reallocating work between Community Hospitals to make room for an ICT community hub, and, in primary care, by disposing of GP practices. The CCG will **increase estates** in the community estate by investing in a new community ICT hub facility and in primary care by constructing a new GP surgery and creating additional capacity in certain sites.

NHS Portsmouth CCG

NHS Portsmouth CCG is working to assess potential to exit, increase or optimise estates to deliver clinical and financial benefits.

- The CCG are seeking to **reduce and/or exit estates** by refurbishing and reconfiguring Community Hospitals (St Marys Community Campus) which will result in large amounts of land release for housing. (St James Phase 1 and Phase 2 projects)
  - Decanting from St James to St Mary's Hospital will allow for estate consolidation and provide land for housing. There will be significant revenue savings from this project.
- The CCG will also **increase estates** with the development of 2/3 clinical hubs and the reprovision of some GP accommodation

FIVE YEAR VISION

In five years' time, we want to see an increase in the utilisation of our current estate and an overall decrease in the volume of assets that the NHS operates. Also we aim to have estate that is more flexible and more receptive to new models of care.

We envisage a future within the STP planning horizon where the direct link between enhancements in health and care, and land and buildings begins to be severed. Fewer people will attend a health facility in person or meet a health and care professional face to face. We will have a reduced number of beds, proactive case management for those at risk, standardised disease management pathways enabled by technology and self-care for a wider range of conditions. Entry and navigation around the system will be via a care coordination facility ensuring effective channel management and care closer to home. We aim to invest in renewing estate that is not currently fit-for-purpose and in the development of hubs which will break down the barriers between primary and secondary care. For investment reasons we will capitalise on monetary opportunities provided by One Public Estate (OPE), and other programmes that overlap with health and care, to help us deliver these changes to the HIOW estate.

Overall we aim to reduce the quantum of estate which will be managed more flexibly, more intensively (better utilisation) and for longer (7 day working).

CHALLENGES

In HIOW we do have a large number of high standard, well-kept sites such as the Hampshire Local Improvement Finance Trust (LIFT) properties. However, we also know that a portion of the NHS estate is not necessarily fit for its current purpose with, significant portions of the estate being poorly utilised, poorly maintained or unused (or a combination). The STP can address these weaknesses whilst helping to reduce the funding gap by highlighting the potential revenue savings across HIOW.

Key issues in HIOW:

- A large amount of community estate is underutilised.
- Three of the five acute trusts have sites that are unsustainable.
- There are significant challenges in primary care with overburdened GPs, growth in demand exceeding growth in workforce and a large number of premises that are not fit for purpose.

In addition, although detailed data is unavailable, our research shows that a significant portion of the estate is not fit for purpose or does not meet modern standards, which in some cases applies to large facilities. Linked with its future forensic services strategy and following input from the CQC, Southern Health, for example, is currently investigating the potential of replacing its medium secure unit. Similar requests from the CQC have been made to UHS in relation to its General ITU.

SAVINGS: TOP-DOWN ANALYSIS

By looking at national case studies and using current knowledge from other workstreams in the STP, we have identified five opportunity areas whereby substantial revenue savings can be made and then an area held for investment costs. These are summarised in the table below.

Opportunity area		Impact	Plan for delivery
	Reduced demand for Estate	Saving	• Acute alliance – efficiencies due to service optimisation, shared services and linked investment strategies • Monitor impact of channel shift and digital
	Increased utilisation	Saving	• Understand utilisation across strategic sites • Bring acute ratio of clinical/non-clinical floor space to optimal amount • Build from plans outlined for better utilisation in SEPs
Flexible Working	Flexible working	Saving	• Increase use of existing flexible work policies and new flexible working schemes • Aim to increase ratio of employees per desk • Provide employees with equipment to work from home
	Reduced operating costs	Saving	• Work with Academic Health Science Network to reduce energy costs on strategic sites • Better facilities management across all sectors • Improve procurement methods in trusts
	OPE and shared services	Saving	• Accelerate links with One Public Estate (OPE) to see how Health and Care share public estate • Broaden back-office services
	Investment	Cost	• Continue with plans outlined for investment from SEPs • Look to understand hubs, their definitions and how they can support new models of care

FIVE OPPORTUNITY AREAS

Reduced demand for Estate

The reduction of demand on the NHS estate will come from optimisation in the acute sector, a more innovative use of technology and improved population health.

The STP proposes a new acute alliance between Solent-based trusts which in time may incorporate the whole of HIOW. We are yet to plan in detail how this alliance will work, however we anticipate that we will benefit financially from joining up acute services. We expect that some back, and possibly front and middle, services will be shared thus providing an opportunity to reduce their total GIA related to these services. Furthermore, in the North, major estate rationalisation opportunities may arise once the sustainability issues in North and Mid Hampshire are resolved.

The use of technology, which is a major theme in the HIOW STP, will allow clinicians to remote monitor patients and help them self-care. This will mean fewer hospital admissions and re-admissions. Also investments that concern the movement of patients from more expensive channels to less expensive ones, such as increased web consultations, will free-up GPs' time. This will result in a reduction in hospital admissions as GPs will be able to use the free time to tackle case management and disease management in a more proactive manner and increase secondary prevention. These changes to patient treatment flows will mean that more clinical and non-clinical acute estate will be able to be released.

Below are the criteria for the impact that reduced demand will have on our estate.

	Impact	**High**	**Medium**	**Low**
Reduced demand for Estate	Criteria	- large uptake of self-service - large impacts of digital technology reducing demand - strong population health in HIOW	- reasonable uptake of self-service - reasonable impacts of digital technology reducing demand - medium population health in HIOW	- negligible impacts from uptake of self-service - negligible impacts of digital technology reducing demand - poor population health in HIOW
	Demand reduction	20%	13%	5%

Increased utilisation

Space utilisation is a measure of whether and how space is being used. Utilisation rate is expressed as a percentage and gives an indication of the frequency that a room is used and takes into consideration the room's capacity. There is a large spread across the sectors of estate in their level of space utilisation. Hospitals are nearly at maximum capacity and have very high utilisation of the premises (estimated at 90%) whereas in community estate the utilisation sits at around 40%. Using sources such as SHAPE, ERIC and discussion with stakeholders, we estimate that our current overall utilisation of premises is as shown in the table below.

NHS sector	Current overall utilisation (%)
Acute	90%
Community	40%
Primary	70%
CCG	55%

Clearly, in the community sector there is a considerable amount more that we can do to better utilise our existing estate. By improving the utilisation in our strategic sites we can reconfigure and release some estate thus making revenue savings. This is already being addressed and work is underway as mentioned in the SEPs summaries from each CCG.

There is very limited opportunity to increase utilisation in the acute sector due the average utilisation being very high and holding a large amount of clinical floor space.

	Impact	**High**	**Medium**	**Low**
Increased utilisation	Criteria	Possibility of: - much improved site organisation - meeting rooms being regularly booked (>70%) - more shared office desks - option to relocate	Possibility of: - reasonably improved site organisation - meeting rooms booked more often (in use >50%) - more shared office desks	Possibility of: - slightly improving organisation of site
	Increased utilisation	20%	10%	5%

Flexible/new ways of working

Flexible and new ways of working give employees flexibility on where, when and how long they work.

Research from DEGW, industry leading workplace consultants, consistently shows that individual office space is only used between 30-40% of the time. Flexible/mobile working makes it possible to use considerably less space and use it more effectively. Research is based on success in the private sector, and whilst it may be difficult to achieve the same level of success in the public sector, the same methodology can be applied for much of our estate. By applying this to health and care we will have to spend some on-going costs for portable electronic equipment and provide remote access to healthcare records.

	Impact	**High**	**Medium**	**Low**
Flexible/ new ways of working	Criteria	Possibility of: - 30% space reduction - shared space areas - multi-functional spaces - 1.5 employee to desk ratio Can be applied to 70-100% of estate	Possibility of: - 15% space reduction - shared space areas - 1.2 employee to desk ratio Can be applied to 30-70% of estate	Possibility of: - 5% space reduction - Possible improvement employee to desk ratio Can be applied to less than 30% of estate
	GIA reduction	30%	15%	5%

Reduce operating costs

In addition to making revenue savings by reducing the GIA on our existing estate, we can also find innovative ways to reduce the operating costs of this estate. The operational productivity and performance in acute sites was a key area addressed in the Carter Review published in February 2016 which highlighted that we could save £1bn on annual revenue costs at a national level. It highlighted that variation of running costs was shown to be at its highest when compared with the use of space in trusts. It is recommended that trusts should operate with a maximum of 35% of non-clinical floor space and a maximum of 2.5% of unoccupied/underused space.

Several areas were highlighted whereby operating costs could be saved in hospitals including energy spend, cleaning and food services. The review indicated that 25% of energy costs could be saved by using LED lighting, combined heat and power units, smart energy management systems and so on. A combined savings potential of 16% was outlined. However, further review will need to be carried out to see how this applies to the acute sector in HIOW and account taken for the inclusion of PFI contracts which are often included in operational cost figures.

Currently Wessex Academic Health Science Network (AHSN) is involved in a benchmarking study to improve energy efficiency for NHS and universities across Wessex. In the NHS side of the study, they are focussing on CCG key strategic sites as well as PFI/LIFT buildings.

	Impact	**High**	**Medium**	**Low**
Reduced operating costs	Criteria	Possibility of: - LED lighting schemes - CHP (combined heat and power units) - smart energy management - innovative use of Internet of Things - reduction in acute non-clinical floor space - improved facilities management Can be applied to 70-100% of estate	Possibility of: '- smart energy management - reduction in acute non-clinical floor space - improved facilities management - Can be applied to 30-70% of estate	Possibility of: - improved facilities management - Can be applied to <30% of estate
	Operating cost reduction	20%	12.5%	5%

Shared services and co-location

This opportunity has two aspects.

The first aspect relates to sharing services. By sharing back-office and administrative services, we can achieve substantial savings through economies of scale. For example, Northumbria have formed a shared payroll function which provides services to over 40 clients and has therefore reduced their cost per payslip to 26% below the national average. In terms of estate in HIOW it may be possible to release estate due to sharing services over wider areas and therefore requiring fewer offices. The new Solent-based alliance could provide an opportunity for shared back-office services.

The second aspect relates to co-location. Since the One Public Estate programme began in 2013, its objective of bringing public sector services into one estate has created a substantial shift in the landscape of public sector asset management. One of its key objectives is to reduce occupied space in order to reduce property running costs. There is a range of different ways that co-location can occur across parts of the public which results in a range of cost savings for the NHS (savings on NHS estate are very project dependent). There have been examples whereby the running costs of public estate have been expected to fall considerably.

One example is the new Mildenhall public services hub in Suffolk which will see a range of public services such as education and health delivered from one or two sites instead of eight, delivering an estimated running cost reduction of 50% over 25 years.

	Impact	**High**	**Medium**	**Low**
Shared services & co-location	Criteria	Possibility of: - significant capital receipts - 20-25% reduction of corporate costs - Few restrictions to land release	Possibility of: - sizeable capital receipts - 5-20% reduction of corporate costs - Some restrictions to land release	Possibility of: - small capital receipts - <5% reduction of corporate costs - few benefits in sharing services - Many restrictions to land release
	GIA reduction	25%	15%	5%

Based on the definitions above we have assessed the relative impact of each opportunity area against each sector on the HIOW estate. This is summarised in the opportunity map below.

	Acute	**Community**	**Primary**	**CCG**
Reduced demand for Estate	High	Medium	High	Low
Increased utilisation	Low	High	Low	Medium
Flexible/new ways of working	Low	High	Low	High
Reduce operating costs	High	Medium	Low	Low
Shared services & co-location	Medium	Medium	High	High

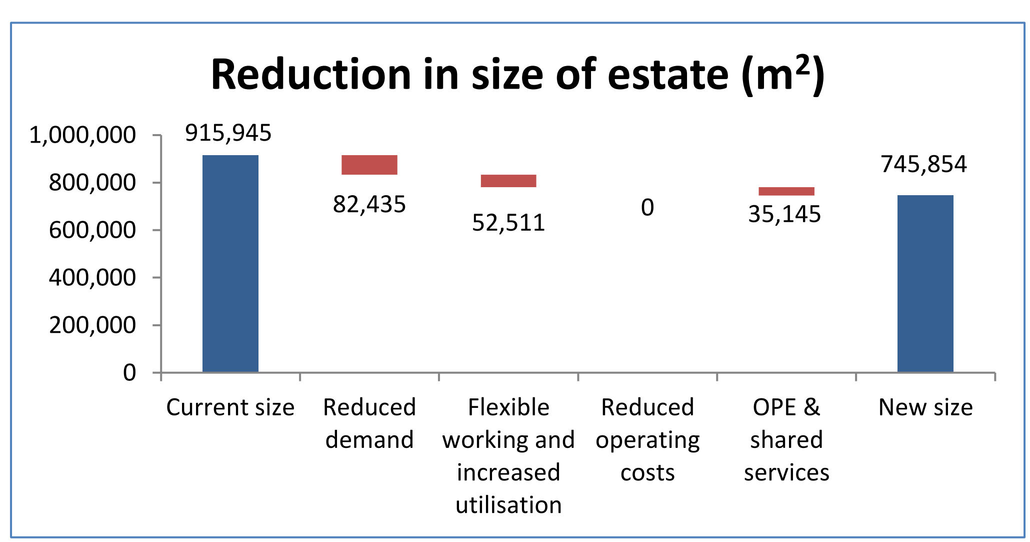
This opportunity map provides a way to estimate the amount of GIA that can be saved. It is important to understand that there are interdependencies between opportunity areas (e.g. the same estate cannot be released twice) and between sectors. First, the savings potential was calculated independently to understand each of the opportunity's relative saving potential; and then dependently with each other, one after the other, which can be seen from the table below. Note that is has been assumed around 40% of the estate will be encumbered in some way.

This is a net revenue savings figure.

Opportunity area	Reduction (%)	New spend	Saving	Size of estate (m2)
Current spend	-	£258,100,000	-	915,945
Encumbered (PFI/LIFT/difficult to apply opportunities)	40%	£154,860,000		
Reduced demand for Estate	9.0%	£140,922,600	£13,937,400	833,510
Flexible working & increased utilisation	6.3%	£132,044,476	£8,878,124	780,999
Reduce operating costs	5.0%	£125,442,252	£6,602,224	780,999
OPE & shared services	4.5%	£119,797,351	£5,644,901	745,854
Total saving			**£35,062,649**	

Some additional considerations have been factored into this calculation including the assumption that the implementation of the revenue savings will accrue some additional revenue spend on the remaining estate. This is because the increased utilisation on estate will require higher maintenance costs thus increasing the annual cost per square metre. We also recognise that whilst revenue savings will be made by moving GPs from their premises into MCP hubs, there will be corresponding revenue costs in the new buildings associated with those hubs.

The impact that this has on the size of our estate is a reduction of 170k m^2 which can be seen in the chart below.



OTHER OPPORTUNITY AREAS

In the first STP estates stakeholder meeting we identified 10 opportunity areas. These include the 5 opportunity areas stated above, but also 5 additional opportunity areas that are either non-monetary or that we cannot estimate at this stage. These 5 are as follows:

Opportunity	Notes
Asset disposal and investment	Not opportunity area as such. It refers to the savings/costs to come out of estates STP initiatives
Intelligent estate and Internet of Things (IoT)	An example of this may be using sensors to monitor whether beds are free in acute wards thus helping to fully utilise space.
Finance: commissioning and incentivisation	Understanding financial contracts which may constrain asset disposal and reducing running costs e.g. PFI and GP premise ownership
GP estate and property challenges	Referring again specifically to GP ownership of their premises, but also the poor condition that many of the premises are currently in
Models of care and service	This will be reflected in the investment section of the STP. Estate that can facilitate MCPs, also perhaps shell and core models

These areas could act as further savings potential, such as intelligent estate being able to reduce running costs; or they could act as barriers to realising the estimated savings potential, such as PFI contracts restricting the disposal of estate. These have not yet been modelled in detail.

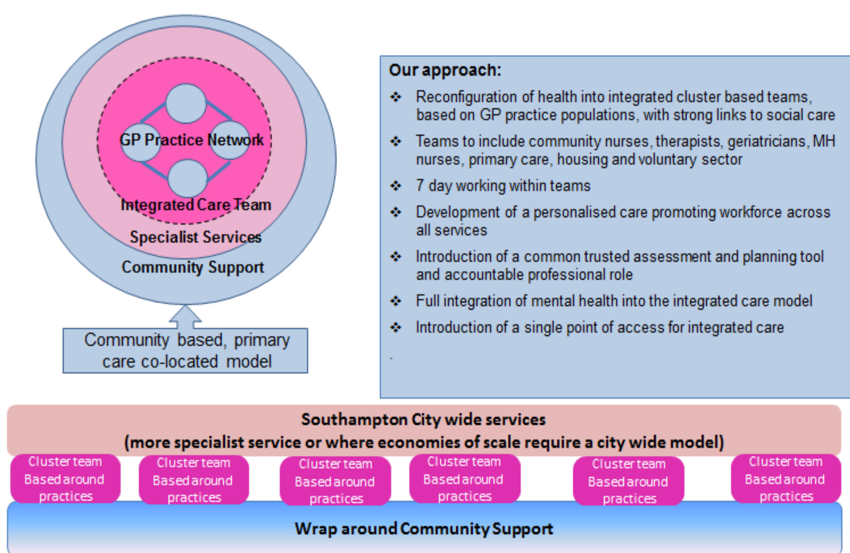
INVESTMENT

So far discussions with stakeholders have been centred on capital investments costs for implementing New Models of Care. This will involve investment in MCP and other types of hubs. Hubs will facilitate the formation of multidisciplinary teams which join up health and social in order to give a more holistic approach to patient care. These teams may include community and mental health nurses, therapists, primary care and elderly care physicians, housing workers and voluntary sector workers. GPs will form the core of MCP hubs.

In HIOW, the programme of change to implement the new models of care, notably investment in hubs, will continue to develop over the next few years. This will involve the continued development of the South Hampshire Multi-speciality Community Provider (MCP), known as Better Local Care, and the North East Hampshire and Farnham Primary and Acute Care System (PACS) Vanguards (or pilots) in various areas across Hampshire. The models of care are predicated on delivery within ‘natural communities of care’ and are defined by a number of factors including, most notably, local authority boundaries, natural and geographic associations and historical definition. Each natural community is developing new ways of planning and delivering care and is likely to have differing demands and challenges due to population growth and the need for more open access, including same-day appointments and weekend opening for GP practices.

Southampton Case Study – 'Better Care' Southampton Programme

The Better Care Southampton programme, jointly lead by Southampton City Council and NHS Southampton City CCG, looks at developing integrated services for patients. A key component of the programme is the formation of multidisciplinary teams organised around "clusters" of GP practices. Below is a diagram of Southampton's MCP model.



The implementation phase will begin in 2016/17. The prospect relies upon an efficient and effective estates infrastructure is required for its success. Funding from OPE 4 and ETTF will contribute to fulfilling an Estates plan which supports the delivery of Better Local Care. There are three key projects outlined in the OPE 4 bid from Southampton, one of which is the provision of a Community Hub to co-locate Public Sector assets and assist with re-generation of the area. It will pilot one of the six clusters for the delivery of Better Local Care Southampton.

Better Care Southampton is one of the areas within the parent Better Local Care programme. The emerging MCP operating model within the Better Local Care, covering the integration of primary and community health and social care services, can be described across 4 domains:

- Improved access to primary
- Extended primary care teams
- Delayering specialist support
- Promoting prevention and self-management

GPs, community and mental health providers, and commissioning colleagues are working alongside other health and care professionals and third sector partners to take forward the operating model that will be required to support these domains within their particular area and are at varying points of progress. Changes have already taken place or are in the process in the three early implementer sites at Gosport, South East Hampshire (Petersfield & Borden) and West New Forest. These implementer sites are being followed by the other natural communities within the overall Better

Local Care programme of change, including Havant & Waterlooville, Fareham, Eastleigh and Southern Parishes, Romsey, Totton and Waterside, Winchester, Andover, Alton, Basingstoke and Southampton. Although the main focus on this change is the support of patient's needs in each natural community, it is also about integrated working with other partners, such as social services and voluntary services.

Similar to the above, work is occurring in the North East Hants and Farnham PACS, additionally involving acute hospital services in the area.

The estate required in the future is likely to depend on the intentions of each local community in providing both primary and secondary care and the level of out-of-hospital services that is agreed, which will need to flex and morph as this develops. This estate should be standardised to facilitate typical new models of care, but also flexible so that it can respond to the needs of the locality. A review of the existing estate in each natural community is being undertaken to establish the current or proposed strategic hub sites required and the likely investment needed to ensure they are fit for purpose. Estate consolidation and rationalisation opportunities linked with the development of extended primary care teams, such as Integrated Care Teams, GPs, Mental Health and Children Services is also being considered.

These proposals are likely to result in numerous changes within the estates of the Provider Organisations and Primary Care practices, as well as Community Health Partnerships, NHS Property Services and the further public sector estate linked with the One Public Estate programme. The changes will be monitored by the commissioners working in partnership with local stakeholders via the Local Estate Forums.

In order to achieve a better understanding of investment in hubs we will need to work collaboratively with providers and other workstreams in the STP, especially digital, to define what a typical hub looks like. Estates, technology and clinical staff need to explore questions relating to a hub's purpose, what services it provides, the impact it will have on primary and acute care, and what estate is needed to facilitate this.

Current sources of capital funding are ETTF, OPE and capital markets. The capital receipts acquired from the co-location and reconfiguration of other community services such as police/fire/leisure will contribute to the capital required for community hubs. However, these capital receipts may not be enough to cover the investment required. In order to raise the required capital we may be able to make use of Public Private Partnerships.

Over the next five years capital funding will mainly cover:

- New MCP and other types of hubs
- Minor and major refurbishment of community/acute hospitals
- Rationalisation of estate – feasibility studies etc.

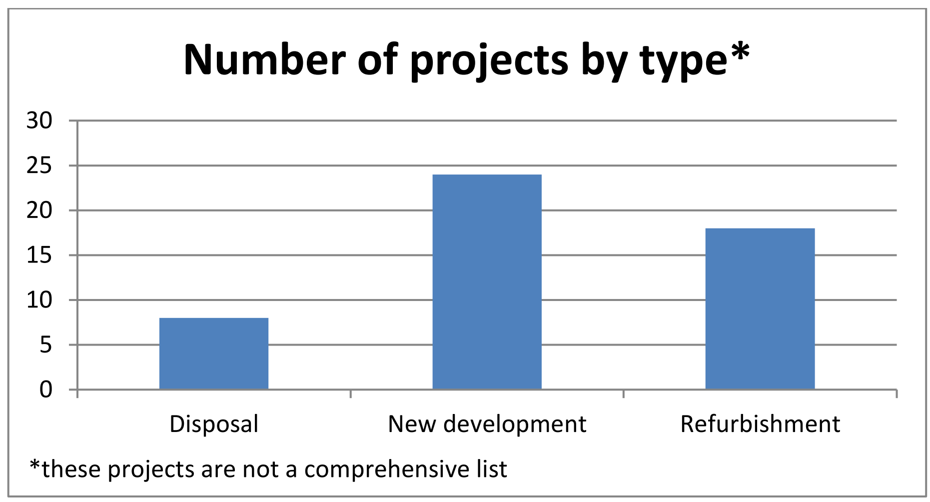
Revenue implications:

- Savings from moving GPs out of premises
- Costs from build/refurbishment of estate for hubs

We do not yet have an estimate of either capital or revenue costs incurred from investment. The revenue savings impact may affect the estimated savings potential.

SAVINGS: BOTTOM-UP ANALYSIS

Over the last 6 months a number of projects have been created which are outlined in local Strategic Estates Plans (SEPs). So far the SEP outlined projects can be categorised as follows:



The majority of projects involve investment, new development or refurbishment. Many of these projects involve the build of community hubs which remove the divide between primary/secondary/ social care and help to facilitate new models of care. This is aligned to the GP Forward View published in Apr 16' which highlights the importance of hubs as fundamental element of future plans in primary care. There are also three projects which involve the creation of an ICT locality hub to support local technology needs which could potentially support initiatives from the technology side of the STP.

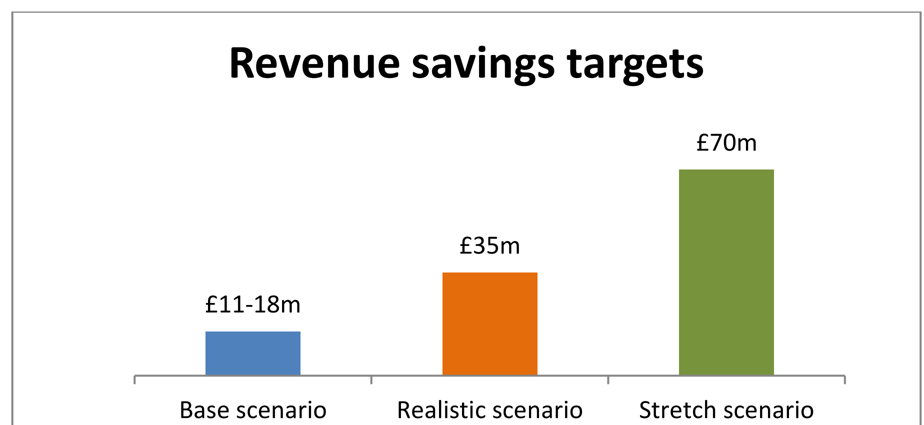
The identified savings are split between the 'reconfiguration' and the 'provider cost efficiency' categories within section 5 of the STP. A third to a half of the savings of this total has already been identified as part of provider cost improvement programmes (£11-18m).

OPPORTUNITY SAVINGS: TARGET SUMMARY

To summarise our savings analysis, we have three scenarios that can unfold over the next five years:

1. The top-down analysis that uses an academic approach of looking at national case studies and how these opportunities can be applied on our estate portfolio. Estimated at **£35m** (realistic target).
2. The bottom-up analysis that builds on the planned work outlined in each of the CCG's SEPs. Estimated at **£11-18m** (base target).
3. An initial figure of **£70m** (stretch target) was proposed to our stakeholders before constraining factors had been taken into consideration. Further review revealed this to be an unrealistic target once the following constraining factors were taken into account:

- Comprehensiveness/depth – contracts around PFI/LIFT buildings mean that the opportunity areas cannot be applied to the entire estate. Any additional encumbered estate will also limit the depth to which the opportunity areas can be applied.
- Timescale – there will be time constraints around realising the potential savings which means they may not be realised within the STP's five year period. This may include lengthy multiple-year consultations.
- Underestimation of interdependencies – feedback from stakeholders indicated that, in the top-down analysis, we originally underestimated the amount of interdependency between the opportunity of 'increased utilisation' and the other opportunity areas.



For the moment the stakeholders will pursue, refine and develop the realistic scenario. Stakeholders' aim is to strive for £35m of contribution to closing the HIOW financial gap by 2020/21. This figure is calculated from a top-down perspective and captured at a snapshot in time. It is subject to further review and refinement in light of the STP transformation proposals and at a time when more granularity is achieved over how the five opportunity areas can be fully realised from local initiatives.

SCENARIO MAP

Opportunity area / Scenario	Reduced demand for Estate	Increased utilisation	Flexible work	Reduced operating costs	OPE and shared services
Stretch	• Significant rationalisation including potential review/repurposing of an entire acute facility • Substantial acute back-office saving flowing from alliance • Nationally identified inappropriate GP contact eradicated through channel shift • Digital moves at a fast pace • All GPs decant to hubs in 5 years	• Substantial improvement in utilisation in community sector, small improvement in acute/primary	• 'Modern' flexible working policies developed and implemented which compare with the average in the private sector and best in the public sector • Comprehensive and rapid mobile working investment and uptake	• Best in public sector class energy efficiency and facilities management value for money and procurement expertise by year 3 • Exceed Carter review recommendations	• Patch develops its own more substantial version of OPE with greater funding and possible investment partners
Realistic	• 'Parcels' are released/repurposed through acute site assembly • Significant back-office savings are identified through the alliance • Channel shift successful but doesn't reach full potential in 5 years • Digital is somewhat investment constrained • 50% of GPs are in hubs by year 5	• Significant improvement in community utilisation, no improvement in acute/primary	• Reviewed and improved policies and comprehensive commitment across patch to align implementation • Mobile working significant but only comprehensive towards the end of the period	• Average public sector value for money and efficiency is slower to realise • Meet Carter review recommendations	• OPE or similar initiatives are able to facilitate optimisation of public sector estate in each of the 20-25 'places' in HIOW with shared back-offices by year 5
Base (current initiatives)	• Current limited 'reducing demand' initiatives	• Small individual site-based efforts to improve utilisation	• Current patchy but improving flexible working policy implementation and limited mobile working	• Some isolated examples in practice in value and efficiency	• Current limited OPE 4 funding focussed around local government with a limited number of schemes

RISKS

There are some risks to implementation of this EEP document which are set out in the table below. At this point in time and with the level of information available, we can highlight these risks and record their corresponding mitigations.

Risk	Mitigation
NHSPS have indicated that may increase the rent for their property in line with market rents. This would increase the revenue costs for our estate.	This document is not the final iteration and the estimated annual revenue savings will be under continual review
More land/property is encumbered than we have estimated because of low-quality estate, organisational self-interest, local politics etc.	Bottom-up estates assembly plans will help to inform the true amount of encumbered estate
Devolution and other ongoing discussions mean it may not possible to build dialogue around saving on estate at the HIOW level	Formal estates group to meet up in regular sessions in order to implement STP Estates priorities
Availability of capital	Less capital intensive solutions
Availability of revenue for when services are in the process of change	Well scoped plans to be submitted in the Sustainability Transformation Fund (STF)
Other workstreams fail to deliver. e.g. limited investment in digital	Constant review and linking of project management together. e.g. ensure alignment of STP and LDR to give best chance of sufficient funding
Uneven appetite for change across the sub-regions within HIOW	Using the formal estates group to promote healthy collaboration and share data/information around where the needs/opportunities lie
Resolution around the acute situation in Mid and North Hampshire results in minimal estates rationalisation	See CTH references to acute services review in the main body of the STP. This document is not the final iteration and the estimated annual revenue savings will be under continual review.

GOVERNANCE

Stakeholders believe that the STP is an opportunity to relaunch and refresh arrangements that have been relatively dormant in recent times to mark a change to a more active and challenging Estates environment.

An estates group needs to be formalised in order to carry forward the work coming from this STP. There is agreement amongst stakeholders that this is the case and that an official 'ways of working' document will need to be published in order to outline the objectives of such a group. Initial suggested objectives for this group are:

1. To oversee progress towards the targets set out in this document by undertaking periodic stocktakes

    a. Achieve target revenue savings by 2020/21
    b. Create a more comprehensive HIOW estates strategy
2. To find solutions to systemic problems at the HIOW level which are or may inhibit progress
3. To facilitate the sharing of needs and opportunities between organisations
4. To feed into LIFT Co in order to source capital

This group will need to meet periodically to ensure that local, place-based initiatives are in line with plans from the STP. A bi-monthly arrangement has been suggested but not yet formalised pending clarity on overall STP delivery governance.

The HIOW locality falls within a geographical area that is predominantly coterminous with the operating area of the LIFT. The LIFT Public Private Partnership was originated by Southampton & Hampshire PCT's and set up to enable the provision of a partner organisation to support the health community in implementing its long term commissioning intention to meet the needs of the local population. Following the reorganisation of health systems in April 2013 the shareholding of Hampshire LIFT passed from the then PCT's to Community Health Partnerships (Ltd company owned by the Department of Health). Since this time Community Health Partnerships and Hampshire LIFT have been working closely with CCG's across the HIOW area in the development of strategic estate plans. These plans have identified a wide range of different estate opportunities which could be implemented and would support the delivery of the outputs included within the HIOW STP estate Submission.

The STP presents an opportunity to review and refresh ownership and management mechanisms and explore asset-backed or special purpose vehicles – building on the LIFTCO – such that arrangements are fully commensurate with the scale of the transformation challenge.

NEXT STEPS

The table below outlines the next steps to assist implementation of the Estates STP workstream. These actions will be an ongoing activity that will require continual review and adjustment.

Action		Description
1 a	Establish formal estates meeting group/entity	A group will be formalised around implementing the opportunities outlined in the STP. Representatives from provider trusts, CCGs and Local Authorities will agree to meet periodically, especially those in attendance at the STP Estates stakeholder meetings.
b	The group's objective	The objective of these meetings will be to ensure that organisations' estate plans are in line with the STP which proposes that we need to work together to make significant revenue savings. A challenging, yet realistic, target of £35m has been set out in the STP. The group will commit to sharing needs/facilities e.g. workspace, and will strive to improve and exchange estates data.
c	When the group will meet	At the final stakeholder meeting, held on 16th June 2016, it was proposed that the group should meet 3 or 4 times within the year.
2	Developing an estates strategy	This appendix document is an enabler for a formal estates strategy to be developed. The strategy will benchmark against the 5 opportunity areas outlined in this document. Against these opportunity areas the following questions will need to be repeatedly addressed: • Where are we now? • Where do we want to be? • How do we get there? An estates strategy document has been released by the government. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144226/Developing_an_Estate_strategy.pdf

SUMMARY

The required revenue savings in HIOW will come from releasing estate and reducing maintenance costs of the remaining estate. Significant revenue savings can be made if we apply the opportunity areas outlined in the document. Current estate plans include significant elements but other elements are absent. Along with revenue savings, a reduced estate portfolio provides non-monetary benefits such as reduced carbon emissions and the process provides a chance to reconfigure existing services.

This document is a planning assumption at a point in time but does not yet fully reflect the changes the STP envisages or quantify the benefits required from the estate. Partners will need to work collaboratively to develop further iterations.

The overall conclusion of the workstream is that this needs to be delivered collaboratively, Commissioners and Providers, Health and Care and with other workstreams of the STP.

APPENDIX 1: LOCAL INITIATIVES

HIOW is covered by eight CCGs. The STP gives regional level strategies to assist CCG's local initiatives. The current local estates initiatives for the eight CCGs are as follows.

NHS North Hampshire CCG

Planned projects are shown in the table below.

Benefit timescale	2015/16	2016/17	2017/18	2018/19	2019/20
Key Projects to be Implemented	• Complete option appraisal at Alton and Basingstoke. • Dispose of Fairway House / Mulfords Hill / Hollies / Headway Place / Eastrop		• Co-location of health services in a new OPE facility in Alton	• Possible disposal of Alton Community Hospital and Alton Health Centre	• New 'at scale' centre in Basingstoke and disposal of 4 GP facilities

NHS South Eastern Hampshire CCG

Benefit timescale	2015/16	2016/17	2017/18	2018/19	2019/20
Key Projects to be Implemented	• Complete utilisation study of Oak Park Community Clinic • Sell surplus land at Oak Park • Disposal of Elizabeth Dibben	• Re-provision of Emsworth GP at EVCH site • Dispose of Emsworth GP site • Look at moving support staff into Havant civic plaza	• Re-configure Oak Park Community Clinic • Construct new Hub in Leigh Park • Sell Havant Health Centre	• Possibly construct new hub in Waterlooville	• Create new hub in Whitehill and Bordon • Dispose of Pinehill • Disposal of Chase CH

NHS Southampton City CCG

Benefit timescale	2015/16	2016/17	2017/18	2018/19	2019/20
Key Projects to be Implemented	• Complete Solent HQ move and Adelaide backfill • Revised estate strategy end 2015, with primary care additions • PCTF tranche 2 applications	• Confirm PCIF applications • Complete Primary Care Hub Strategy • Finalise estates strategy and Western/RSH Outline Business Case	• Complete PCIF investments • Demolish DoP building at RSH	• Complete RSH/Western reconfiguration	

NHS West Hampshire CCG

Benefit timescale	2015/16	2016/17	2017/18	2018/19	2019/20
Key Projects to be Implemented	• Complete clinical vision workshops per locality–Jan/Feb • Complete Options Appraisal for Andover, Ashurst and Milford on Sea. • Complete OBC Hythe Redevelopment • Utilisation review LNFH • ? Establish Programme Board – Winchester • Complete primary care estates survey	• Commence building Hythe War Memorial Hospital • Submission to TF NHSE re Andover • Commence options appraisal Eastleigh & Moorgreen • Ashurst consolidated	• Complete Hythe redevelopment • Commence options appraisal Romsey redevelopment	• Complete Milford redevelopment	• Complete Moorgreen redevelopment • Complete Andover HC redevelopment

NHS Fareham and Gosport CCG

Benefit timescale	2015/16	2016/17	2017/18	2018/19	2019/20
Key Projects to be Implemented	• Utilisation study of FCH. • Sell surplus land at Fareham Community hospital • Look at Gosport 2nd hub in line with MCP's	• Utilisation study of GWMH, Brune MC, Gosport MC and Rowner HC	• Re-configure Fareham Community hospital • Move services in to FCH from facilities that are not fit for purpose	• Construct new hub in Fareham Town Centre • Construct 2ndhub at North Gosport in line with OPE	• Possibly create new hub in North Whiteley

NHS Isle of Wight CCG

Benefit timescale	2015/16	2016/17	2017/18	2018/19	2019/20
Key Projects to be Implemented		• Complete business cases & approvals for two locality hubs (S.Wight & Newport) & re-provide one rural GP practice	• Re-develop the St Mary's site in Newport	• Complete rural GP practice re-provision	• Complete two locality hubs • Two disposals

NHS North East Hampshire Farnham CCG

Benefit timescale	2015/16	2016/17	2017/18	2018/19	2019/20
Key Projects to be Implemented	• Proceed with ITC pilot in Farnham, inc. building adaptations • Proceed with interim ICT base in Farnborough fire station • Develop FRS for ICT accommodation and ways of working • Progress with design & Spec. for Yateley ICT • Implement ICT hub in Aldershot	• Complete feasibility study in to future site options for Fleet, inc. new GP Surgery and Fleet Community Hosp. • Complete works to create Yateley ICT hub • Review outcomes of Community Bed Review • Agree scheme designs for ICT Health Hub in Farnborough • Prepare / submit bids for Infrastructure improvement funding	• Commence Primary Care estate works & rationalisation in Farnborough and in Fleet • Complete appraisal study for CCG HQ office options • Commence design and specification work for Fleet Community Hub and site remodel • Commence Fleet Community Hub site remodel	• Complete FleetmCommunity Hub re-model • Complete Primary Care estate changes in Fleet • Complete ICT Health Hub in Farnborough • Complete Primary Care estate rationalisation in Farnborough • Review and Update Estate Strategy	

NHS Portsmouth CCG

Benefit timescale	2015/16	2016/17	2017/18	2018/19	2019/20
Key Projects to be Implemented	• Disposal of some community buildings • Survey work on GP and community estate • Commence feasibility study • Disposal of light and Gleave Villa • Sale of St James – Phase 1 • Sale of Acorn Lodge and Community Loans Store	• CCG relocate to Civic Offices (achieved early in Feb 16) • Refurbishment of major community hospital (St Marys to enable sale of St James • Ongoing review of void space and lease break opportunities • Completion of Cotswold House refurbishment	• Clinical hubs in place • Vacant possession created in community hospital – expected sale of St James phase 2 • Ongoing review of Solent estate, including admin and back office review.	• Reprovision of GP provision North of City	• Ongoing review of GP estate in light of new clinical hubs and outcomes of feasibility studies.

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Richard Samuel
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Dear Richard

Hampshire & Isle of Wight Sustainability & Transformation Plan

Thank you for sharing with me the submission draft of Hampshire and Isle of Wight Sustainability & Transformation Plan. I have now had a chance to study it and the accompanying appendices and to reflect on the discussions I've been involved in with you at the recent LGA conference, last Friday's stakeholder event at the AGEAS Bowl Hotel and through briefings at both the Southampton Health & Wellbeing Board and CCG Board.

Can I first say how impressed I am with the level of detail – expressed so succinctly – covered by the plan which I know reflects a considerable amount of hard work by your team and the many system leaders from right across the footprint area? I think that you have captured the right challenges that we currently face and I agree with the seven long term priorities for action underpinned by the four enabling whole system solutions.

I have some minor suggestions to make to the proposed priorities and transformation schemes:

1. Closing the Health & Wellbeing Gap – I welcome the focus on lifestyle behaviour issues affecting health (alcohol, smoking and diet), outcomes for people with mental health conditions (although I wonder if we couldn't set a more ambitious suicide reduction target in line with emerging good practice in other areas like the West Midlands and Merseyside), early years and people with priority conditions (cancer and diabetes) and I would expect these to complement and add value to our own local Health & Wellbeing strategic priorities around prevention and early intervention which address health inequalities and community resilience.

2. Closing the Care and Quality Gap – I welcome the focus here on taking forward new models of care (including much-needed transformation of primary care and a greater focus on personalisation) and addressing the sustainability challenges in acute services, mental health services and services for people with learning disabilities; I

especially welcome the proposed alliance model for acute services in the Solent area and for mental health across the whole piece.

3. Closing the Financial Gap – I would welcome further discussion on how additional STP funding will be able to support local ambitions for addressing some of our prevention priorities (in addition to tackling childhood obesity) like, for example, by addressing the physical health needs of people with mental health issues or with a learning disability; it is important that the whole system funding gap covering both health and social care is articulated clearly and consistently throughout the document (that gap being over £1 billion) and that the STP will need to deal with the whole change of the system.

I want to re-emphasize our strongly-held view that 'subsidiarity' should be the overriding principle for ensuring local delivery wherever possible by making full use of the Health & Wellbeing Board infrastructure and maximising opportunities presented to us through the Better Care Fund, pooled budgets and ring-fenced Public Health grant.

My final comment is that I would really relish an opportunity for greater political input to and ownership of the STP governance and delivery system. For example, might it be possible for the lead elected members for health and social care across Hampshire & the Isle of Wight and/or the chairs of Health & Wellbeing Boards to provide some political sponsorship/ assurance for each of the identified workstreams? I'm very confident that I and my fellow cabinet members from Hampshire County Council, Portsmouth City Council and the Isle of Wight Council – notwithstanding any political ideological differences – are able to work well with you here in identifying key points of elected member contact.

Please don't hesitate to get in touch if there is any further assistance I can provide in helping to deliver the STP.

Yours sincerely

Cllr Dave Shields
Cabinet Member for Health & Adult Social Care
Councillor for Freemantle Ward

cc: Simon Letts, Leader of Southampton City Council
Alan Whitehead, MP for Southampton Test
Royston Smith, MP for Southampton Itchen
Caroline Nokes, MP for Romsey & Southampton North

Members of Southampton Health & Wellbeing Board
Members of Southampton Commissioning Partnership Board

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