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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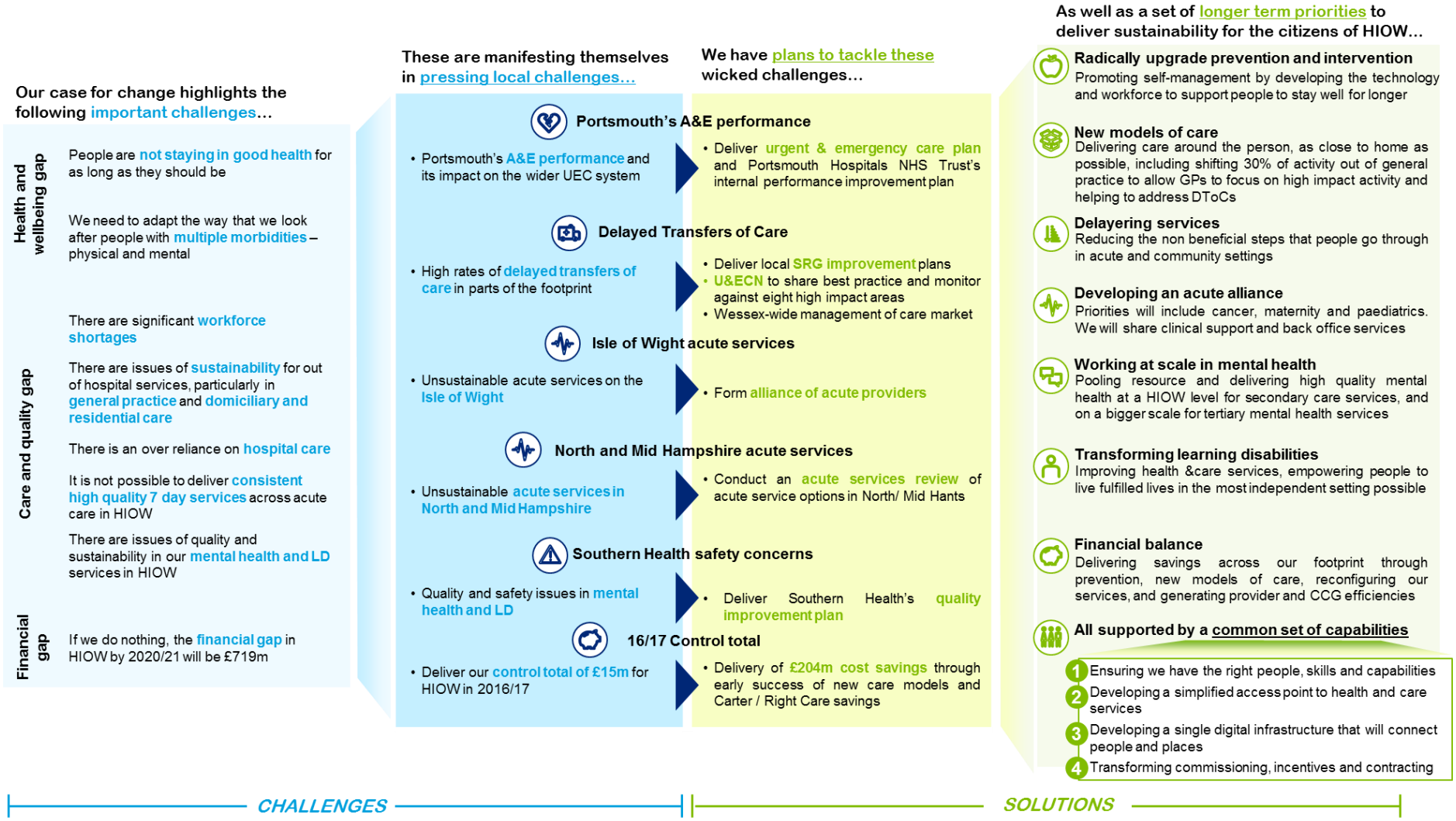
2 EXECUTIVE SUMMARY

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.



3 VISION FOR HEALTH AND CARE IN HIOW

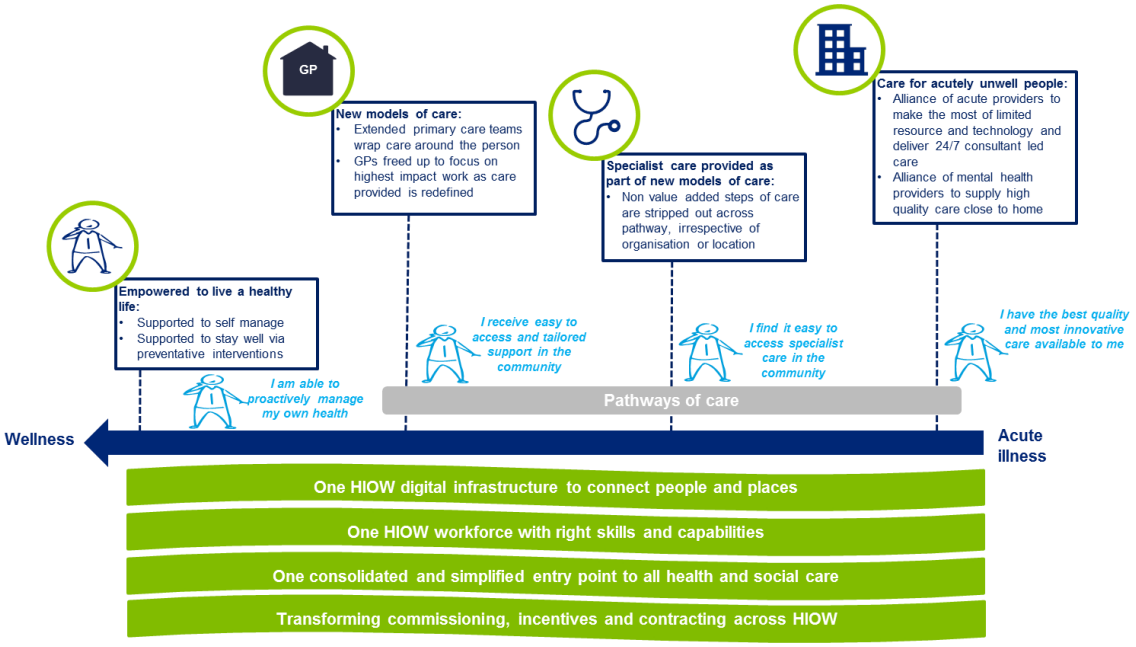
As leaders of the health and care system in Hampshire and the Isle of Wight (HIOW), we are resolved to work together to transform outcomes and improve the satisfaction of local people who use our services, and we are committed to pooling our sovereignty and resources in order to maximise the impact of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

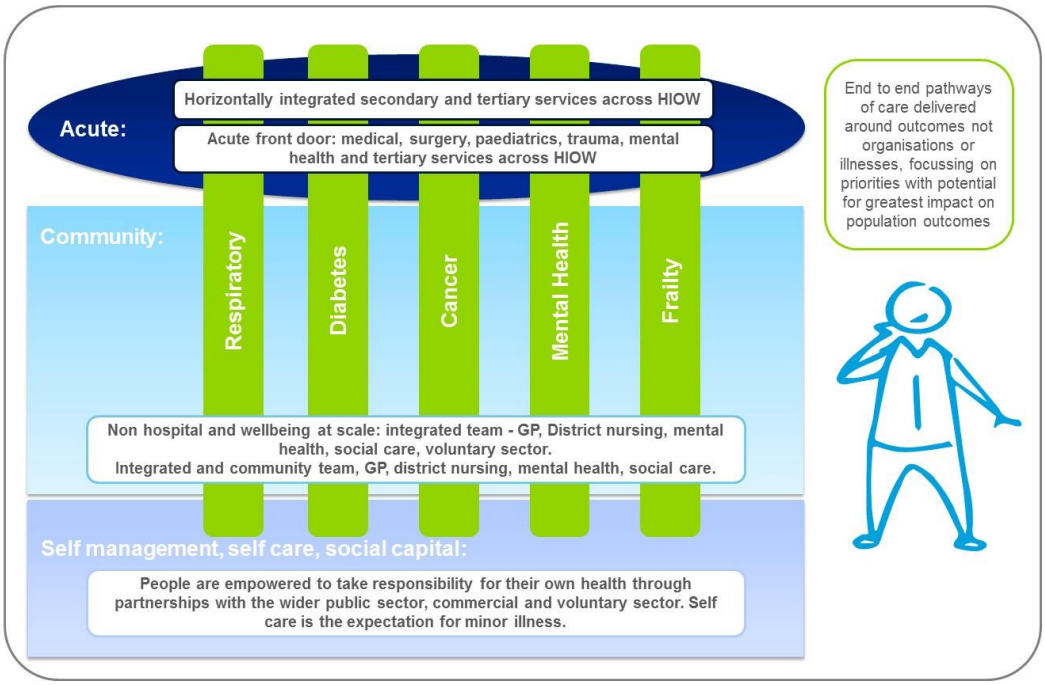
i. We will work as one HIOW to manage our **staff, recruitment and retention**, and to develop one **HIOW workforce strategy** to ensure that we have the skills and capabilities necessary to support our goals.

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

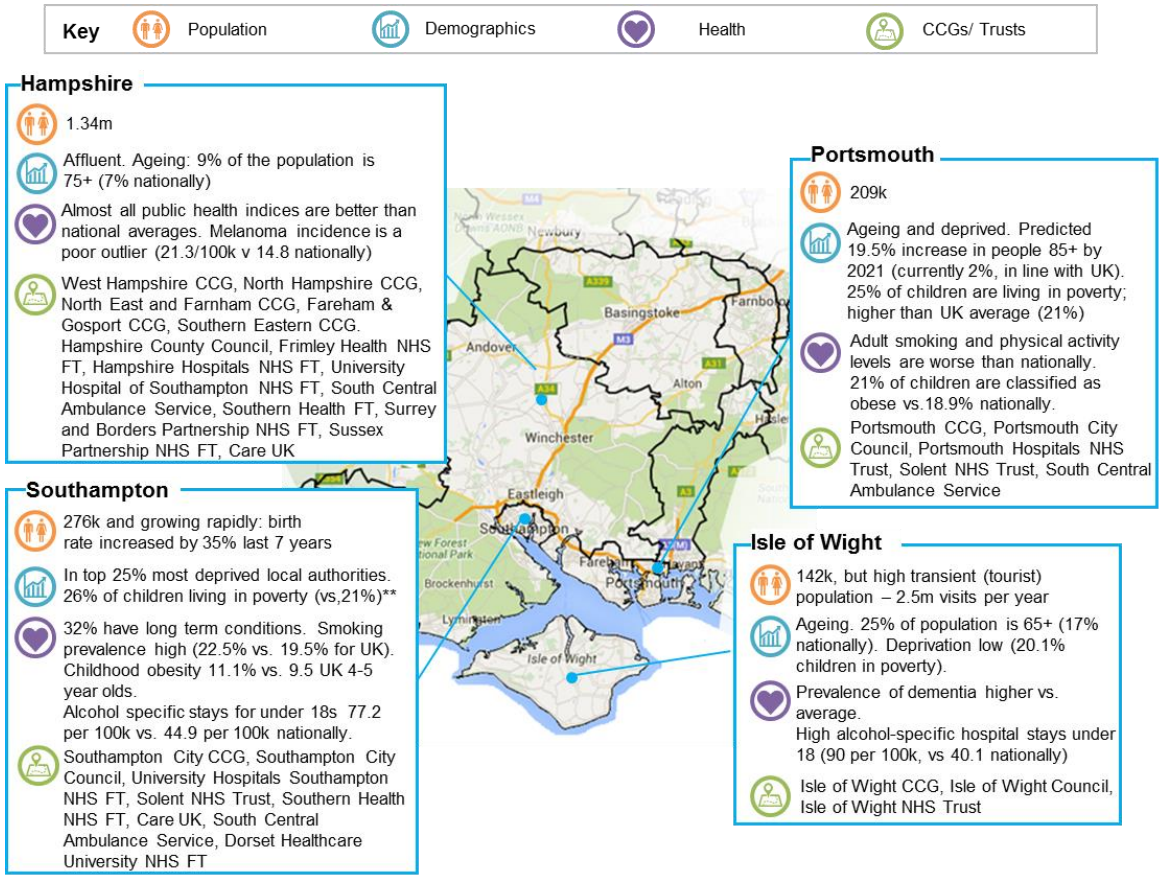
The tiers of planning are flexible, and are intended to be compatible with other initiatives such as the Solent devolution deal and other similar types of collaboration. These conversations are ongoing and will continue to shape the future form of services across HIOW.

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.

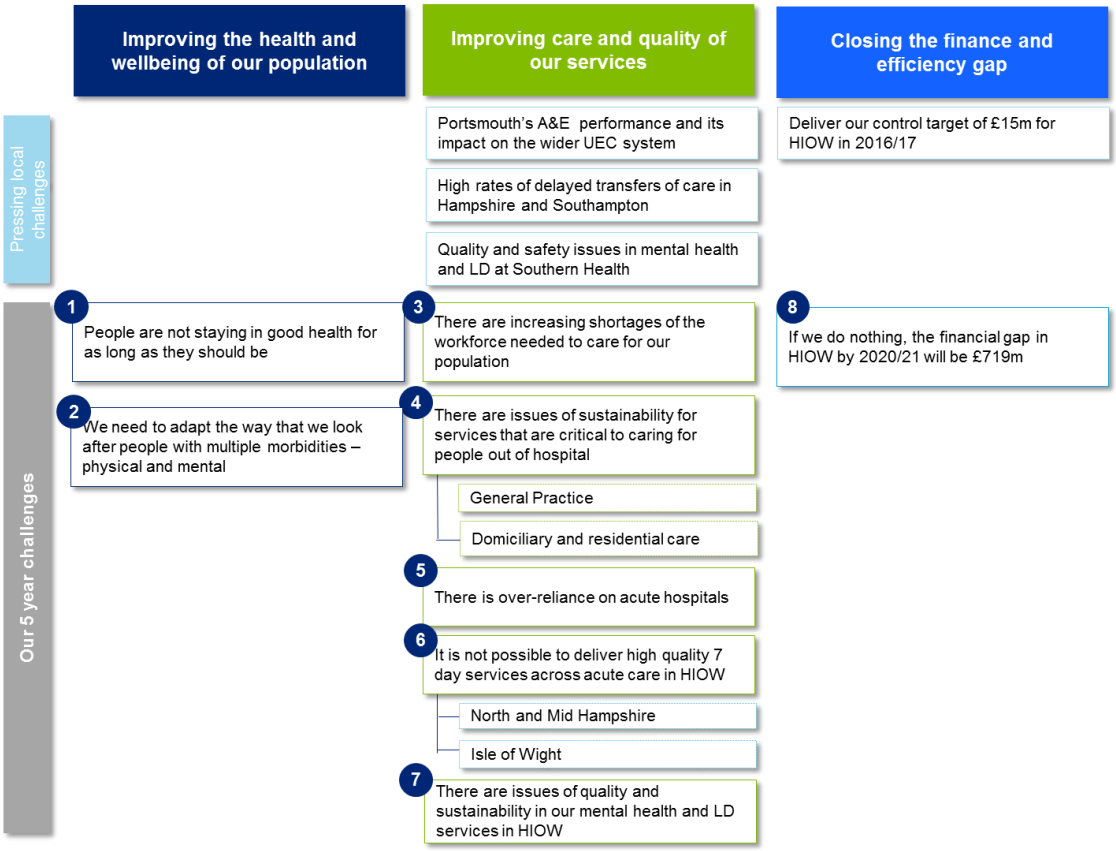


Our HIOW footprint is made up of the following organisations:

- 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:

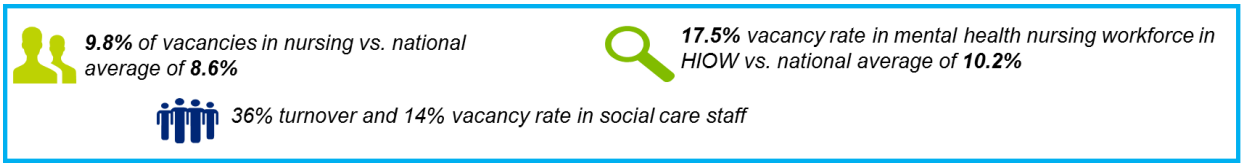
5.4 There are increasing gaps in the workforce required to care for our population

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

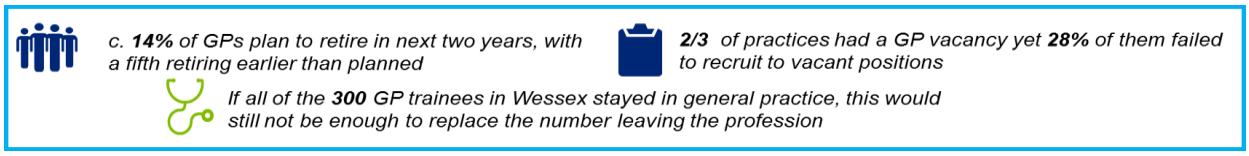
5.5 There are significant issues of sustainability in services that are critical to caring for people in their community

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]



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.

[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.

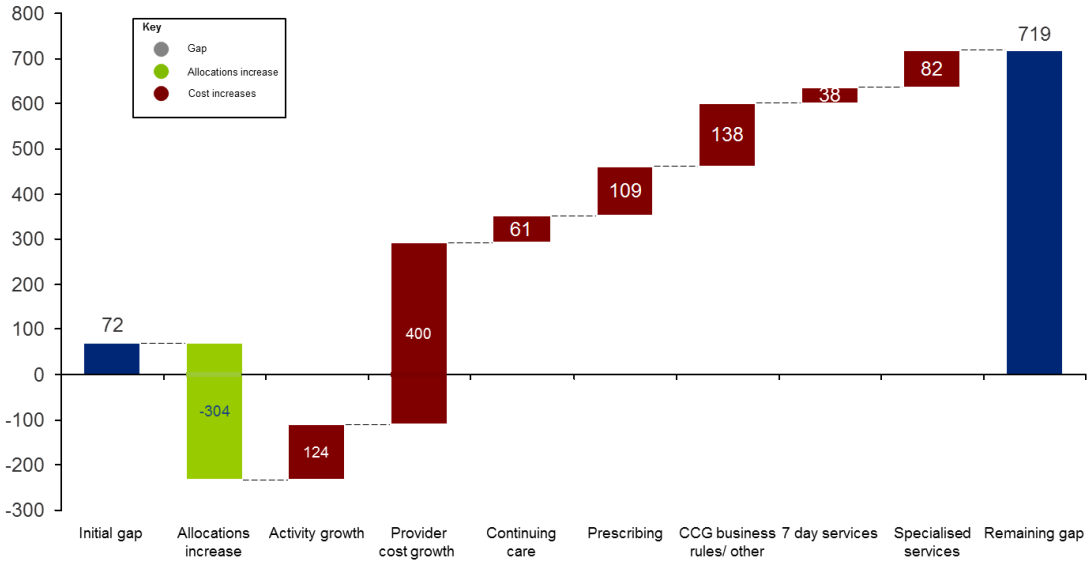
There are also opportunities to improve the experience and outcomes of people living in HIOW with learning disabilities, which include ensuring that they are able to live in the most independent setting possible, and making sure that people with a learning disability receive parity of esteem in terms 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

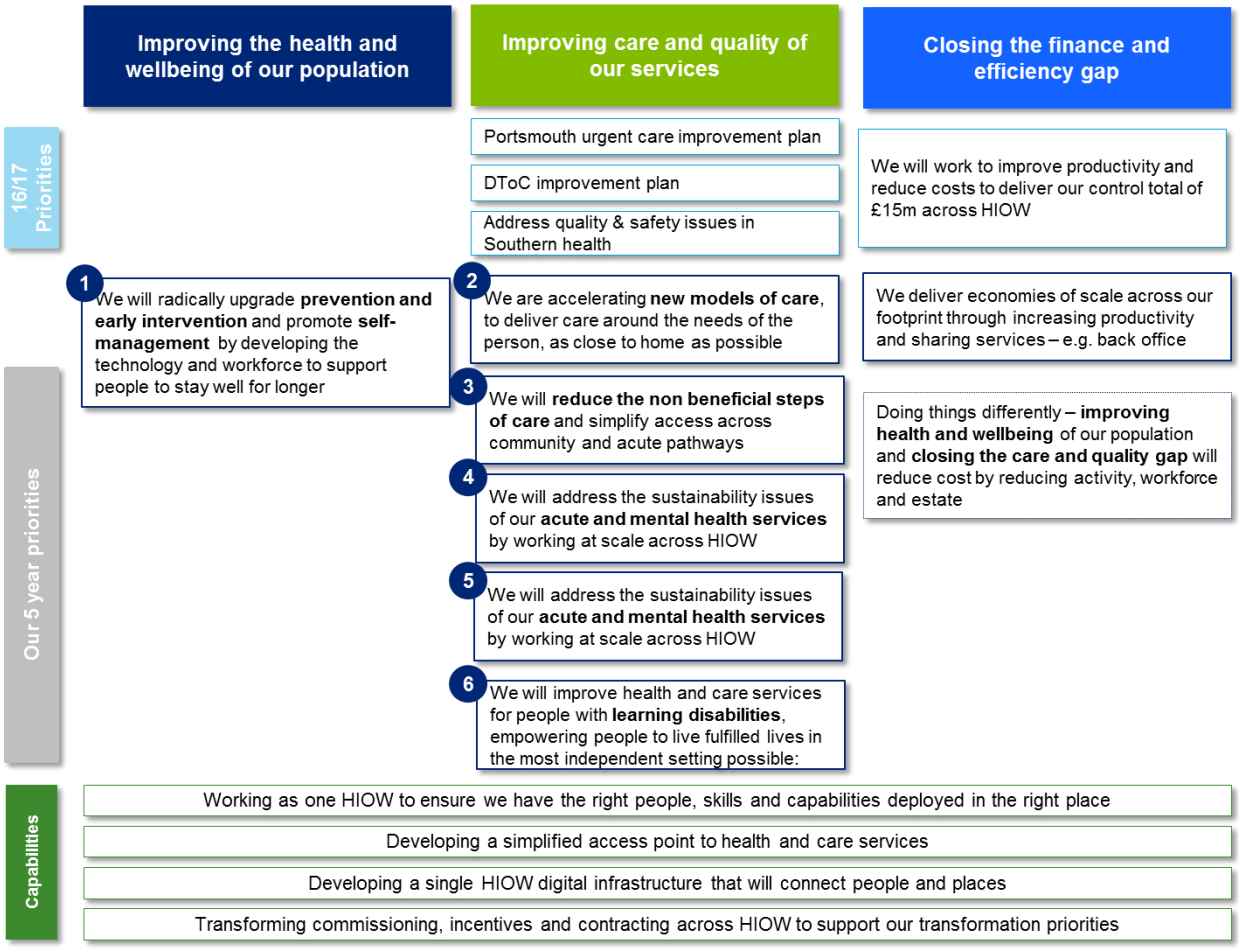
transform care for our population as “doing things better” alone will not be sufficient to address our challenges. This will include building resilience and improving health and wellbeing to reduce reliance on services, transforming community care via new models of care that wrap around the person and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

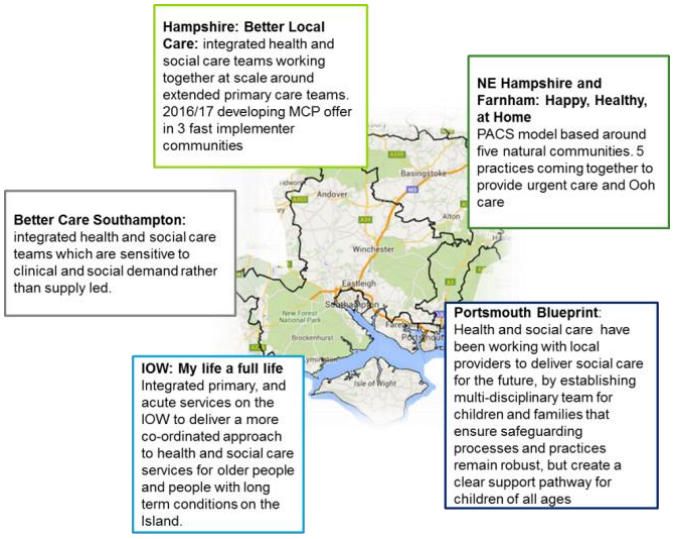
6.3 We will accelerate the implementation of new models of care (NMC) so care is centred on the holistic needs of the person as close to their home as possible

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:

- 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.

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

- 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.

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

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

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.

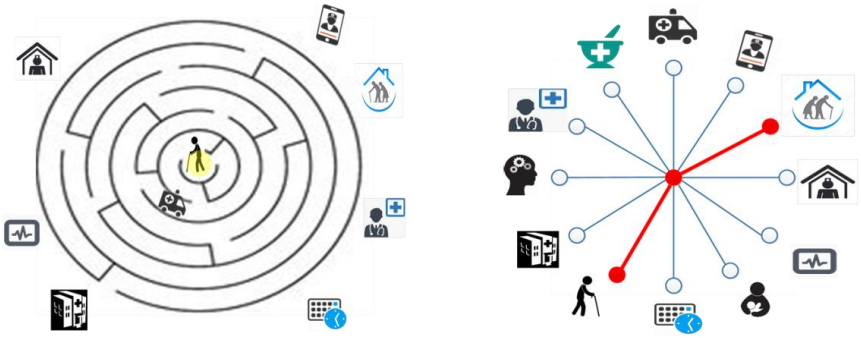
Our workforce is our greatest asset to deliver safe, high-quality services to our population. We will help our providers and commissioners establish the partnership and shared principles to develop a workforce that will deliver better care across HIOW by focusing on the following areas:

- 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.



Now Future

- 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.

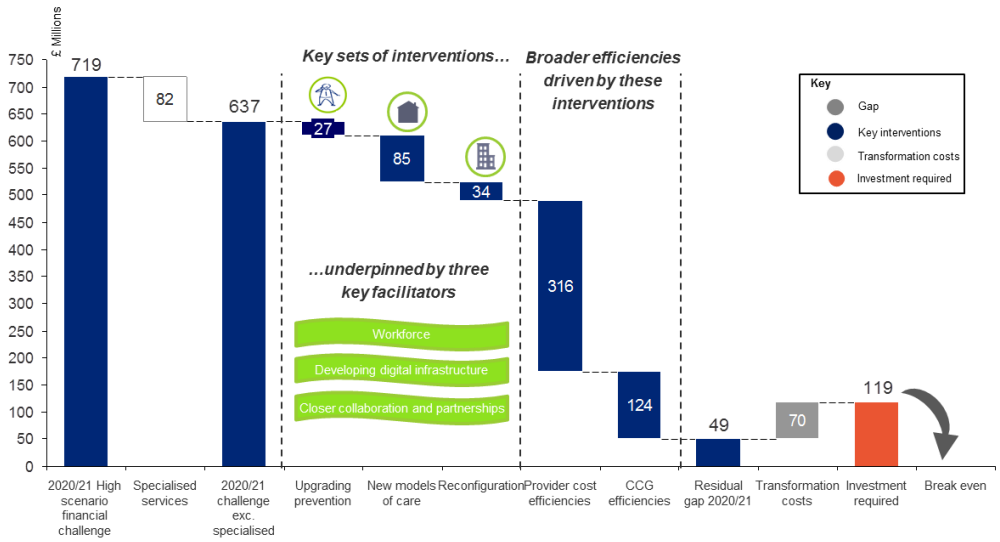
7 FINANCIAL PLAN

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.

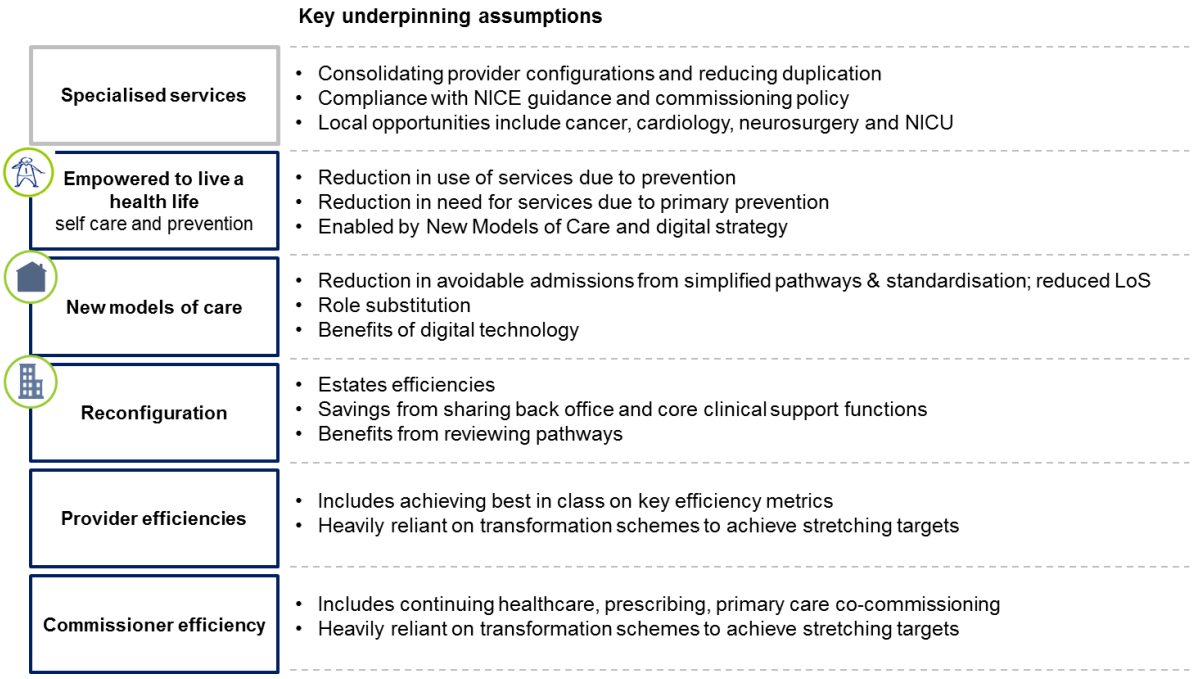
Through radical ways of working we have modelled a scenario that closes our financial gap by 2020/21. Fundamental to this is that large scale commissioner and provider efficiency can only be unlocked if we transform our health and care services to work differently. Even with this programme of radical 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	17/18	18/19	19/20	20/21
	£m	£m	£m	£m	£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

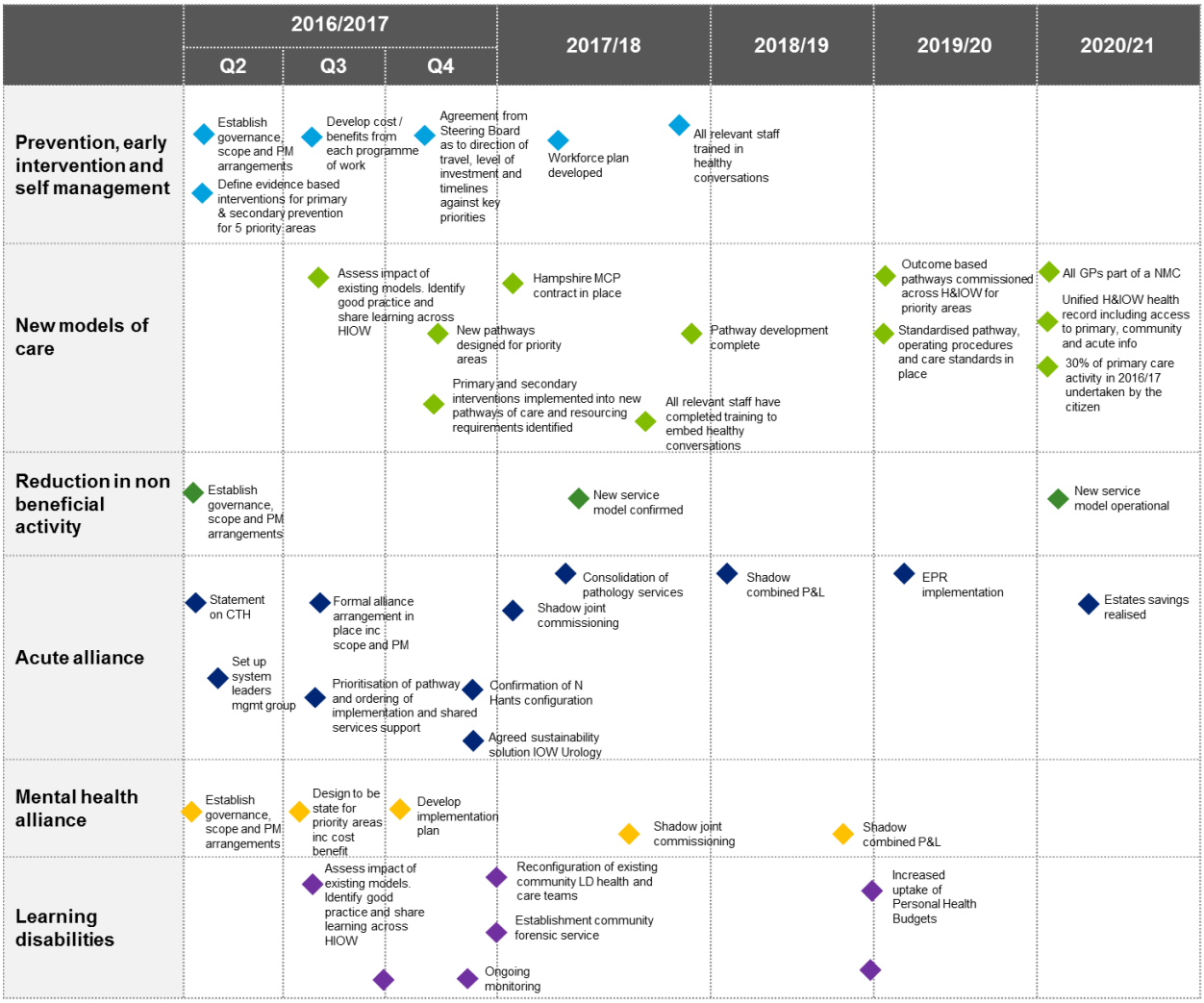
8 IMPLEMENTATION ROADMAP

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	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

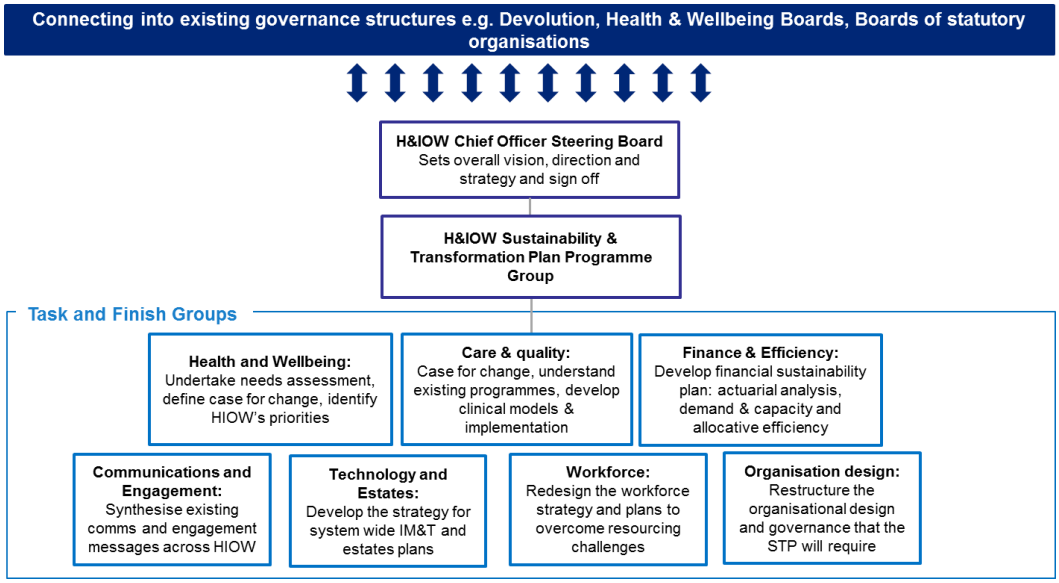
Structure, effective decision making, system leadership

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.

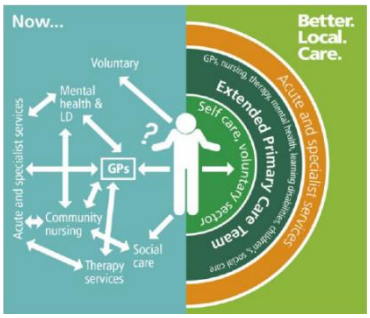
Engaging our staff

- 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.

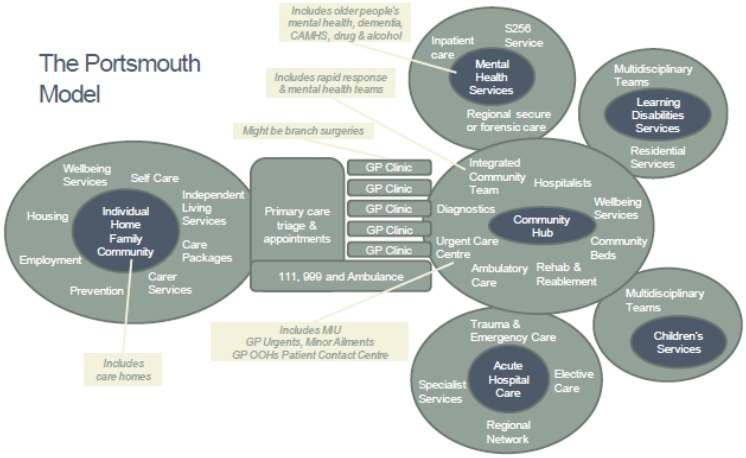
Next steps

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.

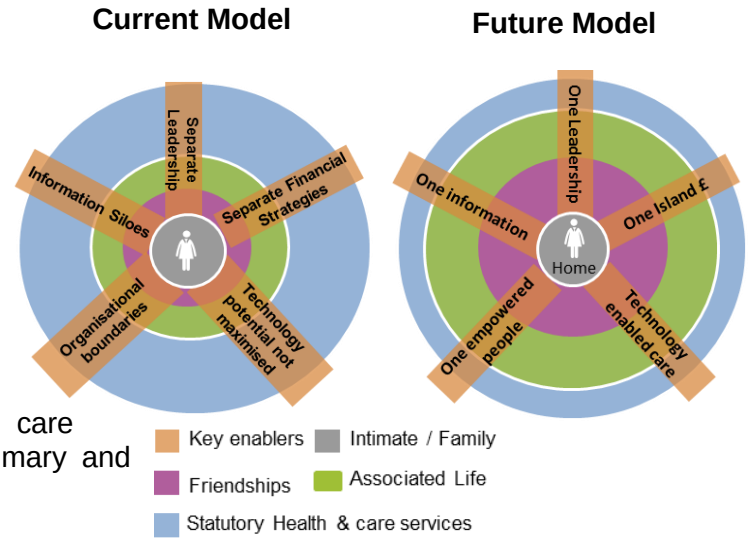
Next steps

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.