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Hampshire County Council

NOTICE OF MEETING

Meeting Health and Adult Social Care Select Committee

Date and Time Wednesday, 15th March, 2017 at 2.00 pm

Place Ashburton Hall, Elizabeth II Court, The Castle, Winchester

Enquiries to members.services@hants.gov.uk

John Coughlan CBE
Chief Executive
The Castle, Winchester SO23 8UJ

FILMING AND BROADCAST NOTIFICATION
This meeting may be recorded and broadcast live on the County Council's website. The meeting may also be recorded and broadcast by the press and members of the public – please see the Filming Protocol available on the County Council's website.

AGENDA

Approx. Timings

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence received.

2. DECLARATIONS OF INTEREST

All Members who believe they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore all Members with a Non-Pecuniary interest in a matter being considered at the meeting should consider whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, consider whether it is appropriate to leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with the Code.

3. MINUTES OF PREVIOUS MEETING (Pages 1 - 16)

To confirm the minutes of the previous meeting.

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5. CHAIRMAN'S ANNOUNCEMENTS

To receive any announcements the Chairman may wish to make.

6. PROPOSALS TO VARY SERVICES (Pages 17 - 32)

To consider the report of the Director of Transformation and Governance on proposals from the NHS or providers of health services to vary or develop health services in the area of the Committee.

Items for Action

- Solent NHS Trust: Proposals to move the Kite Unit — 30 minutes

7. ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES (Pages 33 - 46)

To consider a report of the Director of Transformation and Governance on issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

- Friarsgate Surgery and West Hampshire Clinical Commissioning Group: Update on Closure of Kings Worthy branch surgery — 45 minutes

SHORT BREAK

- Southern Health NHS Foundation Trust: Antelope House – update on urgent temporary closure of beds — 30 minutes

8. FRIMLEY SUSTAINABILITY AND TRANSFORMATION PLAN (Pages 47 - 98) — 45 minutes

To consider the Sustainability and Transformation Plan for the Frimley area following its publication, and to understand next steps regarding engagement and implementation.

9. WORK PROGRAMME (Pages 99 - 112) — 5 minutes

To consider and approve the Health and Adult Social Care Select Committee Work Programme.

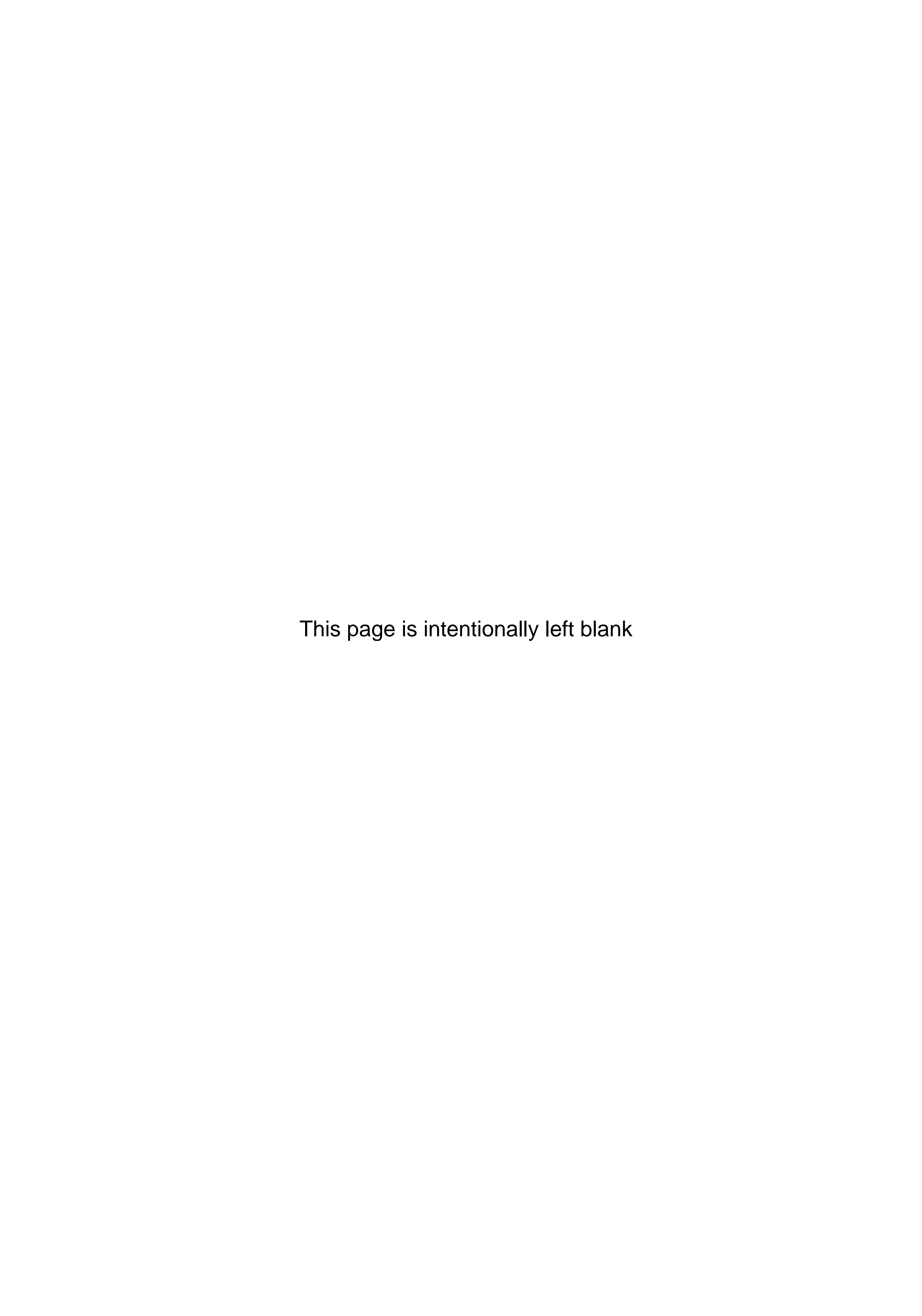
ABOUT THIS AGENDA:

On request, this agenda can be provided in alternative versions (such as large print, Braille or audio) and in alternative languages.

ABOUT THIS MEETING:

The press and public are welcome to attend the public sessions of the meeting. If you have any particular requirements, for example if you require wheelchair access, please contact members.services@hants.gov.uk for assistance.

County Councillors attending as appointed members of this Committee or by virtue of Standing Order 18.5; or with the concurrence of the Chairman in connection with their duties as members of the Council or as a local County Councillor qualify for travelling expenses.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AT A MEETING of the HEALTH AND ADULT SOCIAL CARE SELECT (OVERVIEW AND SCRUTINY) COMMITTEE of the COUNTY COUNCIL held at The Castle, Winchester on Tuesday, 17 January 2017.

PRESENT

Chairman:
p Councillor Roger Huxstep

Vice-Chairman:
p Councillor Chris Carter

Councillors:
p Ann Briggs
p Graham Burgess
p Rita Burgess
a Adam Carew
p Charles Choudhary
p Alan Dowden
p Jacqui England
p David Harrison
a Marge Harvey
p David Keast
p Chris Lagdon
p Martin Lyon
p Fiona Mather
p Chris Matthews
p Floss Mitchell
p Frank Rust
p Bruce Tennent
p Martin Tod

Substitute Members:

Co-opted Members:
Councillors:
a Tonia Craig
a Alison Finlay
a Dennis Wright
VACANT

In attendance at the invitation of the Chairman:
Councillor Liz Fairhurst, Executive Member for Adult Social Care
Councillor Patricia Stallard, Executive Member for Health and Public Health

169. **BROADCASTING ANNOUNCEMENT**

The Chairman announced that the press and members of the public were permitted to film and broadcast the meeting. Those remaining at the meeting were consenting to being filmed and recorded, and to the possible use of those images and recordings for broadcasting purposes.

170. **APOLOGIES FOR ABSENCE**

Apologies were received from Councillor Marge Harvey. Councillor Keith Evans, as the Conservative standing deputy, was in attendance in their place. Apologies were also received from Councillor Adam Carew, and co-opted members Councillors Alison Finlay and Dennis Wright.

171. **DECLARATIONS OF INTEREST**

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore, Members were mindful that where they believed they had a Personal Interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 4 of the Code, considered whether it was appropriate to leave the meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

Councillor Jacqui England declared a general Personal Interest, as she is the Chairman of the Lymington Hospital 'League of Friends'.

Councillor Martin Lyon declared a general Personal Interest, as his wife is an enhanced nurse practitioner employee of West Hampshire Clinical Commissioning Group.

Councillor Chris Matthews declared a general Personal Interest, as he is a Trustee of the Thorngate Almshouse Trust.

Councillor Frank Rust declared a general Personal Interest as he is a Member of the Wessex Clinical Senate, and undertook research in hospitals on behalf of the Nuffield Trust.

Councillor Martin Tod declared a general Personal Interest, as he is the Chief Executive of the Men's Health Forum, which receives funding from Public Health England and the Department of Health.

172 **MINUTES**

The Minutes of the meeting of the Health and Adult Social Care Select Committee (HASC) held on 20 October 2016 were confirmed as a correct record, subject to the apologies of Councillors Alan Dowden and Martin Tod being noted.

There were two matters arising in relation to the Minutes:

- Minute 163: The report on family experience of Southern Health following the death of a service user was circulated to Members in October.

- Minute 166: The recommendations made by the Committee on ‘paying for care’ were accepted by the Executive Member at their decision day on 21 October 2016. Councillor Alan Dowden spoke to this item, noting his absence at the meeting where the HASC considered ‘paying for care’, and his opposition to the decision taken by the Executive Member.

173. **DEPUTATIONS**

The Committee did not receive any deputations for this meeting.

174. **CHAIRMAN’S ANNOUNCEMENTS**

The Chairman made two announcements:

Briefings and Updates

The Chairman noted that updates would be shared after the meeting with the Committee on:

- The Andover Minor Injuries Unit opening hours (Hampshire Hospitals NHS Foundation Trust).
- Progress made against the Care Quality Commission’s recommendations (Hampshire Hospitals NHS Foundation Trust).
- The Kingsley Ward (Melbury Lodge) building works (Southern Health NHS Foundation Trust).
- Ambulance performance update (South Central Ambulance Service NHS Foundation Trust).

Dorset Joint HOSC Update

The Chairman had attended the most recent meeting of the Joint HOSC on the Dorset clinical services review on 27 October, where general updates were heard on the progress of the reviews. A further meeting would take place in February 2017 to consider the consultation, after which time a further update would be provided.

175. **REVENUE BUDGET FOR PUBLIC HEALTH 2017/18**
176. **REVENUE BUDGET FOR ADULT SERVICES 2017/18**
177. **CAPITAL PROGRAMME FOR ADULT SERVICES 2017-18 – 2019/20**

The Interim Director of Public Health, the Director of Adults’ Health and Care and a representative of the Director of Corporate Resources attended before the Committee in order to present the Revenue Budget for Public Health for 2017/18 (see report and presentation, Item 6 in the Minute Book). The Director of Adults’ Health and Care noted that this was the first set of budgets within the newly formed Department, encompassing Adult Social Care and Public

Health.

The presentation outlined the overall County Council financial position, setting out that in line with the decisions previously made as part of 'Transformation to 2017', there would be no new further savings for the 2017/18 year. The delivery of the 'Transformation to 2017' savings were all on target, subject to those areas where Cabinet had agreed a roll-over of savings to the next financial year, or a purposeful delay.

The local government grant settlement announced in 2016 provided definitive figures for 2016/17 and provisional figures for authorities for the following three financial years to aid financial planning. The settlement for 2017/18 was unchanged compared to the forecast position. The July 2016 Medium Term Financial Strategy assumed a 3.99% council tax increase for 2017/18, including 2% for social care.

A new dedicated social care grant would be available for 2017/18 of approximately £4.8m, as well as greater flexibility in the ability to raise funds specifically for Adult Social Care through increasing the precept, although this would be by a maximum of 6% over the next three years to 2019/20.

An overview of the Council's reserves strategy and financial position was provided, which set out that of the £497.3m held, approximately £100.9m, or 20.3% of the reserves, were truly 'available' to support one-off spending. An analysis of the allocation of this £100.9m was provided.

Members heard details of the 2017/18 budget for Public Health. The Public Health grant remained ring-fenced for 2017/18, and to date this had been reduced by £4.28m. By 2021, it was expected that the grant would have reduced by a further £5.24m. It was yet unknown as to whether the grant would continue to be ring-fenced in future years.

Public Health in 2017/18 would be focusing on commissioning high quality services as mandated nationally. The team would also focus on prevention, reducing the impact on reactive services in future by enabling the public to take greater responsibility for managing their health, and giving them and health professionals the tools to enable this.

In considering the more detailed information on the Public Health revenue budget, Members noted the following in response to questions:

- That the NHS were responsible for commissioning dentistry services for children. The Public Health

budget in this arena related to oral health promotion, a service which was currently out to tender. Through the 0-5 health visiting service, all new parents could be educated on the importance of good oral health, and child health monitored. Work was also ongoing with early years' providers to provide guidance on tooth brushing. Other areas of the Public Health budget also contributed towards the aim of good oral health, for example the promotion of healthy eating.

- That the services Councils are mandated to provide through Public Health were currently being reviewed by Government. It was not yet known whether the outcome would see an increase or decrease in the number and type of mandated services.
- The Public Health strategy set out the long-term vision for the service in Hampshire. It was agreed that this would be circulated to the Committee for information.

Public Health strategy to be circulated.

- The reduction in the smoking cessation budget had been achieved through renegotiating the contract for providing this service, and this wouldn't see any change in delivery. The new contract was based on commissioning for outcomes, and would continue to be a universal service, but with a greater focus on vulnerable groups.
- Public Health were directly involved in the Sustainability and Transformation Plan for Hampshire and the Isle of Wight, and the Interim Director of Public Health was specifically leading a work-stream on prevention. Through this, Public Health had identified several programmes which had the potential to deliver savings to the NHS through better outcomes and a reduction in accessed services, for example, the 'Stop before the Op' programme sought to improve outcomes for individuals by helping them to reduce or stop smoking before operations.

Through discussion, greater detail of the spend under each Public Health budget line was requested.

Public Health budget detail to be circulated.

The Director of Adults' Health and Care and a representative of the Director of Corporate Resources attended before the Committee in order to present the Revenue Budget for Adult Services for 2017/18 and Capital Programme for Adult Services for 2017/18 – 2019/20 (see report and presentation, Item 7 and Item 8 in the Minute Book).

Members had previously heard the overall budgetary position for the Council, and therefore heard details of the proposed Adult Services budget for 2017/18. Members heard that there were no additional savings to be made for 2017/18, although the Department are forecast to roll over £13m of efficiencies to the 2017/18 financial year, noting

that some projects would take longer to deliver the required savings.

The Committee had previously considered some of the key issues from the implementation of the savings for 'Transformation to 2017', and were apprised of the decisions before the Executive Member for Adult Social Care on 17 January which related to this programme.

The key priorities for the Adult Services Department for 2017/18, included:

- Demand and complexity: supporting increasing numbers of individuals requiring support, and increasing numbers with one or more complex and long-term needs. The Department had been successful at managing additional need and demand within current resources, noting that approximately £6m of the budget would be allocated to meeting these pressures.
- New Operating Model: a new staffing structure had been implemented, as well as the formalisation of the Senior Management Team within the Adults' Health and Care Department, and this would continue to evolve.
- Supply: the domiciliary care and nursing/residential home markets continue to face ongoing problems relating to staff recruitment and retention, and ensuring quality of care whilst meeting core standards expected nationally. These were all local and national issues, although Hampshire had lots of smaller independent homes, rather than larger national providers, and these issues therefore impacted to a greater extent in the County.
- National living wage: this had been built into the budget but would impact in future years.
- Hospital discharge: the number of individuals requiring a complex mix of social care services when being discharged from hospital had increased, and the numbers and pressures across the whole health and social care system continued to be a local and national issue. Data was presented suggesting that across all hospitals on 16 January 2017, 174 Hampshire individuals had been fit for discharge, and 74 of these required a package of Adult Social Care supported by Hampshire County Council.

On the Capital Programme, it was heard that the additional allocation for 2017/18 was significantly lower than previous years as the funding for Extra Care had now all been allocated. The new funding for 2017/18 focused on smaller scale improvements to operational buildings.

On the 2017/18 Revenue Budget and 2017/18 to 2019/20

Capital Programme, in response to questions, Members heard:

- That the social care levy was limited to the comprehensive spending review period, with no indication that this will continue after this time. It would be for the Council to determine how it wished to step these increases, noting the 6% total cap by 2019/20.
- Approximately £6m had been built into the 2017/18 revenue budget for increased in demand and complexity services, and in 2018/19 this was expected to increase to £8.5m.
- That the consultation on the proposal to increase the 'meals on wheels' cost-per-meal had provided three options for consultees to comment on. Letters had been sent to all the customers of Apetito, the 'meals on wheels' supplier, and 500 responses had been received. Of those, 80% noted that with the increase they would continue to use the service. Of the remaining 20%, most noted they would take fewer meals, and a small percentage said they would stop using the service. The final proposals would be to increase the cost-per-meal to £4.55, which was still significantly lower than surrounding local authorities.
- Hampshire County Council was committed to continuing to provide a 'meals on wheels' service, noting the positive impact this service has on its users, through better nutrition, social interaction and a general check on the wellbeing of the customer. However, the Council had a duty to ensure it was able to provide statutory services within a balanced budget, and providing a 'meals on wheels' service without subsidy would help to meet this challenge. Stopping the service had been considered, and research had shown that in 2015, 67% of local authorities in the South East provided or commissioned a meals on wheel service. In 2017, this figure had dropped to 17%. However, the importance of the service, particularly in ensuring service users had a good level of nutrition, had been noted in the consultation and it was proposed to continue.
- That there continues to be significant challenges in relation to workforce, with flow around the South-East Hampshire region seeing a 30% annual turnover of staff. The Committee had previously heard details of work ongoing to recruit and retain care workers, and this was continuing.
- Hampshire County Council continue to use agency care workers in order to meet sufficient staffing levels in homes, and to provide flexibility in the work force by offering cover when staff became unwell or took planned leave. Detail on the use of agency staff could be shared with the Committee.

  Information on the use of Agency staff to be circulated.
- Work was ongoing to understand how elements of

care could be delivered in innovative ways, reducing the number of people that needed to be supported through a package of care. Examples of this included assistive technologies and telecare.
- That there was not enough rehabilitation and step down care in the County as an appropriate alternative to social care placements. Currently 60 beds were available in Hampshire, plus some independent provision, and by 2020 this would need to grow to approximately 240 beds, to meet the needs of the 'baby boomer' generation.
- A focus on reablement was part of the longer-term strategy for Adult Social Care, creating multi-disciplinary reablement teams who can prepare people for a return to independent life. Additionally, provision for dementia care also needed to be considered,

In relation to ongoing projects relating to the Capital Programme on Bulmer House and Cornerways, it was agreed that updates would be provided outside of the meeting.

Updates to be circulated.

Following questions, the Chairman moved to debate. No debate was heard on the Public Health revenue budget.

On the Adults' Service revenue budget, the main focus of discussion was on the decreased grant funding from Government and the resulting savings that needed to be realised locally in order to be able to provide services, with differing political viewpoints shared by the Committee. Some Members noted their views that the forecasts of spend for 2017/18 were too optimistic.

On the Adults' Services Capital Programme, some Members questioned how the challenges of the future, specifically in relation to dementia care and reablement, could be met in the current climate or reducing spend and investment.

RESOLVED

That:

- That Members support the recommendations being proposed to the Executive Member for Health and Public Health in section 9 (page 8) of the report.

- That Members support the recommendations being proposed to the Executive Member for Adult Social Care in section 10 (page 8) of the report.

- That Members support the recommendations being proposed to the Executive Member for Adult Social

Care in section 9 (page 6) of the attached report.

Councillor Chris Matthews left the meeting at this point in proceedings.

178. **SUSTAINABILITY AND TRANSFORMATION PLAN FOR HAMPSHIRE AND THE ISLE OF WIGHT**

The Programme Lead for the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) provided Members with an overview of the Plan and its delivery (see Item 9 in the Minute Book).

Members heard an overview of the history of the STP, including details of the 'Five Year Forward View' and the historical local issues impacting on health services across Hampshire and the Isle of Wight, including the two Unitary areas of Portsmouth and Southampton. The STP was in part formed by the many strategies and plans already in place across the footprint.

They key work-streams and financial gaps were highlighted to Members, noting that the Plan required significant transformation in the health service; it wouldn't be possible for the NHS meet the health needs of the population in future with traditional models of care and current service structures. The work-streams in the Plan required the NHS and partners to think differently and innovatively to meet these challenges.

At the time of the Committee, some of the work-streams were detailed and in progress, whereas others were still at a strategic level.

In response to questions, Members heard:

- That in the STP delivery plan, each of the work-streams have the proposed outcomes, methodology and investment required to be successful set out. A challenge of the programme would be removing silo working, and creating joined up approaches to funding and delivery.
- Central Government had recognised that STPs would require revenue and capital investment upfront. Currently, not all the investment lines had been clarified, although they were expected to be released incrementally. There was a significant risk of the funds for innovation and transformation not being received, and therefore it will be important to prioritise those programmes who can deliver the most benefit.
- The financial picture set out in the STP was correct as of October 2016. Since this time, the demand on the local NHS had been exceptionally challenging in terms of increased non-elective activity. Resultantly,

reported deficits had increased and the financial challenge locally was more pressing.

- There was a further estimated £60m gap in funding outlined in the STP which was currently unmet. There were high levels of risk attached to the delivery of the work-streams, as well as to the innovation funding which would drive changes in the system. The strategic NHS partners responsible for delivering the STP would need to be agile in their response to challenges to ensure that delivery outcomes remained achievable. Consideration would need to be given to partners funding work-streams if central funding was not forthcoming, noting that this was work that was necessary and important.
- To date the STP had not been a strong brand with the public, given its strategic nature and the size of the footprint it covers. Although the plans and strategies it had pulled together had been informed by public engagement and consultation, the STP itself was not a document that had been through these processes. It was the view of the Programme Lead that the public and key stakeholders should be engaged as part of the implementation and development of the ten key work-streams. The STP Lead would be working with the Health and Wellbeing Boards across the footprint to shape what this will look like. An engagement strategy was being developed to this aim, which would be shared with the Committee.
- The STP is a significant transformational plan and therefore it was expected that some of the emerging models from it would be determined as 'substantial changes of service', in line with health scrutiny legislation. These would still be subject to the same processes and required public engagement. In terms of the specific work-streams:
    - The review of the future of acute services across North and Mid Hampshire would result in options for consultation which were due to come before the Committee.
    - The Solent Acute Alliance would need careful thought about how to frame service change so that this isn't seen as being a negative outcome; that the important factor is better outcomes and safer services, rather than where a service is physically located.
- That part of the radical change in thinking for health in Hampshire and IOW would also need to come from the public, both in terms of better managing their own health, and through thinking differently about how they wish to access health services.
- That the work-stream on the Solent Hospital Alliance had been built through consensus currently, with Portsmouth, Southampton, Lymington and Isle of

STP engagement plan to be shared with the HASC

Wight hospitals holding dialogue on sustainability of services. Hampshire Hospitals at this stage were keen to focus on the acute model of care for North and Mid Hampshire, and therefore although they had been part of the conversations on the Alliance, it was fundamental that they direct efforts on their own model of care. It was hoped that in future a greater Alliance could be explored.

- That the proposal noted in the STP would be to release 300 hospital beds that would otherwise be occupied across the footprint, rather than to take these out of the system. This would be achieved by caring for individuals in a different way, or reducing the use of private or out-of-area beds.
- That the NHS needed to be better at using the vast amount of data held about people's health, enabling the NHS to predict who are likely to require significant intervention and support in future, and targeting these individuals with screening and prevention programmes, where possible.
- That STP footprints were working cross-border on areas of joint interest.

The Chairman noted the significant interest of the Committee in this item, and the possibility after the election of the HASC taking forward a specific working group on the STP. Members specifically noted the high levels of risk attached to the delivery of the STP, and requested that this item be considered regularly on the work programme.

RESOLVED

That the Committee:

- Add the ongoing scrutiny of the Hampshire and IOW STP to the work programme.
- Receive a further update on progress against the 10 work streams in six months' time,
- Request the Hampshire and IOW STP engagement plan.

Councillors Ann Briggs and Alan Dowden left the meeting at this point in proceedings.

179. **ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES**

Portsmouth Hospitals NHS Trust: Care Quality Commission Re-Inspection Enforcement Notice – Urgent Care – Update

The Chief Executive and representatives of Portsmouth Hospitals NHS Trust, together with the Chief Delivery Officer from South Eastern Hampshire and Fareham and Gosport Clinical Commissioning Groups (CCGs), spoke to

the update on progress made against the actions arising from the Care Quality Commission's (CQC's) re-inspection report of the Trust's urgent and emergency care services (see Item 10 in the Minute Book).

The Chief Executive noted the discussions held and robust scrutiny of the CQC's inspection of Portsmouth Hospitals Trust's Urgent and Emergency Services when the Committee last considered this topic in June 2016. Members were reminded of the outcome of 'inadequate', and the conditions placed on the Trust's registration in order to make the required improvements. The Trust was pleased to report that, as a result of a further unannounced inspection in September 2016, these conditions had now been lifted. It was the view of the Trust that these conditions be kept in place locally, as they were important factors in ensuring continued improvement in Urgent and Emergency services.

An urgent care improvement programme and plan had been implemented locally between the Trust, partners and NHS Improvement, and the Chief Executive noted that this had been successful to date and remained the appropriate plan for taking forward sustainable improvements.

The Chief Executive noted that there were still intense issues and pressures on the services and Trust, with more progress to be made locally. There had been marked improvements in local relationships, especially between the Trust and the Ambulance Service, both Board to Board and on the frontline.

From the CCG's perspectives, previously the relationships between the providers and commissioners had not always been cohesive, and it was the role of the Chief Delivery Officer to bring together partners and improve ways of working. South Eastern Hampshire CCG held the lead commissioner role with South Central Ambulance Service NHS Foundation Trust and through this had noted the significant improvements made to this relationship. Commissioners were supportive of the removal of the CQC's conditions on the Trust.

In response to questions, Members heard:

- There had been a reduction in the performance of the four-hour referral to treatment time noted in the CQC's letter, and this was likely due to increased demand and acuity of patients. Currently length of stay had increased in the Trust which had impacted on the rest of the hospital. The overall performance of the Urgent and Emergency service still fell short of the national average, though comparable to similar Trusts locally and nationally.

- Plans were still in place to bring about a sustainable improvement to performance. Recruitment to the Urgent Care team continued, and the clinical model was still under review, enabling it to evolve based on 'what works best'. Additionally, the discharge to assess model had taken time to embed but was now working well, and geriatrician teams remained in the acute unit to ensure that elderly patients were seen and treated appropriately, with the aim of reducing unnecessary admissions.
- A significant amount of work had been undertaken on clinical leadership in the Trust, with ten clinical leaders now working directly with the Executive Board to help define the direction of the Trust. Additionally, the clinical transformation lead remained in place as required by the CQC, and this individual had been tasked with reducing 'learned helplessness' in Urgent and Emergency Care.
- The ambulance escalation policy worked well on some days and less well on others, dependent on how consistently it was applied. The Trust was working to ensure that lead clinicians enact the policy at the same point.
- The Chief Executive was disappointed with the continuing issues with ambulance handover delays. Although the Ambulance Service had the ability to flex resources to meet demand, there was more that needed to be achieved to reduce the impact on ambulances when the Emergency Department was at peak capacity.
- That the Trust was not an outlier on the number of conveyances to hospital by ambulance, but the number of individuals admitted from such conveyances were higher comparatively. This could be due to patients having higher levels of acuity or waiting longer before calling an ambulance, or due to the risk built into the triage method used by the ambulance service. More work needed to be undertaken on this area to better understand the reasons for this statistic.
- The Accident and Emergency Department at Queen Alexandra Hospital was well-sized in comparison to other hospitals, although there were some issues with flow which the Trust was trying to address.
- There were alternatives to Accident and Emergency locally, including walk-in centres and enhanced primary care opening hours funded by winter pressure funding from commissioners. Promotion for these alternatives was led by commissioners, and formed part of the 'Choose Well' campaign.

The Chairman moved to proceed to recommendations.

RESOLVED

That Members:

1. Welcome the progress by Portsmouth Hospitals NHS Trust against the actions of the Care Quality Commission's re-inspection report on the Accident and Emergency Department.

2. Request a future update on performance in six months' time, to include:
   - details relating to patient types accessing the Emergency Department and their outcomes, and;
   - discussion on whether alternative models of care (to be identified through the STP) would reduce pressure on urgent care services in the hospital.

Councillor Keith Evans left the meeting at this point in proceedings.

Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Transforming Care Partnership: Inpatient Care for People with Learning Disabilities and/or Autism

Representatives of West Hampshire CCG and Southern Health NHS Foundation Trust spoke to the report on the Transforming Care Partnership and associated proposals (see report, Item 10 in the Minute Book).

It was heard that the Chief Officer for West Hampshire CCG was the Senior Accountable Officer for the Transforming Care Partnership across the Southampton, Hampshire, Isle of Wight and Portsmouth area. The particular focus of the Partnership was to reduce the number of inappropriate long-term inpatient stays for people with a learning disability or autism.

Approximately 8,500 individuals across the region were registered with their GP as having a learning disability or autism, and of these, approximately 5,000 were in receipt of a care service. Those not in receipt of a service were able to live an independent life with support from the NHS or social care services at the level generally required by the population.

It was proposed that a new model be explored where the focus of forensic mental health rehabilitation services was not ward-based, but instead delivered in the community with temporary support from multi-disciplinary teams. Currently the Cypress Ward in Woodhaven offered six 'beds' or places to those in receipt of rehabilitation services in an open ward environment. The location of the service was not conducive to rehabilitation in the community, given its

isolated location in Tatchbury Mount, Calmore, and the environment in which it is offered was not fit for purpose. It was proposed that there was a disinvestment in this service in order to increase resource into a community forensic rehabilitation service. Beds would always be available for those who required them.

Details of the engagement undertaken with stakeholders to date had been included in the report.

Councillor Fiona Mather left the meeting at this point in proceedings.

In response to questions, Members heard:

- That all the savings from closing the Cypress Ward would be reinvested into a community service.
- Previously, the community forensic mental health service had been very successful at attracting high calibre candidates during recruitment rounds.
- The CCG had been successful in securing the capital funding for the proposal.
- That service users will always have the appropriate support required to support them to live as independently as possible.

The Chairman moved to proceed to recommendations.

RESOLVED

That the Committee notes:

1. The closure of Cypress Ward and the re-investment of £615k in community Learning disability services
2. The new model of care approach that replaces the Cypress Ward with an integrative working provision including:
   - the Forensic Community Learning Disability Team (FCLDT)
   - the NHSE capital investment of £935K for the procurement of Registered Social Landlord (RSL) supported accommodation for PWLD on the Forensic pathway
   - a 24 hours/ 7 days a week supported living provider for the RSL supported accommodation scheme

180. **<u>WORK PROGRAMME</u>**

The Director of Transformation and Governance presented the Committee's work programme (see Item 11 in the Minute Book).

RESOLVED:

That the Committee's work programme be approved,

subject to any amendments agreed at this meeting.

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Chairman, 15 March 2017

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	15 March 2017
Report Title:	Proposals to Develop or Vary Services
Reference:	8186
Report From:	Director of Transformation & Governance

Contact name: Katie Benton, Scrutiny Officer

Tel: 01962 847336 **E-mail:** katie.benton@hants.gov.uk

1. Summary and Purpose

1.1. The purpose of this report is to alert Members to proposals from the NHS or providers of health services to vary or develop health services provided to people living in the area of the Committee.

1.2. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.

1.3. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services agreed by the Hampshire, Isle of Wight, Portsmouth and Southampton Joint Committee in November 2010, last updated in July 2016. This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006, includes new responsibilities set out under the Health and Social Care Act 2012, and takes account of key criteria for service reconfiguration identified by the Department of Health. The 'Framework' can be found on the website through the link below: http://www3.hants.gov.uk/councilmeetings/advsearchmeetings/meetingsitemdocuments.htm?sta=&pref=Y&item_ID=7682&tab=2&co=&confidential=

1.4. This Report is presented to the Committee in 3 parts:

1. *Items for action:* these set out the actions required by the Committee to respond to proposals from the NHS or providers of health services to substantially change or vary health services.

2. *Items for monitoring:* these allow for the monitoring of outcomes from substantial changes proposed to the local health service agreed by the Committee.

3. *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements

1.5. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire, and to support health and social care integration, and therefore assist in the delivery of the Joint Health and Wellbeing Strategy and Corporate Strategy aim of maximising well being.

Items for Action

2. Solent NHS Trust: Move of the Kite Unit from St James' Hospital, Portsmouth, to Western Hospital, Southampton

Context

2.1 The NHS, or any provider of NHS services, is required to consult the health scrutiny committee on any substantial or temporary variations to the provision of the health service, and to provide any information that the committee may require to enable them to carry out scrutiny of the planning, provision and operation of this service.

Background

2.2 Solent NHS Trust currently provides neuropsychiatric and neuro behavioural services from the Kite Unit, located on the St James' Hospital site in Portsmouth, to patients from across Hampshire, Portsmouth, Southampton and outside of the County.

2.3 The Unit has 10 beds, with the length of stay on average being between six and nine months, reflecting the rehabilitation focus of the service.

2.4 Solent NHS Trust have highlighted that the building containing the Kite Unit is no longer fit-for-purpose, owing to:

- A Care Quality Commission inspection from 2014 highlighting that the Unit did not meet all of the requirements to ensure privacy and dignity of service users, and there being ligature point risks.
- The building layout not enabling clear lines of sight, and the low roof being a risk to patient safety.

- It not being possible for more than two females to stay in the unit and have access to single sex accommodation at any one time due to the inflexibility of the building.

2.5 Solent NHS Trust also provides Snowden, a 14 bed neuro-rehabilitation unit in Western Community Hospital, Southampton, which offers a purpose-built environment, with access to supporting facilities such as a gym, café and gardens. The Unit meets the guidance on single sex accommodation, and has anti-ligature features in place.

2.6 The co-location of the Kite and Snowden Units would enable Solent to strategically develop the service as a specialist regional neurological rehabilitation hub.

Proposal

2.7 A detailed paper from Solent NHS Trust is attached as Appendix One.

2.8 Following an options appraisal undertaken by the Trust, the preferred proposal is to relocate the Kite Unit from St James' Hospital, Portsmouth, to the Western Community Hospital in Millbrook, Southampton.

2.9 The Trust plans to relocate the Unit between July and August 2017, following the engagement and communication phase, works being completed to accommodate the Kite Unit, and support from key stakeholders.

2.10 The HASC will wish to consider the cohort of patients from Hampshire which will be affected by this move; in 2016 (up to October), eight patients from across Hampshire were admitted to the Kite Unit. The report sets out that travel time to the Kite Unit for patients and their families will be shorter on average if the Unit is re-sited in Southampton.

2.11 Members will wish to review the proposals to ensure that the following tests of service change have been met:
- That appropriate engagement and consultation has been undertaken with service users (where possible), their representatives and staff.
- That there is a clear clinical case for change, and support from clinicians leading the service.
- That commissioners are supportive of the proposal.
- That the proposals will extend choice or improve the quality of service provided to patients.
- That the service can be sustainably staffed and financed.

2.12 The proposals have been considered by the Portsmouth and Southampton HOSPs, who were both supportive of the move. The local HealthWatch have

been involved in the proposals, and have assisted Solent NHS Trust with its engagement activities.

Recommendations

2.13 That Members:

a. Support the proposal to move the Kite Unit from St James' Hospital, Portsmouth, to the Western Community Hospital, Southampton.

b. Request an update on the move of this service once the move has been completed.

c. Request any further information required on this issue.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

A. Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
B. Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
C. Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Section 100 D – Local Government Act 1972 – background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:

1.1 This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this covering report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

2. Impact on Crime and Disorder:

2.1 This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this covering report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

3. Climate Change:

3.1 How does what is being proposed impact on our carbon footprint / energy consumption?

This is a covering report which appends reports under consideration by the Committee; therefore this section is not applicable to this work report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

3.2 How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this work report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

Relocating Kite Unit

Summary

The Kite Unit, situated on the St James' Hospital site in Portsmouth, provides specialist neuropsychiatric and neuro behavioural services to people from a very wide area.

The unit currently caters for level 1c acuity Neuro rehabilitation patients. This includes individuals with a brain injury whose impairments are largely in the cognitive, behavioural or mental health spectrum. A typical patient is recovering from a brain injury. They are mobile but unable to be responsible for their own safety. They are very forgetful, disorientated and impulsive. They may be angry when frustrated. They are likely to have abused drugs and alcohol. These patients are very challenging in the acute setting. Kite is rightly proud of the service they provide to rehabilitate such individuals.

The facility consists of 10 beds and the average length of stay is between 6 and 9 months. Over time, it has become apparent that the current building which houses the Kite Unit is no longer fit-for-purpose. To ensure we can continue to deliver the very best possible care to our service users, we have considered alternative accommodation for the unit.

Following an options appraisal the proposal, which provides the maximum benefit to service users and staff, is to relocate the unit to the Western Community Hospital in Millbrook, Southampton. Relocation is scheduled for July-August 2017, following the engagement and communication phase and support from key stakeholders.

Case for change

Whilst staff at the Kite Unit always maintain a high level of care for their patients, a previous inspection by the Care Quality Commission (2014) highlighted that the building, which currently houses the unit, is not fit for purpose.

The presence of potential ligature points, the inhibited lines of sight within the facility and ensuring compliance with single sex guidance has been the subject of on-going remedial works. More recently the MHA team commented on the low roof also being a risk to patient safety. Providing safe, quality services is our highest priority.

Whilst we have done everything we can to ensure a safe and equitable environment for our patients, the extent of works required, and the physical layout of the building, makes addressing these issues any further challenging.
In addition, whilst steps have been taken to ensure provision of compliant single sex accommodation, the layout of the building is inflexible and does not allow clinicians to maximise their estate resource, resulting in the inability to take more than two female patients at any time.

Benefits of the proposal

It is our intention to be at the forefront of neurological rehabilitation provision across the Wessex region.

- The co-location of the Kite Unit with Snowdon, Solent's 14-bedded neuro rehab unit, will facilitate improved efficiency, productivity and enhance clinical expertise and skills through improved supervision, training and operational cover.

- The estate will allow greater capacity and flexibility of access. The service will no longer need to limit the number of female patients being admitted to two and future development means we could accommodate up to 12 patients at a time.

- The Western Community Hospital offers a better environment for the rehabilitation of service users. The proposed ward for relocation has been used for older people with behavioural concerns and so is an ideal environment for the client group as many anti-ligature features required are already in place. Patients will also have access to rehab gymnasiums, café facilities and garden areas on the WCH site. The patients will have access to a purpose built environment which complies with single sex legislation and is conducive to safe and effective rehabilitation care.

- The co-location would enable Solent to strategically develop the service as a specialist regional neurological rehabilitation hub. The creation of such a platform gives a concentration of significant clinical weight. This will allow Solent to develop other service collaborations as well as further develop the skill set of existing clinical teams.

Extending choice

We are currently working with commissioners to review the neuropsychiatric out-patient provision which works alongside the Kite Unit. This will remain in Portsmouth and Gosport as per the patient need but timings and days will be reviewed.

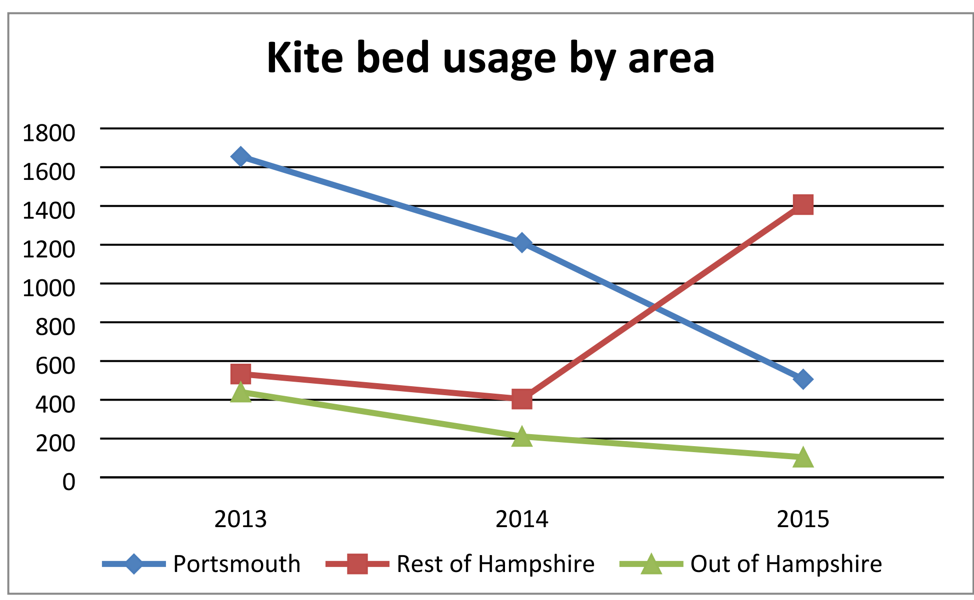
Impact on service users', carers and the public

We have engaged with patients and families, along with other key stakeholders and reviewed geographical areas of our patient cohort. The relocation of the unit will ultimately benefit patients as they will be housed in the right premises and will have easier access to a range of health professionals.

There is a proven need for additional acute complex and specialist rehabilitation beds in Wessex and the region requires more musculoskeletal rehabilitation facilities, as well as viable neurological psychiatric facilities.

We already deliver some of this provision and have the optimum clinical skills to develop a comprehensive regional neurological rehabilitation facility. Further work is underway to progress the strategic longer term requirements.

To establish such a service requires the centralisation of existing services to create a specialist hub on which to develop and build further capacity. The proposed Kite unit relocation is the first step.



The graph above highlights the reduction in number of patients from Portsmouth accessing the service over time.

The relocation of the unit to Southampton will be beneficial to the patients' families who currently travel a considerable distance to the unit.

We are also not serving the needs of the female population, which we serve. Only being able to take two female patients means that on numerous occasions females that we cannot admit are being sent to out of area placements.

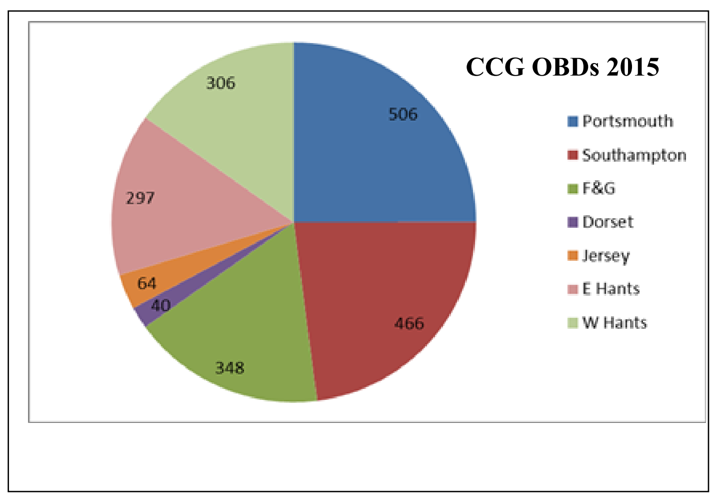
The proposed new site will allow greater flexibility to accommodate female patients.

Occupied bed days

The relocation affects approximately 30 patients per year.

The pie chart below outlines the occupied bed days (OBD) of the unit by respective CCGs for 2015.

Patients are referred from across Hampshire, with a minority from Dorset and Jersey for specialist treatment.



	2015 number of patients by CCG	2016 to date (end Oct) number of patients by CCG
Southampton	4	3 (166 OBD)
East Hampshire	5	1 (305 OBD)
Portsmouth	7	3 (499 OBD)
West Hants	4	4 (642 OBD)
Jersey	1	0
Fareham and Gosport	3	1 (167 OBD)
Dorset	1	2 (276 OBD)
North East Hants	1	1 (32 OBD)
North Hants	0	1 (61 OBD)
Surrey Downs	0	1 (34 OBD)

Risks for continuing to run Kite Unit out of current premises

The presence of potential ligature points, the inhibited lines of sight within the facility and ensuring compliance with single sex guidance were risks we needed to address. Recently the MHA team also expressed concerns with the low roof on the building.

Current facilities are no longer fit for purpose. Solent intends to create a dynamic Neurological Rehabilitation Hub at the Western Community Hospital (WCH).

WCH already houses core neurological rehabilitation services including Snowdon Ward, a 14 bedded neurological rehabilitation unit and specialist community and early supported discharge services.

Rehabilitation, botulinum, orthotic and spasticity clinics also run from this site.

Creation of the hub will allow for effective cross fertilisation of ideas amongst professionals to improve patient care.

Other considerations

Waiting times

We will be able to take an increased number of female patients so waiting times will be reduced for this group. An improved environment will mean that new patients can be admitted in a more timely manner. In our current ward the lack of de-escalation space means that admissions have to be carefully planned and often delayed until previous patient is settled.

Travel time

For Portsmouth patients and their families travel time will be longer but for all other patients it will be shorter. As shown above the demand for Portsmouth patients using the service is reducing.

We have started exploring options and support available for families who require assistance to travel to the unit. Headway have some financial provision accessible for families who fulfil their criteria.

Public transport links to the Western show a similar level of provision as those to St James Hospital.

Environment, including housing

The unit is relocating to an existing hospital site, with existing facilities so will not impact negatively on the environment.

There shouldn't be any relatable/additional impact on housing, transport as the unit will be benefitting from existing infrastructure and services.

The utilisation of the current Kite unit in Portsmouth once vacated will be subject to review as to the best possible plan moving forwards.

Catchment area

The services that Kite provide are predominantly commissioned by the following clinical commissioning groups (CCGs): Portsmouth, Fareham and Gosport and South East Hampshire, Southampton, Dorset and West Hampshire.

Finance

There are some initial costs to Solent to ensure the new building is fully fit for purpose. There will also be removal fees and some protection of travel costs for staff. After this it is anticipated that the move will be cost neutral.

Most patients coming to the unit are funded on a cost per case basis already and thus it is expected that the service will be financially sustainable.

Communication and engagement

We have developed a communications and engagement plan. To date our proposals have been welcomed and fully supported. We have not received any objections from key stakeholders we have contacted in line with our communications and engagement plan.

Key stakeholders supporting the proposal:

Commissioners

To date, we have had full support from all stakeholders and no opposition to the proposal. We made contact made with Commissioners regarding proposed changes in September 2016. Commissioners contacted were Portsmouth CCG; Southampton CCG; West Hampshire CCG; Fareham and Gosport and South East Hants CCG. Following on from Portsmouth HOSC, we have scoped options available for families to support travel costs from Portsmouth to Southampton.

Patients and families

It is fair to state that many current patients are cognitively unable to engage meaningfully with the concept of the relocation. However, we have engaged as much as we can with our patients directly and their families. Families and carers are supportive of the move. Starting in September 2016, we engaged with patients and their relatives/carers through verbal conversations on a 1:1 basis, letters, engagement events and by phone calls .

Staff/clinicians

In the majority of cases, clinicians consulted were positive about the proposed relocation and felt it was the correct strategic direction of travel. Travel protection will be in place for staff as per Solent policy.

Other staff are learning to drive and considering relocating to the new area. Some staff are looking for alternative employment where the move impacts significantly on their personal circumstances. However all remain committed to the relocation being the correct strategic move for the service. Engagement with staff has included one to one meetings and group meetings.

Some members of the team will decide that whilst the move of the service is in the interests of the patients, they will not move cities themselves and will look for new jobs. We are monitoring the situation, and managing this to ensure that people take up the best opportunity for them whilst keeping the unit safely staffed. New employees hired in recent months are informed of the possible move and we have agreed from now to support staff with travel costs in the interim.

Healthwatch (Portsmouth; Southampton and Hampshire)

We met with Healthwatch representatives in October and discussed with them the relocation plans as well as how we intended to engage and communicate the changes with our stakeholders. We have received support from them in managing this process. Southampton Healthwatch have put out information on the proposal via their social media channels while Southampton Healthwatch have added onto their website.

HOSPs (Southampton and Portsmouth)

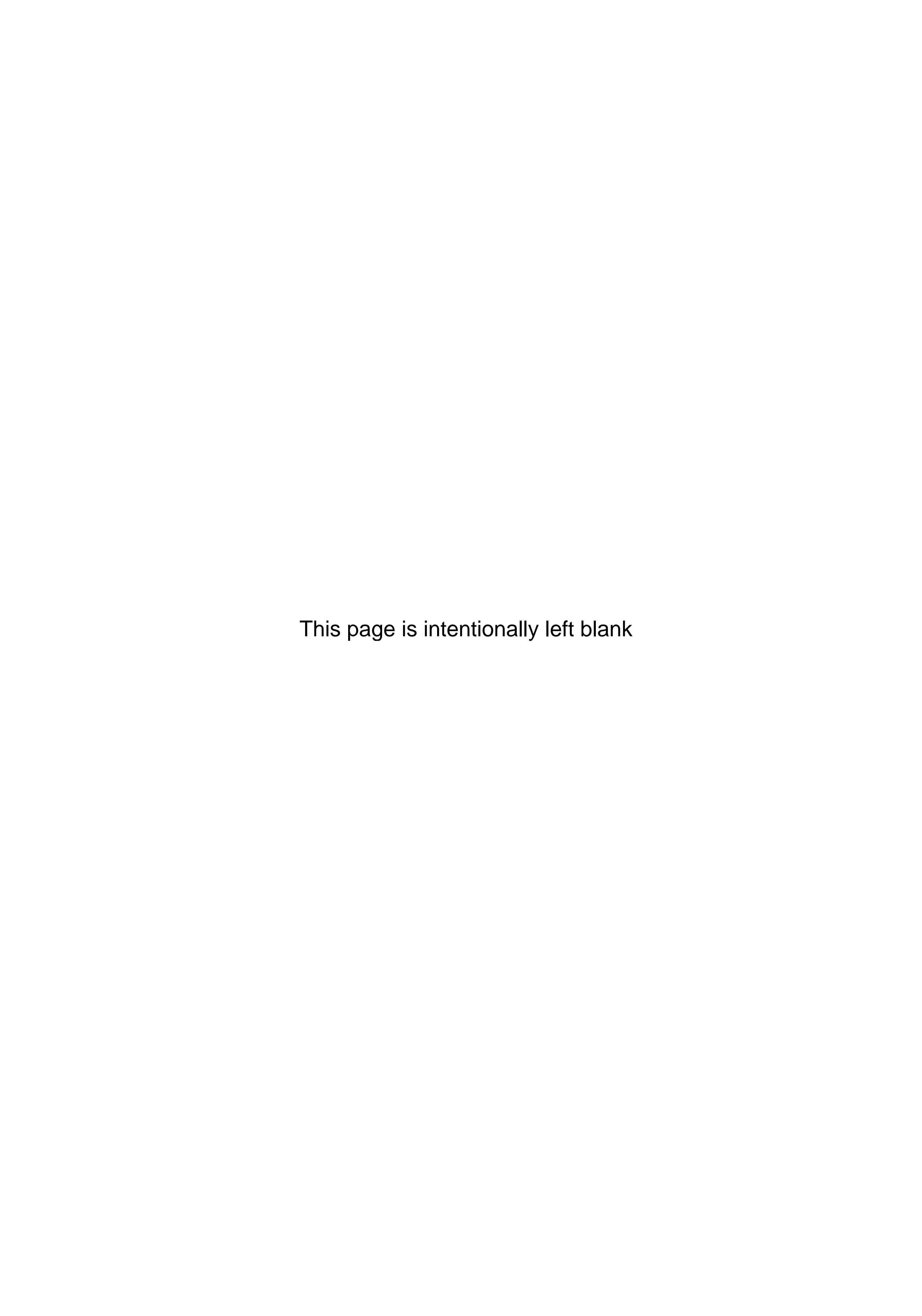
We engaged with LA health overview scrutiny panels from October 2016. Southampton were happy to support and did not require anything additional from us. Representatives

from Solent NHS Trust attended a Portsmouth HOSP panel in December. The panel was supportive of the proposal.

Other communications channels

We have also shared information around the proposal through a range of channels including:

- Press releases and briefing to local media
- Uploaded information on Solent NHS Trust website
- Letters to GPs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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	15 March 2017
Report Title:	Issues Relating to the Planning, Provision and/or Operation of Health Services
Reference:	8187
Report From:	Director of Transformation & Governance

Contact name: Katie Benton, Scrutiny Officer – members.services@hants.gov.uk

1. **Summary and Purpose**

1.1. This report provides Members with information about the issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

1.2. Where appropriate comments have been included and copies of briefings or other information attached.

1.3. Where scrutiny identifies that the issue raised for the Committee's attention will result in a variation to a health service, this topic will be considered as part of the 'Proposals to Vary Health Services' report.

1.4. New issues raised with the Committee, and those that are subject to on-going reporting, are set out in Table One of this report.

1.5. The recommendations included in this report support the Corporate Strategy aim of maximising wellbeing through the overview and scrutiny of health services in the Hampshire County Council area.

Topic	Relevant Bodies	Action Taken	Comment
Evaluation of the closure of the Kings Worthy branch surgery *(Monitoring item)*	West Hampshire CCG Friarsgate Surgery	An update report is at Appendix One.	The HASC considered this item in June 2016, where a number of recommendations were made. Papers relating to these can be accessed here.

Recommendations:

That Members:

1. Note the evaluation update following the closure of the Kings Worthy branch of the Friarsgate Surgery, Winchester.
2. Request any additional information required.

Topic/ inquiry	Source	Action Taken	Comment
Temporary closure of Hamtun Ward, Antelope House	Southern Health NHS FT	Update report attached as Appendix Two	

Recommendations:

That Members:

1. Note the progress by Southern Health NHS Foundation Trust to reopen the Hamtun Ward, Antelope House, and to recruit to staff vacancies.
2. Request a future update on staffing in six months' time.
3. Request any additional information required.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

2. Equality Duty

1.1 The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2 **Equalities Impact Assessment:** This is a covering report for items from the NHS that require the attention of the HASC. It does not therefore make any proposals which will impact on groups with protected characteristics.

2 Impact on Crime and Disorder:

2.1 This paper does not request decisions that impact on crime and disorder

3 Climate Change:

3.1 How does what is being proposed impact on our carbon footprint / energy consumption?

3.2 How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

No impacts have been identified.

Appendix One

Friarsgate Practice:
Report to Hampshire Health and Adult Social Care Select Committee

Quality services, better health

Background

- Friarsgate Practice in Weeke serves a patient population of 24,717. It's branch surgery (serving a population of 1,794), located 3 miles away in Kings Worthy closed on 31 May 2016.
- As requested by the Hampshire Health and Adult Social Care Select Committee on 21 June 2016, this report provides an update on:
  - the evaluation of the Wellbeing Café – a new model of care for frail and vulnerable patients
  - actions taken to improve access to appointments at Weeke
  - transport from Kings Worthy to Weeke

Evaluation of the Wellbeing Café

- A new holistic service, a Wellbeing Café has been provided for frail and vulnerable patients every Wednesday morning from June 2016
- A proactive approach is taken, with patients (typically aged over 65 years with two or more long term conditions) invited to attend the café so that their needs can be addressed in a holistic and integrated way in one visit
- From June to December 2016, over 250 patients have attended the Wellbeing Café
- Key features include extended 20 minute GP appointments, nurse appointments and access to blood tests as required. Care is tailored to individual need and patients and their carers are actively involved in joint decision making
- Social prescribing is a key component provided by a volunteer recruited by Community First who gives advice and actively signposts patients to a range of local community services, charities, clubs and voluntary organisations

Quality services, better health

Evaluation of the Wellbeing Café

- The Practice Patient Participation Group is fully engaged with the Wellbeing Café and has provided help to guide patients to their various appointments, giving them a cup of tea or coffee and introducing patients to Social Prescribing.

Going Forward into 2017

- The Practice has reviewed the model and learning to date, and from February 2017 has commenced a cycle of bi-weekly condition led clinics. This will extend the holistic wellbeing approach to a wider cohort of patients within the Practice, as well as the social prescribing aspect of the service (recognised as one of the 10 national high impact actions to release time for care within general practice). Each clinic, to which patients will continue to be proactively invited, with be supported from a social prescribing perspective by a relevant body or charity to provide signposting and advice.

Evaluation of the Wellbeing Café

- Wellbeing clinics will include:
  - **Frail and vulnerable people:** These will continue – GP led and nurse clinics with access to blood tests. Social prescribing provided by Age UK
  - **Mental Health and Dementia:** GP led with access to blood tests if required; mental health and dementia reviews completed. Social Prescribing provided by Andover Mind and Quit4life
  - **Learning Disabilities:** GP led review; Social Prescribing to be identified
  - **Sexual Health:** Nurse led at the University. Social Prescribing provided by 'let's talk about it'
- The Practice will continue to evaluate the wellbeing café clinics to understand what works best from a patient and practice perspective and to inform the model going forward. This will include a review of patient reported outcome measures and feedback on patient experience. The Practice will also continue to develop social prescribing so that patients have access to signposting advice and support, including the Hampshire County Council website 'Connect to Support'

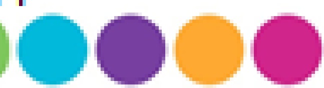
Improving Patient Access

Additional actions taken by the Practice to improve access to appointments:

- **Reducing "did not attend" (DNAs):** Implementation this month of an IT solution, MJOG, which automatically sends an appointment text reminder to patients with the ability, at one touch, for them to cancel the appointment. This system has saved up to 60% of DNAs in some practices, which would make a further 89 sessions available throughout the year for patients registered with Friarsgate. The impact will be monitored.

- **eConsult:** Implementation of a web based tool which gives patients, via the practice website, access 24/7 to medical advice. The patient effectively triages themselves by choosing from a range of options depending on the condition or query they have. There is a comprehensive range of self-help guides for many conditions and some patients may be directed to a pharmacist in the first instance. Those who do require advice from their GP receive a response the same day with what the GP feels is the most appropriate action to take. This may include on-line advice, a telephone consultation or face to face appointment.

Quality services, better health



Improving Patient Access

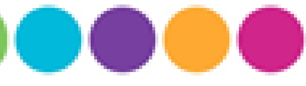
- Currently on average 150 patients are using e-consult every week with a combination of self – help, administration type enquiries, and e-consultations with either a member of the Nursing team or a GP providing immediate access.
- Also under consideration are ways in which the skill mix of the extended care team can be expanded to include a Pharmacist and Advanced Nurse Practitioners to lead the on the day acute care service.
- The results of the latest national GP Patient Survey will be published in July 2017. The survey assesses patients experience of healthcare services provided by GP Practices, including access to GP surgeries and making appointments. The results will help to assess the impact of the actions taken to improve access for patients.

Transport

- To ease transition and determine the real demand for transport, the following were implemented from 1 June 2016:
  - Daily Dial a Ride service at a discounted return fare of £3.80
  - Promotion of the Good Neighbours Scheme
  - Free Wednesday morning mini-bus service
- The free mini bus service between Kings Worthy and Weeke was promoted to all 1,794 patients who were written to with details of the service. All patients invited to attend the Wellbeing Café were also offered the service. Only 10 people utilised the mini bus service between June – August and the decision was therefore taken to stop the service in September.
- The Dial a Ride Service and Good Neighbours Scheme continue to be available and to be actively promoted.
- At the 21 June HASC meeting, the Chairman also agreed to write to the Executive Member for Environment and Transport on issues relating to public transport from the Worthies to Weeke, Winchester

HASC is asked to note the update on Friarsgate Practice in Winchester.

Quality services, better health



Appendix Two

Hampshire County Council
Health and Adult Social Care Select Committee
March 2017

Briefing note: Re-opening of Hamtun ward (PICU) at Antelope House, Southampton

Background

Antelope House is a mental health hospital in Southampton, providing care to 52 patients who are acutely unwell. There is a female ward which supports 21 women, a male ward which supports 21 men, and a mixed Psychiatric Intensive Care Unit (PICU), Hamtun ward, which supports 10 men and women.

We aim to support patients as close to home as possible, so Antelope House is mostly used by people from Southampton. The PICU, however, is used by patients from across Hampshire.

Due to ongoing staffing issues and difficulties to recruit qualified staff, and in order to maintain safe staffing levels, Hamtun ward was temporarily closed on 8 July 2016 for an interim period of 8 months. The aim of the closure was twofold:

1. To swiftly bring staffing to adequate levels by redistributing staff from the PICU to the hospital's other two wards.
2. To utilise the 8-months closure period for targeted and sustainable staff recruitment.

During the temporary closure, the majority of patients requiring PICU treatment were cared for at Huntercombe unit in Roehampton, London, where the Trust purchased 10 beds.

This decision had been made in conjunction with our commissioners at Southampton City Clinical Commissioning Group, and we had also communicated with a number of other stakeholders and interested parties, including local MPs, Healthwatch groups, and Health and Wellbeing Boards.

The plans were presented to HASC members on 20 July 2016.

Management of temporary situation

Throughout the temporary closure of Hamtun ward, we worked closely with the Huntercombe unit in Roehampton, with monthly visits, weekly clinical calls, and clinical discussions taking place daily as appropriate. This allowed us to jointly agree the way forward and maximise on using our local expert knowledge. We also supported carers financially to visit their loved ones.

Progress update

Through the development of a new staffing model and a subsequent targeted recruitment drive, the team were able to recruit to full strength. Although we would be able to fully open

the ward week commencing 6 March, the clinical team have decided to move patients in several phases to ensure all patients and new staff feel safe and well supported throughout the transition. The first patients will move back to Hamtun ward week commencing 6 March, and the ward will be fully operational again by the end of March.

New staffing model

In order to establish Antelope House as a desirable place to work and in order to improve staff retention, a full skills mix review was undertaken involving existing staff, and a new staffing model was developed. A number of new roles were created to enhance the career pathways within the unit from band 2 to band 7 posts. Staff can now choose between three seamless specialist pathways to work towards – clinical leadership, psychological interventions, and advanced nurse practitioners.

The aim is to support all staff in thinking about their development and planning their experience and training to meet their career aspirations. We have also developed tailored training to support people in advancing their skills and knowledge.

Following positive and encouraging feedback from applicants and existing staff we are now looking to use this model in other services across the Trust, in particular in our other PICU at Parklands Hospital in Basingstoke.

Targeted recruitment

We created a number of short films to support the recruitment campaign (please see links below) – one about working at Antelope House, one about people's experiences of using our services, and one about our new career path model and our work with students.

Working at Antelope House: http://www.southernhealth.nhs.uk/work-for-us/current-vacancies/mentalhealth/

Receiving care at Antelope House: https://vimeo.com/199646233

Career pathways at Antelope House: https://vimeo.com/198677086

A four-month social media campaign encouraged potential candidates to work at Antelope House, with adverts, quotes and films posted on a weekly basis. As this approach significantly increased the number of applications for the positions, we will be looking to replicate this for other targeted recruitment drives.

Other activity included adverts in local and regional Scottish papers and establishing links with Scottish universities, as well as recruitment events in other counties.

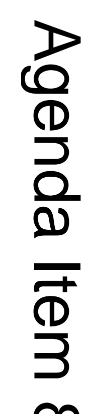
We have also been working closely with three key agencies to identify a group of temporary staff who can work within our service consistently, so they know the services, the patients, and the team. This will provide a buffer in the future to mitigate vacancies.

Mark Morgan

Director of Operations for Mental Health, Learning Disabilities and Social Care

Frimley Health and Care System Sustainability and Transformation Plan

21 Oct 2016 Submission



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Introduction to the Frimley Health & Care STP

Aim: To serve and work in partnership with the Frimley footprint population of 750,000 people, through the local system leaders working collaboratively to provide an integrated health and social care system fit for the future.

Statement

All of the partners involved in the STP are committed to putting residents first. In practice this translates to people receiving/having access to seamless holistic services that meet their need at the earliest possible opportunity – right service, right time and right place. Through focussing on the individual, as opposed to structure, there is an increased focus on prevention and pro-active care rather than reactive treatment. The partners are taking collective responsibility for simplifying the system and making it easier for people to understand and navigate it.

The first two years of our five year STP will be delivered through seven system initiatives that integrate commissioning decisions and provider delivery. These are set out in detail in this submission.

Workforce

The priorities described in the STP will be underpinned by developing the right workforce with the right skills, knowledge and understanding to transform our services and pathways. Consequently one of our initiatives is dedicated to workforce development and the remaining six initiatives having to create a workforce plan. The STP Local Workforce Action Board is utilising Health Education England, universities and other education providers to drive the plans forward.

Summary of progress since June

Established all of the workstreams to provide a coherent plan that clearly demonstrates the impact of each initiative with defined deliverables and benefits to the population.

- Increased the breadth of ownership and leadership of our STP through broad engagement
- Engagement and workshops with providers and commissioners to support alignment of primary and community care strategy and workforce resilience.
- Established the Local Workforce Action Board to respond to the workforce issues arising from each initiative.
- Further aligned the Local Digital Roadmap to the STP Priorities.
- Given a stronger voice to mental health and ensured that all seven key initiatives build in the requirements of the Mental Health Five Year Forward Plan.
- Developed an STP wide Communications and Engagement Strategy.
- Developed and updated the financial plan to reflect guidance and feedback from the September submission.

The Frimley Health & Care STP will provide benefits to the communities and individuals will:

- *Be supported to remain as healthy, active, independent and happy as they can be.*
- *Receive better coordination of heath & social care system - a 'no wrong door' approach.*
- *Know who to contact if they need help and be offered care and support in their home that is well organised, only having to tell their* story once.
- *Work in partnership with their care and support team to plan and manage their own care, leading to improved health, confidence and wellbeing.*
- *Find it easy to navigate the urgent and emergency care system and most of their care will be easily accessed close to where they live.*
- *Have confidence that the treatment they are offered is evidence based and results in high quality outcomes wherever they live - reduced variation through delivery of evidence based care and support.*
- *Increase their skills and confidence to take responsibility for their own health and care in their communities.*
- *Benefit from a greater use of technology that gives them easier access to information and services.*
- *As taxpayers, be assured that care is provided in an efficient and integrated way.*

Plan on a page: The Frimley Health & Care STP

Section One

Introduction

Many of our residents have the skills, confidence and support **to take responsibility for their own health** and wellbeing. We can do more to assist them in this and are committed to developing **integrated decision making hubs** with phased implementation across our area by 2018. Integrated hubs provide a foundation for a new model of **general practice, provided at scale**. This includes development of GP federations to improve resilience and capacity and provides the space for our GPs to serve their residents in a hub that has the support of a fit for purpose **support workforce**. Delivering services direct to residents in locations that suit them, at times that suit them, supports our ambition to transform the **'social care support market'**. Through a personalised yet systematic approach to delivery of health and social care we have the possibility of reducing **clinical variation**. Change will be delivered through advances in technology and we will implement a **shared care record**.

Our priorities for the next 5 years

Priority 1: Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection.

Priority 2: Action to improve long term condition outcomes including greater self management & proactive management across all providers for people with single long term conditions

Priority 3: Frailty Management: Proactive management of frail patients with multiple complex physical & mental health long term conditions, reducing crises and prolonged hospital stays.

Priority 4: Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place

Priority 5: Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

Seven initiatives on which we will focus in 2016/17-17/18

Initiative 1: Ensure people have the skills, confidence and support **to take responsibility for their own health and wellbeing**.

Initiative 2: Develop **integrated decision making hubs** to provide single points of access to services such as rapid response and reablement, phased by 2018.

Initiative 3: Lay foundations for a new model of **general practice provided at scale**, including development of GP federations to improve resilience and capacity.

Initiative 4: Design a **support workforce** that is fit for purpose across the system

Initiative 5: Transform **the social care support market** including a comprehensive capacity and demand analysis and market management.

Initiative 6: Reduce **clinical variation** to improve outcomes and maximise value for individuals across the population.

Initiative 7: Implement a **shared care record** that is accessible to professionals across the STP footprint.

Summary Financial Analysis

- The Frimley system will spend c£1.4bn on health and social care in 2016/17.
- Although there are modest increases in funding over the period to 2020/21, demand will far outstrip these increases if we do nothing.
- We have assumed health providers can make efficiency savings of 3% pa, and demand can be mitigated by 1% pa. This is in line with historic levels of achievement and existing efficiency plans following the acquisition of Heatherwood & Wexham Park hospital in 2014. Including broader efficiencies from Social Care will deliver about £176m by 2020/21.
- If a further £28m can be saved across our main priority areas, this coupled with an allocation of £47m from the national Sustainability and Transformation Fund (STF) will bring

STP 2020/21 Summary

	Do Nothing £m	Solutions £m	Do Something £m
Commissioner Surplus / (Deficit)	(100)	89	(11)
Provider Surplus / (Deficit)	(87)	80	(7)
Footprint NHS Surplus / (Deficit)	(187)	169	(18)
Indicative STF Allocation 2020/21	-	-	47
Surplus /(Deficit) after STF Allocation	(187)	169	29
Social Care Surplus / (Deficit)	(49)	27	(22)
Total Surplus / (Deficit)	(236)	197	7

An underpinning programme of transformational enablers includes:

A. Becoming a system with **a collective focus on the whole population. B. Developing communities and social networks** so that people have the skills and confidence to take responsibility for their own health and care in their communities. **C. Developing the workforce** across our system so that it is able to delivery our new models of care. **D.** Using **technology** to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency. **E.** Developing the **Estate**.

Ensure people have the skills and support to **take responsibility for their own health** and wellbeing.

Lead Director: Lise Llewellyn, Director of Public Health; Project Manager, Ben Rowlands

Overall Objectives

- Develop a range of digital, telephone and face to face support for people with high risk lifestyle behaviours or mental health characteristics
- Introduce a digital support package that encourages behaviour change linking with the One You programme
- Supporting a healthy NHS workforce enhancing the Commissioning for Quality and Innovation initiatives to deliver sickness absence reductions and reduced agency requirements
- Year 1 and Year 2 priorities will be tobacco cessation in elective care, early cardiac detection, diabetes and physical inactivity utilising digital technology via a patient portal and nudge techniques as part of these programmes
- Learn from the Vanguard self-care initiatives, for example, healthy living pharmacies and safe haven model for mental health and replicating effective interventions across the STP footprint
- Support self-care through identification and use of digital platforms such as patient portal, patient facing technology and shared care record across the STP footprint to develop comprehensive care and support planning
- Work in collaboration with the Fire Service to enable joined up front line service delivery

Deliverables

1. Programme implemented across STP to detect higher than normal blood pressure within primary care and the community
2. Roll out of national diabetes prevention programme
3. Offers of quit support for smokers undertaking elective procedures
4. Alcohol Care Teams in hospital sites and brief intervention in health settings building on work of the alcohol liaison nurses
5. Training of staff to improve the understanding of lifestyle risks, maximising every contact counts
6. Obesity reduction programme setup throughout footprint
7. Develop and implement digital programmes to support healthy lifestyles e.g. to encourage inactive residents to increase physical activity
8. Roll out successes of Vanguard interventions

Interdependencies

- Digital transformation initiatives such as patient portal, patient facing technology, whole system intelligence and shared care record
- Health and wellbeing strategies
- Vanguard pilot in North East Hampshire and Farnham
- Underpinning all of the other initiatives within the STP

Milestones

Milestones	*Start Date*	*End Date*
Development of a project to increase referrals to the National Diabetes Prevention Programme	*Feb 16*	*Oct 17*
Project documentation approved	*30 Sep 16*	*17 Oct 16*
Model the financial impact	*Oct 16*	*Oct 16*
Agree definition and terms of reference for steering group	*17 Oct 16*	*17 Oct 16*
Submit the STP		*21 Oct 16*
National Diabetes Prevention Programme Pilot Schemes start		*28 Oct 16*
Develop and agree a detailed framework	*Oct 16*	*Nov 16*
Setup and agree project teams for deliverables	*Oct 16*	*Nov 16*
Develop and roll out programme to reduce the number of people smoking within footprint	*Oct 16*	*Dec 17*
A fully implemented primary care/community programme for early detection of high blood pressure	*Dec 16*	*May 17*
Develop and implement targeted health promotion to reduce alcohol consumption	*Mar 17*	*Oct 17*
Project to promote an increase in physical activity	*Mar 17*	*Oct 17*
Evaluate Vanguard self-care interventions and roll out if evidence supports	*Feb 17*	*Feb 18*
Develop, implement and evaluate a digital platform to support self-care	*Feb 19*	*Jan 20*

Key risks/ Issues

Risks	Mitigation
Lack of agreement on design principles / framework	Ensure maximum engagement ahead of required agreement date
Senior management support	Continual updates to System Leadership Reference Group
Public engagement and involvement	Co-production elements where possible and ensuring continual communication through a variety of conduits
Public health funding risk	Strong return of investment justifies funding

Scope and exclusions

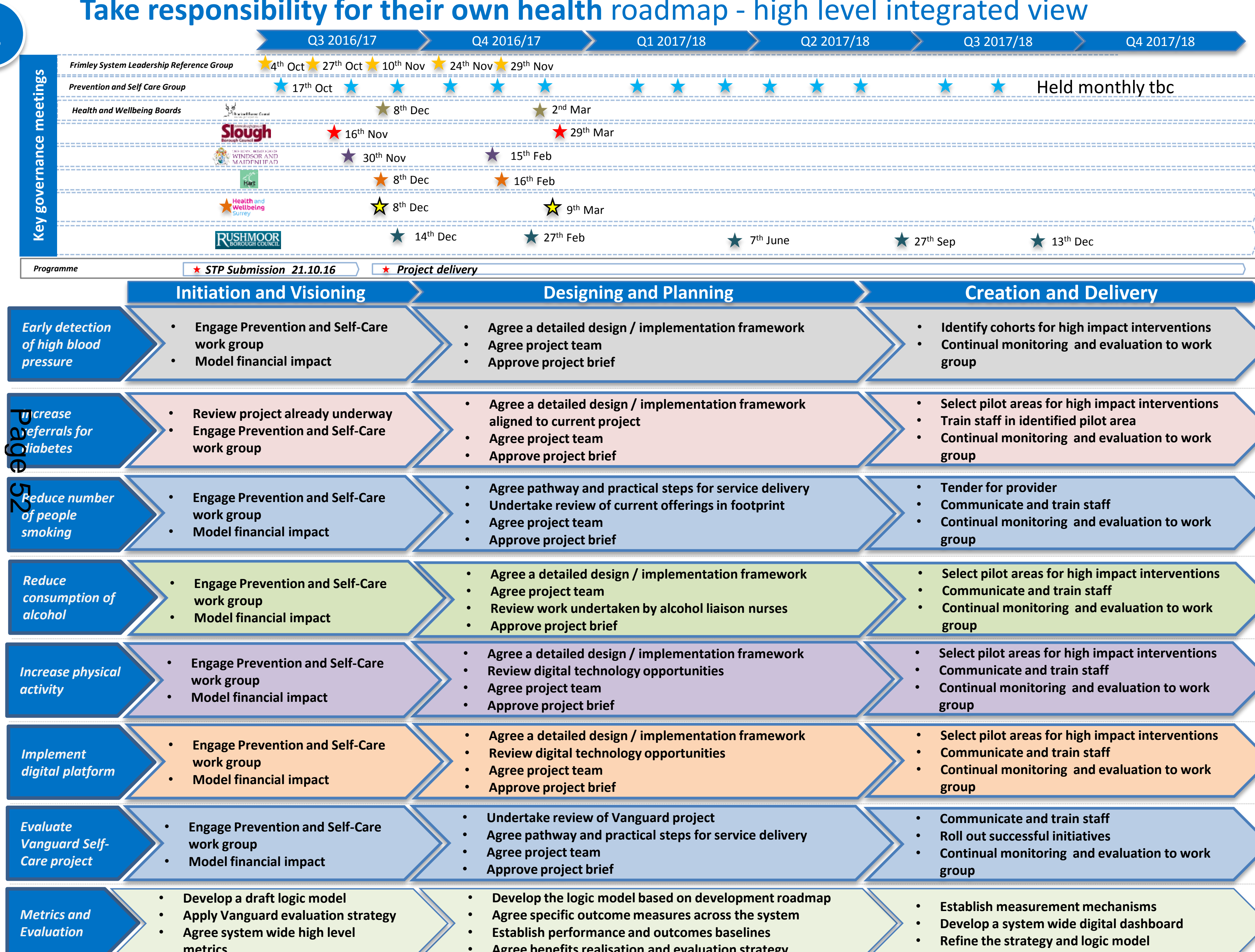
- This project will focus on people within the Frimley footprint which covers 5 CCG areas and serves a population of 750,000.
- Digital enablement to encourage self-care and prevention
- Although other areas of prevention may interface with this project they will not be considered in scope.

Benefits

- Just over £7.6 million net saving over the 5 years
- Reduction in smoking and alcohol consumption
- Earlier intervention for diabetes and hypertension
- Reduced sickness, improving the economy and society
- Improved cohesion between NHS, Fire Service and Local Authorities
- Health and wellbeing improved within Frimley footprint
- Contact with hard to reach groups and increasing reach through digital platform
- Areas with the poorest outcomes will be prioritised in the roll out of all initiatives to ensure we address health inequalities
- Digital ecosystem setup that will encourage sharing of care records and ownership for their own wellbeing

Outcome measures

- Blood pressure detection matches best performer in comparator CCGs
- An additional 18,135 residents are identified through the national diabetes prevention programme
- Reduction in growth rates of diabetes incidence
- Through offers to quit support an additional 463 smokers quit per year
- Reduction in smoking related surgical site infections by 147 per yr
- Alcohol care teams setup across Frimley footprint
- Alcohol related deaths decreased by 20%
- Reduction in number of people with BMI over 30 by 2680
- Frimley footprint physical inactivity decreases to below 20%
- Increase in the availability of patient facing and patient portal technology
- Successful roll out of effective Vanguard intervention programmes



I1
Take responsibility for their own health roadmap - high level integrated view
Section Two
Q3 2016/17
Q4 2016/17
Q1 2017/18
Q2 2017/18
Q3 2017/18
Q4 2017/18
Key governance meetings
Frimley System Leadership Reference Group
4th Oct
27th Oct
10th Nov
24th Nov
29th Nov
Prevention and Self Care Group
17th Oct
Held monthly tbc
Health and Wellbeing Boards
8th Dec
2nd Mar
Slough
16th Nov
29th Mar
30th Nov
15th Feb
8th Dec
16th Feb
Health and Wellbeing Surrey
8th Dec
9th Mar
RUSHMOOR BOROUGH COUNCIL
14th Dec
27th Feb
7th June
27th Sep
13th Dec
Programme
STP Submission 21.10.16
Project delivery
Initiation and Visioning
Designing and Planning
Creation and Delivery
Early detection of high blood pressure
Engage Prevention and Self-Care work group
Model financial impact
Agree a detailed design / implementation framework
Agree project team
Approve project brief
Identify cohorts for high impact interventions
Continual monitoring and evaluation to work group
Increase referrals for diabetes
Review project already underway
Engage Prevention and Self-Care work group
Agree a detailed design / implementation framework aligned to current project
Agree project team
Approve project brief
Select pilot areas for high impact interventions
Train staff in identified pilot area
Continual monitoring and evaluation to work group
Reduce number of people smoking
Engage Prevention and Self-Care work group
Model financial impact
Agree pathway and practical steps for service delivery
Undertake review of current offerings in footprint
Agree project team
Approve project brief
Tender for provider
Communicate and train staff
Continual monitoring and evaluation to work group
Reduce consumption of alcohol
Engage Prevention and Self-Care work group
Model financial impact
Agree a detailed design / implementation framework
Agree project team
Review work undertaken by alcohol liaison nurses
Approve project brief
Select pilot areas for high impact interventions
Communicate and train staff
Continual monitoring and evaluation to work group
Increase physical activity
Engage Prevention and Self-Care work group
Model financial impact
Agree a detailed design / implementation framework
Review digital technology opportunities
Agree project team
Approve project brief
Select pilot areas for high impact interventions
Communicate and train staff
Continual monitoring and evaluation to work group
Implement digital platform
Engage Prevention and Self-Care work group
Model financial impact
Agree a detailed design / implementation framework
Review digital technology opportunities
Agree project team
Approve project brief
Select pilot areas for high impact interventions
Communicate and train staff
Continual monitoring and evaluation to work group
Evaluate Vanguard Self-Care project
Engage Prevention and Self-Care work group
Model financial impact
Undertake review of Vanguard project
Agree pathway and practical steps for service delivery
Agree project team
Approve project brief
Communicate and train staff
Roll out successful initiatives
Continual monitoring and evaluation to work group
Metrics and Evaluation
Develop a draft logic model
Apply Vanguard evaluation strategy
Agree system wide high level metrics
Develop the logic model based on development roadmap
Agree specific outcome measures across the system
Establish performance and outcomes baselines
Agree benefits realisation and evaluation strategy
Establish measurement mechanisms
Develop a system wide digital dashboard
Refine the strategy and logic model

I2

Develop **integrated care decision making hubs** to provide single points of access to services such as rapid response and reablement, phased implementation by 2018

Lead Director : Fiona Slevin-Brown, Director of Strategy, East Berkshire CCGs; Project Manager, Haider Al-Shamary

Overall Objectives

- **System wide population based identification and proactive management of individuals with frailty**
- **Care Model Design:** Develop a system wide model, based on NHSE Frameworks, for multidisciplinary teams to deliver community based care
- **Digital Cohort Identification**: Utilise whole system intelligence, Right Care, and predictive modelling, to identify and proactively manage cohorts with frailty
- **Rapid Local Delivery:** Build on local success and accelerate delivery at pace and scale across the system, with General Practice at the core
- **Digital Enablers:** Use a Shared Care Record, real time analytics, digital care services and multi-media sign posting
- **Wider integration:** Between health, social care and our community partners
- **Mental Health Parity of Esteem:** Join up physical and mental health care for high-need groups, such as people with severe mental illness and older people with dementia
- **Prevention and Self Care:** Collaborate with local authority, voluntary, and community partners, promoting prevention, early intervention, and community support
- **Shared Processes:** Shared risk processes, assessments, and a single shared care plan, targeting high impact interventions to enable proactive and preventative care
- **Workforce Enablers:** Introduce new roles and new ways of working e.g. care navigators, health coaches, clinical pharmacists, and integrated mental health leads

Deliverables

- Identify frail cohort of individuals in order to enable proactive planning.
- Clinical and virtual hubs with co-located MDTs
- MDT coordination of complex care planning and frailty
- Targeted support for defined cohorts based on need
- Aligned crisis response, rehabilitation and reablement
- Rapid access to diagnostics and upstream diagnosis
- Social prescribing and asset based community support
- Aligned, integrated and simplified routes into UEC
- Streamlined primary, community and acute care interfaces
- Specialists and generalists working around the person
- Digital dashboard utilising whole system intelligence
- Flexible workforce able to work across the system

Milestones

Milestones	*Start Date*	*End Date*
System wide workshop on core elements	Aug 16	Sep 16
Modelling the financial impact	*Oct 16*	*Oct 16*
Review the draft STP project documentation	*Sep 16*	*Oct 16*
System leaders on 'TCSL' leadership course	Oct 16	Jan 17
Submit the STP		*21 Oct 16*
Agree delivery and evaluation framework	*Oct 16*	*Nov 16*
Develop logic model and evaluation strategy	*Oct 16*	*Nov 16*
Convene a steering group aligned with 'TCSL'	*Oct 16*	*Nov 16*
Map the current state of delivery	*Dec 16*	*Jan 17*
Agree phased implementation plan	*Jan 17*	*Feb 17*
Approve local planning and scheduling	*Feb 17*	*Mar 17*
Implement quick wins in fast followers	*Mar 17*	Sep 17
Refine the framework through rapid learning	Mar 17	Sep 17
Develop a system wide digital dashboard	Mar 17	Sep 17
Deploy refined framework at scale and pace	Sep 17	Mar 18

Key risks/ Issues

Risks	Mitigation
Lack of agreement on design principles / framework	Ensure maximum engagement ahead of required agreement date
Complex dependences between programmes of work	Programme governance and robust communications plan
Decision making needs to be coordinated across multiple statutory bodies	Robust critical path that takes into account decision making points and clear schedule of delegation

Interdependencies

- Other STP Initiatives and deliverables including Primary Care Transformation, Workforce, Unwarranted Variation, Social Care Support, Prevention and Self-Care
- Local Digital Roadmap and associated digital ecosystem
- Local Integrated Urgent and Emergency Care and NHS111 Redesign

Scope and exclusions

This initiative is concerned with the collaborative design of a system wide integrated care model framework for local delivery and implementation. The evolving scope will need to be aligned to the development of other STP initiatives and deliverables as they evolve.

Benefits

- Early access to proactive integrated services for individuals identified as frail
- Adoption of single trusted assessments and care planning
- Use of a Shared Care Record accessible across all settings
- Individuals will only have to tell their story once
- Individuals supported by personal recovery guides and navigators
- Reduced crisis, impacting on emergency admissions, bed days and admissions into care homes to improve quality of care
- Enhanced supported discharge into community settings
- Improved experience of individuals and equity of access for all
- Helping people maintain independence and manage their own health and care e.g. through expanded use of social prescribing
- Optimising quality of life and increasing healthy lifespan
- Social, emotional and psychological support in partnership with the individual
- Care homes integrated into the wider system

Outcome Measures

1. Incremental reduction in non elective attendance towards 30% for the patient cohort identified as frail and managed within integrated hubs
2. Increase in frail cohort being treated proactively in same day/next day services
3. Reduction in proportion of people identified as frail readmitted within 30 days.
4. 75% of patients identified as frail have a proactive plan in place led by the integrated hub.
5. 50% of those identified as most frail will have a crisis prevention plan in place
6. Patient and carer satisfaction regarding care coordination and telling their story only once.
7. Staff satisfaction with integrated team working specifically regarding risk sharing.

Integrated care decision making hubs Roadmap – high level integrated view

	Oct 16 – Mar 17	Mar 17 – Sep 17	Oct 17 – Mar 18

Key governance meetings
- *Frimley System Leadership Reference Group*
- *Surrey Heath Governance Groups*
- *NEH&F Governance Groups*
- *East Berkshire Governance Groups*
- *Local Authority Governance Groups*
- *Local Workforce Advisory Group*
- *Communications Group*

Programme
- *First Draft Brief 03.10.16*
- *STP Submission*
- *Implementation*
- *NHS Improvement Leadership Programme*

	Designing and Planning	Implementing and Refining	System Wide Rollout
Care Model Design	• Engage system leaders • Convene system wide workshop • Model financial impact • Agree core design framework • Align with NHSE Frameworks	• Agree a detailed design / implementation framework • Align to New Care Models implementation matrix • Map current state and agree implementation priorities • Align with other STP initiatives and deliverables • Develop local implementation schedules • Carry out digital frailty segmentation	• Develop the detailed financial and business model • Identify mild, moderate and high frailty cohorts for interventions • Build integrated care teams and hubs • Accelerate phased implementation
Metrics & Evaluation	• Develop draft logic model based on the NEH&F Vanguard model • Apply the Vanguard strategy to evaluation • Agree high levels metrics	• Develop the logic model based on agreed framework • Agree specific outcome measures across the system • Establish performance and outcomes baselines • Agree a system wide evaluation strategy • Develop a system wide digital dashboard	• Establish population-based measurement mechanisms • Refine the strategy and logic model
Empowering Patients, Citizens and Communities	**Applying the six principles of effective engagement and participation throughout the programme:**	Care and support is person-centred: personalised, coordinating and empowering Services are created in partnership with citizens and communities Focus on narrowing health inequalities Carers are identified, supported and involved	Voluntary, community, social enterprise and housing sectors are involved as key partners Volunteering and social action as key enablers, including healthy living pharmacies
Leadership, Governance and Local Delivery	• 8 local leaders embarking on 'Transformational Change through System Leadership' (TCSL) programme	• Clinical and care leaders sharing expertise and supporting generalists / specialists to work together, sharing responsibility and accountability across MDT's • Establish a system wide steering group / learning network to feed into the Leadership Programme Cohort	• Utilise established local project delivery mechanisms to drive change in alignment with the care model framework • Learning Network to spread existing and emerging best practice
Workforce Redesign	• Identifying new roles / training needs • Connecting with LWAB and LETB for support	• Joint workforce mapping and modelling • Agree shared workforce strategy and align with regional networks • Training needs fully understood and planned	• Implement the new workforce model • Engage front line staff with training and delivery • Capture and build on what works • Clearly defined roles and responsibilities
Local Digital Roadmap	A digital ecosystem that delivers key enablers such as a Shared Care Record, Patient Portal, Technology Enabled Care Services, and system wide Business Intelligence		

I3

Lay the foundations for a new model of **General Practice provided at scale.**

Lead Director: Nicola Airey, Director of Planning, Surrey Heath CCG; Project Manager, Gazelle Robertson

Overall Objectives

- To deliver a sustainable model of general practice including a clinical, business and career model that delivers improved outcomes for our population
- To reduce variation in care and outcomes across the STP with a focus on:
  - Access
  - Mental Health
  - Prevention & early intervention
  - Patient experience
  - Urgent care pathway
  - Planned care referral thresholds
  - Long term conditions clinical outcomes
  - Use of technology to support access
- Generate pace and early delivery through:
  - Additional support to localities that need to strengthen foundations
  - Enabling pacesetters to develop transformational changes early
  - Identify fast followers to spread improvement at pace

Clear articulation of system wide benefits of improvements in general practice

Deliverables

March '19 delivery of FYFV for General Practice across whole STP

- 8am-8pm Mon – Fri GP services including access for MH pts
- Weekend GP services including access for MH patients
- Improved working across primary, community & secondary care
- Early intervention for LTC and complex patients
- General practice working at scale through federations
- Patient portal supported by LDR
- Wider primary care workforce eg. Health navigators
- System wide recruitment, retention strategy
- Consultations using technology eg. Video, emails, telephone
- Real time analytics tools in collaboration with LDR

Interdependencies

Project Workstreams:

-Integrated care decision making hubs; -prevention & self care; -Social care; -Shared care record;

-Unwarranted variation; -Support workforce; -Mental Health

Enabling Workstreams:

-LWAB; -Technology; -Engagement - Estate

Milestones

Milestones	*Start Date*	*End Date*
Engagement exercise to: -develop system wide views on GP transformation -agree current good practice to spread across the system -agree how to work better together and identify potential wide STP activities	*Aug 16*	*Sept '16*
Financial Modelling	*Sep '16*	*Oct '16*
STP Submission		*Oct 16*
Project Brief sign off	*Sep '16*	*Oct '16*
Establish an overarching workstream steering group	*Oct 16*	*Nov 16*
Project Implementation	*Nov 16*	*Mar '19*
Evaluation process	Mar '19	Mar '20

Key risks/ Issues

Risks	Mitigation
Lack of engagement from general practice across the system	System wide ownership of STP priorities, engagement plan and commitment to achieve change
Insufficient resource to undertake associated workstream tasks	a fully staffed PMO driving and supporting the programme with leadership & input from across the system
General Practice workforce not fit for purpose to achieve change	-Workforce subgroup and link into wider workforce planning. -Future proofed business and career models -Retention strategies eg flexible working
Complexity of managing interdependencies across workstreams	PMO leads & system leads working closely together to ensure the alignment of priorities

Scope and exclusions

Working across the Frimley health & care system to achieve general practice transformation through

- care redesign & improved access;
- workforce, education & training;
- IT & infrastructure;
- workload;
- finance and engagement

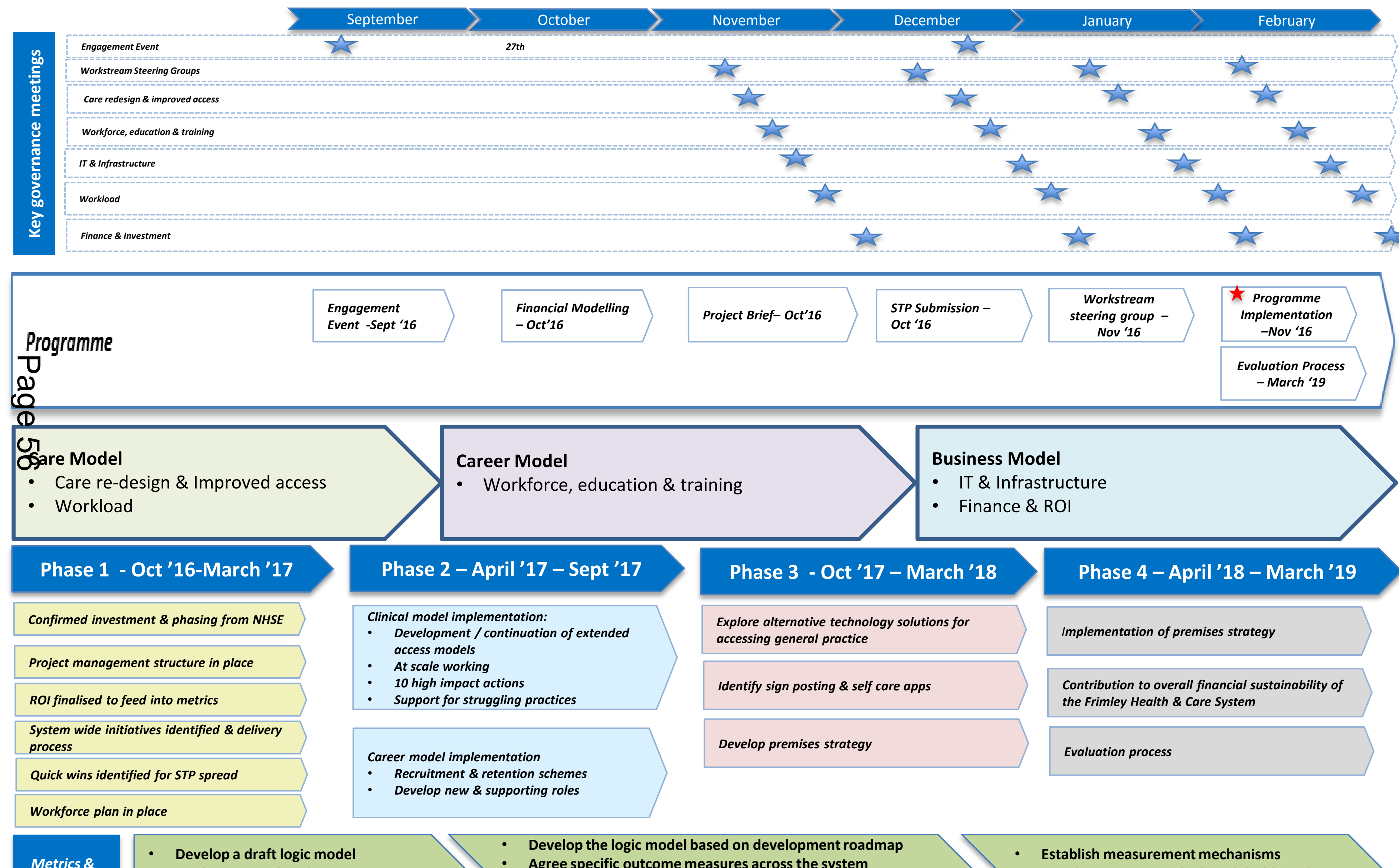
Benefits

- Improved access from an increased number of appointments
- Reduced variation in clinical outcomes and patient experience across the STP with specific ambitions to raise current levels of performance in Slough
- Increased capacity to deal proactively with complex patients including those with LTC
- Increased patient satisfaction and outcomes
- Sustainable and fit for purpose workforce
- Reduction in need to visit hospital services
- Collaboration across the system
- Increased general practice resilience
- Economies of scale & greater system wide efficiencies

Outcome measures

- Reduced variation in % of patients satisfied with opening hours & overall average increase – from 18/19
- % of patients rating their overall experience as good/very good, minimum 3% increase / 85% achieved – from Q4 17/18
- Additional number of appts outside core hours – from Q1 18/19
- Reduced variation in number of people with a LTC feeling supported to manage their care – 18/19
- Development of metrics to identify improvements in early detection & intervention eg cancer diagnosis via emergency routes – 18/19
- Examples of joint working across primary, community & secondary care – from Q1 18/19
- Increased general practice workforce incl. new roles – from Q2 18/19
- % use of digital platform to access general practice – from 18/19
- % of patients redirected to self care from 18/19

General Practice at scale roadmap – high level integrated view



Design a **support workforce** that is fit for purpose across the system

Lead Director: Nicola Airey, Director of Planning, Surrey Heath CCG; Project Manager, Nick Willmore

Overall Objectives

We will work in partnership across the STP to recruit, retain and develop our support workforce to provide a joint workforce across organisations.

Initially we will complete a gap analysis on existing workforce, skills, vacancies and future requirements.

We will increase the pool of staff available in the footprint by:

- Improving recruitment through joint working and agreed terms and conditions across the system
- Improving retention by offering positions across social care, community and acute provision
- Supporting our current staff with the opportunity to move between health and social care, improving understanding of care delivery across the system
- Providing more development and progression opportunities within social care, community and acute care.

We are establishing a rotational apprentice scheme across social care, community and acute care which will begin in April 2017.

A pathway is being developed that will allow bands 1-4 to progress to pre-registration level, and have apprenticeships that will support band 4 staff to progress to band 5 registered nurses.

We will fully utilise the apprenticeship schemes to increase capacity, create new roles to support transformation and provide career progression for those looking for a professional role.

Deliverables

- Provide a workforce strategy that has identified the emerging roles, skills requirements and gaps in workforce provision across the system.
- Deliver a training and development plan that supports staff to work across a variety of settings, and see career progression.
- Establish a rotational apprenticeship scheme across health and social care employers that is increasing the workforce in line with demographic trends.
- Provide career progression programme for bands 1-4, and an opportunity for those who wish to progress beyond this to a first registered position.
- Establish a sustainable support workforce that provides an opportunity to develop new roles in the community.
- Provide the underlying technology infrastructure to support cross organisational working aligned with the LDR

Milestones

Milestones	Start date	End date
Develop STP Workforce Strategy and associated initiatives	13 Sept	31 Dec 16
Project agreement for apprentice scheme		31 Oct 16
Bid for Innovation Fund grant	16 Sept	01 Dec 16
Develop recruitment product for apprentices	1 Nov	31 Dec 16
Identify Training Manager for apprenticeships	1 Nov	30 Nov 16
Identify training provider	30 Nov	31 Jan 17
Recruit first cohort of apprentices	1 Jan	31 March 17

Key risks/ Issues

Risks	Mitigation
Lack of applicants	Working alongside existing hospital apprenticeship arrangements
Lack of placements	Working alongside existing hospital apprenticeship arrangements
Delays in confirming new models for services	Cross team working developing work stream plans
An increase in staffing without role redesign will become a net increase in the spend on services.	The Support Workforce strategy will bring together work stream transformation plans to inform role redesign
Metrics of success are input focused and do not identify added value for people	Design of metrics during scheme implementation.

Scope and exclusions

- The Support Workforce covers a range of roles in health and social care including rehabilitation, reablement, domiciliary and support workers, care and healthcare assistants and residential care staff.
- Staff are employed across the NHS, some local authorities and a wide range of private and third sector businesses.
- It will not cover administrative support roles, nor those identified for professionally qualified practitioners.

Interdependencies

- The detail of workforce changes will be defined by individual work streams and then picked up by this work stream for planning purposes.
- The apprentices will be part of the core workforce undertaking support roles appropriate to their experience.
- Delivery is based on access to the Frimley Health FHFT National Apprenticeship Scheme (NAS) infrastructure which has an anticipated levy of £1.7m pa to cover apprentice training.
- Underpins the effective delivery of integrated care, and enables us to influence and change the social care support market.

Benefits

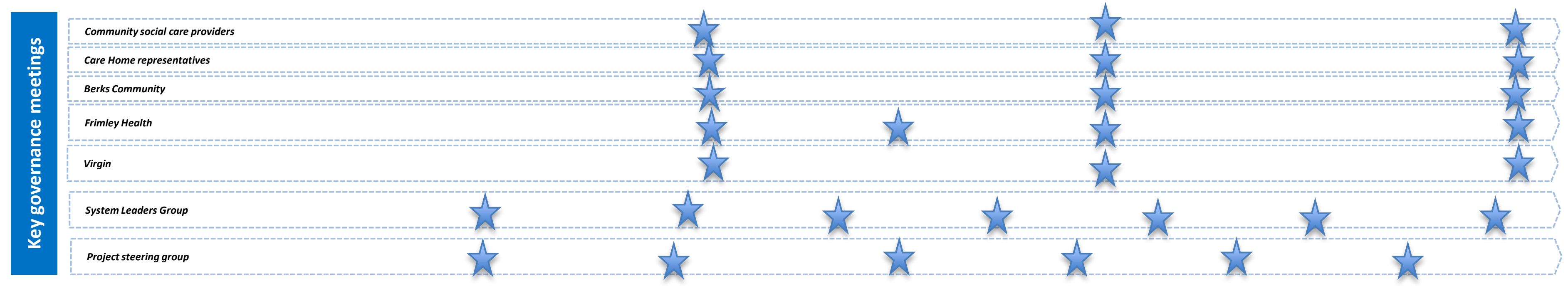
- Offer people seamless integrated care delivery
- Build greater confidence in individuals and their carers and families in the options for receiving care closer to home
- Reduce the risk of delays and gaps in provision by providing a sustainable workforce with more consistent skills
- A more flexible workforce able to pick up more skills and adapt to new roles in line with future challenges
- Attract more staff into these sectors by providing good consistent training across the footprint

Outcome measures

- Number of apprenticeships established in each year
- Improvement of % turnover of staff from current levels across all sectors
- Number of staff rotating across sectors
- Levels of skills attainment across the cohort
- Reduction in agency spend across the cohort

Support workforce roadmap – high level integrated view

October | November | December | January | February | March



Programme

- *Agree Project Brief*
- **Initiate quick wins**
- *STP Submission 21.10.16*
- *Support Workforce Strategy – analysis and planning*

Workforce Strategy

- Analyse workforce data
- Map gaps and vacancies across consolidated local workforce
- Identify potential new roles

- Develop plan to address demographic needs
- Identify opportunities to rationalise service use
- Work with stakeholders to identify new roles
- Link roles to new NAS standards and SCIE roles.

- Agree approach to recruitment
- Agree changes to service delivery
- Define workforce plans to support training and development

Resourcing Arrangements

- Quantify impact of demographic growth
- Identify potential to redefine roles to better utilise support workers

- Map growth against changes and quantify impact
- Identify duplication of time delivering services
- Review commissioning and clinical governance for support services

- Develop common role descriptors
- Define emerging roles
- Revise contracts to reduce duplication
- Develop integrated governance and contract monitoring arrangements

Rotational Apprentices

- Link with HEE apprenticeship lead
- Agree NAS lead employer
- Agree project governance

- Agree resourcing,
- Identify training officer
- Agree workforce contracts
- Align provider arrangements for staff

- Recruit apprentices
- Identify placements
- Confirm standards being used

Metrics & Evaluation

- **Develop a draft logic model**
- **Apply Vanguard evaluation strategy**
- **Agree system wide high level metrics**

- **Develop the logic model based on development roadmap**
- **Agree specific outcome measures across the system**
- **Establish performance and outcomes baselines**
- **Agree benefits realisation and evaluation strategy**

- **Establish measurement mechanisms**
- **Develop a system wide digital dashboard**
- **Refine the strategy and logic model**

Transform the 'social care support' market including a comprehensive capacity and demand analysis and market management

Lead Director: Alan Sinclair, Interim Director of Adult Services, Slough Borough Council; Project Manager, Nick Willmore

Overall Objectives

- There is a need to ensure that there is sustainable social care market in order to support the wider health and social care system. This is currently challenged by increases in demand and activity and the differential way in which care is purchased and delivered across the STP.
- The STP identifies the intention to make better use of home based care, to support innovation in the delivery of accommodation with support and to seek opportunities to make use of technologies that support independence, health and wellbeing in line with the LDR.
- To understand the local social care market in the STP and how best to ensure there is a good capacity and good quality of care at affordable prices
- Alternative care and support options are delivered including alternatives to care homes
- The needs of our most complex people – including people with mental health needs, learning disabilities and acquired brain injury - are understood and models of care are delivered that meet their needs in the least institutional environment
- People who live in care homes are supported well and only admitted to hospital when necessary and supported back home as quickly as possible, utilising digital technology where appropriate .

Deliverables

A market development plan that describes:
- an analysis of demand for social care services
- the modelling of alternative support options across the footprint
- how local authorities are engaging with the care market
- the role of non-institutional care in the community
- how we are promoting innovation and stimulating new models of care

Care Home support that:
- is reducing the number of urgent care admissions
- ensures that people return to care homes from hospital in a timely manner
- is making a difference to the experience of those in care homes
- better supports people with dementia to remain in familiar surroundings.
- has implemented the learning from the ECHC vanguards

A review of people with complex needs that
- has ensured that they are receiving the best possible support
- has increased their independence and control over the way they are supported
- has supported innovation in the way that needs are met
- has supported people to be closer to their natural support networks.

- Review of D2A initiatives to inform future developments

Milestones

Milestones	Start date	End date
Market development plan	3 Oct	31 Dec 2016
Market development plan options sign off	Dec	1Jan 2017
Market development options implemented	Jan 2017	Dec 2017
Care home support plan	14 Nov	1 April 2017
Complex needs review	Dec	April 2017
Complex needs options sign off	April 2017	May 2017
Complex needs options implemented	May 2017	

Key risks/ Issues

Risks	Mitigation
Failure to engage with social care providers (care homes and domiciliary agencies) .	Early joint planning with provider representatives through ASC engagement arrangements.
Impact of customers who are self-funders or from London Boroughs	Identify self-funders and other activity' to inform planning consents to new developments
Lack of new staff to deliver schemes	Initial scope required to use bank/agency staff pending local recruitment and development of rotational apprenticeship scheme
Insufficient activity in EBDs and admissions to allow for full benefits realisation	Detailed analysis of EBD and admission HRG code activity
Multiple grounds for EBDs and admissions could result in impact of schemes not being identified due to other issues	Triangulate data from the acutes against local records and weighting for demographic changes.

Scope and exclusions

- The measures planned will focus on the social care market provision.
- In order to maximise benefits the initial schemes will be focussed on care homes or groups of individuals who make the greatest demand on services in the community or in hospital. Initially this can be measured through hospital returns and levels of residential placements.
- The complex needs review will include people with a learning disability, with mental health needs or with acquired brain injuries.
- The five year strategy will need to develop local measures designed to support people with mental health needs and associated physical conditions.

Interdependencies

- Support workforce – stability and capacity for home based care
- Prevention and self-care – to manage demand for services and reduce need for on-going support
- Social care record – to maximise impact of services
- Integrated Care Hubs – managing demand for services
- Enhanced use of Technology Enabled Care Services to support people to remain at home
- Partnership working to increase housing options

Benefits to local residents

- All services based on maintaining you in a familiar environment
- Reduce the risk of extended admissions to hospital
- Greater choice and control over type and place of care
- Increasing and retaining your independence

Outcome measures

- Care Home Support– Reduce acute admissions from care homes by 20%
- Complex needs review - Number of cases where support can be re-provided, target of 64 with total saving of £980,000

Social care support market roadmap – high level integrated view

September | October | November | December | January | February | March

Key governance meetings

- *Surrey CC*
- *Hants Vanguard*
- *RBWM*
- *BFC*
- *Slough*
- *Berks Community*
- *Frimley Health*
- *Virgin*
- *System Leaders Group*
- *Project steering group (three weekly)*

Programme: *Agree Project Brief* → *STP Submission 21.10.16* → *Sign off plans* → *Agree resourcing* → *On-going Scheme Impact Evaluation*

Market Strategy

- Agree key areas for transformation
- Agree service intervention principles
- Identify areas of greatest impact
- Evaluate potential for change
- Link to mental health strategy

- Consult with providers on principles / potential innovation
- Map demographic needs against services
- Assess unmet need based on existing demand
- Map resources to identify investment needs
- Link to MH Forward View and LD programmes
- Identify digital solutions to link needs to market place

- Define key actions to transform the market
- Quantify impacts expected from strategy implementation
- Agree changes in services with providers
- Evaluate impact of changes in social care on the system.

Care Home Support

- Agreeing intervention model
- Define target group
- Identify high demand services
- Develop pathways to community services
- Link to shared care record

- Map current resources
- Align support to areas
- Identify resource gaps
- Agree resources to be created
- Develop service specification
- Develop governance

- Appoint staff team
- Locate base
- Define metrics for evaluation
- Agree first phase of homes to be supported
- Align with primary care support

Complex Needs Review

- Appoint project team to review complex needs support
- Agree scope and target group
- Undertake desk top review
- Develop plan for re-provision

- Undertake individual reviews
- Develop alternative support plans
- Develop transitions programme for service changes

- Agree providers for individuals
- Draw up service plans for individuals
- Support transitions between services.

Metrics & Evaluation

- **Develop a draft logic model**
- **Apply Vanguard evaluation strategy**
- **Agree system wide high level metrics**

- **Develop logic model based on development roadmap**
- **Agree specific outcome measures across the system**
- **Establish performance and outcomes baselines**
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- **Establish measurement mechanisms**
- **Develop a system wide digital dashboard**
- **Refine the strategy and logic model**

Reducing **clinical variation** to improve outcomes and maximise value for individuals across the population.

Lead Director: Ros Hartley, Director of Strategy and Partnerships, NEHF CCG; Project Manager, Gazelle Robertson

Overall Objectives

- To use the Right Care Approach to reduce variation across our System for the five disease areas initially identified through the programme:
  - -**Respiratory**: development of specialist clinics
  - -**MSK**: consistent pathways rolled out to general practice
  - -**Neurology**: community outreach clinics
  - -**Circulation**: hypertension & stroke pathway development
  - -**GU**: better end of life recognition and drug monitoring
- To establish an agreed process for identifying and reducing variation across further pathways within the system.
- To utilise the medical expertise across our system, and the wider NHS and Social Care community, to ensure care pathways are fit for future service provision with up to date technologies to improve patient care.
- To spread good practice across the STP area to reduce variation in quality and outcomes across the five disease areas

Deliverables

- Specific improvements and reduction in variation across five disease areas through:
  - -consistent pathway development across providers
  - -risk stratification and case management across providers
  - -establishment of community clinics
  - -standardised service specifications
- Intensive data sets across each of the disease areas by CCG and across the STP
- Joint working across primary, community and secondary care
- Reduction in financial spend across five disease areas

Interdependencies

- Integrated care
- Shared care record
- GP Transformation
- Mental Health

Milestones

Milestones	*Start Date*	*End Date*
Engagement exercise to reaffirm priority areas	*Sep 16*	*Oct '16*
Complete financial modelling exercise and identify savings and areas for investment	*Aug 16*	*Oct 16*
STP submission		*21 Oct 16*
Project brief sign off	*Oct 16*	*Oct 16*
Workstream steering group set up and establishment of subgroups with detailed action plans to undertake and complete actions within each of the disease areas	*Oct 16*	*Nov 16*
Programme implementation	Nov 16	Oct 17
Develop an evaluation process with measurable outcomes to ensure programme achieves its aims and delivers change		Oct 17

Key risks/ Issues

Risks	Mitigation
Quality of data to determine variation	Right Care Approach commissioning for value packs and SLA with CSU to obtain, monitor and analyse data
Lack of engagement across primary and secondary care	sign up from across the system and relevant clinicians feeding into workstream -continued engagement, -agreed principles and specific actions jointly developed
Focus on disease areas does not reduce variation	Right Care Approach and deep dive into data packs to reaffirm priority areas and continued monitoring of data to assess impact

Scope and exclusions

- Working across the Frimley Health system, using the Right Care Approach to reduce variation in:
  - -Respiratory – Phase 1 (Oct 16)
  - -Musculoskeletal – Phase 1 (Oct16)
  - -Neurology – Phase 1 (Oct 16)
  - -Circulation – Phase 2 (Sept 17)
  - -Genito-Urinary – Phase 2 (Sept 17)

Benefits

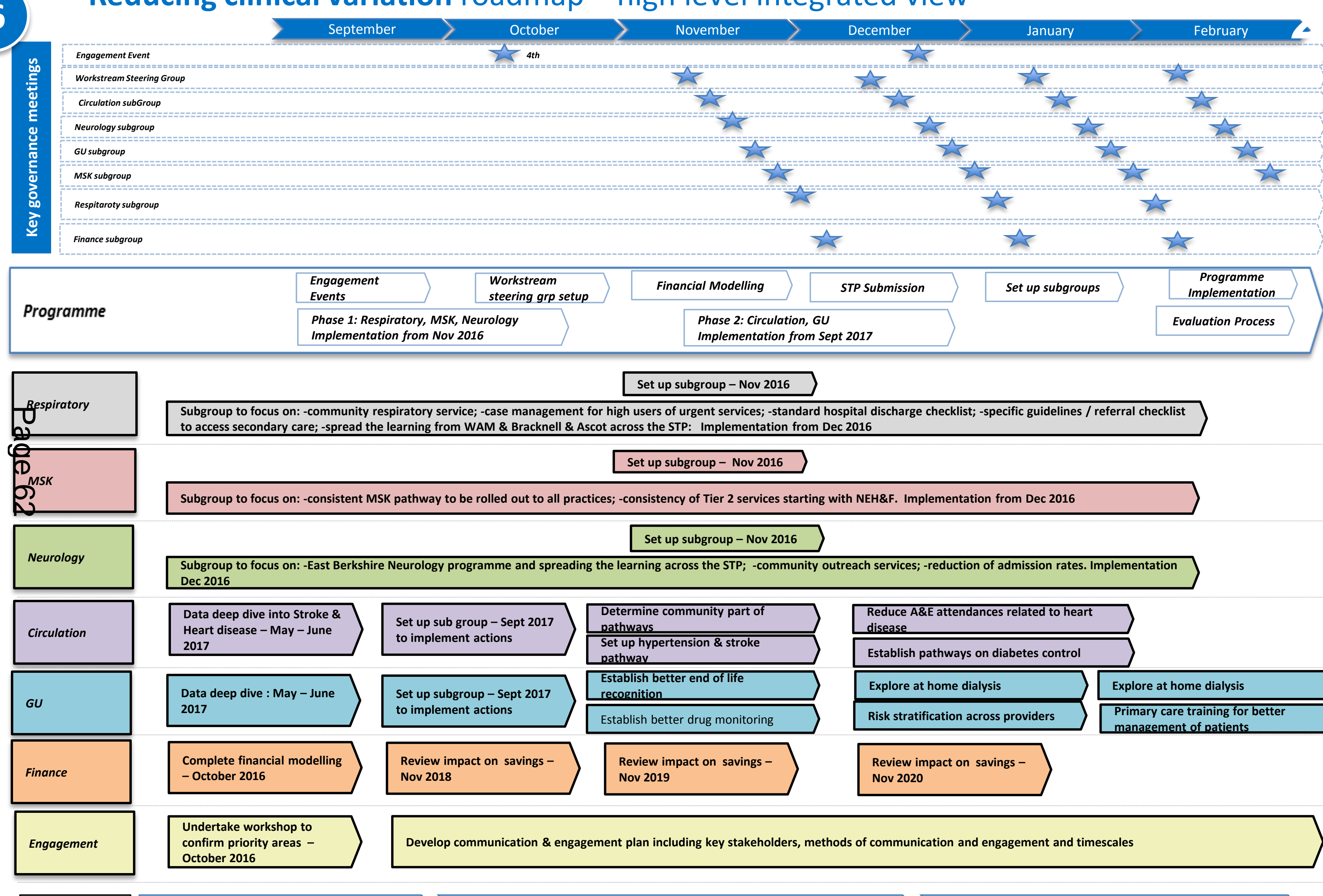
- Reduced spend across each of the pathways totalling £37m, with recurrent savings in excess of £16m from Year 4
- Consistent alternative referral pathways for agreed conditions from Dec 2016
- Equitable health provision for our population
- Evidence based interventions developed across primary & secondary care
- Joint working across primary, community and secondary care
- Reduced variation benchmarked against national and STP data
- Improved outcomes for patients across physical and mental health

Outcome measures

- Continuity of care and clearer information about care choices through standardised pathways – Q4 16/17
- The extent of reduction in variation across the CCGs in each of the selected disease areas over 5 years:

  Phase 1: (Oct 2016) -Respiratory -MSK -Neurology
  to show improvements from April '17

  Phase 2: (Sept 2017) -Circulation -GU
  to show improvements from April '18
- Financial savings achieved over the four year cycle



Metrics & Evaluation

- Develop a draft logic model
- Apply Vanguard evaluation strategy
- Agree system wide high level metrics

- Develop the logic model based on development roadmap
- Agree specific outcome measures across the system
- Establish performance and outcomes baselines
- Agree benefits realisation and evaluation strategy

- Establish measurement mechanisms
- Develop a system wide digital dashboard
- Refine the strategy and logic model

Implement a **shared care record** that is accessible to professionals across the STP.

Lead Director: Jane Hogg, Integration and Transformation Director, Frimley Health; Project Lead, Sharon Boundy

Overall Objectives

The initial objective of this initiative is the collaborative development of a Shared Care Record with system wide agreement of clinical / care professional and citizen collaborative design, to achieve the following:

1. **Integrated Care:** Better informed decision-making across all health and care settings by allowing information generated in one care setting to be seen and acted upon in another, irrespective of geographical or organisational boundaries
2. **Self-Care and Prevention through a Patient Portal:** Citizen access to self-care and support tools via digital ecosystem
3. **Urgent and Emergency Care:** Having access to timely and relevant information will support care professionals. This information will reduce duplication and support the triage process.
4. **GP Transformation:** Supports with a person having to tell their story only once
5. **Unwarranted Variation:** Optimising the use of medicines, especially where such information is not even available.
6. **Infrastructure:** Information will flow safely and securely across all health and care settings

Deliverables

1. Setup shared care record workstream aligned with LDR
2. Achieve system wide agreement on the design framework
3. East Berkshire Connected Care Programme Go-Live
4. Agree phased implementation plan based on local readiness
5. Coordinate detailed process mapping
6. Develop the clinical and care professional led design
7. Turn the design into a functional shared care record
8. Operationalise the validated shared care record in pilot sites
9. Roll out the phased implementation
10. Embed new processes and refine the shared care record
11. Embed a continuous improvement cycle

Milestones

Phase	*Milestone*	*Start*	*End*
Visioning	Align the Shared Care Record and interoperable programmes to the STP	*Aug 16*	*Oct 16*
Planning	Agree principles of a unified system STP / LDR	*Sep 16*	*Nov 16*
	Model the financial impact of proposed scope	*Oct 16*	*Oct 16*
	Submit the next iteration of the STP		*Oct 16*
	Set up Shared Care Record work-stream aligned with LDR	*Nov 16*	*Nov 16*
	Achieve agreement on the design framework **(East Berkshire Connected Care Go-Live in November)**	*Nov 16*	*Jan 16*
	Agree a phased implementation plan based on readiness	*Jan 17*	*Jan 17*
	Develop a detailed iterative planning schedule	*Jan 17*	*Mar 17*
Design	Coordinate detailed process mapping	*Jan 17*	*Mar 17*
	Develop the detailed design – this design will evolve and refine as the shared care record is implemented in order to continuously develop the solution based on end user feedback	*Jan 17*	*Mar 17*
Build	Turn design into a functional shared care record	*Mar 17*	*May 17*
Deploy	Operationalise shared care record in pilot sites	*May 17*	*Jun 17*
	Roll out phased implementation – phasing will be based on three tiers; organisational and local area readiness, as well as the types of data being made available	*June 17*	*TBC*
Stabilise	Embed new processes and refine	*June 17*	*TBC*
Maintain	**Embed a continuous improvement cycle**	*June 17*	TBC

Key risks/ Issues

Risk	***Mitigation***
On-going discussions regarding alignment of interoperable solutions across the system	Managed through the STP LDR board
Suppliers not able / willing to deliver requirements	Apply a robust development and contract assurance mechanism

Interdependencies

- Local area requirements to work across more than one interoperable solution
- Formation of one STP LDR
- LDR work-streams
- Other STP initiatives

Scope and exclusions

The shared care record is concerned with the development of the clinical and care user interface to present a consolidated view of patient information. The project will be delivered through a phased iterative approach, with the initial phase focussed on gathering, agreeing and implementing the requirements across the system from a clinical and care professional perspective. The interface between these requirements and the essential development of the technical infrastructure will be a key dependency. Future iterations of the project will include a patient portal and integrated care planning as examples

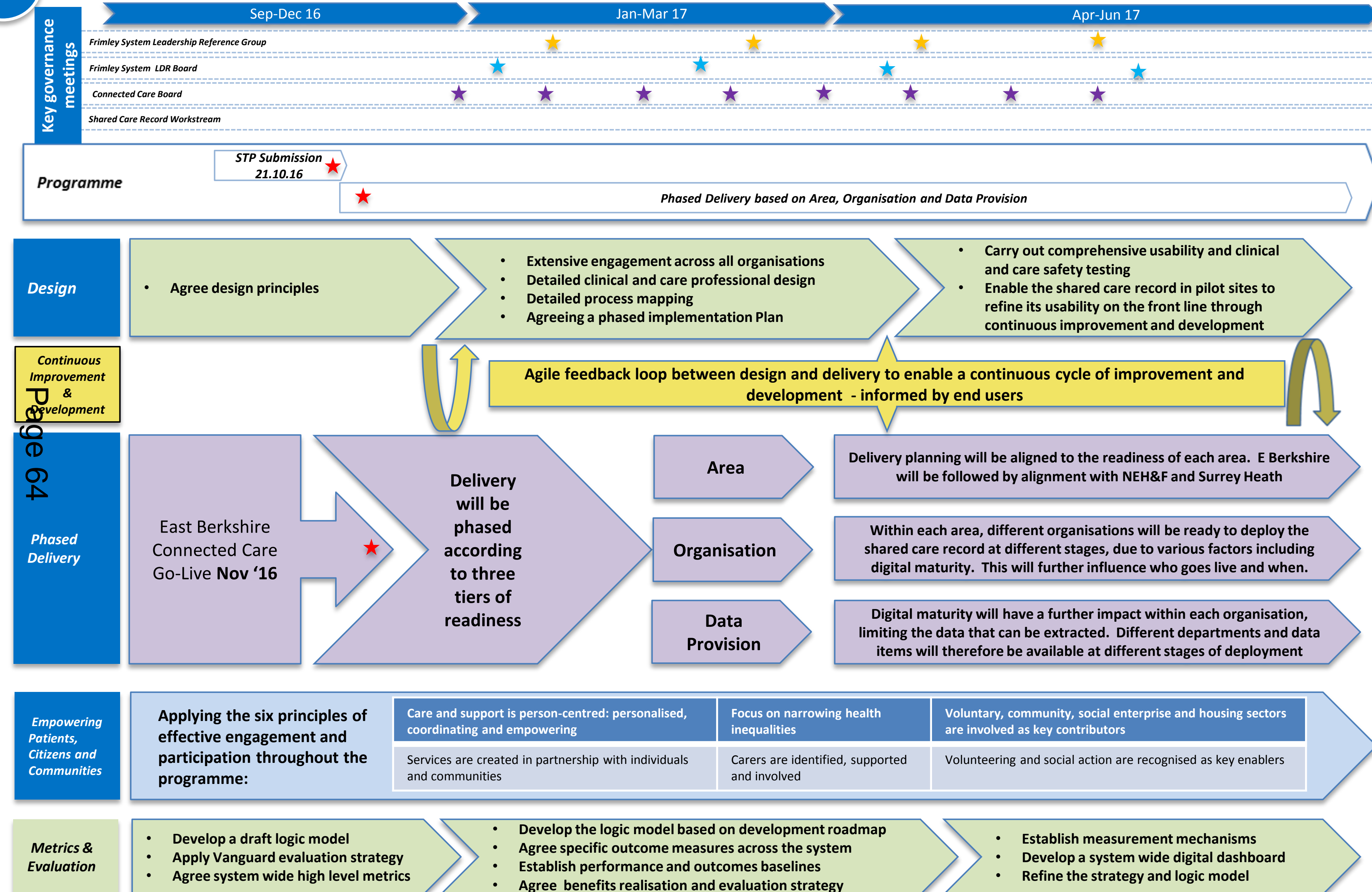
Benefits

Increased satisfaction (tell story once, increased confidence, personalised care)	Efficiency (e.g. reduction in letters, phone calls & faxes, triage and analyses, reduced referrals assessments and tests)
Improved efficiency (e.g. admissions and re-admissions,	Quality and safety of care (eg patient wishes including EOL, better decision making from seeing medical and social history)
Increased staff satisfaction	Improved safeguarding
Individuals engaged in their care-better management of health	Enhanced use of technology to support people to remain at home

Outcome Measures

- % of users who report time saved looking for information (75%)
- % reduction in duplicate tests due to information in shared record (40%)
- % staff who report shared record contributes to better clinical outcomes (75%)
- % of staff who report access to shared care record improved patient safety (70%)
- % of staff who report portal has saved time (regardless of task- e.g. could be admin staff or clinical) (80%)
- % of clinicians (across different settings/clinical specialities) who use portal routinely at point of care.

Shared care record roadmap – high level integrated view



Transformational Enablers

A Population Focus

Purpose: Becoming a system with a collective focus on the whole population we serve and support throughout their lives – not a system based on sectors, organisations, services or parts of the population.

- We are making good progress in becoming a system with a collective focus addressing the whole population. This has been recognised and welcomed by key stakeholders including Health and Wellbeing Boards and Health Watch
- We are working across physical, psychological and social wellbeing
- By taking this whole population approach we aim to ensure we're working for the benefit of the population and individuals within it rather than on the organisations who are fragmenting care and support by the current delivery mechanisms
- This is increasingly reflected in everything we do and is reinforced by our technology enabler, where the information is wrapped around the individual rather than from an organisational perspective
- We are focusing on those groups who are particularly vulnerable within the population, for example those with severe mental health conditions, learning disabilities or acquired brain injuries, where we know services and their impact needs to be significantly improved.

B Developing Communities

Purpose: Developing communities and social networks so that people have the skills and confidence to take responsibility for their own health and care in their communities.

- All our residents and patients live as part of one or several different communities and we are increasing our understanding and connections with these as we move to delivering our initiatives across our localities
- The support that communities can provide for people and their families is substantial in supporting people in crisis, preventative support and helping people to maintain their independence
- Working with all employers in the system will support them in promoting the health and well-being of their employees and encouraging social responsibility within their communities
- There are a plethora of community, faith and voluntary organisations across the Frimley footprint that are already supporting people and with more co-ordination they could support people in a more structured way
- There will be further opportunities for volunteers to actively participate in the health & wellbeing of their community and we are reviewing the social prescribing scheme already implemented in the Vanguard.
- A priority focus will be supporting people to be more included in their community and therefore reduce the impact of social isolation (at least 12% of older people report being isolated which increases the risk of illness)
- Social networks and friendships not only have an impact on reducing risk of illness they also help people recover when they have become ill
- Councils and CCGs are already funding and supporting community and voluntary groups and the focus of this funding will be reviewed
- There is a need to increase support to carers who fulfil a vital function and promote greater resilience and stability.

These two transformational enablers provide an ethos and approach across all of our work.

Transformational Enabler: C Workforce

Purpose: Developing the workforce across our system so that it is able to support self care and health promotion and deliver our new models of care, recognising that this transformation will be achieved through development and retention rather than recruitment and be within today's costs.

The **Local Workforce Action Board** (LWAB) has been formed and has an agenda to deliver a set of overarching priorities and respond to the workforce priorities from each initiative:

System workforce priorities:

System workforce priorities
Completing the analysis of the whole system's workforce to achieve collective understanding of hot spots and priorities
Identify the gaps, duplicates and crucial elements to deliver transformational change
Complete a comprehensive diagnostic of staff satisfaction, recruitment, retention and vacancies across the whole system
Designing and developing a system that provides effective leadership, mentorship and support as we move to a greater emphasis and development of our lower band workforce

Example workforce hotspots:

- 22% of GPs and community nurses are aged 55+ as are 22% of social care workers in local authority and private sector settings
- The number of GPs and community nurses/ 1000 population is lower in our system than the national average and significantly lower in East Berkshire
- Turnover rates vary greatly by sector and profession, with the highest turnover found in the independent home care and care home sector (33% during 2015)

Seven key initiatives workforce priorities:

Initiative	Workforce priorities
Prevention and self management	• Developing prevention as a core capability of staff • Supporting the workforce to be healthy • Learn from the new roles supporting social prescribing in the Vanguard
Integrated decision making hubs	• Investing in new roles including care navigators, mental health leads, pharmacists and extensivists. • Leadership and team development programmes for MDTs • Training in best practice integrated care including case finding and care planning
General practice at scale	• Increasing the number of GPs and develop roles to support them • Develop skills in primary care through training and continuous professional development • Implement new roles, such as mental health therapists and clinical pharmacists • Provide career opportunities and planning, including shadowing and portfolio roles
Support workforce	• Complete a gap analysis of existing workforce, skills, vacancies and future requirements • Establish a rotational apprenticeship scheme across social care, community and acute care • Develop career pathways with level 2/3 qualifications leading to professionally based level 5 qualifications
Social care support Market.	• Maximise the scope of the existing market • Training provider staff to support more complex individuals • Ensuring staff have the skills to meet the changing expectations of the community
Clinical variation.	• Training non-medical staff to manage conditions as part of implementing new pathways • Developing skills in case management for high risk patients • Supporting staff to work across organisations
Shared care record.	• Ensuring the system has the change management capability and capacity to implement well and make the cultural and process changes to drive through the benefits • Support front-line staff to continue to shape design and implementation • Delivering effective training to all staff as part of implementation

Transformational Enabler: D Technology - LDR and STP alignment

Purpose: Using technology to enable individuals and our workforce to improve wellbeing, care, outcomes and efficiency.

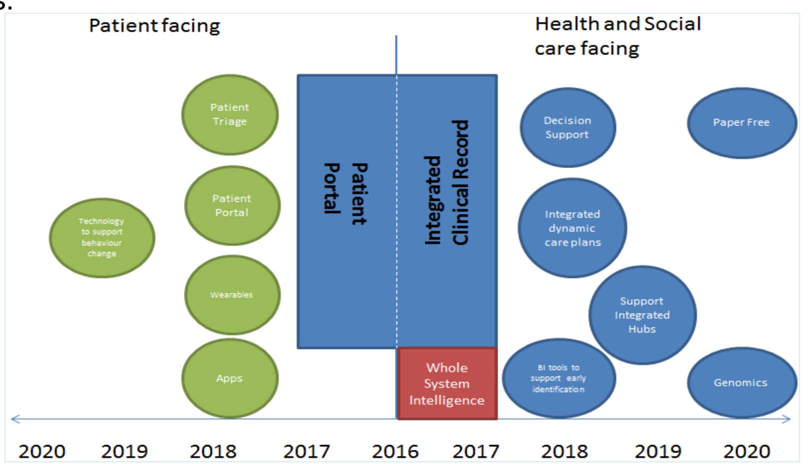
Local Digital Roadmaps

There are currently three LDR's within the Frimley STP footprint which cross multiple boarders. This introduces significant complexity when trying to provide a consistent and coherent digital approach to support the STP priorities. It is proposed that the Berkshire East LDR is dissolved and a single Frimley LDR is established with North East Hampshire and Farnham and Surrey Heath as partners so that it completely aligns with the STP footprint.

This is a primary objective of the STP/LDR leadership and programme teams, with a first meeting of the Frimley Digital Roadmap Board in November. First steps for this Board will be to align interoperable solutions with the Frimley STP footprint working across borders where possible.
In conjunction with the national objective around paper free at the point of care and the associated capabilities, the Frimley LDR will have an overarching vision to deliver three key objectives:

- An information sharing mechanism for health and social care professionals
- A patient facing portal
- Whole system intelligence/Population analytics for new models of care

As illustrated below, these are intrinsically linked and will support all the STP priorities.



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Alignment with STP

It is recognised that technology has a significant part to play to deliver the whole system transformation agenda. The STP priorities and initiatives are now driving the whole digital strategy. Digital transformation threads through all the STP initiatives and significant opportunities have already been identified that can stretch the digital support offered. One example of this is an opportunity to provide behaviour change through to technology to the STP workforce. Learning from this can then be applied to a larger wellbeing agenda for our patients/residents. Details of the workstreams that have been established to support delivery of the universal capabilities and how these have also been aligned with STP priorities and initiatives are included as an **appendix**. This ensures that our workforce is delivering multiple technology and transformation objectives.

Delivering technology that will support the STP

Several workstreams have been proposed and some have already been initiated and more information on these are included as an **appendix**. These workstreams will have clear deliverables, mandates from Chief Executives, and accountability. These are important principles as multi-organisational projects are complex and historically have not delivered at the pace that is required to support STP's. There is a commitment from partners to work differently and at scale. This will not only support the STP, but will ensure that the universal capabilities progress, support paper free at point of care and ensure resources are utilised more efficiently. provides an example of how these workstreams are evolving.

Transformational Enabler: E Developing the estate

Purpose: to deliver an efficient and fit for purpose estate infrastructure across the STP footprint that supports delivery of the seven initiatives and new care models.

Priorities:

- Combining the One Public Estate work across the STP footprint to make optimal use of the estate and deliver co-location of services that improve integration of care and support and efficiency. Considering local options across the public sector for a shared approach to property maintenance and management.
- Securing a local agreement about the use of benefits from disposals and their support to develop our new care models
- Achieve a greater collective influence on NHS Property Services to prioritise the estate improvements required to deliver our STP – many of which are not fit for purpose.
- Address the immediate estate constraints in primary care to ensure it is fit for purpose. This will include:
    - Refurbishing buildings where they don't meet standards
    - Investing in new accommodation that expands the range of services and delivers new care models
    - Delivering co-location options
    - Identify locations for and develop integrated care decision making hubs across all localities by the end of 2018
- Deliver significant capital investment and reconfiguration of acute estate to transform elective care at Heatherwood Hospital and the emergency and maternity departments at Wexham Park Hospital to improve productivity and the quality of care.
- Ensure administrative estate is consolidated to facilitate Carter recommendations.

Mental health and learning disabilities

The Frimley Health and Care STP places a strong focus on supporting good mental health and physical health and will support the delivery of the Five Year Forward View for Mental Health and our local transforming care plans for people with learning disabilities. The delivery of the STP requires mental health and learning disabilities to be integrated throughout the plan and this has been embedded in each workstream. The following table describes this for each initiative.

Initiative	Mental Health Deliverables
Prevention & Self Care	Recovery focussed services: using evidence-based interventions to improve health and wellbeing and help people secure employment. Developing perinatal and child and adolescent mental health services in line with national guidance to reduce incidence of ongoing mental health problems. Tackling health inequalities through screening and treatment, eg. smoking cessation support. Expanding the use of online interventions and use of technology to increase access, choice and engagement in lifestyle change. Use of technology to keep people at home, eg. the innovative test bed programme for Dementia patients. Rapid access to support preventing escalation into crisis and avoidable hospital admission (including mental health liaison services and safe havens/crisis cafes).
GP Transformation	Integration of mental health practitioners in extended primary care teams; including Clinician to clinician video consultation , redesigned mental health practitioner roles, expanding talking therapies for long term condition use, and developing integrated physical mental health and learning disabilities pathways within primary care .
Social Care Support	Effective support to Care Homes including comprehensive training about dementia for leaders, training of staff and in-reach services to minimise non-elective admissions. Integrated community services to support people in their own homes, including effective support of carers.
Unwarranted Variation	Scale learning and spreading good practice including integrated approaches (Surrey Heath and NEHF Vanguard) and evidence–based interventions representing greatest value (Early Implementer site for Increasing Access to Psychological Therapies). Reduce variation in delayed transfers of care, bed occupancy rates and numbers of out of area placements.
Integrated Care Decision Making Hubs	Embed mental health practitioners in the integrated decision making hubs to ensure seamless interface between primary care, secondary care and the acute system for people with mental illness. Share learning from integrated physical and mental health approaches in Surrey Heath and NEHF Vanguard.
Support Workforce	Enabling delivery of safe, sustainable services and achievement of targets to reduce use of agency staff. Embedding psychologically informed approaches to assessment & interventions across the whole health & care workforce. Training in 'Making every Contact Count' and support of Shared Decision Making. Development of new roles to promote wider integration of peer mentors & wellbeing ambassadors. Recruitment & training to promote digital competence, enabling delivery of online and technology enabled interventions.

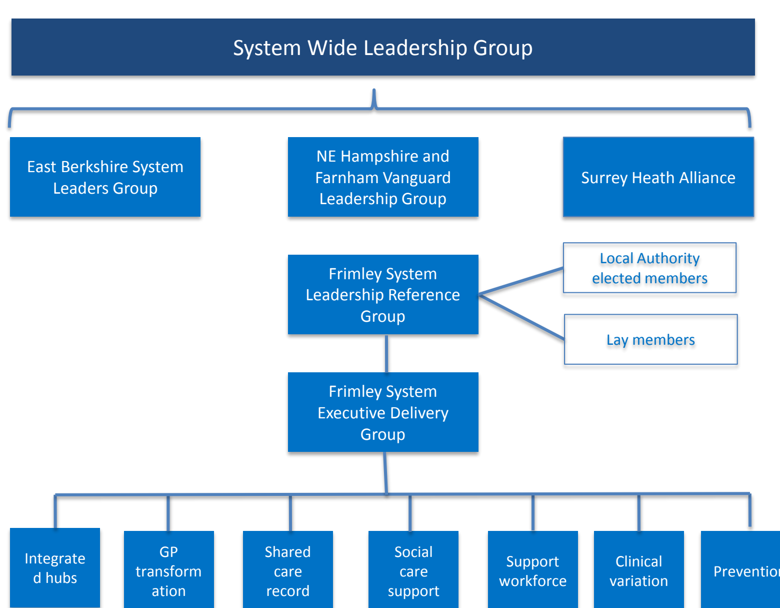
Leadership & governance for delivery

From successful planning to successful delivery

The Frimley system brings together a group of high performing and ambitious providers, commissioners and systems. The leadership and governance arrangements that we put in place to deliver our Plan have been successful. We have reviewed these to ensure that they are now focused on successful delivery and have added a new Executive Delivery Group that will provide programme management and support.

There has been some discussion and exploration across the vanguard and Surrey Heath alliance to identify ways of moving towards an **Accountable Care Organisation** governance structure which may be suitable to roll out across the STP in future years.

Initial discussions have taken place at System Leaders Reference Group about **System Control Totals** and agreement was reached to operate in shadow form across the STP for 17/18. Principles governing this are being developed for consideration. Where possible learning will be considered from national and regional examples where systems are ahead of ours.



Our governance structure

The bedrock of effective leadership and engagement across our footprint is the **3 established system leadership groups**:

- East Berkshire System Leadership Group
- North East Hampshire and Farnham Vanguard Leadership Group
- Surrey Heath Alliance

The **Frimley System-Wide Leadership Group** brings together all of the members from these three groups (50 people) to support collaborative leadership development and cross-system support and relationship building.

The Frimley System Leadership Reference Group
This group, chaired by Sir Andrew Morris, works on behalf of the three established system leadership groups to steer and lead delivery of the STP plan. It brings together the CCG Chief Officers and leadership representatives for the public, local authorities and clinicians.

Frimley System Executive Delivery Group
Comprised of Executive Directors representing the localities and sectors that form the STP. Provides programme management and support to the workstreams and reports to the Leadership Reference Group.

Initiative Delivery Groups
Will be established both from existing delivery groups within the STP areas and newly formed as appropriate, reporting into the Executive Delivery Group.

Wider stakeholders
Wider scale engagement has taken place with groups such Healthwatch, PPI groups and voluntary sector organisations. An Elected members and a Lay members group has been established with the support of the Local Authority as well as an advisory group for mental health.

Finance & efficiency – case for change

Where we are now

A whole system activity and financial model has been developed for all publically funded health and social care across our system. The model shows the size of the financial challenge for our system and the potential impact of introducing new models of care and efficiencies. This has been used to populate the national financial templates.

A ‘do nothing’ base case has been calculated showing the impact of demographic change, inflation and other growth factors including investments required to meet the priorities outlined in the Five Year Forward View such as delivering seven day a week services, improving mental health and enhancing general practice access.

The ‘**do nothing**’ base case split by sector is:

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Frimley STP ‘do nothing’ gap	**2020/21**
NHS Commissioners	£100m
Local NHS Providers	£87m
Local Authorities	£49m
Total	£236m

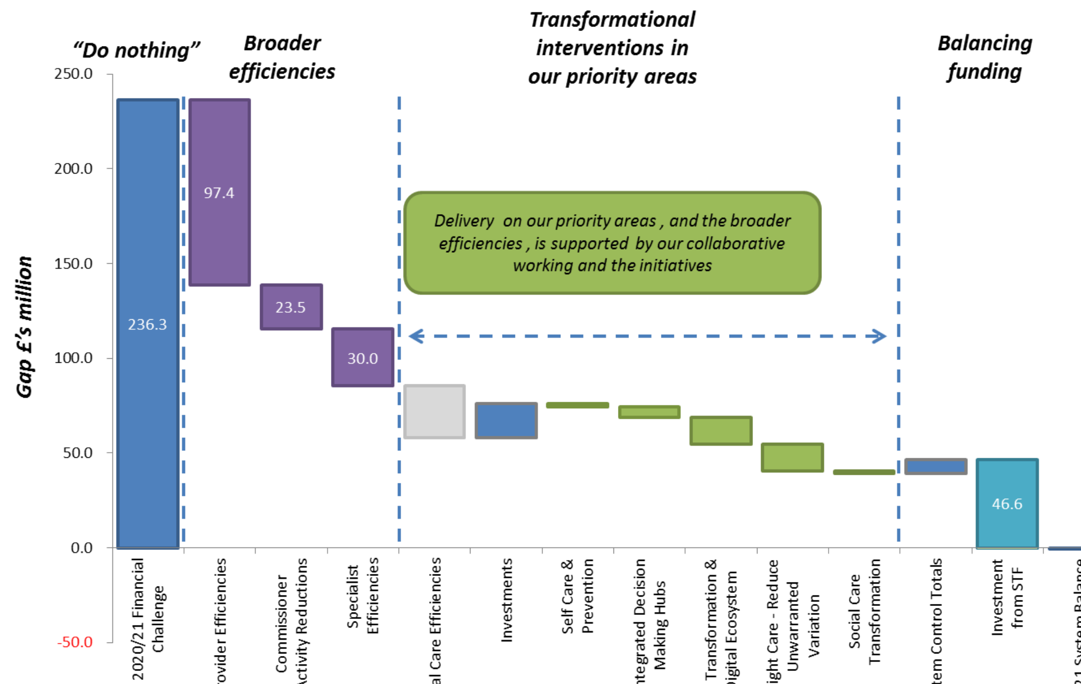
In addition to being unaffordable, the implied demand would require an increase in acute bed capacity of about 10%.

Bridging the gap in 2020/21

Recognising that the system will need to make broader efficiencies a second scenario has been modelled taking the gap of £236m and reducing demand by 1% and delivering 3% health provider savings each year, plus social care efficiencies. This scenario incorporates the medium term efficiency assumptions arising from the acquisition of Heatherwood & Wexham Park Hospital by Frimley Park in 2014. It also assumes that Specialist Commissioners are able to deliver their planned savings.

If this can be achieved it would reduce the gap to £85m, which would need to be met by a combination of transformational savings and an additional allocation from the national Sustainability and Transformation Fund (STF).

Although the broader efficiencies are largely commensurate with previous levels of delivery the challenge in delivering a further £151m of savings (64% of the gap) mustn’t be underestimated. It will require applying Right Care principles to all our activities, and new ways of system-wide working to ensure overall costs are genuinely reduced, rather than just moved between organisations. Without our transformational interventions, these broader efficiencies will not be achieved.



Finance & efficiency – modelling assumptions (1)

Organisational control totals

At the beginning of October NHS providers and CCGs were issued with 'control totals' for 2017/18 and 2018/19. These are effectively the surpluses they are required to achieve. The CCGs in the Frimley Health & Care STP are able to 'drawdown' from surpluses accumulated in previous years by c£1m pa, but for the next two years providers are required to make in-year surpluses of £24m. (For Frimley Health FT this is roughly 3.5% of turnover). We have included these requirements in our plans. For the last two years of the plan we have assumed lower provider surpluses of 1%.

Activity assumptions

We have modelled the impact of existing commissioner activity reduction plans and our system wide solutions on the underlying trajectory for acute hospital activity. The 'do nothing' position reflects impact of the underlying population growth in our area, coupled with the rising demand of an aging population. We believe our solutions will both mitigate the rate of growth (through for example improved self care) and increase hospital efficiency so more patients can be seen within the same resources (through better pathway management and greater use of technology). We are therefore not planning for a significant change in the total acute bed stock

	2016/17	2020/21 'Do nothing'	Increase from 2016/17 %	2020/21 'Do something'	Increase from 2016/17 %
Outpatient Attendances	777,782	909,894	17.0%	789,545	1.5%
Elective Spells	79,030	86,301	9.2%	81,024	2.5%
Non-Elective Spells	73,963	80,927	9.4%	76,586	3.5%
A&E Attendances	247,579	271,685	9.7%	256,358	3.5%

Social care assumptions

Our vision is for a financially sustainable health and social care system, therefore understanding the growing pressures on social care and the interrelationship with heath has been central to many of our solutions. For financial modelling we have taken a consistent approach across the three Unitary Authorities and two County Councils in our area, modelling adult social care, children's social care and public health costs. By 2020/21 we estimate a pressure on these services of c£22m (after taking account of solutions and precept changes). This is broadly matched by the remaining health surplus (having already delivered the assumed control total requirements

Capital investment plans

Significant capital investments are planned for Heatherwood Hospital (a full redevelopment to provide a state-of-the-art elective care centre) and Wexham Park Hospital (new emergency and maternity departments). These are all already provided for in Department of Health capital plans. CCGs are also bidding for capital funding to support primary care redesign, and as a system we are also asking for additional investment to develop our 'digital ecosystem'.

	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	Total £m
Approved schemes and primary care bids	71.5	57.6	21.5	12.5	163.1
Backlog maintenance	36.9	22.8	12.0	9.3	81.0
Sub Total	**108.4**	**80.4**	**33.6**	**21.7**	**244.1**
Total New Capital Expenditure Required To Implement Solutions	19.9	12.8	3.3	5.8	41.7
Total Capital Expenditure	**128.3**	**93.2**	**36.8**	**27.5**	**285.8**
of which is currently committed in DH plans	*79.2*	*58.4*	*0.0*	*0.0*	*137.6*

Finance & efficiency – modelling assumptions (2)

Specialist commissioning

Our detailed financial template incorporates expenditure estimates calculated by NHS England specialist commissioning teams. There is a key assumption that these costs can be contained with their published funding allocations. Although these rise by 16% between 2016/17 and 2020/21, in the underlying 'do nothing' position costs rise faster for specialist commissioning than for normal acute activity (by 34% compared to 17%) and therefore solutions which will save £30m are being identified by specialist commissioning colleagues.

For our STP modelling we have assumed that these solutions will deliver and will not have a detrimental impact on our local NHS providers (the majority of this activity is undertaken elsewhere in the country) and if there are definitional changes in what 'counts' as specialist commissioning, they will be fully matched by funding allocation changes

Commissioner funding allocations

Throughout our modelling we have used the allocations for the CCG, primary care and specialist sectors published in January 2016, and have adjusted for any subsequently agreed recurrent allocation changes.

Excluded items

It should be noted that costs and matching funding for the NE Hampshire and Farnham PACs Vanguard programme has not been included in 2017/18 (c£5m). Also excluded is the recently approved Talking Therapies expansion for Berkshire East.

Primary care assumptions

The financial plan incorporates all primary care (GP) funding, irrespective of whether these budgets are fully delegated to CCG yet. Primary care allocations are due to rise by 16% by 2020/21 whereas core CCG allocations only increase by 12%. This reflects some of the commitments made in NHS England's GP Five Year Forward View document to improve investments in primary care. In addition our solutions invest a further £8.5m in GP transformation over the period. Total primary care expenditure (excluding prescribing) is forecast to rise from £111m in 2016/17 to £136m, over 21%, a larger increase than either the acute or mental health sectors.

Funding support for Frimley acquisition

When Frimley Health FT acquired Heatherwood and Wexham Park Hospitals in 2014 a package of financial support was agreed between the Department of Health, NHS England and local commissioners. In terms of the STP submission our plan matches income to cost for the transaction money and integration so there is no net impact on the bottom line, and the deficit support is included in the overall Trust income assumption

	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
Deficit Support (DH)	16.6	13.8		
Public Dividiend Capital (DH)			11.7	
Capital Expenditure Support (DH)	37.7	11.9		
Transaction Support (DH)	4.4	4.3	2.7	
Integration Support (CCG & NHSE)	1.7	1.5	1.2	
Total	**60.4**	**31.5**	**15.6**	**0.0**

Note: table based on original agreement, some re-phasing has occurred

Financial impact of solutions

Each of the initiatives described in Section Two has been supported by a project accountant who has undertaken the financial evaluation of the costs and benefits. The outputs from the individual workstreams have also be reviewed to ensure savings are not double-counted.

Overall savings are forecast to exceed £65m over the next four years. As shown in the table below, we have chosen to group the majority of savings against five initiatives, with the remaining two (the support workforce and implementing a shared care record) as 'enablers' rather than undertaking a further somewhat artificial apportionment of savings across more categories. But these areas or no less important. In addition, many of the initiatives also underpin the continued delivery of provider Cost Improvement Programmes (CIPs) at c3% pa. For example the Support Workforce programme which aims to improve recruitment and retention and to develop a rotational apprentice scheme, aims to deliver a net benefit of £2.2m over the next four years, but there savings are contained within provider CIPs. Our costings include £500k for programme management to support implementation of the seven initiatives.

	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	Total £m
Self Care & Prevention	1.1	1.1	1.2	1.4	4.8
Integrated Decision Making Hubs	0.7	2.3	3.9	5.5	12.4
General Practice transformation	(1.6)	0.1	2.5	6.2	7.1
Right Care - Reduce Unwarranted Variation	4.3	6.3	11.8	14.1	36.5
Social Care Transformation	0.9	1.3	1.1	1.1	4.5
Total	**5.4**	**11.2**	**20.5**	**28.4**	**65.4**

The digital ecosystem

Our Local Digital Roadmap (LDR) describes our ambition to develop a digital ecosystem across health and social care, and further details are contained in the appendix. We have undertaken a comprehensive review of investment requirements across Frimley Health FT, Berkshire Healthcare FT, Primary Care and the local authorities in East Berkshire. Over the period to 2020/21 the system is already planning to invest £30m of capital and £8m of revenue on this agenda, however to make the Frimley Health and Care System a truly digitally enabled economy, there is a need to invest a further £33m of capital and revenue as shown below.

	Total Bid		
	Capital £k	Revenue £k	Estimated ROI £k
Information sharing	7,209	5,911	14,751
Patient facing technology	4,458	7,259	18,115
Paper free at point of care	4,964	3,395	8,472
Total	**16,631**	**16,565**	**41,338**

Mental Health investments

The other main area of investment, in line with the Five Year Forward View, is mental health, with budgets forecast to increase by over £5m (in addition to normal baseline growth)

2017/18 £k	2018/19 £k	2019/20 £k	2020/21 £k
2,727	3,055	4,254	5,437

Finance & efficiency – overall impact of our plans

Sustainability and Transformation Fund

A national Sustainability and Transformation Fund (STF) is held by NHS England to support local health economies. The amount in this fund increases each year, and rises to £3.8bn nationally by 2020/21. We were notified in June that for 2020/21 our share of this Fund is £47m, and we have incorporated this in our modelling.

At the beginning of October local NHS providers were allocated a share of the Fund to support their financial positions – approximately £22m for both of the next two years. A further £4m has been requested to support the position of Frimley Health for the next two years.

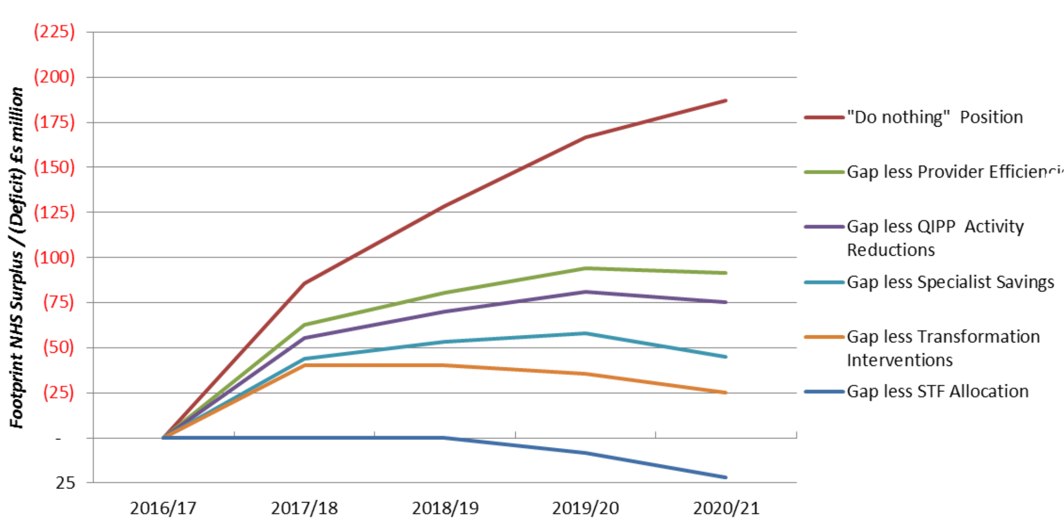
We also know that an additional £1.1bn is available for 'transformation' in these years. A pro-rata share of this for use would be £13.5m, which would help support funding of the solutions we have described in our STP, including the 'double-running' costs. But to continue at pace, deliver financial balance, and realise the benefits for our local population we need more than this. We are therefore requesting a further £2.5m each year. **Therefore the additional ask over announced funding is £20m** (£4m + £13.5m + £2.5m)

Balancing each year of the plan

The graph shows the financial gap for the health system if we 'do nothing', with the cumulative impact of or savings, efficiencies and solutions.

The table to the right gives a high level view of progress towards achieving financial balance across the Frimley Health and Care System.

Annual Impact



	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
Do nothing Health Gap	-85.6	-128.4	-166.6	-187.1
Provider CIPS	24.5	49.6	74.0	97.4
Commissioning QIPPS	9.8	14.4	18.8	23.5
Specialist solutions	11.4	16.9	23.0	30.0
Transformational solutions (net)	-0.3	4.7	12.2	18.4
Control Totals	-23.2	-23.2	-7.2	-7.4
Other	22.0	24.2	16.1	0.0
Agreed STF funding	21.3	21.8		47.0
Requested STF funding	20.0	20.0	38.0	
Health Position	**0.0**	**0.0**	**8.2**	**21.8**
Remaining Social Care Gap	-8.3	-11.9	-13.7	-21.9
System Position	**-8.3**	**-11.9**	**-5.6**	**-0.1**

Finance & efficiency – summary to 2020/21

	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	Increase from 2016/17 %
Secondary Care							
- Acute	485	499	502	510	515	523	5.0%
- Mental Health	71	75	81	83	86	89	18.9%
- Community	58	56	62	62	64	67	20.5%
Continuing Care	63	67	71	76	81	87	31.3%
GP Prescribing	94	94	97	101	105	110	17.0%
Primary Care	104	112	120	124	129	136	21.4%
Running Costs	16	16	16	16	17	17	4.3%
Other CCG	15	16	34	36	36	37	138.3%
Specialist	170	180	182	190	199	209	16.4%
Social Care & Public Health	256	272	277	282	285	295	8.4%
Total	**1,332**	**1,385**	**1,440**	**1,481**	**1,516**	**1,571**	**13.4%**

Key financial messages

- Our current ways of working are not sufficient to bridge the financial gap, and our broader efficiencies leave a £85m gap.
- The increases in CCG funding only cover the costs of inflation, not the demographic impacts – so effectively we have to "meet tomorrow's demand with today's funding"
- Commissioners and providers planning collaboratively will bring the system into balance, and will avoid the unintended consequences of traditional planning and contracting arrangements (for example stranded costs).
- We are not planning for any significant change in physical acute capacity (beds) but existing capacity needs to be redesigned to be used much more productively.
- There is alignment between providers and commissioners on the size of the challenge.
- We have a plan which meets the published control totals for NHS Trusts and CCGs for 2017/18 and 2018/19, and delivers financial balance across the health and social care economy by 2020/21
- To deliver this we need additional Transformation Funding of £20m in 2017/18 and 2018/19

Communications and engagement

Purpose: To support the launch and the delivery of the STP by combining and coordinating the tried and tested communication and engagement channels right across our system. We will continue to build on the successful engagement with and involvement of our workforce, lay members, elected members, PPI/PPE leads and Healthwatch and wider engagement with the voluntary sector and public. We believe that better decisions are made when the public and professionals work together.

Priorities:

- The STP Communications and Engagement Group is well established and has completed the groundwork of mapping the existing engagement activity and channels across the system, developing standard messages, templates and engagement logs.
- Our plan doesn't include any issues that require public consultation so we are aiming for an early publication and launch. We are completing plans for this which will include a series of launch events with a clear description of what our STP offers the public. Case studies are being developed to support communication, including learning from NHS England on key messages.
- We want to continue to learn from and adopt best practice in engagement and co-production developed by the Vanguard, the Surrey Heath Alliance programme and the New Vision of Care initiative. All of these have benefited from working closely across health and local authorities and building on the expertise that exists within our local authority partners.
- Our priorities and initiatives reflect the priorities we have heard from our residents and patients through those programmes and we hope to drive change through the local parts of the system through schemes they already recognise and have helped to shape.
- Our plans include extending the Community Ambassadors programme, which has 80 active volunteers involved in change programmes, supported by a dedicated post with the voluntary sector, induction and training programmes. The Patient Involvement Assessment Framework and KPIs for engagement will also help support delivery of the STP.

The **Communications and Engagement Action Plan** and **STP Engagement Plan** are included as **appendices.**

Appendices

1. Public facing narrative – draft
2. Communication and engagement action plan
3. STP engagement plan
4. STP/LDR workstreams
5. STP technology investment case
6. STP general practice at scale investment case
7. The ten big questions
8. System Partners

Appendix 1: Public facing narrative

Frimley health and care system

- The Frimley health and social care system is performing well and most towns satisfaction with GP services is among the highest in England. However, Frimley want to do more.
- Over the next four years, Frimley will invest £69 million in frontline NHS and care services to improve wait times, treatment and home care for local people.
- An extra £7 million every year will mean people can get a GP appointment from 8am to 8pm Monday to Friday, that's 420,000 more GP appointments across Frimley.
- At weekends, specialist and family doctors, community nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, psychiatrists and pharmacists will offer treatment at the 14 new 'health hubs' likely based in Farnham, Fleet, Farnborough, Aldershot, Yateley, Surrey Heath, Bracknell and Ascot, the Royal Borough of Windsor and Maidenhead, and Slough.
- An additional £11 million for mental health services means patients who need specialist care will no longer have to travel out of the area. This extra investment will also fund more community mental health nurses, seven days a week so people can get the right support when they need it.
- A new multi-million pound radiotherapy centre built on the Wexham Park Hospital site will reduce travel times for local cancer patients.
- Frimley will invest in its frontline staff, GPs will more time to see patients and increase the number of community nurses and pharmacists.
- By putting £30 million into technology, patients will only have to share their medical history, allergies and medication details once, regardless of whether they are in A&E or GP surgery.
- Patients will be able to access their medical record online, and for those with diabetes, heart or breathing problems, technology can monitor things like blood pressure remotely, alerting the doctor to any problems.
- Working with people to tackle preventable ill-health, including help for 18, 000 people to prevent diabetes, reduce alcohol related deaths by 20 per cent, and reducing surgical infections by 150 a year by encouraging people to give up smoking for three weeks before their operation.
- Across the area, £130 million will be invested to bring the NHS up-to-date, including replacing the old Heatherwood Hospital in Ascot with a purpose built new hospital for operations such as hip and knee replacement, upgrading the Emergency Department and maternity unit at Wexham Park Hospital.
- And for GPs, millions of pound of investment for new GP hubs and upgrading GP surgeries across all areas.

Appendix 2. Communications and engagement action plan

The development of the Frimley Health & Care STP is supported by tried and tested co production and engagement channels used to support transformation with the public, voluntary sector, faith groups, and users of our services . We have liaised with our lay members, local authority elected members, PPI/PPE leads as well as local Healthwatch representatives and are planning a wider stakeholder engagement workshop to capture the local voluntary sector organisations. The STP has an established group who's aim is to coordinate the communications providing a consistent approach across the wider STP footprint.

AIM	ACTIONS	Lead	Completion date	RAG
Develop and implement a communications and engagement event with all the leads from each of our stakeholders to identify how to develop communications & engagement for the STP across the system	Developed Communications network & planned	TW & SW	Last mtg 22/09/16	Green
	Develop broader communications network across partner organisations in the STP	TW. Ac & SW	Held 6/10/16	Green
Develop list of communications and engagement leads for Frimley Health and Social Care STP	List agreed but following event on 6/10 further amendments made	GR	22/09/16	Green
	List being reviewed and asking for formal sign up from organisations	TW/SW	21/10/16	Green
Communications across the system - We will reinforce the connections and ensure consistent messages which will provide clarity for staff, patients and the public.	TW agreed to send progress updates to Network	TW	04/10/16	Green
	Communication briefings developed to be shared across the system - We will target messages at a local level through the relevant organisation & jointly develop key messages that can be used in all settings to describe and explain the purpose and vision of our STP	SW	20/10/16	Green
Develop network meeting and governance structure	Meetings now planned monthly and agendas, action log and future actions all noted	ALL		Green
Map engagement activity across the footprint to support the delivery plan, making clear linkages between STP and local activity. We will build on successful and productive engagement already carried out and will learn from, share and replicate best practice.	Template for collating information designed and distributed. Needs to be ready to help support our messaging and priorities prior to launch	SW/ALL	8/11/16	Amber
Develop comms and engagement plan for sharing our draft ambitions through a pro-active public launch that tells the story in simple, clear language, using local examples of where changes have or are already taking place to build confidence in the proposed changes and demonstrate the real, local benefits for patients and staff.	Developing ideas for a video message that can be shared widely Planning a launch event/series of events to launch the STP Briefings as above	ALL	Dec	Amber

Appendix 3: Frimley Health & Care STP Engagement plan

As part of the STP planning process we have strived to involve clinicians across all the initiatives but there is still more to be done. As we enter the delivery phase our staff, stakeholders and local communities will be key to its success and ongoing dialogue is essential.

Stakeholders	Staff & Clinicians	Patient / Public/ Voluntary
System Wide Leadership Group – April, June, Nov 2016	Surrey Heath Alliance	Healthwatch briefings June/ Sept
System Leadership Reference Group - Fortnightly	East Berkshire System Leaders Group	PPI/PPE/Healthwatch meeting Oct 16
Frimley System Directors group – Weekly/ Fortnightly	NE H& F Vanguard Leadership Group	Wider Stakeholder event - Nov
Wellbeing Boards – ongoing Overview & Scrutiny committees – ongoing Lay members of Governing bodies Aug/ Sept	Priority Setting Workshops – May/ June Away days x 2 with FHFT wider leadership team GP Federations LMC reps	Local patient and public engagement events
LA Authority Elected Members Reference Group - June/ Sept	Integrated Care Decision making hubs - Sept	AGMs
Thames Valley Senate - July	GP Transformation workshop - Sept	Annual members meeting for Frimley
TV Urgent & Emergency Care - July	Unwarranted Variation meetings & workshop – Sept/Oct	
Royal Berkshire Fire & Rescue Service Aug/ Oct	Mental Health Workshop – June/ Nov	
LWAB -Oct	Frimley Staff Council	
STP wide Communications event - Oct	AGM Annual members meeting for Frimley	
STP progress updates	STP Progress Updates	STP Progress Updates

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment
Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

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STP Priority 1 — Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection.

LDR Capabilities / Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions
Record, Assessments & Plans					Record Sharing Workstream	
Transfers of Care						
Orders & Results Management						
Medicines management & Optimisation	E-prescribing Workstream					
Decision Support						
Remote & Assistive Technology	Patient Facing Technology/ Preventative Care Workstream	Patient Facing Technology/ Preventative Care Workstream			Patient Facing Technology/ Preventative Care Workstream	
Asset & Resource Optimisation		Infrastructure Workstream				

Outcomes/Benefits

- We are targeting a reduction in obesity, smoking & alcohol for people with mental health conditions, learning disabilities, and for young people & families
- We have prioritised identifying people with hypertension and diabetes earlier, & improving their self care and management
- More people will be supported at home and in their community using digital information, the voluntary sector and health and care professional advice
- People will experience improved reported wellbeing and health confidence and reduced social isolation
- We will achieve earlier diagnosis, improved self-care and clinical management of diabetes and hypertension. This will enable people to avoid developing related complications, reducing their need to use health and care services.

Our aim is to change the focus from managing ill health towards one of prevention, early detection and self care. Overall the health of our population is good so our aim will be to focus on closing the health and wellbeing gap in our communities with poorer health outcomes. We will give greater support for individuals to take responsibility for their own health and care. We want staff in every part of our system to promote healthy messages to our population as part of the care we deliver every day.

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Progr Board
- BE IM&T Committee

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment

Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

STP Priority 2 — **Action to improve long term condition outcomes including greater self management & proactive management across all providers for people with single long term conditions.**

LDR Capabilities	Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions
LDR Capabilities	Record, Assessments & Plans	Care Planning Workstream				Record Sharing Workstream	
	Transfers of Care						
	Orders & Results Management						
	Medicines management & Optimisation						
	Decision Support						
	Remote & Assistive Technology	Patient Facing Technology Workstream					
	Asset & Resource Optimisation		Whole Systems Intelligence Workstream				

20% of our population has one long term condition, 9% have two and 10% have more than two. Our aim is to improve the management of LTCs before they get to a stage where they are complex and multiple. We want to improve the care and outcomes for people with these conditions and to avoid or delay them acquiring more. We know that there is a particular need to make improvements for people with severe mental health, learning disability and acquired brain injury.

Outcomes/Benefits

- Many more people understand and take control of the management of their long term condition
- Effective best practice pathways will be in place across our system, supported where necessary by the combined expertise of the appropriate health and care professionals
- There will be fewer people in our system with multiple long term conditions and co-morbidity
- Carers will be supported to enable the person they are caring for to manage their condition and to reduce the emotional stress of being a carer
- People with long term conditions will report that they have improved health, more confidence, increased wellbeing and that they feel supported
- There will be fewer crises and a reduced use of urgent and emergency services
- We will achieve greater integration in the care provided by all of the sectors in our system with reduced duplication, including integrating physical and mental health.

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Prog'me Board
- BE IM&T Committee

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment

Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

STP Priority 3 — **Frailty Management: Proactive management of frail patients with multiple complex physical & mental health long term conditions, reducing crises and prolonged hospital stays.**

LDR Capabilities / Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions
Record, Assessments & Plans					Record Sharing Workstream Children's Sharing Workstream	Care Planning Workstream
Transfers of Care						Referrals/Discharge Workstream
Orders & Results Management						
Medicines management & Optimisation	E-prescribing Workstream					
Decision Support						
Remote & Assistive Technology						
Asset & Resource Optimisation	Whole Systems Intelligence Workstream	Infrastructure Workstream				

Outcomes/Benefits

- People are involved in and understand their care and feel supported and in control
- A standardised evidence based approach is used to risk stratify our population and identify patients with greater needs
- Effective multi-disciplinary teams with joint decision making and strong clinical leadership are established
- People report improved health status, confidence and wellbeing among our complex and frail patients
- There are fewer crises and reduced use of urgent and emergency services
- More people are supported to live in their own home with fewer permanent admissions to care homes
- High levels of staff and team satisfaction and more opportunities for personal and role development.

Evidence from the leading international integrated care systems shows that health and wellbeing are improved and costs reduced when there is a systematic delivery of population risk stratification, multi-disciplinary assessment and care planning, effective care coordination and care navigation and proactive care. We will use local, national and international best practice to design and develop effective proactive care in all of the natural communities/ localities across our system.

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Prog'me Board
- BE IM&T Committee

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment
Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

STP Priority 4

Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place

LDR Capabilities / Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions
Record, Assessments & Plans					Record Sharing Workstream	Care Planning Workstream
Transfers of Care			Referrals/Discharge Workstream			
Orders & Results Management						
Medicines management & Optimisation						
Decision Support						
Remote & Assistive Technology		Patient Facing Technology Workstream				
Asset & Resource Optimisation						

Outcomes/Benefits

- The public experience a simplified system, have easy access to effective advice on self-treatment and care, and are directed to the most appropriate service where they will be seen quickly
- All patients are able to receive an urgent general practice appointment on the day, 7 days a week
- A responsive integrated care decision making team provides more assessments in the community, supporting professionals to manage patients with urgent care needs
- Patients who require emergency care from acute and/or mental health specialists will be quickly assessed and streamed into the most appropriate management, with fewer delays
- Patients receive supported discharge from hospital into an appropriate community environment, once the acute phase of their care is over
- There is more timely care, with shorter waits across the whole system
- We achieve improved flow through the system including ambulance turnaround, urgent advice and treatment from primary and community services, social care, A&E, within hospitals and after acute discharge
- People report improved outcomes and improved experience of using urgent and emergency care services.

Priorities 1-3 aim to reduce avoidable ill health, care for people in their homes, avoid crises and reduce the need for urgent and emergency care. For patients who still require urgent/emergency care, we will ensure that we have an effective, easily navigated and joined up system. Care will be delivered as close to home as possible and appropriate for both physical and mental health.

Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Prog'me Board
- BE IM&T Committee

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

Appendix 4: STP/ LDR workstreams

STP/LDR Workstream Alignment

Frimley Health/Slough, Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham CCGs

STP Priority 5

Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

LDR Capabilities / Initiatives	Prevention and Self Care	General Practice Transformation	Social Care Support	Support Workforce	Shared Care Record	Integrated Decisions
Record, Assessments & Plans					Record Sharing Workstream	
Transfers of Care						
Orders & Results Management						
Medicines management & Optimisation						
Decision Support						
Remote & Assistive Technology						
Asset & Resource Optimisation	Whole Systems Intelligence Workstream	Whole Systems Intelligence Workstream				

Outcomes/Benefits

- Reduction in variation across five areas: circulation, neurology, GU, MSK & respiratory to realise 65% of the target savings
- Appropriate repatriation of physical and mental health work currently sent to specialist centres across the country
- A demonstrated improvement in the way we give choice and options to people to enable a shared decision making process
- Clinicians have a clear discussion with individuals about the risks and benefits of specific interventions.
- Improved outcomes for patients across physical & mental health
- Stronger patient involvement through shared decision-making
- Reduced clinical variation benchmarked against national and cluster data.

Our aim is to use Right Care methodology to achieve a significant reduction in variation for our patients across the Frimley footprint. We will develop a culture of value & population-based decision making involving clinicians across primary and secondary care to deliver the reduction in variation. We will achieve this by working in the following way:

- Ensure patients are able to make informed decisions about their treatment, and encourage aligned conversations about the risks and benefits of interventions
- Ensure patients access both primary and secondary care, across physical & mental health, as a seamless single clinical system
- Develop a system wide approach to specialised commissioning, including primary, secondary, physical, mental health care
- Beginning a conversation with the local population and stakeholder groups about the need for evidence based medicine, and the potential impact of this upon local services
- Ensuring that clinicians have a clear discussion with individuals about the risks and benefits of specific interventions

LDR Workstreams

Record Sharing Workstream	Patient Facing Technology Workstream	Referrals/Discharge Workstream	Children's Sharing Workstream	E-prescribing Workstream	Care Planning Workstream	Infrastructure Workstream	Whole Systems Intelligence Workstream

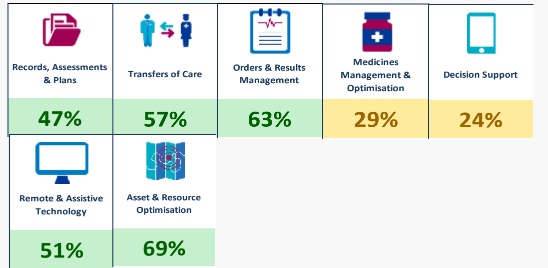
Key

- Vanguard Delivery Group
- New Vision of Care
- Better Care Fund
- Frimley LDR Prog'me Board
- BE IM&T Committee

Appendix 5: STP Technology investment case

LDR- Current State

- Through the LDR process, it is now known that there are gaps in technology maturity that need to be closed in order to best support the STP.
- Nationally there are seven capabilities that need to be at levels close to 100% in order to deliver the national target of paper free at point of care. At a system level we are at:



- In addition, there are 10 Universal capabilities that need to be progressed, and organisational priorities that need to be supported by technology.

Local Context

- In addition to the national priorities outlined above, there are local challenges and opportunities that need to be progressed in order to support the STP priorities.
- A substantial opportunity exists around information sharing projects that are underway across the STP footprint. All health and social care organisations are engaged in complex information sharing projects requiring strong cross organisational boards. In short, partners are used to working at a system level on complex IT projects. Consequently, Frimley STP is well placed for receiving funding to support these and other initiatives as the existing structure supports rapid mobilisation.
- A core challenge is ensuring all organisations are at the same level of digital maturity, in order that that whole system projects can fully deliver. Frimley Health has distinct challenges as they continue the work to merge legacy IT systems across three hospitals., following acquisition. This needs to progress at pace to ensure organisational benefits already identified. Without progress, the broader system benefits will not be achievable. Digital has been identified as a key enabler for all the STP priorities and will affect the realisation of the objectives listed.

Options

No Funding Provision

- This option is to continue funding the digital transformation agenda using existing finite funding streams.
- We are proposing that this is not a viable option in light of the national requirements around paper free at point of care, the wider digital agenda across health and social care and the emphasis on information sharing to improve patient care. Significant progress has been made on information sharing across the system, but this has been at the detriment of other initiatives to drive digital innovation.

Progress with limited national funding

- Partial funding of the overall request will enable the system to focus on gaps in digital maturity to eventually enable some aspects of the transformation required to support the STP.
- Priority will need to be given to the core building blocks in each organisation to ensure that investment in cross organisation projects will deliver the associated system benefits, but this approach risks enforcing silo working and fragmented progress towards interoperability and digitisation, ultimately impacting on the quality of care.

Progress with requested funding

- With the full amount of funding being requested, partners have an opportunity to develop internal systems to progress their digital maturity to ensure a solid equitable foundation.
- There will also be an opportunity to progress the significant transformational projects which will fully support the STP priorities. These include patient portals, remote and assistive technology and whole system intelligence.

ROI

- The technology initiatives can be broken down into three categories- Information sharing, patient facing technology and paper free at point of care.
- Projects are a mix of organisational specific and cross system

Information Sharing

- Medicines optimisations- reduction in adverse drug reactions, waste, corrective treatment , misappropriation
- Reduction in attendances/admissions/re-admissions/delayed discharges/ambulance conveyances
- Reduction in length of stay in high cost beds
- Eliminate costs associated with maintaining legacy systems
- Eliminate paper by using electronic- systems for communication
- Reduce adverse events- through e-alerts- e.g. MRSA prevention, electronic observations.
- Staff reductions – fewer administrative requirements/agency staff

Paper free at point of care

- Improved quality of care through decision support systems
- Enabling timely clinical decision making
- Reduction in duplicate/unnecessary tests
- Time saving/increased staff productivity/efficiency
- Reduction in adverse events
- Medicines optimisation

Patient facing Technology

- Reduction in attendances at A&E, GP, & walk-in centre
- Ability to monitor multi co-morbidity patients from home, reducing returns to A&E
- Increased capacity in primary care- redirect patients to self care and alternative services e.g. pharmacy
- Remote triage higher number of patients
- Reduction in elective/outpatients
- Improve quality of care and outcomes through more consistent monitoring, improvement in long-term health and population outcomes and supports prevention agenda.

Appendix 5: STP Technology – benefits breakdown

Information sharing

Locally information sharing has been identified as key priority. Pre-dating LDR and STP, North East Hants and Farnham participated in the Hampshire Health Record, East Berkshire in Connected Care and Surrey Heath in the Surrey Interoperability programme. Moving forward, we are working towards alignment of these programmes within the STP footprint which is being supported with information sharing identified a key deliverable of the STP and LDR process.

The importance of this is reflected in the request for £13m across the health and social care system to support information sharing projects, including: Shared Care Record, referral management and e-prescribing.

Substantial benefits have been identified to support the investment. These include:

- The improved ability for decision making (staff and patients). Across the system this will result in substantial quantitative savings and qualitative improvements.
- Using data to support health and wellbeing and the better management of conditions to enable individuals to remain as independent as possible for as long as possible and support full recovery following physical and or mental illness regardless of social situation. Projects that support this have identified significant savings including a reduction in admissions, readmissions, delayed discharges, and length of stay.
- Enables better coordination of care ensuring that potential avoidable crisis are averted. These projects will lead to reduction in admissions/re-admissions and outpatient appointments
- Supports integrated team working by enabling the development of integrated care plans for individuals being managed by integrated teams. This supports better care management which will lead to a reduction in admissions and improvements in health outcomes.
- Supports prospective care planning
- Reduction in time looking for information= leading to an increase in clinical efficiency/productivity
- Reduces adverse events and improves clinical safety
- Supports transfers of care, delayed discharges as next of kin and care information (including care plans) will be available to care professionals resulting in a reduction in length of stay or transfers to care homes

Patient Facing Technology

Patient facing technology has the potential to provide the greatest financial saving across health and social care. Substantial transformation behavioural change (staff and patients) will need to take place, but supporting individuals take greater control of their care at a whole system level has enormous potential to reduce pressure across the STP footprint.

Proposed projects to fully exploit the potential of patient facing technology across the STP include a patient portal, telehealth solutions including care companion, self care signposting, read/write access to patient record and appointment reminder technology.

Although evidence is not as strong for financial savings with patient facing technology, there is a drive to deliver whole system change involving patients.

The potential benefits of patient facing technology include:

- The ability for individuals to input data into their own record will create a shared responsibility between people and health and social care services. Increased ownership and monitoring in this way had been shown to reduce A&E attendances, outpatient appointments, walk-in centres, GP attendances and delivered improved health outcomes and management of long term conditions.
- Developing shared responsibility potentially increases individual satisfaction (increased confidence and health/self awareness) and staff levels of satisfaction (reducing vacancies and need for agency staff), reduces system costs in terms of non attendance, reducing waiting times and increased utilisation of staff.
- Ensuring that care professionals have access to information recorded by an individual prior to an initial consultation resulting in efficiency savings and improved qualitative improvements and higher quality of care.
- The ability of staff and patients to monitor health supports the prevention agenda, safeguarding and wider population health outcomes.
- Greater capacity for self care and uptake of alternative care services e.g. pharmacy.

Paper free at point of care

Paper free at point of care is the core deliverable as part of the LDR process and there are substantial benefits in achieving this. There are distinct challenges to achieving this within the Frimley STP with organisations at differing levels of digital maturity. Frimley Health have a substantial work programme to deliver as a result of the merger of three hospitals. This integration work is a fundamental enabler prior to being able to support transformation programmes linked to the whole digital ecosystem. There are also challenges for local authority partners and ensuring they have access to the N3 network and NHS numbers to support social care systems linking with health systems.

Projects to support paper free at point of care include projects to integrate systems across Frimley Health, Electronic Document Management System and E-referrals. In Primary Care, there are opportunities to look at stronger collaboration with care homes including a 24/7 health hub supported by video conferencing

The benefits of paper free at point of care include:

- Reduces administrative costs in paper handling. Distribution of paper at Frimley Health is a substantial outlay using existing systems.
- Benefits in releasing time to patient care as clinical staff become used to paper free system across the system.
- Potential reduction of costly errors with system monitoring of drug, interactions, blood types, inventories, etc.

Notes

- The above cash releasing benefits are dependent on whole system transformation initiatives as part of the STP delivering benefits.
- There is a risk of double counting benefits at this early stage and work will be done to identify what return on investment can be directly attribute to the technology.
- Recent reports (e.g. Wachter) note the cumulative affects of broad health IT as the whole organisation transforms from many initiatives. Full realisation does not occur until 7-10 years post implementation of major health IT projects.

Appendix 6: STP General practice at scale investment case

Going further faster

Frimley STP is able to go further, faster with the transformation of General Practice and delivery of the resulting benefits. This is because:

- We have the foundations in place to deliver at scale and pace. Underpinned by good leadership and engagement, clear gap analysis, evidence within local systems and a compelling case for change.
- Delivery will be based upon spread of good practice across the whole of the STP to give both stability and redesign of services with a reduction in variation between localities (Year 1)
- We are identifying clinical leaders and managerial support to push at our traditional local boundaries (technology, business models with scale, patient empowerment and primary/ secondary care interface) – to give full delivery of FYFV and transformation and sustainability roadmap by 2010 (Year 2)

Illustrative of what Surrey Heath have achieved – investment circa £3M additional (which includes community& mental health investment)

July 2016 National GP Experience Survey

	Surrey Heath CCG	National Average
Overall GP experience good	92%	85% (+7%)
Overall experience in getting an appointment good	85% ↑	73% (+12%)
Satisfied with opening hours	83% ↑	76% (+7%)

Financial investment

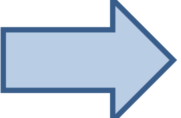
The following investment is required to support us to go further faster and accelerate early delivery of benefits:

1. Investment for the STP for all new **workforc**e role mentioned in FYFV in year 1 across all localities (five CCGs) irrespective of whether already part of PMCF or GP Access Fund. Mental Health Therapists, clinical pharmacists, care navigators and medical assistants.
2. All localities(CCGs) across the STP to receive Funding to Improve Access to General Practice Services in Year 1 (2017/18) irrespective of whether already part of PMCF or GP Access Fund. £6 per head of STP population.
3. Early response to Estates and Technology Transformation Fund local bids (end Dec) so that estates support to transformation can be planned – a vital ingredient to our plans
4. Early release to system of funding for reception and clinical staff training and online consultation systems (full sight of tranche's early so that full programme can be scheduled) to enable cohorts of training & increased pace
5. Pump priming money (non-recurrent) to enable full STP wide workforce assessment & development plan, Integrated Care Hubs across the STP to optimise out of hospital care & upskill other health and care professional to manage less complicated problems. (Support workload transformation)

Non-elective Admissions age > 65 from A&E
Rolling 12 months average/1000

Appendix 6: STP General practice at scale

Local Context



System Wide Strengths:
- Stable & experienced clinical leadership across all areas
- High levels of practice engagement
- Commitment to GP at scale . GP federations in place covering all the population
- Practices with strong training history/workforce innovation
- Population recognises role of general practice at heart of health and care system & local political support
- GP risen to challenge as leader of system change. Role recognised by wider system.
- Clinical & managerial partnership approach
- Strong clinical interface between secondary & primary care

System opportunities
- Outcomes variable, inequalities & scope for spread of good practice (access, LTC management, early identification, self care & prevention)
- Strong case for change - No locality sustainable in "do nothing scenario"
- History of pockets of innovation – can deliver at pace individually (see below)
- Variable investment: negating opportunities for scale

However some areas for improvement:
- High levels of GP referrals
- High and rising levels of emergency admissions
- Some areas lower quartile performance

Evidence of Successful Initiatives

Workforce

Direct Access Physio in General Practice
- Booked by Receptionist
- 15 minute appointments
- Extended scope practitioner
- Referral for exercise, on going physio, injection, investigation, referral to secondary care or GP.
- 20% reduction in physio and secondary care referrals
- 95% FFT

Access

8 to 8 Working (M-F)
- Rapid implementation from concept to delivery
- Data sharing agreement with access to EMIS web
- Larger practices operating solo, smaller practices operating across 2 or 3 sites
- Above national average patient satisfaction (92%)
- Reduced NELs for >65yrs

Infrastructure

Infrastructure investment enabled

Phase 1: Establishment of Integrated Care Decision Making Hub with GP as core member

Phase 2 GP Urgent care hub (from early Nov)
- Same day appts access across 5 GP populations
- Releasing time to offer longer appointments for patients with LTC this initiative improves both urgent appointments and personalised LTC management

Complex Needs

Proactive Care for Complex Needs
- Risk stratification identifying patients who benefits from more intensive support through a period of regular appts with GP
- 20 mins appts every 3 weeks
- Evidence of reduced hospital admissions & A&E attendances

STP Fund
- Early investment
- No phasing
- Across all localities
- Scale and pace of delivery

Workload

Needs based referral
- Single point of referral for integrated community services using a "needs based" approach
- Saves GP time
- Optimises use of integrated community MDT
- Improved access to social and voluntary sector for general practice
- No door is wrong door approach for professional

Future State

- Eliminate variation between localities so collectively are the highest performing general practice system nationally
- Meeting all components of the GPFV before 2020 (March 2019)
- Investment delivers within 2 years STP wide:
  - Sustainable Clinical Model
  - Workforce strategy and clear sustainability plan
  - Business Model that works for practices and health and care system
- Embedded network of innovation & shared learning for general practice
- Urgent care models and resilient system that draws on GP information as part of a "live" system of demand and capacity management
- Fully integrated use of technology throughout the general practice care pathway from appointment booking to self management

Appendix 7 The ten ‘big questions’

The table below gives a brief summary of how our STP and local plans will enable us to address the ten NHSE ‘must dos’

Our priorities		10 big questions addressed?
1. Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection.	1 2	• Enrolling people in the Diabetes Prevention Programme • Do more to tackle smoking, alcohol & physical inactivity • Improve the health of NHS employees and reduce sickness rates • A step change in patient activation and self-care
2. Significant action to improve long term condition pathways including greater self management and proactive management across all providers for people with single Long Term Conditions.	4 2	• A reduction in emergency admissions and inpatient bed day rates (via prevention and improved care pathways for LTC) • A step change in patient activation and self-care
3. Frailty management: providing proactive management of frail complex patients (not just elderly), having multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays and delaying reliance on bed based care.	4 9	• Health and social care integration with a reduction in DTOC • A reduction in emergency admission and IP bed-day rates • Integrated multi-disciplinary teams to underpin new care models
4. Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate	4 5	• Integrated 111/OOH services with a single point of contact • A simplified UEC system, with fewer, less confusing points of entry • Improved A&E and ambulance waits and RTT
5. Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence (using Right Care methodology)	7 10	• Achieving a significant reduction in avoidable deaths • Credible plans for moderating activity growth
Key initiatives i. Ensure people can take responsibility for own health & wellbeing ii. Primary care transformation iii. Transform the social care support market iv. Design a support workforce that is fit for purpose, cross system v. Implement a shared care record vi. Develop integrated care decision making hubs	3 2 9 8 4	• Support primary care redesign, workload management, improved access, more sharing working across practices and improving the resilience of primary care • Expansion of integrated personal health budgets and choice • Developing, retraining and retaining a workforce w/ the right skills • Full interoperability by 2020 and paper free at point of use • A reduction in IP admissions to hospital (+care home admissions)
Areas to be covered in a broader range of footprints		**To be covered in local plans**
• Mental health specialist services and tertiary services • Procurement across different footprints for example 111 tendering • Digital roadmap • Learning Disabilities and Transforming Care Partnership • Cancer strategy • Safeguarding Adults and Children • Specialist acute services • Emergency care networks	6 8 6	• Ensuring most providers are rated outstanding or good • Full roll out of seven day hospital services clinical standards • Reducing agency spend • Improved anti-microbial prescribing and resistance rates

Appendix 8 System partners

NHS Commissioners
- Bracknell and Ascot CCG
- North East Hampshire and Farnham CCG
- Slough CCG
- Surrey Heath CCG
- Windsor Ascot and Maidenhead CCG

Acute care provider
- Frimley Health NHSFT

Mental health and community providers
- Berkshire Healthcare NHSFT
- Southern Health NHSFT
- Surrey and Borders NHSFT
- Sussex Partnership NHSFT
- Virgin Care

GP Federations
- Bracknell Federation
- Federation of WAM practices
- Salus GP Federation (North East Hampshire and Farnham)
- Slough GP Federation
- The Surrey Heath community providers

GP out of hours providers
- East Berkshire Primary Care
- North Hampshire Urgent Care

Ambulance Trusts
- South Central Ambulance Service NHS FT
- South East Coast Ambulance NHS FT

County Councils (including Public Health)
- Hampshire
- Surrey

Unitary Authorities
- Bracknell Forest Council
- Royal Borough of Windsor and Maidenhead
- Slough Borough Council

District and Borough Councils
- Guildford Borough Council
- Hart District Council
- Rushmoor Borough Council
- Surrey Heath Borough Council
- Waverley Borough Council

STP FAQs – Frimley Health and Care System

What is a Sustainability and Transformation Plan?

The Frimley Health and Care Sustainability and Transformation Plan (STP) is one of 44 plans in the country set up to deliver health's Five Year Forward View' (www.england.nhs.uk/ourwork/futurenhs/).

The Frimley Health and Care plan covers a population of 750,000 residents through nine councils (county, borough and district). It sets out how social care and health services delivered by councils and health authorities will become a more integrated system fit for the future.

The plan runs from 2016 to 2021 and builds on the work already taking place to transform health and care provision in the region.

What will the Frimley Health and Care Sustainability and Transformation Plan do?

As there are increasing financial pressures on the health services and social care it must be joined together so we have a clear plan on how to work together in a sustainable way to meet the needs of our residents.

The Frimley Health & Care STP will provide benefits to the communities and individuals will:

- Be supported to remain as healthy, active, independent and happy as they can be.
- Know who to contact if they need help and be offered care and support in their home that is well organised, only having to tell their story once.
- Work in partnership with their care and support team to plan and manage their own care, leading to improved health, confidence and wellbeing.
- Find it easy to navigate the urgent and emergency care system and most of their care will be easily accessed close to where they live.
- Have confidence that the treatment they are offered is evidence based and results in high quality outcomes wherever they live - reduced variation through delivery of evidence based care and support.
- Increase their skills and confidence to take responsibility for their own health and care in their communities.
- Benefit from a greater use of technology that gives them easier access to information and services.
- As taxpayers, be assured that care is provided in an efficient and integrated way.

To date the plan has been co-designed and developed with clinicians and wider staff from all organisations within the system. Going forward we plan wider engagement and co-design of details of the plan with residents, patients and wider stakeholder groups.

STP FAQs – Frimley Health and Care System

What is the focus for the next five years?

There are five priorities for our area:

1. Improve wellbeing and increase prevention, self-care and early detection.
2. Improve treatment planning for patients with long-term conditions, including greater self-management and proactive management across all providers.
3. Provide proactive management for people who have multiple, complex and long-term physical and mental health conditions, to reduce crises and prolonged hospital stays.
4. Redesign urgent and emergency care, including integrated working and primary care models providing out of hospital responses to reduce hospital stays.
5. Reduce variation and health inequalities to improve outcomes and maximise value for citizens across the population, supported by evidence.

What are the key highlights for the Frimley Health and Care STP?

- People can get a GP appointment from 8am to 8pm Mon to Fri, which is 420,000 more GP appointments across east Berkshire, North East Hants and Farnham and Surrey Heath.
- Increased access to urgent weekend care coordinated across healthcare and social care
- More services delivered away from hospital in more appropriate settings
- A new hospital at the Heatherwood site
- New A&E at Wexham Park Hospital
- Revamped maternity services at Wexham Park Hospital

Is the STP all about saving money?

The financial challenges faced by the NHS and local authorities nationwide are well documented and difficult decisions about how to be more efficient in the way we deliver healthcare and social care do need to be made. We will work together to reduce overlaps, become more efficient and invest in out of hospital services to spend the public pound on the most appropriate and sustainable services for the future.

How will patients benefit? How will we notice the difference?

Residents will continue to have access to high quality consistent care as close to home as possible, with specialist services centralised where necessary and social care will work seamlessly with GPs and other community support services.

The plan has been developed by social care professionals, councillors, clinicians and wider staff from all organisations and wider stakeholder groups. We will work with residents to develop the services and support they need.

How will it affect staff?

The STP will encourage staff to work differently and more jointly which will enable better care and support for the people our staff look after.

They will benefit from greater use of technology that gives them easier access to information and releases time to care.

There will be more opportunities to work across different settings within the system.

There will be more seamless processes wrapped around patients and individuals and not organisations.

It has already built greater understanding across different sectors of health and social care and this will continue to help us jointly solve our challenges.

Who is accountable or responsible for delivery of the STP?

All of our organisations have signed up to the plan and are all responsible for making it happen. Going forward, all organisations involved in the STP are ensuring their organisational plans and priorities are aligned with the STP.

We are all responsible for doing our bit, including all of our residents and staff. We will work closely with them to develop the services and support they need to keep them healthier for longer.

Through the STP are we losing the localism and returning back to Strategic Health Authorities?

The STP has focused on taking the best initiatives and examples from across the different areas and looks to scale them up to get the greatest impact. They may be adapted for local need, so that each community can be involved in helping shape them and benefit from them.

Have you had any public involvement in the development of the STP?

Our proposals have been informed by a range of activities and ongoing engagement with the public and clinicians as part of local initiatives such as New Vision of Care, the NEHF Vanguard and the Surrey Heath Alliance, as well as strategic health needs assessments and health and wellbeing strategies from across the STP.

Public engagement is critical and the detail within the plan will be developed with patients and the public.

What's next?

The plan covers a period of five years (from 2016 to 2021) and was submitted to NHS England on 21 October 2016. They are now publically available on all partner organisation websites.

We will now begin a phase of sharing our proposals with local people and groups and gathering their views, to help shape the detail of the plans going forward. We want to make sure that we will deliver care that works for residents and patients, and is sustainable.

STP FAQs – Frimley Health and Care System

Why do we need another plan? Will this one work?

This plan addresses the financial situation of both health and social care. It enables us to work better together. Having this plan enables a coordinated team to come together, and actually holds organisations to account to deliver. We also need to work within the envelope of the public finances we are given.

Will this plan work? Yes based on our existing track record:

We already have an existing track record of working to deliver better quality care through local acute hospitals and we have one of the best A&E delivery boards in the country which is a credit to all partners across health and social care.

We also have a track record around delivering to tackle health inequalities so for example in Slough there is ongoing work for diabetes and in Windsor, Ascot and Maidenhead it is around dementia care. Our prevention agenda is also in partnership for example in Bracknell, Self-Care Awareness Week is a huge joint programme of work. We are also a pilot for the national Diabetes Prevention Programme.

Who is part of the Frimley Health and Care Sustainability and Transformation Plan?

An STP footprint is the term being used to describe the areas that a STP plan covers.

There are 44 STP footprints across the country in total.

The Frimley Health planning footprint consists of a population of 750,000 people registered with GPs in five clinical commissioning groups (CCGs): North East Hampshire and Farnham; Slough; Windsor, Ascot and Maidenhead; Bracknell and Ascot; and Surrey Heath.

The plan is being led by Sir Andrew Morris, Chief Executive, Frimley Health NHS Foundation Trust.

The Sustainability and Transformation Plan planning footprint is the population of 750,000 people registered with GPs in five CCGs:

- NHS Bracknell and Ascot CCG
- NHS North East Hampshire and Farnham CCG
- NHS Slough CCG
- NHS Surrey Heath CCG
- NHS Windsor, Ascot and Maidenhead CCG

Other stakeholders include:

Frimley Health NHS Foundation Trust

GP Federations

- A GP federation is a group of GP practices that decide to collaborate to provide improved access and quality whilst reducing variation in general practices' services.

Mental health providers
- Berkshire Healthcare NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust

Community providers
- Southern Health NHS Foundation Trust
- Virgin Care

Ambulance Trusts
- South Central Ambulance Service NHS Foundation Trust
- South East Coast Ambulance Service NHS Foundation Trust

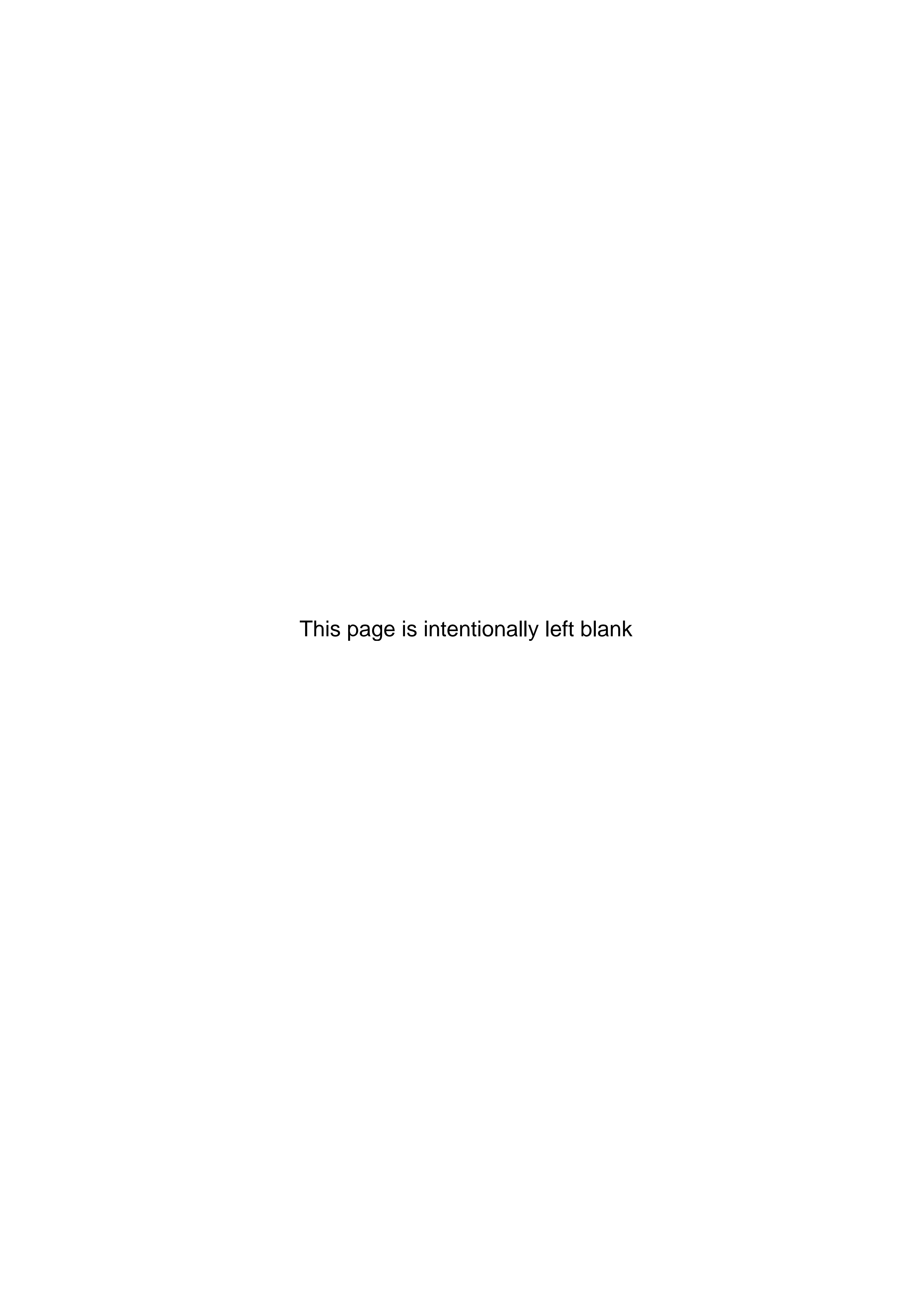
Councils
- Bracknell Forest Council
- Guildford Borough Council
- Hampshire County Council
- Hart District Council
- Royal Borough of Windsor and Maidenhead Council
- Rushmoor Borough Council
- Slough Borough Council
- Surrey County Council
- Surrey Heath Borough Council
- Waverley Borough Council

GP Out of Hours Services
- East Berkshire Primary Care
- North Hampshire Urgent Care

Want to be involved?

Contact us at shccg.communications@nhs.net to find out more about the STP.

Come to our next public meeting from 2-4.30 on Tuesday 31st January 2017, at The Camberley Theatre.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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)
Date of meeting:	15 March 2017
Report Title:	Work Programme
Reference:	8189
Report From:	Director of Transformation and Governance

Contact name: Katie Benton, Scrutiny Officer - members.services@hants.gov.uk

1. Purpose of Report

1.1 To consider the Committee's forthcoming work programme.

RECOMMENDED

That Members consider and approve the work programme.

WORK PROGRAMME – HEALTH AND ADULT SOCIAL CARE SELECT OVERVIEW & SCRUTINY COMMITTEE: 2016/17

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	15 March 2017	20 June 2017	21 July 2017
Proposals to Vary Health Services in Hampshire - *to consider proposals from the NHS or providers of health services to vary health services provided to people living in the area of the Committee, and to subsequently monitor such variations. This includes those items determined to be a 'substantial' change in service.*							
Andover Hospital Minor Injuries Unit	Temporary variation of opening hours due to staff absence and vacancies	Living Well Healthier Communities	Hampshire Hospitals NHS FT	Updates on temporary variation heard at June and September 2016 mtgs. Update: to be reviewed once full operating hours are reached		Further update **(E)**	
Antelope House PICU	Urgent temporary closure of 10 beds due to concerns on safe staffing	Living Well	Southern Health NHS FT	Item heard July 16. Concerns raised to be monitored through monthly updates, next formal item March 2017.	Update to be considered **(M)**		
Dorset Clinical	Dorset CCG are	Starting Well	Dorset CCG /	First Joint HOSC			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	15 March 2017	20 June 2017	21 July 2017
Services review **(SC)**	leading a Clinical Services review across the County which is likely to impact on the population of Hampshire crossing the border to access services.	Living Well Ageing Well Healthier Communities	West Hampshire CCG	meeting held July 2015, CCG delayed consultation until 2016. Update heard at 2 December 2015 and 21 June 2016 HASC meeting, The next scheduled update due after next scheduled JHOSC meeting in October 16.	Verbal update to be received once next meeting has been held. **(M)**		
Friarsgate Surgery, Winchester	Monitoring actions post-closure of Kings Worthy branch surgery	Starting Well Living Well Ageing Well Healthier Communities	West Hants CCG Friarsgate Practice (Local Members Cllr Porter and Tod)	Committee reviewed proposed actions at June 2016 meeting, agreed to follow-up post evaluation. Deferred by Chairman to March 17	Evaluation update to be received **(M)**		
Kingsley Ward, Melbury Lodge	Proposed temporary closure due to required building works	Living Well	Southern Health FT	Item heard July 2016, updates due in January 2017 (during the works) and		Final update **(E)**	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	15 March 2017	20 June 2017	21 July 2017
				summer 2017 (once the works have been completed)			
North and Mid Hampshire clinical services review **(SC)**	Management of change and emerging pattern of services across sites	Starting Well Living Well Ageing Well Healthier Communities	HHFT / West Hants CCG / North Hants CCG / NHS England	Monitoring proposals for future of hospital services in north and mid Hampshire since Jan 14. Latest update indicated whole system review to report in Jan 17 as part of STP. Status: to next appear once options are available.			
Ravenswood House	Proposed temporary move of some medium-secure patients from Ravenswood House to Woodhaven to allow building works to remove ligature points as per the CQC inspection published Feb	Living Well	Southern Health NHS FT	Temporary move supported Jan 15, interim update requested for three months after move, and at the end of the change. Item on future proposals to be received when timely.			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	15 March 2017	20 June 2017	21 July 2017
	2015.						
Stefano Olivieri Unit	Permanent change of service model in ward to mixed OPMH and AMH setting, where appropriate	Living Well Ageing Well Healthier Communities	Southern Health NHS FT	Model agreed March 16, to receive update March 17, to include information on work undertaken with nursing homes on timely discharge.	Update to be heard **(E)**		
Vascular	Future of specialised vascular services in South Hampshire	Starting Well Living Well Ageing Well Healthier Communities	NHS England – Wessex	Final Business case considered by Committee at March 2016 meeting, where it was determined not to be a substantial change. Update to be received once new model embedded		Update on implementation of new model **(M)**	
Issues relating to the planning, provision and/or operation of health services – *to receive information on issues that may impact upon how health services are planned, provided or operated in the area of the Committee.*							
Alton Strategic Review	Review of services led by NH CCG, to	Living Well Ageing Well	North Hants CCG	Engagement due to start taking place in January 2016.			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	15 March 2017	20 June 2017	21 July 2017
	include Alton Community Hospital	Healthier Communities	Southern Health NHS FT	Item to be heard once proposals agreed by CCG (TBC)			
Care Quality Commission inspections of NHS Trusts serving the population of Hampshire	To hear the final reports of the CQC, and any recommended actions for monitoring.	Starting Well Living Well Ageing Well Healthier Communities	Care Quality Commission	To await notification on inspection and contribute as necessary. HHFT: update in Jan 2017 SHFT: Summer 2017 PHT: July 17 Solent: March 2017	Solent NHS Trust **(E)**	Southern Health **(M)**	PHT update on progress **(M)**
Mazars report reviewing deaths of people with a learning disability or mental health problem in contact with Southern Health April 2011 to	Review and recommendations made to Southern Health, commissioners and national bodies on reviews of deaths in care of the Trust	n/a	NHS England Southern Health NHS FT West Hants CCG	Issue heard and reviewed extensively at 9 February meeting. Agreed to monitor and review again in six months' time September 2016		Update **(M)**	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	15 March 2017	20 June 2017	21 July 2017
March 2015			CQC/Monitor	update. Chairman agreed to monitor in interim, next update in summer 17.			
National pressures on hospitals and impact on wider health and social care system	Local and National news stories on emergency department pressures and knock-on effects on hospitals and out of hospital care.	Starting Well Living Well Ageing Well Healthier Communities	HCC All CCGs All Hospital providers All Community providers	To receive regular updates from the system using the new template to alert the HASC to ongoing or new issues.	System resilience update **(E)** **Last item prior to moving to STP scrutiny**		
South East Hampshire Community Bed Model review	To understand proposals for a new model of care in SE Hampshire	Living Well Ageing Well Healthier Communities	SEH CCG Options paper to be considered March 2017	Proposals to be considered - TBC			
Sustainability and Transformation Plan for Hampshire & IOW	To subject to ongoing scrutiny the strategic plan for H&IOW NHS services	Starting Well Living Well Ageing Well	STP	Considered summary and delivery plan January 2017, to be reconsidered summer 2017.		TBC **(M)**	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	15 March 2017	20 June 2017	21 July 2017
		Healthier Communities		Consideration to be given to working group			
Transforming Care Partnership	To consider the implementation of the TCP locally	Living Well	SHIP 8 CCGs	Considered Plan and proposals for Cypress ward Jan 17, to receive quarterly information updates		Quarterly update to be received **(E)**	
Overview / Pre-Decision Scrutiny – *to consider items due for decision by the relevant Executive Member, and scrutiny topics for further consideration on the work programme*							
Budget	To consider the revenue and capital programme budgets for the Adults' Health and Care dept	Starting Well Living Well Ageing Well Healthier Communities	HCC Adults' Health and Care (Adult Services and Public Health)	Considered annually in advance of Council in February Transformation to 2019 proposals to be considered Sept 17.			
Paying for care policy	Consultation held on proposed changes to policy	Living Well Ageing Well	HCC Adult Services	Item considered October 2016, some recommendations commended, others made to EM who		Update **(M)**	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	15 March 2017	20 June 2017	21 July 2017
				agreed them at her DDay. Agreed to monitor once changes embedded.			
Scrutiny Review - *to scrutinise priority areas agreed by the Committee.*							
Mental Health	Follows on from continuing monitoring of mental health-related issues in the HASC and HWBB	Starting Well Living Well Ageing Well	HASC	New Terms of Reference written and agreed with Chairman. Working Group to meet 2017/18.		Revised ToR to be considered **(M)**	
Real-time Scrutiny - *to scrutinise light-touch items agreed by the Committee, through working groups or items at formal meetings.*							
Adult Safeguarding	Regular performance monitoring of adult safeguarding in Hampshire	Living Well Healthier Communities	Hampshire County Council Adult Services	For an annual update to come before the Committee. Next update due November 17.			
Ambulance performance	To review ambulance	Living well	South Central	Item heard at June meeting, agreed to			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	15 March 2017	20 June 2017	21 July 2017
	performance following referral of issues from system resilience groups.		Ambulance Service South East Coast Ambulance Service	hold annual updates and receive quarterly data. Next update Summer 2017 – likely to be July.			
Public Health	To undertake pre-decision scrutiny and policy review of areas relating to the Public Health portfolio.	Starting Well Living Well Ageing Well Healthier Communities	HCC Public Health	Breastfeeding model of delivery considered March 2016. 0-5 services to be reviewed when timely – to include child dental health Items for consideration to be agreed as part of 2017/18 work programme			

Key

(E) Written update to be received electronically by the HASC.
(M) Verbal / written update to be heard at a formal meeting of the HASC.
(SC) Agreed to be a substantial change by the HASC.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1. The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2. **Equalities Impact Assessment:** This is a document monitoring the work programme of the HASC and therefore it does not therefore make any proposals which will impact on groups with protected characteristics.

2. Impact on Crime and Disorder:

2.1 This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

3. Climate Change:

3.1 How does what is being proposed impact on our carbon footprint / energy consumption?

This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

3.2 How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

Hampshire County Council: Health and Adult Social Care Select (Overview and Scrutiny) Committee

Glossary of Commonly used abbreviations in the NHS/Adult Services

Please note this is not exhaustive and will be revised on a regular basis.

AAA	Abdominal Aortic Aneurysm
A&E	Accident and Emergency or Emergency Department (ED)
AMH	Adult Mental Health
AOT	Assertive Outreach Team
AWMH	Andover War Memorial Hospital
AS	Adult Services
BCF	Better Care Fund
BNHH	Basingstoke and North Hampshire Hospital (part of HHFT)
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CX	Chief Executive
DGH	District General Hospital
DH	Department of Health
DTC	Delayed Transfer of Care
ED	Emergency Department / A&E
ENP	Emergency Nurse Practitioner
F&G	Fareham and Gosport
FHFT	Frimley Health NHS Foundation Trust
FT	Foundation Trust
GP	General Practitioner
HASC	Health and Adult Social Care (Select Committee)
HCC	Hampshire County Council
HES	Hospital Episode Statistics
HHFT	Hampshire Hospitals NHS Foundation Trust
HOSC	Health Overview and Scrutiny Committee
HWB	Health & Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICU	Intensive Care Unit
ICT	Integrated Care Team
IRP	Independent Reconfiguration Panel
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
Local HW	Local HealthWatch
MHA	Mental Health Act
MIU	Minor Injuries Unit
NED	Non-executive Director
NEH&F	North East Hampshire and Farnham
NHS	National Health Service
NHSE	NHS England
NHSP	NHS Property Services

NICE	National Institute for Clinical Excellence
NSF	National Service Framework
OAT	Out of Area Treatment
OBC	Outline Business Case
OBD	Occupied Bed Days
OOH	Out of Hours
OP	Out-patients
OPMH	Older People's Mental Health (services)
PFI	Private Finance Initiative
PHT	Portsmouth Hospitals Trust
QAH	Queen Alexandra Hospital, Cosham
RHCH	Royal Hampshire County Hospital (part of HHFT)
RTT	Referral to Treatment Time (performance indicator)
S&BP FT	Surrey and Borders Partnership NHS Foundation Trust
SCAS	South Central Ambulance NHS Foundation Trust (Service)
SECAMB	South East Coast Ambulance NHS Foundation Trust
SEH	South Eastern Hampshire
SEN	Special Educational Need
SGH	Southampton General Hospital
SHIP	Southampton, Hampshire, Isle of Wight and Portsmouth
STP	Sustainability and Transformation Plan
UHS FT	University Hospital Southampton NHS Foundation Trust
WCH	Western Community Hospital
WiC	Walk in Centre