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Hampshire County Council

NOTICE OF MEETING

Meeting Health and Adult Social Care Select Committee

Date and Time Tuesday, 10th July, 2018 at 10.00 am

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

Enquires to members.services@hants.gov.uk

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

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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.

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 5 - 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 - 50)

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 Monitoring

- Hampshire Hospitals NHS Foundation Trust: Andover Hospital Minor Injuries Unit

Items for Information

- South Eastern Hampshire CCG and Portsmouth Hospitals NHS Trust: Spinal Surgery Service

7. HAMPSHIRE CQC LOCAL SYSTEM REVIEW (Pages 51 - 104)

To receive an update on the response of Hampshire health and care partners to the findings of the CQC Local System Review of the Hampshire Health and Care System.

8. ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES (Pages 105 - 108)

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.

- Hampshire and Isle of Wight Sustainability and Transformation Plan Update

9. WORK PROGRAMME (Pages 109 - 118)

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 Committee of HAMPSHIRE COUNTY COUNCIL held at The Castle, Winchester on Thursday, 17th May, 2018

PRESENT

Chairman:
p Councillor Roger Huxstep

Vice-Chairman:
p Councillor David Keast

p Councillor Martin Boiles
p Councillor Ann Briggs
a Councillor Adam Carew
p Councillor Fran Carpenter
p Councillor Charles Choudhary
p Councillor Tonia Craig
p Councillor Alan Dowden
p Councillor Steve Forster
a Councillor Jane Frankum
p Councillor David Harrison
p Councillor Marge Harvey
p Councillor Pal Hayre
p Councillor Mike Thornton
p Councillor Jan Warwick

Substitute Members:
p Councillor Neville Penman

Co-opted Members:
p Councillor Tina Campbell
a Councillor Trevor Cartwright
a Councillor Alison Finlay

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

58. **APOLOGIES FOR ABSENCE**

Apologies were received from Councillors Adam Carew and Jane Frankum.

Apologies were also received from co-opted members Councillors Trevor Cartwright and Alison Finlay.

59. **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 Non-Pecuniary interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 2 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.

No declarations were made.

60. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Health and Adult Social Care Select Committee (HASC) held on 27 February 2018 were confirmed as a correct record and signed by the Chairman.

61. DEPUTATIONS

The Committee did not receive any deputations.

62. CHAIRMAN'S ANNOUNCEMENTS

The Chairman made three announcements:

Care Quality Commission Review

The final report from the Local System Review held in March would be available in June. A summit was due be held, to which HASC Members would be invited. Details would follow in due course.

Working Groups update

The two working groups of the HASC, on social inclusion and sustainability and transformation partnerships, had both met. Cllr Keast, who Chairs the Social Inclusion working group, provided a summary updating Members on the progress of this review, and Members would receive a fuller version of this briefing following the meeting.

Briefings

An update on the move of the Kite Unit had been received and would be circulated following the meeting.

63. PROPOSALS TO VARY SERVICES

Hampshire Hospitals NHS Foundation Trust: Outpatient, X-Ray and Community Midwifery Services in Whitehill and Bordon: Re-provision of Services from alternative locations or by an alternative provider

The Chief Executive of Hampshire Hospitals NHS Foundation Trust appeared alongside a representative from Hampshire CCG Partnership in order to speak to a report on service in Chase Hospital, Whitehill and Bordon (see report, Item 6 in the Minute Book).

Members heard that the Trust had chosen to appear before the Committee at this early stage, as the proposals had caused some concerns locally, and it was important to outline the reasons for proposing the withdrawal of some services from Chase Hospital. The report considered these reasons in detail, but primarily they related to a reduction in the use of Hampshire Hospitals by those in the Whitehill and Bordon area as their preferred provider of acute secondary care services, which had reduced the number of outpatient and other specialty appointments being attended. Most of the population in this area chose instead to receive services from the Royal Surrey, Frimley Park or Portsmouth. The report covered travel times to these hospitals, showing that these services tended to be chosen because the acute services were closer to home than those offered by Hampshire Hospitals in Winchester and Basingstoke.

The reduction in the number of referrals was leading to reduced efficiency in clinical staff time, since they needed to travel from acute service sites in order to attend clinics in Chase. The report showed that approximately 1.5 hours per session were lost through clinician travel, which could better be used at other sites to tackle rising waiting times and an increasing number of patients. The Chase Hospital had a number of different providers operating from the same building, duplicating the same services, which was also inefficient; further thought needed to be given by the CCG, working in conjunction with providers, to see how the mix of providers could be adjusted to reduce these inefficiencies. It was too early at this stage to report on whether any of the services that Hampshire Hospitals proposed to withdraw from the Chase could be replicated by another provider.

In relation to maternity appointments, expectant mothers were currently receiving antenatal appointments from Hampshire Hospitals midwives but choosing to have their babies at an alternative provider. It was proposed that as most of these individuals were choosing to give birth in Royal Surrey County Hospital, it would make clinical sense for their maternity appointments to be supported by the Royal Surrey's midwives.

The Chief Executive of the Trust noted the five tests of service change that the HASC needed to consider in coming to a view on the nature of a service change, and accepted that in relation to GP support, engagement and patient choice more work needed to be completed before the full picture was available. It was also recognised that transport options from Bordon to Alton were limited and further work would need to take place around this.

The CCG and Hampshire Hospital's clinical staff had been supportive in drawing the proposals together, and more work would need to be completed before the final impact of the proposals were known. It was highlighted that the services impacted were a very small percentage of those offered by Hampshire Hospitals, and 13% of those available at the Chase Hospital.

The CCG provided a brief overview of the longer-term plans for the future of services in Whitehill and Bordon, and noted that it was not possible to provide all specialties and outpatient services in each town across Hampshire given the finite resources and funding available for NHS services, but the commitment of commissioners was to provide as many services locally as it was viable and

affordable to do. Chase Hospital was not a natural satellite location for providers, so securing specialist consultant time was difficult, but discussions were ongoing and could be reported to a future meeting. It was also reported that services in Haslemere were changing and some services from there may move back to the Chase, such as physiotherapy, speech and language therapy and podiatry.

In response to questions, Members heard:

- That the midwifery proposals would see Royal Surrey community midwives continuing antenatal clinics at Chase. All expectant mothers who were on a maternity pathway would continue to receive a service from the Trust.
- That modelling around Whitehill and Bordon's future health needs had been undertaken, being mindful of future housing developments, which might make increased outpatient provision in Chase more appealing to Royal Surrey Hospitals.
- Engagement with GPs had shown that they understood the rationale for withdrawing from Chase but wished to see a range of health services in the town. They were working closely with the CCG to look at the future options for Chase, and the future direction on health services in the town.
- There were three elements to patient transport; those who self fund their transport, those who are eligible for patient transport, and those who use the voluntary network of drivers. As part of patient and stakeholder engagement, the CCG would need to understand what sort of transport people would need should they be required to travel farther to access secondary care.
- If analysis work were to show a travel time impact, then this is something the Trust and CCG will need to engage on, in order to understand how to minimise impact. However, it may be that CCG discussions will result in the same services being provided but by a different provider, which would have less impact.
- That the CCG have been working on services in the Chase site for a number of years, working to align the right local health and wellbeing services. The CCG were mindful of the housing being built locally, but this would be closer to the centre and is likely to make the Chase site unviable, as health services will likely need to be built where the majority of the population reside. Work on this was progressing, with a business case for a future health hub due to be submitted in July.
- Part of the rationale for the proposals was to increase the amount of consultant time in other locations by decreasing the travel time needed to access satellite clinics. This would be part of the plan to tackle waiting times; it was much more efficient to provide clinics in larger sites with higher patient numbers.
- Of those accessing the Chase site for outpatient appointments, 75% already use Royal Surrey, and 25% use Hampshire Hospitals. Most of these individuals already access outpatient appointments elsewhere in Hampshire, with approximately 1% of these being provided in Whitehill and Bordon.
- That once the CCG had completed work to see what services could be re-provided in Chase, the next steps would be to review any subsequent impact on other providers in terms of absorbing additional activity, but this

was thought to be minimal given the small number of services being discussed.

The Chairman read out a short statement from Councillor Adam Carew, a Member of the HASC and local member for Whitehill, Bordon and Lindford, who was not able to attend the meeting. In this statement, Cllr Carew outlined his opposition to the withdrawal of some services from Chase Hospital.

The Chairman moved to debate, where Members noted their concerns about the lack of engagement and the additional work that would need to take place before a view could be taken by the Committee on the nature of the service change. Some Members raised concerns about the range of services that would be left in Whitehill and Bordon. Discussion was also held on the need for the NHS to work smarter, and that should the data show that services are underutilised, and that resources are not being used in the most efficient way, that proposals should be brought forward that considered these issues. It was agreed that whilst it was helpful to have early notice of the Trust's proposals, they were not yet developed enough for Members to take a view on them.

RESOLVED

That Members agreed:

a. **That as the proposals for community midwifery services at Chase Hospital would see no change to how expectant mothers will access and attend services, that the HASC agrees that this area does not constitute a substantial change in service.**

b. **To defer making a decision on whether the remaining proposals constitute a substantial change in service and would be in the interest of the service users affected, until the July meeting of the Committee.**

c. **That the Trust and CCGs undertake a period of engagement on the proposals and bring the outcomes of this work to the next meeting of the Committee. That such engagement does not take place until the CCG is clear on what the future of services provided from the Chase Hospital site would look like, should the Trust withdraw from this site.**

d. **To request the following additional information as part of the July report on this issue to the Committee:**
    - **The outcomes of the CCG's discussions with alternative providers.**
    - **The views of local GP referrers.**
    - **The outcomes of engagement work.**
    - **Travel times, public transport options and the cost of these, as well as support available to vulnerable service users.**

- **Further analysis of the impact of the service change on patients once it is clear what services will be based in Chase Hospital in future.**

The Chairman agreed to take the agenda out of order.

NHS North Hampshire Clinical Commissioning Group and NHS West Hampshire Clinical Commissioning Group: Transforming Care Services in North and Mid Hampshire

Representatives of North Hampshire and West Hampshire CCG's attended alongside the Chief Executive of Hampshire Hospitals NHS Foundation Trust in order to update Members on the Transforming Care Service in North and Mid Hampshire (see report and presentation, Item 6 in the Minute Book).

Members considered the presentation, noting the progress made in relation to this work stream since the Committee last considered the topic in January 2018. The integrated care model previously outlined had five key components which centred on:

- Supporting people to stay well
- Improved access to care when needed
- Proactive joined-up support for those with on-going or complex needs
- Better access to specialist care
- Effective step up / step down care, nursing and residential care

Progress had been made against all of the five components, including:

- Work with GPs across the geography to review patient cohorts and to bring primary care together to provide more joined-up services.
- Rolling out extended hours across GP surgeries.
- Redesigning the 111 service to reduce unnecessary attendances to urgent care.
- Reviewing care pathways to ensure that they meet best practice and are accessible to patients.

Options for the centralisation of acute services were still being considered, and these were due to report later in the year once clinicians had completed their appraisal of the different potential pathways, including the potential impact on other acute hospitals. The aim of these work streams would be to increase the sustainability of services in the longer term, and therefore the Trust and CCGs were keen not to rush this work, as it was important to get it right, and there were no safety concerns in providing services in the short term. The Trust were also progressing cancer care and hospice discussions.

Since the last meeting, the Hampshire Hospitals estate survey had now been completed, which highlighted a c£100m need for capital funding to improve the estate across the three hospital sites. The next step would be to draft this work into a business case for the funding required, which would be entered as a bid into the next wave of capital fund allocations.

In response to questions, Members heard:

- That once the acute services reconfiguration work had been completed it would be important to test this with partners and the public, in order to measure the impact such proposals could have if implemented, and to understand the public's support for proposed changes.
- There was a finite amount of capital funding available nationally, which was significantly less than the demand across the country. There was a growing recognition that backlog maintenance is a significant issue. The CCG was working closely with the Trust to prioritise building works and identify those areas that would have the highest impact through improvements to the estate or make available estate that was fit for the future. The next bidding round would be in July.
- That extended hours for primary care didn't necessarily mean longer working hours for GPs. The focus was on providing a range of specialties based on the new model of primary care, such as physiotherapy, mental health workers, and community pharmacists. For example, GP signposting had already freed up 5% of GP time to spend on clinical work. The use of e-consult as a tool for patients to connect with their GP or health professional had also had a significant impact for those surgeries who had rolled out this way of working; the future of primary care would focus more on how technology can assist individuals to both better manage their own health, and to access health services.
- Significant progress had been made in the Trust's aspiration to open a hospice in Winchester, and it was hoped that the remaining capital funds would be raised within the next 12 months. This service would have 10 beds serving the wider North and Mid Hampshire population, but also providing a range of outreach services in a range of settings.

RESOLVED

That Members agreed:

a. To note the progress on developing the agreed options for 'transforming care services in North and Mid Hampshire'.

b. To request a further update in the autumn once the proposals for the future of acute reconfiguration are available to be consulted upon.

64. **PUBLIC HEALTH: SUBSTANCE MISUSE SERVICES**

Councillors Steve Forster and Jan Warwick left at this point in the meeting.

The Chairman agreed to take Item 8 out of order on the agenda.

Representatives of the Director of Public Health attended before the Committee in order to present an overview of the future Substance Misuse model in Hampshire (see presentation, Item 8 in the Minute Book).

The scope of the substance misuse service and the prevalence of alcohol and drug use in Hampshire were outlined to the Committee, as well as the impact such misuse has on families and communities. The aim of the new Hampshire Substance Misuse Strategy was to prevent and reduce the harm associated with

substance misuse (to individuals, their families and communities) and to increase the opportunities for recovery for those dependant on drugs / alcohol.

The priorities of the new service were outlined, including the key work stream of prevention and early intervention. The key elements of the new model were highlighted, which included an adult substance misuse service, a specialist young people's substance misuse service, and a pharmacy drug-treatment service. Within these services would be a range of programmes and elements designed to provide an holistic service. To this end, the successful partner providing the service, Inclusion, who were a Staffordshire-based service who held a number of substance misuse contracts across the country, had entered into a partnership arrangement with a number of other key providers who could provide support to those accessing substance misuse services.

The procurement of the new service had taken place throughout the summer and autumn of 2017 and would be operational from 1 July 2018. As part of the re-commissioning of this service, work had been undertaken with service users and stakeholders to find out what had been working well, what the barriers were to accessing services, and what could be done differently. These thoughts had been incorporated where possible in the new service model. The new model also included a number of best practice tools, such as the 'Don't Bottle It Up' alcohol test which helped individuals to identify personal substance abuse, and the provision of Naloxone in pharmacies and substance misuse services, which had anecdotally helped to reduce the number of opioid-related deaths in Hampshire by approximately 70 to date.

In response to questions, Members heard:

- That Public Health work with licencing authorities and make recommendations on restrictions on licencing, in order to tackle issues such as binge drinking and premises that sell alcohol inappropriately.
- Substance misuse during pregnancy is a key issue picked up through the substance misuse service, and Public Health work closely with health commissioners to secure these service, and to tackle how women with drug and alcohol issues can be supported throughout their pregnancy and postnatally.

RESOLVED

That the update is noted.

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

Councillor Tonia Craig left at this point in the meeting.

Portsmouth Hospitals NHS Trust; Care Quality Commission Re-Inspection – Monitoring of Quality Improvement Plan

The Chief Executive of Portsmouth Hospitals NHS Trust and his representatives attended alongside a representative from Hampshire CCG Partnership in order

to speak to the Quality Improvement Plan and related issues (see report, Item 7 in the Minute Book).

Members heard that a number of papers had been sent to the Committee including progress against the quality improvement plan, which was a detailed overview of all the actions being undertaken by the Trust. This overview provided an indication of those actions that are on track and those where delivery required further action. This spreadsheet was the same document made available to the internal Trust review group considering progress made against recommendations. Also included within the papers were the outcomes and Trust statement on the Care Quality Commission (CQC) investigation into radiology services.

In response to questions, Members heard:

- That the Trust received an unannounced inspection of its urgent care services in February which focused on the Trust's response to winter pressures. The Trust had been one of a number of Trusts inspected due to its status as a 'high risk' system.
- The CQC's urgent care inspection report highlighted some areas of positive progress but was also clear on areas for definite improvement. All the recommendations from this report had been picked up through both the quality improvement plan and the wider system improvement plan. The Chief Executive was confident that those recommendations requiring urgent action had been implemented, and that the comprehensive inspection that had been undertaken in April and May would see improvements.
- It had been three years since the Trust had last been subject to a comprehensive CQC inspection; the reports published since had focused on areas of the Trust's activity but had not provided overall ratings. The inspections were considering all elements of the Trust's business, with the exception of gynaecology. The inspection elements had finished in the last week, with the most recent visit focusing on whether the Trust was a well-led organisation. It was expected that an initial draft report would be available towards the end of June.
- The CCG had been involved in the oversight process, with a significant role in ongoing quality committees, and the Director of Quality and her team actively involved in assisting the Trust. Meetings and the sharing of information took place both weekly and monthly, in order to ensure that actions are being completed. The CCG continued their view that improvement was being evidenced in the Trust, and the new Board were committed to leading the Trust through its improvement journey.
- At the last meeting where Portsmouth Hospital Trust appeared before the Committee, the issue of the urgent care department and acute medical unit's estate was raised and discussion was held on whether works could be undertaken to improve the flow and layout of this area of the hospital. This estate issue remained difficult to resolve, as capital funding for works was a national issue and all NHS bodies requiring finance to support building works were required to enter a bidding process, competing against other bids. The Trust had detailed what an amended urgent care estate model would look like, including what changes would be required and how much this would be likely to cost. A local project team had been appointed

to work on this, and it was hoped that an outline business case would be ready by the end of June for submission.

- The other two major issues previously raised in relation to urgent care were staffing, policies and processes. Since this time, the Trust had made significant investment in staffing, increasing the amount of consultant and doctor support, and ensuring that staffing rotas matched the busiest times in the urgent care department. The Trust also felt that positive improvements had been made in implementing policies around patient flow, but it was recognised that there was still more to do in relation to this, some of which had been highlighted in the most recent CQC inspection report.
- The Trust were content with the progress made around GP triage and treatment in urgent care, with approximately 50 to 60 patients a day being diverted from urgent care.
- There also remained significant issues around finding the most appropriate place for patients once they no longer required acute medical care. Significant progress had been made around these delayed transfers, with the past nine weeks seeing the lowest escalation levels across the system in the past five years. Work was ongoing across the geography with Newton Europe to identify what other actions could be undertaken to continue to improve this position.
- A year ago, the Trust were positioned 136th out of 137 acute hospital trusts for its urgent care performance. Currently, the Trust were performing 76th out of 137, a significant improvement. The current year-to-date figures showed an average 88% performance against the four hours arrival to treatment target, against a national average of 89% against a national 95% target. A year ago, this was sitting at approximately 72%. The Trust still had further improvements to make, but the trajectory was the right one.
- The MRSA rate had seen a slight increase over the previous year, with cases seen showing increased complexity and severity. The Trust were putting actions in place to mitigate the risk of acquiring MRSA in the hospital, but there was an increasing rate of MRSA being acquired in the community. Six cases had been seen in the previous year; each case was reviewed by a panel and investigated in conjunction with the CCG to identify learning.
- There had been discussions previously about accountability at Board level, and the need for every individual to take responsibility for the Trust's improvement journey. The Chief Executive remained very clear about the need for the Board to both hold each other to account, and for this to happen from Board to Ward.
- The issue of accountability was also topical, with NHS Improvement's new Chair making comments on the need for firmer fit and proper person tests, and for the procedures around poor performance and misconduct by leaders to be reconsidered and toughened. The Chief Executive of the Trust noted that the fit and proper person test had been applied to everyone on the Board.
- The changes required to improve the governance of the radiology service had been implemented as soon as the Trust were alerted to them, with all images now reviewed by appropriate clinical staff. The report commissioned by the Trust had recognised that the improved governance processes were now stronger.

RESOLVED

That Members:

a. **Note the progress against the quality improvement plan of the Trust, and the response to the radiology inspection findings.**
b. **Request that a further update is heard at the November Committee meeting or following the publication of the Care Quality Commission's comprehensive inspection, whichever is soonest.**
c. **Request that an update be received at this time on the progress of the capital programme funding for estate works to the QA Hospital site's urgent care and acute medicine units.**

Councillors Alan Dowden and David Harrison left at this point in the meeting.

66. **PROPOSALS TO VARY SERVICES**

Southern Health NHS Foundation Trust: Plans to develop Secure Forensic Mental Health and Learning Disabilities Services

Representatives from Southern Health NHS Foundation Trust presented a report on the plans to develop a secure forensic mental health service, and associated proposals relating to learning disabilities services (see report, Item 6 in the Minute Book).

The programme manager leading the project provided Members with an overview of the proposals, noting that the learning disability service building plans had been co-designed by a group of engineers and architects, with input from service users, in order to ensure that the purpose-built unit met the needs of those using them. In particular, service users had been involved in the interior design of the building, with elements of their art work being incorporated in to decorations and the functional design of the building, following the suggestion of 'must haves' and 'nice to haves' by this group and their carers/families.

In relation to the forensic mental health unit for young people, this Trust were leading on work to modernise these pathways, providing places in Hampshire so that the number of out-of-area placements could be reduced.

In response to questions, Members heard:

- That the capital funding for the projects had been secured, and the Trust had allocated the remaining funding for the building works internally.
- By the time the building works begin, three patients are expected to be affected by the temporary move of the learning disabilities service from Woodhaven to Ravenswood. These service users and their families have been involved in the plans and had been shown pictures of the temporary accommodation and of the designs for the final building on the Tatchbury Mount site. Service users and their families were excited by the new building and were therefore satisfied with the temporary move whilst the new accommodation was being built. All staff who worked with this cohort of service users would also temporarily relocate to Ravenswood, so there would be no change in the personnel supporting these individuals.

- The same range of therapies and services would be available in Ravenswood. As the temporary accommodation was medium secure, rather than low secure, some additional safeguards would be put in place, including an increased staffing model.
- The representatives felt that the Trust were now better at engaging, involving and working closely with service users and their families. The Trust had been open about the plans from an early stage, and this had enabled real and early engagement.
- A public meeting had been held to discuss all of the proposals, and a Facebook page also existed to engage with local stakeholders on the works.

RESOLVED

That Members agreed:

a. That the proposal does not constitute a substantial change in service.

b. That the proposals would have a positive impact on service provision and were therefore in the interest of the patient groups affected.

c. To request:
- **The outcomes of service user and family engagement.**
- **An interim update on the building works.**
- **An update once the works have completed.**

Councillor Mike Thornton left at this point in the meeting.

67. **WORK PROGRAMME**

The Director of Transformation and Governance presented the Committee's work programme (see Item 9 in the Minute Book).

RESOLVED:

That the Committee's work programme be approved, subject to any amendments agreed at this meeting.

Chairman, 10 July 2018

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	10 July 2018
Report Title:	Proposals to Develop or Vary Services
Report From:	Director of Transformation & Governance

Contact name: Members Services

Tel: (01962) 845018 **Email:** members.services@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 (version agreed at January 2018 meeting). 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.

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

a. *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.

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

c. *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 that people in Hampshire live safe, healthy and independent lives.

2. Items for Action

2.1 None at this meeting.

3. Items for Monitoring

3.1 Hampshire Hospitals NHS Foundation Trust: Andover Hospital Minor Injuries Unit

Context

3.2 Hampshire Hospitals NHS Foundation Trust provide a Minor Injuries Unit (MIU) at the Andover War Memorial Hospital. In recent years the Trust has implemented a temporary variation to the commissioned opening hours, due to staff absence and vacancies meaning the Unit could not be safely staffed to cover the required hours.

3.3 The HASC last received an update on the situation in November 2017. At that time the Trust was operating the MIU 7 days a week between 8am and 8pm (compared to commissioned hours until 10pm). However recruitment of Emergency Nurse Practitioners (ENPs) continued to be difficult against a national shortage.

Update

3.4 A briefing (see Appendix) has been received from the Hospital Trust providing an update. This indicates that, with the agreement of West Hampshire Clinical Commissioning Group, the opening hours of the MIU have been reduced to 0830Hrs -1800Hrs for a period of 6 months from 4 June 2018. This is due to the MIU having 5 ENP vacancies.

3.5 The Trust are keen to continue to develop the services provided in Andover War Memorial Hospital and are actively working with partners and commissioners on the development of an Urgent Treatment Centre that will include and expand on the service currently commissioned. The new service is currently at invitation to tender stage and the commissioning plan is for a new service to be in place in July 2019.

Recommendations

3.6 That the Committee:

a. Note the progress on managing the opening hours of the MIU at Andover War Memorial Hospital.

b. Request a further update in six months time.

4. **Items for Information**

4.1 **South Eastern Hampshire CCG and Portsmouth Hospitals NHS Trust: Spinal Surgery Service**

Context

4.2 Elective spinal surgical services are currently provided at both Queen Alexandra Hospital in Portsmouth and Southampton General Hospital. It is proposed that the elective spinal surgical service at Portsmouth Hospitals NHS Trust (PHT) is moved to the Wessex Regional Spinal Unit at University Hospital Southampton NHS Foundation Trust (UHSFT). The proposal includes outpatient and inpatient work. Complex spinal surgical work is already undertaken at UHSFT, as is paediatric and trauma surgery for spinal conditions.

4.3 The number of potentially affected patients is 204 from across the catchment area for the Trust. Of this number of patients approximately 176 are from Portsmouth, Fareham and Gosport and South Eastern Hampshire CCG areas. The Portsmouth HOSP are scrutinising the impact for patients in the Portsmouth CCG area.

4.4 PHT currently has an unsustainable spinal surgical service with only one substantive consultant now delivering the service. In 2010 the Spinal Taskforce produced a paper entitled, 'Organising Quality and Effective Spinal Services for Patients. A report for local health communities'. This stated "Single-handed spinal surgeons should not be working in isolation. Wherever possible, spinal surgeons should work in teams within organisations, ideally with more than one surgeon in each site."

4.5 Over the past three years the Trust has tried to recruit to the service unsuccessfully. By only having one consultant available there is no consistency of medical cover available and the potential risks to quality and safety of care are higher with a service operated by a single clinician. Over the past two years the Trust has been working with Portsmouth, Fareham & Gosport and South Eastern Hampshire Clinical Care Commissioning Groups (PSEH), NHSE

Specialised Services Wessex and University Hospital Southampton NHS Foundation Trust to seek a sustainable solution for the local population.

4.6 It is proposed that following engagement, if approved by the relevant bodies, the change would take effect from October 2018. Centralising services in this way is the national direction of travel for specialist services and has been proven to improve clinical outcomes. The proposal has the support of the orthopaedic clinicians involved and commissioners. There will be an increase in travel time for some patients, however previous engagement indicates people are prepared to travel if it means they are going to receive the best clinical outcome.

4.7 A paper about the change has been provided by PHT, appended to this report.

Recommendations

4.8 HASC to agree:

- Whether the proposed change constitutes a substantial change
- Whether the proposed change is in the interest of the service users affected in the Hampshire area
- To agree any recommendations to the NHS bodies concerned regarding how to take their proposals forward, and to agree whether/when to request a further update.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

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.

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care (Overview and Scrutiny) Committee
Date:	July 2018
Title:	Andover Minor Injuries Unit Update
Report From:	Alex Whitfield, Chief Executive Hampshire Hospitals NHS Foundation Trust

1. Purpose of Report

1.1 This paper updates the Scrutiny Committee on the Minor Injuries Unit (MIU) in Andover.

2. Minor Injuries Unit in Andover

2.1. The Committee was previously updated by HHFT in November 2017 on the progress it had made to manage the working hours of the Minor Injury Unit (MIU) at Andover War Memorial Hospital. This paper provides an update on the current situation.

2.2. In support of CQC observations and to provide leadership and resilience to the MIU, the Trust appointed an excellent clinical lead into the role of Clinical Matron. She has worked hard and set the conditions for the MIU to achieve a GOOD rating from the CQC inspection in December 2017. Despite the challenge to ensuring adequate workforce the team have managed to ensure that current performance is well above the national constitutional standard of 95% of patients seen and discharged within 4 hours. The current performance of the Minor Injuries Unit is 99% against this standard.

2.3 Recruitment of Emergency Nurse Practitioners (ENPs) has been a principal focus in the Medicine Division. However, against a national shortage of ENPs, it has continued to be difficult to recruit to fill the organisational requirement and thus made it very difficult to maintain a safe service in accordance with the commissioned hours. The Trust has been actively growing its own capability but this is taking time to realise. To date, there are six trainees on an internal training programme two of which graduate this year. We are recruiting for September intake and hope to attract more candidates. Currently the MIU has a vacancy of 5 ENPs.

2.4 Noting this risk, the Trust has reviewed the attendance profile of the MIU by hours in the day and has taken the difficult decision to bring forward the closing time to 1800 hrs daily; this is to mitigate the impact on the public. Hampshire Hospitals has sought the agreement of West Hampshire Clinical Commissioning Group to support reduced opening hours (0830Hrs -1800Hrs) from the current operational hours of 0830-1930 for a period of 6 months; this was agreed and began on 4th June 2018. The impact to patients has been paramount in this decision making. Radiology provision in Andover ceases at 1600 hrs and all patients attending afterward would be diverted to Winchester or Basingstoke for assessment. The attendance activity

currently sees a drop off past 1800 hrs and whilst this is an impact to this small cohort of patients the safe delivery of the service during periods of highest demand is preserved.

2.5 As a trust we continue to review the ENP role with a view to managing this limited resource across all three hospital sites. This will enable resource to be focused at the point of greatest pressure though responsive and rotational staff posts. The Trust has appointed a resource lead to specifically target niche roles and to segment the market in order to attract and recruit staff, focusing on the strong local profile of the MIU and the significant role it plays for the local community. To extend the offering of an enhanced service, the Trust is also aspiring to the provision of on-site x-ray and blood testing over weekends to reduce the need of transferring patients.

Andover attendances per month per hour since April 16

Count of Local Patient ID	Column La													
Row Labels	08	09	10	11	12	13	14	15	16	17	18	19	20	Grand Total
2016														
Apr	94	103	80	65	81	57	71	70	44					665
May	102	144	74	82	71	76	63	74	51					737
Jun	104	135	86	87	79	84	87	84	57					803
Jul	122	116	92	108	85	100	90	104	53	1	1			872
Aug	109	144	134	124	98	98	110	114	109	84	72	35		1231
Sep	120	175	154	135	118	105	112	113	120	96	69	25	1	1343
Oct	113	155	115	122	112	113	91	113	103	76	65	20		1198
Nov	103	160	117	114	102	95	99	96	115	55	52	21		1129
Dec	83	132	129	115	100	78	80	95	89	56	37	11		1005
2017														
Jan	89	173	132	112	94	80	91	86	111	64	62	19		1113
Feb	98	113	103	94	83	84	96	93	83	75	62	21		1005
Mar	117	140	115	127	109	105	95	103	121	75	81	23		1211
Apr	115	153	131	109	98	79	109	118	94	77	79	34		1196
May	136	146	121	130	108	114	109	109	104	72	72	23		1244
Jun	148	197	113	136	100	97	83	118	108	117	83	23		1323
Jul	127	160	150	135	121	95	132	116	95	86	83	28		1328
Aug	89	123	109	116	106	98	105	94	94	74	62	18		1088
Sep	109	139	108	118	92	100	99	91	98	69	74	14		1111
Oct	105	121	98	107	108	96	81	83	84	48	53	11		995
Nov	86	117	89	79	79	66	79	78	72	44	42	11		842
Grand Total	**2169**	**2846**	**2250**	**2215**	**1944**	**1820**	**1882**	**1952**	**1805**	**1169**	**1049**	**337**	**1**	**21439**

3. Next Steps

3.1. Hampshire Hospitals Foundation Trust are keen to continue to develop the services provided in Andover War Memorial Hospital and are actively working with partners and commissioners in the development of an Urgent Treatment Centre that will include and expand on the service currently commissioned. The new service is currently at invitation to tender stage and the commissioning plan is for a new service to be in place in July 2019. We see this as a valuable and needed development for the population of Andover.

Spinal Surgical Service Move

Name of Responsible (lead) NHS or relevant health service provider: Portsmouth Hospitals NHS Trust

Name of lead CCG:
Portsmouth CCG
Fareham and Gosport CCG
South East Hampshire CCG
Specialised Services NHS England

Brief description of the proposal:

It is proposed that the elective spinal surgical service at Portsmouth Hospitals NHS Trust (PHT) is moved to the Wessex Regional Spinal Unit at University Hospital Southampton NHS Foundation Trust (UHSFT).
The scope of the change proposal is for all elective work currently undertaken at PHT for patients suffering from spinal conditions. The proposal includes outpatient and inpatient work.

Complex spinal surgical work is already undertaken at UHSFT as is paediatric and trauma surgery for spinal conditions.

The number of potentially affected patients is 204 from across the catchment area for the Trust. Of this number of patients approximately 176 are from Portsmouth, Fareham and Gosport and South Eastern Hampshire CCG areas

Why is this change being proposed?

PHT currently has an unsustainable spinal surgical service with only one substantive consultant (0.85 PAs) now delivering the service. In 2010 the Spinal Taskforce produced a paper entitled, 'Organising Quality and Effective Spinal Services for Patients. A report for local health communities'. This stated "Single-handed spinal surgeons should not be working in isolation. Wherever possible, spinal surgeons should work in teams within organisations, ideally with more than one surgeon in each site."

Over the past three years the Trust has tried to recruit to the service unsuccessfully. This has resulted in lengthy waits for patients and so, two years ago the commissioners, working with the Trust agreed that PHT would accept only 'red flag' referrals from GPs and a small number of consultant to consultant referrals.

By only having one consultant available there is no consistency of medical cover available and the potential risks to quality and safety of care are higher with a service operated by a single clinician. There is also an impact on governance arrangements which provide quality assurance for the service as a whole as these may potentially be less rigorous in a service operated with one consultant.

Over the past two years the Trust has been working with Portsmouth, Fareham & Gosport and South Eastern Hampshire Clinical Care Commissioning Groups (PSEH), NHSE Specialised Services Wessex and University Hospital Southampton NHS Foundation Trust to seek a sustainable solution for the local population. The proposed transfer would also see the consolidation the existing Wessex Regional Spinal service, which has strong governance as well as both clinical and management leadership.

Whilst the CCGs are supportive of the proposal it will need to be considered by their Governing Bodies. When considering the proposal the CCGs will expect to see details of the views of clinicians, key stakeholders and local people and how these have been taken into account.

Description of Population affected: PHT catchment area

The proposal involves the centralisation of the PHT surgical spinal service to University Hospital Southampton NHS Foundation Trust (UHSFT), which also currently provides the Wessex Regional Spines service. UHSFT already undertake the emergency and complex elective pathways so this proposal seeks to centralise the remaining non-complex elective pathway. The number of patients affected is limited to a small number of patients who require this type of surgery (204) as outlined in the table below.

	Activity 16/17	Activity 17/18	Activity 18/19
3 CCGs	163	174	176
Non Contract Activity	1	2	-
Other CCG's	18	17	24

Other Local Area Team	2	3	2
Wessex Area Team Specialised	1	1	2
TOTAL	185	197	204

Date by which final decision is expected to be taken:
The proposal has been put together jointly with the two Trusts, the three CCGs and NHS England Specialised Services Wessex and has also had strong involvement and input from the Solent Acute Alliance Board. Following engagement and involvement to consider the views of patients affected, the proposal will need to be considered by the Boards of the CCGs and both University Hospital Southampton NHS Foundation Trust and Portsmouth Hospitals NHS Trust for a final decision to be taken. It is anticipated that subject to formal agreement the transfer of the elective spinal service could take place in October 2018.

Confirmation of health scrutiny committee contacted:
Portsmouth Health Overview and Scrutiny Panel

Name of key stakeholders supporting the Proposal:

Commissioners
UHS
PHT Medical staff
Nursing staff
Governance personnel

Date:01/06/18

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Case for Change		
1) Is there clarity about the need for change? (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement)	Yes	The spinal service provided at Portsmouth Hospitals NHS Trust is currently unsustainable because of workforce constraints. In 2010 the Spinal Taskforce produced a paper entitled, 'Organising Quality and Effective Spinal Services for Patients. A report for local health communities'. This stated "Single-handed spinal surgeons should not be working in isolation. Wherever possible, spinal surgeons should work in teams within organisations, ideally with more than one surgeon in each site." In addition, continuing to operate the service as it is currently provided will have an impact on the quality, safety and governance of the service provided. By only having one consultant available there is no consistency of medical cover available and the potential risks to quality of care are higher with a service operated by a single clinician. There is also an impact on governance arrangements which provide quality assurance for the service as a whole as these may potentially be less rigorous in a service operated with one consultant.
2) Has the impact of the change on service users, their carers and the public been assessed?	Yes	It is recognised that there will be an impact on service users as a result of the need to travel to Southampton for spinal surgery to be carried out. However the quality and safety of our patients has been the primary focus of this proposal. It is also anticipated that the small number of patients requiring post operative care will be repatriated to Portsmouth.
3) Have local health needs and/or impact assessments been undertaken?	Not at this stage	

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
4) Do these take account of : a) Demographic considerations? b) Changes in morbidity or incidence of a particular condition? Or a potential reductions in care needs (e.g due to screening programmes)? c) Impact on vulnerable people and health equality considerations? d) National outcomes and service specifications? e) National health or social care policies and documents (e.g. five year forward view) f) Local health or social care strategies (e.g. health and wellbeing strategies, joint strategic needs assessments, etc)	Yes	The proposals take account of the service specification for spinal services produced by the Spinal Taskforce. This document entitled, 'Organising Quality and Effective Spinal Services for Patients. A report for local health communities by the Spinal Taskforce' is attached to this paper as background.
5) Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to service quality or the patient experience?	Yes	Centralising spinal services in this way is the national direction of travel for specialist services and has been proven to improve clinical outcomes. It also allows the clinical on call rota to be strengthened and has benefits for operational management and clinical governance.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
6) Do the clinicians affected support the proposal?	Yes	The orthopaedic clinicians support the fact that this is the best option to maintain a quality service for patients.
7) Is any aspect of the proposal contested by the clinicians affected?	No	
8) Is the proposal supported by the lead clinical commissioning group?	Yes	Yes, the proposal has been developed with Portsmouth, Fareham and Gosport and South East Hampshire CCGs and NHSE Specialised Services Wessex
9) Will the proposal extend choice to the population affected?	No	
10) Have arrangements been made to begin the assurance processes required by the NHS for substantial changes in service?	Yes	Given that the proposal affects a relatively small number of patients we have focused our plans for engagement on seeking the views of this specific patient group. Broadly speaking the proposals will impact on two groups of patients; those with chronic back pain and those who have had a disc displacement and require surgery. As a result we have made contact with the following groups and secured an initial meeting to discuss the proposals in detail and seek feedback. This meeting will be held on 12 June 2018: • National Ankylosing Spondylitis Society • National Osteoporosis Society • Partners friend through pain • National Rheumatoid Arthritis Society • Arthritis Care QA We have also sought to engage with the wider community through Locality Patients Groups and CCG Community Engagement Committees whose members include a range of community representatives.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
		We also engage with our communities on an ongoing basis and know that travel and availability of car parking can be a concern. However we are also aware that people are prepared to travel if it means they are going to receive the best clinical outcome and they are able to be repatriated to their local hospital where possible. We are also aware that concern may be raised about the impact of the proposed change on other services provided by the Trust and will be reassuring local people that we are not currently anticipating that there will be any impact.
Impact on Service Users		
11) How many people are likely to be affected by this change? Which areas are the affecting people from?		There are approximately 204 patients affected from the population served by the Queen Alexandra Hospital. With 176 of these from the local CCGs
12) Will there be changes in access to services as a result of the changes proposed?		Patients affected will be required to travel to Southampton hospital for their spinal surgery. This will inevitably result in a small increase in travel time for some patients.
13) Can these be defined in terms of a) waiting times? b) transport (public and private)? c) travel time? d) other? (please define)		
14) Is any aspect of the proposal contested by people using the service?		At this time there has been no formal or informal engagement with service users, however we are aware from our previous engagement work on similar issues that whilst additional travel may be a concern for some, patients are prepared to travel where it means they will have access to the best quality care.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Engagement and Involvement		
15) How have key stakeholders been involved in the development of the proposal?		Those clinicians affected by the proposed changes (both at PHT and UHSFT) have been involved in the discussions and development of the proposals.
16) Is there demonstrable evidence regarding the involvement of a) Service users, their carers or families? b) Other service providers in the area affected?		As stated above, we have plans to seek the views of patient groups about the proposal to consider their feedback and alleviate any concerns.
c) The relevant Local Healthwatch? d) Staff affected? e) Other interested parties? (please define)		Informal discussions have been held with Healthwatch Portsmouth and a description of the engagement activity outlined which they were content with. A full three month consultation will be undertaken with the spinal surgeon affected by the proposal as per the Trust's HR policy.
17) Is the proposal supported by key stakeholders?		Yes, the proposal is supported by clinicians and commissioners.
18) Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this?		Key stakeholders are supportive of the proposal but we will review it in light of feedback received from the patient groups.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Options for change		
19) How have service users and key stakeholders informed the options identified to deliver the intended change?		An options appraisal was carried out with commissioners once it was realised that the service was no longer sustainable in its current form. The option to recruit additional consultants at Portsmouth was not considered realistic. In addition the caseload of patients was not sufficient to warrant an additional increase. The option to keep the outpatient activity at Portsmouth was also considered, however splitting the pathway in this way was considered to be a potential risk to quality and safety as well as potentially causing confusion for patients. Instead it was felt the proposed option was the best outcome for quality and safety combined with allowing those patients to be repatriated back to Portsmouth for ongoing required where necessary.
20) Were the risks and benefits of the options assessed when developing the proposal?	NA	
21) Have changes in technology or best practice been taken into account?	NA	
22) Has the impact of the proposal on other service providers, including the NHS, local authorities and the voluntary sector, been evaluated?	Y	
23) Has the impact on the wider community affected been evaluated (e.g. transport, housing, environment)?	Y	
24) Have the workforce implications associated with the proposal been assessed?		The proposal has come about because of concerns relating to the workforce and the current sustainability of the service. The proposal is intended to resolve these concerns.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
25) Have the financial implications of the change been assessed in terms of: a) Capital & Revenue? b) Sustainability? c) Risks??		A full financial assessment of the proposal has been undertaken and included as part of the business case discussed and agreed with commissioners.
26) How will the change improve the health and well being of the population affected?	NA	

Organising Quality and Effective Spinal Services for Patients

A report for local health communities by the Spinal Taskforce

March 2010

Version 1

DH Gateway Ref. 13885

Update to this report

This document currently refers to a number of 18 Weeks weblinks that will shortly become out of date. At some point in 2010, all content on the 18 Weeks website will be transferred to the DH website (or other suitable home) and the 18 Weeks website will be closed.

Once the relevant content, referred to in this report, has migrated, this report will be updated with the new links as Version 2 and republished on the DH website.

Organising quality and effective spinal services for patients

Foreword

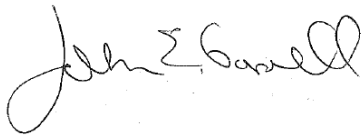
This report is intended to assist the NHS in developing and delivering effective spinal services, creating a set of productive services that deliver quality, timely and clinically appropriate care that meets patients' needs and expectations.

The report was commissioned in response to the national work on delivering 18 week pathways (for all patients who wish to be treated within 18 weeks and for whom it is clinically appropriate). In many Strategic Health Authorities (SHAs), providers were particularly struggling to deliver 18 week pathways for patients requiring spinal surgery. 'Top tips' aimed at organisations providing spinal services, giving operational advice on managing patients and organising service provision were therefore prepared and published in 2008. In preparing the 'top tips', it became clear that some wider issues around the organisation of spinal services also needed to be addressed, to ensure that the right range of services are available for patients and that these services are aligned in a way that is clinically safe and ensures rapid access, both for elective and emergency conditions. Closely aligned to this, the service would also benefit from support and guidance around implementing current National Institute for Clinical Excellence (NICE) Guidelines on spinal conditions including back pain and metastatic spinal cord compression.

The Department of Health (DH) therefore asked the Spinal Taskforce (membership detailed in **Appendix 1**) that developed the 'top tips' to also produce this short, but concise report for local health communities, including SHAs, PCTs, service managers and clinicians. This document will be particularly useful for those planning the delivery of spinal services for a wide population.

The document describes the main types of patients being referred to spinal services and gives advice on how to organise services to meet the needs of these groups, paying particular attention to the quality, clinical outcomes and cost-effectiveness of the services provided. It suggests the creation of a clinical network to offer advice on developing the right services for the local population.

I very much hope that the recommendations in this guidance will help them to address the challenges being faced in their local area.



Mr John Carvell
Consultant Spinal Surgeon and BMA representative
Chair of the Spinal Taskforce

Organising quality and effective spinal services for patients

Introduction

As part of the national work on delivering 18 week pathways (for all patients who wish to be treated within 18 weeks and for whom it is clinically appropriate), it emerged that, in many Strategic Health Authorities (SHAs), providers were particularly struggling to deliver 18 week pathways for patients requiring spinal surgery, with waits continuing to be longer than average waits across the country. The Department of Health (DH) (in collaboration with the relevant specialist associations and professional bodies) prepared a set of **'top tips' aimed at organisations providing spinal services** (see **Appendix 2**), giving operational advice on managing patients and organising service provision. In preparing this, it became clear that some wider issues around the organisation of spinal services also need to be addressed, to ensure that the right range of services are available for patients and that these services are aligned in a way that is clinically safe and ensures rapid access, both for elective and emergency conditions. This report addresses these concerns.

It looks at the effective organisation of spinal services for a wide population to support those planning and commissioning services across an SHA, PCTs and clinical and managerial teams within provider units. The document describes the main types of patients being referred for spinal treatment and advises on how to organise services to meet the needs of these groups, paying particular attention to quality, clinical outcomes and cost-effectiveness.

This report is intended to assist the NHS with the development and delivery of effective spinal services, that deliver quality, timely and clinically appropriate care, which meet patients' needs and expectations. It will also help **support the implementation of specific NICE guidelines on lower back pain and cancer of the spine.** As with guidance such as that issued by NICE, it is important to note that this document does not over-ride the individual responsibility of health care professionals to make decisions appropriate to the circumstances of the individual patient.

Patients requiring spinal services

Key to the organisation of safe and effective spinal services is an understanding of the type of patients presenting with spinal complaints and the services they require. Essentially, services should be arranged so that elective patients receive very early and robust triage and are then promptly referred to the most appropriate area for their condition. This will ensure that any 'red flags' are acted upon swiftly, but also ensure that patients with less clinically urgent needs receive care that is appropriate for their condition, thus preventing a decline into long-term chronic pain. Patients presenting as emergencies require emergency services that are able to promptly assess and investigate their condition, backed by appropriate in-patient provision. Broadly, patients requiring access to spinal services fall into the following main categories:

i. Non-specific low back pain

The largest group of patients will be those with **'non-specific low back pain'.** The vast majority of these patients, when presenting early in primary care, will benefit from simple structured education and reassurance based on the following well recognised national and international guidelines:

- **NICE Clinical Guideline CG88 - Early management of persistent non-specific low back pain**[1]
- The 18 week commissioning back pain pathway[2]
- Welsh government/health advice on backpain

To help implement the suggestions in this report, and the clinical guidelines from NICE, there should be a focus on self-management of pain by providing patients with information about their condition, advising early mobilisation, and providing reassurance that most episodes will improve spontaneously[4].

When symptoms persist for **longer than six weeks**, or are recurrent, patients should undergo bio-psychosocial assessment, with confirmation of the diagnosis. A choice of the core therapies recommended in the NICE "low back pain guidelines" should be offered; exercise therapy, (preferably in groups) manual therapy, or acupuncture. Medication should be reviewed by their GP with advice from a pain specialist if necessary, especially if strong opioids are to be considered.

The Musculoskeletal Framework[5] recommends that the NHS work with employers to encourage good occupational health in the wider community, resulting in a reduction in sickness absence, particularly relating to those with previous sick leave and older workers. Optimally, patients who have failed to respond to one or more of these less intensive treatments should undergo a further bio-psychosocial assessment, and, where there are

[1] www.nice.org.uk/CG88
[2] www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Specialty-focussed-areas/Orthopaedics/pathways

[4] The Back Book ISBN 0-11-702949-1
[5] Department of Health, A joint responsibility: doing it differently – the musculoskeletal services framework, 12 July 2006 (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138413)

significant 'yellow flags'[6] for chronicity and disability. They should have access to a Combined Physical and Psychological Programme (CPP), in line with the NICE guidelines. (See **Appendix 3** for a detailed description of a CPP programme). Patients with on-going pain and related disability for **more than a year** should be referred to a pain specialist where they can be offered a range of treatments, medication review and various specialised interventions - refer to the 18 week chronic pain pathway[7] for guidance on the patient pathway for those with chronic pain.

Surgery (spinal fusion) should only be considered for the small number of patients who have completed an optimal course of care, including a CPP programme. If after this their back pain is still severe, they should consider surgery.

> *In a large spinal service in the North East, only 4% of patients triaged as non-specific low back pain patients were re-referred to any service in secondary care within two years. An audit of these patients in primary care revealed substantial return to work, significant reduction in consultations with the general practitioner and substantial reduction in prescription / over the counter medication.*
>
> *A second unit has recorded that, from initial GP referral, 30% of patients will be discharged without reaching an outpatient appointment (instead, receiving treatment in primary care settings). Of the remaining patients, around 60% could be managed by specially trained practitioners in primary care where their patient history, examination and special investigations have shown that surgery would be inappropriate. Only 4-5% of GP spinal referrals will normally need surgery.*

ii. Radicular pain

The next largest group are those patients with **radicular pain**, (i.e., pain in the leg plus neurological symptoms and signs). These fall mainly into two groups:

- acute radicular compression by a prolapsed intervertebral disc
- spinal stenosis

MRI scanning is normally obtained for these patients and this can be requested by the triage and treatment practitioner who should receive training in interpretation of scans and have access to the reporting consultant radiologist. Referring practitioners should have access to pain management, orthopaedic, imaging, psychology services and consultant surgeons.

Research shows that surgical management of disc prolapse accelerates recovery and that the benefit, disability, and improvements to quality of life in the early stages are statistically and clinically significant. It is thus important that a triage system deals with acute nerve root compression rapidly. Patients require skilled advice on the relative merits of operative and non-operative care, and this should be **delivered within eight weeks** from onset of the pain. Many patients' symptoms resolve spontaneously but others suffer considerably. Patients' individual circumstances and clinical progress are very important in this decision making process.

[6] New Zealand yellow flags: www.nzgg.org.nz/guidelines
[7] www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Specialty-focussed-areas/Cross-specialty

Patients with intervertebral disc prolapse for whom surgery is not initially indicated may benefit from interlaminar epidural steroid or nerve root injection. Pain clinics may accept patients from a trusted referring source with consistent findings on an MRI scan without an intervening assessment appointment (which saves a lot of time), while in some centres root blocks are performed by radiologists, surgeons, and/or GPwSIs as part of the pathway for back pain and radicular symptoms. Pain clinics will also be able to provide appropriate pain management.

Patients with spinal stenosis also require skilled advice on the relative merits of operative and non-operative care, and patients who may benefit from surgery should be referred for a surgical opinion promptly.

iii. Potentially serious pathology

The most clinically serious (but also the smallest) group of spinal patients are those with **potentially serious pathology**. Cauda Equina Syndrome (CES), cancer of the spine (especially metastatic disease), fragility (osteoporotic) fractures, and infection are the principal pathologies under consideration. These patients need to be identified swiftly (using the red flags, as there is international recognition for these). CES is an emergency and requires access to 24 hour MR imaging (A recent BMJ Paper on CES provides additional information on managing this condition[8]). Detailed guidance on the management of spinal metastases has recently been issued by NICE:

- **NICE Clinical Guideline 75 - Metastatic spinal cord compression:** Diagnosis and management of patients at risk of or with metastatic spinal cord compression (Nov 2008)[9]

iv. Spinal deformity

The fourth group comprises the **spinal deformity** patients (adults and children). This group includes patients with scoliosis and kyphosis who require coordinated diagnostic and therapeutic support services, both for children and adults with scoliosis. It is essential that scoliosis services are made available for the population, as demand for these services is growing significantly and is likely to continue to increase in the coming years, particularly for adult spinal deformity. The DH has recently produced 'top tips' for the effective organisation of scoliosis services and these are shown in **Appendix 4**. The National Definition Set for these patients can also be found in **Appendix 5**.

v. Spinal trauma

The creation of regional trauma networks will provide the NHS with a framework measurement against which services can secure improvements in survival and better outcomes and care for patients suffering life threatening and major complex injuries, including those sustaining **spinal trauma**. These networks are currently under development

[8] 'Cauda Equina syndrome' Lavy C, James A, Wilson-MacDonald J, Fairbank J.. BMJ 2009; 338:936: www.bmj.com/cgi/content/extract/338/mar31_1/b936

[9] http://guidance.nice.org.uk/CG75

and will be dependent on provision of services locally. Patients with spinal cord injury need very careful management, with particular attention to prevention of avoidable life threatening complications. At present, local provision for patients with a spinal cord injury varies. When the trauma networks are established, every hospital receiving trauma should have a defined relationship with the appropriate spinal cord injury centre to provide advice, outreach care and education in the needs and immediate management of these vulnerable patients. Those with a spinal cord injury should be admitted to a spinal treatment centre within 24 hrs or as soon as possible.

vi. Other spinal pathologies

Lastly, there will be a small group of patients with **other spinal pathologies** who require specific pathways of treatment. These include congenital and acquired spinal stenosis, spondylolisthesis, and instability, inflammatory spondylitis with/without deformity, rheumatoid arthritis and metabolic disorders. These patients should be referred to a centre for spinal services and may require a multi-disciplinary approach.

Services required to meet the needs of these patients

Fundamental to providing the best quality services and experience for patients is to not only ensure that the right services are available for all categories of patients, but also that there are robust systems in place at all primary access points to ensure effective triage, in particular, to identify the first three categories of patients.

In order to meet the needs of all these groups of patients, it is suggested that local spinal service teams (clinicians and managers) work alongside their lead commissioners to create a clinical network for the provision of spinal services. This needs to go beyond the management of degenerative conditions and include a focus on cancer, trauma and deformity.

The clinical network will be able to advise on developing and delivering a cohesive set of services that includes all Trusts providing either neurosurgery or orthopaedics (or both). For the network to operate effectively, clinicians and managers should work together to enable understanding of the breadth of facilities and support required to provide a comprehensive spinal surgical service, including proper investment in the elements of a multi-disciplinary team, networks and infrastructure. To support this, it would be helpful to identify a clinical lead and it is suggested that this clinician co-chairs the network meetings. Given the significance of rapid triage (as set out above) and the need to ensure appropriate management of emergencies, it is important that all Trusts providing orthopaedic or neurosurgical services participate in the network, even those not providing spinal surgery, to ensure that elective patients are appropriately triaged and referred to the right services within the network and that spinal emergencies are adequately assessed and managed. Tasks that the clinical network may wish to consider include the following:

1. **Identify (and designate) a lead centre (or centres) for the provision of specialist spinal surgery to the local population**. Care for patients requiring specialist spinal surgery is low volume and high cost, and thus should be concentrated in specialist centres, although it is recognised that other centres in the area may also offer some of these services and facilities. The specialist centre/s should:

   - Provide an emergency rota for trauma and access to emergency and urgent spine services, for example for spinal cord compression;

   - Have MRI available 24/7 supported by good tele-radiology links with other centres;

   - Implement the guidelines and recommendations from the Spinal Specialised Services National Definition Set[10], (These can be found in **Appendix 5**) which identifies:

     Six areas of complex spinal surgery:

     i. Deformity (i.e. structural scoliosis, kyphosis, vertebral anomalies and severe spondylolisthesis)
     ii. Reconstruction (tumour, infection and spinal fracture)

[10] Specialised Services National Definition Set: 6 specialised spinal services (all ages), 8th February 2007

iii. Primary cervical, primary thoracic and primary anterior lumbar surgery
iv. Revision surgery
v. Intervention for complex back pain services
vi. Palliative or curative spinal oncology surgery

- Comply with the NICE guidelines on spinal metastases, including access to specialist input on chemotherapy or radiotherapy from oncologists and radiotherapists to support patients with metastatic disease and have access to specialist advice from a sarcoma unit (see paragraph 15 above);

- Have access to expertise in infectious disease management (including microbiology services) to support the treatment of infections;

- Offer specialised services for paediatrics (if providing children's spinal surgery), such as specialist paediatric nursing, anaesthesia, intensive care and rehabilitation, including resources for anaesthesia for MRI and CT scanning in small children;

- Deliver specialist services for scoliosis patients, including a Child Development Centre for paediatric patients (if providing children's spinal surgery), appropriate imaging and spinal cord monitoring for surgery in line with the Spinal Surgery National Definition Set (SSNDS). (The SSNDS for both adults and children can be found in **Appendix 5** and cover both scoliosis and spinal cord injury services);

- Provide a comprehensive service for patients with spinal cord injuries in line with the SSNDS, above. This should include assessment by a multi-disciplinary team, including spinal surgeons and specialists in spinal cord injury rehabilitation;

- Provide vertebroplasty/kyphoplasty and related procedures for patients with painful benign (osteoporotic) and malignant spinal fractures where indicated, including input from specialists in bone metabolism;

- Create links with other providers within their area, providing outreach and specialist advice and expertise as required.

2. **Agree which services should be provided only by the specialist centre/s** (technically complex spinal surgery and/or high risk of major complications) and which should be provided by non-specialist surgical services (routine procedures with low risk of major complications). **Appendix 6** summarises the national consensus on specialist and non-specialist surgery but this may be subject to local variation, based on clinical practice within the local area.

3. **Ensure all organisations providing spinal surgery have links with the lead centre/s, with clear clinical governance links across providers.** Single-handed spinal surgeons should not be working in isolation. Wherever possible, spinal surgeons should work in teams within organisations, ideally with more than one surgeon in each site. They should be working as part of a clinical network and the network will have responsibility for

governance arrangements to support these practitioners (both clinically and operationally) and for succession planning. The network will promote:

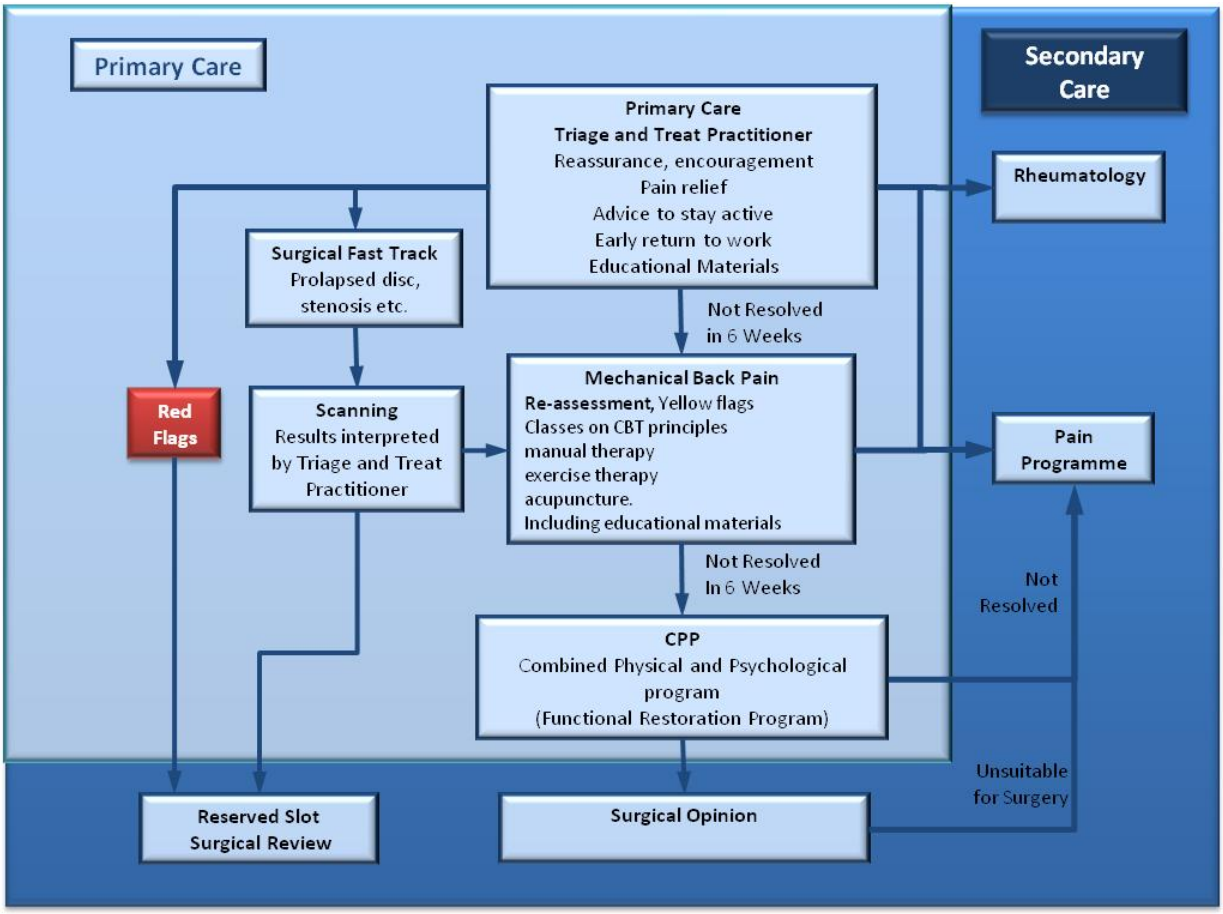
- Common network-wide audited standards of provision of medical, nursing, imaging and operative facilities;
- The development of in-house medical and nursing expertise for all hospitals in the area with an emergency department in the assessment and management of the unstable spine and the neurologically threatened or compromised patient.

4. **Effective triage is essential to deliver the pathways of care for elective spinal conditions efficiently and expeditiously, allowing fast tracking of patients to appropriate treatments.** In order to deliver effective triage, the network should consider developing the role of local 'triage and treat practitioners' (for example a nurse practitioner or extended scope physiotherapist) who are highly trained in triage and assessment and also trained in indications for MRI and interpretation, together with the skills to deliver educational material effectively. An example job description for a physiotherapy consultant and nurse specialist in spinal pain can be found in **Appendix 7**. The practitioners refer for diagnostics, therapies, surgery and CPP. The relationship of these practitioners with other specialists is crucial and close working will allow fast track appointments with surgeons, pain specialists, rheumatologists and others. Joint audit and governance arrangements are required and, in order to monitor practice, should include the specialist teams.

5. **Review the guidelines and recommendations contained with the Musculoskeletal Framework and implement as appropriate.** Specifically, the network should plan for a cohesive set of spinal services that triages patients at the point of referral and ensures that those with low back pain are seen by appropriate practitioners, freeing spinal surgeons to treat those patients requiring specialist surgery, integrating and co-ordinating care across organisational boundaries. NHS Quality Improvement Scotland (QIS) provides very useful information on the organisation of services for patients with acute low back pain[11].

[11] www.nhshealthquality.org

Organisational chart for Lower Back Pain services



6. **Ensure all hospitals receiving trauma have on site expertise in the assessment and management of acute spinal conditions both in the emergency department and on the inpatient ward.** They should also have 24/7 access to CT scanning, seven-day per week access to MRI, together with a defined written protocol to access 24/7 MRI scanning and have an established tele-radiology connection to a spinal centre. They should have the expertise to manage patients with acute spinal conditions either who are not fit for transfer or who have conditions appropriate for treatment in a non-specialist centre.

7. **Carry out a needs assessment for the population, mapping resources and their uses by people with spinal conditions,** including the NHS and other services outside hospital, hospital-based elective and emergency services, and use of diagnostics to understand the treatment that is required, highlighting any gaps in provision. This will inform the structure of the spinal network and align services with providers. As part of this, commissioners will wish to understand the demand for each procedure and the capacity required to meet this. An information pack is provided with this guidance giving activity information for each SHA and a suggested list of issues that commissioners and the clinical network may wish to consider in relation to current spinal activity (as defined in the information pack). The resource mapping should also include a review of the number of spinal surgeons (both orthopaedic and neurosurgeons) working in the service. Condition specific pathways and standards should be defined, for example time to surgery for intervertebral disc prolapse.

8. **Consider issues around training and education and consider how clinicians can best share training and education, audit and governance between primary and secondary care across the pathway and across organisations.** Issues that the network may wish to cover include:
   - The time available for shared clinical training and audit;
   - The assessment of spinal surgeons as defined by competence (rather than numbers of procedures undertaken alone);
   - Arrangements for post-CCT training (for example spinal fellowships and overseas postings). Two years fellowship training at post–CCT level is recommended by spinal societies;
   - The costs associated with speciality spinal training pre and post CCT (for example, courses on fresh cadaveric material are extremely expensive);
   - Mentorship of newly appointed consultants and provision of support from senior colleagues when first undertaking more complex procedures.

Concluding remarks

This report on improving the quality and effectiveness of spinal services has been developed by a clinical reference group at the request of the NHS as waiting times for spinal surgery continue to be longer than average waits across the country.

Adopting the good practice set out in this guide will assist NHS teams in organising, developing and ensuring the delivery of safe, effective and quality spinal services that meet with NICE clinical guidelines. This would create a set of services that deliver timely, clinically appropriate and cost-effective care that meets patients' needs, improves the overall quality of care they receive and enhances their general experience of the healthcare system in this area.

In order to deliver this model of high-standard and high-quality care/service for patients, it is recommended that a clinical network be established to advise on developing the right framework of services for the local population.

It is hoped that the recommendations made in this report will help local health communities organise and deliver the best quality and most effective spinal services for patients.

Appendix 1

Membership of the Spinal Taskforce & Acknowledgements

The Spinal Taskforce was formed in 2008 with representation from all the key stakeholders

Member	**Designation**
Mr John Carvell - Chair	Consultant Spinal Surgeon and British Medical Association (BMA)
Caroline Dove	NHS Elect
Piers Young	DH Musculoskeletal Team
Professor Charles Greenough	Professor in Spinal Surgery and NICE panels on MSCC and back pain
Mr Nigel Henderson	Consultant Spinal Surgeon, British Association of Spinal Surgeons (BASS) and Specialist Advisory Committee (SAC)
Mr Alistair Stirling	Consultant Spinal Surgeon, advisor on training and education - Royal College of Surgeons (RCS), British Orthopaedic Association (BOA)
Elaine Buchanan	Consultant Physiotherapist and NICE panels on MSCC and back pain
Dr Joan Hester	Consultant Anaesthetist and British Pain Society (BPS)
Dr Andrew Jackson	GP and Royal College of General Practitioners (RCGP)
Mr Jeremy Fairbank	Professor in Spinal Surgery and British Scoliosis Society (BSS)
Dr Geoff Hide	Consultant Radiologist and British Society of Skeletal Radiologists (BSSR)
Mr Tim Pigott	Consultant Neurosurgeon and Society of British Neuro-logical Surgeons (SBNS)
Susie Durrell	Consultant Physiotherapist
Maxine Foster	DH Workforce Team

For Appendices 2-7 please refer to supplementary documents:

Appendix 2	**Top tips for delivering 18 weeks for all spinal surgery**
Appendix 3	**Definition of a Combined Physical and Psychological programme (CPP) Programme in NICE Guidelines on Low Back Pain**
Appendix 4	**Top tips for the effective organisation of scoliosis services**
Appendix 5	**Spinal Specialised Services National Definition Set for both adults (part a) and children (part b)**
Appendix 6	**Summary of the national consensus on specialist and non-specialist surgery**
Appendix 7	**Example job description for a physiotherapy consultant (part a) and specialist nurse in spinal pain (part b)**

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee
Date:	10 July 2018
Title:	CQC Local System Review
Report From:	Director of Adults' Health and Care

Contact name: Graham Allen

Tel: 01962 847200 **Email:** graham.allen@hants.gov.uk

1. Purpose of Report

1.1. The purpose of this report is to update the Health and Adult Social Care Select (Overview and Scrutiny) Committee following the Care Quality Commission (CQC) Local System Review. CQC published the Local System Review of Hampshire on 21 June 2018, following a summit with health and care system leaders, partners and other stakeholders on 20 June 2018. CQC's report is an Appendix to this report for information.

1.2. The Hampshire Health and Care System is required to produce an Action Plan to address the findings of the Review, by 20 July 2018. An update on the action plan will be presented to the Committee on 10 July.

1.3. The Select Committee is invited to comment on the issues identified in CQC's report, to contribute to the Action Planning process, which is being led by the Director of Adults' Health and Care on behalf of the County Council and NHS local system leaders. The Action Plan will be signed off by the Hampshire Health and Wellbeing Board.

2. Contextual Information

2.1. In 2017, the Care Quality Commission (CQC) was asked by the Secretaries of State for Health and Communities and Local Government to undertake a programme of targeted reviews in 20 local systems. The purpose of the reviews was to look at how well people move through the health and social care system in a particular area, with a focus on the interface, and what improvements could be made, focusing on the needs of people over 65.

2.2. Hampshire was selected as one of the areas for review. CQC undertook Hampshire's Local System Review between February and March 2018 with an intensive fieldwork visit taking place between 12 and 16 March 2018.

3. Consultation and Equalities

3.1. CQC Reviewers met with groups of service users, carers, and patients, as well as a number of voluntary and community sector partners, as part of the main

Review, and also during a two-day pre-Review visit that took place between 21 and 22 February 2018.

3.2. The intention will be to continue to involve users, carers and patients as part of the process of creating and implementing the Action Plan to address the Review's findings.

4. Conclusions

4.1. The CQC report identified many areas of strength across Hampshire's health and social care organisations. These include:

- a consistent and shared purpose, vision and strategy across all organisations in support of people;
- a strong understanding of the health and social care needs of Hampshire's population;
- good examples of inter-agency work at a strategic and operational level;
- Services and the experiences of residents are high in a number of indicators, when benchmarked against other comparable health and care systems nationally.
- a commitment to providing opportunities for people receiving services and their representatives and carers to influence service development; and
- an advanced use of digital tools to provide support to people and to enable staff in different organisations to share information, reducing unnecessary duplication.

4.2. Recommendations for improvements include streamlining the hospital discharge processes across Hampshire to support people to leave hospital as quickly as possible once they are deemed medically fit to do so; improving the recruitment and retention of key groups of staff such as those who deliver home care; and exploiting opportunities to pool funding and join up services more consistently.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Other Significant Links

Direct links to specific legislation or Government Directives	
The review was carried out under Section 48 of the Health and Social Care Act 2008.	Date July 2008

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:**

There are no equalities impacts arising from this covering report.

2. Impact on Crime and Disorder:

2.1. Not applicable.

3. Climate Change:

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

No impact identified.

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

No impact identified.

Hampshire

Local system review report
Health and Wellbeing Board

Date of review:
12 -16 March 2018

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Social care, and for Housing, Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Delivery Lead: Ann Ford, CQC
- Lead reviewer: Wendy Dixon CQC

The team included:

- Two CQC reviewers,
- One CQC analyst,
- One inspection manager

- Two inspectors
- One strategy manager
- One business support officer
- Two medicines management inspectors
- Four specialist advisors; three with a local government management background and one with an NHS management background.

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system was functioning within and across three key areas:

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how

relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Hampshire County Council (the local authority); Hampshire Clinical Commissioning Group (CCG) Partnership (a formal agreement between Fareham and Gosport, South Eastern Hampshire, North Hampshire and North East Hampshire and Farnham Clinical Commissioning Groups) and West Hampshire CCG (referred to collectively in this report as the CCGs); Hampshire Health and Wellbeing Board (HWB); Hampshire County Council's Health and Adult Social Care Select Committee and elected leaders.
- System leaders from Hampshire Hospitals NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust, Portsmouth Hospitals NHS Trust, Southern Health NHS Foundation Trust, and South Central Ambulance Service NHS Foundation Trust (SCAS)
- Health and social care professionals including social workers, GPs, pharmacy leads, discharge teams, therapists, nurses and commissioners.
- Healthwatch Hampshire and voluntary, community and social enterprise (VCSE) sector organisations.
- Providers of residential, nursing and domiciliary care.
- People who use services, their families and carers who attended focus groups. We also spoke with people in A&E, hospital wards and at residential and intermediate care facilities.

We reviewed 24 care and treatment records and visited 20 services in the local area including acute hospitals, intermediate care facilities, care homes, GP practices, hospices and out-of-hours services.

The Hampshire context

Demographics

- 18% of the population is aged 65 and over.
- 95% of the population identifies as White.
- Hampshire is in the 20% least deprived local authorities in England.

Adult social care

- 369 active residential care homes:
  - 12 rated outstanding
  - 275 rated good
  - 49 rated requires improvement
  - Three rated inadequate
  - 30 currently unrated
- 146 active nursing care homes:
  - Five rated outstanding
  - 96 rated good
  - 37 rated requires improvement
  - One rated inadequate
  - Seven currently unrated
- 207 active domiciliary care agencies:
  - Eight rated outstanding
  - 112 rated good
  - 18 rated requires improvement
  - 69 currently unrated

GP practices

- 127 active locations:
  - 116 rated good
  - Six rated requires improvement
  - One rated inadequate
  - Four currently unrated

Acute and community healthcare

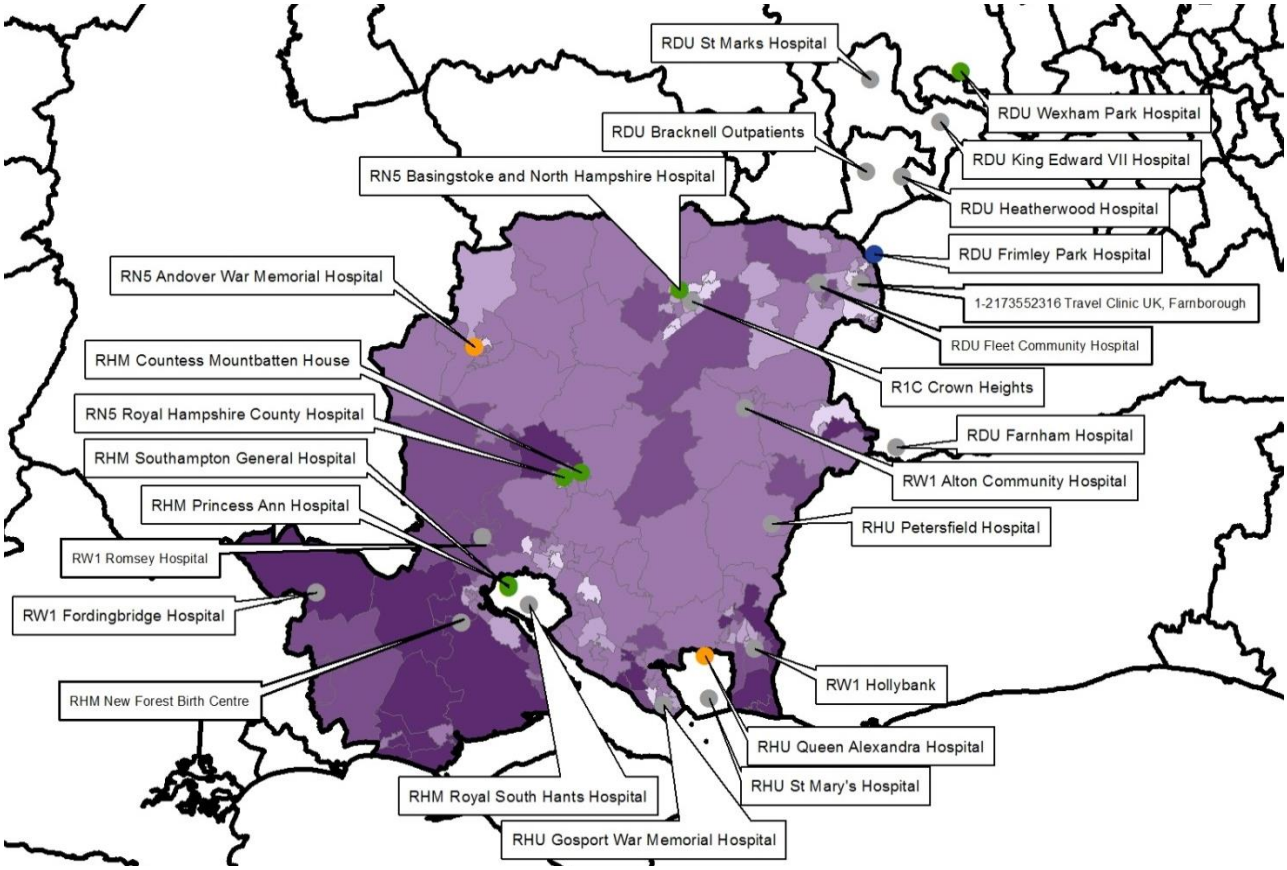
Hospital admissions (elective and non-elective) of people of all ages living in Hampshire were to:

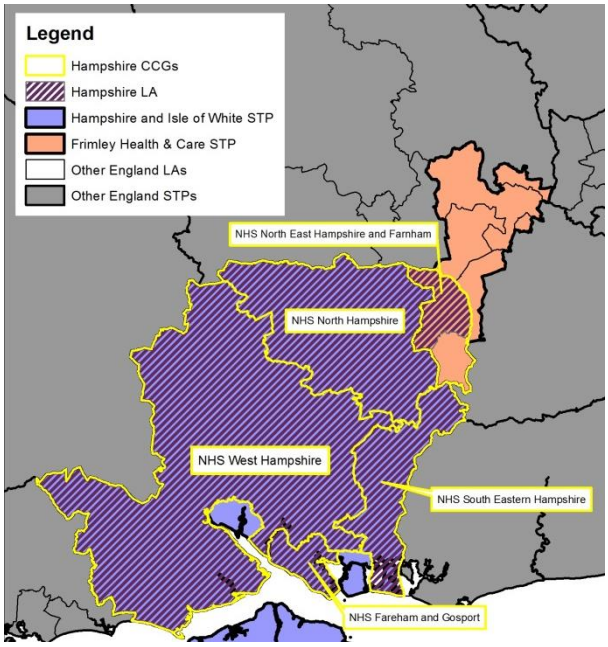
- Hampshire Hospitals NHS Foundation Trust
  - Received 32% of admissions of people living in Hampshire
  - Admissions from Hampshire made up 93% of the trust's total admission activity
  - Rated good overall
- Portsmouth Hospitals NHS Trust
  - Received 24% of admissions of people living in Hampshire
  - Admissions from Hampshire made up 61% of the trust's total admission activity
  - Rated requires improvement overall.
- University Hospital Southampton NHS Foundation Trust
  - Received 20% of admissions of people living in Hampshire
  - Admissions from Hampshire made up 47% of the trust's total admission activity
  - Rated good overall.
- Frimley Health NHS Foundation Trust
  - Received 13% of admissions of people living in Hampshire
  - Admissions from Hampshire made up 22% of the trust's total admission activity
  - Rated outstanding overall.

Community services were provided by:

- Southern Health NHS Foundation Trust, rated requires improvement overall
- Solent NHS Foundation Trust, rated as requires improvement overall

All ratings as at 08/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.





Map one (above): Population of Hampshire shaded by proportion aged 65+. Also, location and current rating of acute and community NHS healthcare organisations serving Hampshire.

Map two (left): Location of Hampshire LA across the Hampshire & IoW and Frimley Health & Care STPs. The five Hampshire CCGs are also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- There was a consistent shared purpose, vision and strategy for health and social care in Hampshire. The Health and Wellbeing Strategy included the vision of 'ageing well' and the system aimed to achieve this by integrating services for older people. This was interpreted in the Public Health strategy, Improved Better Care (iBCF) Plan, and in two sustainability and transformation plans (STPs).

- The leadership and delivery of services for older people were organised into four local delivery systems (north and mid Hampshire, Portsmouth and south east Hampshire, south west Hampshire, and Frimley), which were associated with the four main acute hospital trusts.

- Strategic planning and commissioning were informed by an analysis of local need. The Joint Strategic Needs Assessment (JSNA) was regularly updated and informed the Health and Wellbeing Strategy, iBCF plan and commissioning intentions. This resulted in clear action to address health inequalities in areas such as Gosport and Havant.

- At STP level a workforce planning team had been established but had not addressed the key system-wide problem of recruitment and retention of domiciliary and care home staff. This team at strategic level did not fully include all independent care providers or the VCSE sector, who would be significant to achieving transformation. Short term funded (iBCF) initiatives were being used to enhance core workforce activity with independent care providers to recruit and retain staff in care roles, for example the Partnerships in Care Training (PaCT) workforce development programme.

Is there a clear framework for interagency collaboration?

- There was scope to improve the framework for interagency collaboration, which was complex. There was no single multiagency plan either at strategic level or at local delivery level. The STPs and Integrated Better Care Plans listed a range of key actions which would make a difference at local level, however some system leaders told us they found these difficult to track.

- The interagency HWB Executive, which reported to the Health and Wellbeing Board, monitored the progress of four work programmes; Joint Commissioning development, Help to Live at Home, New Models of Care and Intermediate Care delivery. This ensured a cross-sector overview of this work.

- Partnerships were becoming more cohesive. Stakeholders told us that relationships were improving and were more collaborative than they had been previously. The joint working within the partnership of four of the CCGs in Hampshire made Better Care Fund (BCF) planning easier. Partner organisations were involved in interviewing for each other's senior leadership roles, demonstrating a level of shared responsibility.

- Use of information technology in Hampshire could be a strong enabler of integration. The Hampshire Health Record, a shared record of personal healthcare, had existed for ten years; and the Digital Strategy aimed to build on this.

- Pooling of financial resources was in the early stages, although governance mechanisms for this were developed in the vanguard areas[1].

How are interagency processes delivered?

- Implementation plans were not multiagency and were at differing levels of maturity; this meant that the experiences and outcomes for people using services varied.

- System leaders recognised that they needed to ensure consistency between plans and delivery models. Partnerships were becoming more cohesive and collaborative than they had been in the past. A county-wide Intermediate Care Board had been established to coordinate the delivery of intermediate care services in Hampshire.

- System leaders acknowledged that the plethora of delivery plans and accountability mechanisms made the system complex. Some told us that work was fragmented and there was a need to coordinate within STPs and standardise plans across geographical areas to become more outcome focused. It was sometimes difficult to demonstrate the impact of processes on the wellbeing of older people or on delayed transfers of care because of a lack of consistent measures.

What are the experiences of frontline staff?

- Staff from different health and social care organisations were delivering services together in some localities in Hampshire. For example, the jointly commissioned Bluebird domiciliary care service worked to prevent people being admitted to hospital.

[1] Vanguards are new care models which will act as blueprints for future NHS service delivery

- Staff felt a common purpose in delivering health and care services. Our relational audit showed that staff felt they treated each other fairly, that they could be open and honest and they valued each other's contribution to services. On the other hand, they felt that organisational and personnel changes slowed progress and that financial pressures had a detrimental effect on relationships. They also said that poor communication created misunderstanding and ill-formed decisions and that people did not like to take organisational risks. The free text responses to our relational audit showed that frontline staff were concerned about recruitment and retention. Also, there was a lack of understanding in some areas of each other's roles which led to unrealistic expectations of each other.

What are the experiences of people receiving services?

- People receiving services and their representatives and carers had opportunities to influence service development. Partners in the system had a variety of methods for consultation and co-production. This led to solutions which were tailored to meet the needs of local people, for example, GP community healthcare services in Gosport and Lymington.

- The health-related quality of life score for people with long-term conditions in Hampshire was 0.77 in 2016/17, according to the Adult Social Care Outcomes Framework (ASCOF). This was in line with comparator local authorities (0.76) and above the England average (0.74). People's experience of social care related quality of life in Hampshire was better than 13 of its 15 comparator areas in 2015/16.

- The percentage of people who felt supported to manage their long-term conditions was declining in Hampshire. In 2011/12, 70.4% of people felt supported but this reduced slightly to 65.8% in 2016/17. This was in line with the average for the comparator group but above the England average.

- The satisfaction with care and support services of people over 65 using adult social care in Hampshire in 2016/17 was in the middle of the comparator group and above the England average, according to the ASCOF Personal Social Services Adult Social Care Survey.

- Some people had experienced lengthy delays waiting for continuing healthcare (CHC) assessments to be completed; in 2016, this backlog had reached approximately 236 initial assessments, excluding people living with a learning disability. This meant that people were waiting a very long time for their assessments to be completed and for funding and care packages to be approved, including people who were at the end of their lives. This backlog of CHC assessments was being addressed at the time of our review.

- People told us they would like to see more signposting to services and more care planning before crisis events, such as falls or A&E visits, occurred. People also told us that care was not joined up enough and that they would like to see a single point of access for information about services. However, leaders informed the review team that there was a single point of access in place, referred to as 'Connect to Support'.

Are services in Hampshire well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

Hampshire is a county in the south of England. It is bordered by unitary authorities in Portsmouth and Southampton. The area is mostly rural in the north where the neighbouring counties are Surrey and West Berkshire. To the south, the New Forest and some coastal areas attract tourism and retirees. Other neighbouring authorities include Wiltshire, Dorset and West Sussex. Although the county is relatively healthy and wealthy, there are pockets of significant deprivation and disadvantage, in particular in the coastal areas of Havant and Gosport where there is a higher than average population of over 65s. The population of Hampshire is predominantly white.

The Hampshire Health and Wellbeing Board (HWB) had a clear and consistent vision which was interpreted by two STPs and locality level planning. These incorporated some good practice on integrated care in the community. The system was aiming for joint co-production and some effective engagement mechanisms helped design services within individual organisations.

However, at a local level, plans were at different stages of maturity and work at strategic level had been constrained by frequent leadership changes. HWB governance arrangements were not always supporting partners to drive integration and tended to endorse reports without providing direction or leadership. The system appeared multi-layered and complex to some leaders. There was scope to develop strategic working with other public services such as housing services, to ensure that future provision for older people meets local needs. Hampshire had not fully developed a collaborative mechanism to share learning across organisations and between integrated local care initiatives, which limited the transfer of good practice.

Strategy, vision and partnership working

- The partners had a well-developed shared understanding of the vision and strategy for health and social care for the over 65s. Hampshire Health and Wellbeing Board's strategy for 2013 to 2018 and vision of 'ageing well' was widely understood and was reflected in the Public Health strategy. The HWB had strengthened its partnerships through a series of workshops and was refreshing its strategy at the time of our review. The HWB Executive which reported to the HWB monitored the progress of four work programmes: Joint Commissioning development, Help to Live at Home, New Models of Care and Intermediate Care delivery.

- Strategic planning was informed by a good analysis of local need. The Hampshire Integration and Better Care Fund narrative plan was based on the Joint Strategic Needs Assessment (JSNA). This plan was the high-level vision for integration in 2020 for the CCGs and local authority. The plan focused on prevention, strength-based delivery, new models of integrated care, access to high quality A&E services and effective flow and discharge from hospital. Plans around prevention were reducing admissions to some hospitals in Hampshire when we visited, but plans for crisis and step down care were leading to varied impacts across the county.

- Local clinical commissioning groups (CCGs) were combining efforts to give the integration agenda more impetus. There were five CCGs in Hampshire. Four of these CCGs collaborated under the Hampshire CCG partnership. The CCG Boards sought to combine and the Hampshire and Isle of Wight (HIOW) STP articulated their joint objectives for two million people in Hampshire. As a result, system leaders were gaining a better understanding of their shared challenges.

- The Frimley Health and Care STP planned services for the remaining population in the north east of the county.

- Partners within the system shared the same vision for integration of health and social care services for older people. Two STPs interpreted the aims of the HWB and the iBCF plan. Work towards STP objectives was detailed within local improvement plans, owned by four local delivery systems (north and mid Hampshire, Portsmouth and south east Hampshire, south west Hampshire, and Frimley) and linked with the four main acute hospital trusts.

- The partners accepted the shared challenge around delayed transfers of care. Among its objectives, the HIOW STP listed, "deliver a radical upgrade in prevention", "early intervention and care", and "address the issues that delay local people being discharged

from hospital". The Frimley Health and Care STP planned to focus on similar priorities for 2016 to 2021. The local authority's draft Adults' Health and Care Five Year Strategy 2018 was linked to the HWB strategy and was aligned with these objectives around prevention, maintenance and delivering new models of care. This consistency of approach made it more likely that the partners would deliver the transformation to services.

- The Hampshire BCF plan focused on developing a sustainable out of hospital system model for local communities within each CCG area. The two national demonstrator vanguard sites in north east Hampshire and Farnham and across Portsmouth and Southern Hampshire were consistent with this, developing locally integrated models of care. These involved developing out of hospital services, 'Better Local Care' and 'Happy, Healthy, At Home'. These projects were still in development at the time of our review but were having a positive impact on the accessibility of GP services in Gosport and Lymington.

- In 2017, monies from the iBCF were allocated to the out of hospital care transformation programme which included the delivery of the high impact change model. Parts of the model had been implemented across Hampshire including discharge to assess and trusted assessor. Outcome measures had been identified as part of the Integration and Better Care Fund plan but it was not possible to analyse the success of these due to a lack of data available at the time of our review. During our visits to acute hospital and community based services, we found that implementation of the model was at different stages and staff had very different levels of understanding. Where the model was well understood and there had been some initial successes, for example discharge to assess in the Portsmouth and Gosport area, this had not been extended consistently across the county.

- Strategic working with other public services was not comprehensive. System partners had similar financial constraints and avoided difficult issues such as pooled budgets. The partners worked well on operational issues such as supported housing and had plans to significantly increase extra care housing stock in Hampshire. However, health strategies did not always maximise the benefit of working with other public-sector services to achieve larger scale improvement, for example, through influencing housing strategies for key workers or housing design.

- A&E delivery plans aligned with system objectives. Each local delivery system developed a winter resilience plan which it shared with other systems across Hampshire. The four A&E Delivery Boards provided governance around delivery for system resilience and delayed transfers of care (DTOC), with jointly owned DTOC improvement action plans.

Involvement of people who used services, families and carers in the development of strategy and services

- The Health and Wellbeing Co-Design, Co-production and Participation Sub-Group was launched in 2017 and had an overview of all consultation work and planned to lead on joint co-production in 2018. This laid the foundations for a shared and system-wide approach in future, although this had not been fully implemented at the time of our review.

- System leaders recognised the importance of carers. The Hampshire Joint Carers Strategy was in draft and due to be presented at the HWB in June 2018 with a planned launch soon after. It was the product of wide consultation beginning with a listening event in July 2016. Carers were actively involved in the governance and the editorial group established, so it was more likely to be tailored to their needs. Organisations within the system led various initiatives to involve local people and their relatives and carers in strategy and service design. CCGs consulted through engagement events throughout the community, focus groups, workshops, patient representative groups and groups who represented people who used services, such as advocacy and carers' groups. However, people we spoke to told us this was inconsistent and that North East Hampshire and Farnham CCG had a more advanced ethos of engagement than the others.

- Local people were involved in developing services. For example, through ambulance service led surveys, participation groups for people who use services in GP surgeries, forums and events in acute hospitals, and volunteer patient champions in north east Hampshire and Farnham. In Fareham the hospital Patients, Families and Carers Collaborative quality reviewed multidisciplinary teams. The Frailty Support Service and community phlebotomy service in the West New Forest was designed in conjunction with local people. This meant that people could influence health and social care decisions and service design.

- The CCGs consulted people about what they would like to see in place-based care. 'Your Big Health Conversation' launched by Portsmouth and South Eastern Hampshire CCGs in early February 2017 sought people's views on how services could and should change. The quantitative feedback based on 925 respondents showed that most people saw a benefit in a greater emphasis on community-based care. Most respondents thought that community care should be strengthened and access to GPs should be extended. The local partners had delivered some of the necessary changes and could demonstrate impact.

- Some stakeholders felt that system partners did not do enough to promote public understanding of the sustainability and transformation plans (STPs). One stakeholder group suggested that if the public did not understand these, they might assume the plans were

just about financial cuts. They told us nothing had been done to avoid this misunderstanding. There was an opportunity for the system to improve public understanding of the role and function of STPs and their plans.

- Engagement with VCSE organisations was inconsistent. Although some VCSE organisations felt very engaged in planning new services, other VCSE providers did not feel involved. There was a risk that only some of the VCSE sector was contributing effectively to the prevention and independence agendas.

Promoting a culture of inter-agency and multidisciplinary working

- Partnerships across the Hampshire system were becoming more cohesive. Joint working between the CCGs over the preceding year made BCF planning easier. Stakeholders told us that relationships were improving and were more collaborative than they had been previously. Partner organisations were involved in interviewing for each other's senior leadership roles.

- However, partnership working had been hindered by recent churn at system leader level and the need to re-establish working relationships each time there was a change of senior personnel. The majority of people who responded to our relational audit thought that organisational and personnel changes had slowed progress to integration.

- System leaders told us that the plethora of delivery plans and accountability mechanisms around them complicated the system. Some told us that work was fragmented and there was a need to coordinate within STPs, standardise across patches, streamline reporting and to become more outcome-focused. Plans did not always set clear targets. As a result, it was difficult to demonstrate impact on the wellbeing of older people or on delayed transfers of care.

- Implementation plans were understood across partners but were not combined at multiagency level or at the same stage of maturity. The response to the SOIR listed these plans as: Hampshire and Isle of Wight Health and Care System STP Delivery Plan, Frimley Health and Care System STP Delivery Plan, Hampshire Integration and Better Care Delivery Plan, Portsmouth and South East Hampshire Accountable Care System Improvement Plan/Local Delivery System Transformation Plan, Urgent and Emergency Care Plans and Hampshire Integrated Intermediate Care Plan/Model. System leaders recognised that they needed to ensure consistency between plans. Multiagency operating plans for local delivery were not in place and this meant that people's experiences and outcomes for example, access to GPs or the frailty pathway, varied locally.

- Integrated intermediate care was not fully developed across Hampshire. The system had established a county-wide Intermediate Care Board for this purpose. An Intermediate Care Integration programme had been set up to develop a single intermediate care service provided by Adults' Health and Care (AHC) at the local authority and Southern Health NHS Foundation Trust for the population of Hampshire. Users of this service would mainly be older people who needed short term intermediate care.

- The pace of change within the four local delivery systems varied, reflecting prevailing local factors. For example, the North East Hampshire and Farnham vanguard new models of care programme 'Happy, Healthy at Home' launched in 2015 led to benefits for the local community. The new care models were designed to deliver more care at home and in the community, reducing hospital admission rates and enabling people to be discharged from hospital reducing duplication and improving efficiency and value for money. Other examples included improved access to care via a GP lead clinical team using new technologies to manage people who needed same day appointments seven days a week; this freed up GP time to support people with more complex needs. Likewise, 'Better Local Care', the community provider initiative across the south of the county, demonstrated similar elements of new models of care delivery. However, these approaches were not as advanced in other parts of Hampshire. Arrangements for extending good practice were not clear. This led to some inequity in service delivery across Hampshire.

- Some initiatives for older people had transformed service delivery at local level. For example, partners had a frailty pathway to avoid unnecessary admission, had introduced a GP-led hub at Gosport to take primary care out to the community and provide same day GP appointments, and jointly commissioned the Bluebird domiciliary care service.

Learning and improvement across the system

- Groups, meetings and collaborative arrangements to promote learning were in their infancy. System leaders recognised that there was a need for transfer of learning and good practice on integration between organisations and across the county. At the time of our review, the Solent region had held workshops on collaborative working to encourage joint project ideas, with the idea of starting a shared learning hub. However, this was not fully implemented and was one of the "next steps" to follow from the workshops.

- Innovative joint funded approaches were beginning to support independence for older people. For example, the digital technology provider identified a need to support people living with dementia to stay at home. Their technology extended the ability to care for people living with dementia and kept people doing things they want to do. Early implementation was seen as very important so people would be able to understand how to

use equipment and was built into the dementia pathway; qualitative data demonstrated this had been successful. This initiative was used as part of a change programme to inform the workforce and change practice. The technology was funded from a combination of local authority and Better Care Fund monies.

- The lack of a systematic approach to learning meant that good practice around integration took longer to establish. However, learning had been shared at organisational level in order to extend some projects. For example, projects in nursing homes in Southampton to improve leadership, which had been rolled out across the adult social care system. The partners had responded positively to an assessment of the four local delivery plans produced by an independent expert. Recommendations included: a clearer narrative to engage the public and staff, more integration of health and social care resources at the locality level, collocation of integrated local teams which should include a range of health and social care professionals, pooled budgets and a single point of leadership. Partners were taking action to address these areas for improvement. For example, in Havant we saw a single point of access with primary care and social care professionals working together.

- Some organisations in the system did not treat mistakes as a source of learning for continuous improvement, in a culture of openness and candour. For example, learning from poor performance on safeguarding. We heard how there had been three serious case reviews and the points of learning had not been integrated into day-to-day working across the system.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

We found that governance was robust in some parts of the system but not others. Structures and delivery around integration were fragmented. Use of targets and clear outcomes measures was not systematic. Although the system had implemented some community-based transformation initiatives and prevention schemes, this did not appear to have led to a reduction in hospital admissions across the system, although this varied across the NHS trusts. Partners were unwilling to pool budgets because of risks to their finances.

However, the system had an established shared care record system and a strong base for developing shared information systems. There were effective information sharing arrangements for safeguarding. The Wessex Quality Surveillance Group (which included all public-sector partners in Hampshire and the Isle of Wight) met to share information about organisational and operational risks and poor quality.

Overarching governance arrangements

- Senior leaders and commissioners from the system monitored plans and their delivery through the HWB Executive Group. This reported to the HWB and oversaw progress against jointly agreed strategic objectives, integration and delivery plans at their monthly meeting. The HWB Executive Group also provided leadership to monitor the direct delivery and financial performance of iBCF schemes and operational detail of all section 75 (National Health Services Act 2006) agreements with specific work streams managed in local delivery systems. This ensured that system leaders were aware of progress and could take action on any difficulties.

- HWB governance arrangements were not always supporting partners to drive integration. The HWB was well attended and could hold organisations to account, but tended to endorse reports without providing direction or leadership. System leaders were unsure about what the HWB had achieved. They told us the HWB needed to align the multiple health and social care plans and systems across Hampshire. The HWB lacked a comprehensive work programme and did not actively influence the direction of services or monitor their impact. The role and responsibilities of the HWB in monitoring and supporting initiatives had not been defined. This limited the effectiveness of the HWB in achieving noticeable change.

- Below HWB level, governance arrangements were not integrated. System partners all had their own arrangements and some senior leaders wanted to see more coordination within STPs. STP leads told us that HWB chairs and deputy chairs from across the wider Hampshire footprint (including Hampshire, the Isle of Wight, Southampton, Portsmouth) had met twice so far to discuss common issues and align governance and practice, which meant that progress on internal and external coordination was in the early stages.

- Performance against agreed outcomes was reported at the four A&E delivery boards, which oversaw improvement work for A&E and DTOC. Each local delivery system had an A&E Delivery Board that monitored key performance indicators and projects based on: hospital to home; ambulances; urgent treatment centres; GP access; NHS 111; hospitals and mental health crisis. Monthly board meetings reviewed progress against the plan. The four A&E delivery boards monitored system resilience and DTOC, with jointly owned DTOC improvement action plans. They also monitored reports on high impact change model pilots such as discharge to assess. Because there were four separate boards, there was a risk that evaluation of individual initiatives was not always shared between them

- Local delivery systems monitored progress on their STP implementation plans. This included regular monitoring of progress against key objectives and national and local

targets. Key performance indicators were used to monitor progress on areas such as hospital admissions, delayed transfers of care, hospital bed days and GP referrals. Through close monitoring of systems, the partners were aware of each other's progress.

- Governance was starting to be effective in the accountable care systems. In North East Hampshire and Farnham, part of the Frimley Health Accountable Care System, which was among the first eight designated accountable care systems in England announced in June 2017, the Board began meeting in September 2016. This ensured local accountability of the vanguard project.

- The processes and governance around continuing healthcare (CHC) assessments across Hampshire had been ineffective. This had resulted in a backlog of 236 cases in 2016. West Hampshire CCG, which managed CHC on behalf of all Hampshire CCGs, aimed to clear the backlog by June 2018 by outsourcing the work. They were implementing a consistent approach to the CHC process and were aligning staff groups in relation to assessment, brokerage and procurement, so that performance would be better in the future.

Risk sharing across partners

- The system had a mechanism to share information about risks. The Wessex Quality Surveillance Group was a forum to share intelligence about risks to quality and included public sector health and social care partners. It provided information and early warning of risks and poor quality. New terms of reference had been agreed for the forum in January 2018, so it was too early to assess outcomes from the joint approach at the time of our review.

- The CCGs were looking at new ways of monitoring and sharing intelligence about risk. The CCGs and specialised commissioners in HIOW were developing new ways of working with providers which included how to share intelligence about risk including utilisation risk, production cost risk and volatility risk.

- Otherwise, risk management arrangements were mostly based at organisational level. Healthcare organisations and the local authority had their own monitoring arrangements and risks were escalated where appropriate. Risks were identified at an operational level. Older people who were vulnerable were identified by their GP through use of risk stratification tools and the collective knowledge of health and social care professionals.

- Ambitions around financial risk taking and integration across the whole system were limited. System leaders recognised they needed to understand the whole system transformation plan because of the impact on their financial plans. However, they were under financial

constraints at organisational level and saw this as an obstacle. They did not want to risk investing in integrated services unless they saved money elsewhere. They preferred to work on specific projects to achieve better outcomes for people. This meant that the impact for people was restricted to specific localities until initiatives were rolled out on a county-wide basis.

- There were pockets of integrated risk management at local level in the system. The partners of the Solent Acute Alliance were starting to establish financial risk management to enable greater collaboration between them. In Gosport, part of one of the vanguard areas, GP practices had a model of clinical collaboration that allowed them to work together on initiatives such as same day urgent appointments.

Information governance arrangements across the system

- System partners were overcoming barriers relating to information governance at system level. The Hampshire Health Record was a shared health and care record used to share key information between GPs, hospitals, ambulance services, care homes, out of hours services, NHS community services and local authority social care about people using services. This meant that the partners had a shared health and social care record system from which to further develop integrated information technology. However, this worked better in some areas than others.

- The Digital Strategy aimed to build on this by enabling real time passing or viewing of information between systems and the capability for clinicians to confer and coordinate their actions across organisation boundaries. It would also provide the basis for a HIOW Personal Health Record to enable people to access their full medical record and services like appointment booking and care collaboration.

- Information sharing arrangements were in place in key areas; for example, enabling effective multiagency information sharing about safeguarding. There were also pilot schemes such as sharing medical records between primary care and community health services, which enabled community teams to have the same picture of a person's care as their GP.

- There continued to be barriers relating to information governance at an operational level. Lack of access across health and social care to assessments and care records led to lost time and increased reliance on photocopying and sending records before transfers of care could be arranged.

- Partner organisations did not always share information to facilitate care or to promote the

best interests of people using services. For example, ambulance staff felt that providers did not want to share information following a safety incident. This was due to a mistaken belief that information governance arrangements prevented sharing. However, this could easily be overcome by anonymising the personal details on the record.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including its strategic direction and efficient use of the workforce resource.

We found that the system lacked a comprehensive strategic approach to workforce planning, for example, at HWB level. The HIOW STP Workforce Planning Team had completed the first phase of a project to map the future workforce needed in each local delivery system. Membership of this group included all the relevant public-sector bodies.

However, planning at strategic level did not include independent care providers or VCSE organisations who would be significant partners in achieving transformation. There was no system-wide recruitment of care staff, common approach to pay or strategies around staff development or retention.

There were some initiatives in place to train care home staff and to develop skills for new roles to meet the prevention agenda and short term funded programmes such as through the iBCF.

System level workforce planning

- System-wide workforce planning was not inclusive of key partners at strategic level. The HIOW STP delivery plan had an Executive Delivery Group which oversaw a Local Workforce Action Board (LWAB). Working groups for Human Resources, Education and Development and Workforce Transformation reported to the LWAB. Representatives from primary care, mental health, prevention and out-of-hospital services had been seconded into the Workforce Transformation Group. Although the groups had made progress, the sub group leading on workforce transformation did not include the independent care providers or VCSE sector. This limited the influence these organisations could have on key issues affecting them, such as the availability of care workers.

- The public sector system partners were planning skills development for integrated health and social care. The STP Workforce Transformation Team was working with Health Education Wessex to review existing training placements, future trainees and new roles such as nursing associates and physician associates. For the domiciliary and residential

care providers who struggled to recruit and competed directly with each other for staff, social care and NHS partners launched 'Change Lives – Start with Yours'; a BCF funded scheme which aimed to raise awareness of opportunities and the value of working in adult social care and support for people of all ages considering career options. LWAB representatives were assessing the health and social care workforce needs of each local delivery system and establishing priorities. After this they planned a joint rehabilitation and reablement service, promotion and expansion of apprenticeships and were considering introducing a Homeshare programme. These plans were expected to be implemented from May 2018, with completion by October 2018 at the earliest.

- There was a plan to promote a shared culture. System partners planned to implement a job rotation scheme and organisational development measures such as portability of mandatory training and pre-employment checks for nurses and social care staff. These measures were likely to promote job mobility across sectors.

- The partners had no system-wide long-term approach in place for recruitment, or resolving the important issue of a shortage of care staff. They told us their campaign priorities were to address the shortage of domiciliary care staff, registered managers and to improve nursing capacity in social care settings. The workforce forum partners had not addressed difficult issues such as joint appointments although there was a focus on improving domiciliary care staff capacity. Their plans did not include how best to support the unpaid workforce of carers and volunteers or how to make best use of technology. This limited progress on increasing the staffing for domiciliary care, which restricted choices for older people for care at home or when they were transferred out of hospital.

- The system lacked any clear pay and reward strategies. Independent providers told us the local authority could pay their own care staff more and so they attracted staff away from the independent sector. The partners had not tackled pay harmonisation across public sector providers or included independent providers. Human resources professionals told us that they had tried to do this three years previously and it turned out to be too difficult to gain consensus; so, the issue had remained.

- Workforce retention was a significant unresolved challenge in Hampshire. Hospitals and social care services had higher turnover than the England average for most job types. The workforce programme included plans to address workforce supply and retention, but they were in the early stages. Commissioners had agreed to align specifications to promote a values-based approach in recruitment, aiming to retain staff more, but this was not effective at the time of our review.

- Independent providers were invited to some working groups. For example, to a sub-group related to Skills for Care and the HR Directors' Forum. The workforce forum told us that these groups were still defining outcomes, team definitions and looking at retention. They told us there was an action plan but financial resources to support the actions had not been defined.

Developing a skilled and sustainable workforce

- The apparent lack of creative thinking around provision of skilled domiciliary care staff sometimes had the effect of delaying transfers of care out of hospital for older people. According to NHS mid-year 2017 figures, people in Hampshire were delayed in transferring out of hospital for 9.7 days owing to a lack of care packages compared to 3.8 days in comparable areas. Providers told us it was difficult to recruit staff and that there were delays while packages of care were organised. The system needed to address zero hours contracts and transport provision for care workers. There was full employment in Hampshire and London weighting in neighbouring counties which meant that care staff had considerable mobility of employment.

- Short term funding was used effectively to develop a more sustainable workforce. The iBCF was being used to provide dedicated resources through the established Partnerships in Care Training (PaCT) workforce programme to work with the independent care sector on three key workforce priority areas:
    - Values-based recruitment to attract and retain the right people; this was important because staff turnover in adult social care providers was higher than the national average.
    - Development of management and leadership capability and resilience including development of new skills linked to CQC standards; for example, innovation and entrepreneurial thinking.
    - Supporting new ways of working, for example; strength based working and exploiting digital opportunities such as the technology enabled care.

- Partners within the system were working to improve care and nursing skills. Joint working with Health Education England Wessex Local Team saw £1.7 million invested in workforce development activities to support the initiatives in Hampshire. The local authority's PaCT programme was a collaborative approach to support providers of adult social care in Hampshire to meet their workforce development and training requirements. The key focus was to promote leadership and develop sustainable approaches to build workforce capacity and capability. PaCT was a primary communication and engagement channel between system partners and the VCSE and independent sectors.

- The system was developing new roles and skills to better meet older people's needs. For example, the hydration programme which was designed to increase workforce skills in managing hydration in settings outside of hospital, new roles in west Hampshire including Care Navigators and Frailty Practitioners and implementation of the National Early Warning Score tools in social care. LAWB representatives told us about Skills for Frailty which was leading to quality improvement and social prescribing initiatives; however, the representatives felt these happened in isolated pockets and the knowledge had not been shared across the county.

- There was potential for system partners to extend their capacity by involving the VCSE sector more. Voluntary sector organisations told us that with more involvement and funding they could increase the level of support they offered older people and their carers.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners were providing a diverse and sustainable market in commissioning of health and social care services.

The joining of four of the five CCGs was seen as a positive step to integrated working; however, the impact on providing a whole system approach for the needs of the people of Hampshire had not been demonstrated at the time of our review.

It was not clear if there was a systemic approach to joint commissioning and associated governance. There were pockets of integrated working, for example the community reablement service.

There was work to be done on developing relationships and improving communication between commissioners, the voluntary sector and providers.

Strategic approach to commissioning

- Commissioning across Hampshire was not fully integrated or comprehensive. System partners were taking steps to improve their commissioning capacity. From 31 March 2017, four of the five Hampshire CCGs formed a partnership and shared an Accountable Officer. The HWB told us that this facilitated leverage at scale with the local authority and providers, balanced with the need to retain a local outlook on commissioning decisions.

- A new five-year commissioning strategy and market position statement (MPS) developed by Adults' Health and Care (with input from NHS partners and providers) set the strategic direction for service commissioning. Flexibility in new AHC commissioning plans and frameworks would allow for joint commissioning approaches with partners.

- The local authority was working towards joint commissioning across the system with a focus on supporting independence and prevention. For example, AHC's community reablement service; a multidisciplinary team who worked with people to return them to, or maintain, their optimal independence following ill health or a diagnosis of a long-term condition.

- It was not clear if there was a systemic approach to joint commissioning and associated governance to ensure best use of joint resources. There were pockets of integrated working but they were not working at scale. However, there were some examples of joint commissioning for older people such as the joint hospital prevention service commissioned by South Eastern Hampshire CCG and the local authority. There was also intent to commission bed-based reablement jointly with the NHS through the recommissioning of some of the local authority's care home facilities and the creation of specialist dementia hubs by re-shaping some residential beds.

Market shaping

- The market position statement (MPS) clearly set out the supply and demand issues and the business challenges and opportunities for health and social care across the system. The focus on promoting independence was articulated. The MPS was informed by the JSNA which had robust population analysis. The MPS used the JSNA to identify geographic and individual health conditions hot spots.

- Leaders and staff working across the system told us that the focus of the system was on prevention and "home first" for older people. This focus was supported by the involvement of the VCSE sector, enablement and re-enablement services. However, they acknowledged that sometimes the disparate and locally varied nature of the voluntary sector made it difficult for commissioners to deal with the sector as a coherent whole.

- Hampshire had a high number of nursing home beds. Although Hampshire had a lower number of residential care home beds per elderly population compared to England and comparator figures, this was more than compensated by the higher number of nursing home beds. Between April 2015 and April 2017, there had been small increases in the number of both types of beds in Hampshire and a noticeable 5% reduction in the number of domiciliary care agencies.

- Contracting arrangements for domiciliary care providers did not always work effectively. The County Council's Adults' Health and Care service (AHC) had revised domiciliary care contracting arrangements and reduced the number of providers, in order to guarantee them more work. This was done using AHC's Care at Home framework. However, the local authority recognised these arrangements were not working as intended, and planned to implement a revised approach from July 2018. The new approach aimed to improve capacity through a greater focus on promoting independence. It also aimed to improve terms and conditions for care workers to assist with recruitment and retention and reach into rural areas. This contract would provide support to the developing extra care housing services. It aimed to bring all the NHS commissioned domiciliary care services under one approach.

- There appeared to be a greater emphasis on bed-based solutions as a step-down approach. The system recognised this and planned to implement the Help to Live at Home framework from July 2018. System leaders told us this framework allowed more providers to contract with AHC and CCGs with consistent and more appropriate pricing, while they would continue to appoint lead providers within geographical zones across the county.

- The key commissioning focus on prevention and promoting optimal independence for the people of Hampshire was evident. The local authority had commissioned online resources, 'Connect to Support', to help adults identify a wide range of support to maintain independence. This was being rolled out widely across the county, including into GP practices with a target to increase the hits on the site from 5,000 to 10,000 within the 12 months following our review.

- Extra care housing was being developed to enable high levels of need to be supported in the community with care support on site. There had been a £70m investment to increase the number of units from 800 to 1,500 over a five-year period; details of how this would be achieved were planned for development during 2018.

Commissioning the right support services to improve the interface between health and social care

- Commissioning plans from the CCG and local authority in Hampshire were person-centred and focused on prevention. While people living in Hampshire could benefit from this person-centred approach, at the time of our review, work was still needed to bring this together into a coherent system-wide commissioning strategy.

- People living in Hampshire had relatively good access to GPs outside of normal working hours although this could be improved. Data from March 2017 on provision of extended

access to GPs outside of core contractual hours showed that 6% of the 131 GP practices in Hampshire surveyed offered full provision of extended access over weekends and on weekday mornings or evenings compared to the England average of 23% and the average across Hampshire's comparators of 17%. However, 84% of practices offered partial provision which was significantly higher than the England average (61%) and comparator sites (63%).

- A growing number of people were empowered to take control of their own care. There had been an increase in the use of direct payments in Hampshire since 2014/15, and in 2016/17 20% of people aged 65+ using services were receiving direct payments. This was marginally less than the 20.2% in comparator areas, but more than the 17.6% across England.

- Some system partners felt that communication and relationships between service providers, their representatives and commissioners could be improved. Domiciliary care providers expressed concerns about the commissioning contract and the inequities inherent within it. Twelve providers had been awarded the latest Care at Home contracts. However there remained a number of domiciliary care providers who were contracted under older arrangements and a number that were spot providers for Hampshire. This meant that the 12 providers under the Care at Home contract had to abide by certain contractual requirements, such as staff pay. However, the other providers could pay their staff whatever they chose, which meant that they were more likely to have the staff they needed to offer packages of care that were required. This led to some difficulties in relationships with the brokerage team.

- VCSE organisations stated that there was a disconnect between the local authority's intention around strength-based approaches and capacity building and the actual services that Age Concern supplied that met those requirements. Age Concern felt their outreach services needed more financial support and that their services and those of the VCSE sector more generally were underutilised.

- System partners agreed that The Firs unit, a bed-based functional reablement service aiming to deliver a multi-professional response to transfer of care, could be commissioned more effectively to support a wider cohort of people coming out of hospital, or prevent people going in.

Contract oversight

- Commissioners across the system told us that there were strong governance arrangements around contract and quality monitoring. However, this was still within individual

organisations rather than as part of integrated governance arrangements. In AHC, these assurances included a review of how personalised and appropriate the service was for the person, to ensure that care was person-centred.

- Hampshire health and social care partners worked together to ensure the delivery of high quality care and support. We reviewed evidence that the local authority and CCG quality leads met regularly to discuss providers and share intelligence. There were also joint quality visits undertaken with AHC and CCG colleagues.

- Adult social care providers told us that the local authority and social care quality team closely monitored poorly performing care homes and were proactive in their approach. However, there was still work to do to support care homes to improve.

- However, overall ratings of adult social care services within Hampshire were in line with national and comparator breakdowns. For example, 66% of residential homes were rated good compared to 65% in comparator areas and 62% across England.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how the system assures itself that resources are being used to achieve sustainable high-quality care and promote people's independence.

We found the system did not consistently carry out cost benefit or options appraisal work before schemes or evaluate them after completion. There was a risk that partners would not have clarity about what outcomes would be delivered for their investment.

However, partners were focused on using resources effectively within their individual organisations. Collaborative working and mechanisms for pooling resources were being developed in the vanguard areas.

- System partners could demonstrate some effective use of cost and quality information to prioritise areas for improvement, but this was not applied systematically. For example, an aligned incentive contract was in place in this system aiming for cost benefit. The frailty model also applied an investment model before taking action, but this was not a widespread approach. Lack of cost and benefit information could deter the partners from allocating finance to a scheme.

- Not all schemes were evaluated for their impact on people's health and social care or their

scalability. For example, in west Hampshire there was a diabetes challenge which made services available as a one stop shop in the evening. This resulted in ten people joining the gym as a behavioural change. However, it was unclear to leaders how to extend the scheme across the county so that people living across Hampshire had equal access to the benefits.

- The system was not using benchmarking to test whether it was transforming services in the most cost-effective way. Although there had been some work at organisational level to identify good practice, there had been no system-wide cost or performance benchmarking or search for good practice elsewhere. This was a missed opportunity to learn from other systems.

- System partners reported some information on unit costs as part of their iBCF return. However, information about costs and outcomes was reported at different places and levels in the system. This was time consuming for system leaders to manage. Processes could be streamlined to give more impetus to transformation.

- Collaborative working and joint use of resources were being established in the vanguard areas. All partners agreed to move towards collective contractual accountability for achieving population health outcomes within a fixed budget and measured against a single performance framework. Portsmouth Hospitals NHS Trust and the local CCGs had agreed to replace payments by results with an 'Aligned Incentive Contract' from the beginning of 2017/18. This would be one of the foundations for a single multiagency operating plan from 2018/19, which would lead to integrated services focused on local people.

- Partners had achieved efficiencies within their own organisations. For example, Adults' Health and Care (AHC) had in 2016/17 been able to continue to meet the needs of the residents at the same cost level as 2011/12, while absorbing a higher level of demand and price increases. However, although a jointly funded Integrated Discharge Director post at Portsmouth Hospitals NHS Trust was being advertised, pooling resources and joint risk taking was in the very early stages.

- Progress on the Better Care Plan was reported and monitored. There were shared performance metrics and quarterly reporting. The partners planned to use independent evaluation in future to monitor and inform their developments, for example through the Wessex Academic Health Science Network. This would provide an independent assessment of outcomes and value for money.

- Short term funding was monitored at strategic level. The HWB Executive Group reviewed

the direct delivery of iBCF schemes and operational detail of all section 75 (National Health Services Act 2006) agreements with specific work streams managed in local delivery systems. This ensured joint reporting of transformation initiatives.

- Partners understood where resource gaps were across the health and social care interface. For example, the local authority had increased direct provision though county-wide reablement services. It directly funded provision in hospitals to support transfers to the community. The health and social care partners had set up a Public Services Summit to develop common approaches to financial pressures, which helped mutual understanding.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Hampshire safe?

There was system-wide commitment in Hampshire to keeping people safe in their usual place of residence. A number of initiatives had been introduced to promote this, including the development of frailty pathways, an intensive care home team where nurses identified those care homes that were struggling and worked directly with them, and GPs used a risk stratification tool to identify people at risk of hospital admission. All these initiatives were viewed positively by staff and people who used services.

Safeguarding processes were well embedded across the system and we saw good examples of multidisciplinary team (MDT) working to keep people safe. The digital technology enabled care service (DTECS) used in Hampshire was award winning, part of its function was to help people who had gone missing. The system enabled people to be found more quickly by tracking their movements. Since its introduction repeat missing events had been reduced by 66%.

- Hampshire had effective systems to signpost people to appropriate support when needed. 'Connect to support' was the Hampshire-wide information point to signpost people to services. This website, initiated by the local authority, was designed to be used by the public, health and social care professionals and VCSE partners. There were hundreds of links and telephone numbers for people to use to access services to help keep them safe such as falls prevention and the silver line; this was a telephone line specifically to tackle loneliness in older people.

- One of the initiatives that had been introduced to promote keeping people safe in their own homes included the development of the frailty pathways across Hampshire.

- Frailty focus had been introduced in north and mid Hampshire to enable people to age well, an MDT approach to keeping well and plan for the future was key to the strategy.

- In west Hampshire, a frailty support service had been commissioned with the aim of avoiding unnecessary hospital admission. This was following a pilot where in a 12-month period; more than 300 frail elderly people were treated in their own home with only 75 of those requiring hospital admission. The frailty team would work as part of a team to prevent admission and readmission to hospital. People could be referred by GPs, community staff and the 'Connect to Support' service in Hampshire.

- There was an opportunity for both these frailty services, which were relatively new, to share learning and approaches to ensure pathways were well aligned and access was straightforward to hospital and community staff as we were told this could sometimes be confusing and led to duplication

- An intensive care home team had been developed in the Portsmouth and Gosport areas; nurses worked directly with care homes they had identified as struggling and where systems were not working well. The team then focused on nutrition, hydration and falls in homes and would arrange further training for staff to ensure homes improved standards.

- Hampshire had a lower rate of A&E attendances from care homes. In quarter four of 2016/17, Hampshire had a rate of 647 per 100,000 population aged 65+ which was less than in comparator areas (900) and England (947). This was a longer-term trend – Hampshire's rate had been consistently lower since at least 2014. Similarly, emergency admissions from care homes were lower; 561 in the same time period compared to 675 and 713 in comparator areas and England.

- Safeguarding processes were well established in Hampshire. The local authority provided training across the system including for the independent and voluntary sectors. Safeguarding referrals were taken from the Contact, Assessment and Resolution Team (CART), which was a front door service. Two social workers had been allocated to work with the ambulance trust with the aim of reducing inappropriate safeguarding referrals by offering advice and supporting referrals.

- GP practices were using the frailty index and maintained a register of people with complex needs that was shared with colleagues across health and social care using a MDT approach to monitoring and hospital avoidance.

- A&E attendances had been consistently lower in Hampshire than comparator areas and particularly the rest of England. In the fourth quarter of 2016/17, Hampshire had 8,498 attendances per 100,000 aged 65 compared to 9,595 and 10,534 in comparator areas and England respectively. A low proportion of GP referrals were discharged without follow-up suggesting that there were lower numbers of inappropriate GP referrals.

- Hampshire had a lower rate of emergency admissions than comparator areas and England. In the period that the Department of Health analysed (September 2016 to August 2017), Hampshire's rate was 21,192 which was lower than the 22,906 and 25,009 in comparator areas and England respectively.

- The digital technology enabled care service (DTECS) operated across Hampshire and had won a number of national awards for its service. This had been commissioned by the local authority. Care workers could refer people via the Contact, Assessment and Resolution Team (CART). DTECS also worked with Hampshire Constabulary and took referrals for older people who had gone missing. DTECS could then provide a method for tracking people to help them keep safe and find them quickly if they required. Since the service had been introduced repeat missing events had reduced by 66%.

Are services in Hampshire effective?

There were a number of services in Hampshire to prevent hospital admission and maintain people in their own homes, which worked well. Some of these were not Hampshire-wide and work needed to be done to fully evaluate these and determine which would be most effective. The process to order specialist equipment, particularly specialist beds, needed to be simplified and streamlined.

- There were two out-of-hours providers in Hampshire, including North Hampshire Urgent Care (NHUC) and Partnering Health Limited (PHL). Both were valued by the system and had a focus on people's safety. Doctors used a "patient deterioration application" on their phone which helped decide whether to keep a person at home or to convey them to hospital. Early work with urgent treatment centres was seen as helpful, particular during the crisis flu, where support had been provided to GPs and had been linked to GP extended access.

- The rate of people being admitted to care homes had been consistently below the England rate. In 2016/17, 556 per 100,000 65+ population were admitted in Hampshire compared to 611 across England. This was slightly higher than the rate across comparator areas of 537.

- Frailty services were being developed across the Hampshire system with a strong focus on prevention and better support for this group of people. Since April 2016, a multidisciplinary Frailty and Interface Team had been sited at Queen Alexandra Hospital, Portsmouth. The service ensured admission avoidance for an average six older people daily and managed a further six supported discharges from the Acute Medical Unit. As well as admission avoidance, the service contributed to reducing length of stay with estimated avoided cost of £1.7 million.

- Across Hampshire people who thought they might need help and support were able to contact the CART team and an initial assessment would be carried out. Call handlers were able to carry out a wellbeing check and could authorise some things such as minor adaptations and refer on for assessment as required. We saw from records that, when people were assessed, they were assessed holistically.

- As part of the Hampshire falls prevention strategy and Better Balance for Life initiative, 'Steady and Strong' classes are delivered around the county. We attended a 'Steady and Strong' falls prevention class and observed the activities. People were visibly enjoying the class and the trainer worked carefully to adapt the exercises to individuals' capabilities. As well as physical strengthening, the class provided an opportunity for socialisation as people attended with friends, or made friends within the class.

- People attending the 'Steady and Strong' classes were asked to carry out a self-assessment of their confidence and risk of falling when they began attending the class and then periodically after they had been attending for a while. This data was submitted to the local authority, who coordinated the classes across the county, to measure the effectiveness of the sessions and adapt the content where needed. Self-assessments showed increased confidence levels of people who had attended a number of sessions.

- We saw examples of good working in A&E within reach into other clinical areas. Older person practitioners and the emergency community team were employed and working in the community to support placements in care homes. IT supported this as practitioners had access into other systems.

- A pilot to share notes with between Southern Health NHS Foundation Trust community

teams and primary care teams had been viewed beneficial by staff. This was not county wide at the time of our review but work was being done to spread this across Hampshire.

- Staff told us there was a complex system for ordering equipment, which caused them difficulties in the community and which could lead to delays. This was particularly when ordering specialised beds to maintain people at home. The process involved a number of steps and could lead to delays for people who were on an end of life pathway. Work needed to be done to streamline the service to prevent extended waits for equipment.

Are services in Hampshire caring?

People in Hampshire valued the services available to support them to stay at home. Generally, there was a view that there were a range of support services available, but people were not always aware of them.

- Older people told us that there were a lot of services and support available for older people in Hampshire but these worked separately across the different localities in Hampshire and it was difficult to access information about what was available in your specific area. The 'Connect to Support' service provided a website with a directory of services for example, community activity clubs, nursing homes etc. Information about services in a particular area could be accessed using the person's postcode. Also, the Citizens Advice Bureau were working with Healthwatch to influence general information and advice services across Hampshire but this had not been fully developed at the time of the review.

- Some people we spoke with during the review were aware of services for carers, including carers' support workers and services commissioned from the Princess Royal Trust (PRTC) for carers in north Hampshire, who provided carers' hubs. People raised the point that this assessment service provided by PRTC was commissioned by north Hampshire and was giving good outcomes but this support was not available Hampshire wide.

- The county-wide services available in Hampshire to support older people included the fire service who provided what we were told was "great" support, carrying out safety checks and visits to people's own homes. National Trading Standards were offering a call monitoring service for older people who may be vulnerable to scams. The social prescribing service initiative though delivered by different organisations was county-wide using a recognised model. The model used was evidenced to deliver preventative results for health and social care.

- Not all older people told us they were as involved in discussions and decisions about their care, support and treatment as they wanted to be, this was particularly noticeable with

people who were funding their own care as they told us assessments were difficult to access. However, the records we reviewed during the review showed assessments were timely and holistic covering people's social and health needs. People using services, families and carers were involved in decisions about them.

- In Hampshire, the proportion of people feeling supported to manage their long-term condition has been consistently above the England average. In 2016/17, it was 65.85% compared to 64.0% across England. This percentage had been falling over the past few years as it had across England generally.

Are services in Hampshire responsive?

Some responsive services are provided in Hampshire that supported people to maintain their independence and remain in their own home. These services were not consistent and meant some people's experience were not as positive as others.

- People were usually able to access same day urgent appointments with their GPs in Hampshire. Services operated differently across surgeries. Some offered "sit and wait" clinics; people told us that they could wait for a very long time to be seen at these clinics. The time taken to be seen was not as long in "sit and wait" clinics in located in hub locations, but these were not easy to access via public transport. The wait for routine GP appointments in some areas on Hampshire could be up to 6 to 8 weeks, and not all GP services offered a home visiting service, again impacting on people and or carers without transport. People were recognised as a carer by some GP surgeries, which meant they were flagged as a "priority alert" to ensure they had access to timely appointments.

- The provision of extended access to GPs was broadly similar to the national average and although only 6% of GPs offered full provision, only 8% offered no provision out of hours meaning most people did have some extended access from a GP from their own practice.

- While the percentage of A&E attendances that were referred by a GP were similar to England figures, a low proportion of those GP referrals were discharged without follow-up. This suggested that there were lower numbers of inappropriate GP referrals.

- There were care navigators in post across Hampshire to support people to access services and support, some of these based in GP surgeries. Care navigators told us they were not getting the number of referrals from GPs they would expect and they could be offering more to people. Not all GPs in Hampshire offered enhanced care into care homes which would involve regular 'surgeries' taking place in the care home.

- The Citizens Advice Bureau had a number of walk in centres across Hampshire where a Healthwatch lead was based to provide information and support for people. In parts of Hampshire (Solent) there were urgent response teams which included nurses, therapists and social workers. An urgent response domiciliary care agency service was also available that would support people to stay in their own home for short periods however these services were not county-wide, meaning the service was inequitable across Hampshire.

- Work had been carried out at the local authority, which identified that 40% of people caring for someone in Hampshire were doing so because the person was living with dementia. Technology enabled mechanisms, such as door alarms and pressure pads, were being provided county-wide to people to enable them to stay home. Early intervention was seen as key so people still had the cognition to use any necessary equipment.

- There had been an increase in direct payments in Hampshire since 2014/15 and in 2016/17, 20.0% of people aged 65+ using services were receiving direct payments. This was marginally less than the 20.2% in comparator areas but more than the 17.6% across England.

- The availability of community nursing services in Hampshire was different across the county. The majority of services operated until 22:00 or 23.000; in the Fareham area services were available until 04:00. The 04:00 service had been established recently and was particularly valued by people who were receiving end of life care and their carers. The service also provided support to GP and out-of-hours services.

- Community hubs had been set up across Hampshire to provide information to people and support them to stay independent and well. Not all people who attended the focus groups during the review were aware of these hubs and what support could be offered. There was an opportunity to improve communication with the public about hubs and what they could offer to ensure they were fully utilised.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Hampshire safe?

The numbers of people attending A&E departments and then being admitted to hospital across Hampshire was lower than nationally and in comparator areas. This indicated overall GP referrals and services to keep people in their own home were working well.

People's experience differed once transported to A&E; people taken to Portsmouth Hospitals NHSFT could wait significantly longer to be seen and treated than those taken to Frimley Health NHSFT. None of the A&E departments had suitable areas to manage the care of people living with dementia.

- The NHS constitution sets out that a minimum of 95% of people attending accident and emergency departments must be seen, treated and then admitted or discharged in under four hours. This is one of the core standards and often referred to as the four-hour target. Data showed that none of the four NHS trusts that served the people of Hampshire met the 95% expectation in 2016/17. However, this ranged from 91.6% at Frimley Health NHS Foundation Trust – which was above the England average of 89.1% – to 77.8% at Portsmouth Hospitals NHS Trust. For Hampshire, this meant that people were not always assessed in a timely way on admission by the front door assessment teams, who would identify any interventions or referrals that could be implemented to facilitate discharge or treatment by a more suitable provider of ongoing care. The percentage of admissions that lasted longer than seven days had been consistently, though only slightly, higher than the national average. However, 10% of people admitted were staying for 25 days or longer. This was worse than all of Hampshire's comparator areas. There was a perception of a risk averse culture reported by various staff groups. We were told that ambulance and A&E staff could be overly cautious in their decision making and this contributed to hospital admissions and lengths of stay. This perception was supported by the findings of our relational audit, for which we received 379 responses across the system, where one of the lowest scores was on the statement: "people take organisational risks where it had the potential to serve wider system goals without fear of criticism or failure".

- Bed occupancy varied across the four main acute trusts in Hampshire. During 2016/17 Hampshire Hospitals NHS Foundation Trust consistently had the lowest bed occupancy varying between 81 and 84%. The other three trusts serving Hampshire were all consistently at 90% or above bed occupancy, against the national recommended level of

less than 85% bed occupancy. Hospitals with occupancy levels higher than the recommended rate of 85% risk facing regular bed shortages and people not being admitted to wards that will specifically be relevant for treatment of their condition (for example, someone suffering from medical condition being cared for on a surgical ward) and potential increased numbers of hospital acquired infections.

- There was a perception among care home providers and hospital staff that safeguarding concerns were being raised inappropriately by ambulance staff. In response to these concerns two social workers had been allocated to work with the ambulance trust with the aim of reducing inappropriate safeguarding referrals by offering advice and supporting referrals

- South Central Ambulance Service NHS Foundation Trust confirmed that people's experience was different in Hampshire depending on the hospital location where they were taken to receive treatment. Overall, they reported having good relationships with all hospitals, trusts and staff groups although some hospitals were more effective partners. The Queen Alexandra hospital in Portsmouth was seen as having the most issues, these included difficulty for ambulance crews to handover patients to A&E staff.

- At Basingstoke Hospital within A&E there was no specific dementia friendly space identified which combined a visible and calm area for people living with dementia. Staff on the unit thought the area was not dementia friendly and caused people living with dementia and their families unnecessary anxiety while in the department. A band six nurse had been appointed who would work as a specific dementia coordinator for people who came to the department, helping by signposting to services and supporting staff.

Are services in Hampshire effective?

Assessments were holistic and contained MDT input but were not always timely. There were opportunities to improve communication, MDT working and the understanding of different roles between health and social care staff including independent providers in Hampshire. This would improve people's experience during a hospital stay, for example A&E staff spoken to at Basingstoke hospital were unaware of the frailty service located in the same hospital.

Several initiatives such as discharge to assess, frailty services and the SAFER bundle were being introduced in hospitals across Hampshire. These were at different stages of embedding in different hospitals and it was not always possible to measure success because of the relatively short time these had been operating.

- Communication between independent care providers (domiciliary care agencies and care homes) and hospital staff often broke down. Independent care providers felt they were not

fully involved in discussions about the ongoing care of people. Domiciliary care and day care providers told us they were often not told that people they delivered a service to had been admitted to hospital and were informed by families rather than hospital colleagues.

- Communication within hospitals needed to be improved. Staff in the A&E department at Basingstoke Hospital talked to us about the difficult of managing elderly frail people in the department but were not aware of frailty team based in the hospital.

- The red bag system had been introduced in parts of Hampshire; this was where transfer information, medication and basic information about a person would be transferred with the person, from their usual place of residence to hospital to ensure continuity of care. Staff and services who had used the system told us they found it valuable. However, this was not in place across Hampshire and the incidence where transfer information was not available to staff was increased where the red bag system was not used.

- Case files we reviewed showed people were holistically assessed and the assessments had MDT input. In our relational audit comments were made that demonstrated a lack of understanding between health and social care staff of what was involved in assessment processes by different disciplines, which caused frustration.

- The evidence based SAFER patient flow bundle was being used in acute and community hospitals across Hampshire to improve patient flow and avoid delayed discharge. The SAFER bundle comprises five main elements that should, to be most effective, be implemented together. We looked at patient records and spoke to staff in A&E and on a number of medical wards. In Basingstoke and Lymington hospitals we saw elements of the bundle not being fully implemented. At Lymington hospital, we were told by staff there were only monthly face to face MDT reviews for frail patients, which could delay decision making and therefore discharge. However, following review, senior leaders informed us that MDT review of frailty patients was undertaken as part of the consultant ward rounds, which took place twice a week. At Basingstoke hospital, although social workers were included in the MDT meetings, they were not starting discharge planning or setting an expected date of discharge until they received the assessment notification which built in unnecessary delays.

- In Southampton, there were older persons specialist practitioners (OPSP), these nurses were based on wards which were arranged in localities. The OPSP would go to A&E if someone was being seen from their locality, for example there were wards specifically for people who lived in Hampshire. The nurse would be able to route them to other services in that area such as hospital at home rather than being admitted. If the person was admitted on to the ward the OPSP would support them, their family and the discharge team to find

services in the person's locality and then visit them to ensure the new placement was fit for purpose.

Are services in Hampshire caring?

Frontline staff we spoke to understood the importance of involving people who needed support and their families in decisions in about their care, this was reflected in the records we reviewed which were person centred and considered the whole person not just their medical condition

Some staff were concerned that the wishes of people who were at the end of their lives and their families were not always met, because of a shortage of domiciliary care packages.

- Our review of people's case files showed most care assessments were centred on the needs of the person. There was evidence that the system informed and involved carers, families and advocates when making decisions about future plans. ASCOF data for 2016/17 showed that 74.7% of carers aged 65+ in Hampshire reported being included in discussions about the person they care for; this was above the England average of 71.6%.

- A three-month pilot had started in January 2018, which involved a CHC assessor working with the discharge team at Portsmouth Hospital particularly looking at reducing delays for people at the end of life and being discharged with an advance care plan. This pilot had shown success, however problems accessing packages for people (particularly those who needed four times daily calls requiring two care workers) meant people were not always dying in their preferred place. We were informed following our review, that the trial had been extended and the CHC team were procuring dedicated fast track care at home and increasing nursing home capacity to improve the fast track sourcing times.

- ASCOF data for 2016/17 showed that carers in Hampshire reported quality of life scores and satisfaction in line with the national average. Carers had access to some support in a crisis; the Princess Royal Trust for Carers was commissioned to provide an emergency planning service for carers so support could be accessed quickly if needed. Hampshire Hospitals NHS Foundation Trust provided a carers' badge that meant carers could access parking and visit outside normal hospital visiting times.

Are services in Hampshire responsive?

Not all people in Hampshire received the right services delivered by the right people at the right time. This was dependent on the hospital they were transferred to. Ambulance crews experienced delays in handing over patients to staff in the A&E department in Portsmouth, and Portsmouth was the worst performing hospital across Hampshire with regard to people being seen within four hours.

At University Hospital Southampton, there was a strong commitment to people being seen by the right person at the right time and senior appointments had been made to DTOC transformation roles.

- The NHS Constitution sets out that a minimum of 95 per cent of people attending an A&E department in England must be seen, treated and then admitted to or discharged from hospital in under four hours. This is one of the 'core standards' set out in the NHS Constitution and the NHS Mandate and is often referred to as the four-hour A&E target. NHS England data for 2014/15 to 2016/17 showed that acute trusts in Hampshire had consistently not achieved this target. In 2016/17 Hampshire Hospitals NHS Foundation Trust saw 86.6% of people within four hours, for Portsmouth Hospitals NHS Trust it was 77.8%, for University Hospital Southampton NHS Foundation Trust it was 89.6%, and for Frimley Health NHS Foundation Trust it was 91.6%.

- Ambulance staff they said that the time crews needed to spend in A&E departments before they could handover their patients to staff in the A&E department varied depending on the hospital. Queen Alexandra hospital in Portsmouth was viewed as having the most issues as it was very difficult for crews to access and handover patients. Ambulance staff told us delays in the year leading up to our review had been worse than ever before and there had been incidents as a consequence of this.

- The system's intention at a strategic level was to move forward based on prevention, strengths-based delivery, new models of integrated care, access to high quality A&E services and effective flow and discharge from hospital. This was broadly understood by frontline staff but the level of understanding and how embedded these were in practice varied considerably across hospitals.

- At University Hospital Southampton there was strong commitment to ensuring people were seen by the right person in the right place at the right time. A clinician and manager were in specific DTOC transformation roles to oversee and manage flow across the hospital. The frailty consultant had spoken to colleagues in the CCGs about the benefits of the virtual ward in relation to frailty. Communication was seen as a challenge in making this work especially because of the large geographical area; investment in ICT software and hardware was expected to help with this.

- At Basingstoke Hospital, we were told that people were often admitted to avoid a four-hour breach in A&E and staff were unable to admit a person to reablement services such as the Overton ward or The Firs unit direct from A&E, which meant people would not necessarily be admitted to the right place.

- We reviewed records across acute and community hospitals across Hampshire. The majority did not have estimated dates of discharge from hospital recorded until people had been transferred from A&E and had been admitted to wards. This sometimes led to confusion about the dates staff were working to and could cause delays.

- Safeguarding leads across Hampshire told us of good engagement between consultants and medical staff at acute trusts around mental capacity and best interests assessments for older people. However, at Basingstoke Hospital, staff told us there was limited access to social work support out of hours for people requiring mental health assessments which could cause delays in making decisions regarding further care and treatment.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Hampshire safe?

Although people who returned home from hospital were less likely than in similar areas to be readmitted as an emergency, services did not always work together to ensure the continued safe care and treatment of people in their own homes. Medicines were not always available and understood when people left hospital, and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation sometimes went missing. Work to ensure that the correct CHC processes were followed was underway.

- Discharges from hospital were not always managed safely in Hampshire. We undertook an information flow survey with independent care home and domiciliary care providers. Some providers fed back concerns about the safety of hospital discharges with regard to medicines and DNACPR forms. They told us that DNACPR forms sometimes went missing when a person left hospital. This presented a risk as emergency staff attending a person would not know whether resuscitation was appropriate or against a person's wishes. In addition, information that went in to the hospital using the 'red bag scheme' was not always returned by ambulance staff. On some occasions medicines were not supplied when a person left hospital, or the wrong medicines were supplied. People did not always understand the changes in their medicines which meant that there was a risk these would not be managed safely.

- Some people who use services told us about experiences where discharges from hospital had been unsafe as there had not been services in place to support them when they returned. For example, one person was discharged to a home which had become uninhabitable. They had needed to be readmitted to hospital on an emergency basis while their home environment was made safe, however the person supporting them told us that there was no continued support in place and their home environment was once again deteriorating as they were unable to manage. Another person had to be supported to get into bed by neighbours on their return from hospital. In addition to the impact on the person's dignity, there was a risk that the person could have been left in an unsafe situation without the neighbour's goodwill and support.

- There were 75 responses in total from registered managers of adult social care providers in Hampshire to our information flow survey, and 30 respondents supplied free text comments. Nearly all of the 30 free text comments supplied raised concerns. The most common issues cited were a lack of information being provided when a person was discharged from hospital, and information provided being insufficient or incorrect. As a result of these issues, providers said they often undertook their own pre-discharge assessments and visits in order to ensure they had all the necessary information.

- Another common theme from the information flow tool was around medication issues; either lack of or incorrect information about medications (including changes), or wrong medication or insufficient medication being issued. Another theme was around discharges from hospital being unsafe and leading to risks in the community and/or people having to be readmitted.

- Systems were being put in place to ensure that hospital discharges were appropriate. For people requiring continuing healthcare there was a quality assurance process in place. Data showed that Hampshire consistently had a lower rate of readmissions than comparator areas and England during the period between April 2014 and March 2017. In quarter one of 2016/17, the rate in Hampshire was 17% compared to 18% and 19% across comparator areas and England respectively.

Are services in Hampshire effective?

People's needs after leaving hospital were not always holistically assessed and this meant that people often had to tell their story more than once. Health and social care staff did not always work together effectively to plan people's discharges from hospital and this meant that some people were unable to access further support when they needed it, particularly if they paid for their own care.

When people received reablement services these were effective in reducing the likelihood of a readmission to hospital and there were additional services in place to maintain their recovery

and improve their physical fitness. The trusted assessor model was not effective and was not used appropriately to support people to have their needs assessed in their usual place of residence.

- People we spoke with did not feel that their needs and choices were assessed holistically. They felt that GPs and social workers did not work together or share information about their care needs and people had to tell their story more than once to professionals. The discharge process did not always take into account whether people's needs had changed following their hospital admission. For example, a person who was living with Alzheimer's had been managing to live independently at home and was admitted to hospital following a fall. They left hospital without additional support being put in place on their return home and were left to cope on their own. This resulted in a readmission to hospital and from there they were discharged to a residential care service which meant they were never able to return home or have an opportunity to plan for a change of residence.

- There were concerns raised by people who paid for their own care or were in receipt of direct payments as they did not know who to contact or where to get further support if their needs increased. Some people were anxious about taking up other options such as sheltered housing as they feared losing their property to cover costs and there was not sufficient support to help people navigate through this process. For example, one person told us that they had experienced difficulties in accessing interim funding for support while they were in the process of selling their property. There was a risk of further anxiety and ill-health as people in a vulnerable position attempted to manage their finances and were at risk of accruing debts.

- Staff we spoke with told us that additional referral processes had been put in place to access support such as the frailty service which delayed people's assessments. Although staff had received training, they felt pressured by other issues such as relationships between lower graded staff and consultants and the environment and place where assessments were to be conducted as staff felt unable to leave the wards. This showed that integrated working around the person's needs was not fully understood or embedded.

- Staff told us that continuing healthcare 'fast track' assessments could take up to three weeks. We were told that there had been a significant backlog in the completion of Decision Support Tools going back to 2016 however this had been addressed and was expected to be cleared by June 2018. In addition, the referral conversion rate for fast track referrals was 100% across the five CCGs which indicated that the referrals were appropriate.

- The percentage of older people who were discharged from hospital and then received

reablement had declined each year since 2012/13. In 2016/17, only 2.2% of people received reablement which though the same as comparator areas, was below the 2.7% across England. However, the reablement survey showed that not all the referrals had been appropriate and staff were working to ensure that the people who received reablement would be able to benefit from it. The proportion of older people who were still at home 91 days after discharge into reablement was in line with the England average and comparator average. In some areas, we heard that the criteria for referrals to reablement were too restrictive. For example, although people were staying in hospital longer than they needed to, one service provider we spoke with had capacity to support additional people but could not, owing to the referral criteria.

- A survey of the reablement service had been undertaken in the autumn of 2017 and the findings reflected some of what people told us. There was recognition that communication and advice was not always clear.

- The Community Response Team (CRT) was a non-chargeable service provided by the local authority which provided short term support for adults, for up to six weeks. The service supported people who had been discharged from hospital and/or required a period of enablement to help them to become as independent as they could be while living in their own homes. Where people required additional support following CRT intervention they would be supported to move onto another care agency that provided long term support to them in their own homes. This service was available across Hampshire.

- People who were recovering from an illness, or who had completed a programme of reablement could attend Steady and Strong classes. These physical activity groups were available throughout Hampshire and supported continued recovery. We received positive feedback from people who used the service. People enjoyed the service and many continued to use it for years.

- Other services were not easily accessed by people who were ready to be discharged from hospital. People who were at the end of their lives could not always get packages of care at home in a timely way and there were delays in obtaining equipment. There was a risk that people would not be able to die in their preferred setting because of these delays.

Are services in Hampshire caring?

Staff spent time with people and their families to explain services and find out their choices. The availability of some services – particularly domiciliary care – meant people could wait a long time for services and remain in a hospital setting longer than needed. The backlog of CHC assessments was being addressed at the time of our review and people needing a fast track service were having this met.

- Data from NHS England showed that during quarter four of 2017/18, the referral rates across Hampshire for people to receive continuing healthcare care (CHC) funding was similar to the England average of 21% with the exception of South Eastern Hampshire CCG where the rate was 47%. This had been an improvement from the quarter one figures, when most of the Hampshire CCGs had lower than England rates for assessment and referral conversion.

- In 2016 there had been a backlog of fully completed CHC initial assessments that had reached 236; this was due to a lack of staff to complete these assessments. This meant that people were waiting very long periods of time for their assessments to be completed including those considered to need a fast track service. This had meant some people at the end of their lives were waiting funding and care packages to be approved for a number of months. We were made aware of examples where assessments had not been completed before a person had died.

- Staff told us that, previously, continuing healthcare 'fast track' assessments could take up to three weeks. The delays had been recognised as unacceptable by the system and resources made available to address this backlog. The performance for fast track CHC applications had subsequently improved and assessments were being completed within 48 hours consistently across Hampshire. In addition, the referral conversion rate for fast track referrals was 100% across the five CCGs, which showed that the referrals were appropriate. However, staff told us that although the approval for a package was timely, there were often delays in physically getting the equipment and staff to the person.

- Across the system there was a commitment to offer and involve people in choices about how and where they wanted to receive care and services. We saw staff spending time with people and their families to explain different types of services available and find out what they preferred. However, if a person had made a choice that they would like to receive care at home this was not always possible because of the shortage of domiciliary packages, particularly for people requiring complex packages of care.

Are services in Hampshire responsive?

People who were waiting to return home from hospital in Hampshire were at risk of experiencing significant delays in returning to their usual place of residence. Many people had to wait a long time, sometimes for three or four weeks for packages of care in their own homes. Some intermediate care services were underutilised while domiciliary care provision was stretched owing to workforce challenges.

There was added pressure to in-house services as the two independent providers

commissioned to provide reablement could not manage the demand. This meant that there was a risk of people becoming more unwell while in hospital and being unable to return home, or requiring residential or nursing home care.

- People who were fit to return from hospital to their usual or a new place of residence were more likely to experience a delay in their return than people living in similar areas. This exposed people to further health risks such as a deterioration in their mobility and suffering from a hospital acquired infection. Delayed transfers of care had been significantly high in Hampshire since July 2017. They had been consistently higher than the national average going back even further. In January 2018, the average daily delayed rate per adult population was 22.7 in Hampshire compared to 12.6 in comparator areas and 11.4 across England.

- The largest reason for delays was given as awaiting care package in people's own home though there were also a large number of delays that were due to awaiting a nursing or residential home placement. Although awaiting completion of assessment wasn't one of the main reasons for delays in Hampshire, it was double the England rate. Independent providers we spoke with felt that hospital staff were not always aware or understanding of the services that they could provide and they felt that this contributed to delays. One provider told us that they visited their local hospital to meet with staff and to help them understand how they could support people, but a high turnover of hospital staff meant that this information was lost and needed to be repeated. There was not an integrated system in place to support health and independent social care professionals to understand how they could best support each other.

- Although most of the delayed days were as a result of activity at the main acute trusts, there were a number of delays that came from the community trust, Southern Health NHS Foundation Trust.

- Across the five CCGs in Hampshire there was variability in how much some CCGs were adopting discharge to assess in regards to Decision Support Tools for CHC. In quarter one of 2017/18, all had been completing at least 75% of these tools in an acute setting. As at quarter four of 2017/18, most had decreased with Fareham and Gosport, North Hampshire and South Eastern Hampshire CCGs all less than 50%. West Hampshire CCG however was still completing 95% of Decision Support Tools for CHC in an acute setting.

- The five CCGs had worked hard to reduce a big backlog in delays. However, in quarter four of 2017/18 the majority of referrals were still taking more than 28 days to complete in all CCGs.

- The proportion of discharges that occurred at the weekend was 21% in Hampshire which was in line with, or better than, all of its comparators.

- When people were discharged from hospital, they did not always receive care in the right place and at the right time. People who used services and their carers, as well as independent providers, told us that there seemed to be a reliance on residential care services to support people on leaving hospital. Our data showed that there had been an increase in residential care bed numbers which was higher than the England average and there had been a decrease in the number of domiciliary care agencies which was higher than the England average and comparator areas.

- There were intermediate care beds to support people in the transition from hospital to their usual place of residence; however the service was not joined up across Hampshire. System leaders recognised this shortfall and there were plans in place for an integrated intermediate care service. However, this was in its early stages with mapping of needs underway before an operational model could be agreed.

- There were seven care homes that provided discharge to assess where people could receive care on discharge from hospital. We saw that although occupancy was higher in the winter months these services appeared to be under-utilised and only one service achieving its target of 85% occupancy.

- Reablement in the community was provided by the Community Response Team (CRT) which was an in-house service provided by the local authority and by REACT which was provided by two independent providers across Hampshire. However, the REACT service was struggling to meet demand owing to workforce problems which then impacted on the availability of support from the CRT. Hospital staff told us that sometimes people had to wait for social work assessments and then delays were compounded by a three to four week wait for care packages. There were also delays owing to provision of equipment not being managed in a timely way. The rate of delayed transfers of care due to the reason ‘awaiting community equipment/adaptations’ in Hampshire was 1.4 days per 100,000 aged 18+, over four times the England rate of 0.3 days.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Hampshire

- Although there was an emerging joint strategic vision for health and social care in Hampshire, we did not hear this consistently articulated at operational and implementation levels across all sections of the system.

- We found that work was taking place to develop relationships, but we did not find that they had reached the necessary level of maturity and sustainability to be truly effective in delivering for local people or organisations. This was evidenced by the variation in performance across Hampshire, underpinned by the absence of a shared risk approach; and – despite initiatives by individual partner organisations – the absence of a whole system financial strategy and joint budgets.

- Governance processes, joint decision making, risk sharing and performance management at a joint strategic level appeared under developed.

- Market shaping continued to be led by the local authority with good examples of engagement with partners on the development of a new commissioning framework for homecare.

- Public Health appeared well connected across the partnership and had a valuable contribution at strategic and operational levels.

- We found numerous examples across Hampshire of projects, pilots and initiatives that were working well to support people to remain independent at home, however there did not appear to be consistent and routine systemic approaches to evaluation and potential scalability of these projects.

- Engagement with the voluntary sector, the independent care sector and housing as strategic partners appeared underdeveloped, particularly in relation to workforce planning.

- Workforce challenges across the Hampshire footprint were clearly articulated throughout the review and workforce strategy and leadership sat at STP level via the LWAB. Representation of care providers at board level was absent.

- Information sharing and systems interoperability were frequently cited as barriers to progress.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- The HWB must determine and agree its work programme, how to make the system more coordinated and streamlined and form stronger more coordinated links with the STPs.
- System leaders must develop a comprehensive health and social care workforce strategy for Hampshire in conjunction with the independent sector. This should work in synergy with financial, housing and transport strategies.
- The system must undertake further work to transform the trust and commitment in partnership arrangements and deliver tangible products that will improve services should be undertaken and developed at pace.
- The system must work with partners to develop a consistent approach to the evaluation of health and social care initiatives and their feasibility at a strategic and local level and communicate this information system wide.
- The health and social care system must work with the independent sector, nursing home, care home and domiciliary care to improve relationships and develop the market to provide services that meet demand across Hampshire.
- The system must ensure safe discharge pathways are in place and followed for people leaving hospital.
- The system leaders must revisit all service provision to ensure the delivery of more equitable services across Hampshire.
- The system must ensure that the enhanced GP offer is implemented to all care and nursing homes across Hampshire.
- The system must streamline discharge processes across Hampshire; this needs to include timely CHC assessment and equipment provision to prevent delayed discharges from hospitals.

- A comprehensive communication strategy must be developed to ensure health and social care staff understand each other's roles and responsibilities and all agencies are aware of the range of services available across Hampshire.

- All elements of the high impact change model must be introduced and the impact evaluated system-wide.

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	10 July 2018
Report Title:	Issues Relating to the Planning, Provision and/or Operation of Health Services
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: (01962) 845018 **Email:** 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 Strategic Plan's aims of supporting people to live safe, healthy and independent lives, and to enjoy being part of strong, inclusive communities, through the overview and scrutiny of health services in the Hampshire County Council area.

Topic	Relevant Bodies	Action Taken	Comment
Hampshire and Isle of Wight Sustainability and Transformation Plan *(Monitoring item)*	Sustainability and Transformation Plan Office All Partner Organisations involved in commissioning or providing health and care services	The HASC heard about the H&IOW STP in January 2017 STP January 2017 and resolved to receive further updates The HASC last received an update at the Committee meeting in July 2017 STP Update July 2017 At the September 2017 meeting the HASC agreed the Terms of Reference for a working group to review particular workstreams within the STP in more detail. STP working group set up	The STP working group has met twice and has further meetings planned, to review and comment on work streams within the STP. The STP office has been invited to provide a general update on the H&IOW STP to the whole committee (due to be presentation slides).

Recommendations:

That Members:

a. Note the progress made with the Hampshire and Isle of Wight Sustainability and Transformation Plan.

b. Determine a suitable timescale for any further update.

c. Make any further recommendations as appropriate.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

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 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.

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)
Date of meeting:	10 July 2018
Report Title:	Work Programme
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: (01962) 845018 **Email:** members.services@hants.gov.uk

1. Purpose of Report

1.1 To consider the Committee's forthcoming work programme.

2. Recommendation

That Members consider and approve the work programme.

WORK PROGRAMME – HEALTH AND ADULT SOCIAL CARE SELECT OVERVIEW & SCRUTINY COMMITTEE: 2018/19

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	10 July 2018	18 Sept 2018	20 Nov 2018
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 last heard in June 2017 (via electronic briefing) Next update to be considered July 2018	Update to be considered **(E)**		
Dorset Clinical Services review **(SC)**	Dorset CCG are leading a Clinical Services review across the County which is likely to impact on the population of Hampshire crossing the border to access services.	Starting Well Living Well Ageing Well Healthier Communities	Dorset CCG / West Hampshire CCG	First Joint HOSC meeting held July 2015, CCG delayed consultation until 2016. Last meeting August 2017 to consider consultation outcomes. Decision made by CCG in line with Option B 20 September, which HASC supports.	Verbal update to be received once next meeting has been held. **(M)**		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	10 July 2018	18 Sept 2018	20 Nov 2018
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. Status: last update May 2018. Requested further update Autumn 2018 once proposals for acute reconfiguration available			To be considered **(M)**
Move of the Kite Unit	Move of neuropsychiatric inpatient unit from St James Hospital, Portsmouth, to Western Community, Southampton	Living Well Ageing Well	Solent NHS Trust	Considered March 2017 and support provided by Committee. Monitoring update received Summer 17. Monitoring update received May 2018.			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	10 July 2018	18 Sept 2018	20 Nov 2018
West Surrey Stroke Services	Review of stroke services	Living Well Ageing Well	NE and SE Hampshire CCGs	To be considered once the consultation has closed Heard at June 2017 mtg, where Committee supported proposals. Monitoring heard Nov 17. To be next considered September 18.		Next update to be considered **(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.*							
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. PHT last update received May 2018. Next due Nov 2018 or when comprehensive report published. SHFT – next update Sept 18		SHFT update **(M)**	PHT update **(M)**

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	10 July 2018	18 Sept 2018	20 Nov 2018
Sustainability and Transformation Plans: one for Hampshire & IOW, other for Frimley	To subject to ongoing scrutiny the strategic plans covering the Hampshire area	Starting Well Living Well Ageing Well Healthier Communities	STPs	H&IOW initially considered Jan 17 and monitored July 17, Frimley March 17 STP working group to undertake detailed scrutiny – updates to be considered through this	Next STP updates to be received to formal meeting (H&IOW)		
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			
Older People and Physical Disability Day Services	To consider prior to decision the outcomes of the OPPD consultation	Living Well Ageing Well Healthier Communities	HCC Adults; Health and Care	Considered February 2018. For an evaluation item to be considered once data is available (TBC)	update under chair announcements		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	10 July 2018	18 Sept 2018	20 Nov 2018
Scrutiny Review - *to scrutinise priority areas agreed by the Committee.*							
STP scrutiny	To form a working group reviewing the STPs for Hampshire	Starting Well Living Well Ageing Well Healthier Communities	STP leads All NHS organisations	ToR agreed September 2017	Verbal updates to be received when appropriate		
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. Update Nov 17, next due Nov 18			Update due

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	10 July 2018	18 Sept 2018	20 Nov 2018
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	Substance misuse transformation update heard May 2018. 0-19 Joint Procurement			0-19 joint proc item (M)

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 Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
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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.

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