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Hampshire Health and Adult Social Care Scrutiny Committee - 17 May 2018

Update of Programme to Transform Care Services in North and Mid Hampshire

West Hampshire Clinical Commissioning Group
North Hampshire Clinical Commissioning Group
Hampshire Hospitals NHS Foundation Trust

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INTRODUCTION

The Transforming Care Services Programme (the TCS Programme) was established to bring partners together to address the challenges faced by the health and care system of north and mid Hampshire, with particular regard to providing citizens with safe health and care services that will be sustainable for many years to come in the face of rising demand, demographic growth and financial pressures. The programme recognises the scale of this challenge and the interdependencies of both acute and community models of care to be able to function effectively and efficiently as an integrated health and care system.

This paper provides an update on the progress made following the agreed recommendations from the West Hampshire and North Hampshire Clinical Commissioning Group (CCG) Joint Public Board meeting on 30 November 2017 which were:

1. To continue to develop and implement plans for rolling out more joined-up local health services both in and out of hospital over the next few years;
2. To continue with the current programme arrangements in order to develop proposals for the centralisation of services within the current Hampshire Hospitals' footprint (Andover, Winchester and Basingstoke), thus ensuring that patients continue to have access to the safest and highest quality care, including any necessary capital development to support relocation of services;
3. The other options presented, including a standalone critical treatment hospital, would not be progressed as part of the programme.

Part 1 of this paper provides an update on the approach taken by the TCS programme in response to the recommendations 1 and 2 above. The TCS programme is supporting the coordination and development of proposals for acute services provision, out of hospital care, and the associated capital and estate implications.

Part 2 of this paper explains in more detail the development of care models; models that provide high quality safe services; provide continuity of care based around the needs of patients / citizens which improve health and wellbeing and which are sustainable for the long term.

Part 3 of this paper explains how local people will continue to be engaged with the transformation in terms of the centralisation and with the components of the integrated care model work programme.

Case for change – the Joint Public Board meeting highlighted the case for change against which the options were assessed. A summary of the case for change is presented; further information is available within the public board papers.

The local population is growing, getting older and has changing health needs …	• The local population is growing with an 11% increase predicted over the next 5 years with the largest increase in the over 75s who are predicted to increase by nearly 37% • This will result in a higher prevalence of people with ongoing or complex needs within the catchment of HHFT
… requiring a different sort of care to that historically provided ….	• Care for people with ongoing or complex needs must be provided in a different way than in the past, ensuring a more pro-active approach rather than reactive, delivered by multi-disciplinary teams working together rather than being reliant on GPs to do everything, with easier access to diagnostics and specialist opinion and more consistent quality of care • Technology is supporting integrated care models e.g. virtual outpatient clinics or remote monitoring
… which will result in decreased in-hospital activity…	• Currently 56% of all NHS funds available for the local population are spent in the acute sector • The clinical evidence base suggests that a greater focus on prevention of ill health and on caring for people with ongoing or complex needs in the community can significantly reduce the need for acute hospital care resulting in better health status and greater independence - examples from elsewhere suggest that new models of out of hospital care could reduce the amount of acute activity.
… without which there would be further pressure on already fragile services with an increasing the need for consolidation	• Current acute hospital services are split over Basingstoke and Winchester sites –this results in duplication of services and relatively low volumes of care at each site –below recommended levels by national medical bodies in a small number of services • Services with relatively low volumes of care have been shown to associated with poorer quality of care, probably because teams get less experience and are less able to build their skills • Services with relatively low volumes of care also cost more money to run as they are less well utilised • Services which need to be provided 24x7 are particularly difficult to provide at multiple sites as they require staff to be there 24x7 even if the numbers of patients are relatively low – this is particularly the case for A&E, emergency surgery, obstetrics, and paediatrics • In these specialties there are challenges in staffing

	services on two sites and in ensuring consistently high quality care.
Hampshire Hospitals Foundation Trust (HHFT) has an opportunity to provide higher quality services in a more efficient way by changing the models of care across sites	• Some services e.g. cardiology and hyper acute stroke, have already consolidated onto a single site and see good patient outcomes • Consolidating more services is likely to reduce operating costs with shared rotas and improve quality with higher volumes of activity. • In addition, reductions to length of stay and increasing throughput of theatres, diagnostic services and outpatients will all enable more efficient hospital services and allow investment in out of hospital care

PART 1 - TRANSFORMING CARE SERVICE PROGRAMME - Progress Update

Building on the extensive work of the TCS Review in 2017, the programme has focussed on supporting the development and coordination of proposals for:

a) **transforming services to provide care in the community in a more integrated, proactive and preventative way, and therefore reduce the need for hospital based care**
b) **reconfiguring acute services**
c) **estate and capital implications for the local healthcare system.**

It is these three elements combined which form part of the North and Mid Hampshire system's plan to improve services for the local population.

a) Transforming services

Transforming services for North and Mid Hampshire Local Care system is a long-term programme which involves working across health and social care to improve the quality and patient experience by delivering more care closer to home.

This will be achieved by:-

1. Supporting people to stay well
2. Providing proactive joined up care for those with ongoing or complex needs
3. Ensuring better access to specialist care
4. Further integration of urgent and emergency care
5. Providing effective and sufficient step-up, step-down nursing and residential care

The core building block for this transformation is the primary care collaboration that allows a shared population health model to be developed with other service providers and local communities. The model for this work has been developed in vanguard sites throughout Hampshire and is mapped into a natural communities development plan that will form part of the local care plan. Priorities for 2018/19 have been identified and are being progressed.

Further detail of the transformation and the integrated care models evolving in the community can be found in Part 2.

b) Reconfiguration of HHFT acute services

Acute care is provided at three sites within Hampshire Hospital Foundation Trust's (HHFT) existing footprint: (Royal Hampshire County Hospital (RHCH), Basingstoke and North Hampshire Hospital (BNHH) and Andover War Memorial hospital (AWMH).

At the Joint CCG Public Board Meeting in November 2017, it was recommended that further work be undertaken to consider how best to accommodate services across the three hospital sites. HHFT has been assessing the options and included within this scope are Emergency Department, Emergency and Elective Surgery, Cancer Services, Critical Care, Obstetrics, Neonatal intensive Care and Inpatient

Paediatrics. This clinical assessment, together with associated estates changes is ongoing.

Further detail of the acute services care model can be found in Part 2.

c) Estates

Part of developing proposals was the need to review the condition of the HHFT's existing estate: Royal Hampshire County Hospital (RHCH), Basingstoke and North Hampshire Hospital (BNHH) and Andover War Memorial hospital (AWMH). A 'Six Facet' estate survey has been completed, together with projected costs of the future level of maintenance and this information will be used to inform any future capital funding bids.

The community estate is also a key consideration for the integrated care models and plans to develop a community hub at Andover are in progress. Consideration is also being given to the development of community health and wellbeing and primary care hubs within Alton, Winchester and Basingstoke.

Transforming Care Services (TCS) Programme – Next Steps

April 2018 saw changes to the TCS Programme Management Office (PMO) with the appointment of a new Programme Director and additional resources provided to the PMO from both CCGs. These changes will continue to provide rigour, assurance and confidence to the processes and decision making of the programme on behalf of the Local Care System.

Through May and June the PMO will continue to identify the interdependencies between acute and community models, noting changes to patient flows, any reductions to non-elective admissions and bed days through reducing the unnecessary delays in patients being discharged from hospital. This work draws on national and local data evidence, testing the assumptions borne out in the Transforming Care Service Review 2017. This work is further enhanced by the recent review by Newton Europe which has been commissioned through NHSE/DCLG across the Hampshire County Council area and there is evidence in the system review for the significant bed occupancy reduction opportunities in the North and Mid Hampshire local care system.

The TCS Board has a shared commitment to work in partnership with all provider and third party organisations on the modelling of activity and capacity of acute and out-of-hospital service models as they are further refined.

The estates work stream, together with Local Estates Forum, is co-ordinating the identification and prioritisation of opportunities where capital funding could support integrated service models. Particular focus through May and June will be to ensure compliance with the bidding process outlined for STP Capital funding. The PMO team are preparing information for the Hampshire and Isle of Wight Sustainability Transformational Partnership (STP), Wave 4 Capital Bidding Round, with bids due for submission to the local STP in June with the national deadline in July.

PART 2 DEVELOPING THE COMMUNITY MODEL OF CARE AND SUPPORT – Progress Update

Part 2 of this paper describes in more detail the integrated care model progress. Whilst the detail is presented as discrete sections it is important to acknowledge the interdependencies and alignment between hospital services and those that can be provided outside of hospital setting in local communities.

The development of the care models has been grounded in a good understanding of our population demographics and predicted growth. We work closely with public health and our local authorities to understand our population and a brief review of some of the health issues we have drawn from the population assessment are included below.

2.1 Population data

Population Profiles - The total resident population of North and Mid Hampshire is 418,800 (approx. 1/3 Hampshire total population), with a younger population structure (highest proportion of people aged 0-19 and 35-54 years compared to Hampshire).

The growth in population between years 2016 to 2023 is expected to be 45,754 people, this equates to 11% increase, considerably more than the Hampshire forecast increase of 8%. All age groups are predicted to increase, with the largest increase forecast in the over 75s (37% increase), with a predicted 13,260 more people aged 75 and over living in North & Mid Hants LCS. There is a greater need therefore for proactive services that can support frail people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

Patterns of Illness - Adults in Hampshire in general live longer, have good employment and good opportunities to keep healthy. A Hampshire male resident born today could expect to live in good health for 83% of their life, and a female 81%, this equates to males living in poor health for 13.8 years and females living in poor health for 15.7 years. However there is variation with some people having much poorer health and outcomes. One area in Andover is ranked in the 20% most deprived LSOAs * nationally. This area falls in the Alamein ward in the Shepherd's Spring area. There are approximately 1,400 people living here.

* Measurement of relative levels of deprivation in small areas of England called Lower layer Super Output Areas (LSOAs)

We have a good understanding of the health of our communities within defined natural communities (groupings of GP Practices) to inform transformation plans. A review of disease prevalence for the natural communities in Mid Hampshire been undertaken by Public Health England and is summarized below. A similar detailed review for the natural communities in North Hampshire is underway; however the Joint Strategic Needs Assessment (JSNA) (2017) for North Hampshire identifies similar patterns of illness, with health inequalities related to pockets of socioeconomic deprivation.

Andover	Depression, COPD, Asthma and Hypertension - significantly high prevalence
Winchester City	Overall low disease prevalence except for mental health, significantly high prevalence of depression in St Pauls and Dementia in St Clements
Winchester Rural North	Significantly higher prevalence of: Hypertension, Stroke, Asthma in Whitchurch, Depression in Derrydown
Winchester Rural South -	Significantly higher: Hypertension in Stokewood and Wickham, Stroke in Wickham
Winchester Rural East	Overall low disease prevalence except for: significantly high cancer prevalence in Alresford and Watercress Higher prevalence of CHD; Stroke in Alresford and West Meon
North Hampshire	Across the North Hampshire CCG health inequalities impact differently, as shown in the life expectancy gap between most and least deprived and between genders. There is a rising prevalence of obesity, diabetes, cancer and a higher prevalence of depression. The forthcoming Public Health England profiles for the emerging North Hampshire natural communities will inform transformation plans to support specific health issues in each area.

In keeping with the national picture, changing lifestyles means there will be more people living with long term conditions. To avoid increasing the already pressured acute health services such as emergency and acute medicine, there will need to be a shift towards earlier interventions to improve health and deliver sustained continuing support, provided outside of hospital setting that support people to manage their health and wellbeing.

Emerging health and social care needs - There are a wide number of factors that influence and determine good health, but there is no single definitive measure to tell us if we or our communities are healthy. Factors or conditions that cause premature mortality or illness can help us understand how healthy our population is. The influence of different risk factors varies according to the level of deprivation in an area. Smoking, obesity and high blood pressure are the leading risks in areas of relative deprivation.

For adults, the main causes of premature death are cancer, heart disease and respiratory disease. Certain illnesses (e.g. mental health, MSK and diabetes) not only cause mortality but can also cause significant disability (impacting on employment and future wellbeing) if they are not managed effectively.

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2.2 Integrated Care Model for North & Mid Hampshire

The opportunity to deliver care and front line services more effectively, joining up services provided by different organisations will mean a different look and feel to how people receive care and support. Effective collaborative relationships between secondary care, primary care, community service providers, Hampshire County Council and voluntary sector organisations around this shared purpose is already enabling changes to the way care is being delivered.

The components of the integrated care model

In keeping with other areas across Hampshire, Mid & North Hampshire Local Care System has adopted a model for improving the health and care provided for the population of ca. 440,000 people which has at its heart five components:

1) **Support to help people to stay well**
2) **Proactive joined-up care for those with ongoing or complex needs**
3) **Better access to specialist care**
4) **Integrated urgent & emergency care service**
5) **Effective and sufficient step-up, step-down, nursing and residential care**

Support to help people to stay well; it is important that we are taking effective and concerted action to support people to stay well. Prevention and early intervention programmes, such as those for smoking, weight reduction, lifestyle and long-term condition management, can help people avoid ill health – and increasingly digital technologies can improve this support. It is common for our service users to have social concerns, such as loneliness and isolation that impact their health and wellbeing. Our communities and volunteers are working to support and improve the lives of local people, and health services can contribute to this, for example through social prescribing services.

Support to help people stay well - current position

Prevention work is broad ranging and our current initiatives include:-

- Increasing uptake in vaccinations, particularly within groups that need different access to healthcare and advice as a result of their circumstances.

- Promotion of exercise through initiatives such as ‘Get Hampshire Walking’, which saw over 5000 people completing one of 130 health walks. We have worked in partnership with the council to support over 25% of Hampshire’s schools with the ‘Golden Mile’ initiative.

- Earlier diagnosis of long term conditions through effective screening with earlier intervention such as Healthier You – the National Diabetes Prevention Programme which was launched in Hampshire in 2017 aimed at people who are at risk of developing Type 2 Diabetes. This provides a nine-month course in local communities and aims to help people adopt healthier lifestyles

- Health checks for the over 40’s, people with learning disability, and serious mental illness

- Referral to lifestyle management services such as smoking cessation, weight

reduction programmes and exercise initiatives

- Rollout of Patient Activation Measures programme to improve individual's engagement in self-management.

Improving access to care is also crucial to increasing self-care and therefore preventing ill-health, we have:-

- Launched extended access hubs in October 2017 with additional pre-bookable and same day appointments with additional access to a range of professionals including GPs in the evenings and weekends at Andover War Memorial hospital and Badger Farm Surgery in Winchester. These hubs have delivered 410 additional hours of additional capacity to support West Hampshire patients in primary care. These will be rolled out across our local care system by October 2018.

- Promoted the use of Connect to Support (an on-line directory of local services and community groups

- Trained 51 GP reception staff 28 practices in active signposting to community support for issues ranging from debt management, relationship advice to help with drug and alcohol issues. This has been shown to reduce the need for GP appointments by approximately 5%.

- Implemented e-consult and on-line consultation programme, with over 800,000 people registered across Hampshire, and access to symptom checkers, self-help tools, advice prescriptions and appointments. Using e-consult 60% of people are able to resolve their health concerns without visiting the practice, with an estimated 12,316 appointments saved.

- In partnership with Hampshire County Council provided on-going and additional investment into the wellbeing centres to help prevent mental ill-health. The centres are run by Mind to provide short-term, outcome-focused support to individuals with mental health problems. There are centres across Hampshire including at Basingstoke, Andover, Winchester and Eastleigh.

Next Priorities

We are working with Public Health for Hampshire to deliver the targeted prevention priorities for our population, and supporting the delivery of the STP prevention programme. Smoking, obesity and high blood pressure and mental ill-health are leading risk factors, and targeted work to address these will continue. Additional initiatives being developed include:-

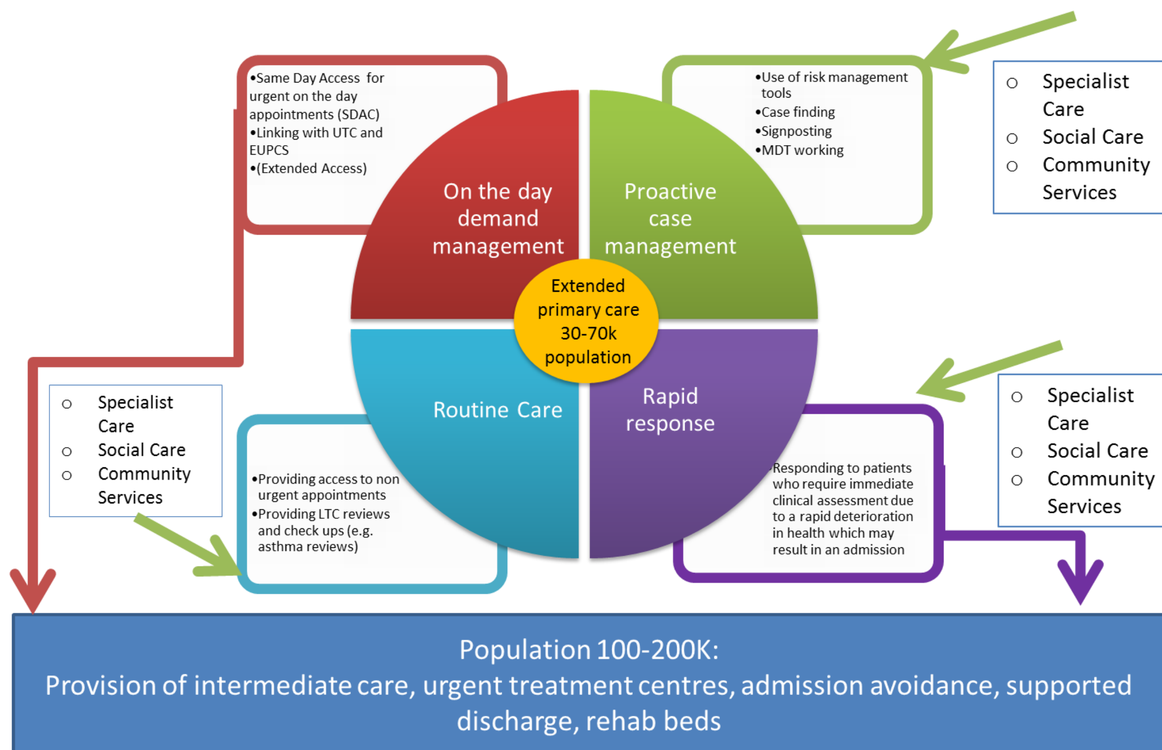
- Fit for Surgery; giving advice and guidance and signposting on reducing smoking and alcohol intake or losing weight before an operation or procedure. The evidence shows that this support can greatly improve the outcomes for the patient

- Making every contact count; ensuring that we take every opportunity for interaction with our workforce to encourage our population to take positive

self-care steps and change lifestyles

- Early detection and screening for cancer and other primary care based prevention programmes targeting the needs of the local populations.

Proactive joined-up care for those with ongoing or complex needs; is a key component of our care model. This is delivered through teams of multiple professions working collectively to deliver joined up care. These teams bring together primary care, community nursing and therapies, paramedic, mental health, social care and the voluntary sector to work together within local communities. The core building block for this transformation is the primary care collaboration that allows new ways of working to be developed with other service providers and local communities. The model below shows how key elements of care will be delivered in local areas by GP practices working together in larger groups or 'natural communities' covering populations of 30-70k. This enables services to be provided at scale.



The ten natural communities in the North and Mid Hampshire Local Care System are at differing stages of development and are being supported in their development, learning from the adoption and progress with embedding different models of care nationally and also from local HIOW STP programmes.

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Proactive joined-up care for those with ongoing or complex needs - Current Position

- Natural community leadership - is in place with well-established natural communities in Mid Hampshire and North Hampshire now developed into a natural community model.

- Multi-disciplinary teams - Proactive care teams established taking a multi-disciplinary team approach to support patients. Practice whiteboard meetings are held with regular multi-disciplinary team meetings to review patients. Mid Hampshire's pro-active care team looks after over 10,000 patients with complex needs in the community supporting them to navigate health and care services.

- Care co-ordination – for the over 75s there is a named GP responsible for the person's care. Care navigators are in place across the Mid Hampshire practices helping patients and their carers navigate the system

- Individualised care plan – practices use risk stratification to identify those most at risk and develop care plans with the patients. A summary care plan can also be uploaded on the shared care record CHIE (formerly Hampshire Healthcare Record).

- Working with care homes – implemented care home forums and piloting of nutritional hydration initiatives across the local care system, also piloted an enhanced care in nursing home service in the North providing enhanced multi-disciplinary teams to support residents. General practices are aligned to care/nursing homes to improve care with regular 'ward rounds' and advanced care planning for the most vulnerable residents.

- Personalised planning (and budgets) – more personal care planning and the use of personal budgets for patients to manage their own care and support is being promoted throughout Hampshire. We have been successful in securing funding to continue to develop this approach for 2018/19.

- Talking therapies and children and adolescent mental health services and the provision of specialist mental health support where required, also improving the experience during the transition between children's and adults services. Uptake for these therapies is currently meeting the national targets for the North and Mid Hampshire local care system.

- 'Knowing me knowing you' postnatal mental health courses run collaboratively by health visitors, iTalk practitioners and wellbeing service at wellbeing centres for women not needing the specialist perinatal mental health service.

- Developed new End of Life quality collaborative in Mid Hampshire which has greatly improved the discharge process and experience of care for patients who previously have been unable to be discharged from hospital. In 2017 our service changes enabled over 100 additional patients to leave hospital and die peacefully in their place of choice.

Next Priorities

The current position shows good progress in developing the natural community based multi-professional teams and a proactive care approach. However, ensuring a consistency of approach and the embedding of best practice across all natural communities remains a priority. Two natural communities have been identified to embed the approach, one in Mid-Hampshire (Andover) and one in North Hampshire (Rural West). These teams will include the development of new workforce roles including, care navigators, frailty specialists, clinical pharmacists working in GP practices and receptionists trained as active sign-posters.

Other priorities include:-

- Children's multi-disciplinary team meetings being piloted during 2018/19
- Development of local and area hubs in Andover, Alton, Winchester and Basingstoke. Local hubs can be virtual with practices working together to provide care to a natural community of 30,000 – 70,000 or co-located in a single building. Area hubs provide services to a wider population of 100,000+ and include more specialist care, diagnostics and inpatient beds.
- Andover health and well-being hub (due for completion March 2020) Andover local hub will be co-located with Andover War Memorial hospital providing a local and area hub on the one site. We have been awarded funding to develop and improve the facilities in Andover, and the hub will help facilitate the five GP practices to work collaboratively to develop new ways of working and provide improved access to care in Andover, enabling primary care clinicians to focus on those patients who need their support most and freeing up capacity in the system.
- End of life care - work collaboratively across the local care system to consider the palliative care needs of the population and develop the end of life care model supported by the potential expansion/creation of hospices at Andover and Winchester.
- NHS Continuing Healthcare – we will continue with our improvement programme to; improve the quality of our service, clear the backlog of cases, develop the funded nursing care service and embed a personalised approach including personal health budgets
- Medicines optimisation – we continue to develop our work programme to help patients: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety.

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Better access to specialist care; specialist input is required for many of our patient's care plans, and we are developing services which bring easier access and more local access to this specialist advice. We are also reviewing the way we manage referrals into specialist care so that we can ensure access to the best specialist advice is achieved first time.

Better access to specialist care - Current Position

We are working as a system to understand how best to ensure patients receive timely and accessible specialist advice. Progress to date includes:-

- Established community diabetes care and support with many other long term conditions supported within the community.
- Community cardiology; a pilot to provide a one-stop shop for the diagnosis and early treatment of cardiovascular issues. This is being delivered as a collaboration between primary and secondary care providers.

Next Priorities

- Improve and develop other community services such as MSK, dermatology, and early detection of liver disease
- Develop a referral support service and referral management pathways, ensuring faster access to the right advice and support
- Continue to review and embed innovation and national guidance and ensure that services are delivered following best practice to deliver real clinical value for patients.

Integrated urgent & emergency care service; across Hampshire we are reviewing how to make it easier for people to navigate the right care and support in time of more urgent need.

Integrated urgent & emergency care - Current Position

- NHS111 can be accessed for advice and guidance and navigation to right place for support
- Same day urgent appointments are provided at all GP practices
- Acute mental health crisis teams are in place to support those in urgent need of support and we have enhanced psychiatric liaison in HHFT, with increased funding for people in crisis to be followed up in wellbeing centres if they don't need secondary care input

Next Priorities

- Improved NHS111, a new clinical assessment service integrated with GP out of hours services to make it easier for people to navigate urgent care services to get the right advice or support, or face to face appointment/visit. The

Improved NHS111 service will also be able to directly book patients into out of hours appointments, urgent treatment centres and other services as they become available. NHS111 will also be accessible online.

- By July 2019 primary care extended access and the current face to face element of out of hours GP services will combine as a single service in the Andover and Winchester areas. The out of hours GP service in Basingstoke will continue its close integration with Basingstoke Hospital emergency department following moving in to new purpose built accommodation in the hospital in May 2018. The co-location of services gives greater continuity of care and flexibility of resource contributing to less duplication in the urgent care system.

- In addition to the above there will be extended access hubs in Mid Hampshire at Andover and Winchester. These hubs offer evening and weekend appointments with GPs, practice nurses and other health professionals providing high quality, convenient and local care.

- Initial work in 2018-19 will review the potential for a same day access centre in Basingstoke. This will provide increased access for our patients to their GP and wider primary care team. The CCG is working with patients, practices and the Borough Council to design the service with an option appraisal having commenced to identify premises. A business case for Wave 4 capital funding is being prepared. The option to extend the service to be an urgent treatment centre is being considered.

- In the early stages of planning the NHCCG is exploring the opportunity for a primary care hub in Alton, and new health facilities in Winklebury. There is also a need for new GP premises in Manydown where the population is expected to have the highest growth in Hampshire. These schemes will be worked up for future capital investment programmes.

- To ensure effective urgent and emergency care in North and Mid Hampshire, by July 2019 Andover War Memorial Hospital will additionally be designated as an urgent treatment centre. It will offer GP-led services and be open 12 hours per day (minimum), seven days a week. It will provide a full range of minor injury and minor illness support, and staff will have access to diagnostics to support patients locally.

Effective and sufficient step-up, step-down, nursing and residential care; effective care rapidly when people with complex needs are in need of greater support can prevent admission to hospital and make sure patients are discharged when medically ready. It includes a range of services, including step up and step down intermediate care services and beds and rehabilitation and reablement services in people’s homes.

Effective and sufficient, step-up, step-down, nursing and residential care - Current Position

This is an area of joint working with both community health and social care providers as people in crisis are vulnerable and need joined up care that is centred on their needs

- A full review of current intermediate care capacity and demand has been completed across the system for supporting delivering appropriate care that assists people in rehabilitation and reablement to support returning to independent living. Research shows that the majority of people whom have lived independently pre-hospital admission will return to independent living with effective and timely support services; this is a core thread of the system improvement programme working to reduce delays in transferring people to effective onward care.

- Supporting a growing demand for support to enable people to live independently is dependent on the alignment of the care at home framework being developed by HCC alongside continued healthcare services that are based on individual assessments conducted outside of hospital. In 2017 less than 50% of long term care assessments were delivered outside of acute hospitals; the target for 2019 is for 85% to be conducted in intermediate care settings or at home. This delivers less dependence on care for the individual and is more sustainable for the system as our population lives longer.

- Care for people suffering with dementia is also an area of priority for the local care system and the rise in dementia friendly GP surgeries is continuing. We are providing greater support for residential and nursing homes to better support dementia patients through accessing specialist care providers; the local care system has allocated improved Better Care Funding to support the enhanced care Home offer for dementia patients.

Next Priorities

- Integrated intermediate care – involves bringing together rehabilitation and reablement services under a single leadership and a delivery model is being developed Hampshire-wide in collaboration with Hampshire County Council and the health provider. In Mid Hampshire a single point of access to these services will go live in May 2018.

- Review the provision of intermediate care beds

- Development of a discharge to assess model to ensure patients return home as soon as they are fit to do so with the right care package in place

- Continue to develop the enhanced support for residential and care homes

2.3 Acute services reconfiguration options

Hampshire Hospitals has consistently agreed that any changes will at least maintain the quality of care for the people of North and Mid Hampshire. In the light of the CCG decision in November 2017, the clinical teams have been considering those services which would have been centralised in a central location, to better understand the costs and benefits of centralising at one of the existing Hampshire Hospitals Sites. At the TCS Programme Board held on 18 April 2018, HHFT reported the progress in assessing the feasibility of centralising some of the acute services, a summary of which is outlined below.

Acute Service Description	Led by	Status at April 2018
Obstetrics - Internal review of the sustainability of current obstetric and neonatal services.	HHFT Family division	Current service is safe. The benefits of centralisation are still clear. Work is underway to understand if the benefits can be realised in the existing estate.
Emergency Department - Internal review of the sustainability of the emergency departments	HHFT Medical Division	Current service is safe but has workforce challenges. Work is underway to understand the implications of any options.
Elective Care - to progress the potential of centralising some elective care provision	HHFT, (involves joint work with Solent Acute Alliance's strategic outline for elective capacity)	Clinical teams are reviewing procedure specifics to understand options and implications.
Cancer Treatment Centre - The Trust continues to have a Cancer Treatment Centre (CTC), as part of its strategy. The radiotherapy and clinical oncology services are challenged due to the vulnerabilities of a single radiotherapy Linac machine and workforce shortages in oncology. Discussions have started with University Hospitals Southampton to see whether a networked model could provide greater resilience.		
End of Life Care – The Trust have well progressed plans for extending the Countess of Brecknock Hospice in Andover in conjunction with the Countess of Brecknock charity trustees and are developing plans for a 10-bedded Hospice through the conversion of Burrell House in Winchester.		

There is no immediate need to change, and the relevant clinical teams are deliberating on various options to understand what the implications would be for any specific services. Clearly, if the clinical teams recommend any changes which require public engagement and/or consultation then the appropriate processes will be put in place.

2.4 HHFT Estates Review - Update

The detailed estates reviews undertaken over the last months have generated information on required maintenance spend for each of the three sites over the next 20 years. The spend in the next 5 years in order to address priority estates items is:

Basingstoke and North Hampshire Hospital -	£67m
Royal Hampshire County Hospital -	£46.5m
Andover War Memorial Hospital -	£1.8m

Masterplans and Development Control Plans are being developed capturing:

a) Backlog Maintenance for all three sites
b) Capital Equipment – assess extent of expenditure required including timescale and priorities. Resilience planning of essential equipment.
c) Digital Developments as part of activities through HHFT's role as Global Digital Exemplar
d) Disposals and commercial estate opportunities

The masterplan will take into account changes proposed within new out of hospital care models in support of demand management reductions.

HHFT is engaging with Hampshire and Isle of Wight STP process to ensure priorities are known and understood so early phases are supported by an application for Wave 4 capital funding via the STP.

2.5 Support to transform

Implementing different ways of working and providing services takes time and needs to be supported by concurrent developments in information technology, workforce, estates, communication and engagement in order to optimise the benefits to people using services and people providing services. HIOW STP leads on these critical 'enabling' programmes working across all areas, linking with local transformation teams to ensure plans are aligned to make best use of all available resources and deliver value.

Part 3 – DEVELOPMENT OF INFORMATION AND ENGAGEMENT CAMPAIGN

As part of our update to Hampshire Health and Adult Social Care Scrutiny Committee on 17 January 2018, we highlighted the importance of information and engagement, at various levels, as an underpinning process supporting the developments of models of care.

We carried out wide engagement in 2017 with local people to provide objective feedback on transforming the way people receive care services. Nearly 1,100 people were involved through on-street or online surveys, focus groups or detailed interviews and the Hampshire Partnership established a co-production group and held workshops for people with lived experience of long-term conditions, and representatives from the voluntary sector, CCG and community provider.

People understood the theme of centralisation and also told us they would like care services to be developed in line with the following person-centred outcomes:

- The way people treat me and those who support me
- The way in which people inform me
- The people who support me
- The way in which I am supported
- Diverse and creative solutions to support me.

We are now harnessing this research to create a system-wide approach to communications and engagement with people in north and mid Hampshire.

We will work with local people through formal and informal groups and use local existing local networks, including social media networks, to reach out to people in these communities. We will also identify opinion formers and leaders within communities and work with them.

We will talk to people about our transformation plans and how we believe we can enhance their experience of health and care closer to home.

The engagement process will involve a range of channels to ensure we capture the views of a wide cross section of the population. The process will include face to face meetings, using the news media and social media, online surveys, web pages and newsletters. We will ensure information is available and accessible, for example at key public areas such as GP practices, hospital waiting rooms, council receptions areas, libraries and areas with a high foot fall, such as town centres.

We recognise that communication is a two-way process and we will listen to local people and use their feedback to inform our plans for transformation.

People will hear how they have helped shape the future of local health care with regular 'You said, We did' updates and ;'You said, we did not because….', which is equally important.

We are also developing a communications plan to raise awareness of the Extended Hours Hubs at Andover and Winchester, which provide evening and weekend appointments with GPs and practice nurses.

LIST OF ABBREVIATIONS

Abbreviation	Explanation
AWMH	Andover War Memorial hospital
BNHH	Basingstoke and North Hampshire Hospital
CHIE	shared care record (formerly Hampshire Healthcare Record)
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CTC	Cancer Treatment Centre
ECIP	Emergency Care Improvement Programme
EOL	End Of Life
HASC	Health and Adult Social Care Committee
HCC	Hampshire County Council
HHFT	Hampshire Hospitals NHS Foundation Trust
HIOW	Hampshire and Isle of Wight
IAPT	Improving access to psychological therapies
JSNA	Joint strategic needs assessment
LCS	Local Care system
MDT	Multi-disciplinary teams
MSK	Musculoskeletal
NHCCG	NHS North Hampshire Clinical Commissioning Group
PMO	Programme Management Office
RHCH	Royal Hampshire County Hospital
SDAC	Same Day Access
STP	Sustainability Transformational Partnership
TCS	Transforming Care Services
UHS	University Hospital Southampton NHS Foundation Trust
UTC	Urgent Treatment Centre
WHCCG	NHS West Hampshire Clinical Commissioning Group