Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

TUESDAY, 4 OCTOBER 2016 AT 9.30AM

THE EXECUTIVE MEETING ROOM, THIRD FLOOR, THE GUILDHALL

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Membership

Councillor Jennie Brent (Chair)
Councillor David Tompkins (Vice-Chair)
Councillor Alicia Denny
Councillor Leo Madden
Councillor Gemma New
Councillor Lynne Stagg
Councillor Brian Bayford
Councillor Gwen Blackett
Councillor David Keast
Councillor Mike Read
Councillor Elaine Tickell
Councillor Philip Raffaelli

Standing Deputies

Councillor Dave Ashmore
Councillor Ben Dowling
Councillor Hannah Hockaday
Councillor Lee Hunt
Councillor Ian Lyon

(NB This agenda should be retained for future reference with the minutes of this meeting.)

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

A G E N D A

1 Welcome and Apologies for Absence

2 Declarations of Members' Interests

3 Minutes of the Previous Meeting (Pages 1 - 8)

The minutes from the meeting held on 26 July are attached for your approval.

4 Systems Resilience Group Plan - Update (Pages 9 - 28)

The following officers will answer questions on the attached papers:

- Sue Damarell-Kewell, Programme Director System Resilience
- Rob Haigh, Executive Director Emergency Care, Portsmouth Hospitals' NHS Trust
- Rob Kemp, Area Manager, South West Hants, South Central Ambulance Service

5 South Central Ambulance Service - update (Pages 29 - 38)

Rob Kemp, Area Manager South West Hampshire will answer questions on the attached report.

6 Emergency Department, Queen Alexandra Hospital - update.

Peter Mellor, Director of Corporate Affairs will answer questions on the report that will follow.

7 Portsmouth Hospitals' NHS Trust - update

Peter Mellor, Director of Corporate Affairs will answer questions on the report that will follow.

8 St Mary's NHS Treatment Centre - update.

Penny Daniels, Hospital Director will present the report that will follow.

9 Portsmouth Clinical Commissioning Group - update (Pages 39 - 44)

Dr Elizabeth Fellow, CCG Governing Board Chair, will answer questions on the attached report.

Members of the public are now permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting or records those stating explicitly that they do not wish to be recorded. Guidance on the use of devices at meetings open to the public is available on the Council's website and posters on the wall of the meeting's venue.

HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Tuesday, 26 July 2016 at 9.30 am in the Conference Room A - Second Floor, Civic Offices

Present

Councillor Jennie Brent (Chair)
Councillor David Tompkins
Councillor Alicia Denny
Councillor Gemma New
Councillor Lynne Stagg
Councillor Gwen Blackett, Havant Borough Council
Councillor David Keast, Hampshire County Council
Councillor Mike Read, Winchester City Council
Councillor Elaine Tickell, East Hampshire District Council
Councillor Philip Raffaelli, Gosport Borough Council

1. Welcome and Apologies for Absence (AI 1)

The Chair welcomed everyone to the meeting and introductions were made.

There were no apologies for absence.

2. Declarations of Members' Interests (AI 2)

No interests were declared.

3. Minutes of the Previous Meeting (AI 3)

Councillor Raffaelli advised that he had been omitted from the list of attendees from the previous meeting.

RESOLVED that the minutes of the meeting held on 21 June 2016 be agreed as a correct record, subject to the above correction.

4. Systems Resilience Group's Plan (AI 4)

Innes Richens, Chief Operating Officer/Director of Adult Social Services, NHS Portsmouth CCG/Portsmouth City Council introduced his colleagues who were present for this item:

- Sarah Austin, Chief Operating Officer, Solent NHS Trust
- Sue Damarell-Kewell, Programme Director System Resilience Fareham and Gosport, Portsmouth and South Eastern Hampshire CCGs
- Sheila Roberts, Interim Chief Delivery Officer, Portsmouth, Fareham and Gosport and South Eastern Hampshire CCGs
- Angela Dryer, Deputy Director of Adult Social Services

- Ed Donald, Chief Operating Officer, PHT.

Innes advised that the SRG's plan details a wider set of actions across Portsmouth and SE Hants which is overseen by the members of the SRG. South Central Ambulance Service (SCAS) is also a critical partner however they were unable to send a representative today.

Sue Damarell-Kewell explained that the SRG's focus is on planning, information and delivery and looking at how organisations can all work together to deliver operational resilience. All leaders come together to monitor and performance manage programs. There are challenges around urgent care and the SRG are looking at helping people stay well for longer and managing conditions out of hospital e.g. caring for patients in their own homes.

Sheila Roberts added that SRG's have been around for a number of years and they are now focussing on interdependencies.

Innes then invited Ed Donald to update the panel on priorities for PHT. The hospital is on an improving trajectory and he was pleased to report that 76% of patients were admitted or discharged within 4 hours in April which increased to 82% at the end of June. Last week this reached 84% so the situation is continuing to steadily improve. There is still an issue with the number of ambulances arriving at the ED, although ambulance delays have reduced significantly. He advised that the panel may wish to follow this up with SCAS.

PHT are also making sure that patients see the most senior doctor and there is a 'pit stop' area at the front of the ED where patients are assessed. A pilot has been run and the average time for minor patients to be seen by a clinician was 50 minutes however, if the staffing was at correct levels this could be reduced to 15 minutes. With regard to an assessment and treatment plan, 100% of patients had received this within 60 minutes as part of the pilot.

With regard to the short stay pathway for patients, this has improved from 60% to 65% and for older population it has increased from 35% to 45%. A comprehensive geriatric assessment has been completed by Dr Ali Bartens. This started in January and 90% of patients now have received an assessment.

Sarah Austin and Angela Dryer were then invited to give the panel an update from the community providers' perspective. Sarah advised that there were three key areas of work:

1) Better services in community so that people with frailty do not have to be admitted to hospital;
2) A community team has been based at the ED at QAH, which is a combined Solent/Southern team, for some years. If a patient requires admission to hospital, staff will now complete a comprehensive geriatric assessment and following this Solent will follow the patient through the system to ensure they know what happens to their

patients. It is about making it possible for them to return home as the quicker they can get home more likely they are to be independent;

3) In-reach into wards by the community social care and health teams known as the discharge to assess model. This means that rather than leaving someone who is well in a bed while they are waiting to be discharged, the patients is either moved back home, moved into a community ward or into a care home, so that no patient is waiting in bed to be discharged for more than 24 hours if they are well enough to be discharged. This is a very big step forward. The discharge to assess model has started before Christmas and this now needs to be geared up further.

Angela Dryer advised that the discharge to assess contract with the provider for 24 hour care for up to two weeks went live in April and as a result long term admissions have fallen. Allowing patients back home is the best place to complete the assessment and identifies when patients will need assistance. This is based on capacity and currently this is manageable.

Angela advised that the other key change is that formerly care packages for patients were cancelled when they were admitted to hospital, which was a problem if the patient needed to be discharged quickly. The ASC team have now agreed with PHT that care packages will not be cancelled if a patient is admitted into hospital and the agency providing the package will still be paid.

In response to questions the following matters were clarified:

- Recruitment of staff across all partners is a problem however this is not unique to this area. The introduction of the living wage will impact the community providers.
- Visits by care providers are determined by individual need so can be up to four times a day. These are supported by nursing or therapy support.
- The SRG has shifted from firefighting to actively planning and the targets set are achievable.
- Some of the elements on the delivery plan are overdue. Money needs to be reorganised to ensure that funding is sustainable. Members of the SRG are looking at how to cover this in a more productive way rather than historically. Finances have not yet been agreed and PCCG is actively looking to recycle money.
- The plan for ED discharges for QA is to increase this to 85% and hold this at this level before increasing the target to 90% once know the changes have embedded and it is known that the improvements are sustainable.
- The key is to achieve the correct flow in the hospital and make sure that patients do not come through the ED unnecessarily. The discharge lounge is working well and use of this will be maximised. Ed advised though that staff at PHT recognised that the department is too small and PHT will be looking at plans to expand the ED department. The challenge of this will be obtaining capital to finance this.
- If a patient can walk off of an ambulance, they will not be put onto a trolley but into a wheelchair instead.

- The pilot scheme in the ED took place following the CQC report was published as the teams at the front door felt they could do better which was very positive. The level of the pilot cannot be sustained as the substantive staff are not in place. PHT are currently focusing on recruiting substantive staff over the next 6 months and it will take approximately two years for them to be fully trained.
- There are no longer 15 minute slots for nursing staff to visit patients in their homes as it is recognised that this is not practical to complete the tasks and also have a decent conversation with the patient. Most visits are 30 minutes long however it is not uncommon for visits to last an hour. Unfortunately the finances are not currently in place to allow for longer visits than 30 minutes. Angela also confirmed that for domiciliary care 15 minute visits only take place for welfare visits e.g. to pop in to check the person is well but for any personal care visits these are allocated a minimum of 30 minutes. Blended visits where two members of staff carry out personal care visits also take place if necessary, although both carers may not stay for the whole visit depending on what is needed.
- Ed Donald advised that the feedback from the CQC weekly assessments is verbal and at present they have not come back with any concerns to the approach PHT are taking to the improvements.
- Staff morale will be revisited and peer reviews of staff will take place over the next few months. It was agreed these results would be shared with the panel once available.
- Members commented that it would be helpful to see the trajectory to see how things have progressed and the targets aimed for. Sue advised that this data was available and could be circulated to the members along with the monthly updates.
- The challenge for the group is what can be done for the resources available. Innes advised that it would be sensible to bring this item back to the panel's next meeting and he would include details of savings targets.

ACTIONS:

- The SRG update for July and monthly updates going forward to be circulated to the panel.
- PHT to share the results of the peer review with the panel once these are available.
- Trajectory data and the dashboard data to be circulated to the panel.

RESOLVED that the report be noted and an update on progress be brought back to the next meeting.

5. Solent NHS Trust - update (AI 5)

Ellen McNicholas, Interim Chief Nurse introduced the report on behalf of Sarah Austin who had to leave the meeting after the previous item. Ellen explained that:

- A significant amount of work had taken place during the lead up to the CQC inspection and Solent are very proud of their staff. The quality summit and final report would be on 19 September and prior to this Solent will receive the report to comment on for to check for factual inaccuracies.
- Earlier this year, the vacancy rate was at 47% for nursing within Solent however recruitment has recently taken place and offers of employment are currently being made and this has reduced to 11%. It is anticipated by mid-end of September all vacancies will be filled.

In response to questions the following matters were clarified:

- With regard to the pressures on the Section 136 suites from the police, Ellen advised that Solent are doing best to ensure safe and effective service and working with police however there is a lack of resources nationally.
- The 136 suite in Portsmouth is one suite but is now separated into two rooms following a recent remodelling. Food is available to patients and they will be taken care of as it can be a lengthy process.
- There are 11 psychiatric intensive care beds which are predominately for Portsmouth residents who require them. Would not accept out of area patients unless there is a spare bed. Ellen said she did not have figures with her on the population of patients in the area requiring medical treatment and would arrange for this to be circulated to the panel after the meeting.
- One of the areas for improvement raised by the CQC was around substance misuse, particularly in the Southampton area. There are plans in place for the points raised following the CQC inspection, however until the report is received a proper action plan will not be able to be drawn up.
- Solent has no patients in Antelope House in Southampton so its temporary closure did not have a direct impact. However Solent are monitoring the situation carefully as it may cause a demand on beds in Portsmouth.
- There is a gap in the number of nurses, physios etc. to meet the needs but this is now being addressed. The University of Portsmouth will be running a nursing qualification from February 2017 with 110 places. This will help to reduce the gap in the numbers of nursing staff.
- The existing skills of staff that were previously based at Baytrees will be assessed to see whether they require any further training to be redeployed.
- There is a psychiatric liaison services which is run jointly by Southern Health and Solent NHS Trust based at QA hospital.

ACTION
Ellen to email to the panel figures on the population of patients in the area with mental health needs.

RESOLVED that the update report be noted.

6. Portsmouth Hospitals' NHS Trust - update (AI 6)

The Chair advised that a deputation request had been received for this item and invited Mr Jerry Brown to the table.

Mr Brown made a deputation about the provision of mental health services to PHT in the period between Solent Health reaching the end of their contract and the new contract with Southern Health commencing in September. The Chair thanked Mr Brown for his deputation.

Peter Mellor, Director of Corporate Affairs, was then invited to the table to present his report. In response to questions the following matters were clarified:

- Mental health patients are admitted to QAH if they have an acute injury that needs treatment and if staff think that the patient may also have a mental health issue they will refer them to Solent or Southern Health for an assessment.
- The Trust's budget is approximately £490m each year. Last year PHT were overspent by £23.5m which the NHS has rightly said is unacceptable. There is £14.6m transitional money available to assist however this money is given in arrears dependent on performance. The NHS has said they will not take into account the quarter 1 performance data to allow the changes to be embedded.
- Peter said that as he had not had sight of Mr Brown's deputation, he could not answer the points raised in this deputation but he could arrange for a response to be sent to Mr Brown which would also be shared with the panel.

ACTION

- The quarterly results that PHT send to the CQC to be circulated to the panel.
- That Peter Mellor arrange for a response to the points raised in Mr Brown's deputation to be sent to him and also circulated to the panel.

RESOLVED that the update be noted.

7. Mental Health Services Provision - particularly CAMHS. (AI 7)

The report was introduced by Stuart McDowell, Commissioning Project Manager, Integrated Commissioning Service and Sonia King, Better Care Centre Manager.

In response to questions the following matters were clarified:

- It is the team's intention to commission an early help service to support young people and to have clinics in seven of the senior schools in the city. These clinics will help sign post them to either ensure they receive follow up in a clinic or that they are sent directly to the CAMHS team.
- The Council offer training for school staff to recognise the signs of mental health issues and are offering self-harm intervention.
- Off the Record is currently funded by Portsmouth CCG until December 2016, it will then go out to tender for a similar service.

- There are a wide range of presenting conditions, anxiety is one of the main ones. The team hare a rota with Sussex, which covers Havant for self-harm but districts have different set-ups. There is also a shared learning Looked After Children team that covers the Isle of Wight, Gosport and Fareham.

RESOLVED that the update be noted.

8. Portsmouth Safeguarding Adult Board Strategic Plan Update (AI 8)

The report was introduced by Rachael Roberts, Service Manager and Robert Templeton, PSAB Chair. In response to questions the following matters were clarified:

- The PSAB meets quarterly and the sub groups undertake various pieces of work. The number of sub groups has been reviewed.
- Priorities for next year will be public awareness and quality and intelligence.

RESOLVED that the update report be noted.

9. Adult Social Care - update (AI 9)

The report was introduced by Angela Dryer, Deputy Director of Adult Services. In response to questions the following matters were clarified:

- The assessment form has now reduced from 18 pages to just four questions.
- The number of deprivation of liberty applications has doubled from 14/15 to 15/16 and is likely to increase further in 16/17.

ACTION

- It was agreed that a more in depth report on Deprivation of Liberty Safeguards come back to a future meeting.

RESOLVED that the update be noted.

10. Southampton, Hampshire, Isle Of Wight and Portsmouth Health Overview and Scrutiny Panels Arrangements for Assessing Substantial Change in NHS Provision (revised June 2016) (AI 10)

The Chair introduced this item. She advised that the purpose of this item is to agree the Framework for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) areas.

The document describes the actions and approach expected of relevant NHS bodies or relevant health services providers and local authorities with health scrutiny functions when proposals that may constitute substantial service change are being developed. It also outlines the principles that will underpin each parties' role and

responsibility.

The document is the fourth refresh of the 'Framework for Assessing Substantial Service Change' and updates the guidance relating to the key issues to be addressed by relevant NHS bodies or relevant health service providers when service reconfiguration is being considered. Emphasis is placed on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit to our respective communities from doing so.

RESOLVED that the revised Framework for Assessing Substantial Service Change be approved.

The meeting ended at 12.10 pm.

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Councillor Jennie Brent
Chair

Attachment

NHS
Fareham and Gosport
and South Eastern Hampshire
Clinical Commissioning Groups

System Information Group
Summary Performance report
14th September 2016

Agenda Item 4

Overall Programme

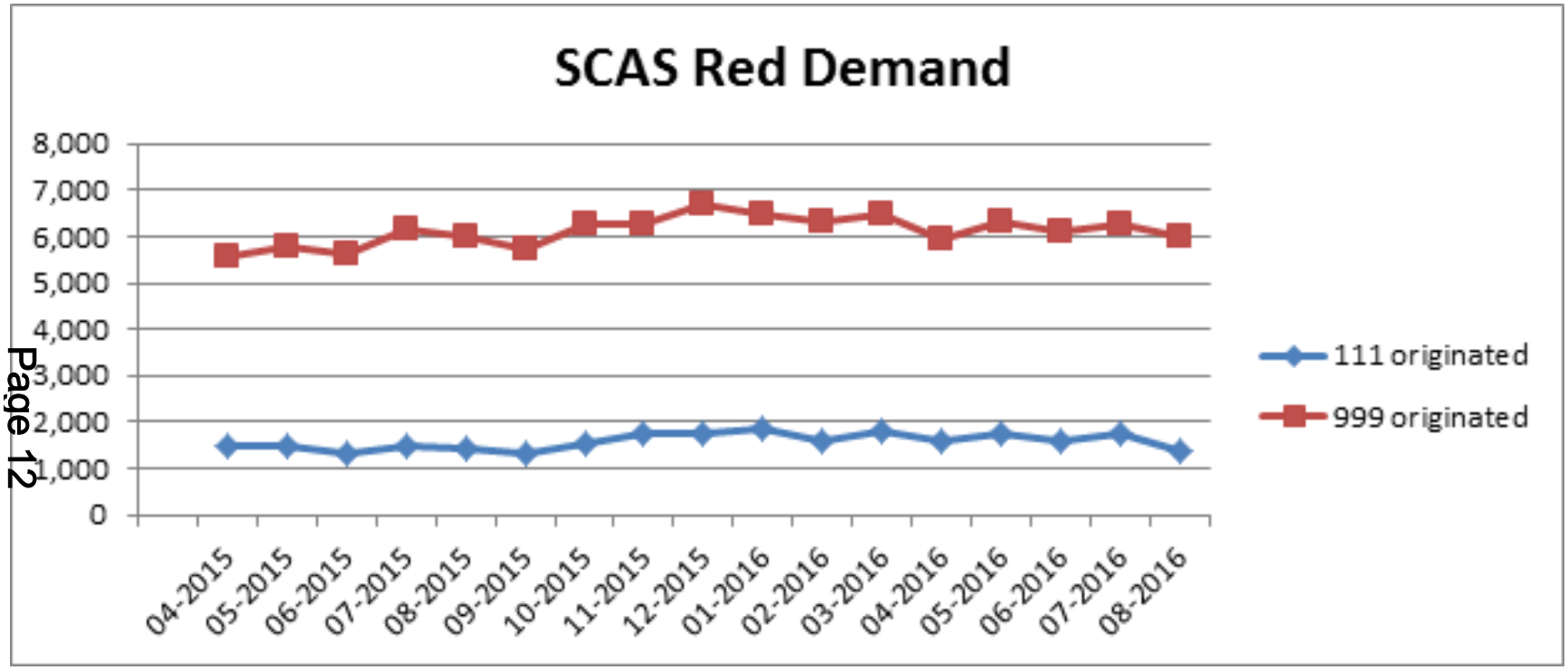
- Performance indicators have been identified by each organisation through their information lead and are under development to form a system wide report. Whilst it has been agreed by SRG members that information would be provided for the July performance report, data feeds for a number of the second level measures has not been received.
- The SRG Information Group have provided analysis on some of the indicators and request members of the Operational Group review and provide context and actions prior to the SRG Board
- As part of the wider development programme SRG members have received Tableau read access which will provide an interactive file updated weekly covering
    - PHT A&E data,
    - SCAS data
    - and if agreed, inpatient and SHFT data set (mid October).

  This can be viewed at postcode, local super output level, GP practice and CCG. Data can be cut by age, gender, method of arrival, time and day etc.
- SRG work stream groups are receiving support to utilise Tableau to identify areas of work and evaluate scheme success.
- As part of the Information Group role specific BI support will be provided to prioritised programmes.
- Further work to embed quality indicators in this report for all elements of the system is underway. The proposal was to include this data in the August report but this has been delayed.

Current Overall Metrics

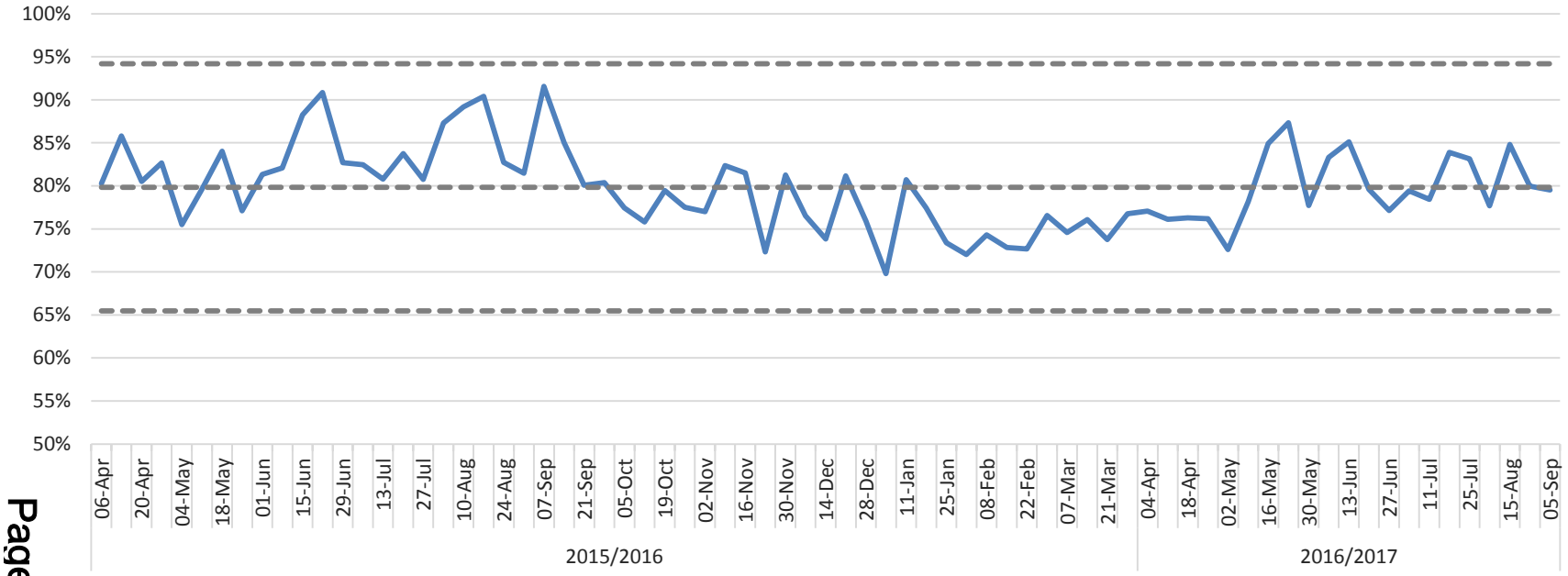
Indicator	Target	WC 2.5	9.5.16	16.5	23.5	30.5	6.6	13.6	20.6.	27.6	04.7	11.07	18.7	25.7	1.8	8.8	15.8	22.9	29.9
Attendance rate	2709	2815	2819	2724	2826	2824	2828	2728	2679	2745	2902	2975	2912	2827	2755	2669	2866	2787	2769
Frail elderly attendances	483	474	414	458	464	488	459	416	448	450	445	491	520	464	445	509	502	432	444
Ambulance conveyance rate	49.8%	48.8%	48.8%	28.4%	50.9%	48.6%	42.2%	50.3%	50.3%	49.2%	49.2%	49.2%	49.2%	49.2%	51.7%	50.4%	47.3%	48.3%	48.5%
Patients seen within 4 hours	95%	72.6%	78.1%	84.9%	87.3%	77.7%	83.3%	85.1%	79.6%	77.1%	79.4%	78.4%	83.1%	83.1%	83.2%	76.4%	83.7%	79.2%	82%
Type 1 conversion rate	33%	31.4%	30.2%	31.9%	34.6%	32.8%	31.9%	33.7%	34.6%	32.4%	29.7%	30.5%	30.2%	29.9%	31.5%	32.8%	33%	33.6%	32.7%
Avoidable breaches: Minors	0	67	67	52	36	66	67	23	30	95	93	61	26	35	49	47	63	26	32
Avoidable breaches: Non-admitted	77	118	122	66	153	212	149	128	180	210	210	265	169	167	200	239	208	263	224
Breaches awaiting specialty opinion	21	49	52	19	22	32	38	20	33	32	30	32	40	28	24	45	27	38	33
Length of stay >7 days (PHT)	410	505	491	488	477	489	474	472	479	482	425	465	481	492	483	482	461	457	484
Length of stay >14 days (PHT)	190	322	324	310	320	322	310	305	304	324	288	309	304	307	315	333	314	301	308
Discharges (Weekday)	575	583	603	703	695	595	663	658	695	674	651	591	591	593	654	618	642	643	612
Discharges (Weekend)	192	176	195	193	189	176	167	196	188	197	167	93	84	161	149	164	173	182	172
Medically Fit for Discharge (Daily Average)	64	143	N/A	158	143	191	196	200	202	N/A	208	195	177	189	225	231	234	227	208
Community Average Length of stay (Spinnaker)	20	21.4	1	22.8	24.5	14.8	13.5	25.6	24.3	22.3	29.4	9.2	9.2	15.6	22.9	N/A	23	20	19.3
Community Average Length of stay (Rowan)	20	14.6	21	21.6	22.1	N/A	13.7	13.1	12	10.3	6	16.9	16.4	9.7	15.8	32.8	31	24.8	15
Community Average Length of stay (Sultan)	20	12.3	N/A	19.5	40	21.5	25	27	18	16.9	24	20.8	12.1	16.8	26	11.9	13.8	16.6	20
Community Average Length of stay (Cedar)	20	23.6	16.7	23	22	68	22.3	32.5	13	12.3	33	31.5	8.5	N/A	48.7	44.4	21.7	48.4	33.5
Community Average Length of stay (Ark Royal)	20	42.3	25.4	42.5	34	33.5	30.5	34	36.5	39.2	25	24.3	45.5	11	24.7	30.5	14	27.5	32.2

SCAS Red Activity



Data Source: SCAS

A&E Performance at PHT

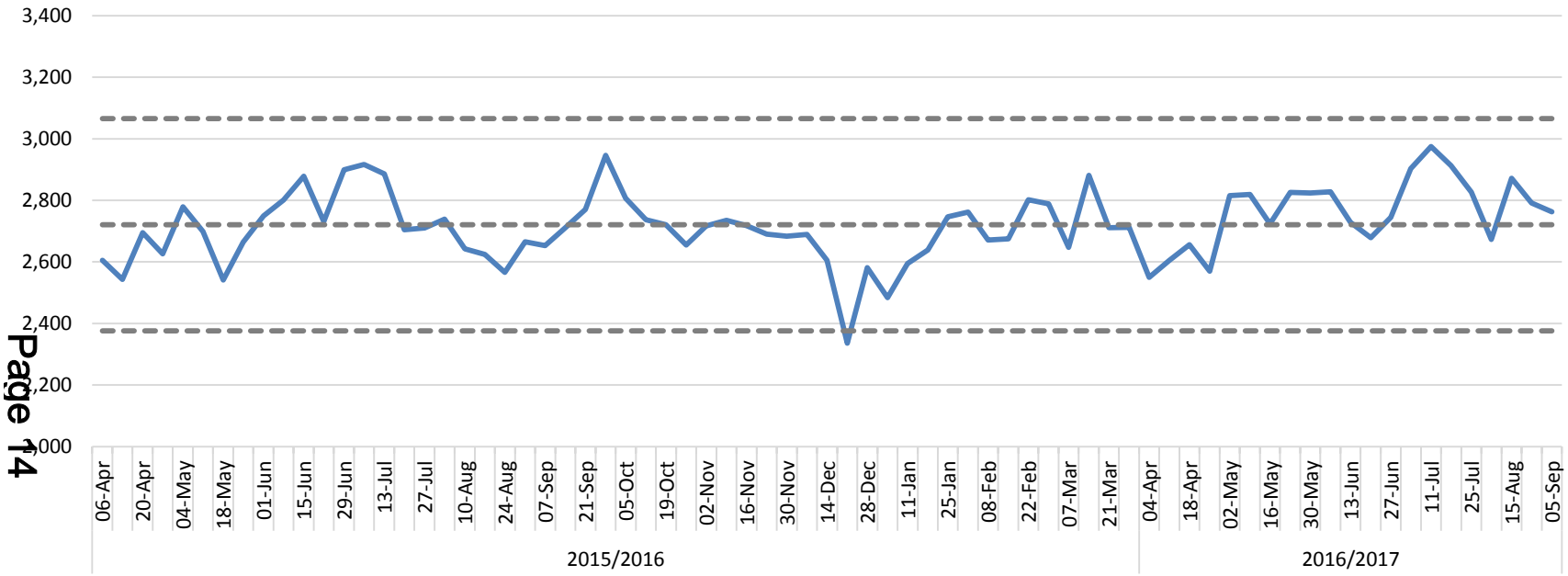


Since mid-May A&E performance has shown some improvement and attendances broadly consistent with a slight increase in the beginning of July.

- For the month of August, A&E performance was 81.33% - which is the highest performing month since Sept 2015. Performance is below the same time last year – which was 86.21%.
- There have been no 12 hour trolley breaches.

Data Source: PHT

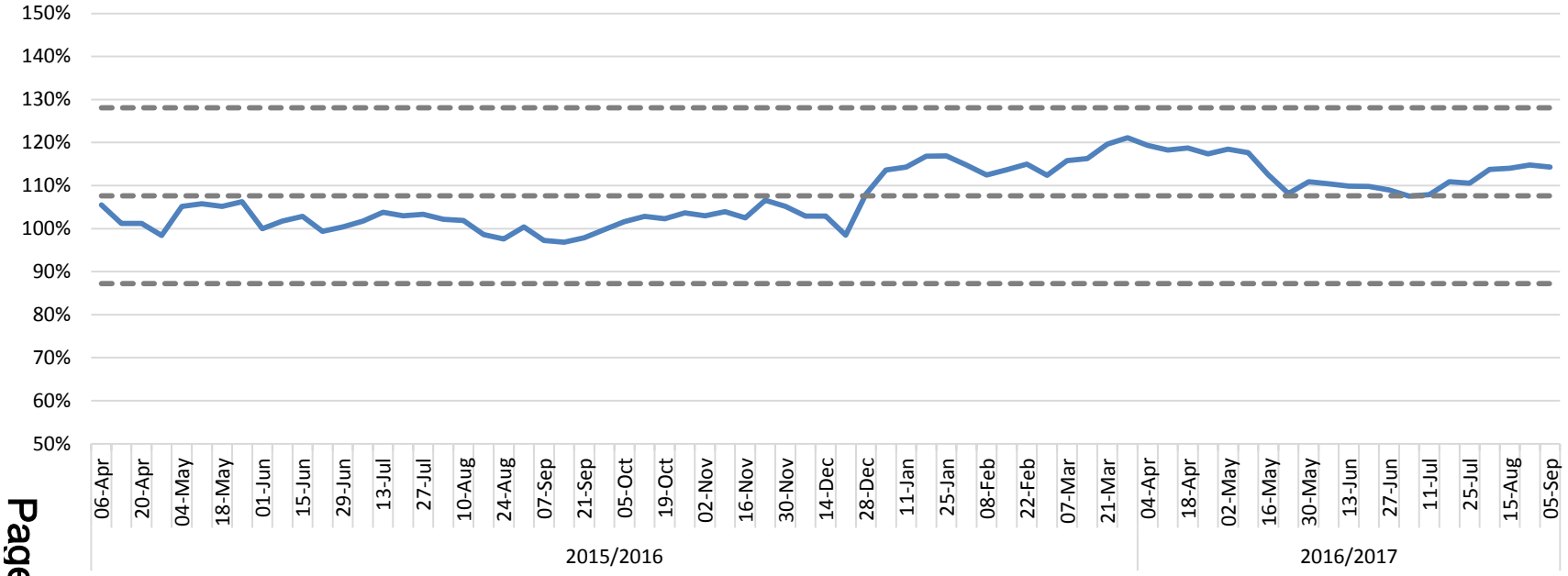
A&E Attendances at PHT



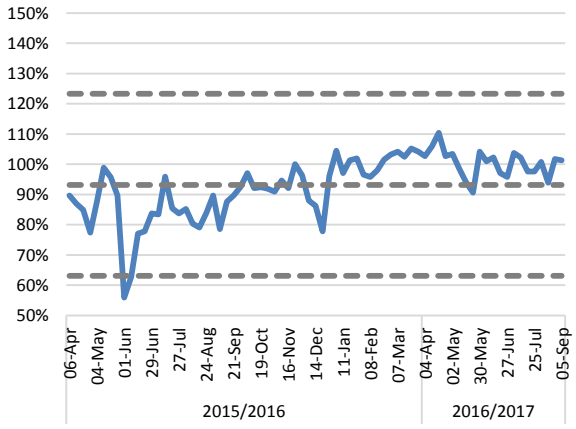
- Attendances activity is currently demonstrating the expected summer increase, replicating that seen at the same period last year.
- Average A&E activity over the last 17 months is 389 patients a day, approximately 307 of which are type 1 attendances.
- 15 minute triage has improved in the last 4 weeks but yet to flow through to impact on admissions. This may be due to the minors pilot.

Data Source: PHT

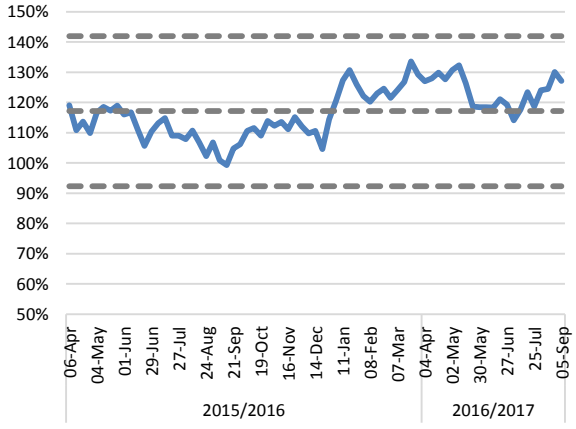
PHT Bed Occupancy (AMU/Medicine/MOPRS)



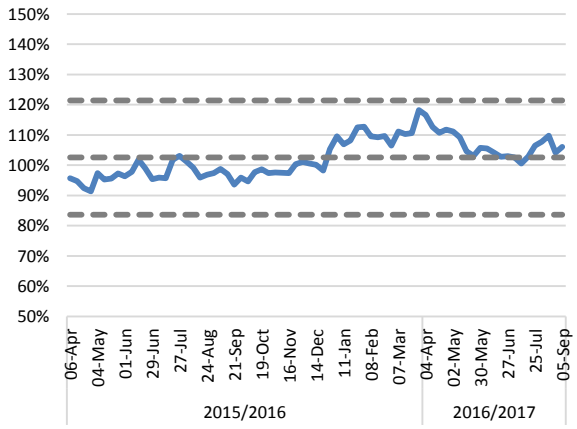
Bed Occupancy (AMU)



Bed Occupancy (Medicine)

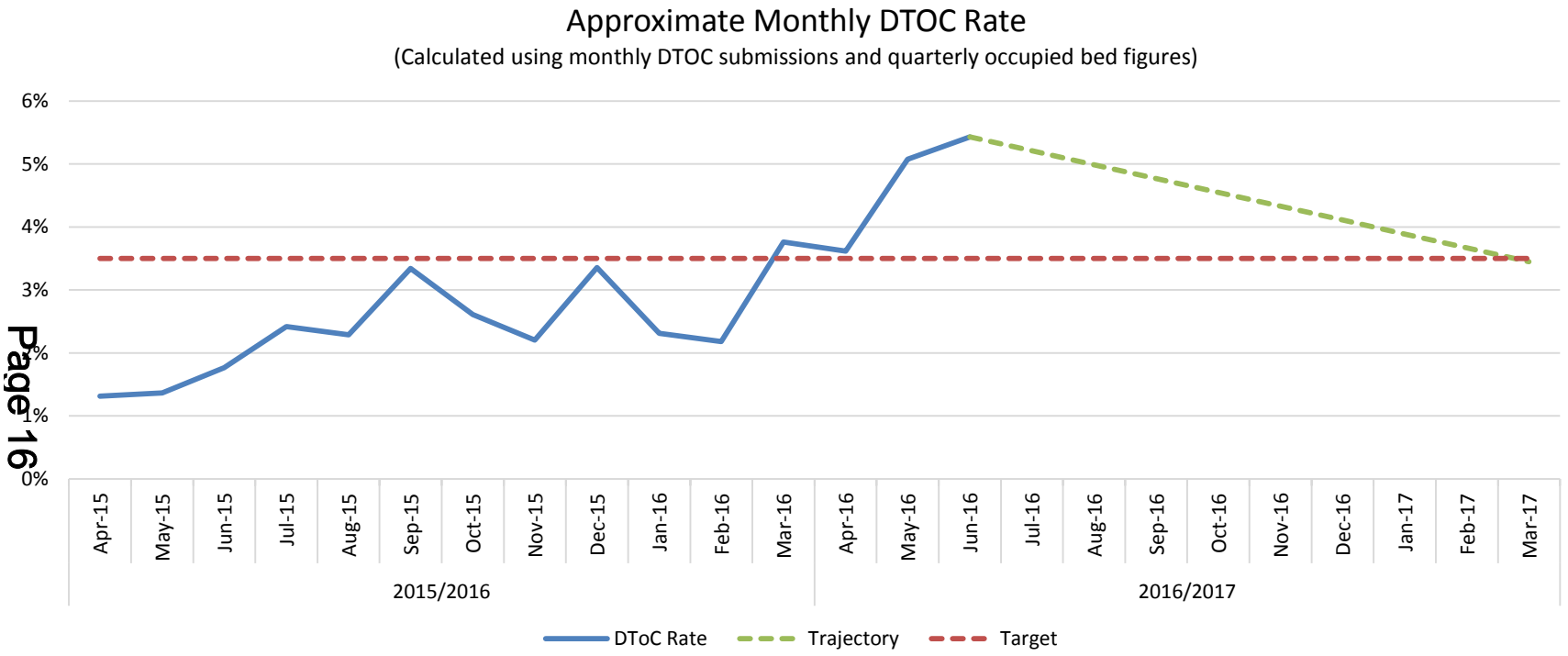


Bed Occupancy (MOPRS)



Data Source: PHT

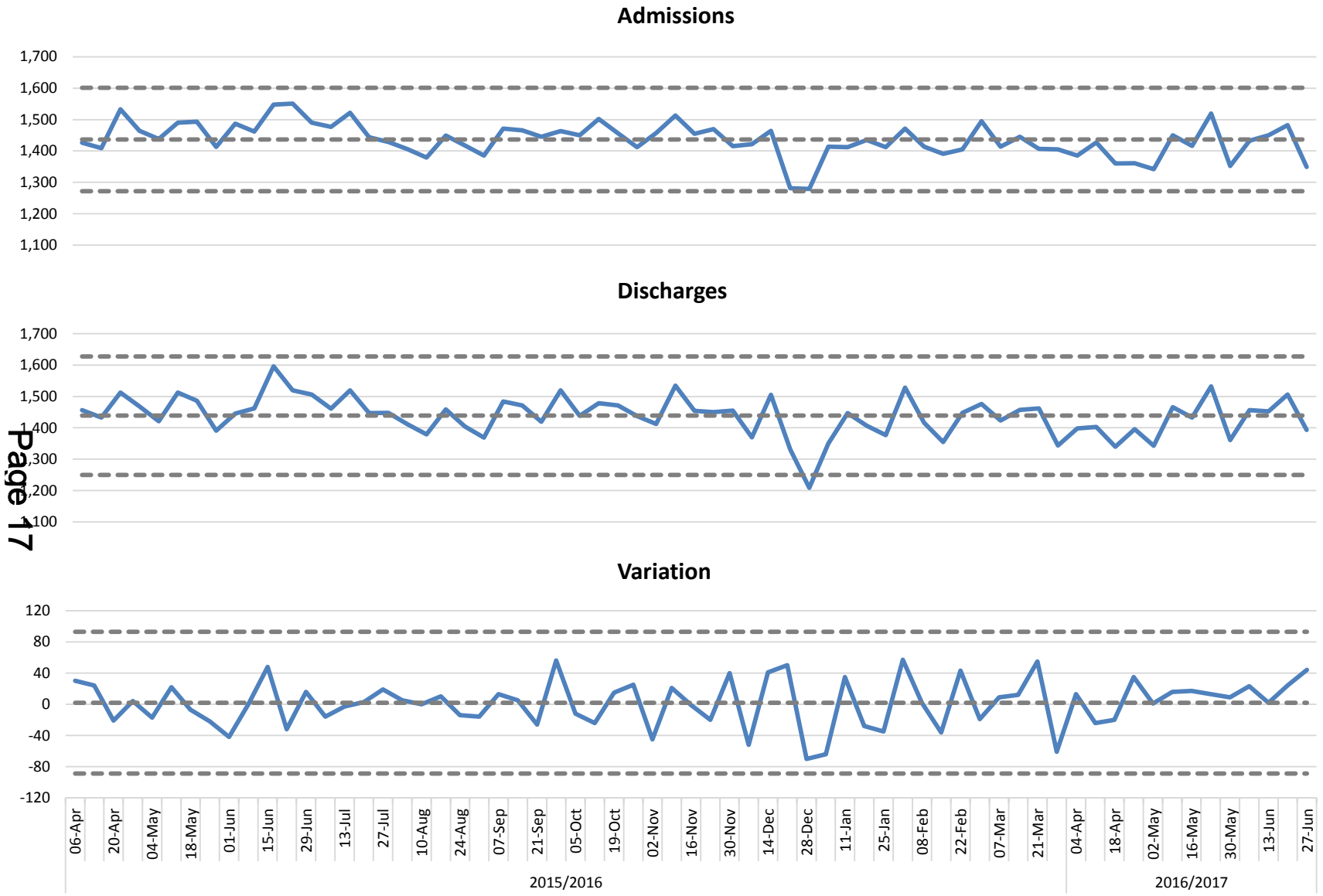
PHT Delayed Transfers of Care



- The delayed transfers of care rate has continued to rise during August. Work to manage the current backlog is beginning to take effect and there has been a reduction in days lost since the last week in August.

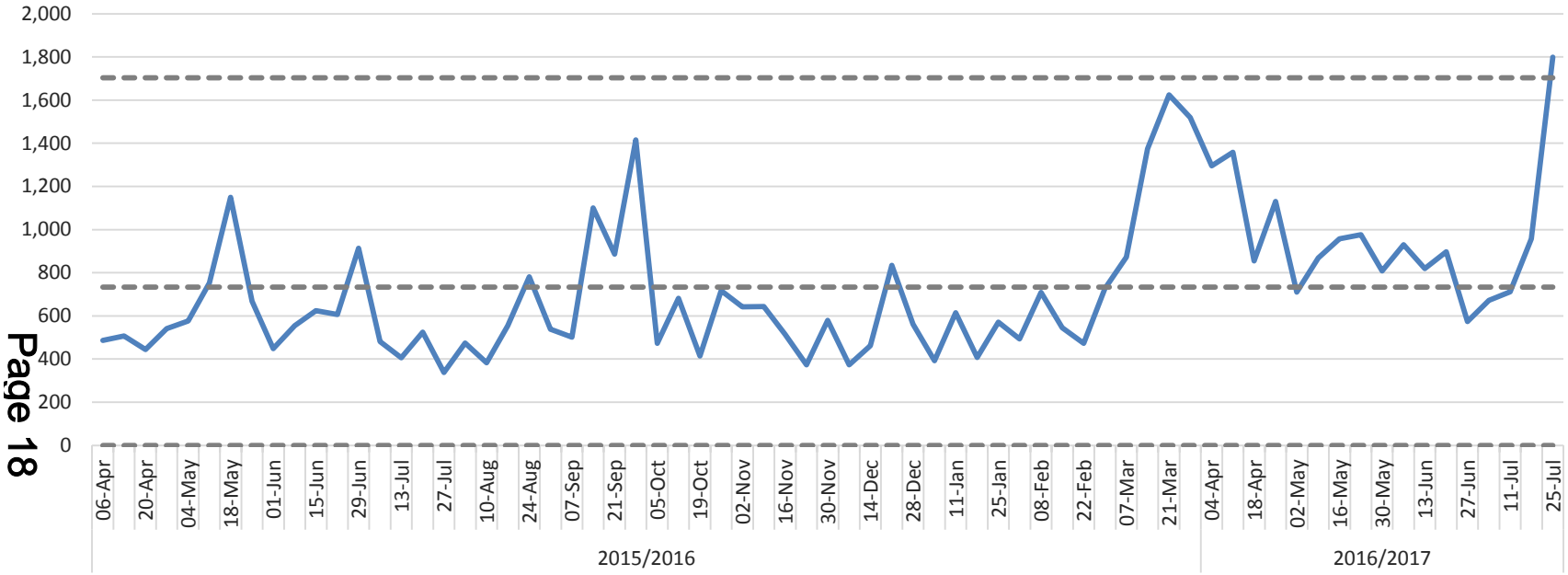
Data Source: PHT submission to Unify and quarterly bed numbers

Admissions & Discharges



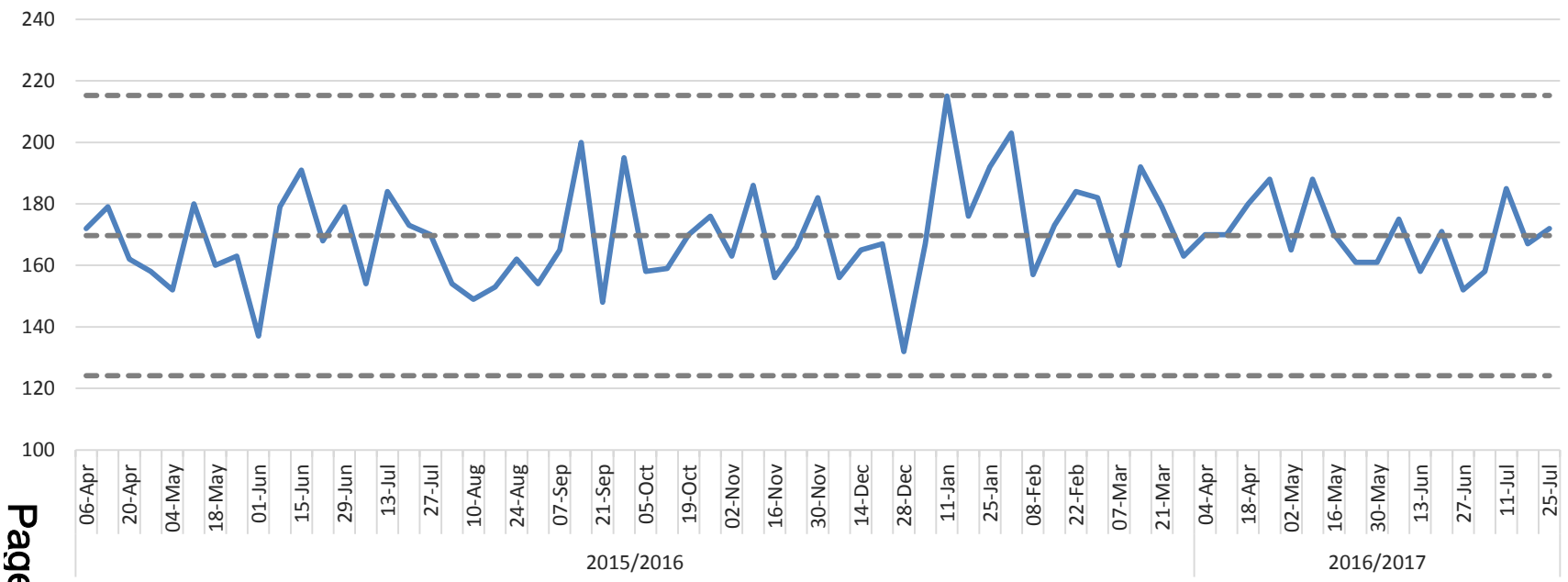
Data Source: SUS PbR Mart (admissions data not received until patients are discharged, so latest weeks removed for consistency)

Excess Bed Days



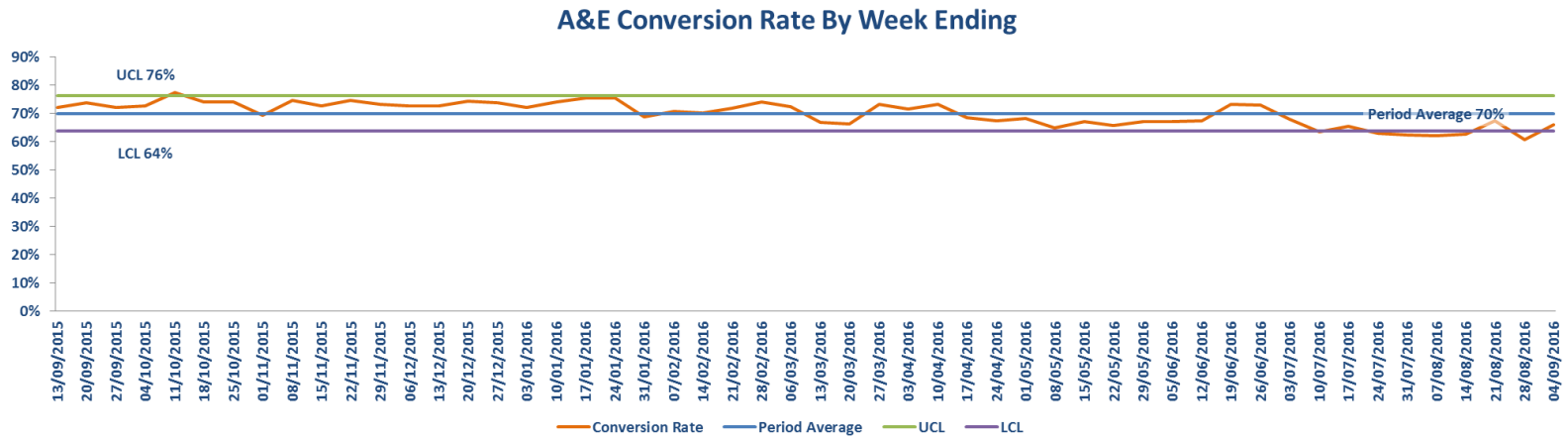
Data Source: SUS PbR Mart (XBDs applied to week in which discharge takes place)

Stranded Patients



Data Source: SUS PbR Mart (stranded patients counted in week in which discharge takes place)

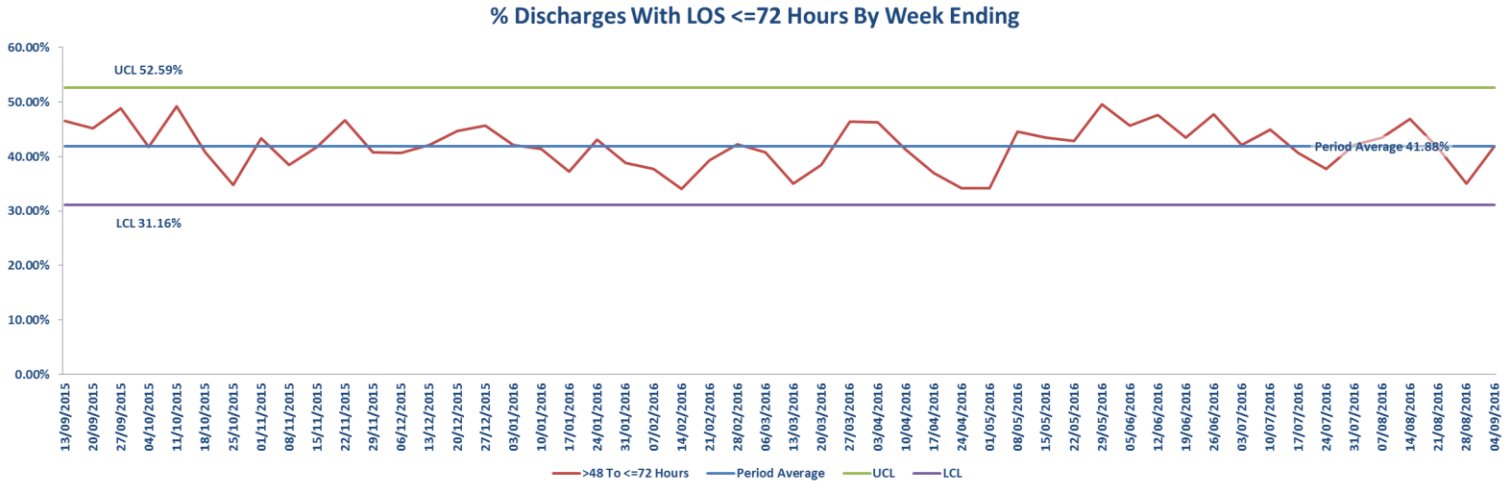
Frailty Interface Team



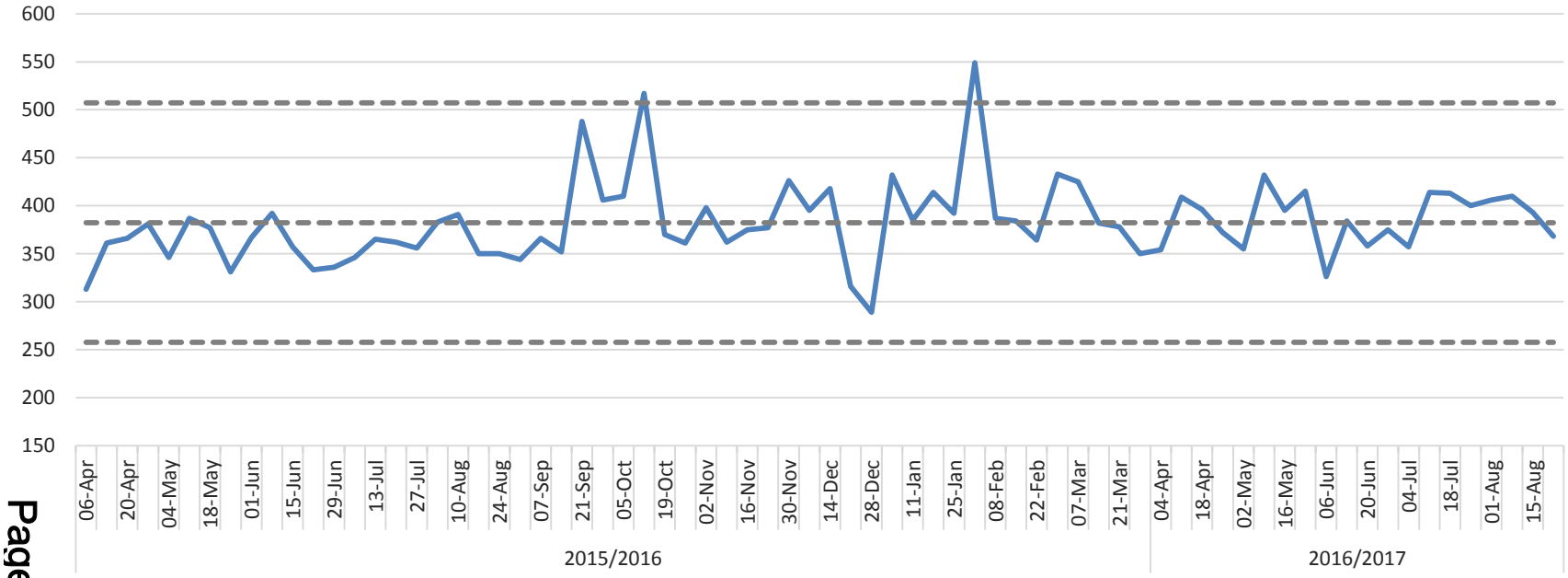
There is a sustained reduction in conversion rates for >85 year olds from April onwards, when geriatrician presence was introduced in FIT.

Average waiting times in ED for >85 year olds has reduced, and shows improved compliance with the 4 hour target. This shows that early identification and assessment of frailty is improving the pathway and timeliness of intervention.

- There are continued, sustained volumes of patients attending ED, for the >75 year olds, showing that reduced conversions is not linked to reduced attendances.
- There is no significant change in re-attendances for >75 year olds, showing that the clinical decision making in FIT to turn around patients promptly, is not resulting in increased re-admissions within 30 days.



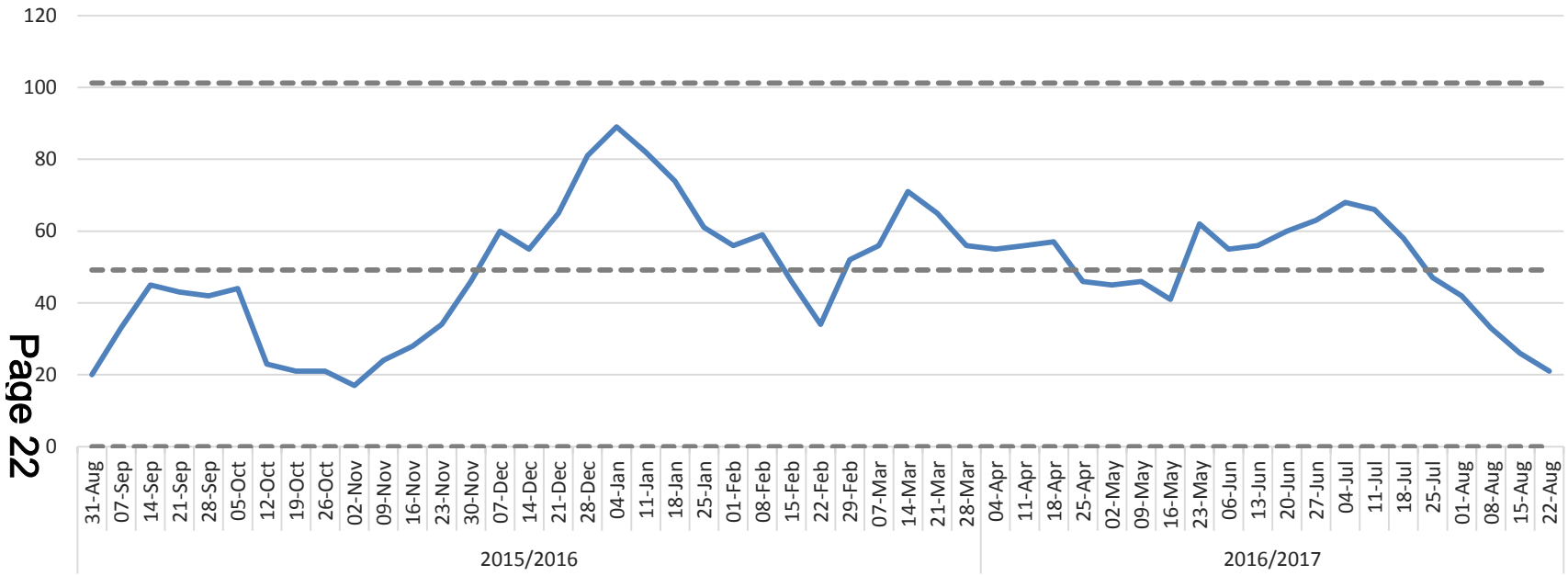
Community Referrals: Southern Health



The increasing trend reflects the increase in referrals from QA Hospital in relation to Discharge to Assess and the increased capacity to deliver packages of care from carers within the team. 70% of referrals to the team come from QA Hospital.

Data Source: Southern Health

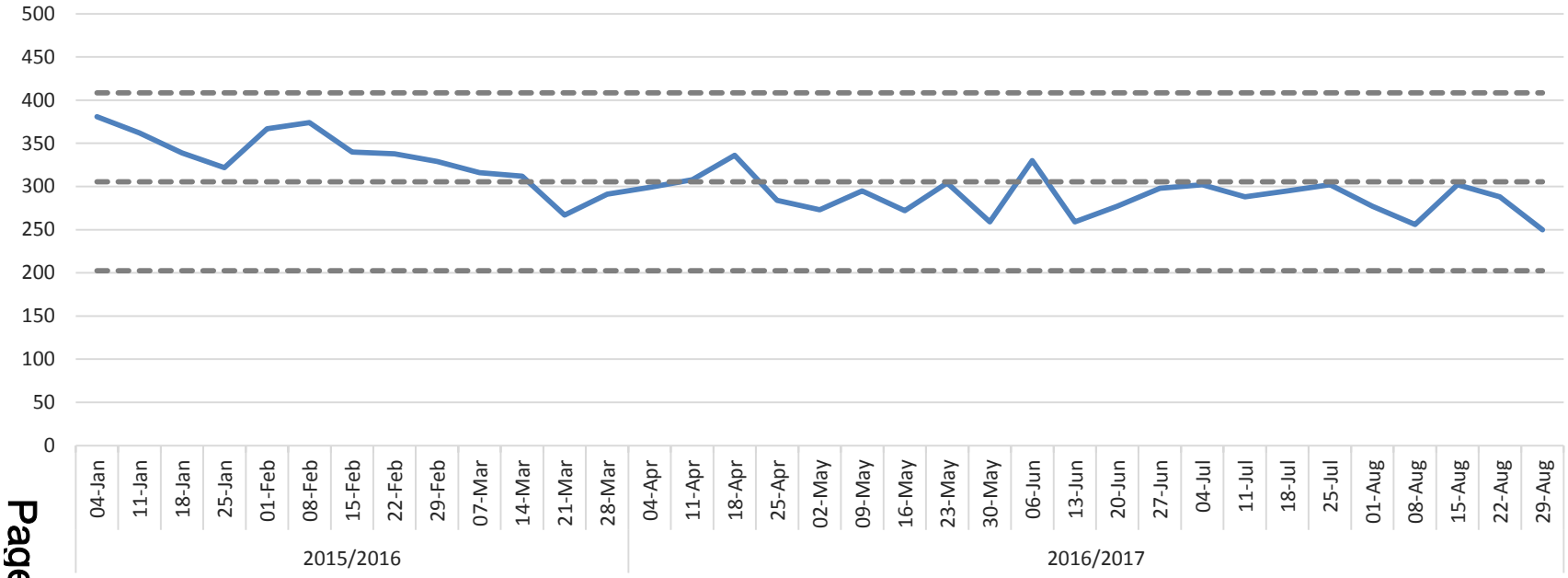
Southern Health DTOC OPMH



- In response to the increasing trend in DTOCs, the Division introduced a weekly conference call with the respective Ward Mangers to support them in escalating blockages and delays.
- We worked closely with our partners in Adult Service and established direct contact between named Social Workers and Ward Managers.
- Long term placement for patients with behavioural problems associated with their dementia remains challenging, although planning earlier and timely escalation of blockages maintains the improvement noted.

Data Source: Southern Health

Community Referrals: Solent



Despite stable trend in new referrals Community Nursing caseload has shown sustained increase since early July; work is being undertaken to validate alongside implementation of revised service specification.

Spinnaker - August 16	
Available Bed Days in Month	460
Occupied Bed Days	496
% Occupied in Month	93 %
Length of Stay Discharged Pts	440
ALOS of Discharged Pts in Month	22
Delayed Transfers of Care	0

Data Source: Solent

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SRG Delivery Plan Summary August 2016

Project Name:	SRG Delivery Plan
Accountable Group:	SRG
PM Support:	SDK

Milestones	Key Actions	Original Completion Date	Revised Completion Date	Action Status	Status Update	Action Owner(s)	Delivery Target	Delivery Target Status at Q1
Preventing Admissions - a reduction in attendances and admissions								
Project scope and outline	Scope work programmes currently in place against national local vision, undertake gap analysis	**7.6.16**	**30.6.16**	**Complete**	Initial programmes scoped. Additional detail required for us in Directory of Services (DOS) App. Gaps in mental health and palliative care info	TD	Reduction in ED attendances overall. Each scheme has established outcome measures	
	Review demand and capacity mapping, develop proposals to be delivered through MCP and other work streams	**31.7.16**	**31.10.16**	**Overdue**	Priority workstreams agreed - nursing homes, mental health, primary care workforce. Demand and capacity work has been delayed to tie in with Hampshire wide Sustainability and trnasformation plan (STP) programme	TD		
111 retender process	111 retender process complete	**31.10.17**		**Not Due Yet**	Additional actions will be included once project plan has been developed and signed off	TD	Number of quality and activity measures within contract	
Out of Hours retender process complete	Out of Hours retender process complete	**31.1.18**		**Not Due Yet**	Additional actions will be included once project plan has been developed and signed off	TD	Number of quality and activity measures within contract	
Urgent care centre provision improved	Agree and implement revised Urgent care centre model to improve service utilisation	**from 31.7.16**		**In Progress**	Working group established to review options	LD	reduction in minors breaches	
Primary and Community Care response in place	Local Hub model developed and tested in Gosport, Portsmouth Hub under development outcome based commissioning programme including payment and contracting mechanisms	**31.3.17**		**In Progress**	programme established and scoping underway	TC	measure to be developed as part of scoping work	
	Specific schemes:IV service, catheter care, acute visiting service, pharmacy support	**31.3.17**		**In Progress**	programme established and range of schemes in place. Further work to be undertaken to identify priorities	PAG		
Non conveyance schemes established	SCAS service development, non-conveyance and paramedic development schemes in place (HIU)	**30.9.16**		**In Progress**	GP non conveyance scheme in place in SE Hampshire and part of Portsmouth Acute visiting service. High Intensity Users project providing paramedic support and education is due to commence in September	RK	reduction in patients conveyed	
Care Homes work programme developed and agreed	Identification of schemes in place. Review of good practice nationally	**30.6.16**		**Complete**	Initial work programme agreed	SDK		
Care Homes work programme implemented	Agree and implement key schemes through Vanguard and Blueprint working groups	**TBC**		**Not Due Yet**	detailed activities to be signed off by sub group	WG		
PHT Transformation Programme								
Improve Performance in A&E to achieve 4 hour target through improved systems and processes, professional standards and workforce changes	Review process pathways in Minors and implement new model	**15.8.16**		**Complete**	Model pilot completed. Commencement date 5th September	SH	78% by June 16, 85% by Dec 163, 89% by March 17. 95% of patients assessed in 15 mins (62% - Sept 16, 95% - Dec 16)	4 hour target - 82% June. 15 min assessment - 68% in June
	Review process pathways in Majors and implement new model	**30.6.16**		**In Progress**	Model pilot completed. Commencement date dependent on additional workforce - Business Case submitted for approval and reconfiguration works commencing 26th Sept for circ 4 weeks	SH		
	Complete A&E capacity and demand profiling and develop workforce model	**31.5.16**	**30.6.16**	**Complete**	Capacity and demand modelling completed. Proposed staff model approved by ECIP	SH		
	Develop and implement appropriate workforce model ensuring staffing capacity meets attendance demand	**31.3.17**		**Not Due Yet**	Business case has been submitted for Board consideration	SH		

Milestones	Key Actions	Original Completion Date	Revised Completion Date	Action Status	Status Update	Action Owner(s)	Delivery Target	Delivery Target Status at Q1
Increase the use of Ambulatory Emergency Care to assess, diagnose and treat patients. Increase the use of rapid access specialty clinics to provide urgent specialist opinion and reduce admissions	Review AEC pathways	**31.5.16**		**Complete**	Review complete	HB	33% AEC target by 16.9.16	21% in June
	Implement recommendations following AEC National Network review	**31.1.17**		**Not Due Yet**	Implementation has commenced	HB		
	AEC estate reconfiguration	**31.12.16**	**Q4 tbc**	**Not Due Yet**	Commencement date postponed to prioritisation of PITSTOP works. Commencement date tbc	LW		
Establish unselected general medical take model with clear lines of responsibility and accountability	Implement unselected general medical take model commenced	**1.6.16**		**Complete**	Model commenced 1st June	AB/MR	85% occupancy in AMU by 16.9.16. number of patients with a length of stay(LOS) over 24 hours	patients with LOS over 24 hours - 38% in June
	Develop and agree standard operating procedures	**30.6.16**		**Complete**	In place	HB		
	Review ways of working and agree workforce structure for the longer term	**30.6.16**	**01.11.16**	**Not Due Yet**	3 month review completed. Agreement by UCTP Board to increase embedding in period allowing full review after 4 month period	AB		
Establish the Acute Medical Unit (AMU) with sufficient capacity to accept medically referred patients from patients from ED within 30 minutes of decision to admit and primary care referrals directly	Recruitment of additional workforce to support new medical model (ACPs/Medical Technicians & Clinical Assistants)	**30.6.16**		**Complete**	ACPs - recruitment completed - 1 year training programme commenced Medical Technicians - recruitment completed	AFC		
	Review processes and procedures within AMU across all staff groups to increase ability to admit referred patients in a safe and timely manner	**5.8.16**	**1.11.16**	**Not Due Yet**	Review has commenced	LF		
Increased focus on effective and timely turnaround of short stay patients to facilitate discharge within 24 hours in AMU and 72hours on the Short Stay Unit	Short Stay pathway commenced	**26.4.16**		**Complete**		MR	65% patients on short stay pathway by 8.7.16	64%- June
	Open D2 as a Short Stay Unit	**1.6.16**		**Complete**		MR		
Establish early comprehensive interdisciplinary assessment and signposting for patients over 75 years to support the reduction in avoidable admissions.	Increase Consultant hours within acute frailty pathway additional consultant hours	**30.4.16**		**Complete**	Cover now 0800 - 2000 Mon - Fri and 0800 - 1800 Sat & Sun	AB	MOPRs 95% bed capacity by 31.7.16. Additional 3 A&E patients over 75 years per day are not admitted	Discharges in <72 hours 42% June
	Map current and design future frailty pathway	**30.4.16**		**Complete**		MP		
	Close E4 escalation beds	**31.07.16**	**31.08.16**	**Overdue**	Closure on track for completion mid July. Closed on July 15th. Reopened July 17th. Closure date yet to be	SE		
	Implement silver phone function supporting referral from Primary Care	**01.04.17**		**Not Due Yet**	Scoping completed, model being developed	AB		
	Ensure all staff trained to work within competency framework	**31.5.16**	**ongoing as per newly appointed**	**Complete**	Completed for staff in post and commenced for newly appointed staff	AB		
	Implement 'pull' model for complex discharges complex of frail older people	**31.8.16**	**30.11.16**	**Not Due Yet**	Date reviewed to reflect dealy of D2A capacity	AB		
	Agree future of frailly inpatient service - Frailty Unit or roving team	**30.9.16**		**Not Due Yet**		AB		
	Implement frailty outreach team	**7.10.16**		**Not Due Yet**		SE		
	Develop in reach model business case for surgical	**31.3..17**		**Not Due Yet**		AB		
Improve discharge processes and delivery across the hospital	Implement ward Discharge Standards/SAFER on all PHT wards	**31.3.17**	**31.09.16**	**Not Due Yet**	Roll out programme agreed at UCTP Board. Accelerated plan agreed by UCTP. Rollout on track	HG	33% of discharges before 12pm by 9.9.16. 100% of ward patients with an estimated date of discharge (EDD)	discharges by midday - 21% in June. Ward patients with an EDD - 87% in June
	Appoint to Head of Discharge and Partnerships role and support to create a Discharge Planning Team	**31.08.16**		**Complete**	Appointment made. Commencement date 1st Sept	HG		
	Relocate discharge lounge	**30.4.16**		**Complete**		HG		

Milestones	Key Actions	Original Completion Date	Revised Completion Date	Action Status	Status Update	Action Owner(s)	Delivery Target	Delivery Target Status at Q1
Create a fit for purpose Operations function and team structure including bed overview, effective on call/ escalation and flow management	Centralise Ops flow team, implement new joint rotas, create substantive transfer team all supportive by agreed roles, responsibilities and SOPs	**31.7.16**	**31.09.16**	**Not Due Yet**		JA	No 12 hour trolley breaches. No non-clinical bed moves between midnight and 6am. Number of escalation beds.	
Integrated Discharge Service								
Development of integrated discharge service, Discharge to assess and frailty intervention team proposals with resource requirements and return on investment case for change.	review of winter pilot and scoping completed	**31.3.16**		**Complete**	Awaiting final financial/ risk share assessment by all partners, additional review by Transformation lead with recommendation. Subsequent finance meeting held in June - still unresolved issues around financials and ORCP monies. To be discussed at SRG Ops on 7th	LD		
	business case developed and approved	**30.4.16**	**31.7.16**	**Overdue**		Work stream		
	Review and reinvestment of winter monies	**30.3.16**	**31.7.16**	**Overdue**		Finance Directors		
Overall programme management, success criteria and governance in place	performance standards and reporting, governance processes in place	**30.6.16**	**30.7.16**	**Complete**	revised project plans and success criteria have been developed	DA		
	delivery lead appointed	**30.6.16**		**Complete**				
	Revised task and finish groups established	**31.7.16**		**Complete**				
	Agree pilot area, methodology and operationalise pilot	**31.7.16**		**Complete**	Commence weekly review of MOPRS stranded patients (DTOCs) from 2nd August.			
Robust integrated discharge service processes and systems developed and adopted by multi-disciplinary teams	community bed direct referral pathway in place	**30.6.16**	**31.8.16**	**Complete**	Review of criteria for all pathway 2 providers to ensure consistency underway	MC		
	IDS assessment processes and professional standards in place	**30.6.16**	**31.8.16**	**Complete**	To include electronic single referral form and assessment fit guidance. Latter signed.	DA		
	IDS Hub model agreed - referral management, capacity oversight, streaming, advice and guidance	**31.8.16**		**In Progress**	IDS vision, HUB model and core functions developed and signed off. Admin roles to be signed off in	Provider leads		
Accommodation	IDS accommodation identified and in place	**30.6.16**	**31.8.16**	**Overdue**	Accommodation has been identified and IT telephony work underway. Move date planned for	DA		
Workforce implications understood and plans for both interim and longer term solutions in place	interim rostering in place	**31.7.16**		**In Progress**	draft rotas have been completed with ward links across 5 organisations have been agreed but yet to	Provider leads		
	outstanding recruitment completed to support IDS and D2A delivery	**31.6.16**	**31.10.16**	**Not Due Yet**	Dependent on Business Case decision	COOs		
	D2A/IDS/Assessment fit training programme delivered (ward staff)	**30.6.16**	**30.10.16**	**In Progress**	IDS visioning event planned for 20/7 and training workshops in August for Board rounds and trusted			
	IDS ward links in place to support all adult inpatient	**30.9.16**		**Not Due Yet**	Currently being scoped. Partners to complete matrix		50% in place by 30.6.16, 100%	
	trusted assessor model in place with clear permissions and responsibilities	**30.9.16**	**30.9.16**	**Not Due Yet**	IDS training events to be held on 10th and 17th August - service model, trusted assessor, single referral from	DA	50% trained by 30.6.16, 100% by 30.9.16	
IDS pathways developed approved and established	additional capacity mobilised for Portsmouth	**30.9.16**	**31.10.16**	**Not Due Yet**	Dependent on Business Case decision	SH		
	review and remodel of OT pathway	**30.9.16**		**Not Due Yet**		SH		
	Hampshire pathway 3 review including inpatient areas	**30.9.16**		**In Progress**	planning meeting set up. Will need to be fast-tracked to ensure adequate D2A Pathway 3 capacity before	PT/MH		
	Remodel CHC pathway in Portsmouth	**31.12.16**		**Not Due Yet**		SH/SN		
Monitoring and Reporting Progress	Bedview is the system used to record all activity and performance data	**30.09.16**		**In Progress**	Bedview modifications to be discussed and agreed	DA/SP		
	performance targets delivered - discharges per week	**31.3.17**		**Not Due Yet**	draft D2A KPIs being revised	Work stream leads	186 by Q1, 216 by Q2, 233 by Q3.	
	performance targets delivered - MFFD patients waiting longer than 24hrs from decision	**31.3.17**		**Not Due Yet**		work stream leads	160 Q1 - Q3, 60 by Q4	As at 18.7.16 - 170 patients

Milestones	Key Actions	Original Completion Date	Revised Completion Date	Action Status	Status Update	Action Owner(s)	Delivery Target	Delivery Target Status at Q1
	performance targets delivered - 5% reduction in stranded patients	**31.3.17**		**Not Due Yet**			28 fewer patients occupying beds	
Escalation								
Escalation	Review of escalation process	**31.8.16**		**Complete**	Commenced - by partners for each organisation and collectively for the system. System wide agreement of triggers to be completed.	SR/ SRG Ops group	TBC	
Emergency Planning	assurance process again by partner and system	**30.9.16**		**Not Due Yet**		SR		
Business Continuity	assurance that in place for all areas partners and system and plan for full review in two years	**TBC**		**Not Due Yet**		SR		
Seasonal Resilience Planning	to re-establish a resilience group for partners and CCGs which sits under the SRG operational group and provides assurance on seasonal plans	**TBC**		**In Progress**	Stocktake under way will be completed by 18th July and reviewed at Operational Group	SR		
SRG Information Support								
establish working group	set up group to provide system wide intelligence for SRG	**31.3.16**		**Complete**	Group established and meetings held fortnightly	SDK	TBC	
Performance Dashboard development	develop agreed system wide metrics to support the system plan including quality performance	**31.5.16**	**30.6.16**	**Complete**	Draft metrics agreed and developed. These will be tested with SRG and refined over the coming months.	IG/OG		
	monthly performance report with narrative and analysis agreed and commenced	**30.6.16**	**Review monthly for the next 3**	**In Progress**	Process in place and first draft with real data to be presented to SRG on 14th July	IG		
Business Intelligence programme	develop a wider programme of system intelligence, planning information and targeted work	**31.7.16**		**In Progress**	proposal to be presented at SRG on 16.6.16	SB/MK/RM		
	deliver initial work programme	**31.3.17**		**Not Due Yet**	projects identified for detailed info support are Nursing homes, DTOCs and escalation	IG		
SRG Development Programme								
Review of SRG function and delivery	Undertake initial diagnostic and agree development programme	**30.4.16**		**Complete**		AS/SDK	TBC	
SRG Development programme	Session 1 Establish core purpose of the group	**2.6.16**		**Complete**		AS/SDK		
	Session 2 Review Practices	**14.7.16**		**Complete**	Action plan developed and underway	AS/SDK		
	Session 3 Improving process to affect better quality of outcomes	**TBC**		**Not Due Yet**		AS/SDK		
	Session 4: Power - maximising shared leadership	**TBC**		**Not Due Yet**		AS/SDK		
Leadership	Individual support sessions to improve governance and assurance of SRG	TBC		**Not Due Yet**		AS		
Best practice	Review good practice from other SRGs and present/ implement findings	30.9.16		**Not Due Yet**		SDK		

South Central Ambulance Service NHS
NHS Foundation Trust

South Central Ambulance NHS Foundation Trust Local Network Update.

Portsmouth

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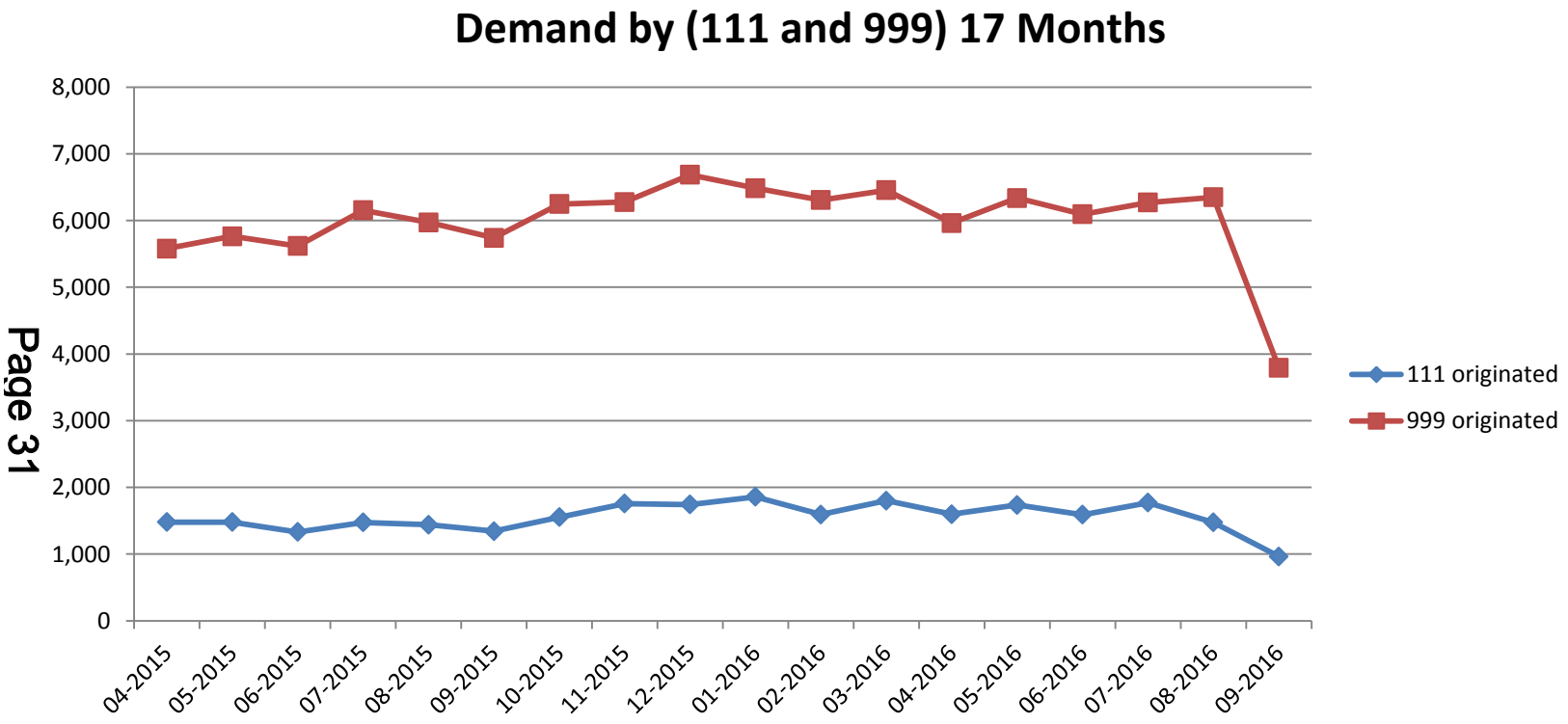
NHS Foundation Trust

Operational Context

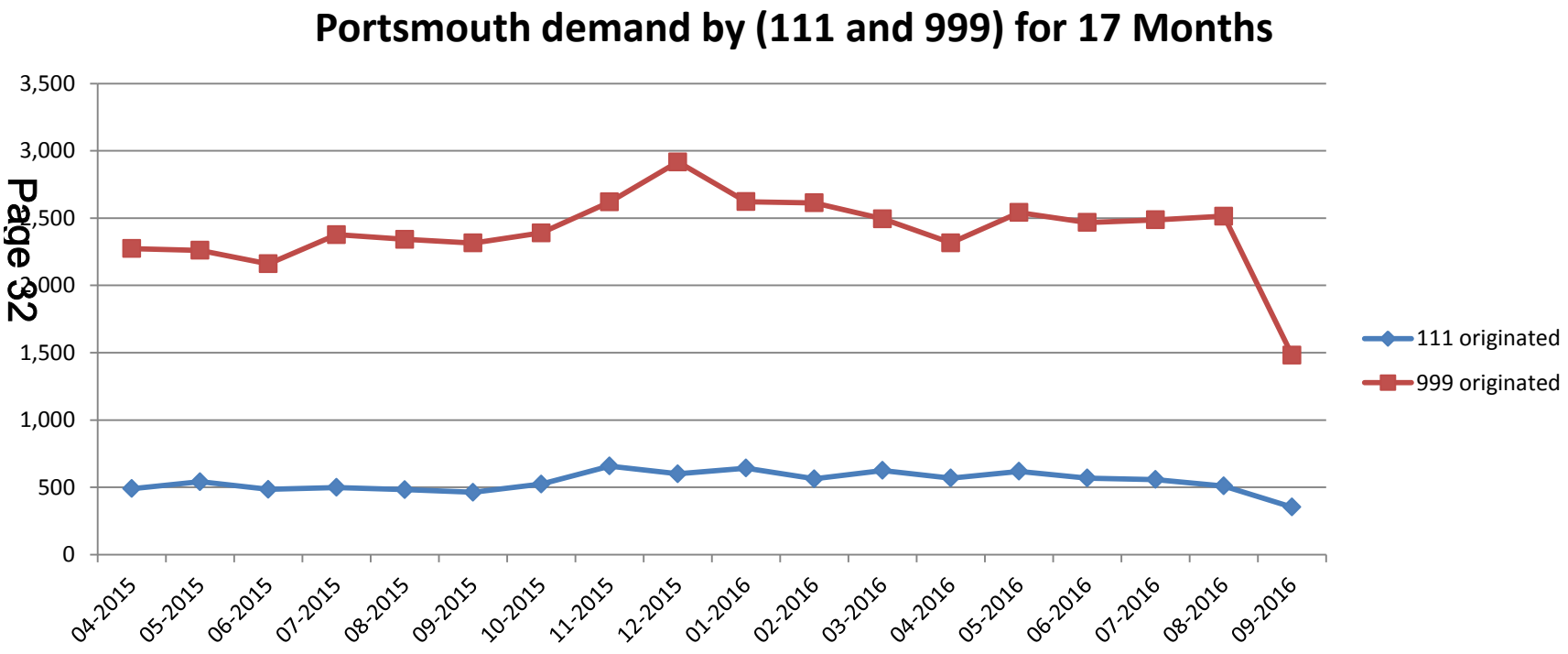
- SE Hampshire Demand
- Portsmouth Demand
- Portsmouth CCG Performance
- Developments
- Risks

Get involved

Activity in SE Hampshire.

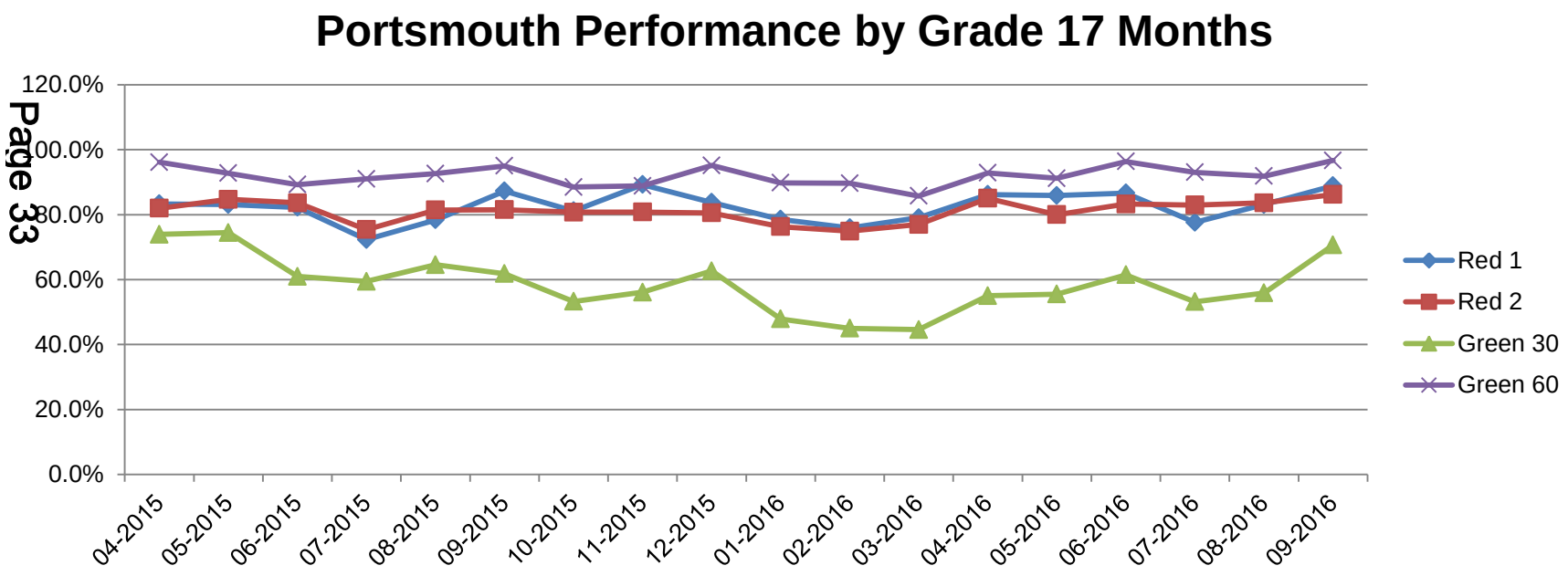


Activity in Portsmouth.



South Central Ambulance Service NHS
NHS Foundation Trust

Portsmouth CCG Performance.



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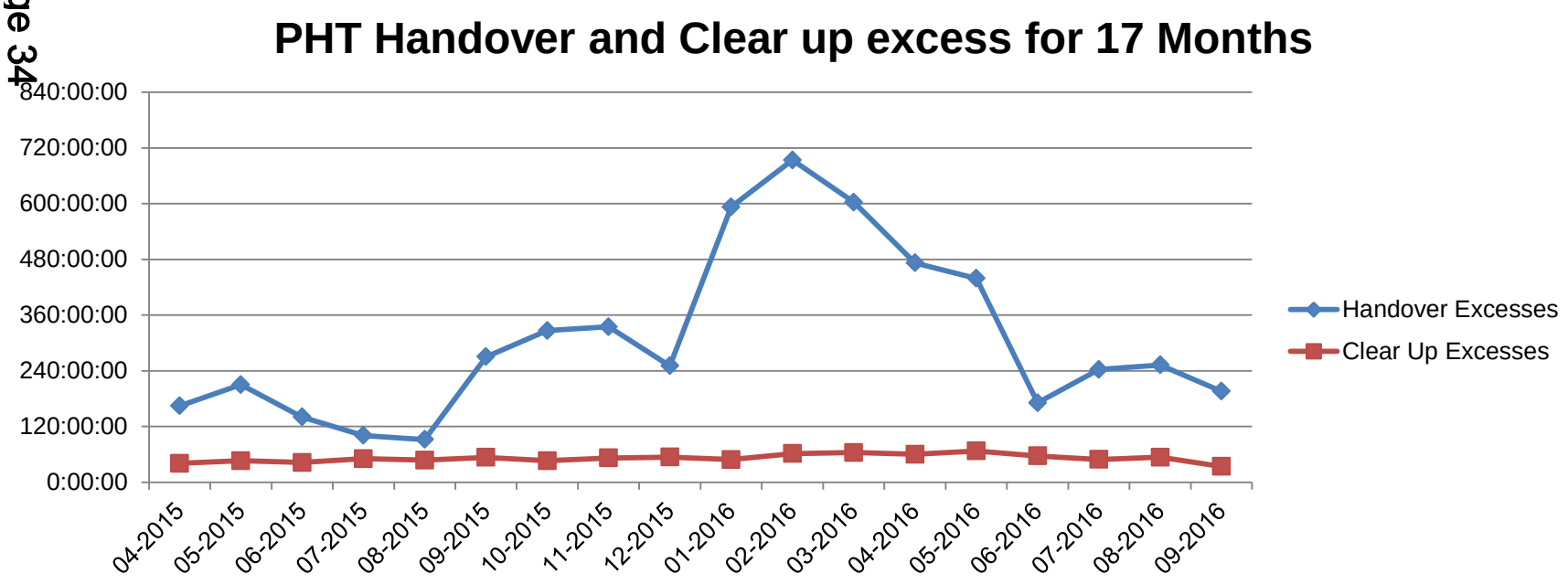
Excess Handover Delays.



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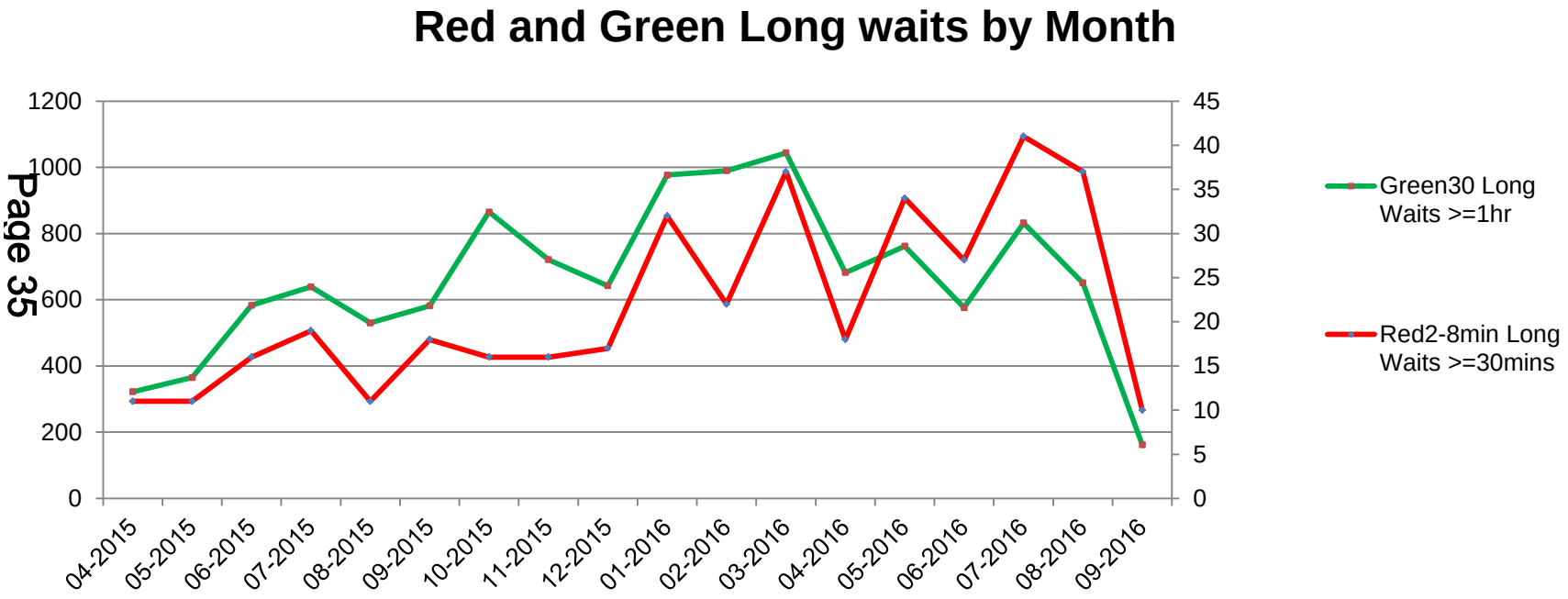
Long Waits by Category.



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Risks

- Retention of experienced staff.
- Recruitment of qualified staff.
- Availability of alternative care pathways.
- Safe Space-picked up by Portsmouth CCG.
- Winter resilience.
- Long waits for Green category patients (risk register).
- Hospital/System resilience and capacity and its impact on Hospital Handover delays.

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Developments and Mitigation

- Specialist Paramedic Recruitment and Retention.
- Band 6 Paramedic.
- Certificate in Paramedic Practice.
- Patient Long wait reviews.
- Rota review to improve staff retention.
- Introduction of ePR.
- Narp.
- Continued link with SRG and wider system resilience/escalation plans and actions.
- System Work streams (including appropriate conveyance, and Care Home, Residential homes, review of Frailty patients (Green)).
- Vanguard Pilot.

Get involved

Questions

NHS
Portsmouth
Clinical Commissioning Group

CCG Headquarters
4th Floor
1 Guildhall Square
(Civic Offices)
Portsmouth
PO1 2GJ

22 September 2016

Cllr Jennie Brent
Chair of HOSP
C/o Members' Services
Floor 3, Civic Offices
Guildhall Square
Portsmouth
PO1 2AL

Dear Cllr Brent,

Update for Portsmouth Health Overview and Scrutiny Panel

This letter is intended to update you and the members of the Portsmouth Health Overview and Scrutiny Panel on some of work the Clinical Commissioning Group has been involved with over the past few months.

This formal update is in addition to the regular informal meetings with your panel colleagues which CCG colleagues and I attend, and which I hope continue to be useful for all concerned. Our website – www.portsmouthccg.nhs.uk – may provide some further details about what we do if members are interested, but of course we are always happy to facilitate direct discussions if there are particular issues which are of interest to the panel.

1 Urgent care

At the last formal HOSP meeting, members received an update on the plans which have been developed following the publication of the Care Quality Commission (CQC) report into Portsmouth Hospitals NHS Trust, earlier this year.

Since that last meeting there has been good progress in implementing the agreed actions, both within Queen Alexandra Hospital, and across the wider health system. Having said that, demand for urgent and emergency care continues to be high, and rising, and concerns remain regarding capacity across the NHS and social care as the winter period approaches. In terms of the progress being made, some specific highlights include:

Discharge to assess – two of the three workstreams will be going ‘live’ across the local health and social care system on Monday 26 September, with the third in development. The first two elements involve discharging patients from an acute setting either to go home, or to

a community bed, after their immediate, acute care need has been addressed. When at home, or in the community bed, the patient can then be properly assessed in a more natural, less pressurised environment, and more appropriate care planning can be enacted. The third element, where more complex patients are assessed in nursing homes, is being prepared for. All of this work is supported by the integrated discharge service, which brings together both health and social care staff, to identify patients suitable for 'discharge to assess' and then to proactively plan their post-acute care at the earliest possible opportunity.

Frailty Intervention Team – this team (known as "FIT") had just begun its work at the time of the last HOSP meeting. The team is working well, and although the programme is still in its very early stages the early signs are that the team is having a positive impact. The FIT works in the Emergency Department (ED) to identify and support elderly people, on arrival, for frailty. This allows a rapid assessment of a person's wider needs – including social, and environmental issues, for example – rather than a simply medical approach, and enables staff to take a more holistic view of the patient.

The 'Pitstop' initiative is also focused on deploying resources to the 'front door' of the ED, but is focused specifically on Minors. Staff are working to triage patients at the earliest possible opportunity, and to move them towards the most appropriate treatment. The early signs are positive – in terms of patients getting a first assessment of their needs within 15 minutes, the PHT baseline was 62%, but that has now moved up to 69% for August. There has also been good progress made with regard to the specific requirements set out by the CQC following the publication of its inspection report.

As required, there has been no further use of the multi-person vehicle known as the 'jumbulance', the Trust has appointed a senior clinical leader to oversee the emergency care pathway, and the CQC has been provided with weekly reports regarding performance. For the fourth requirement, improving the triage process, initiatives such as Pitstop (see above) have begun to show positive results.

As a result of these changes, and others, the CCGs consider that the risk of avoidable patient harm within the Emergency Department has reduced since the inspection report was published – in other words, the department is safer than it was previously.

The national standard for Emergency Department access remains that 95% of patients should be seen, treated, admitted or discharged within four hours. An increasing number of Trusts are falling short of achieving that standard, and PHT performance has stayed at approximately 80% in recent months.

The entire health and social care system is working hard to deliver performance which is more closely in line with the national standard. However, this work is not taking place in a vacuum - the context is that ED attendances are rising, and that increase is also leading to higher numbers of medical and elderly care admissions - so progress becomes harder to deliver all the time. In addition, not all improvements necessarily result in a reduction in waiting times – making the department safer is essential, but the impact of that will not necessarily be captured in the figures showing performance against the four-hour access standard.

2 Health and Care Portsmouth

Our programme of work to deliver the Portsmouth Blueprint continues with our partners in the city.

We have identified the senior leaders for the key pieces of work:

- Innes Richens: lead for the work on single commissioning and governance arrangements
- Alison Jeffries, Director of Children's Services (Portsmouth City Council): lead for developing a different approach to commissioning earlier intervention
- Michael Lawther, Deputy Chief Executive (Portsmouth City Council): lead on the work to bring together enabling functions (such as estate, IT, HR)
- Sarah Austin, Chief Operating Officer (NHS Solent): lead on the work bringing together front-line health and social care services

Good progress has been made on co-locating health and social care teams for both adults and children. The Portsmouth Primary Care Alliance, NHS Solent and the CCG have also developed proposals for the delivery of in-hours primary care services specifically aiming to meet urgent care demand. This has informed the CCG's recent applications for capital resourcing for primary care, via the Estates and Technology Transformation Fund, and supports the development of community based hubs of services in the City.

At a recent workshop for the Health and Care Portsmouth partners, the legal and organisational options for enabling the integration of health and care were discussed with input from legal expertise drawn from the national NHS Vanguard programme. The option to form alliance agreements amongst existing provider organisations drew significant support from partners as a potential immediate step to deliver health and care integration, whilst avoiding organisational reconfiguration which can distract focus from delivering services for people in the city.

Our CCG team, in partnership with Action Portsmouth, recently delivered a one-day workshop. This saw representatives from multiple community and voluntary sector agencies discussing how this sector could form a part of future delivery of health and care in Portsmouth. There will be a series of follow-up meetings with community sector organisations focusing on specific aspects of care (eg long term conditions, social isolation, self-care).

3 Changes to minor injuries services/Guildhall Walk

As panel members will know, changes to the way in which urgent care walk-in services are delivered in the city were implemented from 1 July.

There are now GPs working alongside nurses at the St Mary's NHS Treatment Centre in Milton, offering patients an enhanced minor injury and minor illness service, with diagnostic and other facilities on hand to support their treatment. At the same time, 'walk-in' appointments continue to be offered at Guildhall Walk Healthcare Centre, but they are now only available to people who are registered at that practice for their ongoing care.

The CCG believes that bringing together GPs and nurses at St Mary's Treatment Centre in this way delivers the strongest alternative yet to A&E for local people – the clinical teams there can support almost anyone who feels that they need urgent help for either a minor illness or a minor injury.

It is too early for firm conclusions to be drawn as to the impact of these changes, but the CCG is seeking reassurance regarding two issues in particular – whether or not, as a result of the changes, significant numbers of people are simply losing access to the urgent care support they feel they need, or whether people are in fact bypassing the available urgent care options entirely and instead presenting at A&E with minor complaints.

The early signs are positive. Since 1 July, staff at St Mary's Treatment Centre are indeed seeing a significant amount of additional activity, as would have been expected. At the same time, there is no evidence of any increase in A&E attendances which might be attributable to the changes on that date. It is still relatively early days, of course, and the situation is being kept under review.

4 Primary care changes

As explained in previous updates, the GP Forward View recognises the need for practices to come together to explore new, innovative ways of delivering primary care at scale, and this process is already underway in the city.

In the June update, we highlighted the proposed practice merger of Northern Road surgery (a single-handed practice), and the Portsdown Group Practice. The CCG's Primary Care Commissioning Committee has now approved this merger, and the subsequent simultaneous branch site closure of the Northern Road premises. The creation of the larger practice is designed to help to create more sustainable primary care services in this area of the city.

The same Primary Care Commissioning Committee also approved the closure of the Ramillies surgery as branch premises of the Trafalgar Medical Group Practice.
Both of these changes were approved following engagement with both the registered patient lists, and the affected staff.

Looking slightly further ahead, patients have recently been communicated with regarding a proposed merger between the Portsdown Group and the Derby Road Practice. The proposal envisages the merger potentially taking place in April 2017, and it is also proposed that the Derby Road practice, which is close to the existing Portsdown Practice Kingston Crescent surgery, should close later in that year, perhaps by October 2017.

5 Sustainability and Transformation Plans (STPs)

The NHS Shared Planning Guidance, published in December 2015, asked every health and care system in England to create their own local plans for implementing the Five Year Forward View (5YFV).

The 5YFV sets out a future vision of health care, which includes a more engaged relationship with patients, carers and citizens, and a greater focus on promoting wellbeing and preventing ill-health. To deliver this vision, we need to change the way we do things so that local services work together to close the health and social care funding gaps by 2020/21.

There are 44 STP areas in England, known for the purpose of this work as 'footprints'. The STP will enable health and social care leaders to work together to improve the health and wellbeing of their local communities. They do not replace existing local bodies, or change local accountabilities. Neighbouring footprints will need to work together to plan specialised or ambulance services and when working with multiple local government authorities. Devolution proposals which share the same geography as STP footprints will need to work through the implications together.

The STP for Portsmouth, Hampshire, Southampton and the Isle of Wight (HIOW) is being developed by the Clinical Commissioning Groups (CCGs), GPs, NHS Trusts and other health and care services within this area. It will cover a period of five years (from 2016 to 2021) and the full report is due to be submitted to NHS England on 21 October 2016.
The plan will set out the practical steps needed to deliver the 5YFV and improve the quality of care, health and NHS finance and efficiency in our area. It will also describe how it will deliver the NHS Mandate, as set by the Department of Health.

Each footprint has been asked to set out governance arrangements for agreeing and implementing their local plans. For Hampshire and the Isle of Wight, the STP Chair is Karen Baker (Chief Executive of Isle of Wight NHS Trust) and the STP Lead is Richard Samuel (Chief Executive of South Eastern Hampshire & Fareham and Gosport CCGs). The Executive Steering Group includes representatives of all 30 organisations involved in creating the STP.

Progress to date:

In July 2016, initial draft plans were submitted, and discussed with the national health and social care bodies. We are now working on an update draft plan to submit on the national deadline date of 21 October.

The programme of work taking us through to this next submission deadline covers the following areas:

- Effective Patient Flows: Aim – to ensure that no patient stays longer in an acute or community-based bed than their clinical condition and care programme demands
- Mental Health Alliance: Aim – to improve capacity, quality of care and access to mental health services across the area
- Prevention and Well-being: Aim – to improve the health and wellbeing of our population so that people live longer, healthier lives
- Solent Acute Alliance: Aim – to ensure the best outcomes and safest care for patients, 24 hours a day, seven days a week, focusing on Southampton, Portsmouth and the Isle of Wight.

- North and Mid Hampshire Acute: Aim – to reach a conclusion on the right configuration of acute services in north and mid Hampshire to meet the needs of the population
- New Models of Care: Aim - to improve the health, well-being and independence of people by delivering higher quality, more accessible and more sustainable out-of-hospital care, supporting them to take a more active role in self-managing their care and offering access to improved care when needed.

These areas are supported by enabling workstreams focused on workforce, commissioning, estates and digital.

It is important to emphasise that very little of this activity is entirely new; the NHS community in Hampshire and the Isle of Wight has been working on ways of meeting these challenges for a while, and is already developing new models of care locally, for example, through Health and Care Portsmouth. Most of the proposals for achieving the aims outlined above have been developed with the input of local people and patient groups.

The difference this time is that the plan is bringing together all parts of the NHS locally, including GPs, to make the most out of working at scale rather than in our own local systems. That will ensure that everyone living in our area has access to consistent, high-level care and services.

Once all STPs have submitted updated plans in October, NHS England then expects the plans to be published, and then following further development the preparations for implementation will begin in the New Year. Any specific proposals for significant future service changes which do emerge from our STP will go through a rigorous period of both clinical and public engagement, and indeed formal public consultation if that is appropriate, before any decisions are taken.

Yours sincerely

Dr Jim Hogan
Chief Clinical Officer & Clinical Leader
NHS Portsmouth Clinical Commissioning Group