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# NOTICE OF MEETING

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## HEALTH OVERVIEW & SCRUTINY PANEL

**THURSDAY, 22 NOVEMBER 2018 AT 1.30 PM**

## CONFERENCE ROOM A - CIVIC OFFICES

Telephone enquiries to Jane Di Dino 023 9283 4060 or David Penrose 023 9283 4870

Email: [jane.didino@portsmouthcc.gov.uk](mailto:jane.didino@portsmouthcc.gov.uk) [david.penrose@portsmouthcc.gov.uk](mailto:david.penrose@portsmouthcc.gov.uk)

If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

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### Membership

Councillor Jennie Brent (Chair)  
Councillor Gemma New (Vice-Chair)  
Councillor James Fleming  
Councillor George Fielding  
Councillor Leo Madden  
Councillor Steve Wemyss

Councillor Elaine Tickell  
Councillor Michael Ford JP  
Councillor Philip Raffaelli  
Councillor Mike Read  
Councillor Rosy Raines  
Councillor Marge Harvey

### Standing Deputies

Councillor Jason Fazackarley  
Councillor Jo Hooper  
Councillor Ian Lyon

Councillor Tom Wood  
Councillor Sarah Pankhurst

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(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](http://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 3 - 12)**

**RECOMMENDED that the minutes of the meeting held on 13 September 2018 be agreed as a correct record.**

**4 Director of Public Health** (Pages 13 - 60)

Dr Jason Horsley, Joint Director of Public Health for Southampton City Council and Portsmouth City Council will answer questions on the attached report.

**5 Portsmouth Clinical Commissioning Group** (Pages 61 - 68)

A representative from Portsmouth CCG will answer questions on the attached report.

**6 H&IOW system reform proposal** (Pages 69 - 114)

Richard Samuel, Senior Responsible Officer and Sue Harriman, System Convener for the Hampshire and Isle of Wight Sustainability and Transformation Partnership will answer questions on the attached report.

**7 Portsmouth Hospitals' NHS Trust**

Paul Bostock, Delivery Director will present the report which is to follow.

**8 Southern Health** (Pages 115 - 124)

Debbie Robinson, Interim Director for Mental Health and Learning Disabilities will answer questions on the attached reports.

**9 Dates of Future Meetings.**

To approve the dates of forthcoming meetings, to be held at 1.30pm in the Executive Meeting Room, Third Floor, The Guildhall:

Thursday 28 March 2019

Thursday 13 June 2019

Thursday 12 September 2019

Thursday 21 November 2019

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.

# Agenda Item 3

## HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 13 September 2018 at 1.30 pm at The Executive Meeting Room - Third Floor, The Guildhall

### Present

Councillor Leo Madden (Chair)  
Councillor Gemma New  
Councillor George Fielding  
Councillor Hugh Mason  
Councillor Michael Ford JP, Fareham Borough Council  
Councillor Philip Raffaelli, Gosport Borough Council  
Councillor Gary Hughes, Hampshire County Council  
Councillor Rosy Raines, Havant Borough Council

#### 1. Welcome and Apologies for Absence (AI 1)

Apologies for absence were received from Councillors Steve Wemyss and Mike Read.

The Chair welcomed Councillor George Fielding to his first meeting of the Panel.

#### 2. Declarations of Members' Interests (AI 2)

Councillor Raines declared a personal, non-prejudicial interest as she is a practice nurse at a GP surgery and a community responder.

#### 3. Minutes of the Previous Meeting (AI 3)

The Chair referred to page 2 of the minutes and said that he would write to Dr Horsley to ask for an update on the Public Health Grant and also whether he had an update on suggestions to add to the council's licensing policy to improve safety at public events.

He also referred to page 6 of the minutes on the CCG update relating to the Gosport Independent Panel review report and said he would write to them to see whether the CCG had worked out the implications of this.

**RESOLVED that the minutes of the meeting held on 14 June 2018 be agreed as a correct record.**

#### 4. South Central Ambulance Service update (AI 4)

The report was introduced by Tracy Redman, Head of Operations South East. She explained that in terms of performance to the different categories of calls, all of the areas had improved when comparing this year quarter 1 with last

year quarter 4. In terms of the new service delivery model, SCAS are now in a transformation period. They are in the process of receiving additional resources in terms of vehicles and are planning staff to make sure they can meet the demand for the next few years. Whilst they are transitioning it has not impacted adversely on their overall performance and this continues to be a work in progress. SCAS are working closely with colleagues in Queen Alexandra Hospital (QAH) in terms of handovers. Some vast improvements have been made and they are now considering how this can be sustained. QAH is an outlier in the region in terms of handovers and the Head of Operations is working with colleagues in other areas of SCAS to see if there are any initiatives they use to see if anything can be brought to this area.

In response to questions the following matters were clarified:

- As a health system all partners have a role to play in ambulance handovers. There are challenges within the community in terms of discharging patients which has a knock on effect, as if patients are not being discharged there are no beds for the ambulance patients to be admitted. It is a system wide challenge and this is being tackled with all partners. When hospital discharges are more efficient this improves handover times for ambulances so there is a direct correlation. The Head of Operations added that QAH are open to what changes they need to make this year which includes some interim changes before this winter to the physical layout of the department, before making some bigger changes going forward.
- The work SCAS are doing to improve hospital handovers is around non-conveyance and looking at those patients that could go elsewhere e.g. minor injuries or GPs. This will also improve the outcome for the patient as it will ensure that they receive the correct care.
- As a system SCAS are aiming to reduce hospital handover delays. The work that SCAS are doing around non-conveyance will reduce handover delays.
- The South East area of SCAS has the best non-conveyance rate in the whole of SCAS. They are actively working on this and doing everything they can, but otherwise they are not doing anything differently compared to other areas of the country.
- Category HCP 1-4 is not nationally reported, SCAS are measuring this locally to ensure they can make improvements. Category 1 patients are the 7 minute target patients.
- The target for category 1T patients is 18 minutes, previously this was 19 minutes but SCAS decided to reduce this to 18 to make an improvement. The Head of Operations was unsure where the 19 minute target originated. The Panel suggested that this needed to be reviewed and the Head of Operations said she would take this on board.
- The deployment plan is quite scientific. It is based on demand in an area on types of call, which is how SCAS decide to pre-position the assets.



- The Head of Operations did not have the category 1 times for Hayling Island but said that Hayling Island and Gosport always present challenges because of the geography of these areas.
- With regard to the ratios of cars to ambulances, the Head of Operations said this was around 65% ambulances to 35% cars. This will move to 80% ambulances and 20% cars which is in line with the national programme.
- The spike in handovers in July was largely due to the long spell of hot weather which was a challenge across the system. This highlighted the fact that the system are quite well prepared for the winter weather but more preparation is needed for hot weather.

**ACTION** - The Head of Operations to look into where the 18 minute target for category 1T patients originated and the reasons behind this.

**RESOLVED that the report be noted.**

## **5. Portsmouth Hospitals NHS Trust - Update (AI 5)**

Dr Knighton, Medical Director and Una Brady, General Manager of the musculoskeletal service introduced the report. Dr Knighton added that the CQC report overall rating remains as Requires Improvement but they have had a number of focussed inspections in the intervening period. There is still a long way to go however the regulators have recognised that the Trust have made some significant progress. PHT were encouraged by some of the feedback from the CQC about some of the changes that have been made.

The anticipated date of the spinal service transfer to Southampton remains at 31 October 2018 and Dr Knighton had brought the communication to circulate to the panel as promised at the last meeting. The emergency floor redevelopment is a strategic piece of work and requires all elements of the system to work as efficiently as possible. It became clear that the emergency department and the acute medical area is not fit for purpose. The redevelopment will improve quality and efficiency of care to patients.

PHT are well advanced with winter preparedness and learned a lot from last winter. They are working together with all elements of the system. Whilst there is a long way to go, he said they feel they have much greater sight of the areas needing improvement and are working together in a much more effective way. The aim is to reduce the proportion of patients who are in hospital that do not need to be, so they can reduce their average bed occupancy to 92%. This is the level they can run the hospital system effectively and ensure that ambulance handovers are not delayed.

In response to questions the following matters were clarified:

### CQC report

- The issues leading to the CQC rating of Requires Improvement were multifactorial. PHT have recently had an entire new leadership team

and an organisational restructure to ensure the focus on the operational detail and quality is something they are able to deliver, which was not previously the case. Over a number of years the Trust had developed a culture of specialisation within the medical workforce meaning the core work may not have been as prioritised as it should have been. All of this has been addressed over the last year but is not yet complete.

- PHT received the draft CQC report to check for factual accuracy and they challenged a number of elements, but were careful not to over challenge. They were already aware of some of the areas that were not meeting standards and this was discussed with CQC at an early stage. PHT were addressing these issues prior to the CQC inspection.
- There were a couple of areas of concern raised in the CQC report which came as a surprise to PHT such as medicine management on wards. PHT is much more receptive and the CQC have recognised that. The concerns with maternity services were being addressed prior to the CQC report being published.
- PHT had a very detailed Quality Improvement Plan in previous responses to CQC reports that had a prolonged time span to meet the requirements. This time they have been focussing on the key must do actions. A more concise QIP has been developed which is entirely focussed on the 54 requirements. PHT are co-ordinating the response through the QI action group to deliver on the plan. They have identified this as an opportunity to look deeper into the organisation to identify any recurring themes. The first big conversation to explore why staff might find it difficult to comply with some of the requirements has been held and they have learnt a great deal about ward pressures. This will also be fed into the culture change programme.
- PHT submitted a response to the warning notice to the CQC but they only have received an acknowledgment to this. PHT do not have anything that is off trajectory and there is nothing flagging as red with progress is being made in every area. Members asked if the HOSP could see this response once received and Dr Knighton said this could be shared.
- Medical services is one of the areas at odds to the CQC report. There have been a number of focussed reports on elements of this over the last three years and each of those has a number of areas rated as inadequate. The report this time describes challenges but things are improving. There are still some serious challenges for all of the medical elements but teams are working together that were not a year ago. PHT are looking at how they will describe and reconfigure a model for managing the intake of medically ill patients. This is likely to be a 2-3 year project and something that must be done well with the full engagement of all groups.

The panel noted that there were some outstanding areas arising from the CQC report such as critical care which was encouraging.

ACTION - Dr Knighton to share the CQC response with the panel once received.

#### Elective Spinal Service

- There is a resulting loss of income to the Trust from losing the service. The key driver for the move is to improve the quality of service for patients as it is not a sustainable clinical model. There is only one spinal surgeon who is not full time and therefore unable to provide an emergency service. The volume of work is not huge although significant.
- With regard to implications of the move, PHT are looking at what services may be delivered more accessibly. The General Manager added that children and complex surgery already go to Southampton Hospital. PHT have gone out to community groups and spoken to them about their transport concerns. Those families on lower incomes will have help with transport. Currently many patients are referred to a spinal surgeon where they would be better cared for in a community setting. This is being developed with Southampton and the CCGs at the moment so this will be improved and it may mean that there are less patients going to Southampton. Dr Knighton said he had some further information about communication which was circulated to the panel.

#### Emergency Floor Redevelopment

- The rise in demand for the Emergency Department (ED) has been steady and Portsmouth is not an outlier. There are particular ways patients like to access healthcare and there are those who will always go to the ED rather than a more appropriate setting. There is frustration of primary care colleagues that when a service is provided well people choose not to access it, people will still choose to come to the ED even when there are other alternatives.
- There are a huge number of different workstreams and improvement projects looking at reducing conveyance to the ED. There is no easy answer. They are looking at more consistent provision of a GP led urgent care centre as when it fully staffed it is drawing numbers away from ED. PHT have secured some external funding to provide a mental health assessment unit within the ED which should mean they can better manage those patients with fewer having to stay in the ED. The other big challenge is ensuring the hospital can discharge patients at the end of their stay. Medically fit for discharge (MFFD) numbers have reduced from approximately 300 to 200 which is still a high proportion. Partners are looking to work together to make marginal gains at all elements of the pathway.
- The proposal for the redevelopment to be operational by February 2021 was realistic. It will not be a reconfiguration of an existing site it will be a new build facility that must be built whilst maintaining continuity of service. The construction will take the majority of the time.

- PHT are continually looking to better mitigate the challenges of the physical layout and learnt a great deal from last winter. In order to offer a better experience for patients the ED needs to be less congested with a better flow of patients throughout the hospital.
- With reference to submitting an outline business case to receive funding for this from the STP, Dr Knighton said this had not yet gone forward. If they are not successful they will continue to look for other ways of funding.
- With regard to the PFI and the replacement for Carillion, PHT now had a change of provider and continuity of service has been relatively stress free. PHT have not seen any significant changes.

#### Winter preparedness and planning

- Work is taking place to minimise the impact on patients who have cancelled operations and staff are trying to give them earlier notice if their operation is cancelled. It is important to find a balance between giving notice and not cancelling an operation unnecessarily. PHT do not plan on cancelling elective orthopaedic surgery this winter but there is a chance they may still have to make last minute cancellations given the unpredictability of the winter pressures.
- Patients are informed in their appointment letter that their surgery may be cancelled. The more serious surgery patients are given more detailed warnings. These patients require greater support so are more at risk of it not being available on the day and therefore their surgery cancelled.

#### Delayed Transfers of Care (DTOC)

- There has been a significant improvement in the DTOC figures and PHT are managing these better. July was a very difficult month for the hospital due to the heat causing a higher number of patients being admitted to ED and a greater length of stay of patients. The overall number of patients has reduced and their ability to recover from a busy period has improved.
- With regard to the Gosport War Memorial Hospital now being part of PHT, Dr Knighton said there had been a certain amount of local reaction towards their staff, which died down quickly. There are a number of staff who are still working for PHT who were involved with Gosport War Memorial that feel uncertain on what the review enquiry will look into.

**RESOLVED that the updated be noted.**

#### **6. Solent NHS Trust - update (AI 6)**

Gordon Muvuti, Interim Operations Director, Mental Health Services, Mandy Sambrook, Operations Director for Integrated Adult Services and Mark Young, Head of Estates presented the report. The following updates were given:

### CQC inspection 2018

The Interim Operations Director added that they had received notification that the CQC "Well-Led" inspection is to take place in early November. A more comprehensive inspection was likely to take place a month prior to this but they were yet to receive a date.

### Mental Health Transformation

Both Solent and Southern Health had signed a memorandum of understanding relating to developing the crisis work across Portsmouth and South East Hampshire. This is following some extensive workshops that took place in the summer where patients and carers provided feedback on the elements of crisis provision that would improve their experience.

### Mental Health beds

This morning the Interim Operations Director gave the instruction to re-open the beds that had been closed on Maples ward following the serious incident in May. This is following some extensive work of Estates colleagues to make some steep improvements in a short space of time. There will be a phased re-opening of beds and they should be fully operational by next week.

### Estates - phase 2 works

The Head of Estates said the turf cutting event took place this morning and works are now underway for phase 2 capital scheme.

### Parking

This is going through various groups and they are looking to mobilise some of those actions shortly.

### Catering

A full report with recommendations will go to the board meeting in the next few weeks.

### Winter plans

The Operations Director for Adult Services explained that the 'close the gap' initiative to enable the 92% bed occupancy, that will be needed in the acute trust, was now underway. They have seen a significant reduction in the number of DTOCs and as of today they are down to 0.4%. Within Portsmouth they are looking at moving these upstream within the acute trust and are seeing patients at home for assessment which is known as the home first principle.

In response to questions the following matters were clarified:

- The home first principle is a national initiative system principle to create a culture within the system so that for every patient in hospital they are asking "why not home and why not today". When they see a patient they will categorise them to rehabilitation/re-ablement or care home. If the patient requires an assessment to get them into a new place of care this needs to be completed in a community setting as patients decompensate whilst in hospital whilst waiting for a decision to be made. 40% of patients in hospital do not need to be there but require care. There is a team that will go into hospital to assess patients through the integrated discharge service with local authority social workers and clinicians. If a patient needs an assessment they will make this available in their place of choice which is normally in their home.
- Solent have been working with NHS Improvement to bring in experts that work with the CQC to complete repeated mock inspections, to highlight any areas where more improvement can be made. They are very pleased with the improvements being made so far. Solent received 3 requires improvements, 11 good and 1 outstanding so Solent believe the areas for inspection will be the 3 areas that were requires improvement.
- With regard to getting the mental health beds back in use after the serious incident, the Interim Operations Director said that it was taken through the internal serious investigation route and all the learning from that was shared internally. With regard to the management of the patient and whether anything could have been done differently, the findings show their staff did everything they should have done and they did incredibly well. There was some learning undertaken around timing of the response between partners. There is a national drive for the police to do less not more in intervention units when these incidents occur. Locally Solent have a very good working relationship with the police and have agreed how to manage such situations. The National Police Association are saying that mental health services should be training staff to deal with people with weapons. A local protocol has been agreed with police colleagues which is being refined. Everyone did the best they could but there are definitely areas for improvement.
- The MCP Partnership is between Solent, the Alliance and PCC and progress has been significant over the last few years. The biggest achievement is that there is trust to work together to pull budgets together and to look at patient pathways to ensure they are delivering the best for patients. An example includes integration with social care partners. Solent has been co-located for a long time within the civic offices but they had not been working together. They are now all working together to redesign pathways driven by frontline service. The

Portsmouth MCP is ahead nationally compared to other areas and they are starting to see the benefits already for patients having one contact.

- The Primary Care Alliance is now delivering GP out of hours services and Solent have started to work with them as a community provider to look at how to provide 24 hour care. Solent have a twilight nursing service and a community nursing service and are now starting to map across those partnerships to see how can better work together. They will all be on the same system of record keeping for patient records. Community nurses will update their records which will automatically update patient GP records.

**RESOLVED that the update be noted.**

## **7. Adult Social Care update (AI 7)**

(Councillors Hughes, Ford and Raines left prior to the commencement of this item).

Andy Biddle, Service Manager for Adult Services presented the report.

In response to questions the following matters were clarified:

- Direct payments are a method of delivery that involves people becoming an employer. The service are not persuading more people to have them, it is looking at the system for managing direct payments to enable people to understand the responsibilities they are taking on and to understand the support on offer. Where people manage their own care by direct payments they report a much improved experience as there is a level of control.
- The number of Deprivation of Liberty Safeguards (DoLS) is a mixed picture and there have been improvements in practice. Staff are often dealing with people with varied levels of training. The service are seeing an increased education and therefore more people referred to Adult Social Care. It is a fairly steady state with a regular number of people who are referred to Adult Social Care.
- The cost varies for DoLS. Most of the best interest assessments are carried out by their staff but for the doctors assessment it is about £250 each time. They also use independent assessors that can be in the region of £400.
- The front door referred to in the report is the point at which a patient contacts Adult Social Care either seeking crisis or seeking information. Currently this is not being completed in the most effective way.
- The joint equipment store was tendered and originally was based in Southampton and administered through Solent. Millbrook secured the tender 3-4 years ago and have a warehouse in Portsmouth. Equipment can be collected from the store so there is no lengthy wait and this is

run by the community access team. The service for equipment is better than it was although for some of the specialist equipment people are having a longer wait than they would like.

- The level of complaints is fairly steady and they now have a better idea of the use of equipment over a five year period. Options are currently being explored and they are looking at the best possible fit for Portsmouth in conjunction with Southampton.
- The team are working with Solent NHS Trust and are looking at the number of people who present to both services. The second phase is redesigning to take one case at a time to understand how to make it the best system. The new client record system is called System 1 which is cloud based and costs less to maintain and is more configurable. It is the same system that Solent and GPs use so information can be shared instantly. The new system will go live in March 2019.
- The reference to better use of enabling technology in the report referred to systems that can help manage your home e.g. turning on/off heating. It is hoped that more effective use of equipment might help some be able to live independently.
- Working relationships with PHT are better than they have been previously. Increased resources and a shared winter plan for people going into acute hospital is the key that shows in the numbers. Relationships are clear and well-built but this winter will test the plan.
- The main contribution to the winter plan from ASC will be used to fund a single agency to recruit and train people for contracts. If people decide to stay in the local area it is a side benefit as they can be redeployed in the local workforce.

**RESOLVED that the updated be noted.**

The formal meeting ended at 3.40 pm.

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Councillor Leo Madden  
Chair



# Public Health Portsmouth – Update from DPH – November HOSP

Dr Jason Horsley  
Director of Public Health

# Drug and alcohol update

- Demand for services remains high
- Recommendations / evidence review for Portsmouth Safety Advisory Group and licensing colleagues being presented by Dr Holland
  - Looking at evidence for range of potential interventions to reduce drug related harm at festivals and in nightclub settings
    - Dissertation completed
    - Developing summary of the evidence
    - Will ask him to present to January HOSP – can't attend Nov as preparing for some post-graduate exams
- Innovations in practice to address drug related deaths
  - Naloxone provision to reduce risk of death from overdose
  - Lower threshold access to methadone prescribing
- Vanguard process being used to improve efficiency of service
- CAST – community alcohol support service – developed to improve offer for addressing moderately harmful drinking – seen increase in alcohol treatment.
- PHE innovation fund – bid in for additional funding to support children of alcohol dependant parents – hoping (expecting?) to be successful for this but awaiting formal announcement – additional funding (~500k) to allow support work based in family hubs (recognising that the recovery settings are not appropriate for most children) (for info see <https://www.gov.uk/government/news/innovation-fund-open-to-help-children-of-dependent-drinkers>)
- Working with PHE to look at interventions to improve services locally

# Drug and alcohol service latest performance update

## Latest completion data (August 2018)

Measure	2017/18 baseline			Latest data			
	Number in treatment	Successful completions	Completion rate	Number in treatment	Successful completions	Completion rate	Change from baseline
All Drug: Local Authority	793	79	10.0%	852	94	11.0%	1.1%
All Drug: England	190588	28119	14.8%	190459	27201	14.3%	-0.5%
Alcohol only: local authority	163	54	33.1%	195	89	45.6%	12.5%
Alcohol only: England	74490	29882	40.1%	74725	29038	38.9%	-1.3%

Table 1: Source: NDTMS adult successful completions and re-presentations (partnership) report.

# Obesity

- Childhood obesity still significant problem (see DPH annual report focussing on this at <https://www.portsmouth.gov.uk/ext/documents-external/114.95-phar-2017-web-ready.pdf>)
- Special session of HWBB planned to develop our response locally, including input from colleagues in planning and transport
- Submitting bid for Childhood obesity “trailblazer” bid together with community team and other colleagues – bid for access to ~£100k / yr for 3 years
- Relates to air quality and sustainable transport work

# Air quality

- Board – PH chair for this, trying to bring together a variety of stakeholders to look at options for improving air quality
- Government targets very specific – relate to modelled values of NO<sub>x</sub>
  - Doesn't consider real world measures
  - Doesn't consider impact of particulates
  - May miss potential additional benefits to health in the city from focussing on a modal shift in transport if we only focus on the things that will achieve compliance in the shortest time period
- Link to transport team – access to Transforming Cities Fund (£1.7bn over 4 years divided between 10 cities) – see <https://www.gov.uk/government/news/pm-announces-ten-cities-shortlisted-for-major-transport-funding-across-england>
- Design council – won bid to work with them to look at the problem using their approach together with 7 other LA's in south of England who are working on a variety of different public health problems

# Wellbeing service

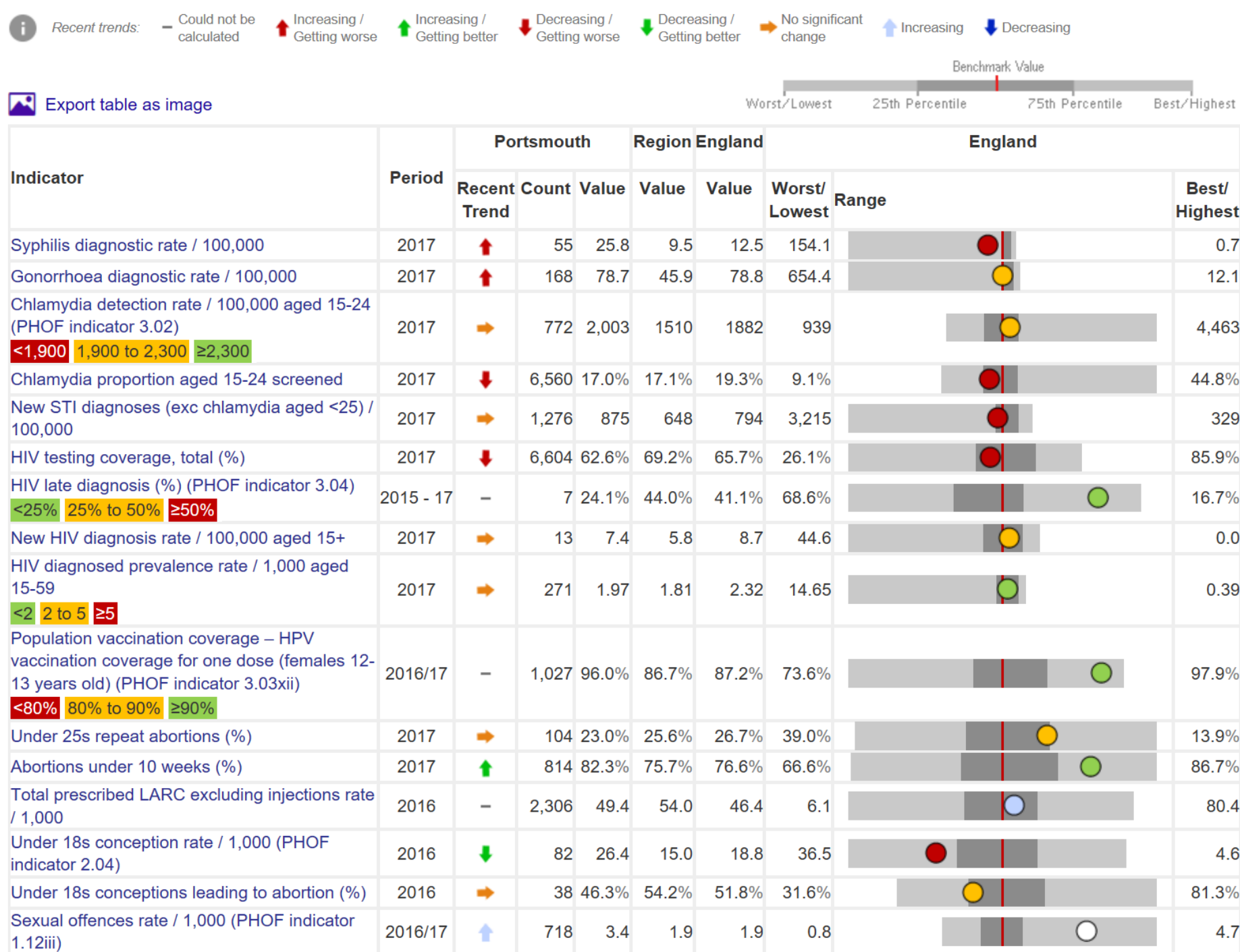
- Dramatic improvement in staff morale and the services accountability over the last 6 months
  - New computer software – recording activity properly, staff much happier and more productive as can record consultations in timely manner and can send prescriptions electronically for patients to pick up on the way home etc
- Seen ~950 people in the first 6 months of 18-19.
- We will bring a full report to HOSP next year looking at performance and full review of data.

# Sexual health

- Worrying trends nationally for increase in some sexually transmitted infections (gonorrhoea, syphilis) (see appendix – presentation)
  - Changes in behaviour, impact of technology
  - Reduction in condom use
  - But less transmission of HIV, and although there is a dramatic rise in the number of cases of syphilis and gonorrhoea the total numbers remain small
- Service has done a lot of good work to embed innovations in the last year
  - Increase in online activity
  - Reduction in number of people needing face to face consultations
  - Making savings required through the reduction in the PH grant
  - But need to recognise that with further reductions, will be impacting on the services ability to meet all demands

# Sexual Health - Portsmouth

## Key Outcomes





# Health protection incidents

- Main one – two isolated cases of Meningococcus type B
  - Acting on national guidance
  - Resulted in joint response between Solent, CCG, PHE and PH team to arrange for ~1000 students to receive prophylactic antibiotics
  - Going to discuss with PHE how well the guidance and current evidence base applies to such large buildings!
- Range of other cases we have assisted PHE in local management of

# NHS STP – Public Health input

- Taken on leadership role (shared with DPH for Hampshire) on “Population Health Management”
  - Data – how can we integrate existing data sets, and use data in a more timely fashion to inform:
    - Commissioning and resource allocation
    - Acute provider responses
    - Research
    - Improve focus on prevention and early intervention for individuals through stratification of risk
  - Increasing focus on prevention in next round of STP planning

# Other areas of joint working

- Exploring options for further integration with CCG and Children's to allow savings and improve cohesion/integration of services
- With Children's and Police colleagues - Support to look at primary and secondary prevention to address child sexual exploitation and exploitation of minors in illicit drug distribution
- Working with Police colleagues in developing long term responses to violent crime
- Will be sharing work with Southampton colleagues where we are undertaking a scrutiny enquiry focussing on prevention the intergenerational impacts of domestic violence
- Supporting university in bid for funding to improve mental health offer to students
- Working with NIHR colleagues to look at options for embedding researchers in Local Authority environments to improve evidence base in interventions and share learning, as well as drive innovation

# Challenges

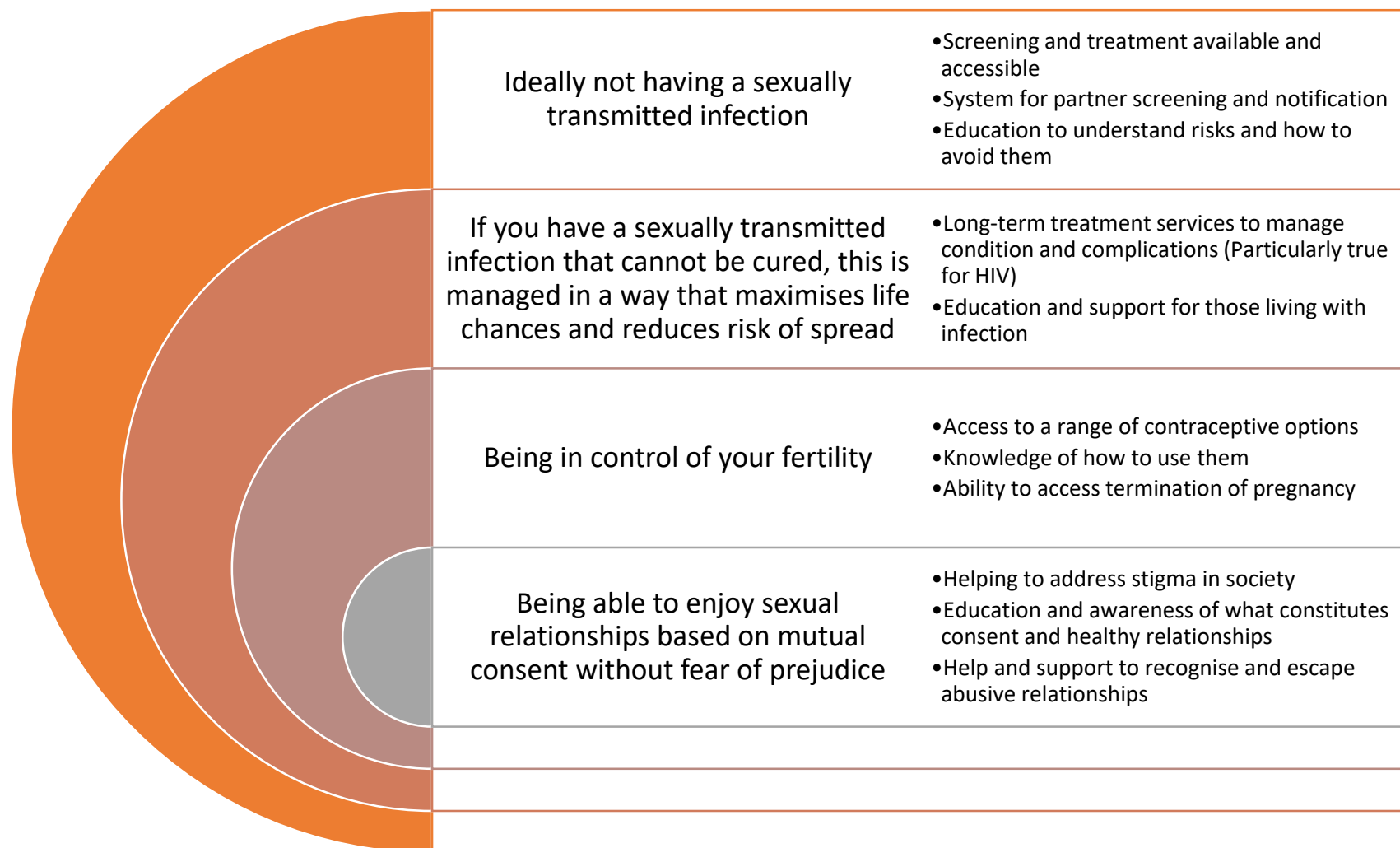
- Budget savings for next year – main reduction will be in value of health visiting and school nursing contract
  - Hoping to have minimal impact on frontline service by adopting section 75 approach with Children's and NHS Solent
- Future years funding – still no decision on how PH will be funded from 2020 on, or on what provision will be expected or mandated
  - Particularly challenging for longer term commissioning
- Impacts of wider council budget cuts on the “wider determinants of health” driving demand for many of our services



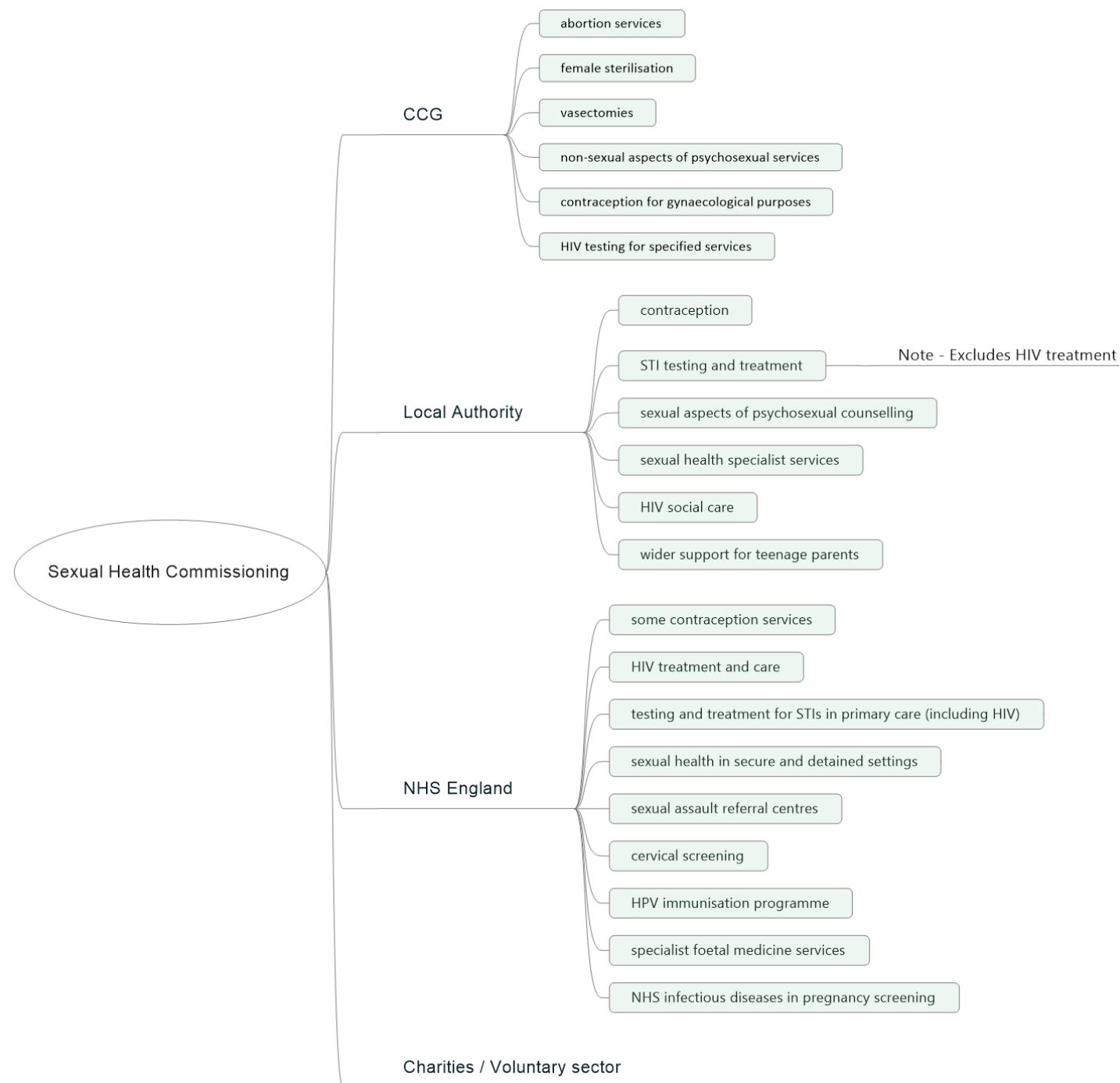
# Sexual health – trends

Jason Horsley

# What do we mean by sexual health?



# A fractured commissioning landscape



# Sexually transmitted infections



## Problems with measuring outcomes

Almost all sexually transmitted infections have an asymptomatic period where they don't cause the individual any symptoms, but can be transmitted

Identifying and treating them in this period has a public health benefit, as it reduces spread to the rest of the population and improves outcomes for those who are infected

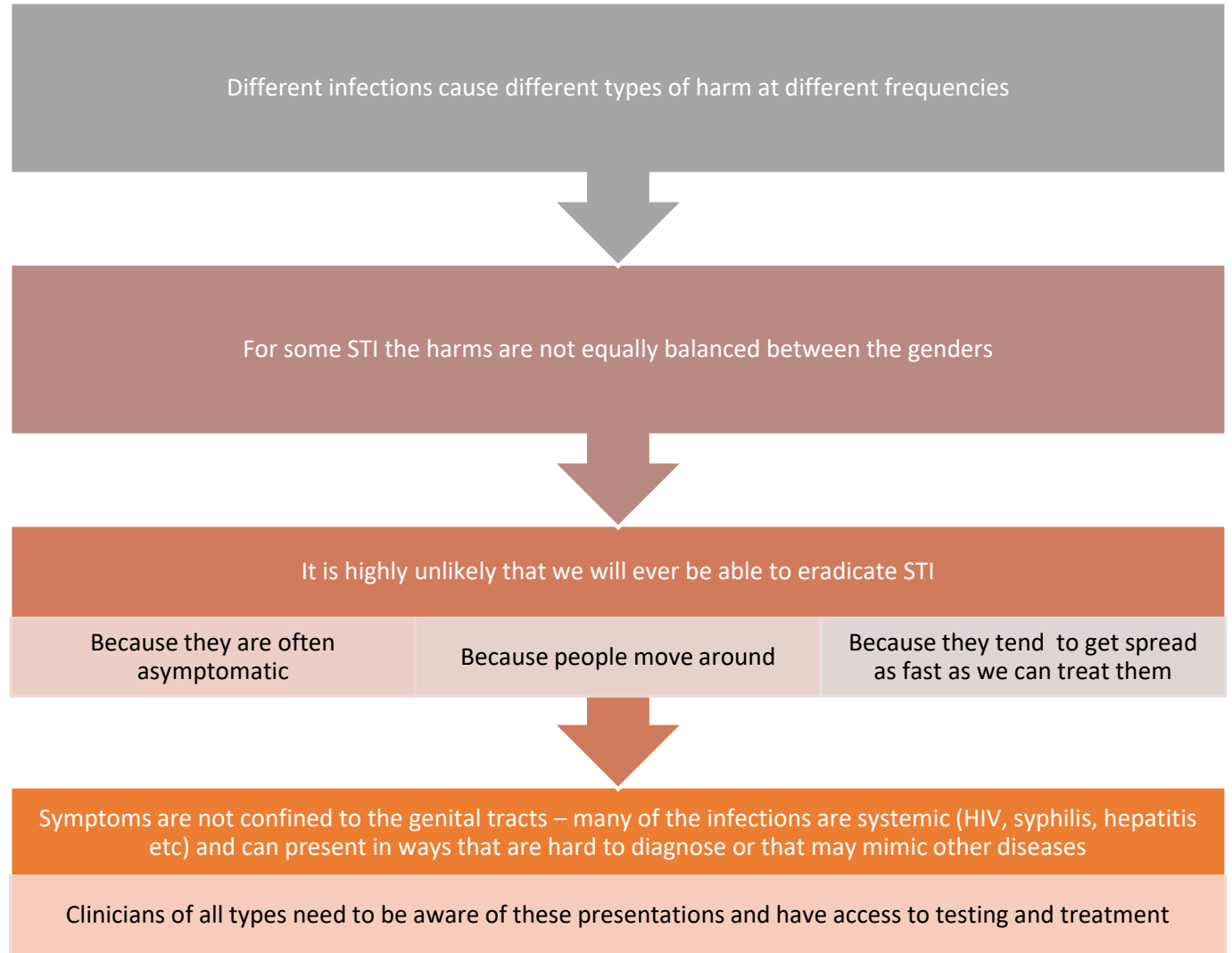
This requires a screening approach – and the more we look for these problems, the more we will find

Take home message for commissioners - Setting targets, especially ones with financial rewards or penalties – based on population prevalence is likely to lead to perverse incentives for providers

- If I get money based on there being a low rate of syphilis in a population, I will have a perverse incentive not to screen for syphilis

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Not all  
sexually  
transmitted  
infections  
are created  
equal



Some of the  
STI we are  
worried  
about

Disease	Symptoms and Complications
Chlamydia	Discharge, pain when urinating, itching, painful testes in men, or bleeding, pain in lower back/pelvis in women. Infertility.
Genital warts and HPV	Local itch, bleeding, aesthetic changes. Increased risk of cancers.
Gonorrhoea	Discharge, burning pain when urinating, swelling, rarely disseminated infection in the bloodstream
Hepatitis A,B,C	Acute or long term damage to the liver – can cause death through liver failure or increased risk of cancer
Herpes	Blistering sores on the infected area (mouth, throat, genitals, rectum), tiredness, swollen glands. Rarely can cause serious infection in the brain
HIV	Extremely variable – weight loss, diarrhoea, increased risk of other infections and cancers through damage to the immune system
Syphilis	Painless sore where infection begins (penis, mouth, rectum), swollen glands, rash, fevers and flu-like illness, weight loss. Years after initial infection can cause (often irreversible) damage to the heart, brain, nervous system, or bones.

# National Trends 2008-2017

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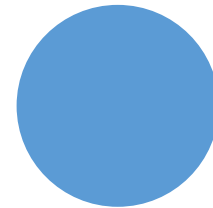


- Number of new STI Dx (excludes HIV)
  - Chlamydia – relatively stable – 10% increase
  - Herpes – relatively stable – 11% increase
  - Syphilis – 148% increase (M 163% >> F 12%)
  - Gonorrhoea – 183% increase in cases (M 225% > F 103%)
  - Warts – 28% decrease (90% decrease in girls age 15-17 - HPV vaccine)
  - Non-specific categories all down
  - TOTAL change is 5% decrease

- STI trends are often influenced by advances in treatment, but also by social changes – for example:
  - HIV was once seen as a death sentence – but although treatment is expensive and challenging, a person with well managed HIV is likely to live a long and relatively healthy life, and if they are on the right treatment their risk of passing on infection becomes very low.
  - Syphilis was extremely rare a decade ago, but is increasing in frequency now. This is probably a result of a reduction in condom use, coupled with an increase in opportunities for transmission related to people meeting through online applications.
  - An increase in oral-anal sex practices has been linked to outbreaks of hepatitis A
  - Pubic lice are becoming increasingly rare, probably because of a trend for people to shave off their pubic hair.
  - Pornography is more available than ever before and this is likely to be influencing peoples ideas of what is normal
    - Increased heterosexual anal sex
    - Increased normalisation of things that have previously been considered “a fetish”

---

# Changing trends



Other factors  
that may  
make a  
difference

## Alcohol and drug use

- Trend for less alcohol use in teens
- Harder to be sure about drugs

Increasing worklessness or exposure to “gig economy” in younger generation

Increasing concept of gender fluidity in today's teenagers

Increases in hate crime

# Summary



Complicated commissioning landscape



Difficult to measure success



Sociological changes are having a significant impact on spread

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© Portsmouth City Council  
ISBN 978-0-9955048-1-3  
Published September 2018

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We would be pleased to receive your  
comments about this report.

Email: [jason.horsley@portsmouthcc.gov.uk](mailto:jason.horsley@portsmouthcc.gov.uk)

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**Jason Horsley**  
Director of Public Health

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## EXECUTIVE SUMMARY

I have chosen to look at the problem of childhood obesity this year. This is a serious problem confronting both the current generation and also future generations, since the consequences of childhood obesity impact both on the individuals affected, and also on the wider society as we battle to make our stretched healthcare resources work effectively.

Obesity harms children's physical and emotional health in their childhood and is likely to go on to harm their adult health, cutting short lives and placing further strain on our health services.

It has been over a decade since the landmark Foresight report<sup>1</sup> highlighted that "Significant effective action to prevent obesity at a population level is required". This gives us a chance to see if we are having the impact we would hope.

Rates of obesity in children have continued to climb in the UK over the last decade. Rates in Southampton and Portsmouth are similar to those seen in our statistical neighbours (cities with similar profiles and similar levels of deprivation). However, being "average" for this problem is not something we can take comfort in – nationally rates of childhood obesity are too high, and are much higher than they were 20 years ago. We have to be ambitious if we are going to make a difference to a problem we cannot ignore.

At a simple level, rising rates of childhood obesity results from a reduced level of physical activity in our children and diets that are too reliant on high calorie processed foods. However, there are a number of cultural shifts underlying these simple drivers that we need to recognise.

There have been numerous interventions that attempt to reduce the rates of childhood obesity in our population. In this report I will make a case that what we have been doing, while helpful, is not enough. In this report we have included a lot of great examples of work that already exists, but that either needs to be done more often or replicated across a wider area. We have also looked for international models that appear to have been effective.

I don't think relying on our healthcare system or even the growing gym industry can be the answer. While the consequences of obesity impact on our healthcare system, the reasons why we have the problem in the first place cannot be addressed through healthcare provision. Too often we have placed the responsibility back on individuals, through healthcare providers and used individualised interventions. I would argue that childhood obesity is a population problem, and needs interventions that reach everyone.

There are things that everyone can do to improve the situation – this is a problem that will need the coordinated actions of central and local governments, schools, food producers and providers, employers, and not least parents and children.

Jason Horsley  
Director of Public Health

# 04

## DANGERS OF OBESITY

We often view obesity as a "healthcare" problem – but it's a problem created by society that has a massive impact on health<sup>2</sup>. GPs, hospital doctors and nurses don't have the capacity to deal with a problem that affects about 60% of the adult population.

Being inactive increases the risk of a range of conditions usually associated with old age including heart disease, type 2 diabetes and certain cancers.

### Obesity harms children and young people:

#### Emotional and behavioural

- Stigmatisation
- Bullying
- Low self esteem

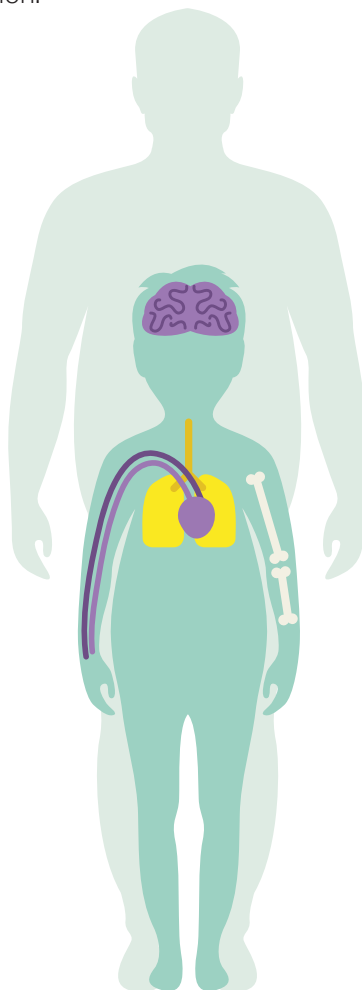
#### School absence

#### Physically

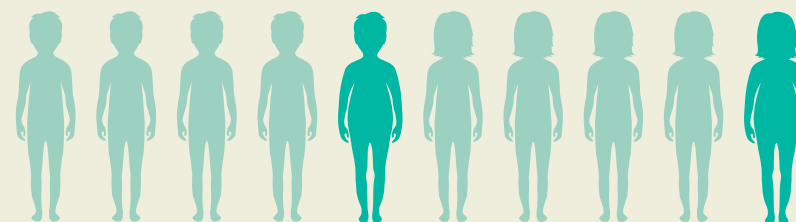
- High cholesterol
- High blood pressure
- Pre-diabetes
- Bone and joint problems
- Breathing difficulties

#### Adult life

- Increased risk of becoming overweight adults
- Risk of ill health and premature mortality in adult life

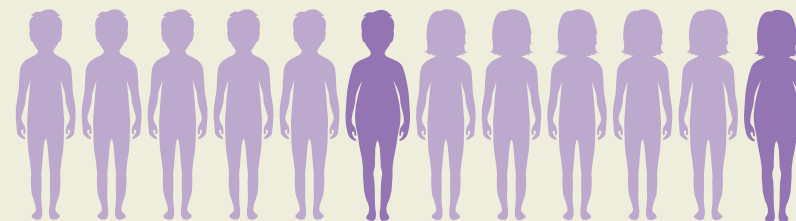


### QUICK FACTS



More than 1 in 5 five-year-olds in England are obese or overweight<sup>2</sup>.

By year 6 (age 11) this is one in three<sup>2</sup>.



In 1980 the rate in 2 – 19 year olds was only one in six<sup>3</sup>.

Overweight adolescents have a **70%** chance of becoming overweight adults<sup>3</sup>.





## TRENDS IN OVERWEIGHT AND OBESITY IN CHILDHOOD

05



The National Child Measurement Programme has helped us to monitor trends over time:

- » Prevalence of obesity and overweight in 5 year olds (reception year) has apparently plateaued – although at a level that is way too high to manage.
- » The prevalence of obesity and overweight in 11 year olds (year 6) is still slowly rising and is now 34.2% for England. In Southampton it is slightly higher (34.9%) and even higher in Portsmouth (35.9%)<sup>4</sup>.

**The rise in obesity between reception year (age ~5) and Year 6 (age ~11) suggests that interventions in these school years could be highly effective.**

Unfortunately excess weight tracks through to adulthood – 61.3% of the adult population is either overweight or obese<sup>4</sup>.

We need to ask ourselves, are we happy to reach England average levels for childhood obesity. Or do we want to do better than that?

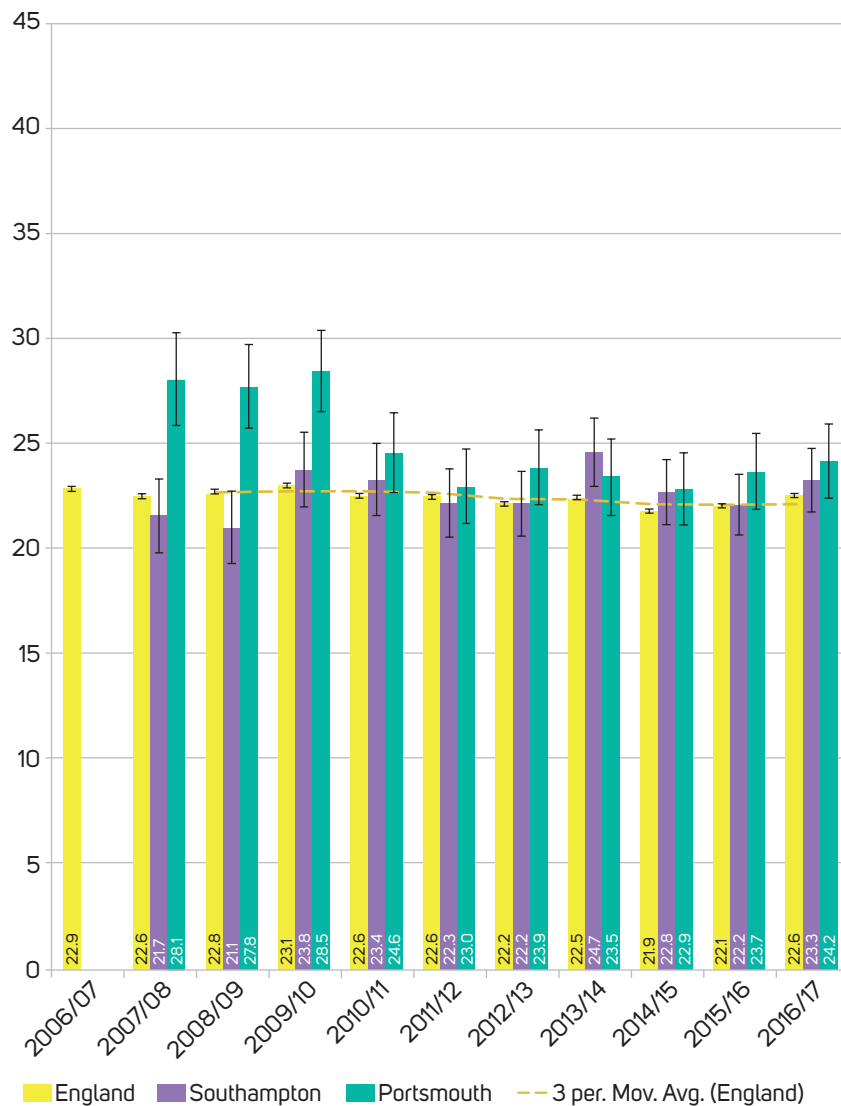
For inspiration we need to look at examples of cities that have made a difference for their residents:

- » Seinäjoki in Finland has reduced obesity in five year olds from similar levels to the UK (1 in 5 five-year-olds) to almost half that.
- » Freiburg in Germany has transformed the environment for its residents to a place where walking, cycling and public transport are prioritised.

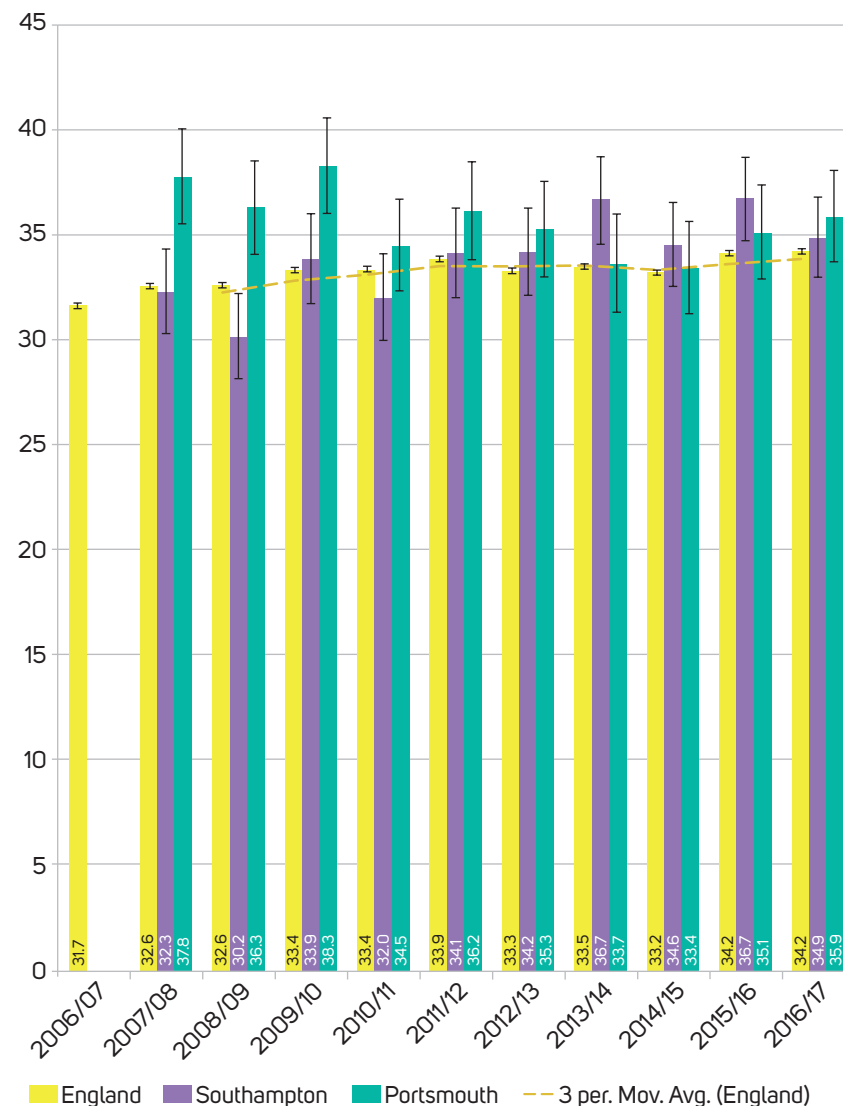
These interventions won't work overnight, but we have to use the most effective ones, and for long enough to see results.

# 06

TRENDS FOR PROPORTION OF CHILDREN WHO ARE  
OVERWEIGHT OR OBESE IN RECEPTION YEAR



TRENDS FOR PROPORTION OF CHILDREN WHO  
ARE OVERWEIGHT OR OBESE IN YEAR 6



## DEPRIVATION PLAYS A MAJOR ROLE, AND IS DRIVING INEQUALITIES IN HEALTH OUTCOMES

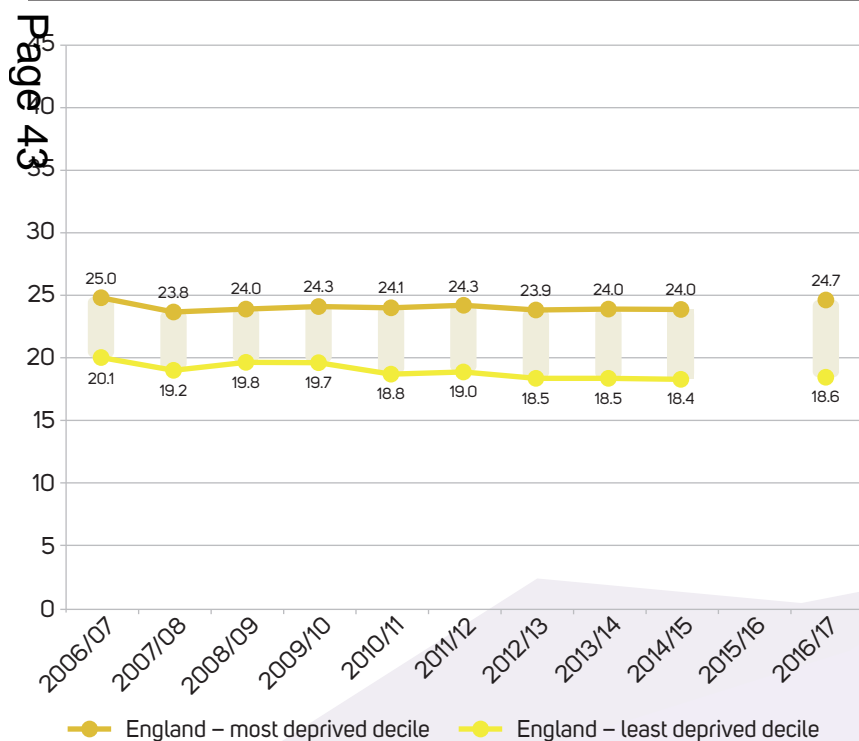
07

The graphs below show the gap between rates of obesity and overweight in the most and least deprived wards in the country.

They show three disturbing facts:

- » First that there is a big difference between the rates of overweight and obesity between the richest and poorest areas in the country.
- » Second that this gap appears to be growing.

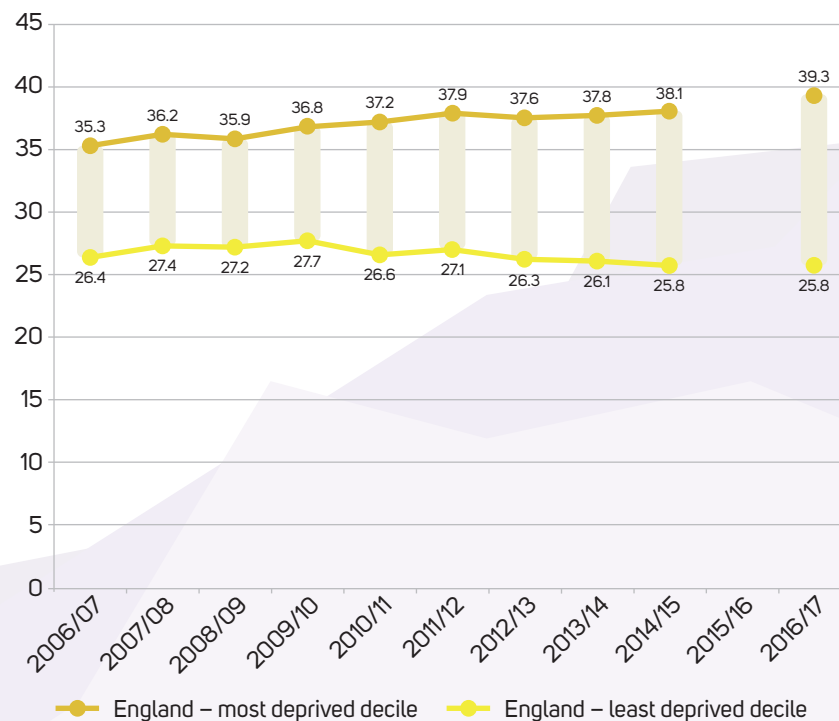
TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN RECEPTION YEAR BY DEPRIVATION DECILE



- » Third is that the gap is growing because rates are getting worse in the most deprived areas, and better in the least deprived areas – suggesting our current interventions are only working in the richer parts of the country.

For our two cities, where there are pockets of significant deprivation, these figures suggest we need to do more to target the most deprived wards in the city.

TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN YEAR 6 BY DEPRIVATION DECILE



How have we got here?

# 08

## HOW HAVE WE GOT HERE?

It is a popular belief that if people ate less and did more activity, then obesity would be solved

BUT...

Years of evolution have designed us to preserve energy whenever possible, and to value high calorie foods. Our genetics mean we get pleasure from eating to excess, and by default we are inherently lazy. Unconsciously we have designed our lifestyles according to these basics.

**The causes are complex as the choices we make are influenced by many factors, they include<sup>1</sup>:**

We need to recognise we are not winning with our current approach.

- The trend for rising rates of obesity has not reversed for over a decade.
- Medical interventions and weight management support through intensive lifestyle advice cannot provide the answer alone. Support programs often have a high drop out rate and we don't have the resources to provide them to everyone who could benefit (over 60% of the adult population).
- Solely encouraging people to take up a healthy diet and more activity, helps only a few.
- We need to make it easier for a majority of people to be active and eat healthier by changing the environment we live in so that these choices are the most effortless ones to make.





## RELATIONSHIP WITH HOW WE MOVE

MOST OF THE EXERCISE WE GET EVERYDAY IS THROUGH MOVING FROM ONE PLACE TO ANOTHER

HOW CAN WE REVERSE THIS TREND AND MOVE MORE?

A majority of the trips we make are for shopping, personal business and visiting friends.



Nationally 62% of our trips are made by car and 25% by walking and the number of trips we have made by walking has been steadily decreasing since 2002. (National Travel survey 2016)



Over the long term the cost of purchasing cars has decreased and 77% households own at least one car. (National Travel Survey 2016)

Increasingly we have made it easy to travel without moving as we have designed cars into every aspect of our lives. We feel it's safer to drive at 30 – 50 mph than for people to travel at 5 – 15 mph on a cycle.



Recently we have made it even easier to move less as we can purchase most of the things we need through online shopping.



People are more likely to walk if they are taking a short trip, on average each walking trip lasts just 16 minutes (National Travel survey 2016)

If our cities were designed around walking, not cars, the walking trips we take should increase. This would have added benefits of:



Reduced air pollution



Reduced road injuries



Stronger social interactions



Sense of belonging



Reduced crime rate



Improved physical and mental health<sup>6</sup>

To see this change we must commit to making walking a priority, ensure walking features strongly in town plans, create a walking network and design streets as places for children to enjoy (Creating Walking Cities a Blueprint)<sup>6</sup>.



# 10

## RELATIONSHIP TO FOOD ENVIRONMENTS

Our food all has an impact on our diet and its nutritional content. It is influenced by how we:



Research shows

- Shops in poorer areas have fewer healthy food options<sup>7</sup>
- Fast food outlets are more common in deprived areas nationally<sup>8,9</sup>
- These factors have been associated with poorer diets and health problems that can result from poor diets<sup>10,11</sup>

The good news is that we have the ability to make changes to the local environments which will help people make better diet choices.

For example, ensuring that healthy options are easy and accessible to all (relatively cheap, available, convenient etc.) is a key factor if everyone

is to have the opportunity to eat a healthy, balanced diet. This includes places like:

- » Businesses selling prepared food for immediate consumption (canteens, cafés, restaurants, takeaways, high-street shops etc.)
- » Supermarkets
- » Corner shops

## CASE STUDIES

# 11

### CASE STUDY: THE DAILY MILE

Arundel Court have been doing the Daily Mile for over a year with Key Stage 2 pupils and it's proved very successful. The students walk, jog or run a mile during each school day.

#### Perceived barriers:

- » **No time?** Once you get into the habit of scheduling 10 mins each day it becomes part of routine.
- » **Limited space?** It doesn't matter, our kids do 7 laps of our go-kart track to make a mile!
- » **Bad weather?** It hasn't been an issues, even on rainy days you can generally find 10 minutes where it isn't pouring.

#### Benefits:

- » Real improvements in fitness and confidence
- » Inclusive (all pupils can participate)
- » Children feel "happier", "increased enjoyment in activity" and "have friends to play with"

#### Would you recommend other schools get involved in the daily mile?

"Absolutely. We've seen nothing but positives and haven't encountered any problems with setting it up. Just give it a go and it'll become routine before you know it".

"Pupils love it, we're looking at rolling it out to all pupils this year"



# 12

## CASE STUDY: ROAD CLOSURE OUTSIDE ST JOHN'S PRIMARY SCHOOL FOR CLEAN AIR DAY IN SOUTHAMPTON

### The event:

A road closure organised outside school enabled the street to be transformed so that children and families could participate in street play, cycle training and Bike Doctor sessions, dance workshops, renewable energy lessons and seed planting activities.

### What happened?

- » Majority of pupils travelled actively to school (walk, scoot, cycle or Park & Stride)
- » 85 bikes fixed by the Bike Doctor.
- » 120 pupils participated in bike agility courses
- » 300 pupils participated in outdoor dance sessions
- » 60 pupils participated in renewable energy workshops

### Who was involved?

All pupils and staff. Southampton City Council School Travel Officer, Sustrans staff, The Environment Centre Team and Global Action Plan staff.

### The legacy:

Success of one-day road closure has led to consultation with residents for a permanent timed road closure outside the school.

## CASE STUDY: POMPEY MONSTERS – WALK TO SCHOOL CHALLENGE

### The programme:

An incentivised programme to encourage long-term behaviour change to reduce car travel to school, thus reducing congestion and improving health.

### Launched in 2017:

Initially piloted in 3 schools over a 7 week period, using a video of the monsters and a visit by 'Stomper'. Parents received flyers to encourage online sign-up.

### Introduction:

Registered pupils received an information pack and the monster characters (who all carry a different road safety message) were introduced. Children also got a chart to record their walks to school, a Park and Stomp (stride) map and a pedometer voucher.

### In action:

The road safety team visited schools, distributing the monster keyrings (incentive for walking, different ones to collect) once pupils proved they walked to school 3 or more times per week.

### Results:

- » 68% of pupils registered to participate
- » 92% collected 4 or more keyrings
- » Over 97% are very likely or likely to continue walking
- » Over 81% said they enjoyed walking to school more frequently
- » Nearly 84% of parents said they valued time walking with their child

### Impact:

- » 60% indicated they now walked 4/5 times per week
- » 96% said scheme helped teach road safety

### The legacy:

The scheme has been rolled out to 3 more schools, with encouraging results to date.



## CASE STUDY: SO18 BIG LOCAL – HELPING TO INCREASE USE OF LOCAL GREEN SPACES

### The programme:

Harefield, Midanbury and Townhill Park in Southampton were allocated Big Lottery funding to each come together to make their areas even better places to live. The project named SO18 Big Local has a number of aims which include getting local people out and about and enjoying the green areas on their doorsteps.

### What happens?

- » Work with local schools to teach children about the biodiversity in the area
- » Engaging with local residents and making them aware of local 'wild' areas
- » Promoting active participation in local hands-on activities in natural spaces

### Who was involved?

SO18 Big Local is driven by a group of people that all live, work or volunteer in the area.

### Impact

- » Awareness has increased – many local residents were not even aware of the local green space available on their doorstep
- » More people engaging in activities in Frogs Copse
- » More people are involved in helping maintain their local green spaces

*"I never even knew this space was here"*



# 14

## CITIES THAT HAVE MADE A DIFFERENCE FOR THEIR RESIDENTS

### FINLAND <sup>12 13</sup>

- » Seinäjoki in Finland has a population of over 60,000 and is a fast growing urban area of Finland. The businesses in the area focus on food, agriculture and agro-technology
- » Seinäjoki managed to half the proportion of overweight and obese five year olds in the city in just 6 years
- » They did this by getting the right policies in place and understanding that preventing childhood obesity lies outside the health sector.
- » The city worked on having a health in all policies approach and by working out how different departments could work together (e.g. planning, education, recreation and health) and having clear role for each department
- » They worked to increase physical activity and improve food choice.



### GERMANY <sup>14 15</sup>

- » Freiburg is a city located in South Germany with a population of 220,000. After the devastation of the Second World War, sustainable development featured strongly in rebuilding the city. Freiburg developed a car-lite system focussing on walking, cycling and public transport. Use of cars is restricted and two-thirds of the land is devoted to green uses.
- » The impacts have been notable, the living standards in this city are among the highest in Germany, and residents have a strong understanding of environmental issues which effects lifestyle choices. This approach to urban planning has improved community cohesion and improved the health as well as safety as children can play safely outside the home. There has also been a reduction in the differences (social inequalities) between the richest and poorest groups, indicating that the whole population are more likely to flourish.



## WHAT ARE OUR OPTIONS?

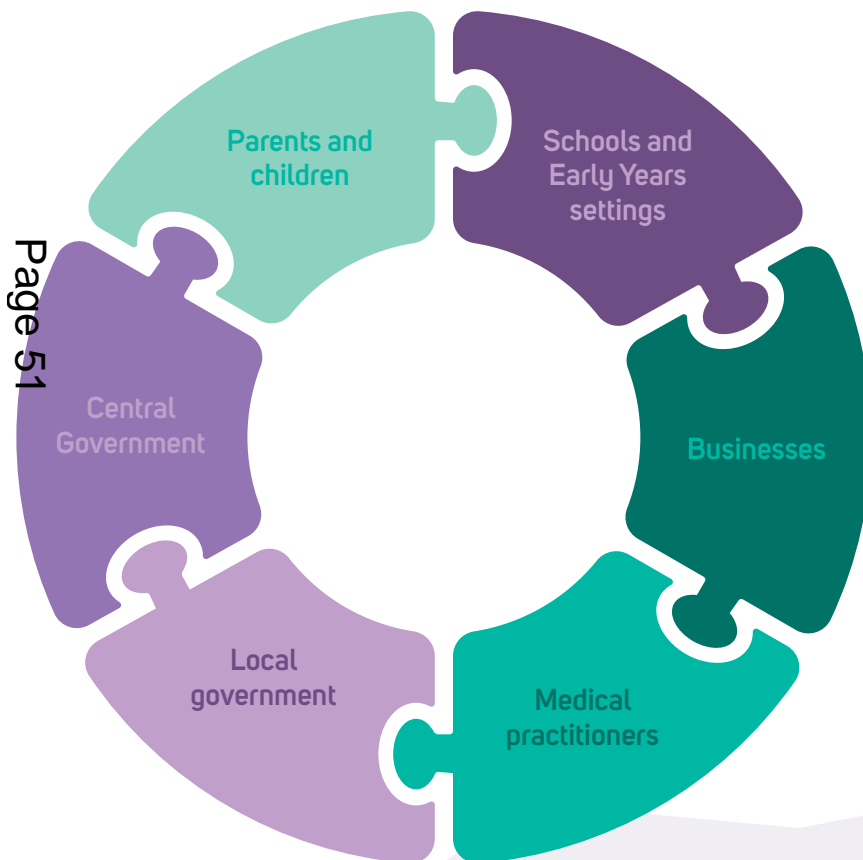
If we are to reduce the high levels of childhood obesity, action is required at all levels to make healthy choices the easier choices—a “whole systems” approach.

### THE PLACE FOR INDIVIDUAL ACTION

People who can have the biggest impact are still parents and children

What would we expect of parents:

- » Be a role model—eat well and move more
- » Teach children about healthy food choices from an early age
- » Be active as a family—make play a part of every day life
- » Reduce screen time
- » Teach kids about advertising and how it is trying to influence them
- » Encourage schools to offer opportunities for physical activity and provide healthy meals/snacks



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# 16

What are our options?

## ROLES FOR EDUCATION INSTITUTIONS

Embrace physical activity

- » Improves school performance!
- » Sport should be fun first (competition has its place but the first aim is to ensure there is something for everyone)
- » It doesn't have to come under the label of "sport" – examples of other initiatives include:
  - » Daily Mile or Golden Mile [thedailymile.co.uk](http://thedailymile.co.uk) or [golden-mile.org](http://golden-mile.org)
  - » Walking buses
  - » Active travel plans
- » Encourage good diets in school. Make sure school foods meet the national school food standards
- » Use PHSE to explore issues sensitively
  - » Understanding healthy diets
  - » Recognising value of physical activity

## ROLES FOR LOCAL BUSINESS

For most businesses the best asset they can have is a healthy workforce. Similarly a loyal, healthy customer base will make them more likely to operate on a sustainable profit.

Many businesses, especially small and medium sized ones, do better when they have higher footfall, which in turn is dependent on measures that increase walking, cycling and public transport.

Businesses have a role to play by:

- » Making it easier for staff and customers to travel by active transport, or provide incentives when they do.
- » Food retailers can make healthy options more prominent on shelves.
- » Food retailers can have healthier snacks at the checkout and price promotions on healthy meal or snack options.

- » Investing in the local community to promote healthier choices.
- » Larger businesses must consider how to support smaller suppliers, and especially when they are offering a healthier alternative.

## ROLE FOR LOCAL GOVERNMENT<sup>16</sup>

My biggest ask of local governments is to use their powers to shape the built and natural environment, and to influence transport.

The Town and Country Planning Association has developed a great list of actions for planning departments to help plan healthy weight environments.

I would also ask elected members to recognise the importance of this problem, and to make addressing it a priority in all their actions. Officers will need their support.





## Planning Healthy – Weight Environments – Six Elements

<b>Movement and access</b>	<b>1</b>	<b>Open spaces, play and recreation</b>	<b>2</b>	<b>Healthy food</b>	<b>3</b>
<ul style="list-style-type: none"> <li>» Clearly signposted, with direct walking and cycling networks</li> <li>» Safe and accessible networks, and a public realm for all</li> <li>» Walking prioritised over motor vehicles, and vehicle speed managed</li> <li>» Area-wide walking and cycling infrastructure provided</li> <li>» Use of residential and business travel plans</li> </ul>		<ul style="list-style-type: none"> <li>» Planned network of multi-functional green and blue spaces</li> <li>» Easy-to-get-to natural green open spaces of different sizes</li> <li>» Safe and easy-to-get-to play and recreational spaces for all, with passive surveillance</li> <li>» Sports and leisure facilities designed and maintained for everyone to use</li> </ul>		<ul style="list-style-type: none"> <li>» Maintain and enhance opportunities for community food growing</li> <li>» Avoid over-concentration of unhealthy food such as hot-food takeaways in town centres and in proximity to schools or other facilities aimed at children and young people</li> <li>» Shops/food markets that sell a diverse offer of food choices and are easy to get to by walking, cycling or public transport</li> </ul>	
<b>Neighbourhood spaces and social infrastructure</b>	<b>4</b>	<b>Buildings</b>	<b>5</b>	<b>Local economy</b>	<b>6</b>
<ul style="list-style-type: none"> <li>» Community and healthcare facilities provided early as part of a new development</li> <li>» Services and facilities co-located within buildings where feasible</li> <li>» Public spaces that are attractive, easy to get to, and designed for a variety of uses</li> </ul>		<ul style="list-style-type: none"> <li>» Adequate internal spaces for bike storage, dining and kitchen facilities</li> <li>» Adequate private or semi-private outdoor space per dwelling</li> <li>» Car parking spaces are minimised across the development</li> <li>» Well-designed buildings with passive surveillance</li> </ul>		<ul style="list-style-type: none"> <li>» Enhance the vitality of the local centre by providing a more diverse retail and food offer</li> <li>» Centres and places of employment that are easy to get to by public transport, and on walking and cycling networks</li> <li>» Facilities are provided for people who are walking and cycling to local centres and high streets, such as street benches, toilets and secure bike storage</li> </ul>	

# 18

## ROLE FOR HEALTHCARE PROVIDERS

I think we have relied too heavily on healthcare providers. They have an important role in recognising when people have a problem and in signposting to help, but healthcare facilities can only help once a problem has started. To be effective we have to work to prevent obesity starting.

There is a significant role for health visitors and midwives to promote healthy eating from the very beginning, and to signpost young parents to information they need to get their children off to the right start.

- » In adults there is good evidence that healthcare providers can make a difference by providing brief opportunistic interventions to motivate weight loss<sup>17</sup>
  - » Primary care appointments are an ideal opportunity for this intervention which could take as little as 30 seconds.
  - » It can achieve moderate weight reduction in patients and has been shown to be highly acceptable by patients.



## ROLE FOR CENTRAL GOVERNMENT

Central government has done a lot over the years to promote physical activity and healthy food. There has been a huge amount of support for sport. New measures like the sugar tax on beverages are welcome.

All too often though, initiatives don't have the impact they could. Initiatives led by governments from all major parties have not been as effective as they could be because we:

- » **Forget to make the healthy choice the easy (and fun) choice** – for example, much of the money spent on sport ends up supporting elite sports-people – there seems to be very little benefit to public health from this. Most people would like to participate in sport as a social activity, and many are put off by highly competitive environments.
- » **Cannot see the possibilities within the framework of existing structures** – for example, much of the money we invest in transport continues to be spent on improving the road network for private vehicles. Active transport could be most people's default choice if the infrastructure was better, yet we don't invest anywhere near as much in it.
- » **Fail to explain to vested interests (media, corporate structures, existing government departments) why change is needed** – in recent years concerns over first the financial crisis, and then the Brexit referendum have dominated political debate, and both civic society and our politicians seem to have lost focus on some of the big challenges of our time. We need strong political leadership.

What would I like central government to do (top three):

- » **Distribution of transport monies needs to change** – Government must ensure that the proportion of transport money that is invested in active transport options continues to grow, and that this money is spent on infrastructure (cycle paths, covered walkways, public transport etc) in preference to publicity campaigns.
- » **Grasp the opportunity to subsidise healthy food production over sugar production** – Historically the biggest beneficiaries of the EU farming subsidies have been producers of sugar beet. This has artificially lowered prices for producing sugar, at the expense of crops which have much greater nutritional value. With Brexit, we have an opportunity to change this, and to prioritise subsidies for healthier food.
- » **Actions to reduce exposure to advertising and to make parents less susceptible to "pester power"** – Advertising to children has shifted mediums and regulation has not kept up. Social media and internet companies need to reduce promotion of unhealthy foods to minors. Similarly supermarket price promotions could be regulated to ensure healthy food is promoted and prominently placed in stores.

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## ABOUT THIS REPORT

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This is my first attempt at writing a joint report for both the cities of Southampton and Portsmouth. There are benefits in comparing the two cities, as they share a number of similar characteristics – they are both Port cities, close to London, and they both have significant pockets of deprivation which makes addressing the public health problems more challenging.

This report is independent of the political administrations and other officers' views. It is my independent review of serious problems that are challenging the health of the people living in the cities.

I have chosen to focus on one topic in particular. This approach allows us to look at a single issue and ask ourselves if we have got the right approach, and if we are doing enough to address the problems it presents. For more of an overview of the various problems that are impacting on health in both cities, we also produce a Joint Strategic Needs Assessment to inform commissioning, and there are a wide variety of helpful statistics that Public Health England collates available at <https://fingertips.phe.org.uk/>

I have made recommendations from this report at a number of levels – not just for the local authorities involved, but also thinking about all the other drivers of a problem, and what could be done by private and public organisations and citizens with the power to improve the situation.

I am very grateful to the following people in particular for their help in producing this report:

- » Ravita Taheem and Andrea Wright
- » Cheryl Scott and John Showalter
- » Jo Proctor and Barbara Hancock SO18 Big Local
- » Ian Bailey Parks and Open Spaces, Southampton City Council
- » Dr Christina Vogel MRC Lifecourse Epidemiology Unit, University of Southampton

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# Agenda Item 5

CCG Headquarters  
4<sup>th</sup> Floor  
1 Guildhall Square  
Portsmouth PO1 2GJ

Tel: 023 9289 9500

12 November 2018

Cllr J. Brent  
Chair  
Portsmouth Health Overview & Scrutiny Panel  
Member Services  
Civic Offices  
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 the work the Clinical Commissioning Group has been involved with over the past few months.

Our website – [www.portsmouthccg.nhs.uk](http://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 Preparing for winter**

The work we are doing collectively to prepare for winter as a health and care system (involving CCGs, all Trusts and local authorities working in the Portsmouth and south east Hampshire area) and within the city began much earlier this year than in previous years and this has enabled us to develop and agree a comprehensive plan with clear actions identified to be taken by all system partners working collaboratively.

The plan has a number of objectives which cover specific service delivery areas and include actions to address the issues that caused particular difficulty last year: capacity, discharge plans, four-hour wait performance and ambulance handover delays, as well as seeking to reduce the risks posed by flu for both our staff and our local communities.

All NHS and care organisations have a role to play in the delivery of the winter plan, which is managed directly by system leaders and the A&E delivery board.

A key aim within the plan is to reduce the capacity gap in acute hospital bed provision from its peak last year of 144 beds. The plan identifies it should be possible to release 90 beds, through improving the way complex discharges are achieved, in both the Portsmouth and Hampshire systems.

The specific Portsmouth element of this plan is required to release 23 acute beds, and reduce the number of medically fit for discharge (MFFD) patients waiting from the weekly baseline position of 49 per week, down to a target of 30 per week.

In the short term we will do this through increasing capacity in the community but with a longer term view to transform services through work to further integrate health and social care. In summary the Portsmouth plan involves:

- **Increasing domiciliary care capacity:** extend an existing, short term capacity boost for a further six months (2 locum social workers, 350 hours of additional domiciliary care); re-focusing Solent NHS Trust end of life care support services to increase productivity and extend referral pathways; and provide further additional capacity (another 600 hours of additional domiciliary care.)
- **Working with the Reablement Team and Community Units to deliver more capacity** with a greater focus on a more dynamic 'in-reach' service, where team members can actively 'pull' patients out of short-stay wards at QA Hospital and into community services without waiting for notification; and
- **Increasing capacity to enable processes around continuing health care to be completed within the community**, once optimisation of the person's re-enablement and rehabilitation has been reached in a community setting rather than in an acute hospital.

Portsmouth City Council is playing an active role in helping to develop and finalise the winter plan and the total investment to deliver the Portsmouth-specific improvements is around £1.25m, split equally between the CCG and the Council.

The Council's financial contribution comes at a time when adult social care is already overspending by £3.1m on its budget for this year, driven by a number of issues including an increase in the cost of community care packages directly related to more complex need, the flexibility required around purchasing residential placements at times of peak pressure and increasing staffing in Council residential homes in order to respond to CQC concerns. All of these contribute directly to delivering capacity in the city to both facilitate discharge from hospital and to avoid admission.

The Council is to receive around £890,000 (a share of a national total of £240m of additional, non-recurrent funding announced by the Department of Health and Social Care in October) and this funding will be directed towards offsetting the costs identified above, which is in line with the conditions for use of the funding set out by the Department.

There have already been some encouraging early signs of progress with the plan in schemes to deliver additional capacity out of hospital, in managing delays relating to patients who are medically fit for discharge, in working jointly on a range of schemes that seek to

support admissions avoidance programmes and in delivering a consistent, improved rate of performance around the four hour A&E wait target.

The challenge posed by winter remains significant for this area but organisations across the system are working together to deliver the winter plan, as well as an associated communications programme with the public, which has also been developed to support this.

## **2 Pilot ‘hub’ for supporting people with long-term conditions**

The CCG is working with city partners to prepare to pilot a long-term conditions ‘hub’ in Portsmouth in the spring of 2019.

The hub will initially involve two practices – Portsdown and East Shore – and is intended to provide support to specific, defined groups of people who are living with diabetes and respiratory illness. The location of the hub has not yet been finalised.

The key objectives of this new approach are: to combine both clinical and wellbeing support, to recognise the importance of maintaining good emotional health for those living with long term illness; to deliver greater consistency in the quality of care through standardised pathways and comprehensive care planning; to promote empowerment of patients, and proactive healthcare, and also to involve the voluntary sector in delivering holistic support.

The CCG is working with the two practices, NHS providers and other stakeholders to complete the business plan for the pilot scheme. Staff from the practices will ‘rotate’ into the hub, and be supported by specialist staff from provider Trusts.

There have been several pieces of public engagement looking at the support of people living with long-term conditions in recent years, which are informing the development of this initiative. To supplement this, an initial discussion about this project has taken place with one of the relevant Patient Participation Groups (PPGs), and more such discussions will follow.

One area to be covered will be how the CCG can work with others to assess patient experience of the trial service, alongside empirical data.

A more extensive briefing can be provided to the Panel at a later date, if desired.

## **3 Your Big Health Conversation update**

We now have the ‘topline’ analysis from Phase 2 of our Big Health Conversation engagement programme.

The Panel will recall that following Phase 1 (gathering people’s views on the changes and challenges facing the local NHS via an online survey), we wanted Phase 2 to have more of an emphasis on focus groups and discussions with a range of different patients’ groups. We were particularly keen to ask patients with first-hand experience of services their views on possible future developments around the services they used. Discussions focused on four main areas:

- Community-based mental health care
- Living with long-term illnesses
- Living with frailty
- Using same-day services

In all we heard from patients and carers from over 20 group discussions, with attendance ranging from 5/6 people to 15 upwards. These were structured conversations – setting out the issues faced today in delivering services effectively, and sketching an outline picture of how services could change in future to try to maintain the best possible outcomes for people.

We are currently developing the full report into our findings from Phase 2 but some of the recurring themes we have heard so far include:

**Mental health:** some inflexibility around the way services are delivered which could lead to people not being able to access the exact support they need; too much reliance on pills or counselling as a solution, with apparently insufficient options in between; concerns about the NHS being able to offer strong support for people in crisis or needing low-intensity talking therapy, but again, not really offering enough between those two points.

**Long term illnesses:** speaking to people living with one or (usually) several long term illnesses brought common themes to the fore that included a strong sense, still, of people feeling as if they are dealing with services which operate in ‘silos’ – having to tell their story over and over again, leading to a sense of frustration around duplication and inefficiency.

All of the things that most people might notice – hard to get through on the phone, long waiting times – also really mount up and multiply in terms of inconvenience when you have multiple health problems. There were differing views on who service users want to lead or coordinate their care between their local surgery and specialists, with specialist nurses, in particular, being very highly thought of.

**Frailty:** with frailty there was a clear sense that carers need support – and don’t always receive it currently, which, in some cases, leads to them feeling as if they are not always included or involved. Some of the other themes, not surprisingly, echoed the findings with other discussions, around the need for greater joined up working, not just responding to emergencies and the need to have enough staff in the community to provide sufficient help and support.

Interestingly, several people referred to loneliness and isolation – that being frail was more than a physical state, it was often a social state as well, and a damaging one at that. Normally people prioritise continuity of care – but for some people it is actually better if a very frail patient sees lots of different staff, because it can help to reduce loneliness.

**Same-day services:** the feedback here was slightly more diverse, possibly to be expected given the topic. Despite the changes to opening hours in recent years, there is still a perception for many that the NHS has not changed to reflect modern life. People still feel that GP surgeries and other same-day services have traditional, limited opening hours.

That said, many people are not attached to the idea that they “must” see a doctor. But the more often people need help, the more they value continuity.

When talking about any sort of ‘hub’ type arrangement for urgent care, some people quickly query the travel distance which is still a key concern for some.

There were also a number of general concerns expressed about whether the local NHS has the money or the staff it really needs to deliver plans around urgent care, however positive these plans are.

There is, and will be, much to digest from all the feedback we have received and, when it is completed, we will be making the full report publicly available and will share it with Panel members. It will also be shared with all of the groups of people who were so generous in giving up their time to talk about their experiences, and their thoughts.

The findings are also already informing work which is beginning to get underway now – including some of the developments we have included in this update, such as the long term conditions hub and mental health crisis services.

There is also likely to be a Phase 3 – taking what we have learned, and then moving into much more specific issues, looking in more detail about where services could be located, and how they could work.

#### **4 Mental health crisis services**

Portsmouth, Fareham & Gosport and South Eastern Hampshire CCGs have agreed with Southern Health NHS Foundation Trust and Solent NHS Trust a fundamental change to the way mental health crisis services will be delivered across the Portsmouth & South East Hampshire locality.

This has followed several months of careful observation around the way teams are currently working, examination of processes and records, and over 150 hours of workshops and consultation involving hundreds of patients/service users, carers and staff discussing how services should look in the future and particularly how people would access community mental health services.

The new service will combine the Southern and Solent crisis teams into a single service model that improves responsiveness and consistency for adults of all ages.

The service will be operational by summer 2019 and will deliver benefits for people living in Portsmouth such as:

- 24/7 needs led crisis service with response time standards
- Self-referral to support self-determination of crisis
- Support for carers
- Peer support to promote hope and recovery
- A supported workforce with the right skills to deliver person centred support and empower self-care

## **5      SystmOne - all Portsmouth practices now using the same IT package**

Over the summer we were able to announce that all GP surgeries in Portsmouth now use the same IT system – paving the way for patients to get more joined-up, efficient care.

All GP practices in the city are now using the SystmOne software which means they share a standard clinical system for everything from storing patient records to booking appointments.

The community and mental health teams run by Solent NHS Trust also now use that same system, and adult social care staff are expected to follow suit next year.

The IT overhaul has direct implications for the quality of care that frontline teams can give to their patients, and should also reduce the frustrations of patients who have regularly had to explain their whole medical history every time they see a new doctor or nurse.

In the past, city residents using the out-of-hours service would be seen or spoken to by a clinician who could not see their notes. Now they can immediately access the patient's full record, no matter which practice they are registered with. That means better care, and a lower chance of the patient being referred back to their own GP surgery.

GPs can now easily access records kept by other healthcare professionals, such as community nurses, to see – for example – whether their patients are waiting for test results, or have other appointments pending. In turn, community-based teams can also easily view a wider range of information about their patients. In the past, frontline staff could not easily access patient data which was held by other parts of the NHS.

Getting all of our practices onto the same patient record system is a huge step forward, and will really open the door so that we can press ahead with joining up services for patients.

Health staff will be able to make decisions about someone's care knowing that they are seeing the whole picture of that person's health, and can rely on using real-time, accurate, and comprehensive information.

## **6      Gosport War Memorial Hospital**

The panel requested an update on the response to the publication of the Gosport Independent Panel report. This update is provided on behalf of the Hampshire and Isle of Wight CCG Partnership (Fareham and Gosport CCG, South Eastern Hampshire CCG, Isle of Wight CCG, North Hampshire CCG and North East Hampshire and Farnham CCG) as Gosport War Memorial Hospital is situated in the area covered by Fareham and Gosport CCG.

For the NHS, there is both a local and a national response.

Locally, the Hampshire and Isle of Wight CCG Partnership (the 'CCG Partnership') has established its programme of work in response the Panel Report. The CCG Partnership has – following a Conflicts of Interest process – designated its Executive Director for Quality and Nursing, Emma Boswell, to take responsibility for leading this work.

A Governance Review Group has been established which has reviewed the report, and set the scope of the work programme. A Gosport Learning and Assurance Board is being established – working with local and regional NHS partners, and safeguarding boards – to oversee the agreed responses to the findings of the Independent Panel. NHS Portsmouth CCG is liaising with the CCG Partnership to ensure that all parts of the local health system are working in a co-ordinated way.

Nationally, the government response is expected soon. This response will clearly be of great significance in influencing the way in which the NHS and other public agencies learn lessons and, where appropriate, enact changes.

This publication will be carefully examined by the CCG Partnership and other NHS bodies – including NHS Portsmouth CCG - and incorporated into the programme of work relating to the events in Gosport.

## **7      Listening to our patients**

We have provided an update on the Big Health Conversation elsewhere in this letter but there are many other ways in which the CCG, and the local NHS, interacts with local patients and partners.

Our 'Listening to Our Patients' document supplements our annual report and is published to outline how the CCG engages with its local community and how it acts on the feedback it receives. The document is available [here](#) and covers the period April 2017 – March 2018.

Yours sincerely



**Dr Linda Collie**

Clinical Leader and Chief Clinical Officer  
NHS Portsmouth Clinical Commissioning Group

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**Hampshire and Isle of Wight**  
Sustainability and Transformation Partnership

## **Hampshire and Isle of Wight System reform proposal**

Statutory body pack

**August 2018**

MOVING FORWARD TOGETHER



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MOVING FORWARD TOGETHER

# Introduction and context

## Purpose of this document

This document summarises the system reform proposal as developed to date through the work of the Hampshire and Isle of Wight Sustainability and Transformation Partnership's (STP) Executive Delivery Group (EDG) and informed by the broader health and care system leadership.

It forms the basis for NHS provider board, CCG governing body and local government cabinet consideration at their respective meetings in autumn 2018.

## Context

The health and care system across Hampshire and the Isle of Wight has been working together to develop a response to the national ambition to improve the integration of health and care for the benefit of local people.

As the Care Quality Commission put it in its 2016/17 State of Care report:

*"People should be able to expect good, safe care when they need it, regardless of how this care is delivered... It's clear that where care providers, professionals and local stakeholders have been able to do this – where they have stopped thinking in terms of 'health care' and 'social care' (or specialties within these) and instead focused their combined efforts around the needs of people – there is improvement in the quality of care that people receive. To deliver good, safe care that is sustainable into the future, providers will have to think beyond their traditional boundaries to reflect the experience of the people they support."*

## National context

The most recent mandate given by the Government to NHS England includes increasing integration with social care so that care is more joined up to meet physical health, mental health and social care needs. More recently, the House of Commons Health and Social Care Committee has expressed its support for improving integration of care, highlighting its potential to improve patient experience.

NHS England's policy goals in relation to this area have been clear for some time. NHS England's ambition to transform the delivery of care in this spirit was first described in 2014's Five Year Forward View (FYFV):

*"The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three"*



## Case for change

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# What do our citizens and our staff tell us?

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## Our citizens have been consistent in telling us that...

- they want **better and more convenient access** to support to help them to live well for longer. We have diverse communities across Hampshire and the Isle of Wight and people want support better suited to their needs;
- **they value and have confidence in General Practice and the wider primary and community team**, but there is a bewildering array of teams who do not appear to communicate with each other. **People often have to repeat their story** multiple times, making accessing care a frustrating experience. So they want all of the clinicians and care workers involved in their care to know their care plan, to work together and to communicate with one another. Many people also want greater control of their care, from better access to their records through to personalised budgets;
- when they have an urgent care need, **rapid access to the right clinical advice and support** is the most important factor to them. They want the health and care system to make sure they know how to rapidly access a complicated and sometimes confusing system;
- when they are managing a long term physical and/or mental health condition they typically want continuity of relationship with a trusted clinician to support them; they want better support to understand and manage their condition; and they want to ensure that when they travel for specialist advice and support, then the journey is worthwhile. Currently **40% of people** whom have a long term condition tell us they **don't feel supported** to manage their condition.
- they are more **willing to travel a little further for specialist care** if the services they access will give them better outcomes. People also add however, that there is nowhere like home and that they would rather be there, than a hospital bed. Unfortunately a quarter of people in hospital still do not feel involved in decisions about getting them home.

## Our workforce are telling us that:

- they are **under more pressure than ever** before. They often feel that there is not enough time in the day, with too many targets to reach and administrative tasks to perform, both of which take time away from patients;
- services are running on such **low staff numbers** that any unplanned sick leave or annual leave has a significant effect. Despite significant efforts of some providers, we continue to exceed our planned expenditure on agency and locum spend;
- care professionals want a means by which to **share information** with other professionals within the system. There is often a poor interface between primary, secondary and community care with time wasted trying to contact other care services;
- whilst it doesn't feel this way in general practice, and in the community and hospital services, our workforce has actually increased over the last few years. However so too has the number of people leaving within two years;
- many frontline staff have spent large parts of their professional careers **trying to integrate care for patients**, often working around policies that construct rather than remove barriers to integrated care at local level;
- they want **better career options** along with opportunities to improve their skills and expertise.

MOVING FORWARD TOGETHER

# What does the data tell us?

**We need to strengthen our approach to prevention, early intervention and supported self-management...**

- We have a national reputation for developing innovative models of prevention, case finding and early intervention and supported self-management. However, we have not systematically implemented these innovative models. For example, within three years, 330 heart attacks and 490 strokes could be averted with improved detection and treatment of hypertension and atrial fibrillation. This represents a cost saving of up to £2.5m for heart attacks and £6.7m for strokes through optimal anti-hypertensive treatment of diagnosed hypertensives.
- For cancer services, for example, we have made real progress in improving the early diagnosis of cancers over the past 4 years, and are now one of the best performing systems in the country. But we still only **diagnose just over half of cancers at stage 1 and 2**.
- The **life expectancy of people with serious mental illness is 15-20 years less** than the average life expectancy in Hampshire and the Isle of Wight, with two thirds of these deaths due to avoidable causes. And yet the number of health checks for people with severe mental illness in HIOW is below the national average.
- We are making improvements, but we are **not yet closing the inequalities gap** - the life expectancy gap (and disability-free years gap) across HIOW is not closing.

**The complexity and fragmentation of our current system (including siloed budgets and payment systems) is currently holding back a system focus on this agenda.**

**We have a significant opportunity to improve discharge and flow across Hampshire and the Isle of Wight...**

- Our citizens continue to **stay in hospital for a long time** even though many are medically fit to leave. As we know the longer people stay in hospital, the more likely they are to develop complications and reduced independence; and it is also expensive to keep someone in hospital unnecessarily.
- Our flow and discharge is noted as being in the **lowest performance quartile in the country**
- We continue to be the **second poorest performing system in the country** with regards to **delayed transfers of care**.
- **We are the second poorest performer** nationally with regards to **CHC assessments in the community**.
- Recent data positions us as having one of the greatest opportunities nationally to reduce **excess bed days** and super-stranded patients.
- There has been a relentless focus on improving discharge and flow across all of our systems and yet despite this the number of delayed transfers of care per 100,000 population remains at the same rate it did two years ago\*

**This data would indicate that continuing to operate as we have done in the past will not yield a different outcome. We need to reform the system in a way that best allows us to tackle the challenges we face.**



## What do we know about new models of care?

The past four years have seen significant progress in developing 'new care models' which are founded on integration between partners and a systematic focus on the whole population's needs. Nationally we have seen both Multispecialty Community Provider and the Integrated Primary and Acute Care Systems develop. More recently the Next Steps on the Five Year Forward View further articulated the ambition '**to make the biggest national move to integrated care of any major western country**'.

Within our patch we are reporting very tangible benefits for our citizens as a result of health and care partners working together / integrating more effectively than we have seen before. In the most developed systems we are seeing:

- **1% reduced emergency admissions** compared to an average of 3.5% growth nationally;
- New models of care are successfully managing and treating people more effectively in the community **reducing potentially "avoidable" emergency admissions by 10%** on last year;
- **4% reduction in GP referrals** on last year;
- **Reduction in the number of people experiencing mental health crisis** / emergency admission to acute mental health beds as a result of enhanced support in the community
- **A&E attendances are holding at the same level** as last year compared to demographically similar systems which have increased activity on last year;
- Citizens engaging with integrated care teams are reporting **significant improvements in health status, personal wellbeing, experience and health confidence**;
- **Staff satisfaction rates significantly improving** where they are operating in integrated care teams.

These achievements are both important for citizens, staff and for the financial health of the system. We know that new models of care work, however, our integrated primary and community teams are at different stages of development and so too are their interfaces with local health and wellbeing footprints and the acute physical and mental health system.



MOVING FORWARD TOGETHER

# Finance and efficiency

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## Increasing value for money

The current funding and budget systems make it hard to reallocate resources to where they are needed most. This can also be prohibitive to collaborative working between partner organisations. Frustratingly for all, the current payment systems can be unhelpful – rewarding activity rather than outcomes.

**Our financial position is unsustainable.** Hampshire and Isle of Wight NHS has forecast a 'do nothing' gap of £577million gap by 2020/21 (23% of our £2.5bn allocation) and in addition to this, the pressures in social care and local government more broadly are unprecedented. Whilst the required level of efficiency has been delivered to date we require a step change in productivity and cost reduction to ensure we meet our financial targets.

In many organisations too much resource and energy is focused on seeking to suppress expenditure in providers or generate additional income from commissioners, rather than work in partnership to focus on cost reduction, quality improvement and living within the system's finite resources. **We will require different approaches**, including **collaboration**, e.g. pathology, pharmacy distribution centres; **scale**, eg: collective procurement; **back-office optimisation**, eg: HR, finance; **greater partnerships**, eg: increasing retention of our workforce, reducing bank and agency costs; and **reduced unwarranted variation** in practice.

If we are to make the transformational changes required to improve outcomes, experience, satisfaction, quality, performance, financial sustainability and address our workforce challenges **we must radically enhance our functionality, removing obstacles to enable far greater collaboration and integration**. These radical changes will become a reality only if there is a collective commitment from all partners to transform and implement a new way of working.

## Reducing complexity

- We have **21 NHS and local authority statutory partners** as signatories to our transformation partnership **and three non-statutory partners** (with leadership responsibilities around workforce, innovation and research).
- We have **grown our workforce by 4.5%** over the past three years. Too much of this growth has, however, been in non-clinical roles. One of the key drivers for this is the continuing burden of reporting, assurance and inter-organisational contract management.
- **We are a complex system.** Whilst there has been collaboration between provider, commissioner and regulatory partners, our system reform work over the past six months has demonstrated significantly greater opportunity to reduce system complexity; reduce the burden of assurance and reporting and ensure all partners collaborate towards clearer strategic goals;
- NHS England and NHS Improvement are currently undergoing a national and regional integration programme. The expectation is that locally the Hampshire and Isle of Wight system will develop **simpler but more effective self-regulation and assurance models** that will allow NHSE/I to work more strategically with the system.

The system reform programme is a means by which we can reduce this complexity and develop strong self-regulation and assurance models.



MOVING FORWARD TOGETHER



## The proposed system

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“Our vision is to support citizens to lead healthier lives, by promoting wellbeing in addition to treating illness, and supporting people to take responsibility for their own health and care. We will ensure that our citizens have access to high quality consistent care 24/7, as close to home as possible.



# Our vision – tomorrow's system

11

Supporting  
people to  
stay well

## We are taking action to prevent ill-health and promote self care...

- Empowering citizens, patients, service users and communities
- Harnessing technology more effectively to support wellbeing

Joining up  
care locally

## We are strengthening local primary and community care...

- Developing integrated health and social care teams designed to support the needs of the local communities they serve
- Providing care in the right place at the right time by reducing over-reliance on hospitals and care homes
- Ensuring a strong and appropriately resourced primary care workforce
- Using technology to revolutionise people's experiences and outcomes;

Specialised  
care when  
needed

## We are improving services for people who need specialist care...

- Identifying, understanding and reducing unwarranted variation in outcomes, clinical quality, efficiency;
- Through consolidating more specialised care on fewer sites;

**We will make intelligent use of data and information to empower citizens, patients, service users and support our workforce to be more efficient and effective in delivering high-quality care**

# Integrated care systems

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The HIOW Executive Delivery Group (EDG) – representing the HIOW health and care system – recommend that to deliver our vision for health and care, we need to reform our system to ensure ‘form follows function’, signalling a shift from the separation of provision and commissioning to integrated planning and delivery. Nationally there is a similar realisation, which has led to the national guidance on Integrated Care Systems.

## What is an integrated care system (ICS)?

NHS England defines ICS as those systems in which:

“Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations”.

## What will an integrated care system do?

National guidance sets a number of expectations for ICS:

- ICS are expected to produce together a credible plan that delivers a single system control total, resolving any disputes themselves.
- ICS will assure and track progress against organisation-level plans within their system, ensuring that they underpin delivery of agreed system objectives.
- [ICS] will be given the flexibility, on a net neutral basis, and in agreement with NHS regulators, to vary individual control totals during the planning process and agree in-year offsets in one organisation against financial under-performance in another.

- NHS England (NHSE) and NHS Improvement (NHSI) will focus on the assurance of system plans for ICS rather than organisation-level plans.

There is an expectation that, over time, ICSs will replace STPs.

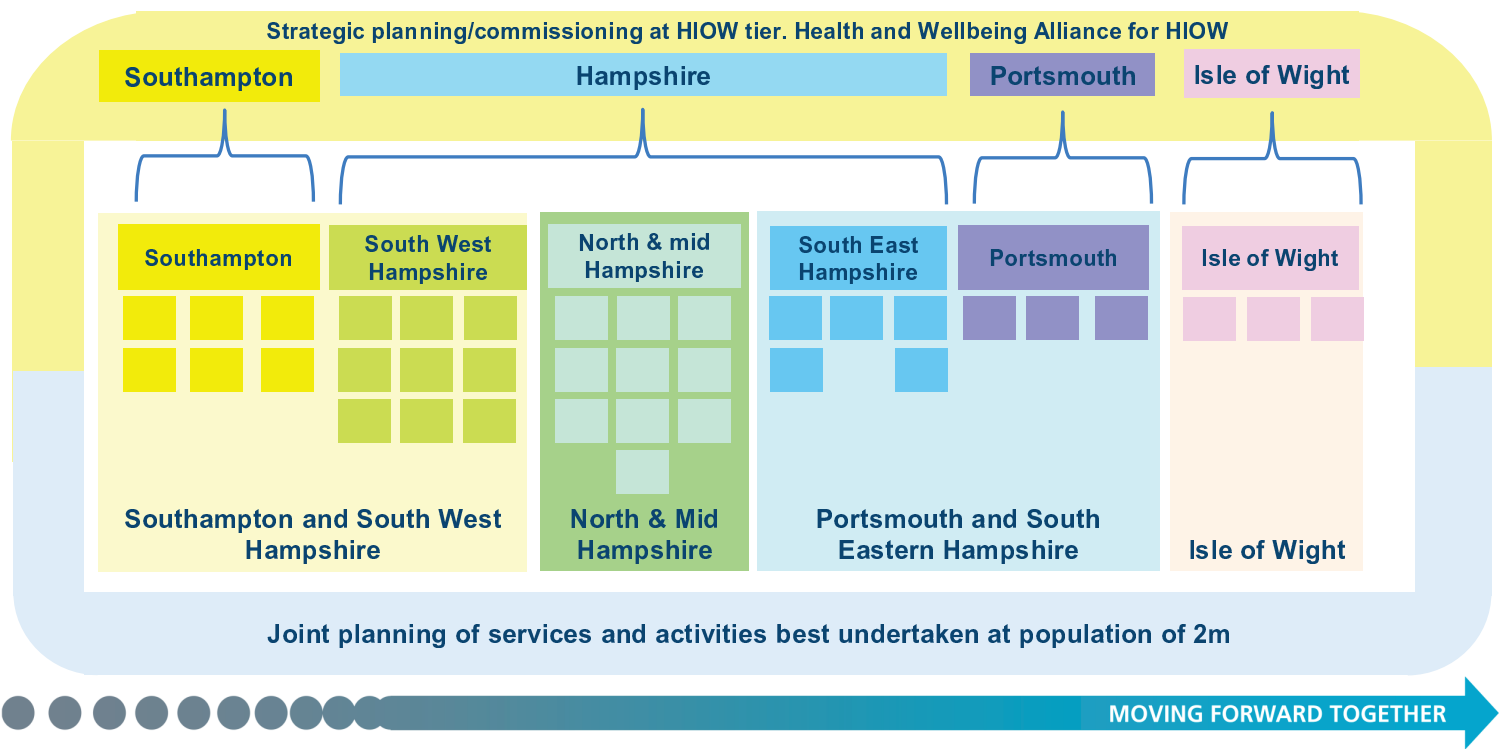
## Benefits of ICS – the national view

- Creating more robust cross-organisational arrangements to tackle the systemic challenges facing the health and care;
- Supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- Delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- Allowing systems to take collective responsibility for financial and operational performance and health outcomes.

## Local alignment

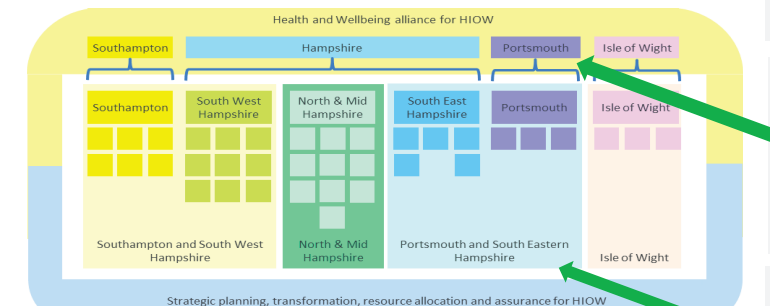
The EDG tasked a sub-set of its members, supported by others, to form a series of task and finish groups to develop the key elements of a proposal for moving the HIOW system towards ICS (“the system reform programme”).

# How could HIOW look in the future?



# The proposed HIOW integrated care system: A whole system planning, delivering and transforming in collaboration

The proposed reformed system envisages providers, commissioners and local authorities working in ever closer collaboration with each other and with citizens and voluntary sector organisations to address the case for change, empowering and supporting citizens to best manage their own health and wellbeing and frontline teams to provide and sustain the best possible services and care.



Notes:

1. The term 'cluster' is used for consistency to describe the foundation of the system where general practices with statutory and voluntary community health and care services work together in 20-100k populations to meet the needs of local residents. A variety of terms are currently used to describe this including localities, extended primary care teams, natural communities of care, neighbourhood teams.
2. Where HWB and integrated care partnerships are coterminous, activities are undertaken together. In areas where integrated care partnerships span more than one HWB footprint, the partners will work together to determine the most appropriate allocation of responsibilities between HWB area and the integrated care partnership to achieve the shared objectives.
3. The Hampshire HWB area also includes North East Hampshire, which is also part of the Frimley Integrated Care System and therefore omitted from the figure above

Component	Purpose and description
<b>Accelerated implementation of 36 clusters</b> Natural communities of 20-100,000 people	<ul style="list-style-type: none"> <li>• The foundations of the reformed system</li> <li>• Strengthening primary care</li> <li>• Delivering integrated mental and physical health, care and wider services to cluster population</li> <li>• 36 clusters, aligned to 'natural communities'.</li> <li>• Proactively managing the population health needs</li> </ul>
<b>Ongoing development of place based planning</b> Existing Health & Wellbeing Board footprints	<ul style="list-style-type: none"> <li>• Integrated local authority &amp; NHS planning</li> <li>• Aligned to HWB (local authority) footprints</li> <li>• Health &amp; LA aligned commissioning resource &amp; agreed leadership/management models</li> <li>• Basis of the JSNA, means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health</li> </ul>
<b>Simplified structure of 4 integrated care partnerships</b> populations of c600k served by acute partners	<ul style="list-style-type: none"> <li>• Support the vertical alignment of care enabling the optimisation of acute physical &amp; mental health services</li> <li>• Design and implement optimal care pathways</li> <li>• Support improved operational, quality and financial delivery</li> </ul>
<b>HIOW integrated care system</b> Drawing together the above component parts, delivering some functions at a scale of 2 million population	<ul style="list-style-type: none"> <li>• System strategy and planning</li> <li>• Implementing strategic change across multiple integrated care partnership footprints/places</li> <li>• Alignment of strategic health and LA commissioning</li> <li>• Provider alliances (acute physical &amp; mental health)</li> <li>• Oversight of performance and single system interface with regulators</li> </ul>

# Conditions for integration

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The development of an ICS for Hampshire and Isle of Wight has been based upon a variety of national guidance and evidence from around the country about best practice approaches. We have studied the work ongoing in Surrey Heartlands Dorset, Manchester and South Yorkshire and Bassetlaw and learnt from their experiences.

The work of the Kings Fund on integration is also helpful in setting out conditions which support greater integration. Their assessment is that current and future ICS must address the following development needs if they are to succeed in transforming health and care, building on new care models and related initiatives:

- Developing trust and relationships among and between leadership teams
- Establishing governance arrangement to support system working
- Committing to a shared vision and plans for implementing the vision
- Identifying people with the right skills and experience to do the work
- Communicating and engaging with partner organisations, staff and the public
- Aligning commissioning behind the plans of the system
- Working towards single regulatory oversight
- Planning for a system control total and financial risk sharing.

The work involved in addressing these needs is time consuming and cannot be rushed: 'progress occurs at the speed of trust', **collaborative rather than heroic leadership holds the key to progress.**



MOVING FORWARD TOGETHER

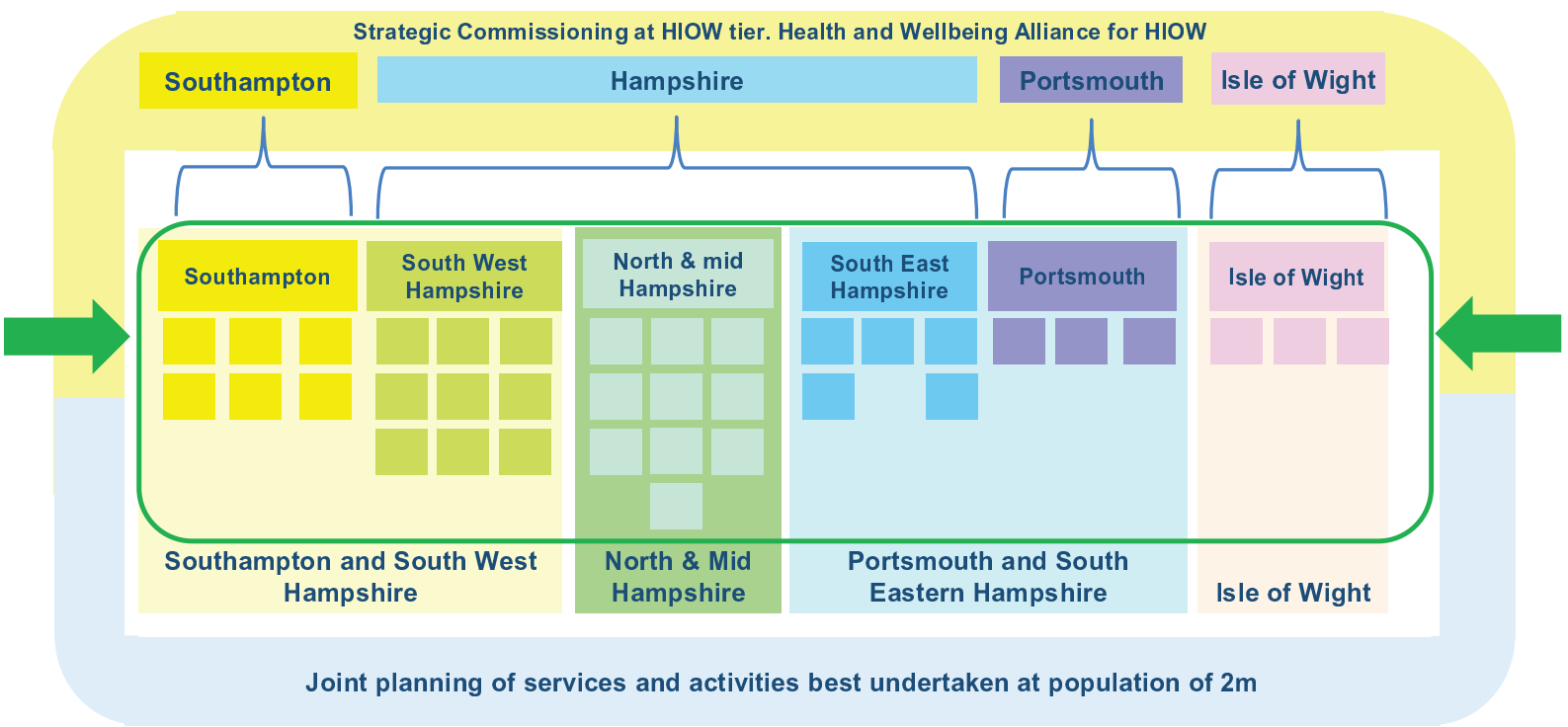
## Components of the system

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Clusters - integrated primary and community care teams

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# Clusters - integrated primary and community care teams 18

Clusters will be the bedrock of the reformed delivery system. The key purpose of our wider system reform arrangements is to support empowered clusters.

## Role and benefits of clusters:

- Clusters will see health and care professionals, GPs, the voluntary sector and the community working as one team to support the health and care needs of their local community. They will focus on helping people to manage long term conditions and improve access to information about healthier lifestyles and improving/maintaining wellbeing.
- Evidence shows that the most successful work of this type will reduce the overall number of people who need to be cared for in hospital and improve the health and wellbeing of communities. Clusters will shift the pattern of care and services to be more preventative, proactive and local for people of all ages

### Impact of clusters for people

- ✓ People are supported to stay well and take greater responsibility for their own health and wellbeing
- ✓ People can easily access support and advice that is timely, delivered close to home and with the right professional to meet their needs
- ✓ People with chronic or complex illness receive care that is consistent, joined up and centred around their needs and wishes, with fewer hand-offs and reduced duplication
- ✓ People are only in hospital for the acute phase of their illness and injury and are supported to regain/retain independence in their usual place of residence
- ✓ People have greater choice and control over decisions that affect their own health and wellbeing

### Impact of clusters for HIOW system

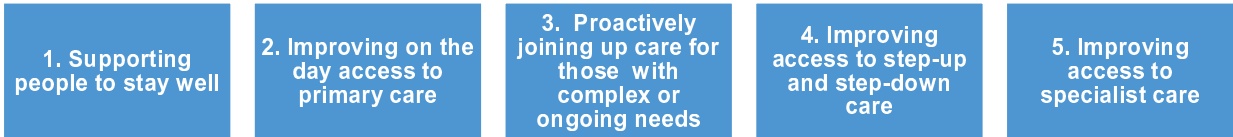
- ✓ Increased capacity in primary and community care to manage local health and care needs
- ✓ Reduction in rate of acute mental and physical acute non-elective activity growth and demand for urgent care services
- ✓ Optimised resource utilisation as a result of better managed chronic conditions and reduction in preventable conditions
- ✓ Reduction in variation in access and outcomes
- ✓ Fewer permanent admissions to residential and nursing care
- ✓ Primary care is sustainable and supported leading to improving GP recruitment and retention rates
- ✓ Attract and retain right workforce in all sectors with particular emphasis on those sectors in greater need such as mental health
- ✓ More efficient bed use and fewer delayed transfers of care

# Characteristics of clusters

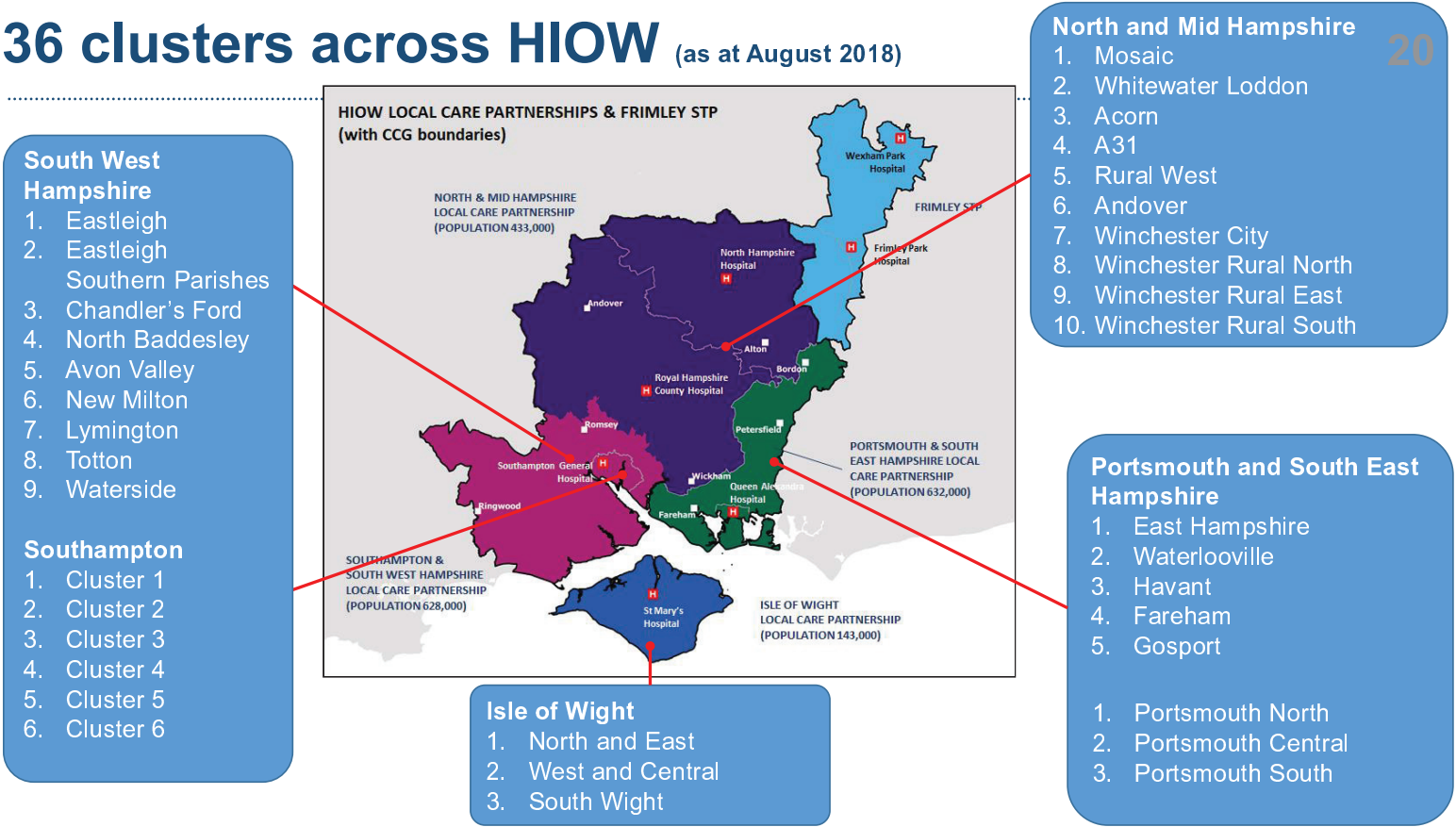
Clusters will vary based on the needs of the communities they serve, but will be built on a common foundation and share common characteristics:

- Clusters will be empowered to innovate in order to best serve their populations. In order to facilitate this, they will work to a specification which is outcome-based, but which is common across HIOW. Developing this specification will be an early priority.
- Cluster footprints align to 'natural communities of care.' Areas must be meaningful to those they serve, as they provide the basis for community-focussed services. Clusters' population range provides flexibility in cluster boundaries to ensure they align with both natural communities and GP registered lists.
- Clusters will include a range of mental and physical health, care and wider services in one place. Multi-professional working will be supported by multi-agency information sharing and, wherever possible, physical co-location.
- Co-ordinate services and teams from across organisations through alignment arrangements (MOU, alliance contract or joint venture) – allowing professionals to maintain their current employment status.
- Multi-professional (including clinical) leadership. Each cluster will have a named lead, and will be supported by a professional managerial team, who will be responsible and accountable for the performance of cluster services and the management of an indicative cluster budget. Clusters will manage their performance based on agreed datasets.
- GP federations will be vital in facilitating clinical leadership in clusters, as well as in leading the transformation of primary care, which will be vital to clusters' capability.
- Clusters will identify, understand and reduce unwarranted variation between their practices. Colleagues and systems across the footprint of HWB and integrated care partnerships will support clusters in this, as well as identifying unwarranted variation between clusters (see below).
- Clusters and acute physical and mental health providers will work together in integrated care partnerships, to ensure alignment of pathways and integrate services to optimise the health and care support they provide, responsive to the populations they serve.

## The 5 core functions of a cluster:



# 36 clusters across HIOW (as at August 2018)



# Balancing autonomy and standardisation in clusters

**A key test of this proposal overall is that cluster governance must accelerate and facilitate, rather than impede, local change and improvement.** Therefore clusters will be encouraged to innovate and improve services for their citizens.

This innovation will be facilitated by both their contract /incentive structure and support from HWB and integrated care partnerships (see next slides).

HWB and partnerships will support clusters in identifying and reducing unwarranted variation, including striking the right balance between standardisation / consistency and local flexibility (ie. standardising only where this adds value).

Standardisation may apply across a HWB or partnership footprint, or more widely, as appropriate. We would expect some pathways, services, systems and processes to be standardised across HWB or partnership footprints, some to be standardised across the whole of HIOW. Elements not standardised will allow each cluster to take the approach which works best for them, but with encouragement and support to consider what other clusters are doing and the potential to spread best practice where it adds value (or reduces duplication of effort) to do so.

As part of this freedom to innovate, we recognise that clusters will continue to evolve. The current structure of clusters across HIOW (see next slide) may therefore change as clusters become established and take on an increasing role in service delivery.

**Operationalising clusters is a key priority. This will include developing an outcomes-based cluster specification and providing management and development resources to clusters from CCGs**



- The 36 cluster teams across HIOW are at variable stages of development and maturity.
- The most established teams, formed under Better Care and Vanguard programmes, offer a wealth of evidence and learning about what works; however we are yet to effectively capitalise on this across HIOW.
- There are currently different names for cluster teams in each care system, reflective of evolutionary local plans.
- However, there are high levels of congruence in the overall description of the function and form of these teams across the system.

- Accelerate and embed the infrastructure for all 36 cluster teams by March 2019
- Evidence impact on patient outcomes, primary care capacity, hospital admissions and system flow

Current thinking about the development of the clusters by March 2019 and March 2020 is described on the following page.

# The developing role of clusters

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	October 2018 – March 2019	By April 2020
<b>Strategy and Planning</b>	<ul style="list-style-type: none"> <li>Cluster priorities identified and delivery plan in place</li> <li>Cluster level population data available and used to support priority setting and planning</li> </ul>	<ul style="list-style-type: none"> <li>Longer-term cluster objectives being shaped, informed by data</li> <li>Mechanism in place for co-production of plans and services with local people</li> </ul>
<b>Care Redesign</b>	<ul style="list-style-type: none"> <li>Practices working together to improve access and resilience</li> <li>Core cluster team membership defined</li> <li>Integrated primary and community care teams in place with joint assessment and planning processes</li> <li>Prototypes in place for highest risk groups</li> <li>Gap analysis undertaken, end state defined for key functions</li> </ul>	<ul style="list-style-type: none"> <li>Components of delivery model in place for each of key functions (minimum 50% completion)</li> <li>Active signposting to community assets in place</li> <li>Shift of specialist resources into cluster teams</li> <li>Integrated teams fully functioning and include social care</li> </ul>
<b>Workforce development</b>	<ul style="list-style-type: none"> <li>Cluster workforce plan defined with targeted action to support recruitment/retention of key roles</li> <li>Cluster level OD/team development plan in place</li> </ul>	<ul style="list-style-type: none"> <li>Development of new/extended roles in cluster teams to meet local need</li> <li>Beginning to share workforce and skills within clusters</li> </ul>
<b>Accountability &amp; performance management</b>	<ul style="list-style-type: none"> <li>Information sharing agreements in place between all partners</li> <li>Plan for shared care record confirmed</li> <li>Cluster responsibilities documented via MOU/alliance agreement</li> </ul>	<ul style="list-style-type: none"> <li>Data used to drive improvement and reduction in variation within and between clusters</li> <li>Shared care record (health) in place</li> <li>Cluster monitoring impact on key outcomes</li> </ul>
<b>Managing collective resources</b>	<ul style="list-style-type: none"> <li>Cluster assets mapped to inform future planning (estate, back office, people, funding)</li> <li>Resources identified to enable/support cluster plan delivery (eg change management)</li> <li>Cluster level dashboard including outcomes in place</li> </ul>	<ul style="list-style-type: none"> <li>Shift of specialist resources into cluster teams</li> <li>Clusters have sight of resource use and can pilot new incentive schemes</li> <li>Cluster level plan to optimise use of assets and early components in place</li> </ul>
<b>Leadership &amp; governance</b>	<ul style="list-style-type: none"> <li>Dedicated professional and operational leadership in place in each cluster</li> <li>Governance arrangements in place in each cluster, eg cluster board</li> <li>Cluster partners identified and engaged in the development and delivery of the cluster plan</li> <li>Cluster engaged in integrated care partnership decision making</li> </ul>	<ul style="list-style-type: none"> <li>Cluster leadership embedded with defined responsibilities for co-ordination of cluster responsibilities</li> <li>Mechanism in place to share learning between clusters</li> <li>Practices have defined how they wish to work together going forward</li> <li>Cluster is full decision making member of integrated care partnership</li> </ul>

## Statutory bodies are asked to:

### Endorse:

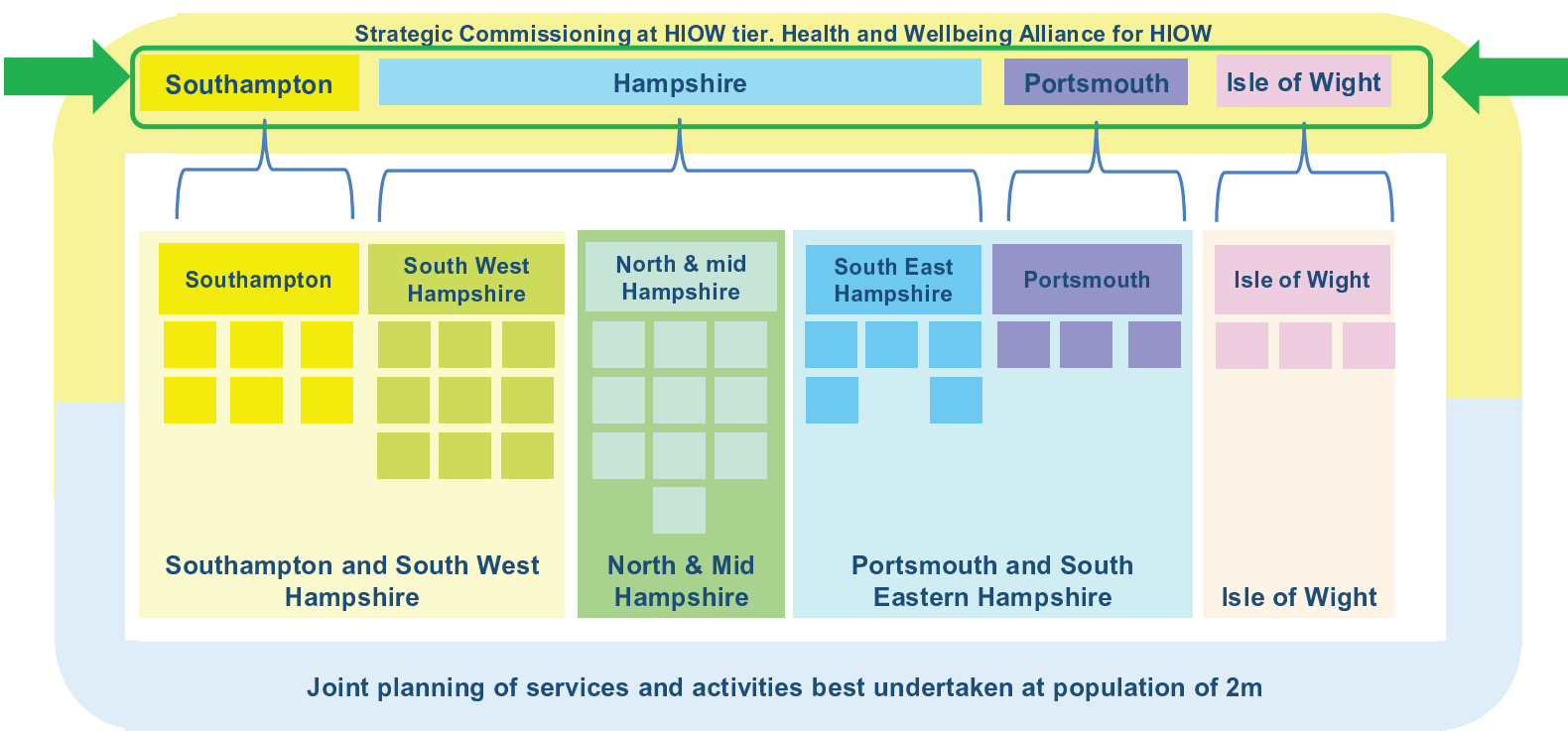
1. The developing role of clusters as outlined on the previous slide
2. The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development
3. the proposed next steps for the cluster task and finish group which are summarised as follows:
  - a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW
  - b. Describe the support requirements and responsibilities to accelerate full cluster implementation
  - c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures
  - d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)




MOVING FORWARD TOGETHER



Integrated planning for a place: Health and Wellbeing Board footprints 25



## Restating the function of Health and Wellbeing Board footprints within an integrated care system

Local government partners have convened to start work on restating the critical function of integrated health and care planning and delivery on a Health & Wellbeing Board (HWB) footprint.

An early draft definition of the function is summarised below:

HWB footprints will continue to be **the focus for place-based planning** (undertaking population needs assessment) and for aligning health, care and other sector resources to focus on delivering the improved outcomes for local people, building on the long-established integrated working arrangements, e.g. Better Care Fund, Section 75 arrangements, etc. Working in collaboration, partners will maximise the potential to further improve wellbeing, independence and social connectivity through the wider determinants of health including public health, housing, employment, leisure and environment.

The statutory role of the HWB with their political and clinical leadership, means that they should be central to the governance of health and care planning for a 'place'. The sustainability of the health and care system depends on public and political acceptability and support – as well as the right systems of design and delivery. So the active and effective democratic engagement at all levels (cluster through to whole HIOW) is vital. Strong and equitable relationships between NHS and local government will provide the necessary collective energy and focus required for system change. Furthermore, cross sectoral partnerships of public, private and voluntary and community organisations have important roles in all components of the system.

Much of our prevention and health improvement activities will continue to be designed and delivered in HWB footprints. We will use our ability to align / pool monies between NHS and local government partners to ensure that a clear focus for each HWB footprint is the resourcing of our 36 clusters (integrated primary and community care teams).

Our HWBs are based on local authority footprints. We will continue to integrate our CCG and LA teams focused on place-based health and care planning on these HWB footprints, reducing complexity and duplication. We will also be deploying some of our health (CCG) and care staff directly to support the operationalisation of our 36 clusters.

All four LAs have committed to meet with health provider and commissioner colleagues during August/September as a task and finish group to further develop the above definition and proposed next steps (see more detailed recommendation on the next page).



MOVING FORWARD TOGETHER

## Statutory bodies are asked to:

Endorse the following recommendations from the EDG, informed by the task and finish group work to date:

1. The emerging 'restatement' of the function of partnership working on a HWB footprint as described on the previous slide
2. The proposed next steps for a task and finish group by the end of September, which are to:
  - a. define the common functions of the role of HWB footprints in an integrated care system
  - b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system
  - c. set out a mechanism for achieving 'active and effective democratic engagement at all levels' across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

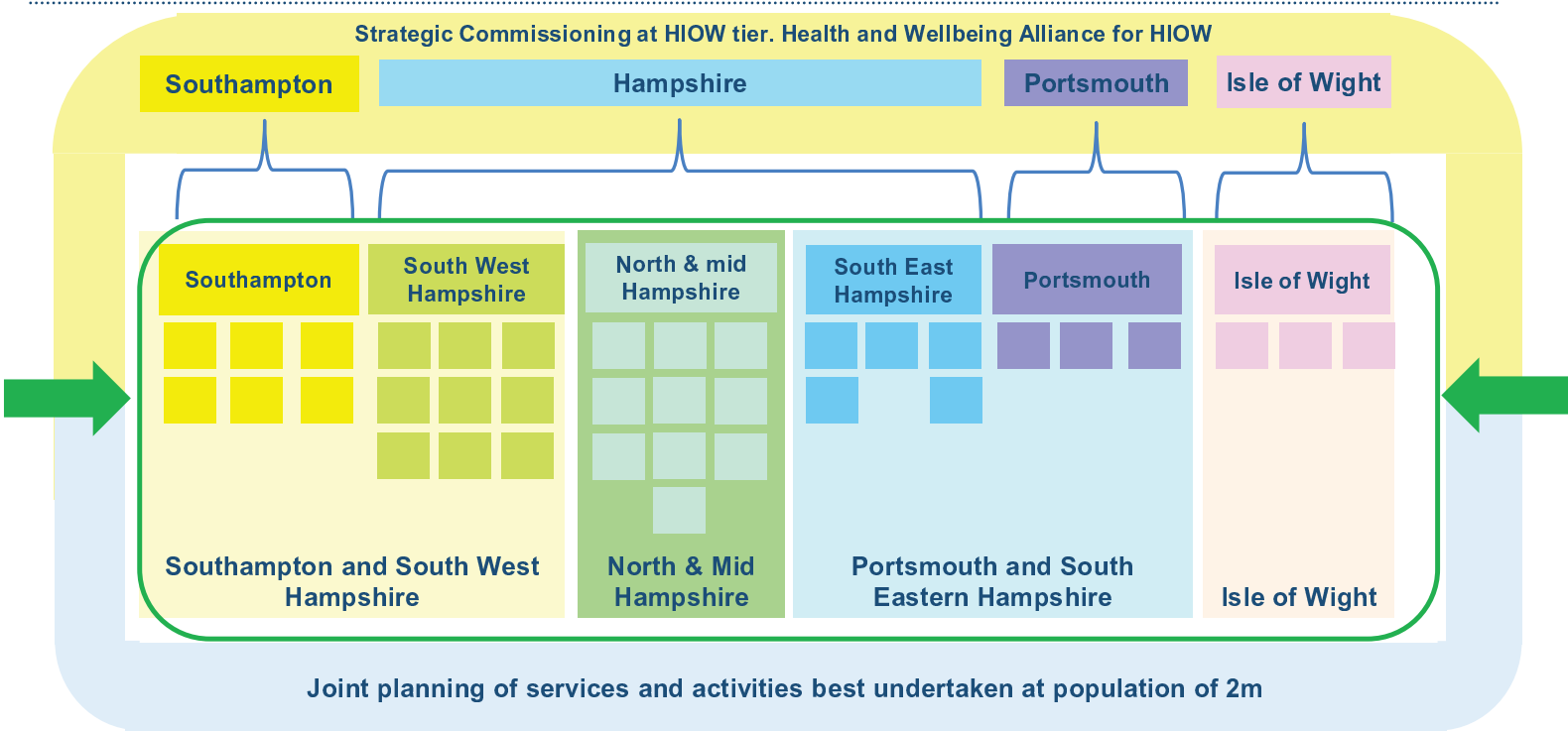
**Leads from the other Hampshire and Isle of Wight task and finish groups on integrated care partnerships, strategic commissioning and clusters will be involved in developing this thinking.**



MOVING FORWARD TOGETHER



# Integrated care partnerships



# Integrated care partnerships

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**Integrated care partnerships are where we align the work of the local clusters, community services, acute and specialised physical and mental health services, for the benefit of the local population.**

Providers of mental and physical health and care services including general practice, NHS commissioners, local authorities and voluntary sector organisations come together in geographies based on the local catchments of acute hospitals to benefit their local population.

The term 'integrated care partnership' [ICP] is being used to describe the collaboration of partners on these geographies.

The ICPs across HIOW will reflect local needs and will differ in the extent of their focus and work programme. For some, the focus may be predominately on improving operational ED performance. In others there is already an intent to work together on a more comprehensive basis with established governance structures to deliver agreed improvement programmes.

**The balance and focus of the planning and delivery that takes place in HWB footprints and integrated care partnerships will vary in each part of HIOW.**



# What could integrated care partnerships look like? 30

The nature of Integrated Care Partnerships [ICPs] will vary according to local circumstances, challenges and opportunities. For some the arrangements will mirror current state. For others their development is such that by **April 2020, integrated care partnerships could be working together to:**

- implement a integrated care partnership delivery plan which sets out the collective priorities of the integrated care partnership, over the medium term (3-5 years) and in the short term (1-2 years) [noting that as previously alluded to, the balance and focus of planning and delivery that takes place in integrated care partnerships is likely to vary in each part of H1OW]
- design and implement optimal care pathways, and to identify, understand and reduce unwarranted clinical, operational and service variation
- make the best use of the collective resources of the integrated care partnership, including workforce, financial resources and estate, maximising system wide efficiencies and encouraging resources to flow to address the key risks facing the partnership
- support the ongoing development of the integrated care partnership:
  - progressively building the capabilities to manage the health of the population, to keep people well and to reduce avoidable demand
  - supporting the ongoing development of clusters, as the bedrock of the local health and care system
  - in some areas, potentially managing the transition to evolved organisational form arrangements that enable members of the integrated care partnership to sustainably meet the population needs

An integrated care partnership board could lead the partnership, providing strong system leadership, actively breaking down barriers that hinder progress in the delivery of integrated care, building trust and acting together to deliver improvements for citizens, for the system as a whole and through which partners hold each other to account for delivery of the shared priorities.

In integrated care partnerships, NHS providers including primary care, commissioners and local authorities work to overcome the barriers to collaboration associated with the separation of provision and commissioning. Whilst recognising the important individual statutory responsibilities of each partner, it is envisaged that:

- CCGs will deploy their people and resources to work collaboratively with other CCGs in the integrated care partnership, focussed on implementation of the integrated care partnership delivery plan – improving services, improving operational performance and delivering cost reduction.
- NHS providers will work together to make strategic and operational decisions that are in the best interest of the integrated care partnership.
- Where possible, in order to reduce duplication and bureaucracy, CCGs, NHS providers and if relevant local authorities, will seek opportunities to optimise corporate support services and infrastructure such as finance, quality, communications and governance teams.

Current thinking about the development of integrated care partnerships by March 2019 and March 2020 is described on a subsequent slide.



## ICPs: an example of a different approach

### We anticipate seeing:

- CCGs deploying their people and resources to work collaboratively with other CCGs in the local care system and with providers
- Providers making decisions and delivering care together – provider alliances
- CCGs, NHS providers and potentially local authorities sharing corporate support services and infrastructure?
- Over the next 18 months, working through together the impact on financial flows, contractual models and organisational forms (drawing national models such as the ICP contract consultation)

### Enabling us to have:

- Better grip on improving the money, performance and quality
- Integrated care partnerships supporting clusters to develop and thrive
- Whole system implementation of improved care pathways, and reduction in unwarranted clinical, operational and service variation
- Collective support for all services in the integrated care partnership to meet operational performance and quality standards
- Reduced transaction costs

The ICP Task and Finish Group has been developing a vision of how the future might look. Each ICP will develop proposals that reflect their local context, challenges and opportunities



# A potential timeline for the development of ICPs

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	October 2018 – March 2019	By April 2020
<b>Strategy and Planning</b>	<ul style="list-style-type: none"> <li>Develop and agree plan to make optimal use of acute and specialised physical and mental health services</li> <li>Aligning the work of clusters at HWB footprint with community and acute physical and mental health services</li> </ul>	<ul style="list-style-type: none"> <li>Agreed single strategy and operational plan for the integrated care partnership describing collective priorities and how those priorities will be delivered</li> <li>Planning undertaken jointly by CCGs, providers and LAs</li> </ul>
<b>Care Redesign</b>	<ul style="list-style-type: none"> <li>Implementing Urgent &amp; Emergency Care priorities for the integrated care partnership</li> <li>Developing optimal care pathways across the integrated care partnership</li> <li>Agreed plan to support the development of clusters</li> <li>Engaging staff and local communities in redesign</li> </ul>	<ul style="list-style-type: none"> <li>100% of clusters thriving, with lower mental and physical acute care demand as integrated teams support people to stay well at home</li> <li>Managing a comprehensive programme of service improvement to address the integrated care partnership priorities</li> <li>Population groups with high service utilisation or unmet need identified and action agreed</li> </ul>
<b>Workforce development</b>	<ul style="list-style-type: none"> <li>Understanding the workforce issues for the integrated care partnership</li> </ul>	<ul style="list-style-type: none"> <li>Securing the right workforce, in the right place with the right skills in the integrated care partnership, and ensuring the wellbeing of staff</li> </ul>
<b>Accountability &amp; performance management</b>	<ul style="list-style-type: none"> <li>Working together to monitor and improve delivery of constitutional standards</li> </ul>	<ul style="list-style-type: none"> <li>Instigating clinically led quality improvement</li> <li>Extensive use of data to drive improvement</li> <li>Oversight of delivery in clusters</li> <li>Leading recovery of standards without outside intervention</li> </ul>
<b>Managing collective resources</b>	<ul style="list-style-type: none"> <li>Understand current resource use in the integrated care partnership</li> <li>Working together to make the best use of the collective resources (workforce, estate, financial) in the integrated care partnership</li> <li>Test new approaches to manage funding flows (e.g. DTOC)</li> <li>Maximising system wide efficiencies</li> </ul>	<ul style="list-style-type: none"> <li>Managing the collective resources of the integrated care partnership</li> <li>Capable of taking on a delegated budget</li> <li>Directing resources to address the key integrated care partnership risks</li> <li>Shared corporate support services</li> <li>Shared medium term financial plan including efficiencies</li> </ul>
<b>Leadership &amp; governance</b>	<ul style="list-style-type: none"> <li>Understanding the context, ambitions and challenges of each member of the integrated care partnership, building trust, acting together</li> <li>Governance structure in place to enable collaboration</li> <li>Cluster leaders engaged in integrated care partnership planning and decision making</li> <li>Members of the integrated care partnership working together to agree any changes required to organisational structures</li> </ul>	<ul style="list-style-type: none"> <li>Joint provider, CCG and LA leadership to enable planning and delivery in the integrated care partnership</li> <li>Care professionals leading service integration</li> <li>Governance mechanisms in place to enable decisions to be made in the best interests of the system and residents</li> <li>Implementing agreed changes to organisational structures to better enable delivery in the integrated care partnership</li> </ul>





## Statutory bodies are asked to:

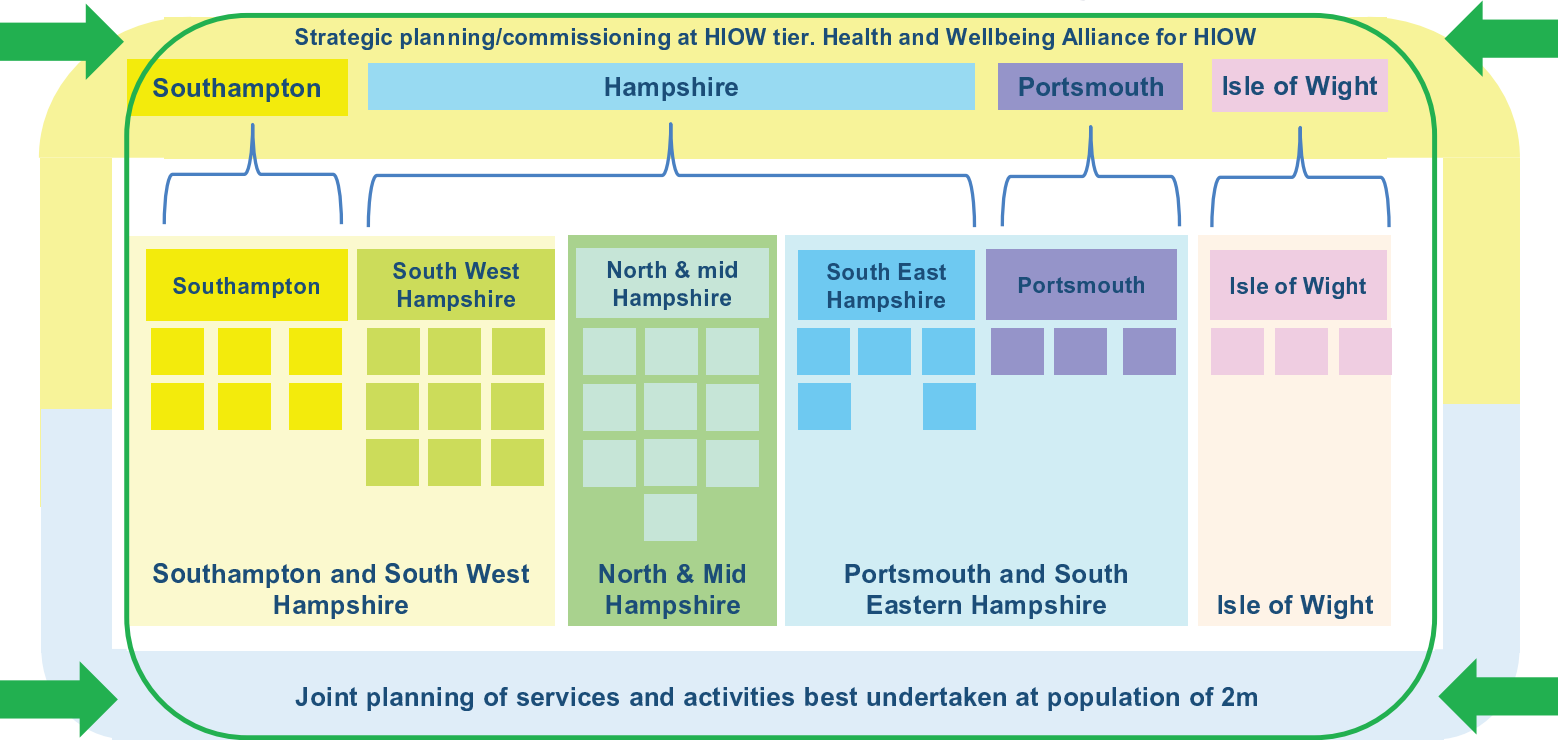
33

**Work with geographically aligned partners within the identified four ICP footprints to:**

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

MOVING FORWARD TOGETHER

# Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight



## Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight

**In order to support and add value to the work of clusters, HWB footprints and integrated care partnerships, it is envisaged that providers, commissioners and local authorities will work together to undertake strategic planning, transformation, resource allocation and oversight activities at HIOW level.**

**This could be achieved, by April 2020, through a single entity for HIOW which, in its mature form, would develop strategy, set priorities and provide strategic leadership and direction to the HIOW integrated care system.**

The strategic planning and transformation function in the HIOW integrated care system would:

- include the input and expertise of providers, CCGs and local authorities
- programme manage the implementation of HIOW level transformational change (change that spans more than one integrated care partnership or which is most appropriately managed at HIOW system level)
- proactively support the development of integrated care partnerships
- manage the specialised commissioning budget for HIOW
- align the resources coming into HIOW from a wide variety of sources around the delivery of the agreed strategic priorities, in order to increase the impact for populations
- act as the assurance body for HIOW, providing oversight of operational, quality and financial performance, and enabling the HIOW integrated care system to take action to improve performance without the need for outside intervention.

Whilst recognising the important role of external regulation, it is anticipated that the integrated care system will increasingly develop the capacity and capability to role-model 'self-regulation' – where robust processes are in place to ensure that action is taken to identify issues and improve performance without the need for outside intervention.

Creating this strategic planning and transformation function for the HIOW, which involves providers, CCGs and local authorities, is an opportunity to bring together in one place a number of functions including: those CCG functions best undertaken at HIOW level, STP functions, functions currently undertaken by the Director of Commissioning Operations, NHS England/NHS Improvement regulatory functions, specialised services commissioning and potentially other NHS England direct commissioning activities; HIOW clinical networks.

**Current thinking about the transition towards this new way of working, by March 2019 and March 2020, is described on a subsequent page.**

The characteristics of the HIOW integrated care system36

It is proposed that, based upon national ICS, national guidance and evidence of best practice, an entity operating at the scale of HIOW could display the following characteristics:

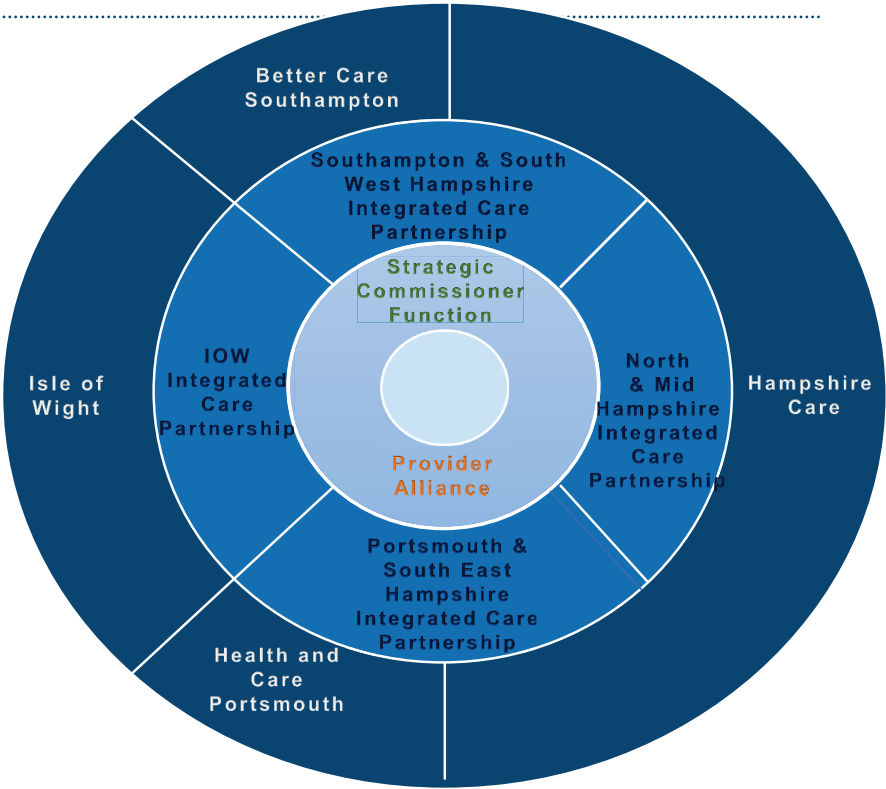
**Subsidiarity:** only undertaking functions that for reasons of cost or complexity need to be undertaken at the scale of 2m+ population. Unnecessary complexity and bureaucracy are stripped out with 80% of the transformation process led by local place-based teams;

**Inclusive:** national models / guidance show that prospective ICS are founded on partnership; for HIOW this would draw together:

- A newly established strategic commissioning function
- the four HWB footprints
- the four integrated care partnerships
- provider alliance

**Founded on self-regulation:** all components of reformed systems have effective self-regulation and enable a model of collective assurance at the scale of the ICS. This allows NHS England and NHS Improvement to deploy resource into the ICS and have a single touch point on delivery to the newly reformed regional and national infrastructure;

**Politically-led:** prospective ICS all demonstrate strong political leadership and close connection with Health and Wellbeing Strategies and Boards.



# Strategic planning/commissioning at the scale of HIOW 37

As an immediate next step in the transition to this future system model, it is proposed that HIOW CCGs and local authorities establish a strategic planning/commissioning function during Q3 2018/19.

By working together at HIOW level, CCGs and local authorities expect to be able to reduce fragmentation and bring the following immediate benefits:

- stronger alignment of health and local authority commissioning
- the development & agreement of consistent whole system strategic priorities for HIOW
- improved and simplified commissioning decision-making for HIOW wide issues.

The functions of the strategic planning/commissioning function in its initial form would include:

- Setting consistent commissioning strategy and strategic priorities for HIOW
- Managing whole system resilience at HIOW level
- Management and deployment of supra-allocation resources (including capital)
- Demand and capacity planning and commissioning decisions about the future configuration of acute physical and mental health services for the 2 million population of HIOW
- Oversight of NHS constitutional standards, financial performance and quality improvement – with work to be done to ensure this activity isn't duplicated elsewhere
- Work with specialised commissioners, understanding current activity flows and costs, inputting to and aligning decision making
- It is also proposed that the strategic planning/commissioning function incorporates the transformation programme function of the HIOW Sustainability and Transformation Partnership.

### Proposed governance:

- Established through a joint committee, in the first instance, during Q3 2018/19
- Members include CCGs, NHS England (specialist commissioning and Regional Director of Commissioning) and local authorities
- Joint committee will have delegated authority to make binding decisions in relation to the in-scope functions and responsibilities
- Expect by April 2019 the governance and organisational arrangements evolve further

The strategic planning/commissioning function is a mechanism through which commissioners can pool skills, expertise, resources and accountability to deliver transformation at HIOW level. There is a strong desire to create a new way of working, rather than add layers to existing ways of working.

# The developing functions at a scale of HIOW

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	October 2018 – March 2019	By April 2020
<b>Strategy and Planning</b>	<ul style="list-style-type: none"> <li>• Clear commissioning priorities agreed for HIOW</li> <li>• HIOW system strategy and priorities being refreshed/updated</li> <li>• Demand and capacity planning for HIOW acute services</li> <li>• Agree aligned planning process for 2019/20-2020/21</li> </ul>	<ul style="list-style-type: none"> <li>• CCGs, providers &amp; LAs setting shared strategy &amp; priorities for HIOW with aligned health &amp; LA planning processes</li> <li>• Fully own a single HIOW system operating plan that brings together plans of constituent parts of the system</li> </ul>
<b>Care Redesign</b>	<ul style="list-style-type: none"> <li>• Decisions being made about future configuration of acute physical health and mental health crisis and acute care</li> <li>• Leadership of plans to improve urgent care for HIOW, including oversight of delivery of the Integrated Urgent Care Plan</li> <li>• Decisions about community services provision for Hampshire</li> </ul>	<ul style="list-style-type: none"> <li>• Well developed plans being enacted to support the development of integrated care partnerships</li> <li>• Programme managing the implementation of HIOW level strategic change programme</li> <li>• Leading on implementation of acute service and estate reconfiguration</li> </ul>
<b>Workforce development</b>	<ul style="list-style-type: none"> <li>• Understanding the workforce issues for the system</li> <li>• Influencing the addressing of key workforce issues</li> </ul>	<ul style="list-style-type: none"> <li>• Strategic workforce plan in place and being implemented</li> <li>• Influencing future workforce supply and training requirements</li> </ul>
<b>Accountability &amp; performance management</b>	<ul style="list-style-type: none"> <li>• Oversight of HIOW winter resilience and preparedness</li> <li>• Oversight of delivery of integrated urgent care plan</li> <li>• Acting as interface with assurance bodies for HIOW</li> </ul>	<ul style="list-style-type: none"> <li>• Collective oversight of quality, operational performance and money</li> <li>• Acting as the assurance body for HIOW – supporting the system to take action to improve performance and address challenges without the need for outside intervention</li> </ul>
<b>Managing collective resources</b>	<ul style="list-style-type: none"> <li>• Agree system wide capital and estate priorities and sign off wave 4 capital allocations</li> <li>• Develop understanding of whole system financial plans and financial risks</li> <li>• Plan for aligned management of specialised commissioning</li> </ul>	<ul style="list-style-type: none"> <li>• Take accountability for a HIOW system control total</li> <li>• Managing collective finances &amp; risk openly and as a system</li> <li>• Aligning resources flowing into HIOW to achieve priorities</li> <li>• Support integrated care partnerships to take delegated budget</li> <li>• Managing the specialised commissioning budget</li> </ul>
<b>Leadership &amp; governance</b>	<ul style="list-style-type: none"> <li>• CCGs operating with a single decision making committee for HIOW level commissioning business</li> <li>• All STP partners involved in the design of the future HIOW level system strategic planning, implementation and assurance function</li> <li>• STP partners providing leadership to strategic change programmes</li> </ul>	<ul style="list-style-type: none"> <li>• A single coherent entity in place that brings together HIOW level CCG functions, STP and NHSE/I functions</li> <li>• Strategic alignment of providers, commissioners and local authorities around the system strategy and priorities</li> <li>• Clear clinical leadership for the system and input from HWB footprints and integrated care partnerships in decision making</li> </ul>

## Statutory bodies are asked to:

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**Endorse the recommendations of the EDG, informed by the work of the strategic commissioning task and finish group, that:**

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.
2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.



MOVING FORWARD TOGETHER

## Summary of recommendations

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**In summary, the governing bodies and boards of statutory organisations are asked to endorse the following recommendations from the EDG, informed by task and finish group work to date:**

### Clusters

1. The developing role of clusters as outlined earlier
2. The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development
3. The proposed next steps for the cluster task and finish group which are summarised as follows:
  - a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW
  - b. Describe the support requirements and responsibilities to accelerate full cluster implementation
  - c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures
  - d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

### Health and Wellbeing Board Footprints

1. The emerging 'restatement' of the function of partnership working on a HWB footprint as described earlier in the document
2. The proposed next steps for the task and finish group by the end of September, which are to:
  - a. define the common functions of the role of HWB footprints in an integrated care system
  - b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system
  - c. set out a mechanism for achieving 'active and effective democratic engagement at all levels' across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

### Integrated care partnerships

Work with geographically aligned partners within the identified four ICP footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

### Strategic commissioning

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.
2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.



MOVING FORWARD TOGETHER

## Next steps

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## System reform programme next steps

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A number of recommendations have been set out linked to each component of the proposed ICS. In addition to those associated with the specific components of the proposal, there are a number of overarching 'implementation programme deliverables', some of which will result as a coming together of the outputs from the various task and finish groups. These include:

- System reform implementation programme plan
- Structure and leadership plan – transitionary and end state
- Development and implementation of a communications and engagement plan
- Request for support (endorsement, agreement in principle, technical and financial) from NHS England, NHS Improvement and other arms length bodies such as the Local Government Association, NHS Leadership Academy, Health Education England
- Proposals to replace STP infrastructure (inc. Chair & SRO) to align with future form
- Organisational change plan and talent management plan
- HIOW ICS Chair and relevant leadership appointments
- Indicative budgets and financial framework for all components of the ICS
- Three year financial plans

**It is recommended that a working group is formed, reporting to the EDG, to support the development of the above. Members of EDG are asked to nominate a representative to represent the interests of their part of the system.**

# Glossary

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# Glossary of terms

**Clusters** - also referred to locally and nationally as neighbourhoods, localities, primary care networks. Multi-disciplinary teams delivering integrated health, care and wider services to cluster populations based on natural communities of 20-100,000 people.

**Health and Wellbeing Board (HWB) footprints** – also known as care systems and are based on local authority footprints. The basis of the joint strategic needs assessment (JSNA), means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health. Locally the HWB footprints come under the guise of Better Care Southampton, Health and Care Portsmouth, Hampshire Care and the Isle of Wight Care Board.

**Integrated care partnerships** – also know as local care partnerships and are based on acute (physical) hospital footprints. Integrating care delivered in clusters with broader community and acute physical and mental health services; optimising the utilisation of acute services; designing and implementing optimal care pathways.

**Integrated care system** - the Hampshire and Isle of Wight health and care system, serving a population of 2 million citizens.

NHS England defines ICS as those systems in which:

“Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations”.



13 November 2018

## **HOSC update on staffing issues within our Older People's Mental Health Services**

I wrote to you back in October 2018 to make you aware of some challenges we have been experiencing in maintaining our staffing levels across our Older People's Mental Health services. We took the difficult decision to suspend admissions to Poppy Ward, based at Gosport War Memorial Hospital (GWMH) and Beaulieu Ward based at The Western, Southampton to ensure we maintained a safe level of care to our patients. We have now reviewed this and want to provide you with an update.

### **Poppy Ward, GWMH**

I am pleased to say that after carrying out some focussed work on our rosters and ensuring shifts are requested in a more timely way for NHSP and agency we have managed to establish consistent and improved staffing levels on Poppy Ward. As a result of this piece of work we have now reopened the ward to admissions.

### **Beaulieu Ward, Western Community Hospital**

Despite considerable efforts, we have been unable to recruit the registered nurses needed to ensure Beaulieu Ward is a safe place for our patients and staff. We are currently relying on a high number of bank and agency staff which is not sustainable.

As a result we have taken the difficult decision to temporarily close Beaulieu Ward, for up to six months (depending on our ability to recruit registered nurses). Patient safety and the health and wellbeing of our staff are always our priority and we feel there is no alternative option at this current time.

### **Staff on Beaulieu Ward**

We have spoken to staff this morning to explain why we are closing the ward and to discuss with them the next steps to support them and the patients.. We hope to be able to use their skills across our other OPMH wards and they will be supported to find their best alternative place of work. They will also be offered the opportunity to undertake additional training and development and to help us reopen the ward as quickly as possible.

### **Patients on Beaulieu Ward**

We will be talking to the seven patients and their families/carers later today to discuss the most appropriate options for meeting the patients' future care, which may include moving to a bed on an alternative ward, a care home placement or being cared for in the community in their own homes. We are working to safely discharge all patients by Friday 16 November. Patients are being reviewed to ensure that care plans and risk assessments are up to date and meet the needs of the patient.

### **The future**

The decision to temporarily close Beaulieu Ward will provide us with the opportunity focus on alternative options for recruiting into the service. We are doing all we can to find a solution to our recruitment issues and a further recruitment plan for OPMH services is currently being devised.

We met with the Hampshire and Southampton Commissioners at the end of last week to discuss the proposal to temporarily close the ward but also the need to take this time to review our services to patients with Dementia and work with them to redesign services that are appropriate for the future across Southampton and Hampshire. Our plan is to reopen Beaulieu Ward as soon as we have the Registered Nurses in post to safely staff the ward.

We will be reviewing this decision on a monthly basis and will keep you fully informed of developments.

## **OUR VALUES**



**Patients &  
people first**



**Partnership**



**Respect**

Please find below an overview of the actions being taken. If you have any further questions, please feel free to contact Nicky Macdonald, Associate Director for Learning Disability and Older Persons Mental Health Services by e-mail Nicky.MacDonald@SouthernHealth.nhs.uk or by telephone on 023 80874681 or Sarah Constantine, Associate Medical Director, by e-mail Sarah.Constantine@SouthernHealth.nhs.uk or by telephone 02380 874319.

Yours sincerely

Paula Hull  
Director of Allied Health Professionals & Nursing

Actions being taken to ensure safe services across our Older People with Mental Health Services	
Patients	Staff
<p>All staff across all seven of our OPMH wards are currently looking at managing care plans and are working closely with adult services at HCC and the CCG to identify which patients can be safely discharged.</p> <p>Options include:</p> <ul style="list-style-type: none"> <li>- Appropriate care homes</li> <li>- Moving forward on Delayed transfers of care (DTC)</li> <li>- Discharge to community team</li> <li>- Possible Out of Area beds.</li> </ul> <p>We are working with patients and their families to keep people safe and expedite long term discharge plans with partners.</p> <p>Our Trust's Patient Experience Lead is enabling families to feedback their experience and our freedom of speak up guardian within the Trust has attended to provide opportunity for staff feedback.</p>	<p>Daily staffing calls are being held to help maintain safe staffing levels on the wards – these address staffing levels shift by shift and day by day.</p> <p>We are working with our Trust's Safer Staffing Lead to help maintain safe staffing levels and a good skill mix.</p> <p>The senior team have cleared diaries to ensure that they can focus on staffing issues and are visible on both the wards on a daily basis to support staff on the wards.</p>
<p>Our OPMH Bed Manager for the Trust is attending extraordinary meetings with HCC adult services and South East Clinical Commissioning Groups to try and see how they can provide additional support.</p>	<p>A new matron and Ward Manager have started with Beaulieu Ward over the last few weeks. They will be leading the review and the recruitment plan and will be looking at staff training and development.</p>
<p>There are currently 12 delayed transfers of care (DTC) patients across the three organic wards two on Beaulieu, six on Poppy and four on Elmwood and the Trust continues to work with commissioners and adult services to address these difficult to place patients.</p> <p>We are maintaining a steady flow of patients with organic needs through Elmwood at Parklands (Our other Organic ward) – this means that we can admit any new OPMH patients with organic needs to Elmwood and Poppy if appropriate as opposed to Beaulieu Ward.</p>	<p>We are also working with system partners to ensure a joined up approach to resolve staffing challenges and ensure patients are able to receive the most appropriate care in the right setting as swiftly as possible, throughout this period.</p>
<p>We are liaising with the psychiatric liaison services in the acute hospitals to ensure that only patients appropriate to be nursed on these wards, are transferred.</p>	<p>The organisational development team are also working with the service to organise sessions with the staff to support the changes required.</p>
<p>A new model of Dementia care is currently being explored with Commissioners and the Trust have identified a number of key clinicians and managers to lead on this work.</p>	



## Breakthrough agreement on improving mental health crisis services

Leading representatives from Hampshire's two mental health trusts, two local authorities, commissioners and other partners have agreed to a fundamental change in their approach to improving the delivery of mental health services.

This breakthrough has followed months of careful observations of how teams are currently working, examination of processes and records, and over 150 hours of workshops and consultation involving hundreds of patients/service users, carers and staff discussing how services should look in the future and particularly how people would access community mental health services. The compelling findings of this extensive work have been crucial in establishing the principles and priorities for change, and that much closer working is needed.

Many patients/service users, family members, carers, staff and partners have given their time and energy to talk about their views on current services, being honest about their experiences, and making suggestions for the future. We are grateful for this important work which has been instrumental in making an agreement for the transformation of services.

It is undisputed that the people delivering care, treatment and support within services are hardworking and compassionate, and they strive to provide quality care. However it is clear that the processes and systems they are working within are not always efficient, can provide challenges in meeting demand.

### What has been agreed?

Southern Health NHS Foundation Trust and Solent NHS Trust have agreed to work in closer partnership, alongside local authority and voluntary sector colleagues, supported by commissioners. We recognise that a key theme of the design was improving crisis response, so we will start by bringing the two crisis teams together into a single service model that improves responsiveness and consistency for adults of all ages.

You said	We will
You want a timely response when you need it	Deliver a 24/7 needs led crisis service with response time standards
You want alternatives to admission	Offer home treatment as an alternative to admission Work with our partners to continue to develop community support, such as wellbeing centres and safe spaces
There shouldn't be a post code lottery	Aspire to have the same service for everyone living in Portsmouth and South East Hants
You should be able to self-define your crisis	Open the service to self-referral
Carers need support too	Open the service to carers to call
You want to talk to people who have lived experience and can give you hope	Work to increase peer support in the service
You want staff to listen and you want to be empowered to look after yourself	Support our staff to develop skills to help you achieve this
You want us to look after our staff	Design a programme of staff support and development

This is the first time that Solent and Southern Health have had an agreement to work together on such a service at this scale.

Clearly, a great deal of work is needed. There will be some changes that can be made swiftly and others will take more time, but there is a consensus that this approach will make a significant difference to the people we support.

This is the beginning of a large scale programme of changes and improvements. We are working to ensure that good governance and robust project management is in place so that our progress will be tracked and measured. We aspire to go live with our combined crisis service by Summer 2019.

We are committed to the principle of coproduction and we will build on the inclusive approach to service change that we have already started. We will continue to communicate and welcome being held to account.

ENDS

**Portsmouth City Council**  
**Health Overview and Scrutiny**  
November 2018

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## Summary

The trust continues to make progress in a number of key areas including the involvement of patients, families and carers, transformation and quality improvement, and further joining up mental and physical health services to improve patient care, aligning to the Sustainability and Transformation Partnership's emerging system reform proposals.

At the same time, the trust continues to tackle ongoing challenges, most notably the reliance on 'out-of-area' mental health beds, and staff recruitment and retention. These are complex and firmly established challenges which require sophisticated, long term plans, and considerable action is taking place in these areas alongside system partners. Sustainable improvements in measured engagement and satisfaction of trust staff and recent successful recruitment campaigns are encouraging signs that action is making an impact, and the vacancy rate across the trust is on an improving trajectory.

The Care Quality Commission published its comprehensive report in October, following a series of inspections earlier this year – the first report of its type since 2014. Whilst the trust overall rating remains one of 'requires improvement', significant and numerous positive changes have been recognised by the regulator and the overall picture is one of steady progress. Of particular note, our community services across Hampshire are now rated 'good' overall, and our learning disability inpatient services are rated 'outstanding' overall. Perhaps unsurprisingly, staffing levels were linked to most areas identified for improvement. The report has provided additional confidence that the organisation's approach is making headway, and the trust remains committed to building on this in the coming months and years.

Southern Health is working in partnership with other agencies across the system to prepare for winter. Our focus is on increasing our capacity and capability to support people to remain independent and at home wherever possible, and expediting safe and timely discharge from acute hospital for those admitted. A number of new schemes, initiatives and campaigns are now in place to enhance our ability to achieve this.

## Recent Care Quality Commission (CQC) comprehensive report

On 3 October the Care Quality Commission (CQC) published their comprehensive report into Southern Health NHS Foundation Trust. Whilst the Trust's overall rating remains as 'requires improvement', the CQC found many signs of progress across the organisation, with over 84% of service areas now rated as 'good or 'outstanding'. The inspection took place in June/July 2018 and is the first comprehensive report into the Trust since 2014. The Trust's community services have received a rating of 'good' overall and our inpatient services for people with a learning disability have been rated as 'outstanding' overall.

It also reflects the significant strides the trust has made to improve its relationship and involvement with the families and carers of our patients and service users, with the CQC feedback showing that: '*Staff had made a genuine commitment to engaging with patients.*'

## OUR VALUES



*We saw that they were patient and diligent in helping patients express their views, and liaised with them in all aspects of their care. The feedback from patients and carers was clear that they felt they were not only listened to, but included and involved in their care.'*

The report describes how staff told inspectors they now feel more valued and supported, and that the CQC has seen a positive change in culture at Southern Health.

Whilst the report gives cause for optimism, clearly the trust has more work to do: particularly in relation to our staffing levels and ensuring there are enough trained staff to best support patients. The trust remains committed to continuously improving its services to deliver the best possible care.

The CQC's findings have been incorporated into a trust-wide quality improvement plan, which is themed across a number of areas. There is executive-level ownership for each theme, and it is hoped that this approach will help staff and stakeholders better understand the improvements required and how progress is being made against each theme.

Below are the trust CQC 'scorecards' which show ratings for each domain (safe, effective, caring, responsive, well-led, and overall) against each core service from 2014 and the latest report from October 2018 (note, I=inadequate, RI=requires improvement, G=good, O=outstanding):

#### 2014:

CORE SERVICE	Safe	Effective	Caring	Responsive	Well-led	Overall
	<b>2014</b>					
OVERALL PROVIDER RATING	RI	RI	G	G	RI	RI
Community health services for adults	RI	G	G	RI	G	RI
Community health services for children & young people	G	G	G	G	G	G
Community health inpatient services	RI	G	G	G	G	G
Community end of life care	RI	RI	G	G	G	RI
Urgent care	RI	RI	G	RI	RI	RI
Acute wards for adults of working age & PICUs	RI	RI	G	RI	RI	RI
Long-stay or rehab mental health wards	G	G	G	G	G	G
Forensic inpatient or secure wards	I	G	G	G	RI	RI
Child and adolescent mental health wards	RI	RI	G	G	G	RI
Wards for older people with MH problems	RI	G	G	G	G	G

#### OUR VALUES



Wards for people with a learning disability/autism	RI	RI	G	G	RI	RI
Community-based mental health services	G	G	G	G	G	G
MH crisis services / health-based places of safety	RI	RI	G	RI	RI	RI
Community mental health services for older people	G	G	G	G	G	G
Community services for people with a learning disability/autism	G	G	G	G	RI	G
Eating Disorder service (not inspected in 2018) *	G	G	G	G	G	G
Perinatal services (not inspected in 2018) *	O	O	O	O	O	O

\* These services were not included in the aggregation of the overall provider rating

## 2018

CORE SERVICE	Safe	Effective	Caring	Responsive	Well-led	Overall
	2018					
OVERALL PROVIDER RATING	RI	RI	G	G	RI	RI
Community health services for adults	G	G	O	G	G	G
Community health services for children & young people	G	G	G	G	G	G
Community health inpatient services	G	G	G	G	G	G
Community end of life care	G	RI	G	G	G	G
Urgent care	G	G	G	G	G	G
Acute wards for adults of working age & PICUs	RI	G	G	G	RI	RI
Long-stay or rehab mental health wards	G	G	G	O	O	O
Forensic inpatient or secure wards	G	G	G	G	G	G
Child and adolescent mental health wards	RI	G	G	G	RI	RI
Wards for older people with MH problems	RI	RI	G	I	RI	RI
Wards for people with a learning disability/autism	G	G	O	O	G	O
Community-based mental health services	G	RI	G	G	G	G

## OUR VALUES



Patients & people first



Partnership



Respect

MH crisis services / health-based places of safety	G	RI	G	G	RI	RI
Community mental health services for older people	G	RI	G	G	G	G
Community services for people with a learning disability/autism	G	G	O	G	G	G
Eating Disorder service (not inspected in 2018)	G	G	G	G	G	G
Perinatal services (not inspected in 2018)	O	O	O	O	O	O

The full CQC report can be found here: <https://www.southernhealth.nhs.uk/news/cqc-finds-further-improvements-at-southern-health/>

### Changing Southern Health's structure to enable more joined-up care

Providing both mental and physical health services brings opportunities to better integrate these services for the benefit of patients. Evidence also suggests that people with severe mental health problems have a shorter life expectancy and to a large extent this is due to physical health problems not being properly managed. People with long term physical health conditions are also more likely to experience mental health problems. So, the case for integration is powerful and Southern Health has a huge opportunity to do this.

Examples of more joined up care already happening include the trust's diabetes service providing direct care into our medium secure mental health unit, and psychological therapy service (italk) providing support to people with long term physical health problems.

The trust is now consulting on plans to create a new organisational structure which will further enable this more joined up way of working to flourish. Services will be planned and managed based on local populations (aligned to system-level footprints), ensuring mental, physical and learning disability health needs are met for patients in each area. The new structure will make more collaborative working between professions more straightforward, whilst maintaining professional skills and networks. It is expected that this new structure will be launched in the New Year, which will lay the foundations for ongoing improvements to integrated care: ultimately delivering better patient experience and outcomes.

### Involving patients, carers and families

Improving the way the trust works in partnership with people who use services, their families and carers is a strategic priority for Southern Health. A considerable amount of progress has been made in recent weeks following the appointment of an experienced head of patient engagement. One example is the new Working in Partnership Committee, which has been recently been established and reports directly to the Trust Board. This committee is chaired by a carer and is attended by representatives from service user, carer, and family groups from across the organisation. It is hoped that this committee will give a greater voice to people using our services and result in tangible and meaningful improvements.

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## **Transformation and quality improvement**

The trust is committed to carrying out large scale change to transform its services, and to adopt proven quality improvement techniques to ensure this is carried out in the most effective way. The trust continues to train staff from across the trust in these techniques who are working with teams to carry out local quality improvement projects. Current projects underway include those aiming to improve recruitment processes, reduce violence and aggression on mental health inpatient wards, improve access to psychological therapy for older people, and improve the prevention of pressure ulcers. Over 200 staff, patients and carers recently attended the trust's first transformation conference where these projects were showcased.

As part of this programme of work, Southern Health and Solent NHS Trust recently agreed to work jointly to transform crisis care mental health services in the Portsmouth and South East Hampshire area, to improve care, accessibility and responsiveness. This followed extensive feedback and involvement of service users, carers, families and staff in over 100 hours of workshops and discussions. It is hoped that this new and improved service will go live in 2019 and both trusts are committed to continuous service user involvement throughout the design and delivery of this service.

## **Secure Services re-provision**

Plans are progressing well to build a new learning disability residential unit (LDRU) at Tatchbury Mount, and to develop Woodhaven Hospital to provide additional and much needed beds for young people with severe mental health problems. Construction has begun on the LDRU, and the new unit and additional beds for young people are due to open in Winter 2019. Patients and families have been closely involved throughout, including on the design and layout of the new unit.

## **Suicide and self-harm awareness, reduction and prevention**

As a mental health provider the trust supports some of the most vulnerable people in Hampshire, many of whom are at a high risk of self-harm. The trust is part of local suicide prevention strategies and has signed up to the Zero Suicide Alliance. The trust is working hard to do all it can to reduce and ultimately prevent suicide amongst the people it supports. This includes training, awareness raising and ensuring it is adopting the best practice. In December the trust is joining forces with Solent NHS Trust to host a suicide reduction conference, to improve collaboration between professionals in both organisations and learning from national and international experts on this subject.

## **Recruitment and retention**

Along with the wider NHS, staff recruitment and retention are challenging. The scale of the problem for the trust is broadly in line with that faced by other NHS organisations.

Significant efforts are underway and ongoing to attract and retain our workforce, including a new workforce strategy which is now being implemented, and an increased focus on social media campaigns and passive recruitment. Thanks to these efforts we have reduced the trust's vacancy rate, and reduced the amount we spend on agency staff by £1m. However there remain specific areas of challenge including consultants, for which an ongoing campaign in national medical journals is taking place.

## **Out-of-area mental health placements**





The trust continues to place some Hampshire patients out-of-county for inpatient mental health care in cases where no suitable bed can be made available in Hampshire. This is far from ideal for the patients and their families and is also not the best use of resources. Many attempts have been made to tackle this challenge, with varied success, but it remains a key problem. This complex problem requires a multifaceted solution, the trust is now seeking the involvement of our staff and patients on this matter, under the leadership and fresh perspective of our new medical director.

### **Winter preparedness**

The trust is working closely with system partners on joint plans to meet the demands of winter. A successful winter recruitment campaign has resulted in over two dozen new staff joining the trust in teams expected to face additional demands. New initiatives aimed at supporting people at home and preventing hospital admissions have begun, including a new frailty support service which has supported over 800 patients in the New Forest and prevented hospital admissions in 81% of cases. In Gosport, a new complex care team has been created, as well as multi-disciplinary long term condition hubs, which aim to improve access to specialist clinicians in local GP surgeries, and 'health connectors' who work with patients to help them find and access health and wellbeing services in their local area. The trust is working with system partners on public-facing campaigns to ensure people make informed decisions about how and where to access care during winter, and tips and guidance for staying well and independent. The trust has also launched two campaigns aimed at patients in our community hospitals – one 'End PJ Paralysis' encourages patients to get up and dressed to improve mobility, and another 'Why not home, why not today?' encourages patients and their families to discuss discharge plans with their clinicians.

### **About the trust**

Southern Health NHS Foundation Trust provides mental health, learning disability and community health services across Hampshire. Employing 6,000 staff and with funding of £309m, it is one of the larger providers of these types of services. It supports 280,000 individual patients each year, with over 1.5 million care contacts. Over 90% of people who rate their care with the trust say they would recommend it to their friends and family. The trust is rated as 'requires improvement' by the Care Quality Commission and its main challenge is staff recruitment and retention. The organisation has faced significant challenges in recent years and is working hard to make care better, more joined up, and to work more inclusively with patients, families and communities.

