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Portsmouth CITY COUNCIL

NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 21 JANUARY 2021 AT 1.30 PM

VIRTUAL REMOTE MEETING

Telephone enquiries to Anna Martyn Tel 023 9283 4870
Email: democratic@portsmouthcc.gov.uk

Membership

Councillor David Fuller (Chair)
Councillor Lee Mason (Vice-Chair)
Councillor Graham Heaney
Councillor Leo Madden
Councillor Steve Wemyss
Councillor Tom Wood
Councillor Vivian Achwal
Councillor Arthur Agate
Councillor Trevor Cartwright
Councillor David Keast
Councillor Philip Raffaelli
Councillor Rosy Raines

Standing Deputies

Councillor Gemma New
Councillor Robert New
Councillor Luke Stubbs
Councillor Ian Bastable

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

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

A G E N D A

1 Welcome and Apologies for Absence

2 Declarations of Members' Interests

3 Minutes of the Previous Meeting (Pages 3 - 10)

4 Update from Solent NHS Trust (Pages 11 - 34)

Suzannah Rosenberg, Chief Operating Officer, will answer questions on the attached report.

5 Update from NHS England on dental practices (Pages 35 - 36)

The update is presented for noting.

6 Update from Sustainability & Transformation Partnership (Pages 37 - 54)

Maggie MacIsaac, Chief Executive (Hampshire & Isle of Wight Integrated Care System), Dr Andrew Bishop, HIOW NHS Covid-19 Clinical Medical Acute Lead and Interim Clinical Transformation Director, and Richard Samuel, Director of Transition and Development, will answer questions on the attached report.

7 Dates of future meetings

The Panel are asked to agree the proposed dates of future meetings (all Thursdays at 1.30 pm):

24 June 2021
16 September 2021
18 November 2021
20 January 2022
17 March 2022

HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 19 November 2020 at 1.30 pm at the Virtual Remote Meeting - Remote

Present

Councillor David Fuller (Chair)
Councillor Lee Mason
Councillor Graham Heaney
Councillor Leo Madden
Councillor Steve Wemyss
Councillor Tom Wood
Councillor Arthur Agate, East Hampshire District Council
Councillor Trevor Cartwright, Fareham Borough Council
Councillor David Keast, Hampshire County Council
Councillor Philip Raffaelli, Gosport Borough Council
Councillor Rosy Raines, Havant Borough Council

Also in Attendance

29. Welcome and Apologies for Absence (AI 1)

There were no apologies for absence.

Councillor Cartwright said he would need to leave the meeting at 3:30pm to attend another virtual meeting.

30. Declarations of Members' Interests (AI 2)

Councillor Steve Wemyss declared a personal and non-prejudicial interest as he works for the South Central and West Commissioning Support Unit.

Councillor David Fuller declared a personal and non-prejudicial interest as he runs a residential care home in Cosham.

31. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes of the meeting held on 17 September 2020 be agreed as a correct record.

Matters Arising

Hanway Road merger - the minutes of the Primary Care Commissioning Committee where the decision was made were circulated to the panel on 29th October and a link to the public report was also sent. The link to the papers can be viewed on the Portsmouth CCG website.

32. Update from Adult Social Care (AI 4)

Andy Biddle, Director of Adult Social Care (ASC), introduced the report.

In response to questions Mr Biddle explained that:

With regard to the delegation of PCCG functions to the Chief Executive of Portsmouth City Council these would not be clinical functions. The CCG is mainly a commissioning body so it would be ensuring that there is sufficient provision of services in Portsmouth. It would be the functioning of the CCG as a day to day organisation to ensure the needs are met, which is a fairly important theme as it is joining up the health and care offer at a local level.

Hospital discharge guidance was received from Government in March 2020 to prepare the NHS for an expected peak of infections due to COVID-19. Reflecting back he thought there was not a full realisation of risk and patients were discharged into care homes but were not tested as this was yet to be implemented. The guidance at the time was followed and any time there was an outbreak Public Health England were contacted to ensure that the correct procedures were followed.

Mr Biddle was not aware of any PCC care homes running out of Personal Protective Equipment (PPE). PPE was monitored on a twice weekly basis and all care providers across the city were in discussions around this.

He explained that ASC firstly organised a stock of PPE then trained staff with best guidance they had at the time. The guidance evolved four times over the course of the pandemic. They also called on the resources of colleagues at the CCG and whenever ASC were planning to do any training they asked them to certify it to ensure the correct procedures were being met. Whenever there were any COVID-19 positive infections, they would consider whether to close the wing down or do cohorting and cared for them in a different area. This led to the Gunwharf unit which became the isolation unit. This was a learning experience and staff adapted to each piece of new guidance. Thankfully at the moment the ASC team have not seen any COVID-19 related deaths for a considerable time.

Mr Biddle said he did not know the numbers of patients who were COVID-19 positive who were discharged into care homes; unless there was a test they could not tell if a patient was COVID-19 19 positive. Mr Biddle said he would provide the numbers of people who were discharged from hospital that were symptomatic.

Mr Biddle felt that ASC is in a better place for the second wave of the pandemic due to lessons learned from the first wave but this did depend on

numbers. ASC had made the decision to keep services stood up this time in terms of respite services for carers. The team are seeing a lot more positive infections and exposures in care environments than in the first wave.

With regard to the Liberty Protection Safeguards (LPS) that was intended to replace the Deprivation of Liberty Safeguards (DoLS), Mr Biddle said they would probably have sufficient staff. He would need to wait for the code of practice to be published, which will detail how to implement primary legislation. It was currently very difficult to judge and the situation would probably evolve, but extra staff would be needed to bring it in. With regard to DoLS approval numbers could be shared with the panel.

The NHS committed to pay for anyone coming out of hospital if they needed residential or domiciliary care. This was known as Scheme 1 funding and was open ended during the COVID-19 first wave. The Government announced that this would end on 30 September 2020. Scheme 2 funding commenced from 1 October 2020 which was for anyone coming out of hospital who with rehabilitation needs who would receive NHS funding for six weeks and then revert to Local Authority funding. The authority is engaged currently in assessment for those people currently in receipt of Scheme 1as there is a requirement to move them onto social care funding by 31 March 2021.

It was Mr Biddle's understanding that there is a shortfall in the council of Providers Support by some millions which is reflected nationally. There were two grants of £1.6 billion nationally which PCC received a portion of but this was not specifically for ASC.

In terms of current testing for COVID-19 it is much more prolific than it was. There is whole care home testing every week for staff including agency staff and every month for residents. The ASC team are also able to access lab testing at Portsmouth Hospitals University Trust to get a test result back that day if needed. When Mr Biddle last reported to Gold Command 10% of resident tests took longer than 5 days for a result and 6% of staff tests took longer than 5 days for a result, which was a massive improvement.

The total number of people with learning disabilities that ASC are working with along with the numbers who are shielding as they are vulnerable would be shared with the panel after the meeting.

In terms of COVID-19 bereavement rates, Portsmouth has a relatively low rate of infection. Nationally 18.5k deaths are attributed to COVID-19 in care homes and PCC rates were relatively low comparatively. He advised he could get the figures from public health colleagues and share these with the panel.

The medically Fit For Discharge (MFFD) list is compiled between ASC, Solent NHS Trust and Portsmouth Hospital University Trust and if someone is on the list that they think is unwell partners would have a conversation internally. There would be a review of the patient's health and Mr Biddle was not aware of any cases recently where someone came out of hospital and partners did not think they were ready. There are sometimes pressures when there is not

somewhere for a patient to be discharged to but this does not often happen. The Gunwharf unit has 20 beds and was full as of this morning.

Staff absences did not have an impact on client care. The ASC team had overstaffed by using agency staff. In addition, as several services in the council closed down during the first wave of COVID-19, some staff were redeployed into ancillary roles.

The panel wishes to thank Andy Biddle, Director of Adult Social Care, for his report and to place on record it's thanks to all the Adult Social Care staff for their excellent dedication and work during the current Coronavirus pandemic.

RESOLVED that the report be noted and the following additional information be supplied to the panel:

- **Numbers of people discharged from hospital into care homes that were symptomatic of COVID-19**
- **Numbers of people who are clinically vulnerable and shielding that are cared for by ASC.**
- **Numbers of people with a learning disability that ASC are supporting.**
- **DoLS number of approvals from the last year.**
- **Figures from Public Health on comparative death rates relating to COVID-19 in care homes.**

33. Update from NHS Southern Health Foundation Trust (AI 5)

Ron Shields, Chief Executive Officer at Southern Health Foundation Trust introduced the report. He drew attention to the £3.5 million that had been awarded to invest in two wards at the Gosport War Memorial Hospital. The programme for completing the work was already underway with Poppy ward being completed first which would take 16 weeks followed by Rose ward. There is ongoing communication with families to make sure that they are supported. The intensive support team has been enhanced and the core of the team are now working in the communities to support the patients that otherwise might have gone to Poppy ward.

With regard to COVID-19, collectively there has been an enormous effort from all NHS organisations to sustain services as best as they are able to provide normal services and support staff. The challenge is to keep staff healthy in order to sustain services to maintain a good quality of care.

There are currently 25 patients across beds within Southern who are positive with COVID-19 and 46 in the Trust as a whole. The plan is to get up to a full 80 beds at the Woodcote Unit by 7 December and the challenge with that is to get the additional staff to man the unit and work is being done to provide more support in the community teams.

With regard to COVID-19 testing, this week Southern Health are moving closer to a position where they can test all NHS and care staff routinely twice weekly and the logistics of this are being worked on currently.

In response to questions the following points were clarified:

The intensive support team is a transient measure. In setting the team up staff have used a core of staff from Poppy ward. The aim is to support people so they do not have to go into hospital. Across the whole healthcare system we are seeing a significant investment into community and the expectation is that this should continue once Poppy ward is re-opened. The panel were very pleased to hear this.

Completion of risk assessments of staff varies slightly. When the report was written 100% of vulnerable staff had completed a risk assessment and 94% of all staff across the organisation had completed one. There has since been 9 or 10 staff join the organisation that are within vulnerable categories who are in the process of completing a risk assessment. This will continue to change as staff come and go and staff need to keep assessing and put in place the right protective arrangements with them.

Numbers of staff having to self-isolate due to COVID-19 fluctuates by the day and the 14 day quarantine period has been a challenge. As of 16 November 2020 there were 70 staff absent from work due to COVID-19 of whom 20 had tested positive with COVID-19.

With regard to immunisations for children, Mr Shields said the immunisation programme is going very well. There is more work to do with children with special needs where there were some challenges, but discussions were taking place and the picture was looking good. Mr Shields said he would provide figures to the panel before the next meeting.

Members thanked Ron for his report and all the work of Southern Health.

RESOLVED that the report be noted and details of the childhood immunisation programme would be shared with the panel in due course.

34. Update from South Central Ambulance Service (AI 6)

Tracy Redman gave a brief introduction to her report. She explained that business as usual demand has started to increase and the hospital is challenged in terms of capacity. SCAS continue to be concerned about staff absence and some mitigation is in place from other agencies and they continue to move forward with their winter planning which incorporated COVID-19.

The panel were pleased to see a year on year improvement in the performance figures. At the request of the panel she said she could provide postcode data for Fareham and Gosport to see whether response times for residents living on the Gosport peninsula are being met. This would be provided for the panel within the next few weeks.

Tracy felt it was difficult to say if people are deciding not to go to hospital due to COVID-19. SCAS have seen an increase in acuity but they normally do at this point of the year. There is no data to support either way. Tracy felt that

primary care is still doing what it needs to do and SCAS are not seeing any additional impact.

Tracy explained that there are two levels of Personal Protective Equipment (PPE) that their crews use. The first is used for all patients which is a mask, apron and gloves and the second is an enhanced level which is used where aerosol may be generated including suction. This involves paramedics wearing hazchem suits and is following national guidance. With regard to the specific incident raised Tracy said if the councillor sent her the details she would look at the detail.

RESOLVED that the report be noted and performance data by postcode for Fareham and Gosport would be provided by Tracy for the panel.

35. Update from Portsmouth Hospitals Trust (AI 7)

The report was introduced by Penny Emerit Deputy Chief Executive and Director of Strategy and Performance. She explained that there were approximately 130 patients with COVID-19 currently at QA Hospital. The rate of infection for Portsmouth was 312 cases per 100,000 which was above the national average. It was expected that the increasing admission rate will continue for a short period before the impact of the second national lockdown are seen.

In response to questions the following matters were clarified:
The front door to the Emergency Department will move in line with the new building. The 111 First Model and utilisation of space will continue with those types of processes through the new building.

There has been an increase in cases and admissions to QA hospital relating to COVID-19 and the link between cases and admissions is seen as you move through the older population. The more vulnerable communities tend to have the admission to hospital. She could not say if there was a direct cause and effect with the return of students to Portsmouth. There is now an increase in testing so they are able to identify people much earlier on who have the virus even if they are displaying no symptoms.

With regard to PHUT doing consultations on the phone during the COVID-19 pandemic, a councillor pointed out that phone calls from PHUT are blocked and some patients do not accept blocked phone numbers. He suggested that this be looked into. Penny said she did not have the technical details but she would take this away and get back to the panel before the next meeting.

In terms of COVID-19 infection in the hospital she would come back with the exact numbers. The Trust have put in place stringent infection control processes in the hospital and apply their testing regime to that to identify whether spread has gone further. In terms of critical care, capacity is used for both COVID-19 and non COVID-19 patients. PHUT have access to up to 24 critical care beds and are already in escalation areas in terms of the number of patients being cared for in the intensive treatment unit.

In terms of the work around 111 and access to urgent care, PHUT were one of two early adopters of this national approach to looking at urgent care. One of the drivers for doing this was try to minimise the risk for infection for patients in waiting areas so there is a clear rationale why now is the right time for this pilot. It provides the patient with one route through which they can support navigation to the correct place. There is a national evaluation running looking at all the pilots and PHUT are also collecting feedback. The feedback from patients in the Emergency Department (ED) is largely positive in terms of the experience. One area of feedback is that patients have asked for more information in advance of coming to the ED so they know to contact 111 first. Penny advised that they are keeping all the feedback under review and are able to look at data across the urgent treatment centres, the 111 service and GP clinical assessment service to understand where patients are going.

The travel and transport plan is a core part of all of the changes ongoing over the next five years in the estate. They will ensure that any patient parking affected is replaced on site.

The intention for outpatient appointments is that where possible these will be done remotely. From a staff perspective many have to travel to the site to carry out their roles, although some can now work from home. Staff car parking is on site and also the park and ride from the Southwick Road site.

In terms of access to cancer services they have managed to maintain performance against the cancer standards and services were maintained throughout the national lockdowns. PHUT also made sure they monitored the levels of activity that they would normally have seen compared to what they were seeing.

The performance of the ED is affected by what is happening in the rest of the hospital. While they wait for the new ED PHUT will continue to make sure they have got improvement activity to ensure emergency patients have safe and timely care.

RESOLVED that the report be noted and the following information be supplied to the panel:

- **Penny to look into the reason for why the PHUT phone numbers are blocked numbers and report back why QA blocks its phone number which may stop some patients receiving important calls.**
- **Current infection numbers of COVID-19 within QAH.**

36. Update from NHS England on dental practices (AI 8)

The Chair explained that NHS England were not able to send a representative to the meeting today due to a number of staff changes and sickness.

The panel noted the update from NHS England on the procurement of dental services in Portsmouth and if members had questions on the update the Chair asked that these be emailed to the Local Democracy Officer to be forwarded

to NHS England for a response. Members noted that NHS England had been invited to the January meeting of the panel to provide a further update.

RESOLVED that the report be noted and a further update be brought to the January meeting.

The formal meeting endedat 3.47 pm.

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Councillor David Fuller
Chair

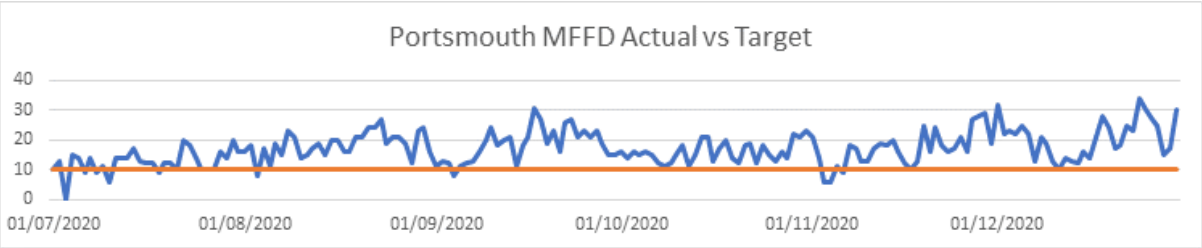
Solent NHS Trust Update to Portsmouth Health Overview & Scrutiny Panel

21 January 2021

1. Covid-19 Response

1.1. Solent & PCC have continued their strong partnership working throughout the pandemic, notably in the delivery of the Discharge Hub which was established in March 2020 in response to national guidance. We have nominated a Senior Responsible Officer who represents both organisations and ensures that our collective bedded capacity and reablement Home First services are used effectively.

1.2. This has given us the best chance to achieve the daily Medically Fit for Discharge (MFFD) target for city of 10 (last winter it was 40). The chart below shows our collective (PCC & Solent) performance for the last 6 months. It is a constant challenge to achieve the target with a multitude of influencing factors. The numbers of patients who are MFFD changes on an hourly basis, as patients are added and removed from the list as they become either fit or not fit for discharge. Other barriers to discharge include patient transport, the supply and readiness of a patient's medication, swab results for a patient's covid status. However, the Discharge Hub team continue to work tirelessly to facilitate as many QA discharges as possible.



1.3. The challenges of the second wave are significant and are now far surpassing first wave levels of demand. We have had to make the difficult decision to suspend all non-urgent services such as: Speech & Language, MSK, Bladder & Bowel, and ask staff to be redeployed to support inpatient services at Spinnaker and Jubilee House and the Portsmouth Reablement and Rehabilitation Team (PRRT). These redeployed staff are providing cover for high levels of covid staff sickness/self isolating and will enable us to open additional capacity at Jubilee, Spinnaker and PRRT.

1.4 We are fortunate that PHU and Portsmouth City PCNs have offered several vaccination slots for Solent staff over the last month.

2. Jubilee House

2.1 The pandemic has delayed progress on the relocation of Jubilee House to St Mary's. HOSP members will recall that last winter the west wing was reopened by Southern Health as additional capacity for Hampshire patients to cope with the winter surge. This year, Solent has reopened the wing, creating additional capacity for any PSEH patient.

3. Covid-19 Vaccination Programme

3.1 Solent has begun administering Covid-19 vaccinations to NHS community and mental health staff from across HIOW as part of the largest vaccination programme the NHS has ever undertaken. A dedicated Covid-19 vaccination hub in Millbrook, Southampton opened on Monday 4 January 2021

3.2 NHS staff working at the hub are initially offering vaccines to community healthcare staff working in HIOW as part of the widening of the Covid-19 vaccination programme. Access to vaccinations at the hub will be widened to frontline social care and care home staff in the coming weeks.

3.3. Further Solent run vaccine services will open in other locations across HIOW in the coming weeks.

4. Mental Health

4.1 The national programme of community mental health transformation and investment remains a priority for NHS England. The programme is being co-ordinated at a Hampshire & Isle of Wight level but with a recognition that developments must be co-produced with people who use services and designed to meet the needs of local communities.

4.2 The Hampshire and Isle of Wight vision is to transform the experience of people who access support for their mental health in three fundamental ways:

- First, at the start of a person's recovery there will be no wrong door. Wherever, and however a person accesses care they will be greeted with compassion, understanding and assessed holistically.

- Second, services will be integrated to better enable multidisciplinary decision-making and effectively step up and down care as needed. The aim being wrapping the right care around an individual quickly and compassionately, helping them to lead their recovery.

- Third, an education, career development, and support structure for the people across the services ensuring a sustainable and continually improving service, offering life–long recovery skills.

4.3 For Portsmouth, Solent is working closely with the CCG and Solent Mind to develop a transformation plan for the city's mental health services.

4.4 The closure of the Oakdene rehabilitation ward (The Limes, St James) in September 2019 has enabled a decant of Hawthorn ward to Oakdene to undertake much needed safety improvements and backlog maintenance. This is a 3 phase project, which once complete, will deliver an enhanced therapeutic environment for both the acute and intensive care mental health wards at The Orchards (St James).

4. Learning from Covid-19 First Wave

Here is a summary document of COVID-19 learning and evaluation regarding frontline teams (attached).

Here is a summary document of COVID-19 learning and evaluation relating to remote consultations (attached).

Suzannah Rosenberg
Chief Operating Officer
Solent NHS Trust

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Spotlight on frontline teams

COVID-19
LEARNING AND EVALUATION

Changes in response to COVID-19

In response to COVID-19 frontline clinical teams went through a rapid transition. Clinical services were adapted to ensure that those people who needed face-to-face care continued to be seen.

Data sources:

1. Interviews with those working on the frontline.
2. Ethnographic notes from observations and meetings with people working on the frontline.

What we heard:

With the rapid onset of lockdown and a need for services across the healthcare system to adapt at speed, enabled much-needed change led by clinical teams. Frontline teams had increased autonomy in making decisions about care and services centred around one goal; the person in Solent's care.

For many, this shared goal unified teams with a sense of togetherness and a 'can do' spirit, enhancing collaboration within Solent services as well as the wider health and social care community.

Autonomy and enablement

Collaboration, integration and innovation

Leadership and peer support

Autonomy and enablement

- The initial few weeks of Solent's response were characterised by rapid and significant change.
- For frontline services, this meant adapting processes to enable face-to-face care when needed, and remote or virtual care and support for others.

- As acute hospitals acted to free up more space, community teams were rapidly required to look after more complex and unwell patients.
- Decision-making was often led by the frontline clinical teams; making clinically-based decisions of how services could run to best look after those within our care.
- Many found they were enabled to make change and decisions swiftly, with enhanced support from corporate services such as IT and Estates teams.
- For most, the removal of previous barriers to change and autonomy was empowering.
- Some teams in the community such as those visiting people's homes, felt there was an imbalance in support between themselves and inpatient areas, for example: guidance around Personal Protective Equipment (PPE) and risk assessment.

> Positive - shows what you can do when you're given the freedom to do it. The trust put in you counts for a lot.

> Lots of challenges around PPE. The Royal College guidelines are different to the Trust guidelines. I didn't want to visit patients without correct PPE guidance.

> Normal barriers are removed – it's amazing what you can do.

Collaboration, integration and innovation

The removal of barriers and local decision making enhanced collaboration, integration and innovation. Many teams talked of working across organisational boundaries effectively, with joint approaches to problem solving.

Frontline clinical, social care and community organisation teams thought innovatively about how best to provide clinical services for those within our care trialling new ways of working. The unified goal of care centred around patients.

Many frontline teams received the support of redeployed staff and had to ensure that they were trained and able to work safely, whilst continuing to adapt services rapidly.

By removing barriers, people many spoke positively about collaborating with other services and professional groups within Solent as well as integrated ways of working across the wider health and social care communities.

> The empowerment and ability to just get on has been refreshing. Local solution-finding has led to so much more connectivity; understanding different professions, different stressors, different ways of working. Much closer relationships with teams.

> The changes have brought us closer together as a team and increased joint working. More awareness of what each other do.

> Looking at issues and patient need from a city wide perspective, rather than one locality, has been really positive.

> It has removed barriers between services.

> Networks and collaborations have worked well. There are better pathways and improved services.

Leadership and peer support: the importance of team

The pressure of this time was undoubtedly huge, people were responding to looking after people within their care as well as dealing with the pressure of blurred boundaries between home, work and family.

Initially, the rapidly changing guidance around PPE fuelled by media reports impacted some frontline workers' perceptions of safety. These were also fuelled by different approaches and equipment used by different organisations.

There was a very strong sense of a 'can do NHS Spirit' unified by a shared goal giving clarity and purpose.

Those in leadership roles spoke of the feelings of absolute responsibility for the safety of their teams and their patients, and the additional stress that resulted. Many worked very long hours to support and protect their teams.

For many the support from leadership and teams was essential in people feeling safe and for mediating levels of uncertainty.

The support from peers and the ability to pull together helped people feel safe in work, even in times of uncertainty.

Feeling informed and connected helped people to manage changes in working practices.

> I'm finding that holding a lot of people's emotions can be challenging. There are staff members who are very anxious and everyone is on edge because their whole life is in turmoil and life generally is upside down. Because I'm a people manager it can be exhausting containing and guiding them through it.

> I have always been proud to work for the NHS and more so now. The way we have all pulled together and everyone is a part of that.

> It's really brought us together as a team in terms of collaboration and problem solving and utilising individual's skills. It's been a real challenge for our service and I think we've really risen to it. The temptation early on was to just stop – some of us were asking how?! But we really did, it was transformative

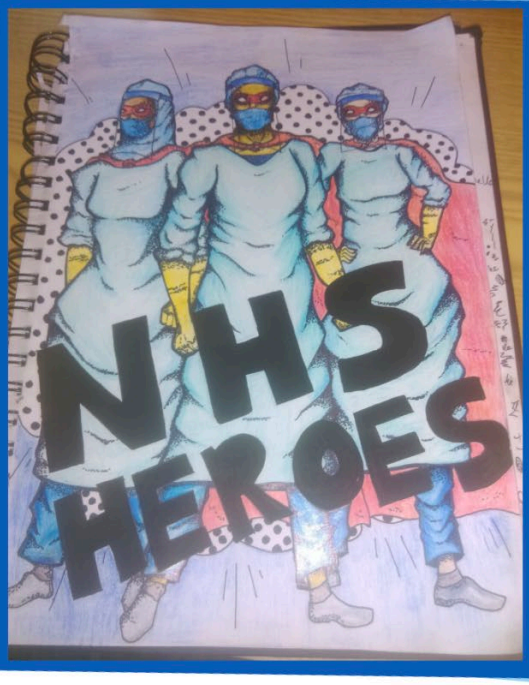
Short case studies

There are so many teams and services that demonstrate excellent practice, here are just a few examples:

Mental Health Community and Wellbeing Team:

This is the team that carry out physical healthcare checks on those with mental health illness, particularly those who are taking medication. They either administer the medication (when it is injected) or carry out physical health checks to assess for side effects etc. With lockdown, it wasn't possible to hold the clinics in person, and so the team had to reorganise themselves to be able to visit their 400 patients at home. It was a totally new way of working for the team; finding their way around the city, wearing PPE in the community, taking blood samples outside of the clinical environment.

The team developed a buddy system so that a clinician would visit the home, and one of their colleagues who was working from home would make the appointments and complete the clinical notes. This saved time, enabled home visits to take place, and ensured a system of peer support. The added benefits of home visits included being able to assess the broader aspects of wellbeing, and an informal food bank was set up by the team to enable the delivery of food packages.



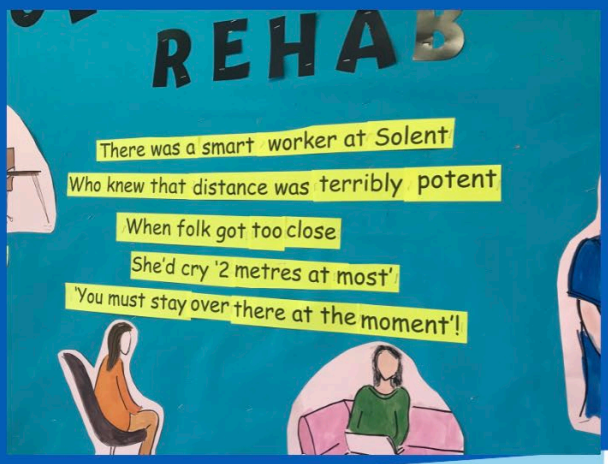
School Nursing - Portsmouth:

With schools closed during lockdown, it was difficult to continue to support and see families. The school nursing team worked with social workers to co-ordinate care across the city. Packs to create memory boxes, feelings boxes and other crafts were made for families and delivered; similar boxes to support healthy weight have also been provided, and supplemented with conversation being held by phone or WhatsApp. In one case, a single mum was living in a hotel room with three teenage girls and collaborative multi-agency effort enabled them to be rehoused, despite lockdown. The picture was drawn by a young girl from a family working with one of our school nurses.

Community Emergency Discharge Team (Southampton) and Community Nursing:

At the start of lockdown, hospitals were asked to discharge as many of their patients as they could back into the community; their homes or residential settings. A number of services joined forces to give a single point of access for the hospital teams. The Community Emergency Discharge Team and the Community Nursing (Twilight) and Palliative Care service joined with the Social Care Team (SCT), and located themselves together in Southampton. This included support from a number of redeployed staff who required a rapid programme of training (side skilling) and shadowing.

The teams worked together to keep as many people safely at home as they could (Home First) - the result, has been a much better understanding of roles and professions, not only within Solent but across different organisations.



Inpatient wards:

Solent has a number of inpatient facilities in both Portsmouth and Southampton. New inpatient facilities were also rapidly established in preparation for any need for bed capacity. Within the space of a month, teams built and equipped wards in both cities, additional staff were found through recruitment campaigns and a programme of redeployment.

Training and 'side skilling' sessions were held for staff to enable them to work in a ward environment; and infection prevention measures were checked, with addition PPE and guidelines distributed across the county.

Learning for improvement

Many processes for approval of change can safely be streamlined and simplified.

Differing guidance and PPE equipment between organisations caused anxiety and confusion.

Many of the support mechanisms were easier to access for teams working at home, but it was difficult to attend Zoom or other sessions held through the day when working out in the community.

Learning from excellence

Empowering frontline teams to adapt and improve their services around patient needs led to rapid and successful mobilisation of services.

Clinical and corporate support services were able to work closely together to establish significant extra inpatient capacity.

Service adaptation was always driven by patient need – this enabled much stronger cross-sector and professional working.

Compassionate leadership across teams led to feelings of security and immense pride.

Key learning take-aways; what you need to know

Frontline teams who had increased autonomy in making decisions were empowered and enabled to create solutions that focussed on the needs of those people within Solent's care.

Communication, wellbeing and support strategies need to take into account the working environment and natural patterns of teams working in the community or on inpatient units (including housekeeping and catering teams).

Maybe those in leadership roles need equal access to on-going development and support to enable them to provide compassionate and personalised care to their teams.

Spotlight on remote consultations

COVID-19
LEARNING AND EVALUATION

Data sources

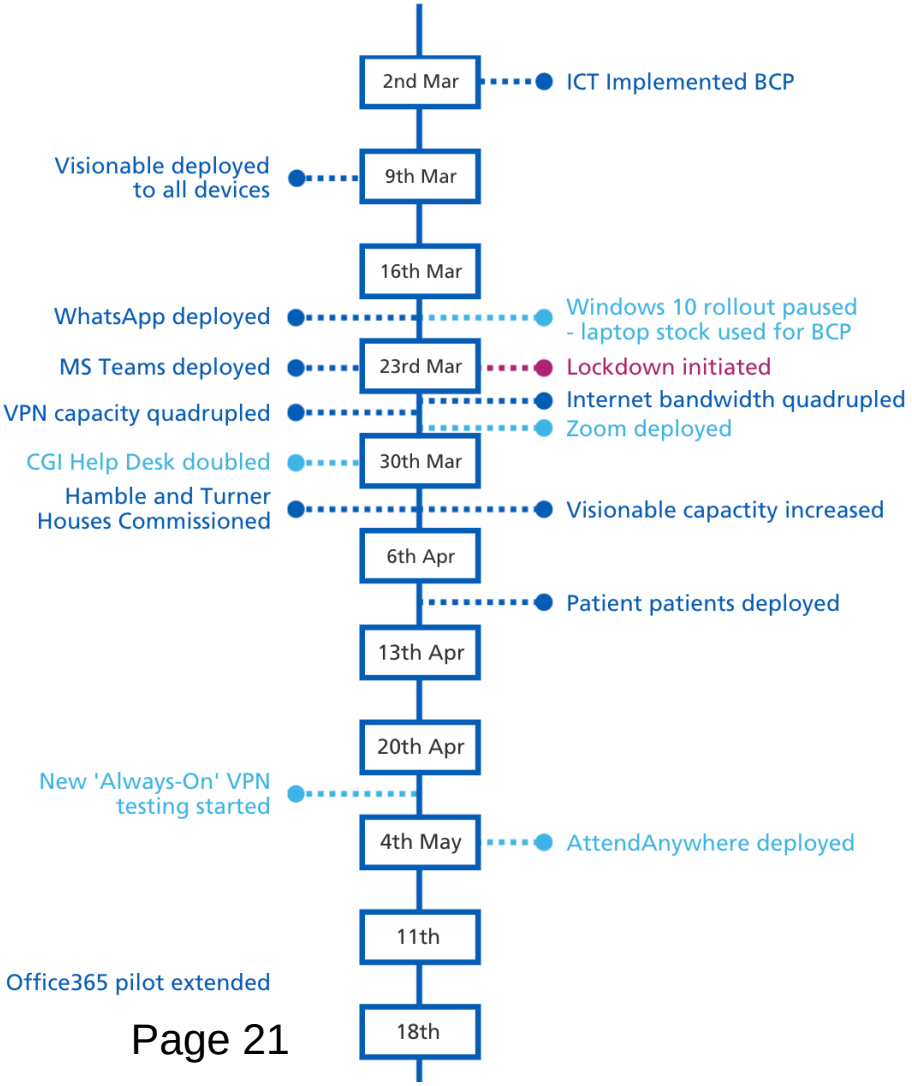
1. Project documents from the ICT team.
2. Clinical record summary data on consultation type.
3. Surveys on the experience of use (375 staff and 495 patient respondents).
4. Interviews with patients and staff.

What happened in Solent?

Prior to COVID-19, Solent NHS Trust was undertaking an ambitious programme of digital transformation.

With the onset of the pandemic, it was clear that a large proportion of our workforce would have to work either from home or in different locations.

Solent ICT team rapidly mobilised a programme of equipment and software roll-out, and established connectivity in a number of new sites across Hampshire. Access to platforms such as Zoom and WhatsApp was approved, and additional video consultation software was made available, starting with Visionable, and then, AttendAnywhere after a few weeks).



This infrastructure enabled remote consultations with patients, even if clinicians were working at home. Patients could be contacted via a phone system or video link.

25th

1st Jun

Rapid move to remote consultation

Face-to-face physical contacts dropped by approximately 50-75% at the end of March when lockdown came into force. Contacts fell to approximately 10,000 a week, then stabilised towards May at about 12,500 a week - this didn't change much between May and August.

Telephone consultations quadrupled from 500 to 2000 a week, over the course of March.

Video consultations saw a rapid and sharp increase as lockdown occurred from less than 10 to over 500 a week. The primary platforms used were Visionable, AttendAnywhere and Zoom.

Context

- 60% of clinicians were conducting remote consultations from home, 30% from their normal place of work.
- Of those working at home, 60% were using their home broadband rather than the Vodafone SIM.

Connectivity

There have been challenges with connectivity.

The responses from the survey data showed over 60% of the calls were reported as easy to connect to and successful.

A further 25% were reported to be relatively easy to get into but there were challenges with calls freezing or cutting off.

Very few reported severe connection issues.

There were some difficulties with a 'lag' or with delays with the video:

> We could connect but there was always a 2 -3 second lag between audio and video.

> The sync was out so we kept talking over each other.

Some experienced challenges with the technology - training or information leaflets would be of benefit. Patients sometimes had to ask relatives to assist them.

> The patient was on their iPhone and to get them connected they had to ask their daughter to help set up.

Effectiveness of the consultation

- It is clear that remote/video consultations are an acceptable method of communication for most clinicians and could be used in combination with face-to-face sessions.
- 60% were concerned that remote consultations weren't as effective as a face-to-face session, but worked well enough given the circumstances.
- 20% of respondents thought they were either as effective or better than face-to-face.
- 96% said they would be happy to use remote consultations in some form post pandemic.
- The needs of the individual patient are important in the type of consultation

What's missing?

A move to remote consultation is by no means a 'lift and shift' exercise, it is a unique type of communication between clinician and patient.

Elements of a traditional consultation that presented challenges were:

- Not being able to do full assessments
- Lacking non verbal cues
- Missing the 'sense in the room'; "It's like two of our senses have been stripped away"
- Patients being so grateful for the call, that they don't reveal all of the issues
- Not having all diagnostic tests available

> We've been providing a service to the best of our ability. But we're all feeling uncomfortable that we're not providing the service that we'd like to.

> I miss the luxury of face to face. It's ok over the phone but the rapport with the patient is slightly blurred. No patients are complaining at lack of face to face but I think it would be better.

> Missing a lot of non-verbal clues around mood, compliance. Plays a huge part in decision making.

Clinicians were also concerned that there was an impact on an ability to build good relationships with patients. Or to make a good human connection.

> I think that the rapport I have built up over the months with patients has been interrupted by this. Over the phone is just not the same as face to face contact.

> I wanted to hold her hand, I wanted to look in her eye when I told her diagnosis.

> The client became tearful at one point – it's harder to show compassion and give comfort/ support over the video.

> Remote consults miss the 'sense' you get about patients. It makes it so much harder to build trust and relationships.

> I worry in case we are missing something that may be easier to pick up F2F, eg .domestic violence issues. People tend to be more open if there is rapport already. The subtle signs/holding back the truth might be missed; a learning disability is not always obvious over the phone.

What is gained?

The environment

There were many situations in which there was a reported advantage to remote consultations, in particular 'seeing' patients in their own environment:

- understanding a child's home environment has helped therapists to understand a family more broadly and often a child is more relaxed at home,
- seeing patients practice exercises in their home enabled therapists to adjust accordingly, which wouldn't be possible in a clinic,
- additional materials could be provided online to support consultations.

> Parents have been able to record their children eating and drinking in a much more natural environment to what would normally occur when I do a home visit...it has allowed me an opportunity to get "inside" the home.

> [Video provides] a great insight in to [the child's] natural environment. It helped me to understand Mum and the wider home/family dynamics.

Many multi-agency meetings have been facilitated via video call, often with more professionals and agencies attending than would have been possible in a face-to-face meeting. This has significant benefits for families, being able to access multiagency support and information in one space.

Inclusion

- Patients and families are now able to be included in in multidisciplinary or multi-agency meetings.
- Relationships with stakeholders have improved.
- The patients have increased access in some ways, for example, reduced pain from travel (eg rheumatology patients).

Use of time

As clinicians adapted to remote consultations, they found that they were 'better' for many types of calls and they could make better use of their time.

One thing that surprised me was how many patients you can manage doing remote phone calls in both my job roles. You can manage less complex patients well with a telephone call.

This was a review that I would have normally gone into school to complete however, I was able to see the child complete a couple of tasks and talk to mum about any other concerns. This then lead to discharge. Time-wise it was really useful; no travel to the school, talked to mum and didn't have to play telephone tennis with them. It was nice to round it up in one go as well being able to see parents and them to see me.

Less faffing around... more time engaging with the patient... that's got to be better value.

I think the remote consults will help with waiting lists and may help with better assessments at speed, rather than always visiting people's homes.

One other positive example was an experience I had of a child being discharged from Southampton. It has always been extremely difficult to organise attendance of appropriate staff at MDTs. They were able to set up a remote MDT meeting on Zoom and this was fantastic. It was great to have everyone in the hospital, along with community therapists, a parent at the home and also a parent at the hospital. It worked so much better and it enabled staff to attend, as otherwise they would have had to take the time to drive over to Southampton when it was much easier for them to spare an hour on Zoom.

Peer support - the importance of team

COVID has strongly highlighted the importance of team and peer support, particularly for clinical decision.

The 'quick question', or 'head around the door to check something' way of working was made very difficult for clinicians as most remote consultations happened from their home.

This increased autonomy came with a sense of increased risk for some.

Additional supervision and support measures have been implemented to try to counteract isolation, including daily check-ins, more supervision, buddy systems and closed WhatsApp or Facebook groups.

"You underestimate the support you get from your colleagues where you can quickly go into the next cubicle and speak to a colleague for another opinion about your patient. Personally I like to ask questions and to chat through a patient's condition so as to learn how to manage these things. You can still call people but it doesn't happen as easily as people are busy so this has become more difficult.

"What has been challenging is not having those ad-hoc conversations that you would usually have when something is playing on your mind.

"You ask yourself "am I taking too much of a risk here?" When you are in a face-to-face team you usually have colleagues around you or with you. There is immediate support. This isn't the same way when working alone at home.

"We were taking calls from people at real crisis level. It definitely helped having the psychologists alongside us on the calls.

"The change was especially difficult for those who are less experienced clinicians or are more risk adverse and they would normally be able to constantly check with colleagues and pull back the curtain to ask someone's advice. Now they are suddenly at home with no sense checking and no corridor consults. It is a big ask.

"It was down to our judgement, which was tricky at times.

Fatigue

The act of carrying out consultations remotely feels more tiring for clinicians. Many reported increased fatigue - both from increased concentration but also from worry about others.

> I have to work harder to pay attention to the cues that I can get, so I'm more exhausted after a clinic.

> It is much harder to read body language remotely. This is perhaps why, despite my commute shortening from 20 miles to one staircase, I am feeling really tired.

> Being out of the way and upstairs is much better, but it has been difficult to juggle with no childcare support. It has also been difficult to hold confidential conversations at home too.

> I don't want to have to shut my child in a bedroom while I make a phone call and it's hard for him to understand why. I can't concentrate properly.

Invasion of personal space

Where consultations were carried out from home, clinicians struggled to find adequate 'space' between work and home. For some this was challenging for confidentiality but also a sense of personal space and safety – a split between the emotive work environment and home.

Patients' view point

Patients were sent the survey either via an automated system following a remote consultation with Visionable and AttendAnywhere, or manually via email or text link by clinicians. They were able to volunteer for a telephone interview at the end of the survey.

How willing would you be to use remote consultation (either instead of, or alongside face-to-face appointments) in the future (n=488)?

Connection

The most common device used by patients for calls is a smartphone (45% overall, and 55% in those aged under 55), followed by either a laptop or tablet. Only 10% used a telephone.

76% used a link provided by the service and 17% used Zoom.

Very few reported having major problems connecting to the call; 76% reported that it was very easy, with a further 18% saying it 'was okay'. Only 5% reported having difficulty.

Acceptability

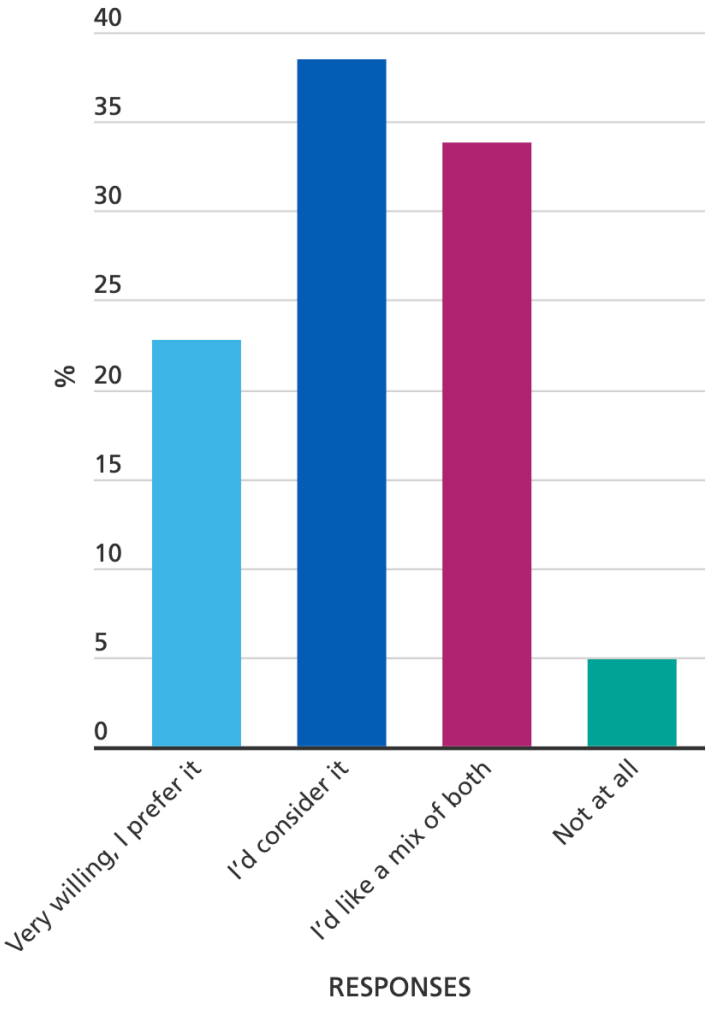
When asked about preference in comparison to face-to-face, respondents state the following about remote consultations:

Acceptability of this type of consultation is high - a third reported 'loving it' and another 43% 'liked it'. Only 4% reported not being happy about their experience.

Just over 10% said they preferred remote consultation, and 55% said they thought they were more or less the same. The remaining 30% said they preferred face-to-face but understood why a remote consultation was necessary.

Overall, 85% said that they were able to get all or most of what they needed to achieve during the consultation.

95% of respondents reported that they would be happy to have some degree of remote consultation going forward.



The benefits

Convenience

Comfort

Safety

Self care

"Easy, and think of the time and money saved by not having to take time off work to drive to the surgery and sit and wait. This is the way forward I think."

"Quick and simple."

"Made it easier to arrange a time and logistics; it meant that M could run off and play whilst we went over more things."

"The ease of being in my own home and not having to travel with a young child is very convenient."

"Being in my own surroundings made me feel more at ease."

"Very relaxing being able to be in my home environment."

"Less hassle than going in in person."

The challenges

There were very few challenges reported, those issues that were mentioned centred on connectivity and communication.

"The video screen froze making it tricky to see what the consultant was showing me."

"The lag meant we were talking over each other."

"He couldn't physically examine me so that diagnosis was likely limited."

"Connection problems, screen freezing and the sound is poor."

"Can be challenging to see what movements I'm doing."

"Trying to show a dentist a child's back tooth isn't easy."

"The exercises are sometimes difficult to understand – this is where a hands on approach might be better."

"Just difficult for the nurse to see my stoma up close...I worry something could be missed as it's hard for her to see it."

Personalised Care

The findings from this evaluation show overall that there is a high level of acceptability for remote consultations by both staff and patients, even when COVID doesn't necessitate them. The vast majority of respondents have felt that there is a place for them in the future and in some settings these do improve the care that is given, and even the interaction with patients.

It is interesting that the concerns felt by clinicians weren't mirrored by patients – and that the period of lockdown demonstrated a willingness and an ability of many to take control of more aspects of their health and self manage more of the conditions that they had. It would suggest from both sides that this is an opportunity for 'handing some control' back to patients and allowing a more personalised approach to interventions and care.

Remote consultations are obviously not suitable for everything, and have their limitations. But they are preferred by many patients and so the opportunity to increase choice for patients about types of consultations has presented itself.

> It feels like patients are starting to take more responsibility for their own health.

> Self-care is better and my time is saved if people are doing more self-care... that doesn't have to change after COVID...[I noticed] changing attitudes about risk and self-care... less ownership of other peoples' feet... we can't afford to go backwards.. It's an opportunity to change how we work.

> For patients, it has made us give people responsibility for self-management. We've been giving people their own things to do and be responsible and then we monitor them. This is something that we've wanted to do for a long time and it has forced that issue forward which is good.

> It's forced us to push forward with the self-management idea that we've had for a long time and not acted on, and it is going well for a lot of patients.

Acceptability

Before COVID, as an organisation, Solent was on an ambitious journey of digital transformation.

A number of factors made this challenging, not least the hesitancy of clinicians who were concerned about the impact on their care and how patients would perceive it.

COVID took this decision out of many people's hands, and enabled a revolution in the perception of different types of consultation.

Many reported how positive this felt, and that there was a chance to rethink many of the ways in which clinical interactions could take place.

From a professional point of view, exploring how we can do things remotely and have good therapeutic connection - perhaps (we should) offer more choice in the future as some people prefer to communicate remotely we have recently discovered.

We have been forced to think more creatively in our offer of support.

The current situation has forced us to innovate, an innovation I hope we will keep.

Hugely happy and I have to ask myself "why haven't we done this years ago?" I guess the answer would be lack of time, sometimes it takes something drastic to make things happen that you've thought about for years.

I would not have agreed with that change but now (reluctantly!) I agree that maybe 80% of work can be done by phone.

Feels like the NHS is in a period of 're-set' for example moving to use virtual consultations/ appointments. No waffle, things just get done and implemented quickly. When forced into rolling things out or making changes, it has gone really well.

Remote consultations have worked very well for lots of things and have given us an opportunity to rapidly pilot things we were hoping to start but we're struggling to get all the ducks lined up.

Consultations now done over the phone, it has been revolutionary; I can't believe we didn't do more of this before lockdown.

We historically tend to do practices a certain way because that's how they have always been done and it never gets looked at. Telephone consultations and chlamydia treatment by post has revolutionised that.

Liked that we have embraced the digital revolution! We want to keep them and develop them… WhatsApp and Zoom. We could use these lots as they meet the needs of our clients. Possibly more inclusive e.g. for teenagers.

As we get better I think for a lot of people it will be as good as a face to face consult if they are able to use it

Learning for improvement

Remote consultations are not ideal for all episodes of care, and the absence of non verbal cues, and the inability to do full physical examinations have an impact on care.

The technology or internet connections aren't yet stable enough. The 3G connection for home working doesn't work well enough for many, and so they use home broadband – the quality of connectivity is often limited.

Remote consultations require new clinical skills, and dedicated supervision. Many staff felt that they were holding additional risk that they were uncomfortable with.

Clinicians were worried about the quality of care that they were giving, and the possible impact on building relationships and rapport with patients. This was particularly problematic when delivering difficult news.

The remote consults felt more tiring for clinicians, many reporting being 'exhausted' at the end of the day.

If people are working at home, there are issues of feeling that personal space and privacy are compromised, and there is a lack of access for peer and colleague support.

The importance of team and the support of colleagues is particularly applicable where clinicians feel they are more isolated or are holding more risk.

Learning from excellence

Solent was able to rapidly enable remote consultations in a short time period, enabling people to work from home and continue to provide care.

Remote consultations are highly acceptable and successful for many types of consultations.

In some cases they improve access and the quality of the interaction. They have been used widely across the Trust, both for individuals and groups.

Innovative solutions such as providing additional online material to support consultations have helped improve the quality of remote consultations.

The ability to see patients or families in their home environments has led to an improved quality of care.

Remote consultation has enabled more effective multidisciplinary and agency working, allowed patients to attend and improved working relationships.

Over 95% of patients and clinicians would like to see remote consultations continued in some form.

Key learning take-aways; what you need to know

The pandemic has resulted in a 'digital revolution' in Solent, with the rapid acceptance of remote consultations as an acceptable element of clinical care.

The delivery of care remotely isn't a 'lift and shift' exercise. Consideration needs to be given to both technical and emotional factors.

Training in IT skills is necessary and there are additional training needs in communication and other clinical conversations when working remotely.

Remote consultations are highly acceptable to patients, and should be considered by all clinicians. There is a significant opportunity to further personalise care by discussion remote options for patients rather than assuming 'clinician knows best'.

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Primary Care Commissioning
NHS England and NHS Improvement
South East Region
Wharf House
Medway Wharf Road
Tonbridge
Kent TN9 1RE

Email: england.southeastdental@nhs.net

6 January 2021

Sent by email

Dear Anna

PORTSMOUTH DENTAL SERVICE PROCUREMENT – UPDATE TO PORTSMOUTH HOSP

Firstly, may I wish you a happy New Year. In my previous updates sent on 4th and 18th November I updated on the completed procurements within Portsmouth.

The building work has commenced at each site and as to date, even with the current national Tier 5 instruction, we have not been advised of any delay to the building work. However as previously mentioned this could change if key personnel are unwell or must self-isolate but if this is the case NHS England and NHS Improvement will update the meeting accordingly. As previously advised the temporary additional activity that is being provided by existing dental practices whilst the procurement was carried out, continues to be in place.

Yours sincerely

Alison

Alison Cross
Senior Commissioning Manager (Dental)

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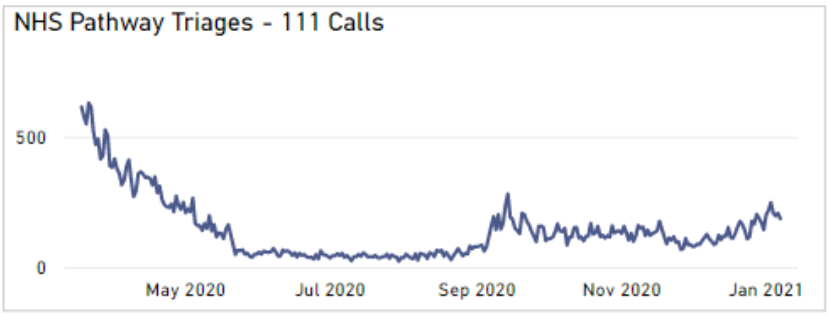
HIOW NHS Response to Covid-19
Update Briefing for HIOW Overview and Scrutiny Committees/Panels
January 2021

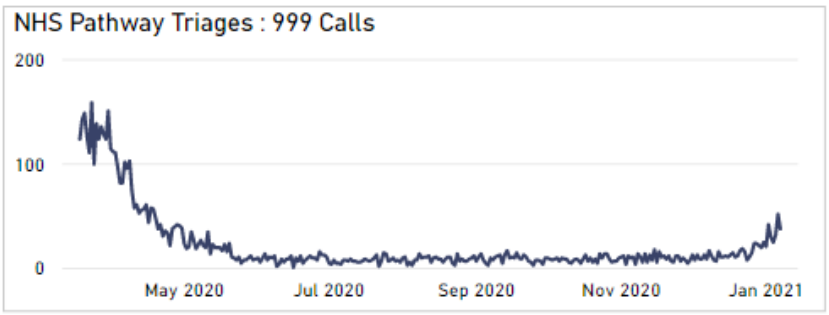
1. Introduction

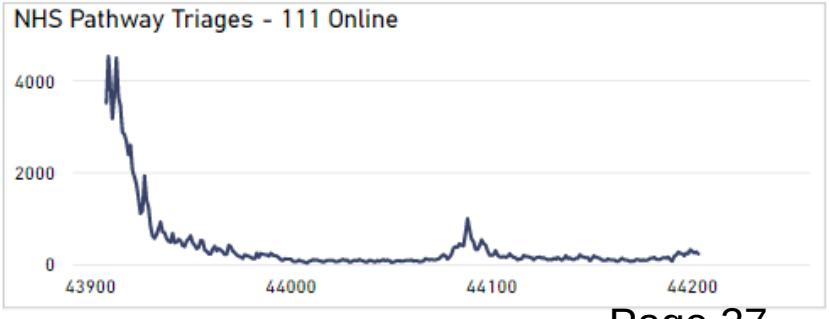
Following the briefing provided in November 2020, this paper provides an update on the impact to date of the pandemic on Hampshire and Isle of Wight; the Covid-19 vaccination programme; the progress of the Third Phase of the NHS Response to Covid-19; accessing Primary Care Services; NHS England and NHS Improvement Commissioned Services; and work to seek the views of key stakeholders and local people.

2. Impact of Covid-19 on Hampshire and the Isle of Wight

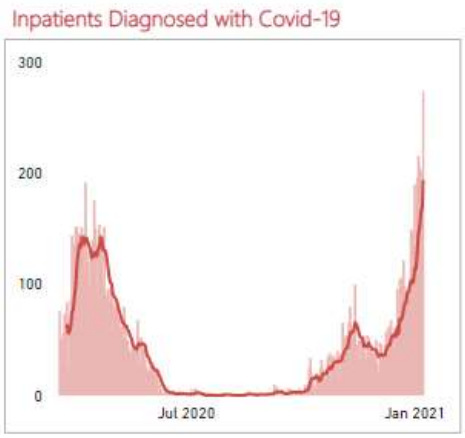
The following graphs show the number of NHS 111 calls, NHS 111 online contacts and 999 calls with potential Covid-19 symptoms.

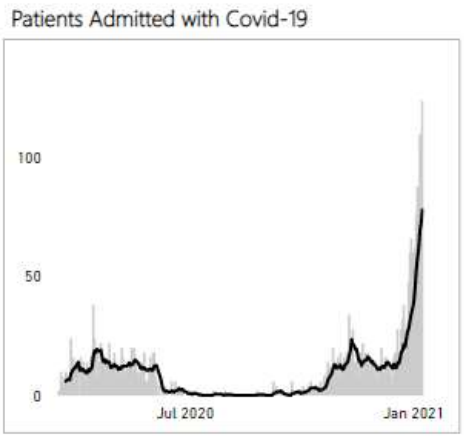


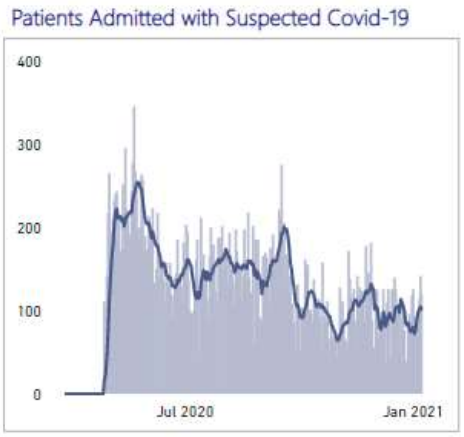


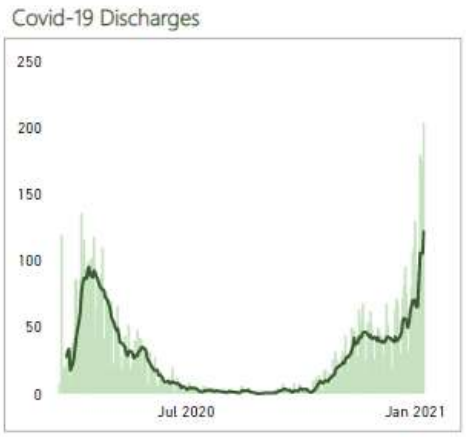


The following graphs show the number of inpatients diagnosed with Covid-19, the number admitted with Covid-19, the number admitted with suspected Covid-19 and the number of patients with Covid-19 discharged.

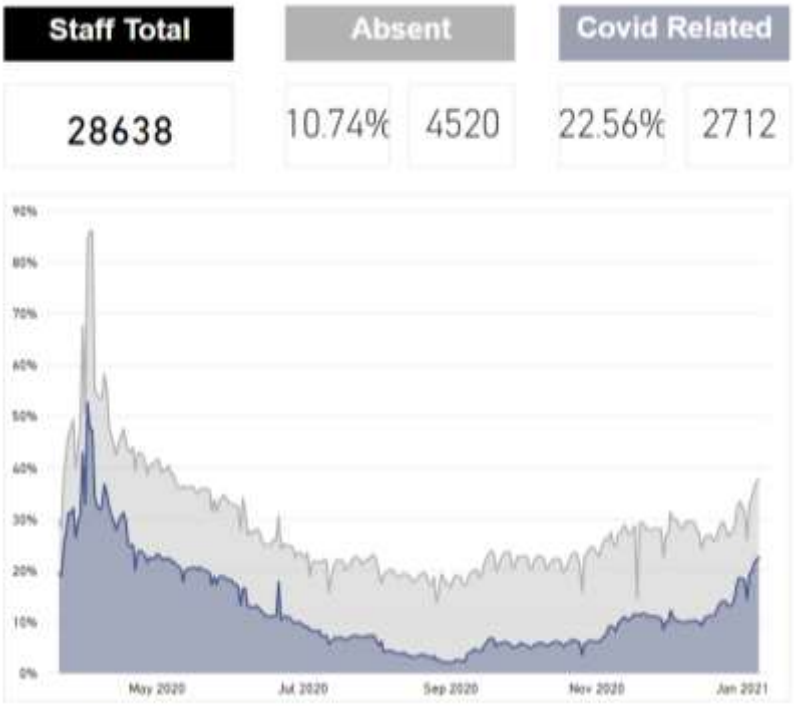








The following graph shows the HIOW staff sickness rate including the sickness rate related to Covid-19.



We continue to support our staff on the impact on them from responding to the pandemic. This support is provided in a number of ways with mental health and wellbeing programmes and bespoke support is in place for all staff groups.

The sharp increase in cases during December and increasing winter pressures is impacting on all of the health and care systems across HIOW, particularly Portsmouth and South East Hampshire. Work is underway to refine our contingency plans to cater for this and the impact on services in January and February. These plans include:

- Working closely with Health Protection Boards to minimise the spread of infection in the communities and to keep people safe and well
- Optimising avoidable hospital admissions schemes to ensure local people are only admitted to hospital when needed
- Increasing hospital discharge schemes to ensure local people are discharged from hospital as quickly as possible when they are clinically fit for discharge
- Promoting the different services available to local people, including 111 First, to help them choose the most appropriate service when they need urgent care or advice
- Ensuring clear escalation processes are in place for acute hospitals to request mutual aid when required
- Working with partners to encourage compliance with the Covid-19 guidance – Hands, Space, Face
- Continued focus on the delivery of the Covid-19 vaccination programme.

3. Covid-19 Vaccination Programme

The NHS has planned extensively to deliver the largest vaccination programme in our history, providing three different delivery methods so we can cope with any type of vaccine:

1. Hospital Hubs – where we know the Pfizer vaccine can be stored safely
2. Local Vaccine Services – provided by GPs working together as Primary Care Networks (PCNs)
3. Vaccination Centres – large sites convenient for transport networks.

Now that we have a vaccine that has been confirmed as safe and effective by the MHRA, we have begun to roll it out to those groups who the independent JCVI have decided need it most as supplies are made available.

Delivering the Pfizer vaccine is complex as it needs to be stored at very cold temperatures and moved carefully in batches of 975 doses. Initially it was delivered from “Hospital Hubs” which have been closely followed by local vaccine services provided by the PCNs. It is also now available in smaller batches, meaning that vaccination teams can go into care homes to vaccinate those who can’t go to other services.

To date (January 11, 2021) across Hampshire and the Isle of Wight, five hospital hubs, 36 Local Vaccine Services and one Vaccine Centre (currently focussing on health and social care staff) have gone live. A further one hospital hub, three Local Vaccine Services and three Vaccine Centres will go live over the next 2-3 weeks. The feedback from both patients and staff has been very positive about how well clinics have run.

As well as at-risk patients we have begun to vaccinate care home staff and some of our frontline staff. It is important that health and care workers protect themselves so that they are there to care for others.

The vaccination programme will be delivered over the coming months, and the NHS will keep expanding the programme as we get more vaccine, and potentially other vaccines come available.

The NHS wants to go as fast as all these factors allow and have been recruiting and training more vaccinators and support staff from across the NHS and outside of it, all of whom will be trained, assessed and supervised.

The public can really help the NHS deliver this effectively to those who need it most. Our asks are:

- We will contact you when it's the right time to come forward, so please don't contact the NHS to seek a vaccine before then;
- Please act on your invite when it comes, and make sure you attend your appointments when you arrange them;
- And of course, please continue to abide by all the social distancing and hand hygiene guidance, which will still save lives.

4. HIOW NHS progress of the Third Phase of the NHS Response to Covid-19

The Third Phase of NHS Response to Covid-19 guidance, issued in July 2020, sets out the following three priorities for the rest of 2020/21:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter
B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally
C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

Our progress to date on these includes:

- There are now only a small number of service changes that were enacted in response to the COVID-19 pandemic, which have not reverted to their previous methods of access. These include:
    - Urgent care in Portsmouth and south eastern Hampshire which has been reconfigured to be offered via NHS 111 First, with the appropriate engagement underway (as reported at previous Committee meetings)
    - Cessation of all domiciliary dental care across the area due to social distancing in line with national guidance. This is being reviewed on a quarterly basis

  All other services have either been restored to original methods of access or with the use of digital and telephone access continuing where required to maintain infection control and social distancing requirements
- New Forest Birth Centre – As updated at the previous Committee meeting, the birth centre has been temporarily closed due to staffing levels until January 2021. This is regularly reviewed and there will be a further review of staff levels in January to decide whether it can safely reopen. This temporary change does not affect antenatal and post-natal services which will continue to run at the birth centre
- We have seen notable improvement in October and November despite COVID-19 pressures with weekly activity volumes delivered rising each week for most activity types

- The number of patients waiting over 52 weeks and total waiting list size levels have stabilised and we met the target levels agreed with NHS England for both total waiting list size and over 52 week waiters
- The number of patients waiting over 40 weeks has however increased, and we have 254 over 78 week waiters – the system priority is to ensure these patients are treated
- Cancer standards are being delivered and recovery trajectories for activity are within 5% of target. Cancer capacity has been fully restored
- Inpatient elective episodes have reached higher than planned levels and are delivering over 100% of historic levels
- Inpatient elective, MRI and CT are all exceeding planned levels and national targets
- Primary care activity has also reached its planned recovery levels, at 95% of historic activity. Face-to-face activity has risen to 60%
- Two week wait referrals are now at 96% of previous levels and we have put on extra capacity to see these patients
- Flu immunisation programme rate is exceeding planned rates, and we have ensured over 75% of over 65s has been vaccinated in each CCG area.

The remaining area of concern against elective plans is outpatient department activity which is 90% of planned levels. We are focused on improving this level.

5. Accessing HIOW Primary Care Services

Practices are working hard to continue to safely deliver care to the population. How patients access general practice has had to change due to coronavirus. If you need GP support, please call your practice or contact them online to arrange for you to speak to a GP or nurse over the phone or via video link as soon as possible. Face-to-face appointments are available to patients if clinically necessary, but you may be asked to discuss your conditions over the phone or online first to assess what would be most appropriate for you. Patients that do visit are asked to avoid waiting rooms or queuing and arrive at the time of the appointment. They are also asked to wear a mask, wash their hands before arriving and to socially distance.

We have promoted how local people can access primary care by supporting GP practices with an ‘access to general practice communications toolkit’. This explains how patients can safely access GP practices. We have also included messages about how and when to access primary care in our winter communications work.

Additionally, we have worked with GPs to enforce these messages through some patient facing videos, explaining how to get an appointment, and what to expect if you do get called in for a face to face visit.

6. NHS England and NHS Improvement commissioned services

NHS England and NHS Improvement South East commission a number of local services. Key updates on these are:

- Pharmacy services – These continue to remain open with some operating to different hours to ensure they are able to catch up with requests and clean
- Dentistry services – All dental practices providing NHS services are able to provide face-to-face care. All practices are offering a telephone triage service for both their regular patients and other members of the public. During this they can provide advice, prescribe medication to relieve pain or treat infections and can make a clinical decision if they feel

that the patient needs to be referred to one of the urgent care hubs if they are unable to carry out the necessary treatment at their own practice

- Optometry services **–** High street optometry practices continue to provide face-to-face routine patient appointments. However, infection control and social distancing measures mean that the number of patients who can be sight tested during testing sessions is reduced.

7. Seeking the views of local communities

It is key that we seek the views of our stakeholders, partners and local communities as we develop our restoration and recovery plans both within local systems but also across HIOW. To support this we are continuing to:

- Work with our Local Resilience Forum partners to track engagement work being undertaken by partners and other agencies to develop a bank of insight
- Work with the local authority Health Protection Boards
- Develop further work to explore people's views of digital access
- Develop further work to explore people's experience of being on our elective waiting list during the pandemic to understand how we can support them
- Plan how we work closely with Healthwatch to understand the views of our seldom heard communities
- Work with our local Primary Care Networks to support them to engage with local communities on the evolution of their services.

8. Recommendation

The Committee is asked to note this update briefing.

Hampshire and Isle of Wight - Becoming an Integrated Care System

January 2021

MOVING FORWARD TOGETHER

Contents

About this document

Hampshire and the Isle of Wight is one of the largest health and care systems in the country with a long history of working with our population and each other, unified in our mission to ***work together to make lives better.*** Our services, planning and ways of working together continue to become increasingly joined up. We have a strong track record of working together as partners, currently evident in our response to COVID-19, at the most local 'neighbourhood' level, the 'places' defined by our local authority footprints, and the 'patient flow' footprints around our hospitals as well as a whole Hampshire and Isle of Wight system.

We are uniting around our shared challenges, both local and at scale, including:

- access to urgent and emergency care
- long waits for planned care
- the resilience of primary care
- mental health provision
- workforce and financial sustainability

We are transforming health and care services and outcomes for local people by:

- Reducing complexity, making it easier to access joined up services
- Improving performance including cancer outcomes, hospital discharge and support for people with learning disabilities
- Innovating including use of digital technology such as online appointments in primary care, shared care records, workforce transformation (for example, staff passports helping us to share and more staff across the system) and new ways of delivering care such as COVID-19 virtual wards, community urgent response teams and NHS 111 First

At the end of 2020, we reconfirmed our commitment to working together and our areas of focus. We have been working as, what is nationally called, a 'sustainability and transformation partnership' (STP) since 2016. We are now more formally referred to as an 'integrated care system' (ICS).

This document introduces the Hampshire and Isle of Wight integrated care system. As the contents listed left show, this document describes why we are working together in this way, who is involved and our plans for the future.

Background

In December 2020, Hampshire and the Isle of Wight was approved as an 'integrated care system'. This new status for our system, acknowledges the great progress we have made over recent years, working together as a partnership of NHS and local government organisations, and with other colleagues, to join up the planning, transformation and delivery of health and care services for our population. In approving us an integrated care system, our national NHS regulators, NHS England and NHS Improvement, have expressed their continued support for our work to date and plans for the future.

As NHS England and NHS Improvement describe in their current proposals for *The next steps to building strong and effective integrated care systems across England*, in an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve. Similar to other integrated care systems across the country, we have been working together to coordinate services more closely, to make real, practical improvements to people's lives and deliver our shared vision for Hampshire and the Isle of Wight which is to ***'together, deliver care that is amongst the best in the world, enabling people to lead healthy and independent lives'.***

For staff, improved collaboration is already helping to make it easier to work with colleagues from other organisations. As a system, our collaboration is supporting us to better understand data about local people's health and provide care that is tailored to individual needs. Operating at neighbourhood, local place and whole system levels concurrently, drawing on the expertise of others such as local charities and community groups, we are helping people to live healthier lives for longer, and to stay out of hospital when they do not need to be there.

Becoming an integrated care system is a natural next step for us. It is an important milestone in our journey. It puts us in the best possible position to continue to adapt and respond to local need, currently so significantly shaped by the impact of COVID-19, whilst increasing the pace at which we transform services to support our population. We are also mindful that this isn't an end in itself. Moreover our integrated care system status allows us to build upon the tremendous amount of work that has already taken place both at scale across the whole of our geography and in our local communities.

Integrated care system status gives us greater freedoms to decide locally how we best work together to improve the quality and resilience of our services, reduce inequalities and improve outcomes for local people. It supports us to harness our strengths, make the most of our local focus whilst realising the benefits of working at scale.

This is exactly what we have seen in recent months across all our partners in response to COVID-19. We are immensely proud of all that has been achieved. We have worked together to support each other and transform our health and care services to respond to COVID-19. By working together, the restoration of services across Hampshire and the Isle of Wight is amongst the best in the country. Along with this, our combined system response to step up the biggest vaccination programme in history has been highly commended and is a credit to everyone involved.

With the benefit of integrated care system status, now is the time to develop an even deeper social movement of people and communities to address inequalities and to improve health and wellbeing for the population. Additionally, as NHS organisations, we know we have scope to play a full part in social and economic development and environmental sustainability, through our employment, training, procurement and volunteering activities, and as a major estate owner.

As a system, we have discussed our ambition to hold onto this momentum and capitalise upon the greater freedoms we have now earned to accelerate our work together. Aligned to the proposals set out by NHS England and NHS Improvement in their consultation document we plan to further develop:

- even stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- collaborative arrangements across the whole of Hampshire and the Isle of Wight and in local systems, bringing together the organisations which provide care in our hospitals and in the community, to join up services and operate at scale where it makes sense to do so; and
- our service planning and improvement (sometimes referred to as 'commissioning') capabilities with a focus on improving health outcomes for our population.

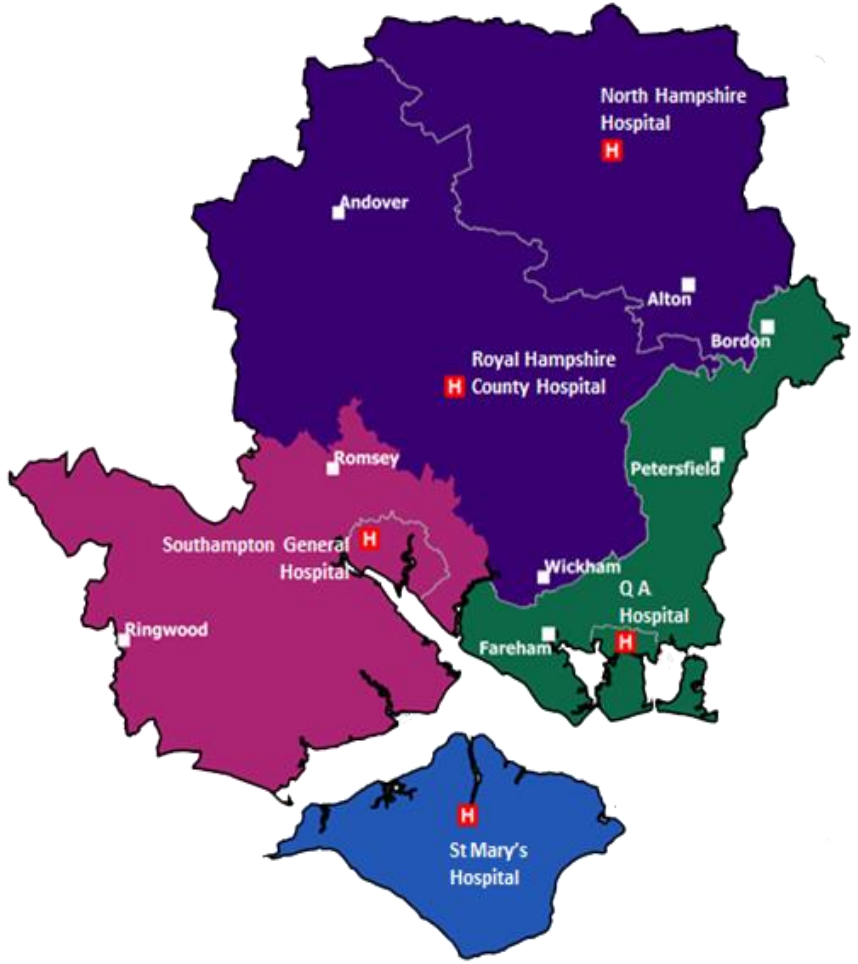
The Hampshire and Isle of Wight system

Hampshire and the Isle of Wight is one of the largest health and care systems in the country with a long history of working with our population and each other, unified in our mission to ***work together to make lives better.***

We serve a population consisting of the area covered by seven of the eight Hampshire and Isle of Wight Clinical Commissioning Groups (CCGs) - Fareham and Gosport, Isle of Wight, North Hampshire, Portsmouth, South Eastern Hampshire, Southampton City and West Hampshire*.

Our footprint covers all of the areas served by the Isle of Wight Council, Portsmouth City Council and Southampton City Council and the vast majority of Hampshire County Council. The long established Frimley area is outside of our footprint – serviced by NHS North East Hampshire and Farnham CCG. **The population we serve totals 1.8 million**.

In the Hampshire and Isle of Wight system we have **154 GP practices**, working in **42 primary care networks**, and over 900 suppliers of domiciliary, nursing and residential care. We also have over 300 community pharmacies, more than 200 providers of dental services providing a range of general dentistry and orthodontics and nearly 200 providers of optometry services. The majority of our **acute, mental health and community NHS care** is supplied by Hampshire Hospitals NHS Foundation Trust, Isle of Wight NHS Trust, Portsmouth Hospitals University NHS Trust, Solent NHS Trust, Southern Health NHS Foundation Trust, South Central Ambulance Service NHS Foundation Trust, and University Hospital Southampton NHS Foundation Trust. Whilst all our NHS providers have specialised services, University Hospital Southampton is a tertiary provider, meaning it provides highly specialised services such as specialist paediatric services across the south of England, with Southern Health and South Central Ambulance Service also providing care across a wider footprint. Our population also accesses care from providers based in Dorset, Wiltshire, Surrey and Sussex.



* In April 2021, all the above CCGs with the exception of Portsmouth will merge to become the Hampshire, Southampton and Isle of Wight Partnership of CCGs

Our case for change

We understand our key challenges and know that our current ways of working need to be refined to help us better support local people. Our 'case for change' is based on the fact that we have:

- **an ageing population** – partly as a result of more successful treatment for long-term illnesses or injury – and that means increasing demands on health and social care
- some communities experiencing unacceptably poorer access, outcomes and life expectancy than the rest of our population. Across our footprint the **difference in life expectancy is 12 years**
- **variable quality and resilience of primary and community services**, with some people reporting difficulty accessing care, especially in light of COVID-19
- **challenges in sustaining high quality hospital based care** particularly in older buildings, and with growing waiting lists for planned (elective) care
- **challenges in recruiting and retaining the workforce** we need
- **a growing financial challenge** with significant financial challenges across local authorities and a number of local individual NHS organisations unable to meet their financial control totals

We also know that local people want:

- more choice and control over their health and wellbeing, and care tailored to their individual needs
- clear accessible information that allows them to better manage their health and care
- greater access to urgent and emergency care
- better, safer care for major health conditions

Over the years we have adopted a variety of different approaches to resolve these challenges. We know that continuing to operate as we have done in the past will limit our ability to deliver and sustain the change required. We need to reform the system in a way that best allows us to improve the health and wellbeing of our population, their patient experience and the financial sustainability of our system.

We know that we must take the best combination of working through local teams and at other times 'at scale', to harness our strengths; making the most of our local focus whilst realising the benefits of working across a wider geography.

"Health and care systems around the world are adapting to respond to the changing needs of their population. In Hampshire and the Isle of Wight, now is the time to harness our strengths, make the most of our local focus whilst realising the benefits of working at scale. It is important that we retain all that we have learnt and delivered during 2020. This is a really exciting opportunity for us to build on the many positive examples of change during COVID-19, to transform how we work and ultimately deliver better outcomes for local people.

Lena Samuels, Chair, Hampshire and Isle of Wight Integrated Care System

What will change?

Change has always happened in the NHS, to keep pace with new treatments, technology, techniques and medicines, all of which need to be provided and supported by staff with enhanced skills. For example, many procedures that would previously have been carried out in hospital are now done in a day, often in local GP surgeries and clinics. Now, more than ever before, the NHS needs to continue evolving to meet the needs of our population. This can only be successfully achieved through more coordination of health and social care services, new approaches to prevention and wellbeing, and the integration of care across different settings. High quality services, whether at home, in the community or in hospital, should be available to everyone.

Current ways of working sometimes make the integration or coordination of services difficult. We need to tackle this, finding the best possible ways of working across organisational and team boundaries. Whilst a number of decisions need to be undertaken independently, in future we see the overwhelming majority of the work to understand the needs of our population, and subsequently plan, transform and deliver our services, being undertaken collaboratively, through the various elements of the integrated care system we are building together.

Operating as an integrated care system is central to our ability to implement the change required and cater for the evolving needs of our population. For some elements, it makes most sense for our hospitals, community services and GP practices to plan, transform and co-ordinate services alongside local authority colleagues and other partners, in geographies based around our larger hospital footprints. For others, it makes sense to plan and deliver transformation together based on our local authority footprints, or at the scale of Hampshire and Isle of Wight, or even beyond.

To many, the arrangements we are putting in place will be nothing new. As a health and care system, we have a long history of partnership working, with organisations and system arrangements morphing and changing over the years. Our notable partnerships include integrated commissioning arrangements between health and local authorities, underpinned by section 75 agreements and the Better Care Fund; our early vanguard work, such as My Life a Full Life on the Isle of Wight and Better Local Care in southern Hampshire; and our approaches to integrated urgent care with NHS 111, urgent care, community services and general practice.

Many of our staff have long been working across organisational boundaries to improve care for local people. Becoming an integrated care system, helps us respond formally to the things our workforce has been telling us needs to happen.

We are also changing the way we spend our money. In the past, we used our investment primarily to respond to the pressures and demands faced by our acute hospitals. We are making a shift of investment to strengthen prevention, personalised, primary and community care; whilst also making investment into our hospital sector. We are also investing in our estate; we will invest over £200m in new facilities over the next few years and have ambitions to invest more in our poorer estates.

Our shared vision

We have worked with local people and a wide range of partners from across the system including clinicians, staff, elected members and Healthwatch to reach a shared vision for the future.

In developing the vision, mission and goals (see right) for our integrated care system, we discussed with local people and other stakeholders, the strategic challenges we face and the work we need to do to overcome them, along with the ambition we have for both our services and the health of our population. Our plans to deliver this vision and overcome our historical challenges are set out in our Strategic Delivery Plan (2019).

The system vision, mission and goals build upon those of our constituent partner organisations and local places. They describe what we aspire to achieve by working together at scale, what we stand for as a system and the impact we intend to deliver for the benefit of local people.

In establishing the Hampshire and Isle of Wight Integrated Care System, we are evolving our culture and refining our leadership and partnership working arrangements to enhance our ability to deliver our vision and plan. We are enabling organisations and places to work even more effectively together to make the most of our resources, tackle the challenges we face, redesign care and ultimately improve the health and wellbeing of the population we serve.

Our vision

Together, we will deliver care that is amongst the best in the world, enabling people to lead healthy and independent lives

Our mission

Working together to make lives better

Our goals

To use our resources to the benefit of local people

To deliver the future in our plans

To empower people to lead healthy lives

To deliver a quality of care for local people of which we can be proud

To create a health and care system for Hampshire and the Isle of Wight within which people want to work

"I am looking forward to building on the great progress that has already been made in establishing the Integrated Care System. I continue to be hugely ambitious for Hampshire and Isle of Wight, for the people we serve and for the health and care services we provide. Transformative change happens when we create the conditions in which teams are able to work together across organisational and professional boundaries to innovate and transform services. This is exactly what we have seen in recent months across all our partners in response to COVID-19 and I'm immensely proud of all that has been achieved. Now is the time to develop an even deeper social movement of people and communities to address inequalities and to improve health and wellbeing. **Maggie MacIsaac, Chief Executive Officer, Hampshire and Isle of Wight, Integrated Care System**

Involving local people

We have a strong track record of involvement and are excited by the potential to engage with our communities as a whole system in new ways and on new topics in the future. Our work will build on the heightened levels of interest in health and care that have developed as a result of COVID-19 and the relationships forged through our partners in the Local Resilience Forum such fire, police and the community sector.

System partners have continued to engage with local people, reaching over 10,000 members of our communities, staff and stakeholders including colleagues from our emerging primary care networks. This engagement on key topics has given us a strong understanding of local issues, attitudes, and concerns, and our approach to engagement at a system level is to build upon the extensive work of our partners. Involving local people will remain core to the development of our integrated care system. Working together as a partnership, we have developed our ambition for patient and public involvement:

- A common vision for patient and public involvement across our system
- A culture where the patient, carers and the public are at the centre of all decision making and where we continually learn from them and their stories;
- A system where leaders and staff have relevant training and understanding of the mechanisms and benefits of patient and public involvement;
- A shared way of working with the ability to work across organisational boundaries for the benefit of patients, carers and the public;
- A system where it becomes easier for people to engage and communicate

In addition to this work we plan to establish an Integrated Care System Assembly. Facilitated by our Chair, the Assembly will be made up of political, clinical, executive, and community leaders from across the system who meet twice a year and act in an advisory role. Recent examples of their work includes development of our system vision and values.

Hampshire and Isle of Wight Voices

We strongly believe in the profound importance of meaningful involvement to ensure residents, patients and staff have an opportunity to shape plans. It is critical that everything we do is grounded in a genuine appreciation for what people feel is important. There are a number of ways we do this, including volunteer programmes, events, workshops, focus groups and one to one involvement. This contributes towards our culture of involvement, co-design and coproduction. To complement this work, in 2019 we developed our citizens' panel - Hampshire and Isle of Wight Voices.

The panel is a representative, consultative body of local residents who support our work to identify local priorities in order to improve the health and wellbeing of our communities. Our 3,000-strong panel enriches our ability to engage with the seldom heard, those not currently involved and those who are disinterested in health and care services. Through our surveys we gain valuable insights and elicit views on specific research questions to inform our assessment of need, decisions on priorities and service design and improvement.

Recent surveys have focused on understanding people's attitudes and capability with respect to accessing care digitally. Interestingly those at high risk of COVID-19 were most likely to have started using digital channels for the first time. Personal interaction remains key to a 'very good' experience of care with 78% of respondents rating their experience of telephone appointments as good or very good. Such insight is helping to shape the development of access to primary care as well as supporting outpatient transformation.

The impacts for local people

Working in this new way will mean that more people have access to higher quality services and better health outcomes for themselves and their families. In fact, we are already enacting many of our plans, with teams working together to care for people experiencing the effects of COVID-19 whilst continuing to support those with other health and wellbeing needs.

By working together we have:

- planned and commenced the biggest flu and COVID-19 vaccination programmes in history, ensuring we quickly and safely protect local people from the threat of serious illness;
- established community urgent response teams across the whole of Hampshire and the Isle of Wight which support people at, or close to home, to reduce the need for them to be admitted to hospital;
- prepared for an increase in ill health over the winter months by ensuring we have appropriate critical care capacity and we avoid any potential care home failures, discharge delays and loss of capacity within our GP practices.
- established 'virtual wards' to enable clinicians to monitor patients' health remotely. This enables a quick response if a person's health deteriorates, reduces the need to be admitted to hospital whilst also allows people to be cared for in community settings, which are often more familiar;
- implemented NHS 111 First across Hampshire and the Isle of Wight, building on the learning from the initial roll out in Portsmouth. This provides people with quicker access to care that is right for their needs;
- committed to addressing inequality and inequity of access to services across Hampshire and the Isle of Wight. Working with district, borough, unitary and county councils, police and housing partners, we are supporting some of the most vulnerable people in our community - those living in poverty and people who are homeless.

We building community resilience, shifting focus from symptoms to the place where people live their lives. For example, our work to gather detailed intelligence about the 1,700 people who are homeless across our system, their medical conditions, and average age has been critical during COVID-19. This has meant that to date, not one person in emergency or hostel accommodation contracted the virus. This join up in care, support, action and insight is truly game changing.

Increasing the capacity of primary level mental health services

By joining up social housing and health services we are beginning to tackle - in a completely new way - the inequalities experienced by some of our most deprived communities. In collaboration between housing partners and primary care networks, we are improving the health and wellbeing of social housing tenants who fall below the statutory threshold to access secondary mental health services. We have trained front line housing officers, tenancy support and homelessness prevention teams in Mental Health First Aid and Connect Five training. This has built their competence and confidence in supporting tenants with poor mental health, increasing community self-care and wellbeing, and ultimately reducing demand for GP services and high intensity users of 111 and 999 services, with the case below saving the NHS £17,000 p.a.

Following a referral from his GP, *"Mr X presented to us with worsening mood as a result of a burglary. His mental health was clearly impacted as a result of this and his home environment played a key role in how he perceived his own mental health. The team were able to work with him directly and became a pivotal part of his care during this difficult period…he became less reliant on primary care as a result. The overall effect was a better outcome for the patient and reduced attendances to his practice."*

Our integrated care system – key components

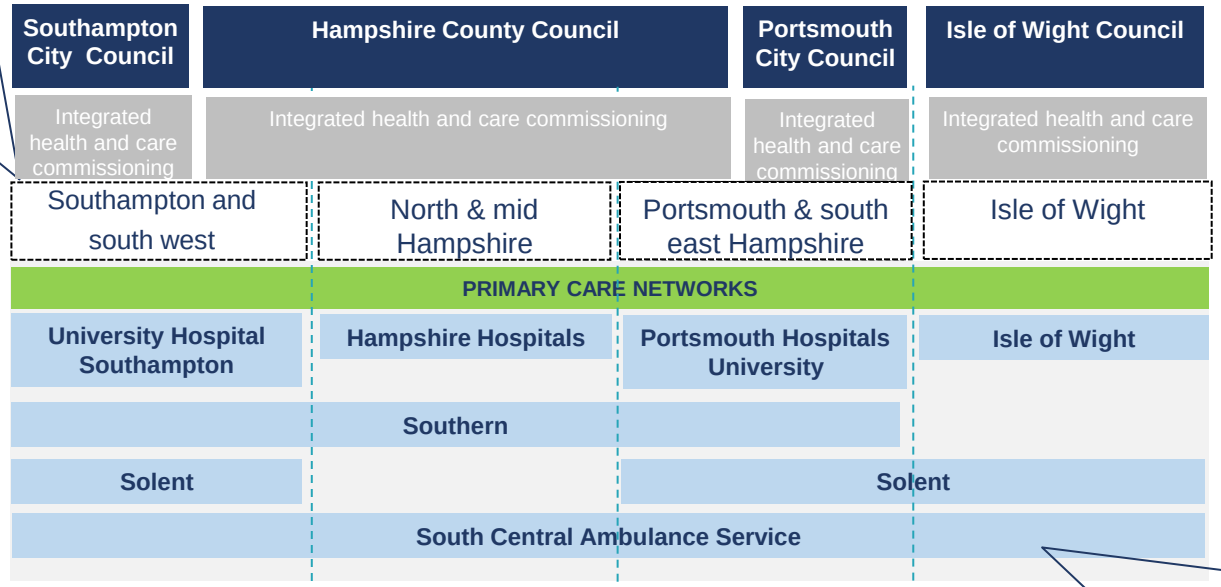
Upon becoming unwell, a member of the public in Hampshire and the Isle of Wight could have interactions with any number of our services depending on their specific needs. Here we describe how these different components will work together to provide the best possible care.

Local partnerships bring together NHS organisations, local authorities and other partners to co-ordinate and improve the care and hence health and wellbeing of people in their area. In Hampshire and the Isle of Wight we have four geographies, based on how patients 'flow' through the NHS system and which hospital services are used by which communities.

An example is Portsmouth and south east Hampshire. Here, organisations such as Portsmouth Hospitals University NHS Trust, South Central Ambulance Service, Southern Health NHS Foundation Trust, Portsmouth City and Hampshire County Councils, Solent NHS Trust and local GP practices will work together to ensure that people are cared for in the best possible way.

The discussions and decisions will vary between geographies, remaining responsive to local need.

Our **four upper tier local authority** areas will continue to be the focus for place-based planning and for aligning health, care and other sectors to deliver improved outcomes. Partners work together to further improve wellbeing, independence and social connectivity through the wider determinants of health including education, housing, employment, leisure and the environment.



Our 42 primary care networks are the foundation of our health and care system, where the majority of our 154 general practices work together in networks and with statutory and voluntary community health and care services. Working in teams of people with a variety of expertise, they deliver joined up care to support the mental and physical health and wellbeing of the population, proactively managing the health needs of the population they serve.

The Hampshire and Isle of Wight acute alliance comprises our hospital trusts working together to improve such things as the amount of time people wait for inpatient treatment and access to diagnostics.

Our community and mental health alliance involves Southern Health NHS Foundation Trust together with Solent and the Isle of Wight NHS Trusts working to tackle challenges such as ensuring people with severe mental illness are cared for as close to home as possible.

The Hampshire and Isle of Wight People Plan

As the panel right, summarises, across Hampshire and the Isle of Wight we currently employ 96,500 people in clinical and non-clinical roles, all of whom make up our rich and diverse system.

In 2020, we produced the Hampshire and Isle of Wight People Plan which describes our ambitions for our highly valued workforce.

It outlines the actions we will take to deliver a system wide approach to workforce planning across health and care. It also refers to the learning from our response to COVID-19.

WORKING AT SCALE

Collaborating | Developing | Expanding

We have identified a range of actions we believe will benefit from 'at scale', whole-system working for each area of the national people plan and assessed how achievable they will be to deliver, the scale of benefit and level of risk. They include:

LOOKING AFTER OUR PEOPLE...

Working together we will:

- Develop **communities of practice** within health and wellbeing, diversity and inclusion and Freedom to Speak Up to focus on best practice and increase consistency of approach
- Increase **flexible working** opportunities across our system by developing shared principles and approaches to how we recruit, promote and develop our staff
- **Open access to occupational health** provision (regardless of host organisation) so staff can use the service closest to them and where appropriate, swiftly access the treatment they need
- Deliver and grow our **keyworker housing** programme so our staff are supported to find good quality and affordable housing

NEW WAYS OF WORKING AND DELIVERING CARE...

Working together we will:

- Develop a **returners and reservists strategy** so we have additional staff we can call on in times of need
- Prepare our workforce to be confident and competent with **digital transformation** so they embrace change and can better support they people they care for
- Introduce **new roles**, in partnership with Health Education England, so we offer exciting career development opportunities and better support our existing staff
- Increase our **portability programme** to other parts of the system so we make best use of our most precious resource and to enable people to rotate, work as part of a HIOW collaborative bank and redeploy into other roles
- Implement our **collaborative bank** to increase workforce opportunities, align terms and conditions and reduce agency and locum usage

Our Hampshire and Isle of Wight people plan describes our ambitions for the 96,500 highly-valued people working within our health and care system. It outlines the actions we will take to deliver those ambitions, what learning we have taken from our response to Covid-19 and what we have achieved so far by working together.

OUR PEOPLE PLAN AMBITION

To take a system-wide approach to workforce planning across health and care in Hampshire and the Isle of Wight that focuses on the areas of greatest need or potential and strengthens the alignment between NHS provider organisations social care, primary care and the independent sector.

OBJECTIVES - WE WANT TO:

- ensure we have enough people with the right skills, experience and values now and for the future
- create healthy, inclusive, empowering and well-led cultures people want to join and stay working within
- provide exciting ways of working and accessible career opportunities that use all the Hampshire and Isle of Wight care system has to offer.

ENHANCING BELONGING IN THE NHS...

Working together we will:

- **Share leadership development** programmes and create more system focused programmes so our leaders learn and create system solutions together
- Create talent management processes across our system which ensure there is **greater diversity of talent** within very senior roles
- Create a workforce which is **representative of our communities** at all levels through targeted recruitment, development and talent management

GROWING OUR WORKFORCE...

Working together we will:

- Deliver our **nursing supply programme** to ensure we have sufficient, high quality nurses across our system and value and support our student nurses
- Review our **education and development** functions to identify what could be done at scale and how we can open course access to all (regardless of host organisation)
- Transform how we recruit new staff, through the introduction of an Isle of Wight **recruitment portal**, shared campaigns to inform and embrace our future workforce and collaborate in areas such as **international recruitment**
- Develop a Hampshire and Isle of Wight **Apprenticeship Academy** so we give every opportunity for people to reach their true potential

Next steps

Our immediate steps to improve the way we care for local people and support their health outcomes include:

- a keen focus on the wider determinants of health, such as housing and employment, and reducing inequalities, utilising population health management techniques which allow us to analyse information and develop targeted approaches in partnership with our colleagues in academia, police, fire and the pharmaceutical industry;
- working with teams to align local plans and ensure that the whole is greater than the sum of its parts. This will involve addressing long waits for planned inpatient care, our urgent and emergency care performance and investment in mental health;
- continuing to work collaboratively during winter, the second wave of COVID-19 and to address the related longer term health, wellbeing and wider socio-economic impacts;
- improving our system business intelligence capability, developing a single data repository to enable a significantly more efficient method of collecting and analysing our data to inform decision making at all levels;
- full population health management capability embedded at all levels of the system;
- better understanding people's experience of care during COVID-19 and the learning we can take from this to improve support for our population in the future.

The simplification of our commissioning arrangements is also essential, with plans underway for six of our seven CCGs to formally merge in April 2021. The merged CCG will be organised with the flexibility to maintain a strong local focus as well as achieving the benefits of working at scale. Working closely with colleagues in Portsmouth CCG, and through Hampshire and Isle of Wight wide strategic commissioning arrangements, we will ensure a streamlined approach towards local and pan-system decision making.

As mentioned on page 10, we will have local teams with a local budget for each place in our system; they will hold the responsibility for the planning of health services for the local population and local decision making authority, enabling the important work with primary care, local government and alliances with provider partners described in our application to be effective. Our aim is to retain the benefits of the current CCG model – the local focus, local relationships with partners and local clinical leadership – whilst also gaining greater benefits of working together at scale.

The system is led by our Chief Executive Maggie MacIsaac and our Chair Lena Samuels. In addition, we are currently recruiting to a set of executive joint roles across both the integrated care system and the Hampshire, Isle of Wight and Southampton Partnership of Clinical Commissioning Groups. This team of people, along with clinical, local authority and NHS trusts executives, non-executive directors and Healthwatch will form our Integrated Care System Partnership Board, the decision making body for our system.

We are aware of the need to further develop as a system, recognising the context of COVID-19. We are also aware of the need to keep our plans live and responsive to any developments in national guidance, such as the current national consultation regarding legislative change. We are committed to the following:

- The development of our system wide alliances to further evolve community and mental health models of care, and the networking of acute care provision
- Continuing work on our financial plans to move towards financial balance and shared financial risk, developing the capability to undertake sophisticated modelling of the current and future health and care needs of our population
- Ongoing development of our alliances in place which supports local leadership, governance and transformation, with strong clinical leadership including primary care reflected in these arrangements.