NHS
Hampshire and Isle of Wight




Hampshire and Isle of Wight - Forward Plan

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Introduction

Building a better future together

The Hampshire and Isle of Wight integrated care system is committed to improving the health, happiness, wealth and wellbeing of the population. Building on our strong track record of working together as partners and with local people, we look to the future with great optimism. We are united in our work with people and communities, creating a society in which every individual can thrive throughout the course of their life, from birth to old age. Our mission is to deal with the pressures and challenges of today, seize opportunities and together build a better future.

We are focused on the following aims for our integrated care system. In doing so, we will reduce the demand for health and care services, further improve the quality of service we provide, relieve pressure on the people who work in our organisations and be able to live within our financial means.

Our joint forward plan is set in the context of an increasingly difficult operating environment for all partner organisations. Overall, our population is ageing and living with increasing frailty and multiple health needs, and some of our communities are amongst the most deprived in the country. Our system has recovered relatively well in operational service delivery terms following the pandemic but is significantly financially challenged.

The scale of the challenge faced by the system requires a multi year recovery focus, which not only addresses core aspects of the drivers of the deficit, but also addresses long standing issues which have resulted in fragmented and inconsistent pathways of care, resulting in inequity for our patient population.

Addressing the issues that affect people's health and wellbeing in such a challenging environment requires us to think differently. This plan, alongside our partnership strategy, is a living document. It will continue to iterate as we evolve and embed new joint working arrangements and make progress together. Our strategy and plan is not about simply doing more, it is about taking a radically different approach, and always improving services.

Our two-phase plan

Resetting the system: Our focus in 2023/24, is on 'system reset', recovering activity levels, staffing and spend to pre pandemic levels, including through enhanced grip and control and priority transformation programmes focused on urgent care, local care, discharge and elective care, with NHS and wider partners at system and through local delivery. This reset and transformational work will enable us to eliminate our system deficit by the end of 2024/25 and continue to impact positively in the longer term as we realise the benefits of working together as an integrated care system, developing new care models, maximising capacity and reducing unwarranted variation.

Renewed focus on population health and wellbeing: Alongside our system reset, our renewed focus on population health and wellbeing will deliver impact through prevention and health promotion in years 1-3 and ultimately, in the longer term, improve the health, happiness, wealth and wellbeing of the local population; thus reducing the need for health and care services.

The population we serve

The Hampshire and Isle of Wight integrated care system is the 10th largest of the 42 systems across England. Our four places – Hampshire, Portsmouth, Southampton and Isle of Wight - are the foundation of our system.

Overall, our population is ageing and living with increasing frailty and multiple health needs, especially in rural areas, particularly west Hampshire and the Isle of Wight. In urban areas such as Southampton, Portsmouth, and north-east Hampshire, the population is more ethnically diverse compared to the rest of the area (overall 93.8% white). There are also higher levels of deprivation and mental health vulnerability in these areas. The age of people living on the Isle of Wight is similar to other places popular with retirees, but more people live alone. We also have coastal communities; 92.7% of the Island's population are resident in areas defined as coastal. These areas have lower life expectancy and higher rates of many diseases.

Healthy life expectancy has decreased in most areas, meaning people are living more of their lives in poor health. This is particularly the case for people living in the most deprived areas. Smoking, poor diet, physical inactivity, obesity and harmful alcohol use remain leading health risks, resulting in preventable ill health. In Hampshire and Isle of Wight we see:

- Higher levels of emergency care compared to the rest of England, especially in more deprived areas, where access to primary care, outpatient and planned care are lower.
- Deaths from cancer, circulatory and respiratory diseases are the greatest causes of the differences in life expectancy between the most and least deprived. More deprived areas see higher levels of heart disease, diabetes, chronic obstructive pulmonary disease and mental health issues. People living in these areas are also more likely to experience not just one, but multiple ongoing health conditions.
- A boy born in our most deprived areas will live on average between 6.1 years to 9.1 years less compared to a boy born in our least deprived area, and for a girl, between 2.3 years to 5.5 years less.
- Covid-19 has created additional health and social care needs and

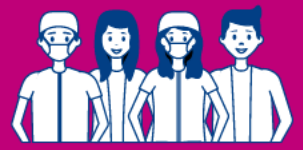
  disproportionately impacted people living in more deprived areas, people with learning disabilities, older people, men, some ethnic minority groups, people living in densely populated areas, people working in certain occupations and people with existing conditions.
- Premature mortality in people with severe mental illness is higher than the national average on the Isle of Wight, Southampton and Portsmouth.

Alongside our work as a whole system partnership, various partners will continue to work together to do all they can to meet the health and care needs of local people in increasingly effective ways. This includes:

- Partnerships in each of our places, e.g., Hampshire, Southampton, Isle of Wight, Portsmouth and at neighbourhood level;
- Partnerships working with people with very specific needs, for example around housing;
- Collaboration within 'sectors', e.g.: primary care, acute hospital trusts and the voluntary and community organisations.

Hampshire and Isle of Wight

77,500



NHS AND SOCIAL CARE STAFF

3 ACUTE HOSPITAL TRUSTS

4 HEALTHWATCH PARTNERS

SERVING A POPULATION OF

1.9 MILLION

WHO WE ARE:

- 139 GP practices
- Over 200 optometry services
- 42 primary care networks
- Over 200 providers of dental services
- Over 900 suppliers of domiciliary care
- 2 community and mental health trusts
- Over 300 pharmacies

AN ALLIANCE OF VOLUNTARY AND COMMUNITY ORGANISATIONS WORKING IN PARTNERSHIP

ANNUAL BUDGET:
£3.8 BILLION

OVER 19,300
BIRTHS ANNUALLY

1
AMBULANCE SERVICE

1
ONE INTEGRATED TRUST PROVIDING ACUTE, MENTAL HEALTH, COMMUNITY AND AMBULANCE SERVICES

4
UPPER TIER LOCAL AUTHORITIES:

AND 10 DISTRICT AND BOROUGH COUNCILS

Tackling health inequalities

Our Public Health Directors and their teams, have been central to our work as a system in understanding and addressing health inequalities common across our geography and specific to our local places, neighbourhoods and communities. Our Prevention and Inequalities Board provides strategic leadership in ensuring we maximise health and wellbeing through the prevention of ill-health and the reduction in health inequalities, by working together as a system and with communities. Tackling inequalities features as a core pillar across the breadth of our joint forward plan priorities. Through the work of our Inequalities Board, we bring together clinical, managerial and public health leadership to focus on defined priorities, provide leadership for the development and implementation of the prevention and inequalities elements of the Integrated Care Strategy and joint forward plan to ensure our system wide work and plans align with place-based plans such as Health and Wellbeing Boards and place-based partnerships.

Our system wide **work programmes** include use of the Core20plus5 framework to reduce healthcare inequalities and leadership for the five high impact actions to reduce health inequalities:

1. strengthening leadership and accountability
2. restoring elective services inclusively
3. mitigating digital exclusion
4. improving data recording with a focus on ethnicity
5. accelerating prevention

Our Prevention and Inequalities Board has agreed the **plus priority adult populations** for Hampshire and Isle of Wight:

1.People experiencing homelessness
2.Minority ethnic communities most affected by Covid-19
3.People with a learning disability
4.People with a Serious Mental Illness
5. Asylum seekers, refugees and unaccompanied minors

Our Prevention and Inequalities Board has also agreed the **plus priority children and young people's populations** for Hampshire and Isle of Wight:

1. Looked after children and children leaving care
2. Children experiencing homelessness
3. Children in gypsy and traveler communities
4. Children of adults in the Core20plus5 groups

In relation to Core20plus5, core delivery programmes are in place to reduce inequalities in access, experience and outcomes for our plus populations including those experiencing homelessness, those with a serious mental illness and asylum seekers and refugees .This includes the Health Begins at Home programme, work on intermediate care via a specialist homelessness in reach service into Portsmouth Hospitals Trust, a mental health transformation "step out of housing" model, trauma informed specialist outreach, work to build on the 'Everyone In' initiative and a Minding The Gap programme. For those with Serious Mental Illness there is an Advancing Mental Health Equalities programme which oversees the delivery plan covering areas such as No Wrong Door, co-occuring conditions work and a new aligned model of support aligned to primary care networks building on the voices of people with serious mental illness. Through this programme there has been a continued improvement in the number of people with serious mental illness receiving a physical health check. There is also an Afghan Mental Health Project which aims to better understand the mental health needs of Afghan refugees living in hotels in Hampshire. There is also a Core20plus5 Community Connectors programme which is bringing forward the voice of lived experience into service redesign and an innovative health hub model which has provided a wide range of health services to communities including those from the more deprived areas in non-traditional settings.

We are working with local communities to understand what is most important to them

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In developing this plan, we have reflected on insight from our local communities, which partners across the partnership have sought in a number of ways. We considered the below in creating our strategic priorities.

What we did

- Surveys on a range of topics, online and face to face, in clinical and community settings, with many directly targeted to different local communities
- Co-design groups, workshops and events on topics such as our community involvement approach, digital transformation and the development of the new integrated care partnership
- Attended local community events, both in person and virtually
- Discussed issues at regular integrated care board and other groups with representatives from across communities
- Focus groups on a range of topics
- Funding partners such as Healthwatch and community groups to undertake targeted research
- Engagement programmes to support procurement and transformation plans

What we heard

- People want more join up between different services, from GPs to hospitals to social care; education and housing too
- People want to be more involved in how their care is delivered, to have better communication with health and care services, and be clearer about what is available to them
- Access is an issue, with people identifying the need for more specialist access and shorter waiting times, and more consistent support services across our geography
- Whilst people say digital technology has its benefits, it is important to ensure that no-one is left behind. Face to face appointments are still highly valued
- Cost of living is a concern across the system. Also people see opportunities to improve and expand the health and care workforce including use of volunteers
- Other issues weigh on people too. For example, in rural areas, equipment and plant theft are big concerns. In urban areas people are concerned with protecting their homes and property
- Travel for Access patients need services to be accessible; having them nearer to home, access to good transport links, including public transport.
- Carers and young carers support, and greater collaboration with schools, primary care and other health services is vital

Financial context

The NHS in Hampshire and Isle of Wight receives £3.8bn for the health and care of its population, equating to approximately £2,000 per head of population. This is a relatively high level of funding per head of population compared to the rest of the country; however, in the context of increasing demand for services and rising costs, we will continue to see a challenged financial environment.

Nationally and in our system, local authorities are facing financial pressures in adult and children's social care, public health and the broader services that impact health and wellbeing outcomes. At the same time the health and care system faces further activity, workforce and financial challenges going forward across the NHS, local authorities and the voluntary sector.

All NHS organisations have a statutory duty to break even. In 2022/23, the Hampshire and Isle of Wight system reported a deficit.

Over 2023/24 and 2024/25 we will 'reset' our financial position, to return to a balanced breakeven position.

[Placeholder for chart of trajectory to breakeven]

We are on a journey to return to a sustainable and balanced financial position, over the coming years, which will require achievement of the joint aims set out in this plan, to transform and reshape our services to meet the needs of our population and live within our means.

The scale of the challenge faced by the system requires a multi year recovery focus, which not only addresses core aspects of the drivers of the deficit, but also addresses long standing issues which have resulted in fragmented and inconsistent pathways of care, resulting in inequity for our patient population.

Addressing the issues that affect people's health and wellbeing in such a challenging environment requires us to think differently. This plan, alongside our partnership strategy, is not about simply doing more, it is about taking a radically different approach.

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Longer term financial strategy

Following our return to financial balance, our collective transformation will continue over the following 3-5 years, to develop a stable, sustainable and affordable model of care.

With our partners, we will review and reshape our total investment in health and care to increase the proportion of spending in primary, community and mental health care, to better prevent and manage healthcare needs and reduce growth in demand for the most expensive hospital and specialist services.

We will achieve this by:

- Supporting the capacity and stability of primary care, pharmacy, optometry and dental services across Hampshire and the Isle of Wight to ensure people can access the right care when they need it.
- Commissioning to actively reduce health inequalities across our populations.
- Work with our local authority partners and the wider Integrated Care Partnership to ensure our collective resources are keeping people safe, well and healthy, including through using section 75 arrangements to further integrate services.
- Working together to carefully prioritise capital investment in Hampshire and the Isle of Wight, to achieve our strategic goals, unlock transformation, and support better healthcare.
- Developing our business intelligence and strategic commissioning capability, so we can analyse and review spending in new ways to align our spending more closely to the current and future health needs of our populations.
- Reshaping our contracting models and financial flows where needed to support transformation, including moving away from transactional ‘fee for service’ models to exploring contracting for whole care pathways, or for ‘year of care’ for specified patients or populations.
- Looking across care pathways from primary care to community, acute and specialised care to identify opportunities to deliver care more effectively and efficiently, capitalising on the opportunities presented by the delegation of primary, pharmacy optometry and dental, and specialised commissioning from NHS England to integrated care boards.

Understanding our challenges

NHS Hampshire and Isle of Wight

The scale of the challenges faced by the Hampshire and Isle of Wight system requires a multi-year recovery focus, which addresses long standing issues which have resulted in fragmented and inconsistent pathways of care, resulting in inequity for our patient population, as well as core aspects of the drivers of the financial deficit.

Productivity

- **Productivity has declined**; despite a rise in income there has been a decline in financial positions since 2019/20
- **Occupied Bed Days have increased**. People are spending more time in a hospital bed after treatment has ended due to challenges in getting them back to their usual place of residence
- **Workforce costs have risen**: There is increased use of temporary staffing despite core workforce numbers increasing.
- **Non-pay costs are higher than envisaged.** The cost of drugs and services are higher than planned

Excessive System Pressures

- **Emergency activity has risen** above 2019/20 levels and 8% higher than nationally.
- **Rising emergency lengths of stay**, partly due to delays in discharge linked to the availability of physical and mental health and care services in the community.
- **Short-term operational pressures** has led to inefficiencies and under-delivery of Cost Improvement Programmes (CIPs); many focused on closing escalation beds, improving discharges, reducing agency spend and improving procurement, which were not delivered due to a mix of activity levels and inflation.

Population health needs

- **Significant areas of population growth in some areas of the system.** Test Valley and Basingstoke and Dean - 12% and 10% respectively compared to 6% England average (2011 – 2021).
- **Models of proactive, preventative physical and mental health care not yet scaled** to impact across the system footprint. Outcomes and activity indicate that focusing on cardiovascular disease prevention and proactive care for older people are priorities

Underlying Challenges

- **High levels of independent sector choice** within the Hampshire and Isle of Wight integrated care system
- **Some estates are no longer fit-for-purpose** leading to inefficient use of buildings.

Structural Issue

- Delivering 24/7 services on the Isle of Wight requires **additional cost to ensure sustainable and resilient service delivery**
- The Hampshire and Isle of Wight system is over target for its population allocation, and as at 2023/24 a significant reduction is required

In order to address these challenges we have identified priority transformation schemes that will support the rebalancing of the system in the medium term alongside the longer term impact of our interim integrated care strategy.

Approach to planning: system recovery and transformation

NHS Hampshire and Isle of Wight

In developing our joint forward plan, with a particular focus on system recovery, we have concentrated on four key areas. These elements also set us up for the delivery of our broader integrated care partnership strategic priorities.

System working

Systems working

Establishing shared accountability and system wide risk-management, quality impact and programme delivery architecture

Productivity and efficiency

Productivity and efficiency

Collective focus on addressing pay and non-pay opportunities including temporary staffing and areas of significant growth in 2022/23

Establishing grip and control

Grip and control

Establishing effective governance, monitoring and reporting to ensure we are jointly tackling the scale of our financial challenge in a proportionate, responsive and robust way

Developing new models of care

Ensuring people receive the right physical and mental health care for their needs, in the right setting, quickly and efficiently; implementing new care models for urgent and emergency care, local care, discharge and elective care that improve outcomes, reduce non-elective activity, release unfunded beds and restore elective capacity

We have also identified critical enablers to our recovery and longer term transformation:

Strategic partnerships

Systems working

Progressing the partnerships supporting sustainable care on the Isle of Wight; bringing together community, mental health and learning disability providers; developing our integrated care partnership; supporting provider partnership on the elective care hub and other acute services; enabling effective and impactful place partnerships

Enhancing our use of digital, data and business intelligence

Digital and data

Developing, adopting and scaling digital technologies to support productivity and demand management programmes; embedding use of data and business intelligence to identify areas of unwarranted variation in access, outcomes and productivity; development of data-driven population health management, system evaluation and benefits-realisation

5 YEAR FORWARD PLAN

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OUR CORE PURPOSE:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support social and economic development

Key to achieving these outcomes:

- Providing swift access to efficient, high-quality care for those who need it
- Keeping people as healthy and independent as possible

OUR SYSTEM PRIORITIES:

Delivered through whole system partnership working and described in our strategy and plans:

DECEMBER 2022 - ICP strategy published:

Focus on underlying health, happiness, wealth and wellbeing of population

Addressing inequalities within and between communities - more widely than access to and experience of healthcare

MAY 2023 - NHS Operating Plan:

Describes 2023/24 plans to deliver Year 1 of the strategy and joint forward plan

Focus on immediate steps to enable system recovery

COMING JUNE 2023 - Joint Forward Plan:

Focus on quality, efficiency and sustainability of care models and services

Tackling inequalities within healthcare

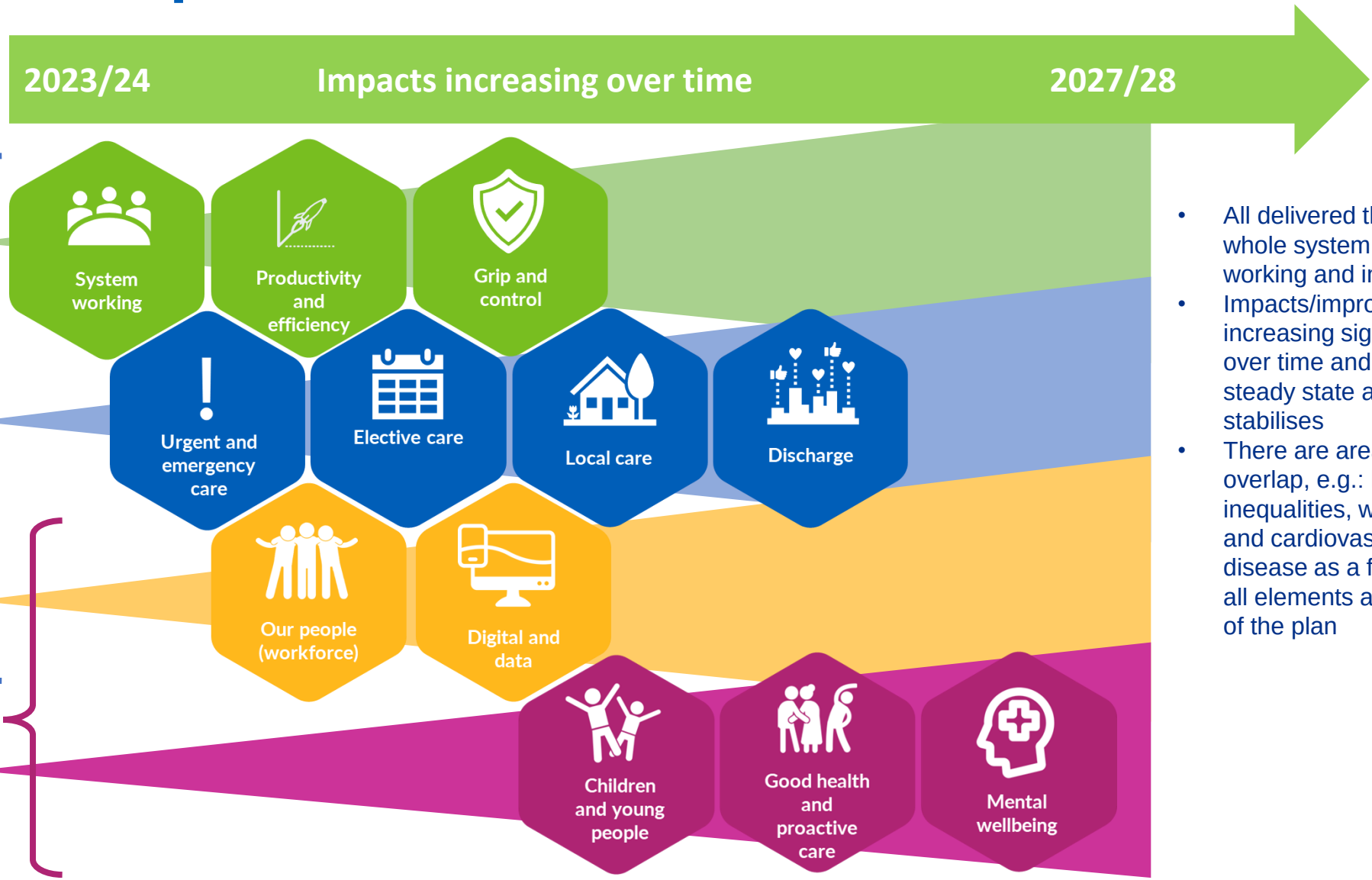
Plan for the next 5 years

Partner organisations' strategies and plans

Our two-phase plan

Resetting the system **- our Integrated Care Board and NHS Trust Partner priorities**
Delivering impact and improvement from 2023/24

Renewed focus on population health and wellbeing **- our Integrated Care Partnership priorities**
Prevention and health promotion impacts from 2023/24 and delivering improved population heath and wellbeing in medium to longer term



- All delivered through whole system partnership working and integration
- Impacts/improvements increasing significantly over time and become steady state as system stabilises
- There are areas of overlap, e.g.: health inequalities, workforce and cardiovascular disease as a focus across all elements and phases of the plan

Our priorities

System transformation programmes focus on improvements in models of care. Much of this work will continue in delivery and benefits realisation into years 2 and beyond of our plan

NHS Hampshire and Isle of Wight

Free up beds and reduce demand in acute care

Reduce acute demand

- Reduce conversion rates (attendance to admission).
- Reduce outpatient follow ups and 'did not attends.
- Reduce emergency hospital attendances.
- Primary/ community care coverage.

Increase flow out of hospital

- Support discharge of patients who no longer meet criteria-to-reside.
- Reduce bed days for unplanned care by reducing numbers of long staying patients and addressing length of stay in pathways for discharge home with health and care support.

Focus on care for older people (local care)

- Reduce readmissions to hospital for >75s.
- Reduce bed days for unplanned care in community hospitals.
- Reduce admissions for >80s through proactive, integrated community-based care.

Increase elective activity income

- Attracting additional income from achieving 109% elective recovery fund target
- Increase productivity in elective capacity – e.g., improving theatre utilisation, delivering outpatient impact outlined above

Transformation Programmes

Urgent & Emergency Care Programme

Best practice, standardised approach to Urgent and Emergency Care delivery, optimised use of alternative pathways and improved efficiencies and scaled up urgent community response and virtual ward provision (includes integrated urgent care, urgent treatment centres, same day emergency care, community models and increased capacity in NHS 111 and 999 call handling).

Local Care Programme

Preventative and Proactive Case Management roll out starting with frailty; same day access to primary care; enhanced integrated care closer to home and neighbourhood model of care; focused cardiovascular disease and diabetes work targeting areas of deprivation/ inequalities.

Discharge Programme

'Home First' model of discharge and improved processes within discharge pathways.

Elective Care Programme

- Meeting national waiting time targets including through mutual aid and system waiting list.
- Outpatient transformation including promoting use of Advice and Guidance and Patient Initiated Follow Ups and improved access for specific specialties.
- Elective Hub
- Reduced variation
- Diagnostics strategy including community diagnostics centres

Underpinning enablers and new ways of working include

Our joint forward plan also describes how we intend to deliver our integrated care partnership strategy, setting out our initial areas of focus as a wider system partnership

Children and young people

- **Focus on the "best start in life" for every child** in the first 1,001 days of their life
- **Working together to improve children and young people's social, emotional and mental health** through prevention and early intervention
- Co-locate services to enable a **family-based approach**

Good health and proactive care

- **Improving outcomes and management of cardiovascular disease for those at risk and those with early signs of developing cardiovascular disease**
- **Improve social connectedness and decrease social isolation** by working with communities to understand their needs and to develop and ensure the sustainability of community assets

Mental wellbeing

- **Developing trauma informed approaches across services to reduce health inequalities and improve emotional wellbeing**
- **Promoting emotional wellbeing as a system,** aligning our messages and co-ordinating our communications and ensuring people know how to access wellbeing support when they need to.

Our people (workforce)

- **Develop integrated workforce planning** to understand key issues from a workforce perspective for all partners
- **"Back to basics" programmes** to attract and recruit future workforce, supporting retention with aligned career structures
- **Identify shared challenges and solutions to increase recruitment with voluntary and community sector partners**

Digital and data

- **Improve how we share information** between organisations and remove the organisational, digital, data and technology boundaries
- **Increase digital skills,** awareness, and empowerment of patients

The "Hampshire and Isle of Wight way"

As we work together to deliver our priorities, we will continue to learn together, and build our culture, capabilities and collaboration as a new integrated care partnership

Behaviours and mindset:

- Building trust and rapport
- Active listening
- Valuing the contributions of all partners
- Being brave, bold and curious
- Remembering that everyone is participating with the best intent
- Giving permission and trying new activities

Alongside our system wide priorities, we also have plans to address local priorities, as identified by our health and care partnerships in each place

Hampshire

- Improve physical, mental health and emotional **resilience for children, young people and their families**
- Support people to **live healthier lives**, focussing on lifestyle risks
- Support people to **stay well and independent into old age**
- Collaboration for **palliative and end of life care**, including bereavement support for all ages
- Reduce unwarranted variation in health outcomes

Isle of Wight

- Embed **prevention** into all health and care pathways
- Deliver **at-scale prevention**, with a focus in redressing health inequalities
- **Fully integrated frailty pathways** across the Island
- Making 'home' and the community the 'hub' of care
- **Work in partnership** with others on island and mainland
- New workforce models
- **Optimise approach to accessing services**, especially for people **experiencing crises** e.g. 'no wrong front door'
- Reduce **unwarranted variation** in care pathways - access and outcomes

Portsmouth

- Embedding the **population health management approach**, including proactive case management
- supporting **primary care resilience** and developing community based services
- Specific focus on adults with **neurodiversity and substance misuse**
- Holistic approach mental wellbeing and **reduce mental ill health** in adults
- Improve children's services with a focus on **education, safeguarding, physical and mental health outcomes**
- Improve **community care and support options** for individuals

Southampton

- **Reduce inequalities** in early childhood and improve outcomes
- **Improve mental health and well being for all ages**
- Tackle loneliness
- Make use of **digital tools to support independence** and healthier living
- **Promote mental health and wellbeing** (increase access)
- **Proactive Care** - 'One Team' approach and integrated community care
- Develop **community networks** (e.g. virtual care and 'remote offers')
- Maximise **prevention and early intervention**, make every contact count
- **Improve** coordination around **end of life care**

Place-based health and care partnerships:

- Understand and work with communities
- Join up and coordinate services around people's needs
- Address social and economic factors that influence health and wellbeing
- Support quality and sustainability of local services

Delivering our joint forward plan

Our priorities – Local Care

Deliver Local Care in a person-centred and joined up resilient teams across primary care, community services and partners.

Deliver same day access to urgent and episodic care, proactive and preventative care for people with chronic disease and complex care.

Aims and objectives	Key actions	Impact
• To ensure that people receive care in the right place, at the right time, in their homes and communities where possible, focusing on proactive care, avoiding unnecessary hospital admissions and enabling timely discharge. • To have same day access for urgent & episodic care by implementing a streamlined, scaled model to deliver urgent and episodic care. Releasing capacity to focus on proactive, chronic disease management and complex care. • To focus on proactive care and prevention for people with chronic disease to provide longer term stability to the system, reduce non-elective acute admissions for people with chronic disease and improve outcomes. • Inequity in service access and outcomes is reduced. • Address and reduce health inequalities and inequity in service access and outcomes. • That services support people to stay well and take greater responsibility for their own health, decreasing and delaying the need for longer term health and social care support.	**Improving Same Day Access model for Urgent and Episodic Care** • Full definition and planned roll out of scaled model for same day access to primary care, streamlining urgent and episodic care management and including direct access pathways. Building on Acute Repository Infection /same day access targeting defined cohorts. • Identify the resource required to manage a single point of contact same day hub • Transitional implementation plan at Place for urgent and episodic care ahead of Winter. **Providing more proactive and preventative care for people with Long Term Conditions** • Full definition and planned roll out of proactive and preventative care model with key clinical conditions. • Fully defined frailty and complexity plan by place based system, including Proactive case management, virtual wards and urgent community response, To include: • Optimising virtual ward capacity, urgent community response capacity and frailty provision against agreed trajectories • Development and implementation of frailty clinical pathway and enhanced neighbourhood model of care across all systems. • Build clear preventative care strategic priorities and plan using Population Health Management. **Diabetes, Cardiovascular disease and respiratory disease** • Diabetes / Cardiovascular disease defined strategic priorities and proactive/preventative care plan at Place. • Respiratory defined strategic priorities and delivery plan at Place. • Consistent achievement of key clinical outcomes delivery for diabetes and Cardiovascular disease across all Primary Care Networks/practices to deliver demonstrable improvement, specifically targeting areas of deprivation/inequalities. **Integrated Care Closer to Home** • Integrated neighbourhood teams improvement and resourcing plan at Place. • Development of Primary Care Networks/ practice integrated neighbourhood teams against core principles to hold proactive and preventive caseload and enhance integrated care closer to home.	**For our residents:** • More people receiving proactive care in their home environment. • Ability to access same day care from primary and community care teams. • Fewer people living with and suffering from the complications of preventable disease. • Reduction in the gap in healthy life expectancy. **For NHS organisations:** • Increased primary and community-based capacity and utilisation. • Emergency care activity at 19/20 levels (attendance and unplanned admissions greater than 1 day). • Improved workforce retention within primary care. **For the system:** • People living healthier, longer lives, reducing reliance on services. • Teams working together, reducing duplication. • Data driven care stratification, identifying areas of unwarranted variation.

Our priorities – Elective Care

- This programme covers planned care (inpatients and outpatients), diagnostics and cancer.
- Providing patients with high quality, equitable and research led care delivering an enhanced patient and carer experience.
- Meet the national operating plan targets and providing a high quality, and value cost-based system built around the patient.

Aims and objectives	Key actions	Impact
• Delivering equitable access to care across Hampshire and the Isle of Wight • Reducing time to diagnosis and treatment • Delivering this by working collaboratively across all of our NHS, Independent Sector Providers and Networks • Delivering this productively and efficiently • Transforming the way care is delivered by introducing new diagnostics tests, changing care pathways, working virtually or digitally	• Create a single Patient Tracking List in some specialities to balance patient referrals and waiting lists between the providers. This will be a phased approach across specialities with a completion date of March 2024. • Phased roll out patient initiated follow up and advice and guidance as standard across agreed specialties. • Change outpatient pathways by increasing patients who have direct access tests, whose clinical team are able to access advice and guidance, see patients virtually where suitable and increase patient initiated follow ups, currently on going speciality by speciality. The specialities agreed for this year will be completed by March 24, however this is a phased approach to completion and more will follow through 24/25. • Open 1 new Community Diagnostic Centre and increase the number of tests delivered in Andover, Portsmouth, Lymington and Southampton. • Work with our clinical leads across Hampshire and Isle of Wight to improve theatre efficiency, day cases rates and length of stay. The planned care board approved the approach to this in the April board meeting and establishing an Integrated Care System wide theatre services group by end of quarter one. • Review and transform end of end pathways including tier 2 services and access to the independent sector for NHS care. Ongoing, March 24 completion. • Create a new Endoscopy Network and seek approval to expand endoscopy capacity in Southampton and Portsmouth. The endoscopy expansion is due to open in 24/25. The planned care board is taking a paper in the next board meeting on endoscopy which will include the network set up for approval. • Complete the business case and start work on the new elective hub based in Winchester. The completion for the hub is 24/25. The business case is well in progress with a view to be finalised by quarter one. • Invest in our Cancer Pathways to support earlier referral and quicker diagnosis and care. On going improvement pathway.	**For our residents** • No patients will wait more than 65 weeks for treatment by March 24. • No more than 6.4% of patients with Cancer will wait longer than 62 days for their care to commence. • 75% of Cancer will be diagnosed by day 28 of the pathway. • 85% of patients will have their diagnostics tests completed with 6 weeks of referral. **For NHS organisations:** • Only when is it absolutely necessary will patients be followed up in Hospital Outpatients, reducing outpatients follow ups by 25%. • An improvement in the use of theatres, increasing to 85% utilisation, an increase in day case rates and a reduction in length of stay by 23/24. • Improve outpatient did not attend rates by reducing did not attends by 25%. **For the system: TBC**

Our priorities – Urgent and Emergency Care

Focuses on significantly reducing acute demand through improved delivery of the right care in the right place to avoid unnecessary admissions.

Reduce the number of people in acute hospital without a meeting the criteria to reside.
Through creating a more consistent approach to delivery, maximising capacity and efficiency and targeted use of non-recurrent funding allocations.

Aims and objectives	Key actions	Predicted impact

• Maximise the impact and capacity of admission avoidance schemes to support timely access to appropriate care including:
1. Increasing Same Day Emergency Care
2. Increasing capacity in 111 and 999 to direct people to the right services
3. Integrated Urgent Cares
4. Urgent Treatment Centres
 	
• Reduce the number of people in acute hospital not meeting the criteria to reside.
 	
• Create a more consistent approach to delivery, maximising capacity and efficiency and targeted use of non-recurrent funding allocations.
	• Establish and embed standard tools to plan, drive and track delivery of initiatives
	• Develop Integrated Care System wide Plan to achieve the financial and activity targets – including triangulation of activity, finance and workforce, based on Local Delivery System level plans.
	• Continue to refine Local Delivery System plans. To include agreed Place based plans and trust agreed trajectories for increasing same day emergency care and build on process mapping workshops to further develop plans to optimise use of alternative pathways and improve efficiencies .
	• Urgent and Emergency Care Board to explore Hampshire & Isle of Wight task and finish groups to take forward key priority areas to enable a more consistent and standardised approach to Urgent and Emergency Care delivery to include:
	  • Integrated Urgent Care,
	  • Urgent Treatment Centre, same day emergency care,
	• Implementation through 23/24 inline with outputs of task and finish groups & financial constraints across Hampshire and Isle of Wight and Local Delivery System level delivery.
	• Develop dashboards to track impact and facilitate delivery
		For our residents:
		• Increasing access to Same Day Care
		• Reducing wait times for patients who require Urgent & emergency care services
		
		For NHS Organisations
		• Seeing patients in the right place, in the right time
		• Reduction in occupied bed days
		• Increased performance against constitutional targets
		• Overall reduction in cost of delivery of services
		
		For the System
		• People living healthier, longer lives, reducing reliance on services
		• Teams working together, reducing duplication
		• Data driven care stratification, identifying areas of unwarranted variation

NHS
Hampshire and Isle of Wight

Our priorities – Discharge

Drive a robust 'Home First' model of discharge to support more people to safely return home with appropriate interventions to meet individual assessed needs thus enabling people to receive the right care, at the right time, in the right place by the right person.

Aims and objectives	Key actions	Impact
• Improve processes within discharge pathways • Optimise productivity and efficiency against existing schemes/capacity and reduce liability against Hospital Discharge Pathway spend. • Reduce the number of people in hospital not meeting criteria to reside • Reduce requiring permanent care home placements	• Develop Hampshire and Isle of Wight trajectories using trend data to achieve reduction in not meeting criteria to reside based on Local Delivery System level plans - Completed March 2023. • Refine/agree delivery plans in each Local Delivery System in line with the planning timetable. • Established governance structure for programme, regular meetings in place with board to launch in May with addition of working group (Completed April 2023). • Implementation of Hampshire & Isle of Wight not meeting criteria to reside plans during 23/24 through discharge task and finish group and Local Delivery System Bronze & Silver Forums. • Develop short term service specification. • Establish Discharge Programme Board inaugural meeting 22/05/23, membership agreed, draft terms of reference developed. • Workshops held during May including review of Hospital Discharge Pathway discharge capacity spend further workshops scheduled to review short term discharge beds (utilisation, criteria, purpose, clinical effectiveness etc) and to also review single point of access to address any unwarranted variation. • Work in conjunction with Fusion Programme to introduce Discharge Programme and agreed Fusion lead. • Map and test existing discharge flows – Clinical team visits to sites to 'test' discharge pathway flows – end May/early June.	• Improve discharge rates - 50% reduction in bed days related to patients with no criteria to reside. • Reduce average length of stay for patients <80 years and 80% reduction in patients staying in hospital significantly longer than necessary. • 95% people able to be discharged to their own homes (increase from 84%) on Priority 0 & Priority 1 pathways. • Length of stay reduction in short term services.

Our priorities - Children and Young People

This programme sits within our integrated care partnership strategy and aims to ensure all children to have the best possible start in life, regardless of where they are born, and have positive physical, emotional and mental wellbeing.

Specific intended benefits include: reduced health inequalities, improved mental health and wellbeing (reduced anxiety, reduced suicides, reduced eating disorders) and physical health, improved educational attainment, better inclusion and engagement in schools, societal benefits e.g. reduction in crime.

Aims and objectives	Key actions	Impact
• Focus on the "best start in life" for every child in the first 1,001 days of their life; Deliver a coherent cross-agency pathway of support for the first 1001 days of life – from pregnancy through to age 2.5 – to secure the best possible outcomes for children as they approach early years. • Working together to improve children and young people's social, emotional and mental health through prevention and early intervention; to ensure young people and their families are able to access information, advice and support at the earliest possible stage. This will ensure that, so far as practical, we are able to support needs before they escalate and further impact of the young persons long-term outcomes. • Co-locate services to enable a family-based approach; Transformation of Family Hubs and Start for Life services (0-19 years), in line with published Department for Education /Department of Health and Social Care guidance. This programme will share learning and practice across the Integrated Care Board footprint, maximising resource, skills and transformation potential.	• Develop clear performance metrics at Place and System across the Plan – including baselining data for the ages and stages questionnaire scores. • Delivery of the Hampshire & Isle of Wight Maternity Programme (linked programme). Alignment of local maternity and neonatal system and Local Delivery System -based Commissioning Arrangements. Ensure effective Local Delivery System -based Maternity Commissioning and relationship with local maternity and neonatal system. • Portsmouth, Isle of Wight and Southampton - Delivery of Family Hubs Programmes. Sharing best practice with Hampshire. • Agree commissioning approach for the Healthy Child Programme delivered by the new NHS Community Provider (from 2024) between Place-based Public Health Teams and Local Authority Children's Service, focussing on integrated service delivery models with Local Authority's. • Launch programme to ensure consistency and sustainability of Digital Platforms for young families – (Family Assist, Healthier Together etc). • Reviewing Public Health Healthy Child. Programme including learning from more intensive early support model. • Explore a unified Digital Offer for new parents across the Integrated Care System (e.g. enhance Healthier Together, roll-out Family Assist etc.). • Pilot emotional health training in Portsmouth and Southampton to the wider workforce who come into contact with Children and Young People with Anna Freud Centre	• Improve Access and Waiting Times for Children and Young People Mental Health Services. • Increase focus on prevention and early help working with Public Health and Local Authority Children's Services. • Increase the community based and self help offers for Children and Young People. • Families have access to a seamless and welcoming support offer which is accessible for families when they need it; supported by an empowered workforce that supports the Start for Life programme. • Improve service quality and access for Children and Young People in mental health crisis. • Improve transition for 16-17 years olds and access to mental health services for 18 – 25 year olds. • Improve service quality, develop the workforce and embed the use of data and outcomes to demonstrate service effectiveness. • Increase equity of access, experience and outcomes for most vulnerable children and young people. • Activity and financial impacts of delivery are a work in progress currently.

Our priorities - Mental wellbeing

Prioritising and promoting mental health and wellbeing is a priority across all partners, for all population age groups
“Focus on illness is too strong and should be more of a focus on wellness”
“Secondary care in mental health is just the tip of the iceberg - there needs to be many rafts of supporting scaffolds in place”
“We need to challenge ourselves that access is the same and equitable”, and continue to improve parity of physical and mental health
We need to state tangible solutions with ambitious targets and do a few things well

Aims and objectives	Key actions	Impact
• Developing trauma informed approaches across services to reduce health inequalities and improve emotional wellbeing. • Promoting emotional wellbeing as a system, aligning our messages and co-ordinating our communications and ensuring people know how to access wellbeing support when they need to. • Improve emotional wellbeing and prevention of risk factors for mental health - including excess morbidity and excess mortality associated with severe mental illness. • Addressing inequalities in access and outcomes and enabling people to navigate through services.	• Develop joined-up place-based signposting to local services and support that promote positive mental health and wellbeing as well as support those at times of distress building on the current No Wrong Door programme. • Increase access to appropriate and local mental wellbeing support and early intervention support for all residents. • Reduce the burden of mental wellbeing due to the cost of living pressured through increased access to support and focused work on financial anxiety and mental wellbeing. • Senior leaders across the 18 organisations who signed the Trauma Informed concordat commit to delivery of the Trauma Informed Strategy, allocating any necessary resources and providing support and commitment at a senior level. • Through designated Single Point of Contact across the 18 organisations and with support from senior leaders, the 18 organisations deliver their bespoke delivery plans. • Commitment from Integrated Care Partnership partners to provide overarching support to the trauma informed Board, supporting coordinated delivery of one overarching trauma informed Strategy. • Map the range of mental health and wellbeing support that is available to people working across Hampshire to enable policy and workforce development programmes to be embedded in all organisations e.g.: Mental Health First Aiders.	• Self-reported wellbeing - people with a low happiness score. • Self reported wellbeing: people with a high anxiety score. • Reduction in rates of deaths by suicide. • Research shows the potential public health and economic benefit of programmes that target and prevent mental health problems and empower more people to live well. • Reduction in people adopting harmful coping mechanisms as a result of trauma (drug and alcohol addiction, eating disorders, self-harm, gambling, smoking, risky behaviour, multiple sexual partners). • Improved use of trauma informed language in communication and assessments over 3 years due to having a greater understanding of the story behind the presenting behaviour. • Improved self-care and wellbeing amongst staff. • More of the workforce trained in being adverse childhood experience aware and trauma informed. • The best start in life for every child in the first 1000 days. • Reduced demand on children needing mental health support. • Improved children and young people’s social, emotional and mental health.

Our priorities - Good Health and Proactive Care

If trends continue, preventable ill-health and deaths will grow, as will health inequalities and our services will become increasingly unsustainable. There is a great deal we can and are doing, but there is more we could do together.
Deprivation is often hidden in rural communities – we need to prioritise areas of greatest need/ inequality – recognising we can't do all of this at once.
There is a role for all partners in improving health of our population, not just in terms of managing the conditions that people have already been diagnosed with, but addressing some of the wider determinants of health, so that people can live more years in better health.

Aims and objectives	Key actions	Impact
• Improving outcomes and management of cardiovascular disease for those at risk and those with early signs of developing cardiovascular disease, focusing on narrowing the gap in health inequalities, reducing unwarranted geographical variation through: 1. improving opportunities for physical activity, healthy eating, reducing harmful drinking and stopping smoking 2. identifying those at risk earlier • Improve social connectedness and decrease social isolation by working with communities to understand their needs and to develop and ensure the sustainability of community assets. • Take a life course approach to improve social connectedness, thereby reducing social isolation and loneliness and building social capital through supporting organisations and individuals/communities across Hampshire and Isle of Wight and addressing inequalities in specific communities. • Improve mental and physical health for all ages and increase independence in older adults, reducing the need for health and care services as well as reducing unemployment and increasing productivity.	• Develop a system-wide Cardiovascular disease approach including communications, priorities and trajectories articulated, using a population health management approach and community insights to inform priorities for action Commitment from Integrated Care Partnership partners to develop organisational plans by 30th September 2023 to address risk factors for Cardiovascular disease. • All Integrated Care Partnership partners to produce an organisational plan to tackle loneliness at work. • Produce a Integrated Care Partnership framework to support co-production of place based plans to build social connectedness within local communities, alongside community voluntary sector colleagues and primary care. • Develop a system level communications plan to reduce stigma associated with loneliness, signpost to support and share local opportunities / positive stories supported by all Integrated Care Partnership partners and delivered at place.	• Halt the fall in Healthy Life Expectancy and the increasing gap between the most affluent and the most deprived in Hampshire and Isle of Wight. • Reduction in heart attacks and strokes over 3 years. • Improve detection of Cardiovascular disease risk factors and close the prevalence gap across core Cardiovascular disease risk factors. • Decrease the % of adults who feel lonely often or always or some of the time (public health outcomes framework 2019/20 baseline) • Including reducing differences by ethnicity, employment status, disability, deprivation, age and sex • Increase % adult carers & social care users who have as much social contact as they would like public health outcomes framework. • Improve self-reported wellbeing: satisfaction, worthwhile, happiness, anxiety public health outcomes framework. • Increase workplace productivity and reduce workplace stress / sickness absence. Equip local residents with skills to increase employability. Percentage of people in employment (public health outcomes framework: 16-64 years and 50-64 years).

Our priorities – Our People (workforce)

We have significant shared system workforce challenges spanning recruitment, training and retention. Our collective workforce is our area of greatest opportunity and where we can make a powerful shared impact. We know that we will not be able to begin to deliver on our shared strategy without our people.

Aims and objectives	Key actions	Impact
• We will develop a set of shared values, strengthening partnerships and working together on integrated workforce planning. This will support us to understand how we meet our current workforce challenges together, including addressing inequalities, and reducing practices leading to competitive behaviours. • We will get back to basics with Integrated Care Partnership programmes to attract, recruit and retain our workforce • The wellbeing of our workforce is essential, we employ a large number of people across Hampshire and Isle of Wight, will work with our Good Health Programme to ensure Integrated Care Partnership employers across Hampshire and Isle of Wight fully engage with the opportunities this presents.	Working through the Integrated Care Partnership we will bring partners together to develop shared values and approaches to workforce planning.	Shared set of values supports consistent behaviours throughout the Partnership, fostering strong relationships needed to orchestrate change. Addressing inequalities in our workforce supports developing a workforce representative of our population and helps to address health inequalities in our communities. Improving workforce wellbeing, improves attendance, reduces temporary staffing and increase productivity

Our Priorities – Digital and Data

By harnessing the power and innovation of technology it will help us to deliver better quality, more efficient care, closer to people's homes and communities, in a way that fits people's individual needs and lifestyles.
Joining up data, technology and information systems will also support us to join up our care and improve services and support our workforce to be more efficient.

Aims and Objectives	Key actions	Impact
Empowering people to use digital solutions: Supporting people to see digital care as being as valuable as traditional care, eg: widespread access to digital health records, home monitoring, virtual consultations and practical support to help people engage with digital care, underpinned by face-to-face care for those unable to.	1. Maximise digital uptake especially through promoting and enabling our citizens to access and engage in digital services. 2. Promote inclusion and provide resources and support for citizens to engage in digital to ensure equality of access to all health and care services 3. Incorporate citizen-centred service design in the implementation of digital solutions through user-feedback and consolidation of services to simplify their use. 4. Bridge the gap between digital and non-digital solutions to widen digital offering for citizens of all levels of competency.	**For our residents:** • They can view and input information into their own health and care records. They only need to provide information once. • They can receive care at home where appropriate, are involved and have control of their care • They can manage their own appointments: book, cancel, and re-schedule • They can access a range of services, both digitally and non-digitally. They trust that their information is safe and secure. **For NHS organisations:** • Frontline workers are able to spend more time with their patients. • They have modern, reliable and fast digital solutions and equipment that enable them to work more productively • Frontline workers can review and update patient records when and where they need to, using joined up systems that talk to each other **For the system:** • Colleagues can easily communicate with each other across different organisations involved in the care of our patients • Transfers of care between teams and partners are seamless and smooth • We have access to real-time information to understand service performance and to help make decisions • We understand the health of our population and can work effectively with partners
Supporting our workforce: Staff will be able to access joined up care records, across our system, without multiple log-ins. They will have the skills and confidence to work digitally and flexibly. Our leaders will enable delivery of our digital ambitions and we attract talented digital experts to work here.	1. Oversee the creation of a digitally competent workforce through the evaluation and education of our workforce in digital skills and best practice 2. Ensure that equality, diversity and inclusion is embedded as a requirement in digital transformation, ensuring that no-one is left out or left behind 3. Develop a design and usability awareness and specialist capacity across the system to drive efforts in improving the user experience of digital tools.	
Improving how we share and use information: In the future everybody can easily access their own comprehensive digital health record and add to it themselves. Analysis of joined up patient information will play a crucial role in providing proactive care and support, that improves our population's health and reduces inequalities.	1. Develop our Shared Care Record by increasing the breadth and depth of information shared and enable better sharing of citizen information between our partners. 2. Reducing boundaries by reducing the number of systems, consolidate systems where appropriate and encouraging collaborative procurements. 3. Enable collaborative working, for example improving primary and community care through integration of tasking and care planning.	
Modernising and integrating our digital systems: We want all of our organisations' to be digitally mature, investing in implementing new digital health records that connect across organisations and support joined up care. Up-to-date infrastructure will provide strong foundations for the future.	1. We will level up the Digital Maturity of all providers by continuing to invest in Electronic Patient Record solutions. 2. Digitally transform Diagnostics & Imaging to enable workforce planning, reduce rework and improve the turnaround of results. 3. In primary care we will continue to provide core capabilities and work to deliver enhanced capabilities where required, and in social care we will deliver Digital Social Care Records.	

Our Priorities – Digital and Data: Population Health Management

By harnessing the power and innovation of technology it will help us to deliver better quality, more efficient care, closer to people's homes and communities, in a way that fits people's individual needs and lifestyles.
Joining up data, technology and information systems will also support us to join up our care and improve services and support our workforce to be more efficient.

Aims and Objectives	Key actions	Impact
Our system will be described as a system with 'maturing' population health management (PHM) capability by 2025 as described in the NHS England Population health management maturity matrix with some aspects of population health management capability in the system classified as 'thriving'. Therefore population health management data and insight is being used across the system to inform targeted actions and decision-making to improve outcomes and reduce health inequalities.	• All primary, secondary, mental health and community data linked in HealtheIntent (population health management platform). • All system partner organisations (including local authorities, police, fire, and where appropriate, voluntary and community organisations) are signed up to the population health management data sharing agreement to support shared working. • Delivery of wrap-around facilitation and support programme for use of population health management data to deliver local priority. • Delivery of wrap-around facilitation and support in use of population health management data and analytics to inform and support our systemwide cardiovascular disease programme. • Population health analytics regularly used within multidisciplinary teams (primary and secondary) to support rapid improvement cycles. • Social care individual linked in HealtheIntent platform. • Analytical support available for Primary Care Networks to help understand high/rising risk patients. • Population health finance and cost data brought into HealtheIntent and used to forecast demand and risk to inform new contracting models.	• Clinical, operational and strategic workforce across our system have access to high quality population data for planning and direct care resulting in more effective care, commissioning, planning and prevention programmes. • Workforce across our system using population health management data and intelligence to improve care, reduce health inequalities and integrate services due to increased population health management capabilities. • Population health data and insight are contributing to an improved financial position for the system as services are better targeted, less duplicative and thoroughly evaluated.

Our priorities – Productivity, efficiency & grip and control

Achieve our return to financial balance as a system by controlling costs, increasing productivity, and aligning our finances to deliver our wider objectives.

Aims and objectives	Key actions	Impact
Increase workforce productivity and reduce overall pay costs, through: • Substantial reductions in agency expenditure (less reliance and lower rates). • Revised provider staffing establishments. • Substantial reduction in integrated care board workforce capacity through restructuring and running cost allocation reduction. We recognise the importance of our partnership and contributing organisations as Anchor Institutions within our communities, and the positive impact that we can therefore make. Deliver reduced non pay costs through: • Consolidation opportunities and strategic partnerships e.g. joint procurement, consolidation of corporate functions. • Reviews of partnership and joint funding arrangements to support best use of collective resource (including all age continuing health care and BCF arrangements) • Integrated care board corporate non-pay review	• Review of all investments made in the last three years to ensure they are sustainable • Strengthening of all core interventions and procedures relating to workforce expenditure and controls. • Capitalise on opportunities afforded by natural turnover to 'rebalance' workforce capacity, team structures, pay grades, and skill mixes. • Integrated care board workforce to be resized. • Identify and capitalise on opportunities arising from adoption of innovation (i.e. automation/ digitalisation). • Undertake opportunity analysis on consolidation of support and back office functions. • Identify areas for greatest cost efficiency through system-wide efficiency planning for 23/24 and 2024/25 with clear measures of success. • Establish appropriate system controls and contractual arrangements for non-pay costs – particularly drugs and supplies and services. • Scope and establish joint procurement initiatives, evaluate existing contracts and approaches to contracting and identify areas for de-prioritisation. • Create a cultural shift (clarity, transparency) to a system approach to efficiency savings	• Reduce agency staffing costs to 2019/20 levels, or below, and agency cap not to be breached. • Substantially reduce pay costs associated with 2019/20 to 2022/23 workforce growth to achieve sustainability. • There is a planned agency reduction in 2023/24. • Additional staffing costs to be modelled potential benefits could deliver in Q4. • As a system we are able to 'grow our own' and make a positive impact as Anchor Institutions in our community.

Systems working

Alongside our transformation priorities, we also have three major cross-organisation strategic change programmes

NHS Hampshire and Isle of Wight

We will continue to progress our major cross-organisational strategic change programmes to leverage longer-term sustainability across the system

	Mental health and community services	Isle of Wight sustainability partnership	Hampshire Together – New Hospital Programme
Purpose	**To improve mental health and community services, by addressing unwarranted variations in provision, access and outcomes across Hampshire and Isle of Wight**	**To achieve sustainable health services for the Isle of Wight population, by working in partnership with larger specialist providers in Hampshire**	**To modernise our hospitals and health services, bringing 24/7 acute services together and ensuring care is delivered in buildings that are fit for purpose**
Case for change	Complexity and fragmentation make it hard to access care Pathways are fragmented, with inconsistent models of care Unwarranted variation in patient access and outcomes Service provision is not aligned to need Historical inequity in the distribution of resources Workforce gaps, particularly in mental health services	Small (140,400) and physically-isolated population facing inequalities and deprivation. Sub-scale services that are: • Fragile, often relying on a single clinician, and at risk • Disproportionately expensive to cover on a 24/7 basis Overstretched leadership team across range of services: acute, ambulance, mental health and community	Replace outdated estate – Trust has 11th worst estate in country, and it would cost less replace than to refurbish Address sustainability issues – both clinical and financial, with 24/7 specialist services spread across sites now Respond to population needs – growing and changing Redesign services – embracing digital developments etc.
Proposals	**To take forward recommendations from recent review** 1. Develop a shared clinical strategy for integrated care 2. Develop a strategy for place and place-based leadership 3. Review use of community physical health bed capacity 4. Establish a more strategic approach to funding services 5. Bring services together into a new Trust across system	*From* **Strategic partnerships** The partnerships continue to be crucial but are not sufficient for the scale of challenges faced. *To* **Transfer responsibility to specialist providers** The Isle of Wight NHS Trust will be an acute provider, with other services transferring to specialist partners.	We have undertaken intensive engagement to develop options for consultation. Proposals are: • **To consult the public** on options for reconfiguring hospital services and for building a new hospital • To use the opportunity of £550m capital investment via the **New Hospital Programme**
Next steps	We are undertaking a joint programme of work across partners in response to the five recommendations. This will be further iterated as we develop the operating plan and joint forward plan. The strategic case for the new Trust has been developed and agreed through Boards (provider and ICB). The case was submitted to NHS England on 13 March for review and approval to proceed to the next stage: Full Business Case.	Our approach is set out in a Joint Strategic Case: • to develop the island health and care partnership • to transfer non-acute services to specialist providers (ambulance, mental health and community) • to form a hospital group The ICB Board and system partners confirmed support for the Joint Strategic Case in March, with partners committed to implementing the next steps for each health sector.	We are awaiting national confirmation of £550m and ministerial review of the conditions relating to this funding. In the meantime, we continue to: • Respond to the further work identified through Stage 2 assurance of the pre-consultation business case • Improve our understanding of the population and their needs, particularly to explore the scope to re-dress inequalities for groups with protected characteristics
Recovery	**Service strategy and care models aligned across the integrated care system, with a more proactive approach and greater focus on local care services. All strategic cases for major initiatives reflect the strategic direction and explain how the changes proposed facilitate delivery of these care models across Hampshire and Isle of Wight.**		

Systems working

We will increase our effectiveness as a system through the development of our Integrated Care Partnership

Our Integrated Care Partnership provides the framework for health, social care, wider public sector, voluntary and community services to work together in a coordinated and collaborative manner. This is key to addressing our challenges around better management of complex and long term care needs and managing resources in a more joined up way to improve efficiency. The Integrated Care Partnership is a key vehicle through which we work together to deliver our overarching system partnership strategy, to tackle the wider determinants of health such as housing, education, employment and the environment that people live in, as these wider determinants affect people's health and quality of life and drive greater need for health and care services.

Progress in 2022/23: Our Integrated Care Partnership has made great progress over the last year, including:

- Designing the model for the Integrated Care Partnership – Joint Committee, assembly and a way of working
- Defining the purpose and the governance for the Integrated Care Partnership – drafting a terms of reference for the Integrated Care Partnership Joint Committee
- Holding two Integrated Care Partnership assembly events to engage broadly on the development and the delivery of the Integrated Care Partnership strategy
- Engaging with Health and Wellbeing Boards on the Integrated Care Strategy and the development of the Integrated Care Partnership structures
- Publishing the Interim Integrated Care Partnership Strategy in December 2022.

Ongoing development

- Delivering year one of the Interim Integrated Care Strategy: establishing programme structures, deliverables and measures of success to ensure the delivery of the strategy supports improved outcomes of our four places
- Ensure robust and effective governance in place to realise collective benefits
- Establish mutual accountability for the delivery of the vision of the integrated care system
- Continuing culture and development work including vision and charter of behaviours.

Our Priorities – Always Improving

In addition to our strategic Integrated Care Partnership priorities and the activities we have identified as most crucial to our financial recovery, we are committed to the delivery of a number of ongoing transformation programmes. These include programmes spanning Mental Health, Learning Disability and Autism, End of Life and Maternity transformation.

Aims and Objectives	Key actions	Impact

Our Southampton, Hampshire, Isle of Wight and Portsmouth Local Maternity and Neonatal System works together to improve outcomes for women, pregnant people and their babies across Hampshire and Isle of Wight. This is done through cocreation and reshaping of maternity and perinatal health services. We tackle inequalities in outcomes, experience and access for all women and pregnant people's experience of maternity. We work with community, primary care and system partners to deliver simpler, safer, and more joined-up care at the right time.	• Our Local Maternity and Neonatal System has set five year strategic transformation plans. We will:
	  • Implement recommendations around coproduction and health inequalities to shape how we review and improve services.
	  • Align our maternity transformation to our Integrated Care Partnership strategic priorities particularly around health inequalities and against the first 1001 days of life.
	  • Implement patient safety recommendations on oversight and quality so the Local Maternity and Neonatal System can act as oversight.
	  • Develop a long-term workforce strategy and plan for maternity services.
	  • Deliver Maternity Transformation Plans 23/24 onwards (including Ockenden and East Kent recommendations, and Long Term Plan ambitions).
		• Our strategic transformation plans will:
		  • Put coproduction at the foundation of any strategic intent in maternity services transformation plans
		  • Improve the maternity services health outcomes for our most vulnerable communities
		  • Deliver system oversight of quality improvement for maternity services Plan for a future workforce that is fit for purpose.
		  • Transform our services to the best standard through responding to national recommendations in the Ockenden and East Kent reviews and Long Term Plan ambitions

Palliative and End of Life Care remains a priority: we know the impact that we can make through early identification and planning, we know that the projection in number of deaths will include, and there are many variation and inequalities in our services that we can address which will help to support the workforce, reduce costs and meet national directives. It is the right thing to do for our patients, carers, their loved ones, our communities and to support our staff.	• Strengthening the Palliative and End of Life Care Board, in particular strengthening system leadership.
	• Delivery of our key workstreams: 1 Strategy, 2 Wessex Anticipatory Care Planning Audit, 3 Training and Education, 4 Community Engagement, 5 Bereavement and Care After Death.
	• Finalise and deliver our all ages strategy, built on engagement with our community This will help us to agree focus areas and through a strong delivery plan increase pace of programme delivery.
	• We will continue to embed work and perspectives at every level of the system.
		• Transformation is built upon 6 ambitions in outcomes:
		  • Each person is seen as an individual (care is personalised).
		  • Each person gets fair access.
		  • Maximising comfort and wellbeing.
		  • Care is coordinated (through shared care records and joined up evidence and information).
		  • All staff are prepared to care (and we can evidence their confidence, knowledge and skills).
		  • Each community is prepared to help

Our Priorities – Always Improving

In addition to our strategic Integrated Care Partnership priorities and the activities we have identified as most crucial to our financial recovery, we are committed to the delivery of a number of ongoing transformation programmes. These include programmes spanning Mental Health, Learning Disability and Autism, End of Life and Maternity transformation.

Aims and Objectives	Key actions	Impact
We believe that children, young people and adults with a learning disability and/or autism have the right to the same opportunity as anyone else to live healthy lives, achieving their goals and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.	Our 5-year strategic transformation plans show we will: • Use data and insights to identify themes for service improvement across short, medium, and long term. • Increase update in annual health checks, and improve consistency of health action plans. • Utilise Core20PLUS5 to address inequality. • Deliver keyworker pilots to improve outcomes for Children and Young People. • Invest in diagnostic capacity and provision of services to meet growing demand. • Support workforce training, retention and recruitment e.g. through mandatory roll out of Oliver McGowan training, and supporting workforce planning. • Embed coproduction into service development. • Develop new care models across the Integrated Care System and deliver more services in the community.	Our strategic transformation plans will: • Move people into the community reducing reliance on inpatient care. • Address inequalities and increase prevention. • Reduce overmedicalisation and prevent avoidable deaths. • Increase health and wellbeing for children and young people, particularly in first 1001 days. • Meet increasing demand. • Help us to recruit and retain staff. • Give people with lived experience a bigger voice in what services are developed and improved.
By the end of 2027/28 there should be no observable barriers to access for community mental health services, in whatever community you feel to belong to and whether the care is provided in primary care, secondary, by the voluntary sector, or from local councils at any tier. Collaboration between mental health staffing from any organisation should be business as normal. Individuals should not experience a cycle of assessment, rejection and re-referral. People will be able to access support within and from their community .	Key actions already underway: • Develop a mechanism to enable people to self refer into community mental health services • Bridging the gap with Voluntary, Community and Social Enterprise colleagues by targeting and supporting work in 12 communities of interest e.g. people affected by alcohol to support with their mental health. • Received 46 applications for grant funding, 18 organisations have been successful in receiving their grants to support programmes such as; 1. support for carers for people living with dementia, 2. trauma informed therapies • To hold an information and network event with the 18 successful organisations to share their learning and best practice and to understand what the future plans are.	• People will be able to self refer for community mental health services. • Each Primary Care Network will have multidisciplinary and multi organisational collaboration arrangements. • Workforce delivery of care will be personalised and guided by a trauma-informed approach. • People with lived experience will be fundamental to design and delivery of services. • Mental health and substance misuse services will be integrated to support people with co-occurring conditions. • Equalities will be advanced.

Our Priorities – Always Improving

In addition to our strategic Integrated Care Partnership priorities and the activities we have identified as most crucial to our financial recovery, we are committed to the delivery of a number of ongoing transformation programmes. These include programmes spanning Mental Health, Learning Disability and Autism, End of Life and Maternity transformation.

Aims and Objectives	Key actions	Impact
Our Integrated Care System's strategic vision and transformation for health and care pathways for adults living in Hampshire and Isle of Wight who experience a self-defined mental health crisis or mental health emergency is to provide safe, high quality, equitable and seamless 365 day services for acute and crisis mental health care, with incremental improvements in every year from 2023/4.	• 'All Age' Psychiatric Liaison Model – bring together two separate teams to build a financially sustainable service which provides a Core 24 service. • Deliver one Crisis Resolution and Home Treatment model, bringing together existing teams and reducing variations in the service model. • Full evaluation of current nine Crisis Alternative services to understand benefits and inform future commissioning decisions. • Reduce variation in the therapeutic inpatient offer across the system including workforce model.	• Co-produce and engage both with communities and strong multi-professional clinical networks to develop new and improved models of care and support. • Integrate population health, prevention of trauma, prevention of crisis and population level suicide prevention approaches into the programme and across all mental health care for acute and crisis. • Ensure that financial investment within the acute, crisis and mental health emergency is effective, value for money, equitable and delivers improvements for communities and people.
Children and Young People's Mental Health spans two of our Integrated Care Partnership priorities. Despite exceeding national targets wait list for assessment and treatment in specialist services continue to grow. There are real life consequences to this delay.	• Develop an implement a dedicated needs-based neurodiversity service • Address significant workforce challenges in terms of vacancies and the fragmented nature of service delivery. Take a coordinated approach across partners on this challenge.	• Improved access and waiting times for children and young people's mental health services. • All children no matter what level of need will be supported to recover well locally, either at home with a personalised care & support package, or in an appropriate health or care facility. • Our services promote resilience, build life skills and competencies through strong prevention and early intervention services delivered in partnership. • We have an appropriate workforce providing high-quality children and young people's mental health services.

Capital and Estates

Capital investment is an important reflection of our strategic priorities. As a system we have worked together to allocate the capital available to us for 2023/24 and 2024/25 to enable our major strategic schemes as well as to support building maintenance and refurbishments, equipment and vehicle replacement, and investment in digital.

During 2023/24 we will develop an integrated care system infrastructure strategy that identifies the key estates and infrastructure priorities for our system, to support delivery of the joint forward plan, address key estates risks and support productivity.

Over the coming years, major capital schemes include:

- Isle of Wight Trust: Investing In Our Future, a scheme to deliver (a) an Integrated community hub in Newport High Street. (b) High Care Unit - Refurb and expansion of intensive treatment unit (c) A major refurbishment and expansion of the emergency care floor (d) Reconfigure acute beds. Redevelop underutilised space in level B pathology. New 18 bed acute ward to enable reconfiguration of acute bed, better elective and emergency separation. Start of consolidating cold services in the north of the site.
- Western Community Hospital
- New emergency department at Portsmouth
- Diagnostic equipment and endoscopy
- Electronic patient records and frontline digitalisation
- Primary Care – improvement grants, general practice information technology, big third party schemes
- On the horizon:
    - Hampshire Together
    - Elective hub

For 2025/26 – 2027/28, we will work as a system to prioritise our capital spend according to a transparent set of criteria, including for example strategic importance, clinical and operational risk, productivity impact and contribution to Net Zero. Each year we will publish capital resource use plans to set out our investment decisions.

Sustainability

Our region faces significant risks from climate change - many of the causes of climate change are also the causes of ill health and health inequalities in our region. The carbon footprint of the Hampshire and Isle of Wight Integrated Care System is over 760,000 tonnes CO2e. In October 2020, the NHS became the world's first health service to commit to reaching carbon 'net zero', in response to the growing threat to health posed by climate change. The 'Delivering a Net Zero Health Service' report sets out a clear ambition and two evidence-based targets:

NHS Carbon Footprint: Directly controlled emissions arising from the use of energy and water, the generation of waste, the use of travel for Trust business, anaesthetic gases and metered dose inhalers. Target: to reach 'net zero' by 2040 and an ambition to reach an 80% reduction by 2028 to 2032 (compared with a 1990 baseline).

NHS Carbon Footprint Plus: As well as the above this includes other emissions which can be influenced; arising from NHS supply chains (from goods and services procured) and within communities, such as those arising from staff commuting and patient and visitor travel to NHS sites. Target: reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 (compared with a 1990 baseline).

In support of the NHS becoming the world's first health service to commit to reaching carbon 'net zero', primary and secondary care organisations in the system are undertaking some great work – but more needs to be done. To speed and scale up carbon reduction across primary and secondary care we need to integrate and coordinate good practice across the system and our region. As a system, we will leverage the transition to net zero and public health improvement at a strategic and system level across primary and secondary care, by:

- Acting as a leader and catalyst for transformation within communities and partners.
- Ensuring system wide accountability.
- Enhancing collaboration across the integrated care system and beyond.
- Aligning with local authorities and other key partners.
- Ensuring consistency in approach.

This will help NHS organisations progress faster than they would otherwise, reduce costs across the system, prevent unnecessary duplication of effort and enhance protection of the most vulnerable from climate change. We will prioritise initial effort on procurement, medicines, sustainable and digital care, air quality, travel and transport, estates, communications and capability building; those topics where greatest improvement can be made at a system level.