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Core Programme 1: Prevention at Scale

Programme Objective: To improve healthy life expectancy and reduce dependency on health and care services through a radical upgrade in prevention, early intervention and self care: a sustained focus on delivering prevention at scale in HIOW

Programme Description
Working across the system we will deliver initiatives to prevent poor health consistently and at scale, integrating with public health, CCG and vanguard agendas

The aim of the Prevention workstream is to improve the health and wellbeing of our population by
- Supporting more people to be in good health for longer (improving healthy life expectancy) and reducing variations in outcomes (improving equality)
- Targeting interventions to improve self-management for people with key long term conditions (Diabetes, Respiratory, Cancer, Mental Health) to improve outcomes and reduce variation
- Developing our infrastructure, using technological (including digital) solutions to reduce demand for and dependency on health and care services
- Developing our workforce to be health champions; having ‘healthy conversations’ at every contact. Improving the health of our workforce as well as the people of HIOW

Outcomes and benefits to be delivered

By 16/17 – Delivery plans for scaled up behaviour change initiatives that will improve health outcomes will be developed

- Improving Health and Wellbeing – reducing the gap between how long people live and how long they live in good health
- More people able to manage their own health conditions reducing the need and demand for health services
- More people supported to give up smoking, achieve a healthy weight and drink sensibly (reducing lifestyle related diseases)
- Increased proportion of cancers detected early, leading to better outcomes/survival

Projects Timescales

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<td>• Initiatives at Scale delivery plans developed and implementation prepared</td>
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<td>• Behaviour change delivery plans developed</td>
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Key personnel

CEO/SRO Sponsor – Sallie Bacon, Acting Director Public Health, Hampshire County Council
Programme Director – Simon Bryant, Associate Director of Public Health (Interim) | Fiona Harris Consultant in Public Health (Locum), Hampshire County Council
Public Health leads in Southampton, Portsmouth, IOW & NHS E(W)
Finance – Loretta Outhwaite, Finance Director IOW CCG
Quality lead – Carole Alstrom (Deputy Direct or Quality, Southampton CCG)

Stakeholders involved

- Acute Trust – Providing emergency and Surgical care
- Public Health Service Providers
- Primary Care
- Community Care
- Mental Health Service providers
- Local Authorities
- STP Partners | Work streams HEE
- NHSE – Screening and Immunisations
- CCG’s
- Public and patients

Revenue investment assumed and financial benefit

Investments Required: £0.6m

SAVINGS: £10m per annum by 2020/21
Project Objective: To scale up existing prevention interventions that have been demonstrated to be effective in improving health outcomes to ensure everyone has access to the interventions and that these are delivered consistently across the STP area.

Project Description

The Initiatives at Scale prevention project represents the short term deliverables (quick wins) to make significant savings and reduce health complications and/or workload across the system.

Initiatives at scale deliverables

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<td>“Stop before the op”</td>
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<td>Changing behaviour using advice and information</td>
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<td>Cancer – improved screening uptake</td>
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<td>Digital entry for lifestyle services</td>
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<td>Sexual health – digital self-service</td>
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Outcomes and benefits to be delivered

- Reduce complications in electives due to impact of smoking
- Reduce A&E attendance for minor conditions
- Provide universal access to support lifestyle change using digital technology
- Introduce STI Home-Sampling Kits in place of face to face appointments for low-risk asymptomatic residents

Revenue investment assumed and financial benefit

Investments Required: £0.6
Savings: £10m net per annum by 2021

Project Timescale

Outcomes and benefits to be delivered

Projects

1. **“Stop before the op”**
   - Reducing complications in electives due to impact of smoking

2. **Changing behaviour using advice and information**
   - Reducing A&E attendance for minor conditions

3. **Cancer – improved screening uptake**
   - 13,000 fewer people have received screening than comparators

4. **Digital entry for lifestyle services**
   - Digital front door for services to support lifestyle change (stop smoking/weight management/alcohol interventions)

5. **Sexual health – digital self-service**
   - Introduce STI Home-Sampling Kits in place of face to face appointments for low-risk asymptomatic residents

Key personnel

Project Manager: Simon Bryant/Fiona Harris
Workstream Owners:
Chloe Todd – Stop before the op
Fiona Harris/Debbie Chase – A&E initiative
Nikki Osbourne – Cancer Screening
Simon Bryant – Sexual Health

Stakeholders involved

- Acute Trusts
- Strategic Networks
- Primary Care
- Commissioners
- LA Public Health Teams
- STP Partner work-streams
- Patients/Public

Contributes to overall finance investment and savings of programme:
**Project Objective:** Developing and expanding behaviour change initiatives (both patient and professional) to be delivered consistently and at scale to improve health outcomes

**Project Description**

The Behaviour Change prevention project represents the short to medium term deliverables that support healthy choices and support the effective management of Long Term Conditions.

**Behaviour change deliverables**

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Details</th>
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<tr>
<td>Focused Stop smoking services</td>
<td>Identify and target smokers with Long Term Conditions to receive smoking cessation support</td>
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<tr>
<td>Healthy conversations training</td>
<td>Alcohol Identification and Brief Advice routinely delivered in all primary and secondary care settings</td>
</tr>
<tr>
<td>Diabetes: NHS Diabetes Prevention Programme (NDPP)</td>
<td>National Pilot</td>
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<tr>
<td>Lifestyle change Service for Diabetes</td>
<td>Supporting people to manage their own condition with lifestyle/healthy choices support (with NCM)</td>
</tr>
<tr>
<td>Cancer Early diagnosis</td>
<td>Supporting early identification of Cancer</td>
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<tr>
<td>Work Place Health</td>
<td>Implement the Workplace Wellbeing Charter in every organisation</td>
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</table>

**Outcomes and benefits to be delivered**

- Identify and target circa 37% of people who smoke who have a long term condition and ensure that they are directed to smoking cessation support
- Alcohol Identification and Brief Advice routinely delivered in all primary and secondary care settings
- Supporting people to manage their own condition with lifestyle/healthy choices support
- Application to implement NDPP as part of the second wave in Hampshire, Southampton, Portsmouth and Isle of Wight
- More people identified with Cancer at Stage 1 or 2
- Develop our workforce, to shift the focus from treating illness to promoting wellness and resilience, building the skills and capabilities across our care professionals

**Project Timescale**

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<td>Healthy conversations – alcohol brief interventions</td>
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<td>Diabetes: Primary care prevention</td>
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<td>NHS Diabetes Prevention Programme (NDPP)</td>
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<td>Cancer early diagnosis</td>
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<td>Workplace Health</td>
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**Key personnel**

Project Manager: Simon Bryant/Fiona Harris
Workstream Owners:
- Chloe Todd – Smoking
- Sian Davies/Em Rahman – MECC
- Helen Cruikshank – NDPP
- Simon Bryant – Cancer and Workplace Health

**Stakeholders involved**

- Acute Trust – Providing emergency and Surgical care
- Public Health Service Providers
- Primary Care
- Community Care
- Mental Health Service providers
- Local Authorities
- STP Partners | Workstreams HEE
- NHSE – Screening and Immunisations
- CCG’s
- Public and patients

**Revenue investment assumed and financial benefit**

Contributes to overall finance investment and savings of programme:

- Investments Required: £0.6
- SAVINGS: £10m net per annum by 20/21
Prevention at Scale Programme: Service Redesign and Change

Project Objective: Service redesign and development to improve consistency of delivery at scale resulting in improved outcomes for the population

Project Description
Service development and redesign project represents the medium to longer term deliverables that support prevention and early intervention to improve health outcomes

Outcomes and benefits to be delivered
- Improve falls prevention services to ensure all those who have had a fall or at risk of a fall have access to effective prevention services
- An evidence based approach to treating and preventing childhood obesity is developed
- Improving prevention and early intervention support for those with Mental Health

Revenue investment assumed and financial benefit

Project Timescale

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<td>Falls</td>
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<td>Childhood obesity (cause and effect and interventions)</td>
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Key personnel
Project Manager: Simon Bryant/Fiona Harris
Workstream Owners:
Fiona Harris – Falls
Simon Bryant – Mental Health
Sian Davies – Obesity

Stakeholders involved
- Acute Trust – Providing emergency and Surgical care
- Public Health Service Providers
- Primary Care
- Community Care
- Mental Health Service providers
- Local Authorities
- STP Partners | Workstreams HEE
- NHSE – Screening and Immunisations
- CCG’s
- Public and patients
Prevention at Scale Programme: Mental Health

Project Objective: Redesign and transformation of Mental Health prevention and early intervention services to support early diagnosis and improved access to evidence based care

Project Description

We are committed to more being done to prevent the development of mental illness and promoting earlier intervention not only in primary care but by making every contact count. By 2020 we will achieve this by:

- Improving the response to mental illness in primary care
- Expanded access to evidence based psychological therapies to 25% of adults with anxiety and depression each year, including those with a LTC, veterans and an SMI, using innovative technologies to improve access and recovery
- Increase the number of people with serious mental illness who have a health check and follow-up intervention
- Reduce suicide by 10% through co-ordinated efforts and delivery of the suicide prevention plans.
- Increase access to Recovery Colleges
- Perinatal Mental Health Services - improving identification of those at risk
- Dual Diagnosis – joint project between the prevention and Mental Health workstream

Outcomes and benefits to be delivered

- increased number of people with serious mental illness who have a health check and follow-up intervention
- increased number of people with a LTC having a psychological intervention
- 10% reduction in suicide through co-ordinated efforts and delivery of the suicide prevention plans
- Increase access to Recovery Colleges
- Improved identifications of those at risk of post natal depression accessing and benefiting from Perinatal Mental Health Services
- Improved identification, treatment and outcomes for those Dual Diagnosis

Project Timescales

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<td>Expanded access to evidence based psychological therapies to 25%</td>
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<td>increase the number of people with SMI who have a health check and follow-up</td>
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<td>Dual Diagnosis</td>
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Key personnel

Joint Working across Workstreams
Mental Health – Hilary Kelly
Prevention – Simon Bryant

Stakeholders involved

- Wessex Mental Health Clinical Network
- Mental Health Providers
- Acute Trust
- Public Health Service Providers
- Primary Care
- Community Care
- Wessex Cardiovascular and Cancer networks
- Wessex Children and Young people network
- Mental Health Alliance

Revenue investment assumed and financial benefit

Investments Required: £STF
SAVINGS: £10m per annum by 2020/21
Core Programme 2: New Models of Integrated Care

Programme Objective: To improve the health, wellbeing and independence of HIOW population through the accelerated introduction of New Models of Care and ensure the sustainability of General Practice within a model of wider integrated health and care. This will be delivered through the Vanguard programmes and local health system New Care Models delivery arrangements

Programme Description
The programme will deliver place-based integrated care in each HIOW locality, focusing on the accelerated spread and consistent implementation of ‘big ticket’ interventions

Programme

<table>
<thead>
<tr>
<th>Core Programme</th>
<th>Fully Integrated Primary Care</th>
<th>Integrated Intermediate Care</th>
<th>Complex &amp; End of Life Care</th>
<th>LTCs: Diabetes &amp; Respiratory</th>
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<tr>
<td>Foundation for independence &amp; self care</td>
<td>Care navigators &amp; social prescribing; building skills &amp; capacity to shift current primary care activity to a non-clinical workforce</td>
<td>Joined up, enhanced multi-professional primary care team and extended access care hubs in localities</td>
<td>Integrated health &amp; social care: domiciliary recovery &amp; rehab teams, non-acute beds, urgent community response</td>
<td>Dedicated support for those patients at greatest risk, including the 0.5% of patients with the most complex needs</td>
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<td>Moving to a de-layered community model for Long Term Conditions, including case finding, shared care &amp; psychological support</td>
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These are driven by the three MCP/PACS vanguards and new care models programme arrangements. with structured clinical engagement and co-production with other STP Workstreams where there are key pathway interfaces (e.g. acute alliance for complex, EOL care and LTCs). Successful delivery will mean patients are enabled to stay independent for longer, have improved experience and engagement in health and care decisions alongside improved access and outcomes facilitated by proven care models

Outcomes and benefits to be delivered

- Improved outcomes for people with long term conditions/multiple co-morbidities
- Reduced A&E attendances/admissions for target conditions
- More people maintaining independent home living
- Extended primary care access and increased GP capacity to manage complex care due to improved skill-mix in wider workforce
- More sustainable local health and care economy

Revenue investment assumed and financial benefit

| Investments Required: £36m per annum by 2020/21 + funding for national priorities | Savings: £45.6m per annum by 2020/21 |

Projects Timescales

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<td>LTC - Diabetes &amp; Respiratory</td>
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Key personnel

CEO/SRO Sponsor: Karen Baker
Programme Director: Alex Whitfield, Chief Operating Officer, Solent
Programme Director: Chris Ash, Strategy Director, Southern Health
Finance Lead: Andrew Strevens, FD Solent
Project manager: Becky Whale
Clinical Leads: Dr Barbara Rushton, Dr Sue Robinson, Dr Sarah Schofield
Quality leads: Sarah Courtney, Acting Director of Nursing Southern Health & Julia Barton, Chief Quality Officer/Chief Nurse Fareham & Gosport and SE Hants CCGs

Stakeholders involved

- NHS Improvement
- UHS, PHT, HHFT, IOWT
- SCAS
- All CCG’s
- NHS England
- Public and politicians
- HCC, SCC, PCC and IOW Council
- Public representative organisations
- Solent and Southern
- Primary care
- CQC
- Voluntary and Community Sector
New Models of Care: Foundations for Independence and Self Care

**Project Objective:** To put in place workforce models and sets of functional capabilities that will enable appropriate redirection of clinical activity and processes in primary care towards increased self-care and prevention; allowing clinical time to be targeted where it will add most value.

**Project Description**
This project will focus on putting the skills and capacity in place to move current primary care activity from clinical to non-clinical. The project will build on good practice already happening in Hampshire and Isle of Wight and seek to accelerate the implementation and spread of good practice across the system. This will include:

- Care Navigators (linked to wellbeing hubs)
- Social Prescribing
- Patient Activation Measure (PAM)
- Web GP

**Outcomes and benefits to be delivered**

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<thead>
<tr>
<th>Outcomes</th>
<th>Benefits</th>
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<tbody>
<tr>
<td>By 16/17 – Rollout of technology enablers covering 50% of HIOW population</td>
<td>By 17/18 – Each natural community of care in HIOW has access to a menu of services</td>
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<tr>
<td>Reduced demand on clinical time in the primary care setting</td>
<td>Improved self-management of chronic conditions and/or minor illness</td>
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**Project Timescale**

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<td>Web-based triage and signposting roll out across whole HIOW</td>
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<td>PAM rolled out across HIOW</td>
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**Key personnel**

- **Workstream Owners:**
  - Web-based triage and signposting – Jane Druce
  - Patient activation – Lisa Hodgson
  - Care navigation/ social prescribing – Lisa Hodgson

**Stakeholders involved**

- NHS Improvement
- UHS, PHT, HHFT, IOW
- All CCG’s
- NHS England
- Public
- Politicians
- SCAS
- HCC, SCC, PCC and IOW Council
- Public representative organisations
- Solent and Southern
- Primary care
- CQC
- Voluntary and Community sector

**Revenue investment assumed and financial benefit**

- **Investments Required:** £0.5m per annum + IT spend
- **SAVINGS:** £9.34m (£8.84m net) per annum
New Models of Care Programme: Fully integrated primary care

**Project Objective:** Joining up the clinical professionals working around the patient in the primary care setting to meet needs, improve access, increase efficiency, change professional mix, and increase ‘right first time’ contacts.

**Project Description**

This programme will focus on two lead priorities, namely:

- **Working at scale to reform urgent access**
  - GP practices collaborating to deliver access for urgent needs across an extended 7 day period. This can only be achieved working at scale, and cannot be delivered without the requisite net investment set out in the 5YFV without destabilising core primary care. The focus of this development will be around a network of ‘hubs’, almost all either ‘virtual’ or within existing healthcare premises.

- **Extended primary care team**
  - Services operating within the currently fragmented out of hospital system merging to deliver a single, coordinated extended primary care team for local populations. This team will include greater skills mix and diversity of roles (not least to mitigate the medical workforce supply risks), a single clinical record with population health management capabilities, and an enhanced non-clinical base focussed on social support and prevention.

**Outcomes and benefits to be delivered**

- **By 16/17 – First wave primary care hubs evaluated. Pilot extended primary care teams in operation in three areas**

- **By 17/18 – 50% coverage of ‘hubs’ and extended primary care teams**

  - Reduced ED attends, NEL, GP demand, MH demand
  - £25.96m gross savings per annum by 2020/21, with big focus areas on prescribing, reductions in outpatient attendances, and overall emergency demand.
  - Freeing up GP time to focus on complex patients and so capacity enables other workstreams.

**Revenue investment assumed and financial benefit**

- **Investments Required:** £19m (GP 5YFV) per annum
- **SAVINGS:** £25.96m (£6.96m net) per annum

**Project Timescale**

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<td>MDT Primary Care Teams</td>
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<td>Urgent Access Care Hub</td>
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<td>Integrated Out of Hours &amp; Single Points of Contact</td>
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**Key personnel**

- **Workstream Owners:**
  - MDT Primary Care Teams – Paula Hull
  - Urgent Access Care Hub – Kerry Cooper

**Stakeholders involved**

- NHS Improvement
- UHS, PHT, HHFT, IOW
- All CCG’s
- NHS England
- Public
- Politicians
- SCAS
- HCC, SCC, PCC and IOW Council
- Public representative organisations
- Solent and Southern
- Primary care
- CQC
- Voluntary and Community Sector
New Models of Care Programme: Integrated intermediate health & social care

Project Objective: Create fully integrated health and social intermediate care services that will be designed around the services people need to recover and function independently

Project Description
This project will focus on development of a recovery focussed model, de-escalating care intervention at the earliest possible juncture, right-sizing support around individual patient need, includes:

- Domiciliary recovery and rehabilitation support teams
- Non-acute beds (health and social care)
- Emergency Department Liaison (e.g. FIT Portsmouth, CEDT)
- Urgent community response

As partners, we will establish single services and teams that will feature:

- Single leadership under a shared management arrangement
- Trusted assessment and a single framework by which to commit resources
- Single quality governance arrangements
- Transparent performance and utilisation information that contributes to overall system resilience

Outcomes and benefits to be delivered

**By 16/17 – 50% of HIOW covered by these arrangements**

- Reduced ED attends, NEL, LOS, admissions to care homes, domiciliary care demand, GP activity.
- 12% reduction in nursing home admissions.
- 3% reduction in NEL in ambulatory care sensitive conditions year on year. (Need to know % of NEL which are ACS).
- 3% reduction in DTOC and LOS
- MCAP hospital utilisation studies in HIOW (2012) – 30-40% OBD opportunity

**By 17/18 – 100% of HIOW covered by these arrangements**

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<td>Isle of Wight</td>
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Key personnel

Workstream Owners:
- Southampton – Lesley Munro (Solent)
- IOW – TBC
- Portsmouth – TBC
- Hampshire – Dr Jane Williams (SHFT) & Sally Jones (HCC)

Stakeholders involved

- NHS Improvement
- UHS, PHT, HHFT, IOW
- All CCG’s
- NHS England
- Public
- Politicians
- SCAS
- HCC, SCC, PCC and IOW Council
- Public representative organisations
- Solent and Southern
- Primary care
- CQC
- Voluntary and Community Sector

Revenue investment assumed and financial benefit

- Investments Required: £18m per annum
- SAVINGS: £23.04m (£5.04m net) per annum
New Models of Care: Complex care and end of life

**Project Objective:** Put in place de-layered access to specialism, intensive care coordination, and appropriate capacity to support the most complex patients within the registered list.

**Project Description**
This project will focus on scoping and implementing dedicated physical and virtual support options for the patients at highest risk or with complex, predictable care needs, including:

- Clinical support for the top 0.5% complex patient caseload within primary care
- Residential home clinical support
- Augmented community end of life care (last 4 weeks) pathway

Service model configuration will be optimised around local populations and this is expected to be around the acute trusts. Delivery of this workstream requires high level of engagement with appropriate clinical reference groups for these areas.

**Outcomes and benefits to be delivered**
- By 16/17 – Risk stratification undertaken to identify priority target groups
- By 17/18 – Standard protocols & service offer for top 0.5% registered lists in place in 50% of HIOW. Care homes service available for top 30 homes in HIOW

- Reduced ED attends, NEL, LOS particularly at EOL or from care homes.
- £21m NEL savings, with MCAP audits suggesting potentially higher OBD savings from early discharge
- Identified opportunity re frequent attenders / admitted patients c.£12m per annum
- Improved patient experience and engagement in health & care decisions

**Project Timescale**

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<td>scope fully</td>
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<td>End of life</td>
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**Key personnel**

**Workstream Owners:**
- Top 0.5% - Abi Barkham
- Care Homes – Lisa Hodgson & Lynda Lambourne (SCAS)
- End of Life – TBC

**Stakeholders involved**
- NHS Improvement
- UHS, PHT, HHFT, IOW
- All CCG’s
- NHS England
- Public
- Politicians
- SCAS
- HCC, SCC, PCC and IOW Council
- Public representative organisations
- Solent and Southern
- Primary care
- CQC
- Voluntary and Community Sector

**Revenue investment assumed and financial benefit**

| Investments Required: £2.5m per annum | SAVINGS: £15.07m (£12.57m net) per annum |
New Models of Care Programme: Long term conditions: Diabetes, Respiratory and Cardiac

**Project Objective:** To further develop and enhance the care pathway for people with chronic conditions that support improved self-management, education and targeted community support to maintain health and independence.

**Project Description**

This project will focus on moving to a predominantly community based model for long term conditions to include:

- Patient empowerment and focus on self management / education programme
- Increased/expanded focus on prevention and early identification of patients at risk of chronicity
- Focus on LTC services will be to work along the whole LTC spectrum from diagnosis and self-management, living for today, change in condition and include transitions to end of life care
- Targeted case finding and systematic registration, recall and review of patients
- MDT case management and shared decision making
- Access to psychological support
- Improve access to high quality information for patients and their families to aid and enhance the philosophy of self-management

The project will build on integrated pathway already happening across HIOW and seek to accelerate the implementation and spread of good practice across the system for key areas including (but not limited to):

- Diabetes
- Respiratory
- Cardiology

We will achieve this through:

- Patient and stakeholder engagement – designing services from a patient perspective ensuring health, social and holistic needs are addressed
- Working closely with the acute alliance and prevention programmes
- Linking with existing third sector organisations
- Bridging the gap between primary care, community services and secondary care
- Enabling extended care in a community setting wherever possible
- Population based outcome contracts

**Outcomes and benefits to be delivered**

- Improved patient experience
- Greater patient involvement with health and social care decisions
- Improved outcomes and reduced exacerbation for patients with chronic conditions
- Improved independence/interdependence for people with LTCS
- Reduction in activity associated with: primary care, ED, Non elective admission, outpatients and elective admissions

**Project Timescale**

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<td>Respiratory pathway</td>
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<td>Cardiac pathway</td>
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</table>

**Key personnel**

- **Workstream Owners:**
  - Diabetes – Dr Kate Fayers
  - Respiratory – Fiona Maxwell
  - Cardiac – TBC

**Stakeholders involved**

- NHS Improvement
- UHS, PHT, HHFT, IOW
- All CCG’s
- NHS England
- Public
- Politicians
- SCAS
- HCC, SCC, PCC and IOW Council
- Public representative organisations
- Solent and Southern
- Primary care
- CQC
- Voluntary and Community Sector

**Revenue investment assumed and financial benefit**

- **Investments Required:** £1.5m per annum
- **SAVINGS:** £13.04m (£11.64m net) per annum
New Models of Care Programme: LTC diabetes workstream

**Workstream objective:** A sustainable model of integrated multidisciplinary care delivered across natural communities of care, focussed on the following key principles:

Working with the Prevention programme we will:

- Roll out of national Diabetes Prevention Programme: aiming to identify those at high risk and refer them into evidence-based behavioural interventions to help them reduce that risk through achieving and/or maintaining a healthy weight, recommended levels of activity and a healthy, balanced diet.
- Targeted case finding in primary care by use of existing health check programmes and utilisation of the every contact counts philosophy
- Development of health and wellbeing models who are able to offer signposting to smoking cessation, weight management, active lifestyle services

**Patient engagement and activation**

- Shared decision making ‘no decision about me without me’
- Care planning: development of generic care plans with individualised targets and goal setting owned by the patient and shared across all health care professionals
- Increased access to peer support e.g. sugar buddies
- Use of social media, technology and apps e.g. Diasend
- Patient access to medical notes
- Structured educational programme, including personalised advice on nutrition and physical activity, that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education arranged around the needs of the patient.

**Primary care**

- Reduction in clinical variability across GP practices
- Developing a knowledge economy stretching from specialist to patient: providing a continuous education programme for health care practitioners
- Virtual hubs and extended MDT working with primary care at scale
- Workforce development e.g. expanding the role of care navigators, exploring diabetes technicians and patient educators
- Development of suite of tools (care planning, motivational interview techniques, use of technology, signposting e.g. IAPT, third sector organisations, health and well being services)

**Delayering Specialist Care**

- Professionals supported to work to the top of their licence
- Clear pathways for escalation/access to advice and guidance with reference to national best practice/guidelines
- Deliver care closer to home with patients able to access appropriate level of specialist care in a timely way
- Using the acute alliance to develop agreed pathways and amalgamated services e.g. MDT Foot clinics
- People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.
Core Programme 3: Effective Flow And Discharge

Programme Objective: To ensure no patient stays longer in an acute or community bed based care than their clinical condition and care programme demands and as a result reduce the rate of delayed transfers of care by improving discharge planning and patient flow, and by investing in capacity to care for patients in more appropriate and cost effective settings.

Programme Description
To address the issue of rising delayed transfers of care in HIOW we will deliver a 4 project plan focused on the underlying causes:

• To ensure that every patient has a Discharge Plan, informed by their presenting condition & known social circumstances, and which is understood by professionals; the patient; their relatives and carers (where appropriate) and includes plans for any anticipated future care needs
• To improve the value stream and utilisation of existing or reduced acute & community care space and resources, to provide safer, more effective patient and systems flow and resiliency.
• To identify patients with complex needs early in their journey and design an appropriate Onward Care support that prevent readmission, eliminate elongated acute spells and minimise patient decompensation
• To develop and provide cost effective Onward Health & Social Care services that where possible, reduces the cost of care whilst maximising patient outcomes

Outcomes and benefits to be delivered

1. Patients supported in the setting most appropriate to their health and care needs leading to improvements in LOS for patients currently residing in acute and community hospital beds (P1)
2. Improvements in LOS for patients staying 7-30 Days through multi agency stranded patient review (P1 & 2)
3. Improvements in LOS for episodes of 2-7 Days through SAFER effective flow management, removal of internal delay and 7 day services (P1 & 2)
4. Improvements in LOS for episodes of 0-2 days though the implementation of ambulatory care front door turnaround teams (P2)

Revenue investment assumed and financial benefit

Investments Required: £1m in 16/17

SAVINGS: £15m per annum by 2020/21

Projects Timescales

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<td>Every patient has a Discharge Plan</td>
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<td>Community notifications are automated (2 way)</td>
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<td>Care plans shared across community &amp; acute settings</td>
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<td>Multi- disciplinary teams are established</td>
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<td>Revision of CHC processes</td>
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<td>Increased use of the voluntary sector to support discharge</td>
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<td><strong>Development of onward care services</strong></td>
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<td>Care home development programme</td>
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<td>Domiciliary care services development</td>
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<td>Living well programme</td>
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Key personnel

Joint SRO: Graham Allen, Director of Adult Services HCC
Joint SRO: Heather Hauschild, Chief Officer West Hampshire CCG
Programme Director: Jane Ansell, West Hampshire CCG
Programme Adviser: Sarah Mitchell, Social Care Consultant (HCC)
Finance Lead: Mike Fulford, Finance Director, West Hampshire CCG
Programme Manager: Mike Richardson, SHFT
Quality lead: Fiona Hoskins, Deputy Director of Quality North East Hants & Farnham CCG

Stakeholders involved

• Patients/ Public through Wessex voices
• Primary Care & Community Services
• Voluntary Sector
• NHSI/NHSE/WAHSN
• Crisis care concordat
• HIOW CCGs
• NHS England
• HIOW Adult Social Care Alliance
Effective Flow Programme: Discharge Planning

Project Objective: To ensure that every patient has a Discharge Plan, informed by their presenting condition and known circumstances, which is understood by the patient, their relatives and carers and includes the Expected Date of Discharge (EDD), arrangements for the day of Discharge and, if needed, an outline of any anticipated onward care needs.

Project Description

The long term ambition of this project is to ensure every patient has an Automated Care Plan, accessible by Acute and Community MDT teams, consistently updated in real time by the lead professional at the point of care, accessible by the patient and their care team. In order to achieve this, existing challenges with Discharge Planning need to be addressed.

The key actions and activities for the project are:

- Every patient has a Discharge Plan created at pre-operative assessment, or on arrival at ED/AMU that includes input from the community and primary care. All plans will have an Expected Date of Discharge in line with NHS guidance.
- Multi-disciplinary/ multi-agency teams, including the voluntary and community sector, supporting discharge at the front door including minor needs being addressed through supported D2A
- A 2 way Community/PC notification process will be developed using planned changes under NHS Digital frameworks to enable community teams to react to admissions
- Clinical criteria for discharge will be established to facilitate nurse led discharge
- Patient and relative engagement will be enhanced to ensure compliance with organisational ‘Choice Policy’ and manage reluctant discharge downstream.
- 7 days services provision will ensure no patient waits in hospital because of a lack of service provision at weekends to level day of week discharge profiles
- Streamline restarts processes & improved turnaround for Discharge Summaries
- Development of trusted assessors (HIOW Trusted Professional) programme will commence to ensure assessment of need commences at the earliest opportunity and that process and systems duplication is minimised

The key measures of success for the Discharge Planning project, will be: Reduction in gap between Clinically Stable & Actual Date of Discharge; Reduced number of bed days DTOC/non-DTOC due to late planning arrangements; Increased number of patients going home on the first Planned Discharge Date and a decrease in patients needing management under the Choice Policy. At least 80% of the number of weekday discharges also happen on weekend days. No of restarts of existing care packages

Outcomes and benefits to be delivered

By 16/17 – Every patient in hospital will have a Discharge Plan, informed by their presenting condition and known social circumstances.

By 17/18 – Every patient will have an Automated Care Plan, accessible by Acute and Community MDT, the patient and their care team, consistently updated in real time at the point of care.

- Reductions in LOS due to lack of planning next steps
- LOS reductions including DTOC cases, due to patient choice and reluctant discharge
- Supports day to day operational flow & bed usage through more accurate EDD setting
- Supports no decision about me without me
- Development, in conjunction with NMC of alternatives to acute care pathways
- Integrated Discharge Teams, that work seamlessly to progress patient discharge

Revenue investment assessed and financial benefit

Contributes to overall finance investment and savings of programme:

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<tr>
<th>Investments Required: £1m in 16/17</th>
<th>SAVINGS: £15m per annum by 2020/21</th>
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Workstreams

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<td>Clinical criteria for discharge</td>
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<td>Access to discharge planning 7 days a week (including primary care and community records)</td>
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<td>Discharge menu accessible via DOS</td>
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<td>Reluctant discharge/choice framework (early notification process)</td>
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<td>Patient, relative and carer engagement strategy</td>
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<td>Discharge planning on admission guidance</td>
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<td>Data modelling of scenarios and improvement trajectories</td>
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<td>Integrated front door teams (to plan patients’ discharge)</td>
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Key personnel

- CCGs North Hampshire: Zara Hyde-Peters; West Hampshire Natasha Kerrigan (South) Jenny Erwin (Mid); IOW CCG Gillian Baker
- Acute-UHS: Jane Hayward/James Adam (c); PHT: ED Donald & Rob Haigh (c) IOW: Shaun Stacey & TBA HHFT: Julie Maskery & John Duffy
- Community- SSHFT Laura Rothery Solent: TBA
- Mental Health Alliance: Hilary Kelly
- Social Care Alliance Managers under the leadership of Sarah Mitchell
- NHS Digital- Chris Day /Sunil Rathed North Hampshire CCG

Stakeholders involved

- Patients
- NWB
- Clinical Pathway Leads
- NHS I- Systems Experts
- NHS England
- HIOW Commissioners
- HIOW Social Care Alliance/ Hospital Managers
- HIOW Operational Leads
Effective Flow Programme: Effective Management of Patient Flow

Project Objective: To improve the value stream and utilisation of existing or reduced acute & community care space and resources, to provide safer, more effective patient and systems flow and resilience.

Project Description

The ambition of this project is to accurately and consistently understand and manage the capacity, demand, acuity levels, utilisation and efficacy of every bed based care space across the Acute, Community and Mental Health sectors and to use that knowledge in real-time to risk assess healthcare services across HIOW.

Key actions for this project are:
- A Live Bed State for all bed based care settings including those currently managed in social care to ensure the transparency of pressure and effective use of NHS resources
- A focus on patients going home before lunch to ensure that capacity is freed up ahead of the afternoon & early evening peaks
- Implement weekly Stranded Patient Reviews to ensure that changes to Discharge Plans are refreshed and accurate EDDs are maintained
- Incorporate and if needed develop, NEWS information to risk assess ward level acuity to ensure staffing levels are able to facilitate timely discharge without compromising patient care.
- Reconfirmation of the principles of SAFER actions including effective board rounds, Red days & Green days, EDD revision and patient communication
- Implement revised Front Door Streaming models in all settings
- Monitoring of the application of 7 Day Service principles to support smoothing of ‘day of week ‘discharge.
- Develop roles across organisations to reflect the value all staff groups can make to discharge
- Support delivery of the A&E Constitutional standard through effective flow
- Focus on the challenge of timely and appropriate( MH Concordat) repatriations

The key measures of success for this project are:
- Planned vs actual discharge date; Improved A&E performance through a reduction in Waits for a Bed
- Earlier time (of day) of discharge-40 % medicine discharges home before lunch
- Shorter time to admission to a ward
- % ambulatory care/ improved utilisation of CDU capacity
- LOS benchmarks favourably vs Right Care and AEC thresholds

Outcomes and benefits to be delivered

- By 16/17 – Existing acute & community care space and resources will be effectively managed to provide safer, more effective patient and systems flow and resilience.
- By 17/18 – Capacity, demand, acuity, utilisation, efficacy of every care space in the Acute and Community sector will be accurately and consistently understood.

- • Real-time understanding of current bed state
- • Reduction in delays due to in hospital and external delays
- • Reduction in XBD charges to CCG’s (£30m over 5 years)
- • Move to Right Care & AEC excellence on LOS due to a reduction in internal delays on the clinical and discharge journey

Revenue investment assumed and financial benefit

- Contributes to overall finance investment and savings of programme: Investments Required: £1m in 16/17 SAVINGS: £15m per annum by 2020/21

Key personnel

- CCGs North Hampshire- Zara Hyde-Peters; West Hampshire Natasha Kerrigan(South) Jenny Erwin (Mid); IOW CCG Gillian Baker
- Acute-UHS: Jane Hayward/ James Adam (c); PHT: ED Donald & Rob Haigh (c) IOW: Shaun Stacey & TBA HHFT: Julie Maskery & John Dutty
- Community- SSHFT Laura Rothery Solent: TBA
- Mental Health Alliance: Hilary Kelly
- Social Care Alliance: Hospital Managers under leadership of Sarah Mitchell
- NHS Digital- Chris Day /Sunil Rathod North Hampshire CCG

Stakeholders involved

- • Patients
- • NWB
- • Clinical Pathway Leads
- • NHS I- Systems Experts
- • NHS England
- • HIOW Commissioners
- • HIOW Social Care Alliance/ Hospital Managers
- • HIOW Operational Leads

Project Timescale
Effective Flow Programme: Complex Discharge & Hard to Place Patients (HTPP)

Project Objective: To identify patients with complex needs early in their journey and design an appropriate Onward Care support that prevent readmission, eliminate elongated acute spells and minimise patient decompensation.

Project Description

The ambition of this project is to ensure that no patient, however complex, should spend more than 14 days in an acute or community care setting, if they are clinically stable for discharge, unless it is deemed by the MDT that hospital is the appropriate care environment.

This Project will be delivered using a strong collaboration between the HIOW Social Care Alliance developed specifically for this programme, the Acute Alliance and the voluntary sector. Initially the project will be a Hard To Place Patient Review which will see partners work in conjunction with patients and their families to place patients that have waited a significant time in the acute sector for transfer. It will also:

- Reiterate the Care Act Compliant counting rules for a daily reconciliation of delays
- Look to improve delays associated with the Assessment notices and CHC timelines, through improvements to process, systems and the development of Trusted Professional roles
- Robust management of Choice/Reluctant Discharges
- Improved utilisation of the services offered by the Voluntary Sector in the design of Onward Care solutions

The key success measures of success for this project are:

- Number of patients being discharged per week from an agreed baseline
- A reduced number of days lost for patients who are medically fit/clinically stable
- Average cost of care packages / placements for people leaving hospital consistent with those in the community
- Number of patients needing IFR
- Trusted Assessors / Care Homes assess patients within 24 hours of referral
- All CHC assessments carried out in the community
- Leaving Hospital policy implemented in every hospital
- Feedback from patients reflect safe and timely discharges achieved

Outcomes and benefits to be delivered

By 16/17 – Patients with complex needs will be identified early in their journey. Elongated acute spells will be eliminated, and patient decompensation will be minimised.

- Reduction in the LOS of Hard To Place Patients (often but not exclusively DTOC)
- Reduced numbers of CHC assessed in hospital
- Accurate reporting of DTOC Care Act compliant
- Reduction in the average cost of packages/placements due to reduced decompensation of patients/appropriate assessment of CHC

Revenue investment assumed and financial benefit

Investments Required: £1m in 16/17
SAVINGS: £15m per annum by 2020/21

Project Timescale

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Key Personnel

Senior Advisor and Project Leader: Sarah Mitchell HCC Social Care Advisor
System Leads:
- Social Care Alliance
- Acute Trust Alliance
- HIOW CCGs
- NHS Digital - Chris Day / Sunil Rathod North Hampshire CCG

Stakeholders involved

- NHS I/NHS England
- Primary Care
- Community Services
- Voluntary Sector
- Wessex Voices – patient and public
- Crisis Care Concordat
- HIOW CCGs
- HCC, SCC, PCC and IOW Council
- HIOW Social Care Alliance
- WAHSN
Effective Flow Programme: Development of onward care services

**Project Objective:** To develop and provide cost effective Onward Health & Social Care services that maximise patient outcomes and reduce the instances of avoidable readmission.

**Project Description**

The purpose of this project is to future-proof the cost of end to end care and support for the population through the development of the existing Onward Care model and the exploration and testing of alternative Onward Care models. The Project will: Understand the future needs of the HIOW population through demographic analysis and public health data

- Look at the current Domiciliary Care market provision and seek to reinvigorate interest in the Care sector through a range of incentives and recruitment initiatives including the development of an enhance university recruitment programme in collaboration with local academic leaders.
- Evaluate a model of community support based on the Living Well Cornwall model.
- Look at the role of the Discharge Summary in the management of Complex Discharge management in the community.
- Develop Care Home support models including community hubs to meet the needs of the full range of patients and staff in care homes and to support patients in their own place of residence.
- Roll out the LA Directory of Services e.g. Connect to Support so that patients and their relatives can seek readily available support mechanisms and reduce the risk of admissions.
- Proactively use Assistive Technologies in designing Onward Care support models in new and existing housing alternatives.

The key measures of success for this project are: Balanced demand and capacity in the care market Safe and timely discharge to reduce readmission for failed discharges; Effective discharge destination mapping; Reduced % of patients admitted to NH/RH; Reduced number of days recorded “waiting for a package of care”; % occupancy achieved in placement capacity (SHREWD); Reduced number of days lost due to choice of care home; Reduced inappropriate admissions from care homes.

**Outcomes and benefits to be delivered**

- Reduced DTOC to on or below the 3.5% expected rate of delays
- Reduce XBD by 25% from their July 2016 rate
- Reduce the Cost of Care to LA’s through strength/ asset based care
- Right Care, Right Place for patients
- Improved Outcomes through effective planning for deterioration
- Investment in Community and Primary Care to support OOH care

**Revenue investment assumed and financial benefit**

Contributes to overall finance investment and savings of programme:

| Investments Required: £1m in 16/17 | SAVINGS: £15m per annum by 2020/21 |

**Key personnel**

Senior Advisor and Project Leader: Sarah Mitchell HCC Social Care Advisor

System Leads across:
- HIOW Social Care Alliance
- HIOW Acute Trust Alliance
- HIOW CCGs
- NHS Digital
- Wessex Academic Health Science Network- Philippa Daighton

**Stakeholders involved**

- NHS I
- Primary Care
- Community Services
- Voluntary Sector
- Healthwatch and Wessex Voices – patient and public
- Crisis Care Concordat
- HIOW CCGs
- NHS England
- HCC, SCC, PCC and IOW Council
- HIOW Care Providers
- HIOW Education Providers and Employers

**Project Timescale**

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Core Programme 4: Solent Acute Alliance

Programme Objective: To deliver the highest quality, safe and sustainable acute services to southern Hampshire and the Isle of Wight. To improve outcomes, reduce clinical variation and lower cost, through collaboration between UHS, PHT, IoW NHST & Lymington Hospital. To provide equity of access to the highest quality, safe services for the population.

Programme Description

An Alliance between three hospital trusts to improve outcomes and optimise the delivery of acute care to the local population, ensuring sustainable acute services to the Isle of Wight.

This will be delivered by structured clinical service reviews. A first wave of collaborative transformational supporting services projects will include: Back Office Services Review; Pathology consortia (re-visited); Theatre Capacity Review; Pharmacy collaboration; Estates/Capital; and Out Patient Digital Services. The Better Birth Maternity Pioneer programme will also be implemented.

The acute alliance support the objectives of the cancer alliance and are linking directly with relevant clinical service reviews and prevention projects, including increased screening uptake and delayering access to increase early diagnosis.

Outcomes and benefits to be delivered

- Reduced clinical variation and improved outcomes
- Sustainable acute service to the Isle of Wight
- Improved length of stay
- Channel shift (digital outpatients)
- Elective demand control (in-line with best practice/guidance)
- Efficiencies of £156m by 2020/21
- Additional opportunities of £9m (elective demand reduction via RightCare). 40% of the estimated opportunity sits with North and Mid Hampshire

Projects Timescales

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Key personnel

The Chair of the Alliance Steering Group – Sir Ian Carruthers
Chief Exec Lead – Fiona Dalton
Programme Director – Tristan Chapman
Finance Lead – David French
Medical Director Lead – Simon Holmes
Director of Strategy Lead – Jon Burwell
Informatics lead– Adrian Byrne

Stakeholders involved

- NHS Improvement
- All CCG’s
- NHS England
- Public & patients
- Community Services
- Primary care
- CQC
- Cancer Alliance
Solent Acute Alliance: 2% Business As Usual CIP

Project Objective: Every organisation will target 2.5% CIP across the acute alliance. We anticipate 2% CIP will be delivered through the annual CIP cycle and partnership working would offer a further 0.5% opportunity. Ideas for partnership working are being developed through the Acute Alliance. We will align our CIP cycle and share methodology and ideas to maximise delivery across the acute alliance.

Project Description

The CIP work stream aims to deliver 2.5% recurrent cost savings per annum. CIP programmes will be governed and structured within existing CIP processes. CIP sharing events between the three trusts will be held to share ideas for CIP schemes. Each clinical service will present 17/18 CIP plans to trust executives for sign off. Identified CIP projects will form the CIP savings plan for implementation.

CIP delivery will be monitored internally in conjunction with finance teams internally within each trust. Quality assurance will be completed with nursing and medical directors to ensure that CIP plans do not impact on the quality of services to patient

Outcomes and benefits to be delivered

- Reduction in LoS
- Increased productivity (OP, theatre, diagnostics)
- Reduced cost (pay & non-pay)
- Improved service efficiency and asset utilisation

By 16/17 – CIP leads will collaborate on CIP process review and idea sharing. CIP plans for 17.18 will be set with clinical leads

By 17/18 – CIP plans for 17/18 will be implemented. Clinical presentations for 18/19 plans will take place and be approved by trust executives

Revenue investment assumed and financial benefit

Consumes to overall programme investments SAVINGS: £126.6m net

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Project Timescales

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Key personnel

CIP programme leads x 3
Finance leads x3
Service clinical leads

Stakeholders involved

- NHS Improvement
- All CCG's
- NHS England
- Public & patients
- Community Services
- Primary care
- CQC
Solent Acute Alliance: Clinical Service Review

**Project Objective:** To deliver the highest quality, safe and sustainable acute services to southern Hampshire and the Isle of Wight. To improve outcomes, reduce clinical variation and lower cost, through collaboration between UHS, PHT, IoW NHST & Lymington Hospital. Benchmark against RightCare data and investigate clinical flows and outcomes.

**Project Description**

UHS, PHT and the Isle of Wight Hospital Trusts will work as one to deliver the best health care outcomes delivered at the best value for the whole, collective population. Serving a population of 1.3m we will develop and deliver services that benchmark with the best in the world. Care will be delivered locally where possible, but centrally where this improves outcomes.

We will work with community providers allowing seamless services, and providing care and contact only when it offers best value. The alliance will support changes in clinical pathways or operational structures when these changes provide significant benefits in clinical outcomes, value, safety, resilience, expertise and delivery of national standards.

Trusts will remain sovereign organisations responsible for performance, quality, safety and finance. The alliance will facilitate service reconfiguration whilst maintaining individual financial stability.

Principles for service configuration include providing equal access to the highest quality service to the population, core services being provided at each centre, specialty collaborations using hub and spoke models, support of 24/7 provision and effective use of estate.

The clinical service reviews build on successful joint working in Cancer services across Alliance trusts.

**Outcomes and benefits to be delivered**

- Reduction in LoS
- Improved outcome metrics
- Reduction in admissions
- Reduction in OP/FU attendances
- Sustainable plan for services on IOW
- Delivery of national standards (RTT, 7 day services)

**Capital investment assumed and financial benefit**

| Investments Required: £5m (Capital) | SAVINGS: £2.6m (Revenue) |

**Project Timescales**

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**Key Personnel**

- Simon Holmes - Medical Director PHT
- Mark Pugh - Medical Director IoW
- Derek Sandeman - Medical Director UHS
- Clinical leads x 16 (x3 trusts)
- Management and strategy leads
- Finance lead

**Stakeholders involved**

- NHS Improvement
- All CCG’s
- NHS England
- Public & patients
- Community Services
- Primary care
- CQC

**Appendix A: Core Programmes**

- Clinical leads x 16 (x3 trusts)
- Management and strategy leads
- Finance lead
Project Objective: To deliver the highest quality, safe and sustainable acute services to southern Hampshire and the Isle of Wight. To improve outcomes, reduce clinical variation and lower cost, through collaboration between UHS, PHT, IoW NHST & Lymington Hospital. Benchmark against RightCare data and investigate clinical flows and outcomes.

Project Description

The urology review will firstly focus on options of providing a sustainable acute urology service on the Isle of Wight.

The team will also look to understand and adopt best practice across UHS/PHT and identify opportunities for collaboration.

Urology review will take place in the first wave of CSR from Oct-Dec 2016

Outcomes and benefits to be delivered

- Reduction in LoS
- Improved outcome metrics
- Reduction in admissions
- Reduction in OP/FU attendances
- Improved benchmarking against right care figures
- Sustainable plan for services on IOW
- Delivery of national standards (RTT, 7 day services)

Revenue investment assumed and financial benefit

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Key personnel

John Makunde, Clinical lead IOW
Julianna Hayward, Managerial lead IOW
Matt Hayes, Clinical lead UHS
Simon Holmes, Medical director PHT
Management and strategy leads x 3
Finance lead

Stakeholders involved

- All CCG’s
- NHS England
- Public & patients
- Community Services
- Primary care
- CQC
Project Objective: To deliver the highest quality, safe and sustainable acute services to southern Hampshire and the Isle of Wight. To improve outcomes, reduce clinical variation and lower cost, through collaboration between UHS, PHT, IoW NHST & Lymington Hospital. Benchmark against RightCare data and investigate clinical flows and outcomes.

Project Description
The spinal review will identify a partnership model to recruit spinal surgeons and maintain the PHT service at PHT. It will also identify options of providing a sustainable spinal service for the Isle of Wight.

The team will also look to understand and adopt best practice across UHS/PHT and identify opportunities for collaboration.

Spinal review will take place in the first wave of CSR from Oct-Dec 2016

Outcomes and benefits to be delivered
- Reduction in LoS
- Improved outcome metrics
- Reduction in admissions
- Reduction in OP/FU attendances
- Sustainable plan for services on IOW
- Delivery of national standards (RTT, 7 day services)

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Key personnel
Simon Holmes- Medical Director PHT
Mark Pugh- Medical Director IOW
Derek Sandeman- Medical Director UHS
John Scadden/Thomas L Reilley- Clinical leads IOW
Chris Dare- Clinical lead UHS
Management and strategy leads x 3
Finance lead

Revenue investment assumed and financial benefit

Contributes to overall finance investment and savings of programme:
Investments Required: £0.5
SAVINGS: £156m net

Stakeholders involved
- All CCG’s
- NHS England
- Public & patients
- Community Services
- Primary care
- CQC
Project Objective: To deliver the highest quality, safe and sustainable acute services to southern Hampshire and the Isle of Wight. To improve outcomes, reduce clinical variation and lower cost, through collaboration between UHS, PHT, IoW NHST & Lymington Hospital. Benchmark against RightCare data and investigate clinical flows and outcomes.

Project Description

The ENT service review will firstly focus on options of providing a sustainable acute ENT service on the Isle of Wight.

The team will also look to understand and adopt best practice across UHS/PHT and identify opportunities for collaboration.

ENT review will take place in the first wave of CSR from Oct-Dec 2016

Outcomes and benefits to be delivered

- Reduction in LoS
- Improved outcome metrics
- Reduction in admissions
- Reduction in OP/FU attendances
- Improved benchmarking against right care figures
- Sustainable plan for services on IOW
- Delivery of national standards (RTT, 7 day services)

Revenue investment assumed and financial benefit

Contributes to overall finance investment and savings of programme:

- Investments Required: £0.5
- SAVINGS: £156m net

Key personnel

Simon Holmes - Medical Director PHT
Mark Pugh - Medical Director IOW
Derek Sandeman - Medical Director UHS
Management and strategy leads x 3
Finance lead

Razvan Tasca - Clinical lead, IOW
Paul Nichols - Clinical lead, UHS
Clinical lead, PHT

Stakeholders involved

- All CCG’s
- NHS England
- Public & patients
- Community Services
- Primary care
- CQC

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Appendix A: Core Programmes
**Project Objective:** To deliver the highest quality, safe and sustainable acute services to southern Hampshire and the Isle of Wight. To improve outcomes, reduce clinical variation and lower cost, through collaboration between UHS, PHT, IoW NHST & Lymington Hospital. Benchmark against RightCare data and investigate clinical flows and outcomes.

**Project Description**

The haematology review will firstly focus on options of providing a sustainable acute haematology service on the Isle of Wight and reduce reliance on locum/private providers.

The team will also look to understand and adopt best practice across UHS/PHT and identify opportunities for collaboration.

Haematology review will take place in the first wave of CSR from Oct-Dec 2016

**Outcomes and benefits to be delivered**

- Reduction in LoS
- Improved outcome metrics
- Reduction in admissions
- Reduction in OP/FU attendances
- Sustainable plan for services on IOW
- Delivery of national standards (RTT, 7 day services)

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**Key personnel**

Matt Jenner, Clinical lead UHS
Mary Ganzowkowski, Clinical lead PHT
Diane Adams, Clinical lead IOW
Management and strategy leads x 3
Finance lead

**Revenue investment assumed and financial benefit**

Contributes to overall finance investment and savings of programme:

Investments Required: £0.5

SAVINGS: £156m net
Solent Acute Alliance: Outpatient Digital

**Project Objective:** To reduce unnecessary outpatient attendance when an alternative can be safely offered. Using digitally enabled pathways to improve value and patient experience. There are two categories: OP digital technologies and OP/FU pathway change.

**Project Description**
Progress is already in track developing alternative OPFU pathways in Hampshire using technology such as ‘My Medical Record’. Case studies such as the virtual fracture clinic in Glasgow, which has reduced face to face follow up by 71%, gives us confidence we can go much further.

Focusing on Outpatient follow up, the Acute Alliance is working with digital partners to offer alternative patient pathways. The OP digital work stream aims to reduce face to face follow up by 20% across the Acute Alliance.

**Outcomes and benefits to be delivered**

- 20% reduction in face-to-face follow ups
- Improved patient experience through digital enabled pathways
- £13.8m savings

**Project Timescales**

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**Key personnel**
- Clinical Service Leads
- Adrian Byrne – IT Lead UHS
- Chris Tite, IT Lead PHT
- Maher El-Alami, IT Lead IOW
- Andrew Shorkey, Strategy Lead IOW
- Debbie Burrows, Transformation lead PHT
- Angie McClaren - Service Improvement lead - UHS
- Joanne Case - Head of service improvement - IOW

**Stakeholders involved**
- UHS, IOW, PHT
- NHS Improvement
- CCGs
- NHSE
- STP Digital Programme

**Capital investment assumed and financial benefit**

- **Investments Required:** £1m (capital)
- **SAVINGS:** £13.8m net
Solent Acute Alliance: Pathology

**Project Objective:** To provide a sustainable and efficient pathology services across the Solent Acute Alliance. To identify opportunities to improve value and quality through collaboration on a ‘service by service’ basis. Benchmark against NHSI data and investigate variation.

**Project Description**

The Pathology work stream aims to review pathology provision across the three trusts in the Solent Acute Alliance. In 2012 a business case was developed for consolidation of Alliance pathology services, this did not go ahead.

A review has suggested that circa £2m of the savings identified in this business case might still be available. Pathology will join the clinical service review process covering sustainability, efficiency, quality and safety.

Alongside the clinical service review, Carter benchmarking results will be reviewed for further opportunities to create efficiency through working together.

**Outcomes and benefits to be delivered**

- Sustainable pathology services across Solent Acute Alliance
- Maximise operational efficiency
- Maintain quality and safety of clinical care, including interdependencies across the three trusts
- Support research activity across the three trusts
- Release financial benefits achieved via consolidation of individual services

**Project Timescales**

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**Key personnel**

Ian Howard - Finance lead  
Nick Hurlock - Managerial lead UHS  
Helen Tasker - Managerial lead IOW  
Paul Cook - Clinical lead UHS  
Strategy leads  
PHT - TBC

**Stakeholders involved**

- NHS Improvement
- All CCG’s
- NHS England
- Public & patients
- Community Services
- Primary care
- CQC

**Capital investment assumed and financial benefit**

- **Investment Required:** £3.75m (Capital)
- **SAVINGS:** £2.25m net (Revenue)
Solent Acute Alliance: Estates

Project Objective: To explore opportunities to offer ‘UHS estates limited’ service provision to STP partners to offer efficient and effective provision of estates services (including high value equipment).

Project Description
As a foundation Trust UHS has created a wholly owned subsidiary to provide estate and equipment cost effectively. This service could be offered to wider partners across the Alliance and STP to offer greater savings.

Activities to enable delivery include:
- Review of capital spend available to complete through UEL
- Feasibility study
- Analysis of financial benefits of UEL

Outcomes and benefits to be delivered
- Enhanced facilities
- Operational efficiencies
- Opportunities and incentives for staff
- Maximised NHS income streams
- VAT efficiencies (20%) (exact figure dependent on the value of schemes)

Project Timescales

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Key Personnel
- David French - Chief finance officer, UHS
- Chris Adcock – CFO PHT
- Chris Palmer – CFO IoW
- Kim Perry - UEL

Stakeholders involved
- UHS, IOW, PHT, Wider STP Partners

Revenue investment assumed and financial benefit

| Investments Required: £0.5 | SAVINGS: £156m net |

Contributes to overall finance investment and savings of programme:
Solent Acute Alliance: Pharmacy

Project Objective: To improve the cost efficiency and maximise income generation through collaboration across Solent Acute Alliance pharmacy services.

Project Description
A project team has formed between pharmacy services at IOW, UHS and PHT looking at methods of increasing income generation and reducing cost through collaboration. Two proposals have been brought forward:
1. For PHT to run a distribution and production facility for the acute alliance as they have a wholesale license and can supply other Trusts.
2. For UHS to expand UPL to provide outpatient dispensing service to the acute alliance trusts.

Consolidating Aseptic production facilities has been considered and will be reviewed in 17/18. UHS needs to replace an existing facility as part of ‘business as usual’ investment. The practicalities and benefits of consolidation beyond this are not clear and require further investigation.

Outcomes and benefits to be delivered
- Cost reduction in the distribution of drugs to the acute alliance
- Improved purchasing power
- Income generation from outpatient pharmacy facilities
- VAT savings from outpatient pharmacy facilities

Project Timescales

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Key Personnel
- Sue Ladds, Pharmacy lead UHS
- Gary Edgson, Finance lead, IOW
- Gillian Honeywell, Pharmacy lead IOW
- Jane Hayward, Strategy lead UHS
- Amanda Cooper, Director of Medicines Optimisation & Pharmacy, PHT

Stakeholders involved
- UHS, IOW, PHT

Capital investment assumed and financial benefit

Investments Required: £1.3m (capital)

SAVINGS: £1m
Solent Acute Alliance: Theatres

**Project Objective:** Repatriate patients receiving care in the private sector to the NHS. Increase utilisation of NHS theatres. Re-utilise bed capacity made available through other STP workstreams. Reduce identified procedures of limited clinical value (PoLCV). Benchmark against RightCare data and investigate clinical flows and outcomes.

**Project Description**

Across HIOW circa 8000 cases are outsourced to the private sector, both from providers and CCGs. Bringing this work back into the NHS would deliver a further contribution against fixed assets and fill capacity released by reduced DToC and other workstreams mitigating demand for non-elective medical care.

The work stream aims to treat an additional 5000 patients in the NHS (a combination of work outsourced directly from CCGs, assuming 50%, excl ISTC) and 100% of cases outsourced by providers.

**Outcomes and benefits to be delivered**

- Repatriation of surgical work to the NHS
- Increased theatre capacity across Alliance
- Improvements at Lymington, PHT, UHS and IOW sites
- Reduced waiting times for surgery
- Reduced PoLCV

**Project Timescales**

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**Key personnel**

- Sue Leamore, Strategy lead UHS
- Andrew Shorkey, Strategy lead IOW
- Leisa Gardiner, Management lead IOW
- CCG leads

**Stakeholders involved**

- UHS, IOW, PHT
- CCGs
- NHSE

**Capital investment assumed and financial benefit**

- **Investments Required:** £16.70m (capital)
- **SAVINGS:** £5m (revenue)
Solent Acute Alliance: Back Office Service Review

**Project Objective:** To ensure the provision efficient and cost effective back office services across UHS, PHT and IOW. To use Carter benchmarking data to identify areas for improvement and lower cost, through collaboration between UHS, PHT, IoW NHST & Lymington Hospital. Benchmark against NHSI data and investigate variation.

**Project Description**

Historical data from 5 years ago identified that back office costs were, in the NHS, £2.8bn with £616m 22% savings being possible. Since that time some considerable cost reductions will have been realised in HIOW particularly through SBS and CSU’s but we are aware of the considerable gains made in other areas of the Public Sector – particularly Local Authorities – in the past 5 years. We would be seeking to learn from these and explore opportunities for collaboration and cost sharing.

**Outcomes and benefits to be delivered**

- Collaboration on strategic workforce and IT planning and decision making
- Reduced costs via benchmarking, adoption of best practice and consolidation.
- Proposals progressed via benchmarking analysis and business cases
- Finance ‘quick win’ identified – potential savings of £400k.

**Revenue investment assumed and financial benefit**

| Investments Required: £0 | SAVINGS: £0.4m net |

**Project Timescales**

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<td>Identify Best Practice evidence</td>
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**Key personnel**

- Paul Goddard
- Adrian Byrne
- Steve Haris
- Gary Edgson
- Paul Dubery
- Mark Elmore

**Stakeholders involved**

- UHS, IOW, PHT
- NHS Improvement
- Acute back office staff
- CCGs
- NHSE
Core Programme 5: North & Mid Hampshire

Programme Objective: To create a sustainable, high quality and affordable configuration of acute services for the population of North & Mid Hampshire and the out-of-hospital services to support that configuration (linking with the New Models of Care programme)

Programme Description
A sustainable, quality configuration of acute services for the population of North and Mid Hampshire will be achieved through 3 key activities:

- Review and deliver the optimum acute care configuration for North and Mid Hampshire
- Deliver new models of care (incorporated in New Care Models programme)
- Deliver of provider CiP plans

Outcomes and benefits to be delivered

- Sustainable access to 24/7 consultant delivered acute care for the North & Mid Hampshire population and improved outcomes through care closer to home
- Improved quality and performance targets
- Deliver performance targets
- Delayer / remove boundaries between acute/community/primary care/mental health/social care
- Deliver system level savings
- Align incentives in the system to deliver a shared control total
- Efficiencies of £60m by 2020/21

Projects Timescales

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Key personnel

CEO/SRO Sponsor – Heather Hauschild, Chief Officer West Hampshire CCG, Mary Edwards, Chief Exec Hampshire Hospitals & Paul Sly Interim Accountable Officer North Hants CCG
Clinical Sponsor – Tim Cotton, Andrew Bishop & Nicola Decker
Programme Director – Heather Mitchell, Director of Strategy, West Hants CCG
Programme Director - Niki Cartwright, Interim Director of delivery NHCCG
Finance Lead – Mike Fulford, Finance Director, West Hants CCG; Pam Hobbs, Finance Director North Hants CCG & Malcolm Ace FD HHFT
Quality lead – Edmund Cartwright, Deputy Director of Nursing West Hants CCG

Stakeholders involved

- NHS – GP’s Specialist Commissioning, HHFT, UHS, SHFT, CCG’s, SCAS
- Public & Patient Groups
- Government – Local authorities, HCC, Public Health, Local Councillors / MP’s
- Regulators – NHSE, NHSI

Revenue investment assumed and financial benefit

Investments Required: £TBCm dependant on recommended configuration
SAVINGS: £41m CIP per annum by 2020/21

By 16/17 - The best option for configuration of services in North & Mid Hampshire will have been identified
By 17/18 - Consultation on and agreement of option for configuration of services in North & Mid Hants

• By 16/17 - Consultation on and agreement of option for configuration of services in North & Mid Hants
• By 17/18 - The best option for configuration of services in North & Mid Hampshire will have been identified
North & Mid Hants Programme: Optimum acute care configuration

Project Objective: To create a sustainable, high quality and affordable configuration of acute services for the population of North & Mid Hampshire

Project Description

• To reach a conclusion on the configuration of acute services in North and Mid Hampshire.
• To develop services that improve quality and contribute to the financial target as described in the STP.
• To work in parallel with the Solent Acute Alliance and the New Models of Care STP workstream, and to test the acute service reconfiguration proposals against emerging findings.

Outcomes and benefits to be delivered

- Sustainable access to 24/7 consultant delivered acute care for the North & Mid Hampshire population and improved outcomes through care closer to home
- Improved quality and performance targets
- Align incentives in the system to deliver a shared control total

Project Timescale

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Key personnel

CEO/SRO Sponsor – Heather Hauschild, Chief Officer West Hampshire CCG, Mary Edwards, Chief Exec Hampshire Hospitals & Paul Sly Interim Accountable Officer North Hants CCG
Clinical Sponsor – Tim Cotton, Andrew Bishop & Nicola Decker
Programme Director – Heather Mitchell, Director of Strategy, West Hants CCG
Programme Manager - Niki Cartwright
Finance Lead – Mike Fulford, Finance Director, West Hants CCG; Pam Hobbs, Finance Director North Hants CCG & Malcolm Ace FD HHFT

Stakeholders involved

- NHS – GP’s Specialist Commissioning, HHFT, UHS, SHFT, CCG’s, SCAS
- Public & Patient Groups
- Government – Local authorities, HCC, Public Health, Local Councillors / MP’s
- Regulators – NHSE, NHSI

Revenue investment assumed and financial benefit

Investments Required: TBC dependent on recommended configuration

SAVINGS: TBC dependent on recommended configuration

Appendix A: Core Programmes
North & Mid Hants Programme: HHFT CIP Plan

Project Objective: To secure cost improvement through the annual CIP plan cycle

Project Description
To deliver annual recurrent efficiencies consistent with the recommended option for the configuration of acute services.

The selection of the recommended option will instigate a different range of CIP activities based on:
- Optimum estate configuration
- Optimum clinical and nursing staffing
- Optimum configuration of clinical and other support services

Underpinning all CIPs will be a commitment to excellence in procurement, the attainment (where practicable exceeding) Operational Productivity goals and standards and the elimination of waste in non-clinical services

Outcomes and benefits to be delivered

- Annual CIP efficiency of at least £10.5 million per annum 2016/17 – 2020/21

Financial benefit

£ SAVINGS: £41m CIP per annum by 20/21

Project Timescales

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Key personnel

CEO/SRO Sponsor – Heather Hauschild, Chief Officer West Hampshire CCG, Mary Edwards, Chief Exec Hampshire Hospitals & Paul Sly Interim Accountable Officer North Hants CCG
Programme Director – Heather Mitchell, Director of Strategy, West Hants CCG
Finance Lead – Malcolm Ace FD HHFT

Stakeholders involved

- Hampshire Hospitals NHS Foundation Trust
- Relevant Commissioners
- Relevant social care providers
Core Programme 6: Mental Health Alliance

Programme Objective - To improve the quality, capacity and access to mental health services in HIOW. This will be achieved by the four HIOW Trusts providing mental health services (SHFT, Solent NHST, Sussex Partnership FT and IoW NHST), commissioners, local authorities, third sector organisations and people who use services, working together in an Alliance to deliver a shared model of care with standardised pathways

Programme Description

We are committed to valuing mental and physical health equally to ensure that support for mental health is embedded holistically across the system and not seen in isolation in order to achieve parity of esteem. We will ensure that people experience a seamless coherent pathway that incorporates the key principles of prevention, risk reduction, early intervention and treatment through to end of life care. The Five Year Forward View for Mental Health, Dementia Implementation Plan, Future in Mind and the Wessex Clinical Network Strategic Vision provide us with a blueprint for realising improvements and investment by 2020 /21 and the mechanism for mobilising the system.

We will achieve this by working at scale to:

Review and transform:
- acute and community mental health care pathways
- rehabilitation and out of area placements
- mental health crisis care pathways

Transformation of mental health services for children and young people including access to tier four beds for young people will be aligned to the Mental Health Alliance and the STP delivery plan. This transformation programme will be underpinned by integrated approaches to commissioning mental health services on an Alliance wide basis. We are committed to reviewing how money from physical health services can be transferred into mental health services. We will develop the workforce to deliver holistic and integrated services for people.

Outcomes and benefits to be delivered

- Adult mental health services will provide timely access to recovery based person centred care in the lease restrictive setting for the least amount of time
- People in mental health crisis have access to 24/7 services
- Services will meet the ‘Core 24’ service standard for liaison mental health
- Out of area placements will be reduced with the aim to eliminate these by 2020/21
- Young people will have improved access to emotional wellbeing services through the Future in Mind Transformation Plans

Revenue investment assumed and financial benefit

Investments Required: £45m assumed to include partial funding of 5YFV. Additional funding required from STP to meet full 5YFV

SAVINGS: £28m per annum by 2020/21

Projects Timescales

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<td>Acute and community mental health pathway review and redesign</td>
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Key personnel

CEO Sponsor: Sue Harriman, Solent NHS Trust
Medical Director and SRO: Dr Lesley Stevens
Programme Director: Hilary Kelly, HIOW STP
Quality lead: Mandy Rayani, Chief Nurse Solent NHS Trust

To support delivery of this programme we have formed a Mental Health Alliance with membership from HIOW Mental Health Providers, CCGs, Local Authorities and the third sector.

Over the development of this plan we have sought clinical input and leadership through our STP Mental Health Clinical Reference Group

To support the work of the Alliance and our aspiration for developing new ways of commissioning we have in place an STP Mental Health CCG Planning Group

Stakeholders involved

- NHSI
- Primary care
- CQC
- Voluntary & Community Sector
- Wessex voices: patient & public
- Wessex Mental Health and Dementia Clinical Network
- Crisis Care Concordat
- HIOW CCGs
- Surrey and Borders NHSFT
- NHS England
- HCC, SCC, PCC, IOW Council
- Health Education England
- Wessex Academic Health Science Network
Mental Health Alliance: Acute and community mental health pathway review and redesign

**Project Objective** - to review and redesign current acute pathways and community service provision and develop a network of services through the Mental Health Alliance

**Project Description**

In line with the Crisp report: Old Problems, New Solutions  Improving acute psychiatric care for adults in England we are committed to improving patients experience and outcomes by transforming the way that acute and community services are delivered across HIOW. This will mean that as many people as possible are provided with quality care as close to home as possible and are supported to live independently. Our goal is that equitable recovery based services will be commissioned and delivered on a HIOW Mental Health Alliance wide basis within a single model of care, agreed - standardised pathways and protocols, aligned and managed in one system.

The programme will include developing an innovative approach to service configuration which best suits the need of people who use the services, their carers and the workforce. The following services will be included:

- Adult inpatient assessment and treatment wards
- Liaison mental health
- Psychiatric Intensive Care Units (PICU)
- Crisis resolution home treatment
- Community mental health

**Outcomes and benefits to be delivered**

*By 2016/17 a needs and demand profile of our local population will be in place*

*By 2017/18 a sustainable solution for inpatient, PICU and community provision will be agreed*

- Support as close to home as possible at times when people need it
- Reduction in the number of admissions under the mental health act
- Reduced variation in service provision and improved outcomes and experience
- Sustainable acute mental health services across HIOW

**Revenue investment assumed and financial benefit**

Investments Required: £9.20 m  SAVINGS: £19.28 m

**Project Timescales**

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<tbody>
<tr>
<td>Needs and demand profiling of the local population</td>
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<tr>
<td>Benchmarking innovative ways of working</td>
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<tr>
<td>System review of acute and community mental health care</td>
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<tr>
<td>Review services in line with constitutional standards, usage, local need, carer and client experience, clinical standards</td>
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<tr>
<td>Coproduce Alliance wide recovery based pathways and care models</td>
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</table>

**Key personnel**

CEO Sponsor: Sue Harriman, Solent NHS Trust  
Medical Director and SRO: Dr Lesley Stevens  
Programme Director: Hilary Kelly, HIOW STP

**Stakeholders involved**

- NHSI  
- Primary care  
- CQC  
- Voluntary & Community Sector  
- Wessex voices: patient & public  
- Wessex Mental Health and Dementia Clinical Network

- Crisis Care Concordat  
- HIOW CCGs  
- Surrey and Borders NHSFT  
- NHS England  
- HCC, SCC, PCC, IOW Council  
- Health Education England  
- Wessex Academic Health Science Network
Mental Health Alliance: Review and Redesign of the HIOW Mental Health Rehabilitation Pathway - Out of Area Placement Protocol

**Project Objective** - To change the way in which services are delivered within HIOW, ensuring people currently supported in expensive out of area placements are repatriated and supported in services, locally provided, which are much more cost effective and closer to home.

**Project Description**

This programme aims to ensure an effective HIOW process to reduce the number of Out Area Placements (OAP) and establish a mental health rehabilitation pathway that has a managed functional network of services across a wide spectrum of care, and the exact components of the care pathway provided determined by local need. It is likely to comprise:

- Inpatient and community based rehabilitation units
- Community rehabilitation teams
- Supported accommodation services
- Services that support service users’ occupation and work
- Advocacy services
- Peer support services.

**Outcomes and benefits to be delivered**

- Expensive out of area placements are repatriated and supported in services, locally provided, which are much more cost effective and closer to home.
- Significant reduction in current out of area placements
- Significant reduction in placements outside of area in future

**Project Timescales**

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<tr>
<td>Stocktake, map existing local providers and analyse options to expand the range &amp; choice local services Needs assessment Establish a protocol, process and pathway</td>
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<td>Develop and agree delivery of a HIOW intensive recovery-focused rehabilitation care pathway for people with mental health issues bringing health, social care and housing support together (HIOW CCGs, NHS Trusts Alliance and Local Authorities).</td>
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<tr>
<td>Explore options to pool resources to develop a new, joint and coordinated mental health rehabilitation pathway for HIOW via a HIOW Mental Health Alliance Contract 2017-20.</td>
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**Key personnel**

CEO Sponsor: Sue Harriman, Solent NHS Trust
SRO/Executive: Sue Lightfoot, IW CCG
Programme Director: Hilary Kelly

**Stakeholders involved**

- NHSI
- Wessex voices: patient & public
- Wessex Mental Health and Dementia Clinical Network
- HIOW CCGs
- Surrey and Borders NHSFT
- NHS England
- HCC, SCC, PCC, IOW Council
- Health Education England
- Wessex Academic Health Science Network

**Revenue investment assumed and financial benefit**

| Investments Required: £2m | SAVINGS: £6.28m net |
Project Objectives: To develop HIOW crisis pathways and system response and develop and agree STP wide pathways and protocols and new ways of working to ensure people presenting in mental health crisis have access to timely appropriate care

Project Description:
- STP wide strategies, pathways and protocols for all agencies meeting crisis needs
- Programme and project Management support for multi-agency crisis concordat HIOW group
- Crisis prevention strategy to reduce crisis upstream and promote effective de-escalation, including secondary care input into primary care setting
- Single point of contact out-of-hours triage linked with peripatetic mental health services and professionals advice to reduce emergency presentations
- Mental health clinical team providing pre and post crisis support at home
- Use of technology to provide rapid access to evidence-based interventions and reduce the need for face to face interventions such as the use of EIP Apps
- Emergency department response and facilities for mental health crisis
- Provision of short term respite housing for individuals close to crisis point
- Develop the capacity and capability for all individuals to hold a crisis plan
- System response and review 136 suite capacity and use for those detained under section 135 and 136 of the Mental Health Act 1983

Outcomes and benefits to be delivered

By 16/17 – clear strategies and system wide pathways and protocols have been agreed across all partners to address crisis presentation, with early pilots in place

By 17/18 – A single point of contact for anyone seeking help with a mental health crisis is established, with access to a range of immediate support

- More people will have been supported to avoid a mental health crisis and will present at a location appropriate to their mental or physical health need.
- Individuals for whom a crisis presentation can be foreseen will have a their own crisis plan shared by all agencies that support them, including primary care.
- All acute hospitals will have all-age mental health liaison teams in place, that meet the ‘Core 24’ service standard as a minimum this will ensure reduced length of stay and improved patient flow through the system.
- There will be a reduction in attendances to emergency departments
- 60% of people with first episode psychosis starting treatment with
- A NICE-recommended package of care with a specialist early intervention in:
  - psychosis (EIP) service within two weeks of referral
  - Reduction in the use of detentions in a place of safety by at least 50%

Revenue investment assumed and financial benefit

Investments Required: £0.20m  SAVINGS: £2.45m net

Workstreams
- Development of STP wide pathways and protocols
- Crisis prevention strategy to reduce crisis and de-escalate effectively
- Use of technology to provide rapid access to evidence-based interventions and reduce the need for face to face interventions such as the use of EIP Apps
- Access to out-of-hours triage and mental health services to reduce emergency presentations
- Improved emergency department response to mental health crises
- System response and review 136 suite capacity and use for those detained under section 135 and 136 of the Mental Health Act 1983
- Development of short term respite to avoid crisis and improve crisis planning

Key personnel
CEO Sponsor: Sue Harriman, Solent NHS Trust
Medical Director and SRO: Dr Lesley Stevens
Programme Director: Hilary Kelly, HIOW STP

Stakeholders involved
- NHSI
- Primary care
- CQC
- Voluntary & Community Sector
- Wessex voices: patient & public
- Crisis Care Concordat
- HIOW CCGs
- Surrey and Borders NHSFT
- NHS England
- HCC, SCC, PCC, IOW Council
- Wessex Mental Health Clinical Network
Enabling Programme 7: Digital

Programme Objective: To give patients control of their information and how it is used, allowing patients to manage their long term conditions safely and enable patients to access care at a time, place and way that suits them. To build a fully integrated digital health and social care record, and the infrastructure to allow staff to access it from any location.

Programme Description
This workstream is designed to:
- increase the quality of service provision
- reduce the pressure on care services and
- improve efficiency

The ambitions of this programme are to:
- Provide an integrated digital health and care record
- Unlock the power of data to inform decision making at point of care
- Deliver the technology to shift care closer to home
- Establish a platform to manage Population Health
- Drive up digital participation of service users
- Drive up digital maturity in provider organisations

- In addition the footprint will share the benefits and potential the ‘digital centre of excellence’ award given to the University Hospital Southampton.

A strategic roadmap for the delivery of the programme has been developed and agreed.

Outcomes and benefits to be delivered
- An integrated care record for all GP registered citizens in Hampshire and IoW
- Flexible IT systems enabling care professionals to work from any location, with access to citizens health and care records
- Citizens able to self manage their health and care plans – eg managing appointments, updating details, logging symptoms
- Real time information to support clinical decision making

Projects Timescales

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<td>HIOW Technical Strategy</td>
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<td>Patient Data Sharing Initiative (Phase 1)</td>
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<td>Patient Portal</td>
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<td>E-Prescribing &amp; Medicine Reconciliation</td>
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<td>Digital Communications across Care Providers</td>
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<td>Wi-Fi for HIOW &amp; Cyber Security</td>
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<td>Channel Shift (Phase 1-e-consultations)</td>
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<td>Care co-ordination centre Infrastructure</td>
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<td>Optimising intelligence capability</td>
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<td>SCAS LiveLink Pilot</td>
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</table>

Key Personnel
Lisa Franklin - SRO
Dr Mark Kelsey – Clinical Lead
Roshan Patel – Finance Lead
Andy Eyles – Programme Director
Mandy McClenan – Acting Programme Manager

Stakeholders involved
All HIOW partners and programmes

Investment required

| Investments  | Required: £35.4m | Revenue: £10m per annum by 2020/21 |
## Enabling Programme 7: Digital

### How will Digital enable the core programmes?

<table>
<thead>
<tr>
<th>Digital Project</th>
<th>Transformational Benefits</th>
<th>Solent Acute Alliance</th>
<th>New Models of Care</th>
<th>Mental Health Alliance</th>
<th>Effective Patient Flow and Discharge</th>
<th>Prevention at Scale</th>
<th>North &amp; Mid Hampshire configuration</th>
</tr>
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<tbody>
<tr>
<td><strong>Patient Data Sharing Initiative</strong></td>
<td>A shared record would enable all health and social providers to access a single source of patient information which would reduce the need for patients to repeat information, save professionals time and reduce duplication of diagnostics.</td>
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<td>Integrated complex care plans allow multi-disciplinary teams to develop and deliver plans for identified groups of patients, by providing a single up-to-date record which can be shared and updated across a whole health community.</td>
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<td>Digital care plans that includes social care information and patients’ personal circumstances provide the admitting hospital with the information they need to assess. As a result preparations for complex discharges can begin much earlier in the process.</td>
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<td>Help clinicians to identify those at risk using intelligent analytics to target brief intervention</td>
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<td>Link patients directly to their results and advice on treatment, if needed</td>
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<tr>
<td><strong>Patient Portal</strong></td>
<td>A patient portal will allow patients to co-manage their healthcare online reducing the need for hospital visits. It will offer 24/7 support and information, allow patients to cancel and re-book appointments online, view their record and facilitate online consultations</td>
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<td>Helping to keep relatives/carers informed and engaged.</td>
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<td>Provide patient access to self-help interventions for smoking, alcohol interventions, weight self-management and increasing activity levels. Linking to health portal can help personalise information</td>
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<td><strong>E-Prescribing &amp; Medicine Reconciliation</strong></td>
<td>Safer and more effective prescribing through a fully integrated, end to end medicines management which allows automated supply, decision support and real time monitoring. This will comprise EPMA in hospitals including closed loop prescribing for safety, medicines reconciliation and standards for coding (DM+D).</td>
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<td>Ensuring that TTOs are ready and available immediately the patient is discharged from Hospital</td>
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<tr>
<td><strong>Digital Communications</strong></td>
<td>Instant messaging and telepresence enables professionals in different care settings to interact easily with group video calls enabling multi-disciplinary teams to meet online.</td>
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<tr>
<td><strong>Wi-Fi for HIOW &amp; Cyber Security</strong></td>
<td>Ability for staff to access and update patient records, and for patients to access online resources at all health and social care sites.</td>
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<td>Broadly available Wi-Fi will allow community teams that are either co-located or working in the community to get access to their line of business of systems and the HHR.</td>
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<tr>
<td><strong>Channel Shift (Phase 1 e-consultations)</strong></td>
<td>Provides access online resources 24/7. Reduces need for face-to-face consultations, leading to practice efficiency savings. Provides opportunity to collect comprehensive history and early identification of symptoms leading to more productive consultations.</td>
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<tr>
<td><strong>Care co-ordination centre infrastructure</strong></td>
<td>A HIOW level ‘flight deck’ for co-ordinating health and care service delivery, building upon the infrastructure for 999 and 111 calls, providing routing for primary care appointments, referring to clinical hubs, and improving maintaining a live directory of services.</td>
<td>✔️</td>
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<td>Improved decision support directly influencing the effectiveness and efficiency of resource deployment.</td>
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<tr>
<td><strong>Optimising intelligence capability</strong></td>
<td>Unlocking the power of information we have is central to our digital roadmap. The analytics capability will drive improvements in service outcomes at a population health commissioning level as well as at a clinical decision making level. Providing risk analysis, cohort identification &amp; tracking, outcome evaluation and clinically lead intelligence &amp; research.</td>
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</table>
**Project Objective:** To provide a integrated digital health and social care record which is accessible to patients and professionals.

**Project Description**
This project will deliver major enhancement to HIOW’s interoperability capabilities. A major upgrade to the HHR will enable support for mobile working and customisable dataset interfaces for clinical staff. An integration engine and master patient index will provide the backbone of integration across care settings and integrated care plans functionality will provide a single source for care plans to be created, stored and accessed.

**Outcomes and benefits to be delivered**
- Access to an integrated digital health record on smart devices will enable professionals to work flexibly including at the patient’s bedside.
- Improvement in the digital health record view will mean professionals can access, search and find patient information from across the system easily and quickly.
- Access to a integrated digital health record will reduce need for patients to repeat information, save professionals time and reduce duplication of diagnostics.
- Integrated care plans allow multi-disciplinary teams to develop and deliver plans for identified groups of patients, by providing a single up-to-date record which can be shared and updated across a whole health community.

**Project Timescale**

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<tr>
<td>Secure funding, establish project resource and project governance</td>
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<tr>
<td>Upgrade Digital Health and Care Record upgrade</td>
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<tr>
<td>Implement HIOW Integration Engine and Master Patient Index</td>
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</table>

**Key personnel**
- Project Sponsor – Peter Cambouropoulos
- Project Manager (TBC)
- Clinical Lead Dr Mark Kelsey

**Stakeholders involved**
- Urgent Care Provider
- Acute Trusts
- Community Trusts
- CCGs
- Primary Care
- Local Authorities
- Solution Suppliers
- SCW CSU
- Wessex AHSN
- NHS E & NHS Digital
- Voluntary sector

**Investment required**
- **Capital:** £35.4m
- **Revenue:** £10m per annum by 2020/21
Digital Programme: Patient Portal

**Project Objective:** To provide a Patient Portal that is accessible by all patients in HIOW on multiple devices and is their main route in to the HIOW health and care system.

**Project Description**
This project will deliver a single patient portal that is accessible by patients of all HIOW care services on multiple devices and is their main route in to the HIOW health and care system. The portal will allow patients to view their records and pathways in the shared record, access self-help information, manage their appointments, provide pre-assessment data, order repeat prescriptions and ultimately contribute to their care management alongside health and care professionals.

**Outcomes and benefits to be delivered**
- Allows patients to co-manage their health care online
- Uses diagnostic data to direct patients to targeted self-help
- Reduces the need for hospital visits
- Offers 24/7 support and information
- Allows patients to cancel and re-book appointments online
- Reduces GP surgery visits
- Captures pre-assessment data before patients visit hospitals
- Helps patients and clinicians to share information online

**Project Timescale**

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<tr>
<td>Secure funding, establish project resource and project governance</td>
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<tr>
<td>Conduct an appraisal of technologies and technical design</td>
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<td>Procure required technologies &amp; services</td>
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<td>Pilot the patient portal in two organisations to view/edit/record care plans</td>
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<td>Roll-out patient portal across all HIOW organisations</td>
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</table>

**Key personnel**
- Project Sponsor – Chris Tite
- Project Manager (TBC)
- Clinical Lead (TBC)

**Stakeholders involved**
- Acute Trusts
- Community Trusts
- CCGs
- Primary Care
- Local Authorities
- Solution Suppliers
- HIOW academic community
- Wessex AHSN
- SCW CSU

**Investment required**
Contributes to overall capital and revenue investment of programme:
- Capital: £35.4m
- Revenue: £10m per annum by 2020/21
Digital Programme: E-Prescribing & Medicine Reconciliation

**Project Objective:** To provide patients and professionals with a seamless Medicine Management system reaching across different care settings.

**Project Description**

There is a requirement for a fully integrated end to end Medicine Management system reaching across different care settings. This comprises EPMA in hospitals including closed loop prescribing for safety, transfer of known meds (meds reconciliation), standards for coding (DM+D). This information to be available in all settings at any time combined with any hospital admission information. This links to work in the shared Hampshire record (HHR). E-Prescribing is not enough in isolation to support NHS Mandates on patient safety and efficiencies.

**Outcomes and benefits to be delivered**

- A fully-integrated end-to-end medicines management platform allows automated supply, decision-support for clinicians and real-time monitoring.

- For those who have ePMA this is about adding: Positive patient ID technology with the wristband bar code. This will address a patient safety and also form part of digital maturity DM+D so that safer handover is achieved with a view to this being fully automated.

- Automation would also reduce the handover time. Greater control of medicines and a comprehensive audit trail is fundamental to providing seamless care and supporting patient safely and efficiencies.

**Project Timescale**

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<tr>
<td>Implement positive patient ID technology across HHFT, UHS and IOW Trusts</td>
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<tr>
<td>Establish a digitally enabled handover drug regime process between care settings.</td>
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<tr>
<td>Roll out e-prescribing across remaining trusts</td>
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**Key personnel**

- Project Sponsor - Adrian Byrne
- Project Manager – (TBC)
- Clinical Lead (TBC)

**Stakeholders involved**

- Acute Trusts
- Community Trusts
- Primary Care
- Solution Suppliers

**Investment required**

| Capital: £35.4m | Revenue: £10m per annum by 2020/21 |
Digital Programme: Digital Communications Across Care Providers

**Project Objective:** To provide the capability for professional to communicate securely digitally across care settings.

**Project Description**
This project will deliver technology that makes use of new and current technologies to enable professionals to communicate securely across care setting. The project will provide a platform for video chat, telepresence and instant messaging capabilities.

**Outcomes and benefits to be delivered**
- Reduces professional travel time and costs
- Instant messaging and telepresence enables professionals to interact easily. Group video calls enable multi-disciplinary teams to meet online
- Provides potential platform for patients to conveniently access care professionals.

**Project Timescale**

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<tr>
<td>Implement Skype for Business – Presence and instant messaging for those that have migrated to NHS Mails2</td>
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<tr>
<td>Implement Skype for Business - Audio and video, peer-to-peer calling and desktop sharing for those that have migrated to NHS Mails2</td>
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<td>Federation of SfB on NHSmail 2 with local instances of SfB/Lync used by organisations that chose not to migrate to NHSMail2.</td>
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<tr>
<td>Establish virtual waiting room to enable patient video consultations with clinicians.</td>
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<td>TBA</td>
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<tr>
<td>Link communication across all service provider organisations</td>
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**Key personnel**
- Project Sponsor – Sheree Palaczky
- Project Manager – (TBC)
- Clinical Lead – (TBC)

**Investment required**
Contributes to overall capital and revenue investment of programme:
- Capital: £35.4m
- Revenue: £10m per annum by 2020/21

**Stakeholders involved**
- Acute Trusts
- Community Trusts
- Primary Care
- Local Authorities
- Solution Suppliers
- NHS Digital
Digital Programme: Wi-Fi for HIOW & Cyber Security

**Project Objective:** To provide patients and professionals access to Wi-Fi across all health and social care sites

**Project Description**

This project will ensure there is Wi-Fi coverage across all primary, secondary and social care sites in HIOW. The solution would enable any user to connect securely to their own network and systems from any site. The solution would also ensure Wi-Fi is available to patients across the footprint.

The project would also raise awareness and importance of cyber security & cyber hygiene by training in cyber security and cyber hygiene and identifying those areas in need of investment/improvement.

**Outcomes and benefits to be delivered**

- Clinicians are able to access and update patient information easily from any location
- Reduces the need to carry paper records
- Reduces the need to travel to ‘base’ to access and record information
- Patients are able to access online resources from any location
- Improves patient experience and reduces recovery times
- Enhance awareness of cyber security and ability to recognise and respond to potential threats

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<td>Conduct appraisal of technologies and technical design</td>
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<td>Procure required technologies &amp; services</td>
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<tr>
<td>Implement Wi-Fi across primary care sites</td>
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<tr>
<td>Implement Wi-Fi across secondary and social care sites</td>
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**Key personnel**

- Project Sponsor – Ahmad Chughtai
- Project Manager – (TBC)
- Clinical Lead – (TBC)

**Stakeholders involved**

- Acute Trusts
- Community Trusts
- Primary Care
- Local Authorities
- Solution Suppliers
- SCW CSU

**Outcomes and benefits to be delivered**

- By 16/17 – Confirmed technical approach and commenced roll-out across primary care
- By 17/18 – Roll-out across primary care, secondary care and social care complete

**Investment required**

Contributes to overall capital and revenue investment of programme:

- Capital: £35.4m
- Revenue: £10m per annum by 2020/21
Digital Programme: Channel Shift – e-Consultations, Telehealth, Self-Service

Project Objective: To provide patients with the ability to interact digitally with care professionals and to enable them to manage their own care.

Project Description

This project will look at and identify the best telehealth apps available across the HIOW footprint bringing together joint experiences and expertise’s to support the transformation in which we will work with citizens in the future. Technologies such as telehealth, telecare, telemedicine, telecoaching and self-care apps will all change the way in which care can be delivered empowering citizens to manage their own healthcare in a way in which is right for them.

Outcomes and benefits to be delivered

- Provides access online resources 24/7.
- Reduces need for face-to-face consultations, leading to practice efficiency savings.
- Provides opportunity to collect comprehensive history and early identification of symptoms leading to more productive consultations.
- Provides patients with tools to enable them to manage and take greater control of their care.

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<td>Deliver E-Consulting Phase 1</td>
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<td>Deliver E-Consulting Phase 2</td>
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<td>Review and implement telehealth and LTC apps requirements and available products. Produce recommendations for implementation.</td>
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<tr>
<td>Implement telehealth and LTC apps solutions</td>
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<td>Establish process and governance for product evaluation</td>
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Key personnel

- Project Sponsor – Sheree Palaczky
- Project Manager (TBC)
- Clinical Lead – (TBC)

Stakeholders involved

- Urgent Care Provider
- Acute Trusts
- Community Trusts
- CCGs
- Primary Care
- Local Authorities
- Solution Suppliers
- SCW CSU
- Wessex AHSN
- NHS E & NHS Digital
- Voluntary sector

Investment required

- Capital: £35.4m
- Revenue: £10m per annum by 2020/21
Digital Programme: Care Coordination Centre Infrastructure

**Project Objective:** To deliver the technical infrastructure and capabilities to enable the care coordination centre to operate effectively.

**Project Description**
This project will design and deliver the technical infrastructure and capabilities for care to be coordinated across our system. Building upon, and integrating with, the infrastructure for managing 999 and 111 calls, it will enable 24/7 monitoring of vulnerable citizens, routing for primary care appointments, referrals into and between services, plus live video links to aid provision of multi-disciplinary care. It will provide both local and HIOW-level ‘flight decks’, to support our collaborative and integrated model of care across systems, plus continual gap analysis and refinement of the directory of services.

**Outcomes and benefits to be delivered**

- By 17/18 – Selected Technical Solutions, Detailed Planning and Infrastructure Development complete
- By 18/19 – Technical Infrastructure Implemented, Go-Live and Acceptance delivered

This is a critical enabler of the STP, as it is fundamental to delivering and joining up the various parts of the care system, such as:
- our population health management approach
- simpler access to care, with arrangements in place to refer citizens quickly to the most appropriate service, advice or website
- earlier and streamlined assessment of need, with better use of information and by securing a wider range of specialist input
- improved decision support, directly influencing the effectiveness and efficiency of resource deployment across the system
- support more people in their own home or community (shifting care from acute), by remote monitoring and/or by linking citizens to the relevant specialist by video (rather than having to travel)

**Investment required**

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<th>Component</th>
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<td>Project Implementation, Go-Live &amp; Acceptance</td>
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**Key personnel**
- Project Sponsor – Lisa Franklin
- Project Manager – Vince Weldon – SCAS
- Clinical Lead – Lynda Lambourne – SCAS

**Stakeholders involved**
- South Central Ambulance
- Urgent Care Provider
- Acute Trusts
- Community Trusts
- CCGs
- Primary Care
- Local Authorities
- SCW CSU
- Wessex AHSN
- Local Hubs (MCP or local equivalent)
- Acute services alliance
- Mental health alliance
- NHS E & NHS Digital
- Voluntary sector
- Solution Suppliers
Digital Programme: Optimising Intelligence Capability

Project Objective: To improve health and care outcomes and achieve behavioural change by optimising our intelligence capability.

Project Description

This H&IOW wide user-led initiative aims to enhance insights and enable behavioural change by tackling real challenges across the system. Adopting population health management models and moving upstream to a stronger role in prevention will enable us to predict health risks for particular populations. Identified ‘super users’ from across the system will drive this programme and the implementation of business intelligence visualisation will enable clinicians and other staff groups to leverage data-driven insights. Patient & public engagement will be a fundamental aspect of our work, by building trust and ensuring that implementation pathways are patient/public centric.

Outcomes and benefits to be delivered

- Data-driven insights will support clinicians to increase efficiency, and improve the performance of local service delivery.
- Unlocking data connections and building our analytical capabilities will empower us to create reliable and actionable insights
- The adoption of population health management will improve health outcomes and achieve behaviour change at the same time as lowering costs.
- The programme will deliver insight and intelligence to inform future strategies and transformation plans.

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Key personnel

- Project Sponsor – Katie Cheeseman
- Project Manager – (TBC)
- Clinical Lead – (TBC)

Stakeholders involved

- Urgent Care Providers
- Acute Trusts
- Community Trusts
- CCGs
- Primary Care
- Local Authorities
- Commerce
- SCW CSU
- Wessex AHSN
- South Central Ambulance Service
- NHS E & NHS Digital
- Universities

Investment required

Contributes to overall capital and revenue investment of programme:

- Capital: £35.4m
- Revenue: £10m per annum by 2020/21
Enabling Programme 8: Estates

Programme Objective: To provide the estate infrastructure needed to deliver the new models of care and to deliver savings by rationalising the public sector estate in Hampshire and the Isle of Wight

Programme Description

The Estates programme has two core and interdependent objectives:
1. To enable delivery of the STP core transformational workstreams and
2. To drive improvement in the condition, functionality and efficiency of the Hampshire and IOW estate.

Outcomes and benefits to be delivered

- Improved planning through better sharing of information and expertise.
- Reduced demand for estate which will release surplus estate for other uses such as housing. Current estate has been classified to identify key strategic sites to be fully utilised and estate that is no longer providing a high quality environment for staff and patients. The priority is to replace the worst estate.
- Increased utilisation of key strategic sites to meet requirements of core STP workstreams and improve efficiency. This will ensure that services are provided from the best facilities, contributing to improved patient health and wellbeing. A small number of utilisation audits have been completed which have identified scope to increase utilisation by up to 30%.
- Flexible estates solutions that enable new care models to be delivered. A core group of HIOW estates leads is in place and are supporting all STP workstreams and the local estates forums. 4 HIOW estates workshops have been held, including primary care commissioners, to identify the estates solutions which enable new models of care including area and local health hubs. These will provide extended access and an enhanced range of services which reduce the need for patients to travel to the main hospital.
- Redesigned facilities which facilitate increased mobile working, working closely with the digital and workforce enabling teams. We will increase the number of hot desk facilities to enable staff to access bases closer to their patients, reducing travel and increasing productivity.
- Optimised use of estate as part of ‘One Public Estate’ programmes enabling patients to access a wider range of services as part of one-stop shops that are tailored to meet local needs.
- 19% reduction in estates footprint and £24m revenue saving by 2020/21

Revenue investment assumed and financial benefit

| Investments Required: £5.3m | SAVINGS: £24m per annum by 2020/21 |

Projects Timescales

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<td>STP estates transformation</td>
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Key personnel

- Inger Bird (SRO and Programme Director)
- Michelle Spandley (Chief Finance Officer)
- Becky Whale (Programme Manager)
- Strategic Estates Advisors and Estates Leads from provider organisations, CHP and NHS Property Services

Stakeholders involved

- All enabling and core programmes
- Local Estates Forums and Strategic Partnership Board
- One Public Estate programme
- Housing providers
- Elected representatives
- Communications team

Appendix A: Enabling Programmes
Estates Programme: Reduce Demand

Project Objective: To reduce the volume of assets that the NHS operates from through improved system planning and co-ordination, shared information and expertise, and which responds to the impact of digitisation and implementation of new models of care across Hampshire and IOW.

Project Description

Reducing our demand for estate will mean that we can generate efficiencies and savings through reduced running costs and release of land for other purposes. The programme will deliver a 19% reduction in estates footprint by 2020/21/. This will be achieved by:

- Facilitating the disposal or poor quality estate that is no longer required in line with system and local plans
- Enabling consolidation of estate as part of the hub development and in response to increased digitisation/flexible working.
- Improving the information held and shared around our estate to support better system-wide planning and implementing improved centre management for ongoing co-ordination and management

This will delivered in partnership with local strategic estates forums and strategic partnership boards. It has close interdependencies with other estates projects.

Outcomes and benefits to be delivered

- Overall improvement in condition of retained estate
- 19% reduction in footprint (land and buildings)
- Reduction in % of void space

Revenue investment assumed and financial benefit

See estates appendix
Increasing utilisation of our key estate will mean that more services can be located together, other estates can be released and we are achieving best value for money. The programme will aim to deliver 85% utilisation in key strategic community-based sites. This will be achieved by:

- Completing utilisation studies of key strategic buildings to inform future planning
- Developing incentives that support and enable improved utilisation of key sites
- Enabling delivery of new model of care and extended hours through increased utilisation of existing sites.
- Improving the information held and shared around our estate to support better system-wide planning and implementing improved centre management for ongoing co-ordination and management

This will delivered in partnership with local strategic estates forums and strategic partnership boards. It has close interdependencies with other estates projects.

### Project Description

**Outcomes and benefits to be delivered**

- Increased utilisation of key community assets (target > 85% utilisation)
- Increased number of area and local hubs fully operational

**Revenue investment assumed and financial benefit**

*See estates appendix*

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<td>Utilisation studies of key sites</td>
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<td>Scope and pilot local incentives to support increased utilisation</td>
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<td>Estates delivery of core workstream requirements: Hub development/ Extended hours etc</td>
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### Key personnel

- Inger Bird (SRO and Programme Director)
- Michelle Spandley (Chief Finance Officer)
- Becky Whale (Programme Manager)
- Strategic Estates Advisors and Estates Leads from provider organisations, CHP and NHS Property Services

### Stakeholders involved

- All enabling and core programmes
- Local Estates Forums and Strategic Partnership Board
- One Public Estate programme
- Housing providers
- Elected representatives
- Communications team
Estates Programme: Flexible Working

**Project Objective:** To maximise estate benefits from increased mobile working culture and technologies in order to use existing space more effectively and reduce overall need for estate

**Project Description**

The demands for clinical and administrative delivery space will change in response to emerging new model of care and an increasingly mobile workforce, both enabled by new technologies to facilitate more flexible delivery. This project will focus on developing estates solution that support this development. This will include:

- Increased availability and access to hot-desking and drop-in facilities that support a mobile workforce the system
- Providing appropriate space for co-location and shared delivery of integrated care and extended primary care access teams.

This will delivered in partnership with local strategic estates forums and strategic partnership boards. It has close interdependencies with other estates projects and with the workforce and digital enabling programmes.

**Outcomes and benefits to be delivered**

- Increase in the number of shared space and clinical hubs
- Reduction in the number of desks per WTE

**Key personnel**

- Inger Bird (SRO and Programme Director)
- Michelle Spandley (Chief Finance Officer)
- Becky Whale (Programme Manager)
- Strategic Estates Advisors and Estates Leads from provider organisations, CHP and NHS Property Services

**Stakeholders involved**

- All enabling and core programmes
- Local Estates Forums and Strategic Partnership Board
- One Public Estate programme
- Housing providers
- Elected representatives
- Communications team

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<td>Development of policies to enable remote/flexible working with Workforce workstream</td>
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<tr>
<td>Provision of hot-desking /drop in facilities</td>
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<td>Provision of space for integrated MDTs / extended care team</td>
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**Revenue investment assumed and financial benefit**

See estates appendix
Estates Programme: Reduce Operating Costs

Project Objective: To release efficiencies and increase value for money delivery through reduced energy costs, facilities management costs and improved procurement methods (Carter savings).

Project Description

Reducing operating costs in out buildings will means that we can generate efficiencies and ensure we are getting best value for money. This will be achieved by:

- Closer working with the AHSN to deliver savings from areas such as energy costs
- Improved facilities management
- Realising benefits from Carter review (acute and community)

This will delivered in partnership with acute and community provider, local strategic estates forums and strategic partnership boards. It has close interdependencies with other estates projects.

Outcomes and benefits to be delivered

- Reduction in energy costs per sq. mtr
- Realisation of Carter savings opportunities

Revenue investment assumed and financial benefit

See estates appendix

Project Timescale

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<td>Benefits plans in place for reduced energy costs in each organisation (with AHSN)</td>
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<td>Carter benefits plans in place (acute)</td>
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<td>Carter benefits plans in place (community)</td>
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Key personnel

- Inger Bird (SRO and Programme Director)
- Michelle Spandley (Chief Finance Officer)
- Becky Whale (Programme Manager)
- Strategic Estates Advisors and Estates Leads from provider organisations, CHP and NHS Property Services

Stakeholders involved

- All enabling and core programmes
- Local Estates Forums and Strategic Partnership Board
- One Public Estate programme
- Housing providers
- Elected representatives
- Communications team
Estates Programme: One Public Estate and Shared Services

**Project Objective:** To optimise use of public sector estate and release efficiencies through use of shared accommodation for co-located/integrated service delivery, back office and administrative functions.

**Project Description**

The focus of this project is to ensure alignment with ‘One Public Estate’ programme and ensure benefits are maximised in Hampshire and IOW. The project will deliver an increase in shared facilities. This will include:

- Ensuring all areas have place-based plans in place which are aligned to OPE objectives and requirements
- Developing solutions that support need for increased housing for key worker and vulnerable populations, in line with local requirements
- Maximising opportunity for shared public estate that delivers best value solutions for whole system

This will delivered in partnership with OPE programme local strategic estates forums and strategic partnership boards. It has close interdependencies with other estates projects. OPE leaders are engaged at all level including local estates forums and are setting up a one public estate health-focused forum across Hampshire.

**Outcomes and benefits to be delivered**

- Increase in % of shared buildings
- Increase in integrated health and wellbeing services

**Project Timescale**

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<td>All areas to have place-based plans in place, and strengthening of LEF arrangements to support delivery</td>
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**Key personnel**

- Inger Bird (SRO and Programme Director)
- Michelle Spandley (Chief Finance Officer)
- Becky Whale (Programme Manager)
- Strategic Estates Advisors and Estates Leads from provider organisations, CHP and NHS Property Services

**Revenue investment assumed and financial benefit**

See estates appendix

Appendix A: Enabling Programmes
Estates Programme: STP Transformation

**Project Objective:** To provide estates guidance, expertise and solutions which respond to the requirements of the core transformation workstreams and enables delivery of new models of care.

**Project Description**
This project will support the core transformation workstreams by providing estates expertise and support to develop and implement solutions that enable the delivery of new care models and system transformation. This will include providing support to enable:
- Development of the hub model in Hampshire and IOW
- Pathway development for management of acute front and back door
- Redesign of PICU and mental health bed requirements in order to reduce the number of patients who are in hospital out of Hampshire.
- Changes in overall bed/theatre requirements as a result of improved pathways and processes
- Changes to the estate in response to increased digitisation and increased self-care.

This will be delivered in partnership with acute, primary and community providers, local strategic estates forums and strategic partnership boards. It has close interdependencies with other estates projects.

**Outcomes and benefits to be delivered**

- **By 16/17 – 15% Area Health Hubs in place**
- **By 17/18 – 75% of Area Health hubs in place**

- 150-230 reduction in beds
- Reduction in out of area patients
- Integrated health hubs in place providing increased access for patients in fit for purpose facilities

**Project Timescale**

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<td>MHA programme: PICU and mental health beds</td>
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<td>Patient Flow: Acute front/back door and bed requirements</td>
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<td>Acute Alliance: Bed and Theatre improvements</td>
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**Key personnel**
- Inger Bird (SRO and Programme Director)
- Michelle Spandley (Chief Finance Officer)
- Becky Whale (Programme Manager)
- Strategic Estates Advisors and Estates Leads from provider organisations, CHP and NHS Property Services

**Stakeholders involved**
- All enabling and core programmes
- Local Estates Forums and Strategic Partnership Board
- One Public Estate programme
- Housing providers
- Elected representatives
- Communications team

**Revenue investment assumed and financial benefit**

See estates appendix
Enabling Programme 9: Workforce

Programme Objective: To ensure we have the right people, skills and capabilities to support the transformed health and care system by working as one HIOW to manage staffing, development, recruitment and retention.

Programme Description
To work as one system to develop the right people, skills and capabilities to support the transformed health and care system. By working as one we will ensure we remove organisational and professional boundaries and make better use of resources across the system. We will exploit the potential of new technology and reduce unnecessary competition for limited staffing resources.

Outcomes and benefits to be delivered

- A flexible workforce shared across geographical and organisational boundaries, working in new ways with extended skills to deliver the core STP programmes
- Health and care roles which are more attractive to local people, enabling the development of a stronger community based workforce
- Significant reduction in the use of temporary and agency workers
- Increasing the time our staff spend making the best use of their skills and experience
- No overall growth in the workforce over the next five years

Financial benefits
The workforce financial benefits are quantified within each of the core programmes. However anticipated workforce cost reduction will be:

- Reduce system temporary staff spending costs by 10%
- Reduce corporate costs by 15% through redesigning services for the system rather than each organisation within the system
- No system increase in workforce costs.

Projects Timescales

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<td>Recruitment and Retention a) Strategy b) Recruitment hot-spots</td>
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Key personnel

Sue Harriman (CEO/Lead AO for workforce)
Sandra Grant (Programme Director)
Ruth Monger (Co Chair of LWAB) Health Education Wessex
Local Workforce Action Board members
HR Directors across H&IOW & Staff Side representatives

Stakeholders involved
All enabling and core programmes
Staff and staff side
Communications team
The project aims to rapidly develop a STP wide workforce plan supported by a system wide workforce data and information dataset, which will support the Core programme assumptions and plans for the changing workforce.

Outcomes and benefits to be delivered

By considering financial assumptions, previous trends in local workforce plans, national requirements, five year forward view implications, supply challenges and the developing local STP service initiatives we have formed a draft, high level workforce plan.

To inform this work going forward key workforce principles were agreed how we will manage our challenges together.

- Workforce planning events - attended by workforce planning leads, finance leads and HR Leads to ensure a plan with the required level of detail. This will ensure we meet with the national HEE workforce planning requirements.
- Each quarter a system-wide monitoring process will take place - to ensure we are delivering against plan.
- A set of workforce information relevant to each Core Workstream will have been established to inform activity, financial, workforce & planning discussions and to prevent double-counting of any potential savings through working differently.
- We will commit to developing and jointly owning a system-wide Workforce data set, managing capacity challenges together rather than competing for resources which results in variation of quality and increasing workforce costs across the system.

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<td>Draft workforce plan</td>
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<td>Monitoring and analysis</td>
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<td>System-wide Workforce data set completed</td>
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Key personnel

Sue Harriman (CEO/Lead AO for workforce)
Sandra Grant (Programme Director)
Ruth Monger (Deputy Chair of LWAB) Health Education Wessex
Local Workforce Action Board members
HR Directors across H&IOW & Staff Side representatives

Stakeholders involved

All enabling and core programmes
Staff and staff side
Communications team
Project Objective: The key objective of the project is to improve the recruitment and retention of staffing groups historically difficult to resource and retain.

Project Description

The main aim of the project is to set out a strategy and plan that targets the workforce areas that HIO require in order to deliver on the Core Programme plans and underpinning workforce change requirements.

Outcomes and benefits to be delivered

The project will deliver the required outputs through two key workstreams:

a. Strategy – a system approach
Once the system is clear regarding its workforce requirements a gap analysis can take place to ensure we form a System-wide Recruitment and Retention Strategy.

b. Recruitment hot-spots
It is recognised that where there are workforce shortfalls in one area of the system this can impact upon many other areas within the system. The Local Workforce Action Board and Staff Side working group will identify recruitment hot-spots of this type and work together to find solutions.

The first of this type has been the domiciliary care workforce. A business case was developed to gain HEE funding for this. This has been approved and recruitment will take place shortly for a lead role to design a co-ordinated approach to this issue across the local health and care system. Further a domiciliary care event will take place on 10 November with the opportunity to hear from Oxford Hospitals regarding their model which has had a great impact upon their DTOC level.

Project milestones

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<td>Establish system wide recruitment and retention strategy</td>
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<td>Produce domiciliary business case</td>
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<td>Design and deliver domiciliary care workshop</td>
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<td>Conduct workforce recruitment drive</td>
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Key personnel

Sue Harriman (CEO/Lead AO for workforce)
Sandra Grant (Programme Director)
Ruth Monger (Deputy Chair of LWAB) Health Education Wessex
Local Workforce Action Board members
HR Directors across H&IOW & Staff Side representatives

Stakeholders involved

All enabling and core programmes
Staff and staff side
Communications team
The main aim of the project is to explore and embed a workforce solution that promotes resource flexibility across HIOW and to ensure we have the right workforce to meet the demands of the STP over the five years and an efficient as well as effective back office support network.

The project will deliver the required outputs through two key workstreams:

a) Workforce - It must be made easier for staff to work within a wider geography. To do this we will:
   • Introduce a ‘passport to work in Hampshire and the Isle of Wight’ avoiding the need for unnecessary bureaucracy between organisations.
   • Develop rotational opportunities for staff across the System, piloting this initially to ensure it can be successful
   • Embed a system wide approach to the provision and management of temporary/agency staff

b) Corporate back office functions
We will conduct a review of how we could improve the quality of service and make better use of resources across the commissioning and provider systems in areas such as Human Resources, finance, contracting, etc. A scoping report for this will be provided.

---

**Project Objective:** The main objective for this project is to ensure we have a flexible and efficient workforce across HIOW

---

**Project Description**

The main aim of the project is to explore and embed a workforce solution that promotes resource flexibility across HIOW and to ensure we have the right workforce to meet the demands of the STP over the five years and an efficient as well as effective back office support network.

**Outcomes and benefits to be delivered**

The project will deliver the required outputs through two key workstreams:

a) Workforce - It must be made easier for staff to work within a wider geography. To do this we will:
   • Introduce a ‘passport to work in Hampshire and the Isle of Wight’ avoiding the need for unnecessary bureaucracy between organisations.
   • Develop rotational opportunities for staff across the System, piloting this initially to ensure it can be successful
   • Embed a system wide approach to the provision and management of temporary/agency staff

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<td>Rotational opportunities pilot</td>
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<td>Embed a system wide approach to the provision and management of temporary/agency staff</td>
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**Key personnel**

Sue Harriman (CEO/Lead AO for workforce)
Sandra Grant (Programme Director)
Ruth Monger (Deputy Chair of LWAB) Health Education Wessex Local Workforce Action Board members
HR Directors across H&IOW & Staff Side representatives

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**Stakeholders involved**

All enabling and core programmes
Staff and staff side
Communications team
The project aims to link closely with the Digital enabling programme to support the ‘self-care and virtual care’ agenda and all associated educational support for staff and patients. The project will deliver the required outputs through two key workstreams:

a. Education - An education lead needs to be allocated to the Digital programme to ensure our staff have the skills to support people to self-care and deliver virtual care using digital portals. We need to ensure we plan future workforce roles considering the impact of this upon our service provision and our health and wellbeing agenda. We need to be clear about the opportunities this presents and the education agenda for both our staff and our patients/service users.

b. A Workforce – Technology impact scoping document will be submitted to the Local Workforce action Group by February 2017.

**Project Objective:** The main objective of this project is to ensure we are utilising available technology effectively both for staff and patients and that we provide education support.

### Project Description

The project aims to link closely with the Digital enabling programme to support the ‘self-care and virtual care’ agenda and all associated educational support for staff and patients.

### Outcomes and benefits to be delivered

The project will deliver the required outputs through two key workstreams:

a. Education - An education lead needs to be allocated to the Digital programme to ensure our staff have the skills to support people to self-care and deliver virtual care using digital portals. We need to ensure we plan future workforce roles considering the impact of this upon our service provision and our health and wellbeing agenda. We need to be clear about the opportunities this presents and the education agenda for both our staff and our patients/service users.

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### Key personnel

- Sue Harriman (CEO/Lead AO for workforce)
- Sandra Grant (Programme Director)
- Ruth Monger (Deputy Chair of LWAB) Health Education Wessex
- Local Workforce Action Board members
- HR Directors across H&IOW & Staff Side representatives

### Stakeholders involved

- All enabling and core programmes
- Staff and staff side
- Communications team

### Appendix A: Enabling Programmes
Project Objective: The main objective of this project is ensure we have a training and development process that effectively utilises technology where appropriate and reduces time to attend and complete staff training requirements.

Project Description

The key aim of the project is review who we provide training across HIO and plan and set of recommendations of how we will better support staff in training utilising technology over the five years of the STP.

Outcomes and benefits to be delivered

The project will deliver the required outputs through two key workstreams:

a. Making best use of our resources - Whilst there have been great developments in providing electronic training for staff within the local area, this is not consistent across Hampshire and Isle of Wight. A report recommending a joint approach to this, resulting in reduced travel for staff and increased provision of e-training modules by 20% will be provided to the Local Workforce Action Group. Resources are sometimes wasted by staff having to travel to an organisational based training programme which may not be near to their place of work or home. By working as a system offering ‘postcode’ focused training this will save costs, increase working time available and improve the quality as we learn from each other. A report recommending our approach to this will be developed by the training and education leads within the local system and provided to the LWAG.

b. Ensuring our staff are best equipped for the future - A Community Education Provider Network will be formed to increase the number of students/trainees in primary and community settings.

A training and education plan will be developed to support the delivery of the workforce plan, ensuring we take due consideration of technology opportunities and changing roles.

A five year training and education plan will be developed to ensure we have a longer-term system view of the future workforce.

Project milestones

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<td>‘Postcode’ training report</td>
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<td>Community Education Provider Network established</td>
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<td>A five year training and education plan</td>
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Key personnel

Sue Harriman (CEO/Lead AO for workforce)
Sandra Grant (Programme Director)
Ruth Monger (Deputy Chair of LWAB) Health Education Wessex
Local Workforce Action Board members
HR Directors across H&IOW & Staff Side representatives

Stakeholders involved

All enabling and core programmes
Staff and staff side
Communications team
The key aim of the project is to ensure processes and procedures are agreed across HIOW to enable a consistent approach to support staff through organisational change across the STP.

The Local Workforce Action Group has been established for H&IOW and has met monthly since July 2016. This reports through to both the STP Steering Board and to the Regional and National Workforce Action Boards.

A system-wide Human Resources Forum has been established meeting fortnightly and will now include HRDs from the City and County Councils. Each Core Workstream has an HRD allocated to ensure they are receiving support in developing robust workforce plans for each service development.

In October the first Regional Staff Side Partnership Forum took place where we considered how best to ensure there is a strong focus of partnership working within the STP. A paper will be shared with the LWAG in November regarding the proposed structure for this.

As system work progresses an agreed joint organisational change process will need to be developed including clearing house arrangements, shared organisational change processes, terms and conditions reviews etc. The principles for this will be developed by April 2017 but may be required earlier should service/organisational mergers or changes demand.

It is important to note that organisational processes regarding consultation and negotiation, cannot be superseded by system-wide approaches but should not hinder the required level of transformation.
Enabling Programme 10: New Commissioning Models

Programme Objective:
To adapt our methods, tools, resources and architecture for commissioning health and care, to reduce unnecessary duplication of commissioning work and facilitate the delivery of the STP. To generate cost reductions in expenditure on Continuing Health Care and Prescribing through working at scale.

Programme Description
The Programme aims to align commissioning intentions and planning for the future form and function of commissioning across HIOW, to enable:

- Commissioning activities orientated around tiers
- Closer integration of health and social care commissioning around ‘place-based’ solutions
- Contracting and payment approaches that support the implementation of new models of care & alliance / MCP / PACS or ACO contracting, including progressing:
  - PACs model in NE Hampshire and Farnham
  - Accountable care system for Portsmouth, SE Hampshire and Fareham and Gosport
  - My Life a Full Life on the Isle of Wight
  - Develop place based systems across Hampshire (building on the Vanguard work of Better Local Care) and Southampton.

Additionally, the Programme aims to improve the delivery of CHC processes and reduce variation in prescribing practices.

Outcomes and benefits to be delivered
- Outcome based commissioning to local populations with aligned incentives within the system to facilitate the delivery of patient-centred integrated services
- Effective Commissioning at scale to allow management of system control total and to develop the role and structure of commissioning within the new contract system, releasing efficiencies.
- Place based solutions to move at pace in the delivery of new models of care and acute alliances.
- Improved performance in timely delivery of CHC processes.
- Improved patient outcomes benefits and savings benefits through reduced variation in prescribing practices.

Financial benefit

SAVINGS: Reduced system infrastructure costs £10m per annum by 2020/21
CHC £36m. Prescribing £58m.

Projects Timescales

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Key personnel
CEO Sponsor – Dr Jim Hogan
Programme Director – Heather Mitchell
Programme Advisor - Innes Richens & Helen Shields
Finance Lead – James Rimmer

The eight Clinical Commissioning Groups across Hampshire and the Isle of Wight have established a Commissioning Board and a commitment to collaborate fully on the commissioning of acute physical and mental health services.

Stakeholders involved
NHS - GP’s, Specialist Commissioning, Acute Trusts, Community SCAS, Trusts, CCG’s, Pharmacies.
Public and patient groups, Government - Local authorities, HCC, Public health, Local Councillors / MP’s
Regulators – NHSE, NHSI
Project Objective: To align commissioning intentions and planning for the future form and function of commissioning as we develop new care models and contracting approaches, building on previous existing collaboration within the system.

Project Description

The Commissioning Transformation project aims to change the way in which HIOW commissioning organisations function and are formed, moving from current processes through three distinct phases to population based capitated contracting for outcomes by 2021. The HIOW Commissioners recognise that in the short-medium term there is a need to build on the current collaborative commissioning arrangements, to ensure consistency in the contracting for 2017/18 and to establish the future contracting and commissioning framework to deliver the 5 Year Forward View ambitions for new care models and alliance / MCP / PACs or ACO contracting.

It has been agreed to establish a SHIP8 Commissioning Board with an aim of overseeing the following work:

Contracting for 2017/18 – 2018/19
- Agree the priorities for collaborative commissioning
- Oversee the development of taking the CI’s and STP plans into detailed contracting plans
- Allocate CCG workforce to the development of the plans
- Oversee the collective contracting approach across SHIP8

Population based contracting – 2018/19 and beyond
- Agree the vision for population based contracting across HIOW
- Develop the medium / long term governance structure/architecture for commissioning

The membership of the SHIP8 Commissioning Board will include: CCG Accountable Officers, and some representation from CCG Chief Finance Officers, Commissioning Directors, Clinical Directors, and Lay members.

CCG leaders agreed five areas where the five Hampshire CCGs will extend collaboration:
1. Strategic planning and service design: developing collective and consistent strategic approaches to address the key challenges facing the NHS in Hampshire
2. Contract and performance management: developing a single approach and function for managing contracts and performance with providers
3. Managing talent and capability: deploying the skills of the clinical and managerial leaders in CCGs in Hampshire on the challenges and tasks we face
4. Designing and introducing the future strategic commissioning model: determining the future role of commissioning as new care models are established
5. Support services: Teams providing support services working as one across the five CCGs, reducing duplication and sharing best practice

Outcomes and benefits to be delivered

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<td>To ensure a consistent approach to contracting across the HIOW system</td>
<td>Integrated system operating to aligned incentives to improve outcomes</td>
<td>Fully aligned system focused on delivery for patient outcomes</td>
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Revenue investment assumed and financial benefit

| Investments Required: £0 | SAVINGS: £10m per annum by 2021 |

Project Timescale

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<td>Collaborative commissioning arrangements</td>
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<td>SHIP 8 - Alliance contracting</td>
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<td>Population based contracting</td>
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Key personnel

CEO Sponsor – Helen Shields  
Clinical Lead: Dr Jim Hogan  
Programme Director – Heather Mitchell  
Finance Lead – James Rimmer  
Project Manager: TBC  
Workstream Owners: TBC

Stakeholders involved

NHS - GP’s, Specialist Commissioning, Acute Trusts, Community SCAS, Trusts, CCG’s, Pharmacies.  
Public and patient groups, Government - Local authorities, HCC, Public health, Local Councillors / MP’s  
Regulators – NHSE, NHSI
Commissioning Programme: Continuing Healthcare (CHC)

Project Objective: To share learning and where appropriate develop a system wide approach for CHC which ensures the delivery of financial savings whilst maintaining the quality of care and compliance with the national framework.

Project Description

Schemes to deliver financial savings:
- Timely completion of review
- High cost placements – initial focused work to reduced non-care costs followed by transition to incorporate into normal business
- LD complex housing – every placement re-negotiated and considered for either de-registration or move to more cost-effective alternative (where clinically appropriate).
- Integration of financial management accountant and robust invoice reconciliation into normal business.
- Ongoing review of care groups and normal business activity to identify potential financial cost efficiencies as part of normal business.
- Negotiation of high cost placements.
- Review of how care is delivered e.g. Supported Living from a Residential model.
- Care at Home Procurement
- High cost Specialist Residential and Dom care contract negotiations
- Complex Care framework tender
- LD Dom care framework tender, and LD case reviews and contract negotiations
- ABI / Neuro rehab – framework tender with Surrey Downs
- CHC reviews backlog to be undertaken in a timely manner

Schemes to deliver cost avoidance for CHC
- All new packages are negotiated as part of normal business approach.
- Thirty standard CHC Contract beds have been tendered for, to support the management of costs and quality within the City.
- Eighteen CHC Challenging Behaviour beds have been tendered for in order to deliver care closer to home and to manage the escalating costs of beds for this cohort of individuals
- CHC integrated with Portsmouth City Council ASC approximately 4 years thus making some efficiency savings through process etc.
- Use of Hospices to increase capacity in market and reduce excess bed days
- Care provider negotiations to manage uplifts requests
- Brokerage service – deliver best price for package of care costs.
- Exit from underutilised block contracting arrangements

Outcomes and benefits to be delivered

- Establish a network across the STP footprint with a shared vision for CHC
- Improved financial management (savings delivery) whilst maintaining quality of care and requirements of national framework

Revenue investment assumed and financial benefit

Investments Required: £0

SAVINGS: £36m per annum by 20/21

Workstream Leaders:
Carol Alstrom, Deputy Chief Nurse, Southampton City CCG
Michael Cooke, CHC Clinical Lead, Southampton City CCG

Project Group Members:
CHC leads from West Hampshire CCG, Isle of Wight CCG and Portsmouth CCG

Key personnel

Workstream Leaders:
Carol Alstrom, Deputy Chief Nurse, Southampton City CCG
Michael Cooke, CHC Clinical Lead, Southampton City CCG

Project Group Members:
CHC leads from West Hampshire CCG, Isle of Wight CCG and Portsmouth CCG

Stakeholders involved

- Isle of Wight CCG
- Portsmouth CCG
- West Hampshire CCG (Covers Hampshire 5 CCGs)

Appendix A: Enabling Programmes

Establish STP wide CHC Project Group to lead workstreams to meet throughout the 5 year period

Establish robust normal business processes across the STP footprint covering but not limited to reviews, high cost placements, financial management systems

Learning Disabilities specific workstream linked to Transforming Care covering complex housing and high cost placements

Frameworks/tenders to support appropriate provision of care including specialist placements

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**Project Objective:** To identify and implement improvements in prescribing, procurement and the use of medicines in all sectors across the STP so as to improve patient outcomes, safety and value. The Workstreams have been identified as those that will benefit from being addressed at scale rather than at an individual organisation level.

### Project Description
- Transfer of care initiatives to refer patients to community pharmacy following an in-patient stay
- Pharmacy support for multidisciplinary medication review of patients living in a care home environment.
- Wholesale adoption of Repeat Dispensing
- Review the current system for the supply of prescribable continence and stoma products to reduce spend, improve patient experience and reduce GP workload
- Benchmarking of PbR excluded high cost medicines across providers including maximising the use of biosimilars
- Review of current take up of primary care rebates and evaluation of an STP wide process for evaluation and claiming rebates
- Implementation of the Hampshire infant feeding guidelines and appropriate prescribing of specialist infant formulae

### Outcomes and benefits to be delivered
- All hospitals should have systems in place to refer patients to their community pharmacy on discharge for support with their medicines
- All CCGs should have programmes in place to ensure that care homes have pharmacist input into medication review of all residents.
- All practices should aim to have at least 60% of repeats issued as electronic repeat dispensing. This will have a significant impact on GP workload and should reduce the level of medicines waste.
- South Eastern Hampshire are currently progressing this and, dependent on results, should be rolled out across the STP.
- All providers should ensure that the use of biosimilars are implemented in a timely manner to ensure cost efficiencies are realised. Benchmarking will include consideration of the adoption of BlueTeq for certain medicines to ensure use is in line with NICE.
- Currently uptake of rebates varies between CCGs and there is duplication of work in administering the schemes.
- Joint work stream with children’s commissioning. There is the potential to reduce the current spend on infant formulae whilst improving patient outcomes.

### Revenue investment assumed and financial benefit

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<th>Investments Required:</th>
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<td>SAVINGS:</td>
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### Project Timescale

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<td>Transfer of care initiatives to refer patients to community pharmacy following an in-patient stay (CH)</td>
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<td>Implementation of the Hampshire infant feeding guidelines and appropriate prescribing of specialist infant formulae (AC)</td>
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### Key personnel

**Project Manager:** Neil Hardy (Simon Cooper – Analytics and Finance)
**Workstream Owners:** Clare Howard, Jason Peett, Sue Ladds, Amanda Cooper
Gill Honeywell, Simon Cooper, Aude Cholet

### Stakeholders involved

- CCG Heads of Medicines Management
- HIOW LPC / community pharmacists
- Care Home teams
- Provider Chief Pharmacists
- GPs, Non Medical Prescribers
- Wessex AHSN / Wessex Local Pharmacy Network
- Patients / carers