Agenda

Solent NHS Trust In Public Board Meeting

Date: Monday 3 April 2023
Timings: 09:30 – 13:20
Meeting details: Kestrel, 2nd Floor- Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Board Requirement
1	09:30	5mins	**Chairman's Welcome & Update** • **Apologies to receive**	Chair	To receive
			Confirmation that meeting is Quorate *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chair	-
			Register of Interests & Declaration of Interests	Chair	To receive
2	09:35	30mins	**Staff Story** **Schwartz Rounds –** *Jacqui Wilkinson with Nicola Lowther, Associate Practitioner, Lead for Health Care Support Worker Development and*	Chief People Officer	
3	10:05	5mins	***Previous minutes, matters arising and action tracker**	Chair	To approve
Quality and safety first					
4	10:10	10mins	**Safety and Quality – contemporary matters including:** • **Board to Floor feedback verbal update** • **Freedom to Speak Up verbal update**	Chief of Nursing and AHPs Chief of Staff	To receive Verbal update
Items to receive					
5	10:20	10mins	**Quarterly Safe Staffing Report**	Chief of Nursing & AHPs	To receive
6	10:30	20mins	**Chief Executive's Report**	CEO	To receive
7	10:50	10mins	**Annual Staff Survey Report**	Chief People Officer	To receive
10-minute break					

8	11:10	35mins	**Integrated Performance Report** *Including:* • *Safe* • *Caring* • *Effective* • *Responsive* • *People* • *Finance* • *Research and Improvement* • *System Oversight Framework* • *Self-Declaration NHS Provider Licence*	Executive Leads	To receive
9	11:45	5mins	**Annual Audit Timetable and Delegations**	Chief of Staff	To approve
10	11:50	10mins	**Creation of a New Trust for Community, Mental Health and Learning Disability Services Across Hampshire and the Isle of Wight Integrated Care System** Including: • Strategic Case • Community and Engagement Plan • Programme update	CEO	To receive
Governance					
Reporting Committees and Governance matters					
11	12:00	15mins	**People Committee -** *Exception report from meeting held 16 March 2023* • People Committee Terms of Reference	Committee chair	To receive
12			**Mental Health Act Scrutiny Committee-** *Exception report from meeting held 16 February 2023*	Committee chair	To receive
13			**Audit & Risk Committee –** *Exception report from meeting held 9 February 2023*	Committee chair	To receive
14			**Quality Assurance Committee-** *Exception report from meeting held 23 March 2023* • *Patient Safety Quarterly Report including Learning from Deaths, Serious Incidents and Complaint – Qtr 3*	Committee chair	To receive

15			**Non-Confidential update from Finance & Infrastructure Committee–** *non confidential escalation report from meeting held 27 March 2023*	Committee chair	Verbal update
16			**Charitable Funds Committee –** *Exception report from meeting held 9 February 2023*	Committee chair	To receive
17			**Remuneration and Nominations Committee –** *Non-confidential update from meeting held 24 March 2023. Except report presented to Confidential Board*	Committee chair	To receive
18	12:15	10mins	**Board Effectiveness Review**	Chair	To receive
19	12:25	30mins	**Patient Story**	Chief of Nursing and AHPs	To receive
20	12:55	20mins	**Reflection on Patient and Staff Stories Joint Summary Report**	Chief of Nursing and AHPs Chief People Officer	To receive
Any other business					
21	13:15	5mins	**Any other business and reflections including:**	Chair	-
22			• ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***	Chair	
23	13:20	---	**Close and move to Confidential meeting** The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)	Chair	-

Date of next meeting:

- ***5 June 2023***

Item 3.1

Minutes

Solent NHS Trust In Public Board Meeting

Date: Monday 6 February 2023
Timings: 09:30
Meeting details: Kestrel, 2nd Floor- Highpoint Venue, Burseldon Rd, Southampton, SO19 8BR

Chair: **Mike Watts,** Acting Trust Chair (MW)	
Members: **Andrew Strevens,** CEO (AS) **Jackie Munro**, Deputy CEO & Chief of Nursing and Allied Health Professionals (JM) **Dan Baylis**, Chief Medical Officer (DB) **Suzannah Rosenberg**, Chief Operating Officer (SR) **Rachel Goldsworthy**, Chief of Staff, Governance & Corporate Affairs (RG) **Nikki Burnett**, Chief Finance Officer (NB) **Debbie James**, Director of Strategic Transformation (DJ) **Gaurav Kumar**, Non-Executive Director (GK) **Stephanie Elsy,** Non-Executive Director (SE) **Calum Mercer**, Non-Executive Director (CMe) **Vanessa Avlonitis,** Non-Executive Director (VA)	**Attendees** **Angela Anderson,** Deputy Chief Nurse (AA) **Alasdair Snell,** Deputy Chief Operating Officer (ASn) **Apologies:** **Shahana Ramsden**, Chief People Officer (SRa)
Patient Story (item 2) **Lorna Thomas,** Community Partner (LT) **Ophelia Matthews**, Head of Experience of Care (OM)	**Staff Story (item 3)** - *Virtual* **Kate Long** (KT) **Laura George** (LG) **Zoe Simmons** (ZS)
Information Governance Update (item 10) **Sadie Bell,** Data Protection Officer and Head of Information Governance (SB)	

1	**Chair's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests**
1.1	MW welcomed Board members and attendees to the meeting. There were no apologies to note. Welcomed AA & AS in their deputy roles, attending as part of their induction.
1.2	The meeting was confirmed as quorate. The declarations of interest form was circulated and there were no updates to note.
2	**Patient Story**
2.1	JM welcomed LT and OM to the In Public meeting. LT provided an overview of the organisation 'Busy People' and ongoing partnering with the Trust. • The Board were briefed on activity to support those with learning difficulties and improve services and accessibility of information. • LT informed of work undertaken with the Experience of Care team, including being members of virtual panels, providing advice on projects and input into the Complaints and Communication Checkers Panel to ensure accessibility of documentation. • Support of the Experience of Care Team was explained, including pre-meetings and flexible working.

	• The importance of adapting communication and acknowledging differences was noted. • LT shared reasons for working with Solent, including helping/supporting the local community and making them aware of resources available. • LT commented on strong and friendly communication with the Trust, with equal partnership and understanding.
2.2	JM asked about potential further work to support those with learning difficulties. LT commented on the use of 'jargon' and the importance of clear language.
2.3	DB commented on work across other areas of Southampton, for example in acute settings and shared positivity of partnerships.
2.4	AS emphasised the importance of ensuring accessibility of information and reflected on complaint letter sign-off, with consideration of ensuring clear and understandable language.
2.5	AA queried other actions to attract those with learning disabilities to take up employment with the Trust. LT explained challenges in terms of money and care packages. The need for full understanding to make informed choices and support where possible was emphasised. The Board thanked LT & OM for joining the meeting. *LT & OM left the meeting.*
3	**Staff Story**
3.1	MW welcomed KL, LG and ZS to the meeting. KL briefed the Board on the Trust apprenticeship offer for both clinical and non-clinical apprentices of all age ranges. KL shared planned activity for National Apprenticeship Week and noted retention of 90% of apprentices to date. Continuous support and development was highlighted.
3.2	LG and ZS shared their background and individual experiences of completing apprenticeships with the Trust. Management support was shared and the importance of investing in staff and the value of apprenticeships emphasised.
3.3	DB reflected on positivity of this career structure and the importance of encouraging apprenticeship routes across the whole of Hampshire and Isle of Wight (HIOW). DB also commented on the importance of strong leadership/line management to support apprenticeship roles. DJ agreed and queried further support required to enable line manages to upskill using this route. KL informed of clear messaging to promote apprenticeship offers and considerations aligned to active recruitment.
3.4	MW asked about potential barriers and learning to consider. KL briefed on areas of challenge, including ability to release apprentices for the 20% off the job training element. AS highlighted alignment to business planning discussions, including issues regarding backfill and funding. Importance of apprenticeships for developing staff was reiterated.
3.5	VA queried consideration of apprenticeships for posts going out to advert. KL confirmed requests for all recruitment managers to consider applications and potential apprenticeship opportunities. Ongoing learning was noted.
3.6	NB reflected on positive way to ensure inclusivity, equality, and diversity to those who otherwise may not have been able to fund further qualification opportunities.
3.7	AS emphasised support required for services, management and apprentices and shared planning to complete a promotional campaign with the Communications Team in relation to benefits and development. The Board thanked attendees for sharing their experiences. *KL, LG and ZS left the meeting.*

4	**Previous minutes, matters arising and action tracker**
4.1	The minutes of the last meeting held on Monday 5 December were agreed as an accurate record, subject to minor amendment.
4.2	It was agreed that the following actions remain on the tracker for further update at the next meeting: • AC004997 • AC004998 AC004999- An update in relation to parking concerns was shared. Ongoing discussions with staff and NHS Property Services were noted. SR emphasised the importance of careful considerations on a case-by-case basis with clear messaging. Review of communications and alignment to Freedom to Speak Up and People services was confirmed. It was agreed to close the action from this meeting, acknowledging ongoing discussions and update on escalations as required.
4.3	Matters arising There were no matters to discuss.
5	**Safety and Quality – contemporary matters including:** • **Board to Floor feedback** • **Freedom to Speak Up update**
5.1	JM briefed the Board on 2 Mental Health Act CQC visits undertaken on Brooker and Kite ward. It was confirmed that actions and learning had been identified and considerations were being held to address. Positive feedback was noted and response to new lines of enquiry across services shared. The Board were informed of changes to CQC inspectors and JM highlighted consideration of approach to delivering information and ensuring appropriate relationships/connections.
5.2	MW acknowledged pressures across the NHS and asked about CQC feedback from other Trusts. JM commented on pressures and significant factors, however emphasised the importance of maintaining quality as well as the CQC maintaining their standards.
5.3	SE reflected on feedback from recent MHA inspection at NHS Bath And Northeast Somerset, Swindon And Wiltshire and asked about further inspections anticipated. JM confirmed risk-based approach being undertaken and reiterated the importance of focus on quality and understanding improvements whilst ensuring appropriate evidence was in place.
5.4	RC queried potential Non-Executive Director briefings to update on Fresh Eyes Visits. Usefulness of a Board wide assurance update was noted and it was agreed to provide a quarterly report to the Quality Improvement and Risk (QIR) Group, Quality Assurance Committee and Trust Board going forward.
5.5	Board to Floor JM confirmed that an annual update summarising all visits would be provided to Board and included within the Trust Annual Report.
5.6	There were no Freedom to Speak Up matters to raise.
6	**Quarter 2 Safe Staffing Report**
6.1	AA presented the report and informed of changes to reporting periods (6 monthly to quarterly) to ensure more regular aligned updates going forward and provide greater assurance on pressures.

6.2	The Board were briefed on key highlights from the report. • Continued safe staffing pressures were noted and AA confirmed compliance to ensure that levels of quality and safety were maintained. • AA provided an update in relation to ongoing work to implement the acuity dependency tool and explained expected improvements. • Sustained pressures and concerns within the Community Nursing Service were highlighted. It was confirmed that a new tool had been developed and AA shared plans for implementation.
6.3	VA emphasised extensive scrutiny and assurance provided via the Quality Assurance Committee and commented on agreed usefulness of breakdown of registered and non-registered staff data.
6.4	MW queried further actions being undertaken to address concerns within the Community Nursing Service. AA shared ongoing work, including considerations to ensure further understanding of skill mix, with the opportunity to test. DB emphasised fundamental risks, associated challenges and critical planning elements involved. RG asked about assurance in terms of the E-Rostering system. JM commented on the importance of investment and resource to manage effectively, however acknowledged challenges in relation to capacity. Positive work within the areas where investment had been made was shared. Discussions were held regarding model complexity and ongoing consideration through business planning routes.
6.5	MW queried potential emerging good practice at national level. AA reflected on the usefulness of the acuity and dependency tool and feedback provided. **The Board noted the Quarter 2 Safe Staffing Report.**
7	**Chief Executive's Report**
7.1	AS presented the CEO report. • It was confirmed that this would be the last In Public Board meeting for SR and JM. AS formally thanked them for their contributions to the Trust. • AS provided an update regarding the new digital service and significant cutovers taken place at St Marys Hospital and Western Community Hospital, with no issues reported. • The Board were briefed on feedback from the Royal College of Nursing (RCN) and Chartered Society of Physiotherapy industrial action. AS thanked leadership teams for their support and co-ordination and confirmed that a detailed update would be provided during Confidential Board. • Positivity of 75% flu vaccination rate was noted. • AS reported discussions held with Penny Mordaunt (MP) regarding Highcliffe GP Surgery. It was confirmed that approval was awaited from the Secretary of State and the Board discussed high level of political context/activity. • Consistent BAF scores were shared.
7.2	<u>Royston Smith (MP)- Westwood House visit</u> AS briefed the Board on positive visit held ahead of changing the site to a respite day centre for children. It was noted that Royston Smith was supportive of the approach being taken regarding final extension for the veteran's centre, before vacating the site.

7.3	Regarding industrial action, VA commented on lack of harm identified and queried follow up work taking place. AS assured that there were no issues of note and confirmed learning elements to consider, together with partners. DB asked about potential issues caused to waiting lists and AA explained full review across all areas, with no direct impact identified. MW asked about additional staffing requests. AA shared planning for areas of derogation and confirmed that these were not enacted.
7.4	Regarding the BAF, CMe queried inclusion of clear risk appetite definition. Challenges were discussed and further considerations agreed in relation to generic mitigating statement to cover external factors. **The Chief Executive's Report was noted.**
8	**Recent National Publications and Solent's Response**
8.1	The report was presented to provide an overview of national publications, guidance and letters issued by NHS England to provide assurance to the Board of appropriate, proportionate action taken in response to these publications.
8.2	SE commended extensive assurance provided and queried response regarding the quantity of items issued. AS confirmed that the ICS had formally responded to the Heward Review, which had been supported. **The Board noted the update.**
9	**Integrated Performance Report**
9.1	AS explained changes to service delivery and associated impact on data, for example references to Jubilee Ward. The Board were informed of broader discussions required in Confidential Board regarding Business Intelligence challenges and associated impediments to business planning.
9.2	<u>Safe</u> • An increase in the number of Slips, Trips and Falls was reported on the new Jubilee Unit. The Board were assured of review being undertaken by the Falls Lead, with measures to improve being considered. It was confirmed that Safe Staffing was also being reviewed within the ward. • Review of delivery of the medical model, with expected impact on VTE Risk Assessments, was noted. • Feedback and associated learning following division of Hawthorns Ward was shared. • Regarding incidents outside of their allocated range, MW asked about potential need to reassess. The importance of continuing strong reporting culture was emphasised, however the Board acknowledged potential change in boundaries required. **Action- AA to consider further outside of the meeting.** • Incidents relating to wheelchair services were queried. JM explained continued monitoring and raising of concerns despite not providing wheelchair services.
9.3	<u>Effective</u> • SR briefed the Board on concerns relating to delayed transfers of care of homeless patients in community beds. City responsibility was noted and SR explained potential impact to the Trust, which may result in a change of the length of stay data.

	• CMe queried inclusion of targets within the bed occupancies/length of stay data. SR agreed further amendments required to data format, to ensure identification of outliers, and confirmed that work to include was ongoing.
9.4	<u>Responsive</u> • Increase in the number of inappropriate out of area placements for mental health patients, linked to the reduction in beds on Hawthorns Ward, was reported. • VA asked about period of data reported for out of area placements. ASn provided an update on process and assured of usual positive benchmarking. • MW queried all potential services that were reliant on other organisations, such as GA and imaging. SR highlighted other areas and commented on usefulness of a detailed overview. • VA asked about support for the increase in Integrated Learning Disability caseload. ASn briefed on recent deep dive completed via the performance governance route. Financial pressures were noted and alignment to Project Fusion in relation to capacity and demand were highlighted.
9.5	<u>People</u> • An increase in sickness rates were noted. JM highlighted associated factors, including seasonal trend, stress and wellbeing. • The Board discussed turnover and how measured, even if moving to another role internally. Opportunities of ICS/Project Fusion for an 'every contact counts' approach was discussed.
9.6	<u>Finance</u> • NB provided an overview of the current position, including agency spend, external system factors, balance of non-recurring initiatives and systematic schemes. • MW commented on workforce savings and vacancy factors. NB shared transformation schemes developed, with a planned 5% vacancy assumption. Discussions were held regarding over-recruitment and NB highlighted planning approach/approved budget plans.
9.7	<u>Provider Licence</u> It was confirmed that a new Provider Licence would be introduced from April 2023. RG informed of assurance exercise taking place to provide assurance of licencing requirements.
9.8	There were no specific escalations to highlight in relation to: • Caring • System Oversight Framework • Research- the Board commended impressive work in terms of research and quality improvement at national and local level. The importance of considering integrated messages across all areas of the report were acknowledged. **The Board noted the Integrated Performance Report.**
10	**Information Governance Update**
10.1	*SB joined the meeting.* RC introduced the report to Board as the standard summary of the Trust's current Information Governance Compliance with Law, National Requirements and Mandatory NHS Requirements. Key areas covered were noted as follows: • Data Protection Legislation • Freedom of Information Act • Information Management • Information Security • Cyber Security

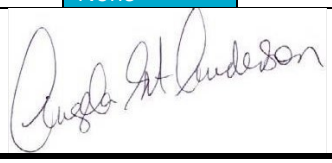
10.2	SB provided an overview of progress in relation to the development of the Cyber Dashboard. It was confirmed that activity was being undertaken as a priority and further update would be provided to the Board as available.
10.3	SB provided an overview of key highlights. • Regarding Data Protection, SB reported security and the medical devices project as the 2 main areas of focus. It was confirmed that process efficiencies had been identified. • It was noted that Subject Access Requests and Freedom of Information Requests were in a place of best practice, with close service working to consider efficiencies and pre-publishing of information. There were no concerns to report. • The Board were briefed on incident levels and SB confirmed ongoing considerations of alignment with Southern Health NHS Trust and the Isle of Wight NHS Trust. • Regarding Cyber Security, SB informed of increased risk in relation to hardware and actions being taken to address challenges. Ongoing service focus and business as usual planning was confirmed. • The Board were assured of continued monitoring in relation to cyber security levels.
10.4	MW queried prioritisation in terms of compliance status. SB referred to detailed action plan in place, with key dates to ensure addressed within the next 2-3months. **The Board noted the Information Governance Update.**
11	**People Committee Exception Report**
11.1	MW briefed the Board on key activity from the Committee. • People Services support provided to the RCN Industrial Action was noted. • The Board were informed of positive progress in relation to the 6 priority actions. **The People Committee Exception Report was noted.**
12	**Mental Health Act Scrutiny Committee Exception Report**
12.1	There was no meeting held to report.
13	**Audit & Risk Committee Exception Report**
13.1	There was no meeting held to report.
14	**Quality Assurance Committee Exception Report**
14.1	Key business was shared, including the need for critical Board level advocacy in relation to Community Engagement. The Board discussed the importance of this work across the ICS and ensuring co-production in approaches to Project Fusion, with best practice from across organisations reviewed. The need for further consideration of requirements for Board level advocacy were acknowledged. **The Board noted the Quality Assurance Committee Exception Report.**
15	**Non-Confidential update from Finance & Infrastructure Committee Exception Report**
15.1	There were no non-confidential items to report.
16	**Charitable funds Committee Exception Report**

16.1	There was no meeting held to report.
17	**Remuneration and Nominations Committee Exception Report**
17.1	There were no non-confidential matters to report.
18	**Any other business and reflections including:** • **Lessons learnt and living our values** • **Matters for cascade and/or escalation to other board committees**
18.1	VA commended the quality team for their work in relation to implementation and delivery of the Patient Safety Incident Response Framework across the organisation. It was noted that Patient Safety training would be provided to the Board in due course.
18.2	JM reflected on ensuring accessibility of meeting papers/outputs. RG informed of summary document publicised following each meeting and commented on usefulness of reviewing with OM & LT to ensure the document was 'easy read'.
18.3	No other business was discussed and the meeting was closed.
19	**Close**

Action Tracker

Overall Status	Source Of Action	Department	Date Action Generated	Minute Reference/ Additional URN	Action Number	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
On Target	Board meeting - In Public	Executive	05/12/2022	4.2	AC004997	In Public Board- Action Tracker	Regarding action AC004847 (*Effective (reduced capacity due to vacancies) - The need for co-ordination across the ICS was highlighted and JM commented on further work to consider innovative remote working for community services. It was agreed that JM review further with Clinical Directors and Heads of Quality & Professions to understand potential opportunities.* ***Action- JM.)*** **- It was agreed to provide a further update at the January Quality Assurance Committee, with update provided to Board via exception. Action- JM.**	Jackie Munro	**Closed. On-going system work now in place.**
On Target	Board meeting - In Public	Executive	05/12/2022	8.7	AC004998	In Public Board- Integrated Performance Report	People- NB queried differing target levels detailed within the report and the People Strategy in relation to sickness/turnover. It was agreed to review as part of the Workforce Report at the People Committee. **Action- SRa.**	Shahana Ramsden	The Workforce Data and Metrics report has been re-designed to support alignment of data and will be presented to People Committee on 26th January.
On Target	Board meeting - In Public	Executive	06/02/2023	9.2	AC005062	In Public Board- Integrated Performance Report	Safe- Regarding incidents outside of their allocated range, MW asked about potential need to reassess. The importance of continuing strong reporting culture was emphasised, however the Board acknowledged potential change in boundaries required. **Action- AA to consider further outside of the meeting.**	Angela Anderson	

Item No.	5		Presentation to	In Public Board		
Title of paper	Quarterly Safe Staffing Report Quarter 3 October – December 2022					
Purpose of the paper	This report provides an overview of the Nursing & AHP safe staffing status for the period October - December 2022 and is set out in line with the National Quality Board (NQB) standards.					
Committees /Groups previous presented and outputs	Nil					
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X
Action required	For decision		For assurance	X		
Summary of Recommendations and actions required by the author	The In Public Board is asked to: • Following review of workforce metrics, quality indicators and divisional commentaries the staffing levels across the nursing & AHP workforce in Solent NHS Trust were maintained. • Note the continuing development of the safe staffing report and the ongoing work to improve the approach to safe staffing and improve reporting matrix. The Q3 report has a quarterly view as well as a monthly view. Therefore, future reports will provide quarterly comparison. • Feedback from the Q2 report requested a breakdown of temporary staff usage by registered and non-registered. This has not been possible to complete for the Q3 report but will be included in future reports.					

To be completed by Exec Sponsor - Level of assurance this report provides:							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	**Angela Anderson**		Exec Sponsor signature:				

Executive Summary

This report provides Trust Board with an overview of the Nursing & AHP safe staffing status for the quarter 3 period October – December 2022. It provides assurance that arrangements are in place to safely staff the services in line with the National Quality Board (NQB) (2016) safe staffing guidance.

It also aims to provide assurance that nurse staffing levels within each ward /service are appropriate to meet the needs of patients and service users in our care and explain the approaches in place to monitor and manage staffing levels.

The Board is asked to note the current reported position and to endorse the action being taken to maintain and monitor safe staffing levels across the organisation.

Quarter 3 continued to be challenging for all services. Safe staffing and patient safety were managed effectively by reviewing caseload and flexible working. The impact of the outbreaks was monitored consistently and mitigations in place to manage effectively.

Surge capacity was utilised throughout the quarter in Jubilee (10 beds), Spinnaker (5 beds) and Fanshawe (2) in response to system pressures.

It is noted that there have been some challenges obtaining data for the purposes of the report and to enable comparison with Q2. The changes required to the establishment for Jubilee following their move and increase in bed base in October does not appear to have been completed this has therefore created anomalies in the reporting of CHPPD and in relation to vacancy factor.

Absence remains an area of concern, with a 12% increase noted throughout the quarter especially within Jubilee, Lower Brambles and Snowdon ward.

Community Nursing across both cities remains a concern and service lines continue to explore how recruitment strategies can be employed to generate interest and career development pathways.

Adults Southampton held a recruitment event in December that attracted attendees to a variety of roles within the service line. To date, three staff have completed recruitment checks and are ready to commence in service. The positions are a combination of clinical and administration staff. There are a few attendees currently within the recruitment processes. The learning from this event will inform future events.

Following review of workforce metrics, quality indicators and service line commentaries the staffing levels across the nursing & AHP workforce in Solent NHS Trust were maintained during this period and where there were concerns mitigations were put in place.

1. Background

1.1 Solent NHS Trust has a duty to ensure staffing levels are adequate so that our patients are cared for by appropriately registered and experienced staff in safe environments. This right is enshrined within the NHS constitution (2015) and Health Act (2009) which make explicit the Board's corporate accountability for quality. Demonstrating sufficient staffing is one of the quality and safety standards as set out in 'Hard Truths' (2014) a publication from the Care Quality Commission (CQC).

1.2 This report provides inpatient data published and now includes Care Hours Per Patient Day (CHPPD) data. The significance of this data and its inclusion will be developed over the future quarterly reports.

1.3 Whilst Solent NHS Trust recognises that the national mandate for reporting relates to in-patient nurse staffing levels the Trust continues to include and acknowledge the contribution other disciplines make to ensure that clinical teams deliver safe, effective, and high-quality care in an increasingly complex environment.

2. Overview of reporting period

Safe staffing meetings have continued during this reporting period. Daily huddles within individual services were maintained and concerns escalated via the service line and organisational assurance framework as deemed necessary.

There were little to no national restrictions from an infection prevention perspective regarding Covid during Q3, however internal restrictions continued to be in place within clinical environments as deemed appropriate and necessary. It is noted there were 18 SARS-CoV-2 outbreaks including staff clusters across inpatient and community services.

Within the reporting period particular attention was paid to the recovery of services and to the well-being of our teams. The safe staffing meetings enabled our Ward / Service Leaders and Matrons to escalate their successes and challenges to the Chief Nurse and / or their delegate.

Throughout the quarter, work has been ongoing to review the current safe staffing schedule and it is anticipated within Q1 2023 / 24, a new schedule will commence, this will include bringing similar services together to enable best practice and comparison.

The concerns raised in Q2, relating to patient and staff safety and wellbeing within the MH Acute Admissions Ward continued throughout Q3. The concerns predominately related to skill mix and knowledge base, acknowledging there has been multiple new starters to the clinical areas across both the registered and non-registered workforce throughout 2021 / 22 and 2022 /23. The review and rapid improvement programme continued within Q3 with a weekly safe staffing meeting schedule introduced.

Mental Health and CAMHs services continue to report challenges with staffing and the increasing demand for services. Focused work has begun to develop a CAMHs Academy to attract and train nurses who wish to develop a career in CAMHs, this is predominately focused on the international cohort of nurses.

A focused HCSW recruitment event planned for Q3 within Adults Southampton did not materialise due to a low number of applicants. However, all individuals that had applied were invited to interview with successful recruitment.

Following introduction of Auto allocate within Health roster in Adults Southampton, Adults Portsmouth Community services have begun implementation within the Q3. The programme supports matching skill set requirements and geographic “clustering” of caseloads to support daily allocation.

3.0 Workforce

3.1 The following section of the report demonstrates the adult inpatient workforce skill mix and usage of temporary staffing at the end of Q3. This includes unavailability matrix and Care Hours Per Patient Day (CHPPD).

3.2 Table 1 below shows the skill mix across the first three quarters of 2022 / 23 and where temporary staffing has been utilised by quarter and appears relatively consistent across each quarter. It is acknowledged that during this period, additional bed capacity had been utilised predominately within the Portsmouth place in response to HIOW system challenges which is reflected in the small increases across non-registered and temporary staffing. In addition, patient acuity, complexity, and dependency have impacted upon staffing in relation to increased observation requirements.

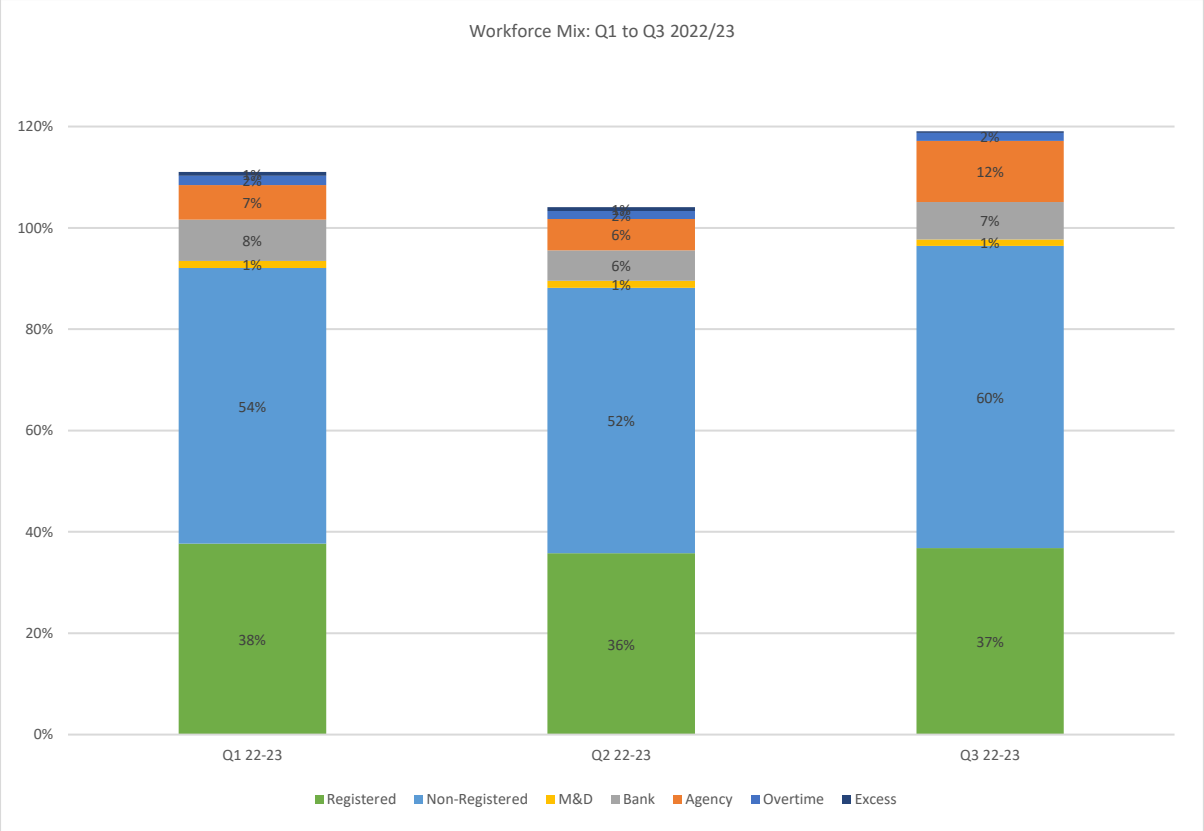


Table 1 Workforce by % Q1 – Q3 2022 / 23

3.3 Table 2 show the skill mix by inpatient area and an overarching position for adult's community services.

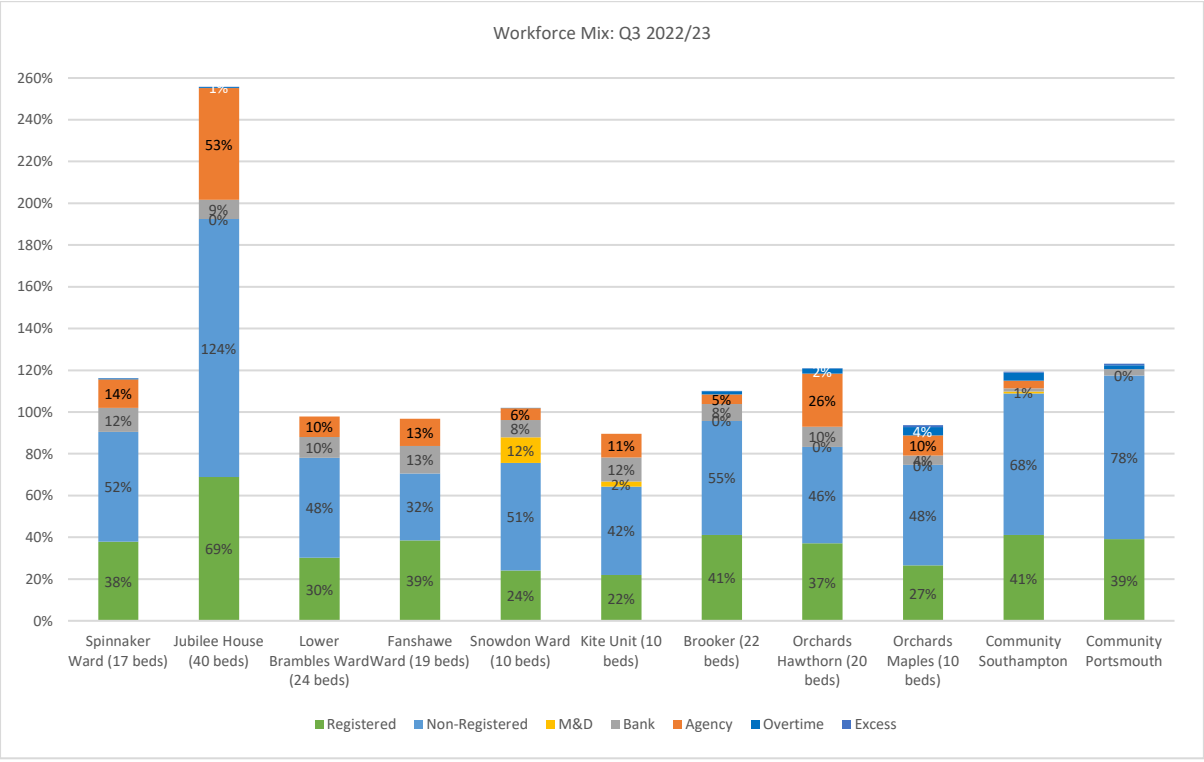


Table 2 Workforce mix by % December 2022 / 23

3.4 The revised establishment for the Jubilee Unit has not yet been amended to reflect the increase in bed capacity from October 2022 and this is reflected in the data so therefore the unit appears to be over plan. In addition, the unit has been using a higher level of temporary staff. This appears to be predominately agency staff as opposed to Solent NHS Trust bank staff.

3.4.1 Within the quarter there has been an increase in the use of agency staff from 6% in quarter 2 to 12% in quarter 3 across all inpatient and community services.

3.4.2 Within Mental Health Inpatients, Hawthorn ward appears to be an outlier in relation to its use of temporary staffing, particularly agency. This increase is attributable in the main to the response required to address the clinical concerns within the ward environments and the decision to temporarily reconfigure the wards to create two smaller acute admission ward.

3.4.3 Q3 has seen an increase in the percentage of non-registered substantive staff within the overall staffing establishment, increasing from 52% in Q2 to 60% in Q3. The biggest increases can be seen within Spinnaker (37% to 52%) and Jubilee (46% to 124%) the latter directly attributed to the change in ward profile following the move in October.

4.0 Care Hours Per Patient Day (CHPPD)

4.1 CHPPD is calculated using the daily staffing numbers and the daily patient count at midnight and then aggregated for the month. Whilst this method does not represent the total and fluctuating daily activity, turnover or the peak bed occupancy it provides reliable and consistent information and a common basis for comparisons to measure, review and reduce variation at ward level within organisations and within similar specialties across different trusts. CHPPD data should **not** be considered in isolation but should be viewed with additional data sources as changes in speciality, staffing levels and service moves occur. Reviewing it in isolation could demonstrate a misleading picture in terms of safe staffing levels. It is worthy to note that there is no option within CHPPD data to benchmark nationally or a best practice %. The comparison, alongside professional judgement occurs locally and with reference to previous individual wards data.

4.2 Additional work is required to ensure CHPPD for each clinical environment is reviewed. This will be considered as part of the revised format of reporting on safe staffing and will form part of the Workforce Development Programme throughout 2023 / 24.

4.3 Table 3 below demonstrates the CHPPD across Q1 – Q3 2022 /23. The overall average CHPPD has increased within Q3, notably within the non – registered workforce.

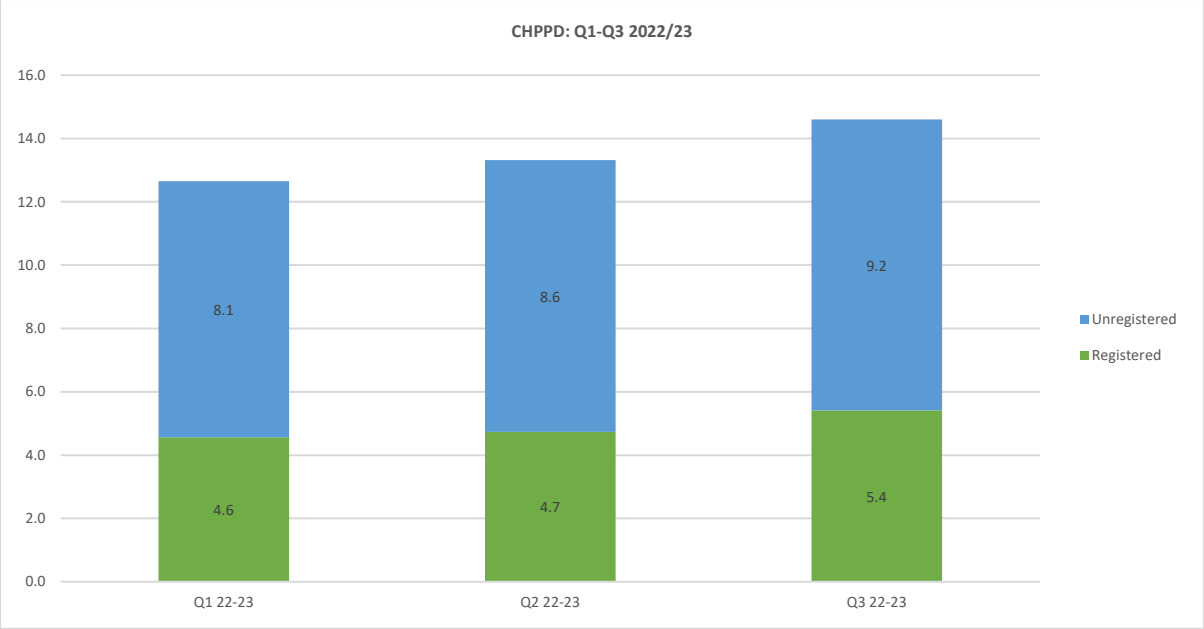


Table 3 CHPPD by Q1 – Q3 2022 / 23

4.4 The table below demonstrates the CHPPD with Q3 (with the exception of Jubilee)

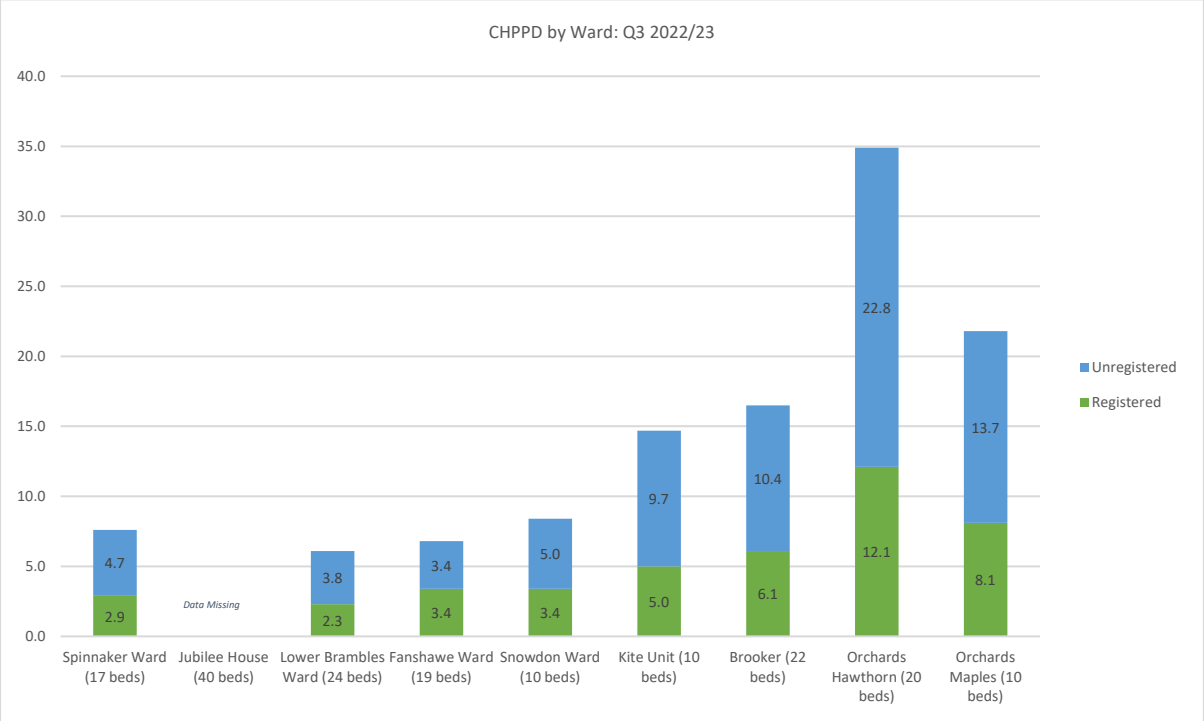


Table 4 CHPPD within December 2022

4.5.1 In comparison to Q2 the data demonstrates broadly consistent CHPPD levels with exception of 2 areas Hawthorn and Maples. There has been a significant increase in the CHPPD in Hawthorn ward throughout Q3, from 12.1 in Q2 to 34.9, this reflects the focused work undertaken within Hawthorn and the decision to create 2 smaller inpatient wards as referenced above.

4.5.2 The CHPPD within Maples in relation to HCSWs has decreased from Q2 (24.6) compared to 13.7 in Q3, this variance appears to be linked with the move of the unit back into the Orchards after being in a standalone building at the end of Q2 beginning Q3 and the reflected change in staffing, it also coincides with the change in use of beds to support flow with an increase in bed occupancy on Maples as an admitting unit for detained patients before being transferred to Hawthorn ward. Review of the Q4 and whole year data will help to understand the impact of the changes in terms of the CHPPD.

5.0 Non-Productive / Unavailability

5.1 A key factor in managing safe staffing is the management of the unavailability of staff to support the roster period. Currently, the trust target for non-productive working is set at 22%. Within the 22% allocation there are specific trust targets for annual leave, study leave and sickness.

A roster is a tool that is used to ensure that the right people with the right skills are in the right place at the right time, to meet the demands of the service whilst taking into account staff numbers, capacity, capability, adequate rest and headroom.

5.2 The data in table 5 below shows unavailability by theme across Q1 to Q3 and will support comparison against key performance indicators as listed within the eRoster Policy (2020), Appendix A.

5.2.1 Within Q3 it is noted there has been a decrease in the allocation of annual leave in comparison to Q1 and Q2, parental leave has maintained a static position however, there has been a significant increase in sickness absence within the quarter from 30% previously to 42%. Short term absence due to respiratory illness and Covid symptoms was the predominate cause of absence.

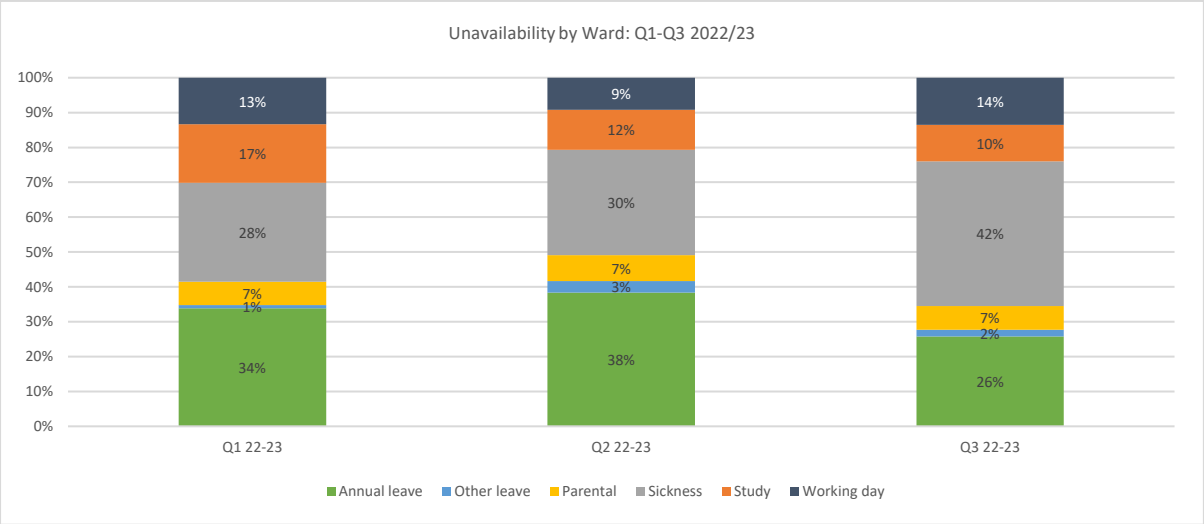


Table 5 Unavailability comparison Q1 – Q3 2022

5.3 The data within table 6 shows the unavailability for December 2022.

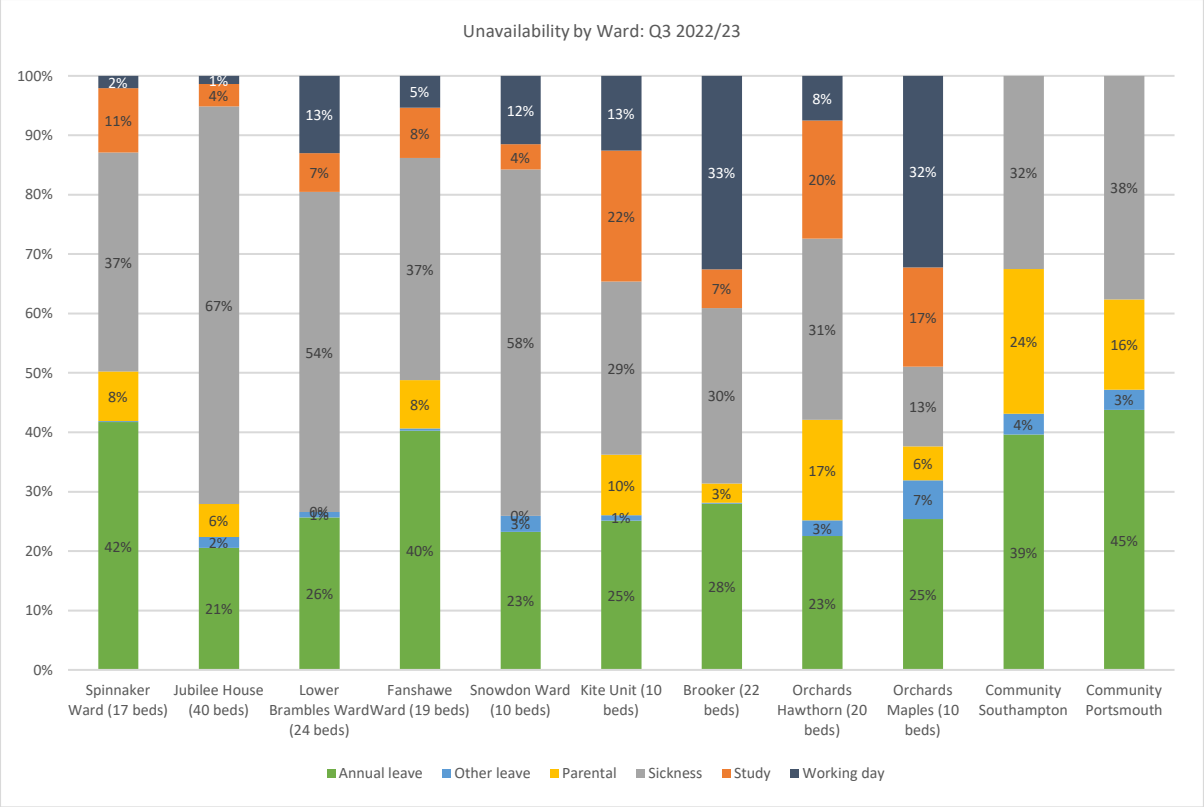


Table 6 Unavailability by ward / service December 2022

5.4 The Q3 data shows significant increase in sickness absence rates from Q2 as a percentage of overall unavailability. Jubilee's absence increasing from 37% (Q2) to 67% (Q3), Lower Brambles from 36% (Q2) to 54% (Q3) and Snowdon from 29% (Q2) to 58% (Q3). Conversely, Kite saw a significant improvement from 50% (Q2) to 29% (Q3).

5.4.1 In comparison to Q2 annual leave as a percentage of overall unavailability appears to have reduced across all but one unit (Spinnaker ward 39% to 42%). It is acknowledged that there have been challenges to ensure all staff utilise their annual leave entitlements that had been accrued throughout the Pandemic and with "carry over" of leave being closely monitored, this will be continued into Q4, with Annual leave being a key performance indicator as listed within the eRoster Policy (2020), Appendix. A.

6.0 Recruitment and Vacancies

6.1 International Recruitment (IR) continued throughout the reporting period with health care professionals onboarded into RMN, RN and OT roles.

The trust has met its 2022 /23 target for international recruitment for community nursing (24) and has met its interim target for RMNs (13). A further 7 RMNs will arrive in Q4 to fulfil the target for 2022 /23.

6.2 As a consequence of the challenges within the MH Inpatient wards noted in the Q2 Safe Staffing report, the development of the "transition" programme, bridging the gap from the OSCE Preparation Programme to joining the ward team has proved very successful, with excellent feedback from both the participates and the ward teams. It is anticipated this will support improved retention.

6.3 It was noted in Q2 that several IENs had left the Trust, this has stabilised within Q3 with no further resignations. The trust has welcomed 88 IENS since 2021 with 12 resignations (13.63%). This will be continuously monitored, and themes of leavers explored.

6.4 It is acknowledged that the ability to recruit and retain community nurses across all bandings continues to be extremely challenging for services across both Southampton and Portsmouth and is in line with the national picture. This is monitored / reviewed within safe staffing meetings, with additional focus and support when required.

6.5 There has been discussions with the Mental Health and Adults service lines Leadership Teams to see how the Mental Health & Community IENs transition programmes can be adapted to provide an enhanced robust clinical induction for any nurse who is new to a mental health or community role. The transferability of the learning from the IEN programme is a positive step to support this transition and acquisition of skills which will aim to support attraction and retention.

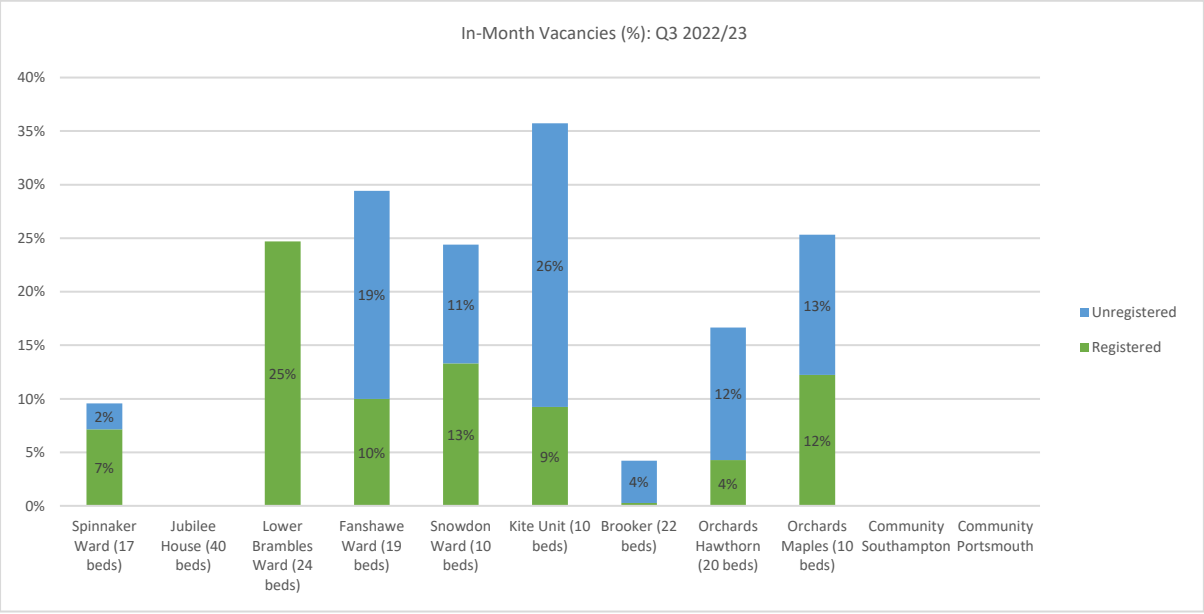


Table 7 Vacancies as a percentage by registered and non-registered staff for Q3 2022

6.6 Table 7 above shows the vacancies as a percentage by registered and non-registered staff. Workforce establishment summits were commenced in November 2022 for all service lines as part of workforce planning and in preparation for the business planning process.

6.7 The available vacancy data for Q3 is not fully reflective of the overall position, whilst our figures indicate that we are over established (over budgeted position), we know that we have continued high use of temporary staffing in these areas and our staff in post position does not match the establishment. There is work planned to address this as part of our commitment and investment to

safer staffing and this reporting. This will involve aligning our structures in ESR (and other systems including Health Roster) against what is needed to maintain safe rosters.

At the close of Q3 there was 33.9 FTE vacancies in registered and 38.2 in non-registered nursing roles across the reported areas.

7.0 Acuity & Dependency

7.1 Acuity and Dependency tools provide an evidenced based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure nursing establishments reflect patient needs. Within the reporting period, there has been further communication with national teams about acuity and dependency tools and licence.

7.2 The mental health inpatient wards completed their Mental Health Optimal Staffing Tool (MHOST) training within Q3 and have completed their first audit in January 2023. The results are currently being analysed and will form part of the Q4 report.

7.3 Whilst there is a plan for the adult inpatient wards to complete the Safer Care Nursing Tool (SCNT) training, there is a national update to the tool due imminently, the decision has been made to wait for the update before implementation therefore this is anticipated to progress in Q4 and Q1 of 23/24.

7.4 The Community Nurse Safe Staffing Tool (CNSST) training has been completed for those nursing leaders who will be supporting implementation and cascade training, pending agreement of a system go live date in collaboration with the SE Region task and finish group in Q4.

8.0. Safety and Quality Incidents / Nurse Sensitive Indicators (NSI)

8.1 Nurse Sensitive Indicators (NSIs) refer to quality indicators that can be linked to nurse staffing issues, including leadership, establishment levels, skill mix and training and development of staff. This information can be used to further support ward staffing requirements identified through acuity and dependency measurement. The NSIs support identification of whether there has been any adverse impact because of below planned staffing numbers.

8.2 The NSIs / incidents are reported within the quarterly Patient Quality and Safety report and by individual services via their assurance framework. For the Safe Staffing report, incidents directly relating to staffing levels affecting patient care and affecting staff will be identified. The tables below indicate the number of incidents within the reporting period.

Community Services	
Team	Number of incidents
Community Independence East (BHC)	1
Community Neuro Rehab Team (WCH)	1
Community Neuro Service	1
PRRT IC Rapid Response Team	29
Sp Palliative Care Service	3
West Locality (WCH)	1
Total	36

Table 9 Number of incidents for Q3 citing staffing affecting care & staff within community services.

8.2.1 The Portsmouth PRRT team have reported the majority of the incidents in Q3 relating to staffing levels impacting upon patient care and staff. The incidents relate to vacancy and the impact of care delivery. The number of reported incidents for PRRT has increased from 16 in Q2 to 29 in Q3.

A reduction in incidents within the Specialist Palliative Care was noted in Q3 (3) from Q2 (10).

Overall, there has been a decrease in the number of incidents relating to staffing levels affecting patients / staff from 45 (Q2) to 36 (Q3) across the community services.

Mental Health Community Services	
Team	Number of incidents
Assessment to Intervention Team	4
Community Intensive Rehab Team	6
MHS Crisis Team (SMH)	38
Orchard Therapies and Admin (SJH-LIMES)	2
Recovery Team North	1
Total	51

Table 10 Number of incidents for Q3 citing staffing affecting care & staff within MH community services.

8.2.2 There has been a significant increase in the number of incidents reported in Q3 for the MHS Crisis Team from 2 (Q2) to 38 (Q3). This correlates with the concerns raised within the team during the quarter and lead to a focused review of the staffing and caseload led by the Chief of Nursing & AHPs and their deputy.

Overall, there has been an increase in the number of incidents relating to staffing levels affecting patients / staff from 13 (Q2) to 51 (Q3) across the mental health community services.

Inpatient Services	
Ward	Number of Incidents
Fanshawe Ward (RSH)	1
Jubilee Unit (Harry Sotnick House)	3
Lower Brambles Ward (RSH)	5
Snowdon Ward (WCH)	6
Spinnaker Ward	5
The Orchards Acute - Hawthorn (OCSJ)	4
The Orchards PICU - Maples (OCSJ)	2
Total	26

Table 11 Number of incidents for Q3 citing staffing affecting care & staff within Inpatient Services

8.2.3 Across Q3, most incidents with cause 1 and / or cause 2 relate to staffing levels affecting patient care / affecting staff relate to skill mix and reduction of total number of nurses on duty.

Jubilee reported 3 incidents across the quarter and 1 of those directly related to staffing levels affecting patients / staff. It indicated that only 1 permanent registered member of Solent NHS Trust staff was within the workforce for that shift, with the remainder consisting of temporary staff.

In comparison to Q2 there has been a slight increase in the number of incidents reported relating to staffing affecting patient / staff from 20 to 26 in Q3.

8.7 NSI – Nutrition

Whilst the Safer Care Nursing Tool (SCNT 2018) references Nutrition - number of patients having had nutritional screening per 1000 occupied bed days as an NSI, there have been no incidents reported within the quarter that identify nutrition as a cause, cause 2 and / or contributory factor.

It has been established that all inpatients' wards within Solent NHS Trust offer protected mealtimes and all patients have a MUST risk assessment on admission and every 7 days during their stay. This is audited on a six-monthly basis which identified our Solent NHS Trust inpatient wards were compliant.

8.8 In summary, within future reports there will be further development to compare incidents across the reporting periods and identify where the impact of staffing levels has affected patient care and staff.

9.0 . Complaints and Service Concerns

9.1 In order to review the correlation between safe staffing, the receipt of complaints and service concerns, the SCNT (2018) recommends that official complaints about nursing / care staff received (per 1000 bed days) that identify three areas:

- Communication
- Patient care
- Values and Behaviours of Staff

9.2 Table 10 shows service concerns received in Q3 and comparison to Q1 and Q2. ADP and Mental Health saw a slight decline in services concerns, whilst an increase is seen in ADS.

Number of Service Concerns	Q1	Q2	Q3
Adults Services (Portsmouth)	9	5	3
Adult Services (Southampton)	6	7	9
Mental Health Services	10	15	13
Total	**25**	**27**	**25**

Table 12 – Service concerns for Q3 2022/23

9.2.1 Of the service concerns received the themes across Solent NHS Trust in Q3:

- 23 (13%) service concerns were attributed to Communication
- 8 (5%) service concerns were attributed to Patient Care
- 22 (13%) service concerns were attributed to Values and Behaviours

It is acknowledged the above data does not provide the % attributed directly to the service lines and is a trust wide position.

9.3 In Q3, it is noted there was a decrease in total complaints received from Q2 (38) to Q3 (31). The complaints attributed to Mental Health, ADP and ADS are demonstrated in the table below.

Service	Complaints Q1	Complaints Q2	Complaints Q3
Adults Services (Portsmouth)	5	1	4
Adult Services (Southampton)	0	1	1
Mental Health Services	1	9	5
Total	**6**	**11**	**10**

Table 13 Complaints by service

In comparison to Q2 Mental Health following a focused review have reduced the number of complaints.

9.3.1 Of the complaints received with Q3:

- 4 (13%) Complaints were attributed to Communication
- 10 (32%) Complaints were attributed to Patient Care
- 3 (10%) Complaints were attributed to Values and Behaviours

It is acknowledged the above data does not provide the % attributed directly to the service lines and is a trust wide position.

10. Risks Escalated to Risk Register in Relation to Safe Staffing

10.1 In order to triangulate safe staffing, it is proposed within future reports to identify where concerns in relation to staffing have been escalated to the Solent NHS Trust risk register. The table below identifies the number of risks currently recorded, where staffing is reported as being below planned levels.

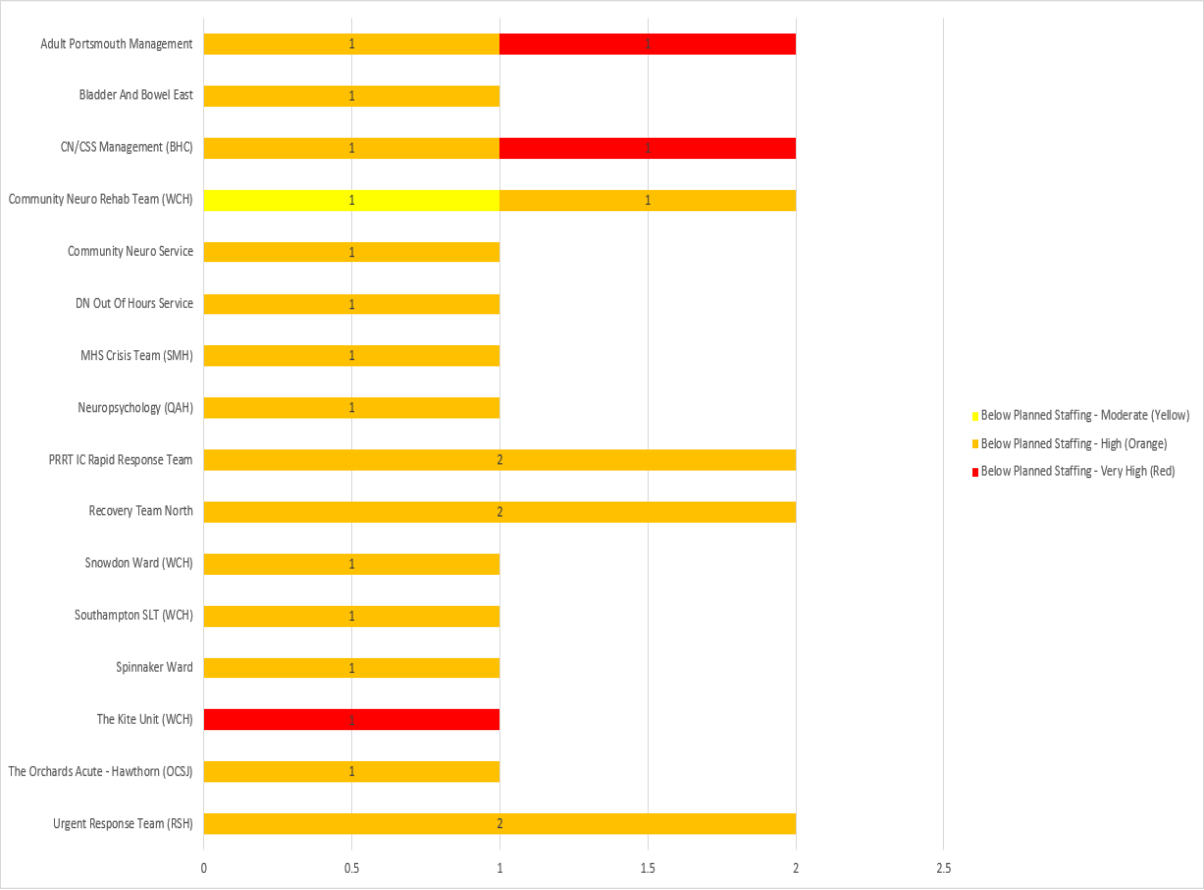


Table Risks citing staffing levels within Q3 impacting upon patient care / service delivery

10.2 The overarching theme in relation to risks relating to safe staffing are that staffing levels are below planned, potentially leading to sub optimal care. The mitigation is a reliance on both temporary

staffing and existing staff undertaking excess hours to ensure the staffing numbers remain with the planned levels.

There are three risks noted to be very high

Very High Risks	
Adults Portsmouth Management	Overarching whole service below planned staffing risk, controls and actions have a focus on staff wellbeing.
CN/ CSS Management (BHC)	Community nursing below planned staffing risk. Daily capacity reviews at morning meetings and RAG rating caseloads and staffing. Vacancy rate 29%. Review of template. Additional Band 4 recruitment in place. Insulin administration successful and review of screening to reduce assessment where they are not required.
The Kite Unit (WCH)	New inpatient below planned staffing risk. Ward doctor cover. Currently the ward Doctor cover on KITE is with Locum doctors including the consultant cover. Yet to recruit into substantive posts (adverts are out).

Table 14 Very high risks relating to staffing affecting patient care / service delivery

10.3 The Head of Risk and Litigation meets monthly with Head of Quality & Professions to review current risks, determine mitigation and escalation / de-escalation. These are monitored within individual service line assurance frameworks.

11. Conclusion

In Q3 of 2022/23 workforce concerns relating to safe staffing is the top risk across the organisation.

During the reporting period the safe staffing escalation meetings have reverted to a monthly schedule except for mental health inpatients and Crisis Team. However, it was noted that should individual services be particularly challenged with regards to safe staffing and require additional support from the Chief Nurse Directorate, the HR Team and / or health roster team this would be supported. It is noted that within individual services, daily huddles with senior leadership to discuss staffing levels for the forward 24-hour period are in place.

Community Nursing services across both cities continue to be challenged and this has been escalated to the Chief of Nursing & AHPs and specific actions taken in response.

Additional bed capacity continued to be in use throughout reporting period particularly within the Portsmouth system and Quality Impact Assessments had been completed.

Jubilee House moved to its new location within Q3 bringing challenges relating to infection prevention, health and safety and safe staffing. Remedial action was undertaken and throughout the quarter has seen improvements to the environment, However, challenges remain within with the allocation of staffing and TUPE arrangements of staff from previous employers. These are being managed effectively by the senior leadership team and HR.

Appendix. A

http://intranet.solent.nhs.uk/DocumentCentre/PublishedPolicies/HR35 eRostering Policy v6.pdf

Item 6

CEO Report – In Public Board

Date: 23 March 2023

This paper provides the Board with an overview of matters to bring to the Board's attention which are not covered elsewhere on the agenda for this meeting. The Board is asked to note the content of this report. Operational matters and updates are provided within the Performance Report, presented separately.

Section 1 – Things to celebrate

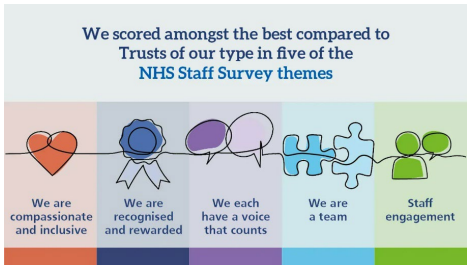
Celebrating Solent's apprentices

The latest annual award ceremony was held to recognise the amazing work of Solent's apprentices and the wide ranging contribution they make to local communities. I was delighted to present the category winners of the awards during the special event at King's Community Church in Hedge End in February.

Supporting families and parents across Portsmouth, Southampton and the Isle of Wight

Family Assist Solent – Solent's online portal, has been helping parents and families access information and support during pregnancy, birth and beyond, in its first year.

In its first twelve months, families across Portsmouth and Southampton cities and the Isle of Wight have accessed the platform over 35,000 times, benefitting from the free, comprehensive, easy to access service from local health professionals, providing information up to age 11, with more guidance for older children being developed.



Staff survey results

The annual NHS Staff Survey results were published earlier this month. I am immensely proud that our response rate and scores are amongst the best when compared with other combined community, learning disability and mental health trusts and was found to be top performing in five out of the nine key themes, and above average in the other four.

The results, which are testament to the commitment and dedication of everyone in Solent, demonstrate that as a Trust we have a compassionate and inclusive culture with people sharing that they feel that their role makes a difference and that they feel a strong personal attachment to their team where they are really valued.

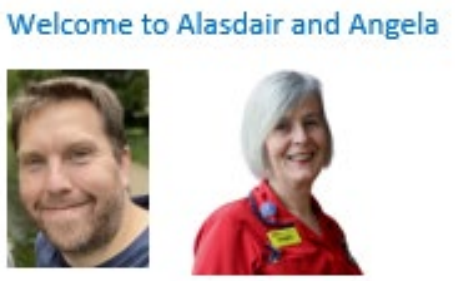
Section 2 – Internal matters (not reported elsewhere)

Board news

Since the last report there have been several changes to the Executive team and wider Board.

Firstly, I would like to formally give my heartfelt thanks to both Jackie Munro, our former Chief of Nursing and Allied Health Professionals and to Suzannah Rosenberg, former Chief Operating Officer for their support and dedication to Solent over the years. Both Jackie and Suzannah recently retired and we wish them well in their future adventures.

We have welcomed Alastair Snell as Interim Chief Operating Officer and Angela Anderson as Interim Chief of Nursing and Allied Health Professionals. Both Alasdair and Angela bring a wealth of experience and expertise to the Board and both these roles are vital to the continued success of Solent playing an integral part in supporting the transformation journey that lies ahead.



At the end of March we also say goodbye to Calum Mercer, Non-Executive Director and Chair of our Audit & Risk Committee, and again would like to take the opportunity to thank Calum for his leadership and support, and wish him well in his future endeavours. We are actively working towards finding a replacement Audit & Risk Chair.

Great Care

Safety matters

Nothing additional to report, any safety matters are covered within the industrial action update.

Demand and Capacity

Contemporary update urgent care and Winter pressures

The Urgent and Emergency Care systems in Southampton and Portsmouth have become more stable in recent weeks despite periods of industrial action. In Portsmouth we are now making plans to close the 5 surge beds on Spinnaker ward which will support greater rehabilitation opportunities for the patients on the ward. As part of the HIOW business planning process attention is focussed on agreeing (funded) stretch trajectories for Virtual Ward and Urgent Community Response activity throughout 23/24 in line with the Governments Forward View plan for the NHS.

Great Place to Work

Workforce matters

Industrial Action

The RCN strike action planned for 01 and 02 March 2023 was cancelled due to progression on pay talks with the Government and RCN, with a possible agreement announced on 16 March 2023. CSP (Chartered Society of Physiotherapists) participated in strike action on Thursday 09 February 2023, we had 57 colleagues take part. Up to 25 Junior Doctors participated in strike action through the BMA (British Medical Association) from 7am on 13 March 2023 to 7am on 16 March 2023. As a Trust we continue to support staff to have a voice and have engaged positively with the respective unions in terms of the safety and arrangements during strike days. It continues to be a difficult decision for our staff to take strike action, but we have been encouraged by the feedback from our staff on the way we have managed this for them. We have been able to provide a balanced approach, so that people can exercise their legal right to take formal industrial action, whilst ensuring a continued focus on maintaining safe and quality care for our patients.

A proposal of a 5% pay rise from 01 April 2023 has been offered to NHS staff in England, as well as the offer of a one-off payment to top up the past year's pay award. It is understood that the unions are recommending members back the deal for the offer which covers all NHS staff except doctors, who are on a different contract. As with previous pay awards, the People Team are putting plans in place to ensure that we provide ongoing communications and have robust processes in place to implement the agreed actions.

Operational Workforce Planning 22/23

Our workforce plan was submitted to the ICB on 16 March 2023. The finance and workforce teams have worked in collaboration to align our staffing and financial plan. All workforce growth has been through a robust QIA process with the Executive team and considered against safer staffing and investment criteria. We will be developing attraction strategies particularly for Nursing and Health Care Support Workers in Adults and Childrens.

A Kind Life

Solent are working in partnership with 'A Kind Life' to create a culture free from bullying and harassment, where we see more positive behaviours that build teamwork and fewer negative behaviours that undermine teamwork, harm patient safety and our own wellbeing. An Alignment Workshop will be held on 22 March with representatives from service lines and corporate services, along with other identified groups to create a new best practice approach to bring this to life for our staff.

Reverse Mentoring

To support our ongoing commitment to creating an inclusive culture across Solent, we have developed a Reverse Mentoring programme, which will generate opportunities for Senior Staff to be mentored by less senior colleagues from diverse backgrounds. Following a very positive response to our request for mentees and mentors, briefing, induction and training programmes will be delivered throughout the month of March.

Great Value for Money

Estates and infrastructure

ICT Future Operating Model

The ICT team have been working across the trusts sites since December to project manage the safe cutover of our networks from the historic CGI contract to the renewed operating model. The project has gone without major issue to date and is due to conclude by 24 March 2023. The next phase of delivery will see the roll out of our newly configured laptops which will increase performance, when coupled with the new networks, for staff by the summer.

Western Community Hospital

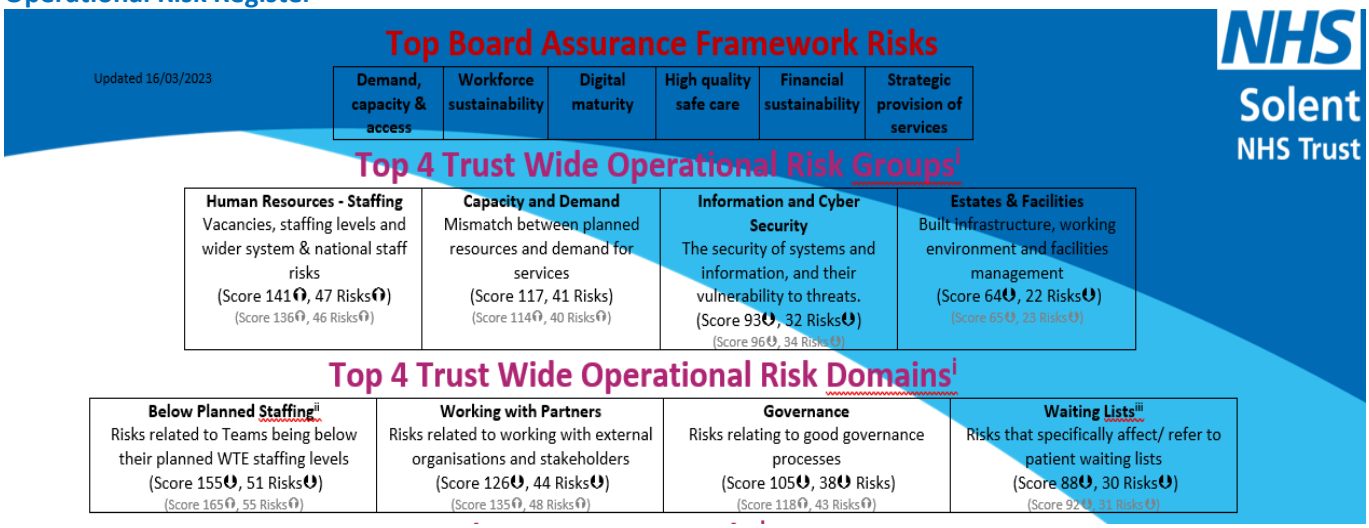
I am delighted to say that at the end of February, we completed phase one of the construction project and finished demolition of the Tannersbrook Ward at the Western Community Hospital. Phase two now begins; building a new innovative rehabilitation wing for the hospital, on track to open in summer 2024.

This final part of the demolition work saw a mobile jaw crusher brought on site to break down every single piece of the brickwork and concrete in the old building into smaller chunks that were then recycled for further use across the site.

The act of repurposing concrete in this way is common practice in construction but often the crushed concrete must be brought in externally, at a cost to the project and the environment. We have been able to create the material needed ourselves and the crusher is renowned for its maximum productivity and lower operating costs, making the process a sustainable solution. Overall, over 90% of the demolished building has been recycled.

Our key risks

Operational Risk Register



The risk pyramid summarises our key strategic and trust wide operational risks. Our top risk groups are:

1. Human Resources – Staffing
2. Capacity & Demand
3. Information and Cyber Security
4. Estates and Facilities

Our top Risk Domains are:

1. Below Planned Staffing - the most prevalent risk
2. Working with Partners
3. Governance
4. Waiting Lists

All operational risks are being actively managed through our care and governance groups and assurance is sought at the relevant Board Committees.

Board Assurance Framework (BAF)

The organisations strategic risks, within the Board Assurance Framework are summarised as follows.

BAF Risk	Raw Score	Residual Score	Target Score
Demand, capacity and accessibility	S5 X L5 = 25	5S x 4L = 20	S4 x L4 = 16 – by End July 2023
Workforce sustainability	S5 X L4 = 20	S4 x L4 = 16	S4 x L3 = 12 by summer 2024/25
Digital Maturity	S5 X L4 = 20	S5 x L3 = 15	S4 x L3 = 12 – by March 2023
High quality safe care	S5 XL5 = 25	S5 x L3 = 15	S5 x L2 = 10- by end Q3 2022/23
Financial sustainability	S4XL5 = 20	S4 x L4= 16	S3 x L3 = 9 – by end 2023/24
Strategic provision of services	S5 X L5 = 25	S5 X L4 = 20	S3 x L3 = 9 – by 1 April 2024

The full report is presented to the Confidential Board.

Section 3 –System and partnership working

Clinical Delivery Group Update (now named Clinical Transformation Group)

The Group last met on 2 March 2023 and acknowledged the challenges associated with Acute Mental Health and Crisis Beds workstream, in particular in relation to common data sets, complexity of services, level of variation and differing population needs. It was agreed that refinement of ambition and deliverables is required and will be reported to the May meeting. A deep dive in relation to the Child & Adolescent Mental Health workstream is expected at the April meeting. Primary Care workstream colleagues attended the meeting to present their emerging objectives and vision – it was agreed that further refinement of outcomes, milestones and associated cost-benefit considerations be considered.
The group also agreed to re-brand as the 'Clinical Transformation Group' to provide clarity in respect of the work of the group, which runs in parallel to the Project Fusion and focuses solely on the ten clinical transformation programmes.

Project Fusion

The strategic business case, setting out the strategic rationale, options and preferred way forward for the proposed new community and mental health provider for Hampshire and the Isle of Wight, is being shared at Public Boards this month. The case is supported by the Hampshire and Isle of Wight ICB and the next phase will include review by NHS England. A detailed programme update, setting out the key elements of the next phase of Project Fusion, and the communications and engagement plan for the programme are also being reviewed by Trust Boards this month.

Department of Health and Social Care visit 10 March

On Friday 10 March, colleagues from the Department of Health and Social Care (DHSC) came to visit some of our teams in Adults Portsmouth, to view how our services operate in action, and see the Local Authority collaborative and patient-centred approach we take.

This was a great opportunity to demonstrate our community values and importance in managing the pressures being reported across health and care, which can be used to demonstrate good practice for others, whilst seeing the great work being done in Portsmouth referenced far and wide.

Feedback we have received from our DHSC colleagues following the event, including Helen Caulsey, Deputy Director, Community Health Services, mentioned how useful and informative the visit was by seeing how the use of physical space can impact on care (e.g. how we utilise the Spinnaker day room for surge beds), how staying in hospital longer can sometimes improve longer term outcomes (e.g. people going straight home rather than needing to step down for short periods of time) and how co-location of health and care is really beneficial to service delivery.

The DHSC team are keen to stay in communication with us to see how policy in action can be fed into future policy planning. We have extended an invitation for the team to return in the future to view other parts of our services.

Item 7

NHS Solent NHS Trust

NHS Staff Survey 2022

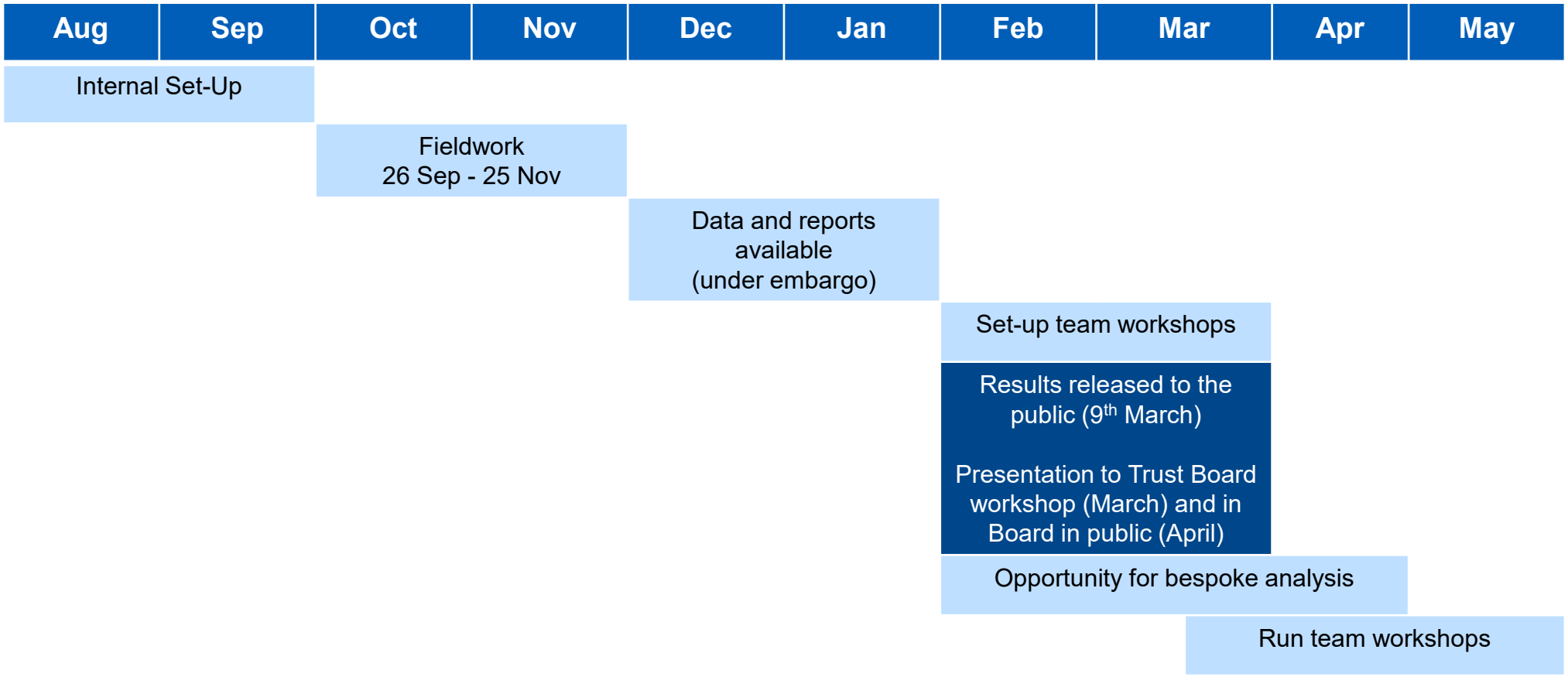
March 2022

Executive summary

- Staff still really engaged with high response rate maintained, but need to review the way we are using postal surveys to improve further next year
- Solent has maintained a strong performance in staff satisfaction during challenging times, now top amongst our peers for 5 of the 9 key measures
- However, we are seeing our scores decline for recommendation as a place to work, and whilst this is a national trend, we should continue to keep a strong focus on creating an environment where people can thrive and be at their best
- Whilst it is a difficult time for NHS workers, Solent appears to be doing a great job in
  - fair treatment of staff
  - engaging staff through challenging work
  - empowering them to make change and
  - providing learning & development opportunities
- But there are some areas where we need to pay attention:
  - our ability to address concerns from staff or patients as well as clinical practices (this is a decreasing area)
  - the ability of the appraisal process to have an impact

Where are we right now with the NHS Staff Survey?

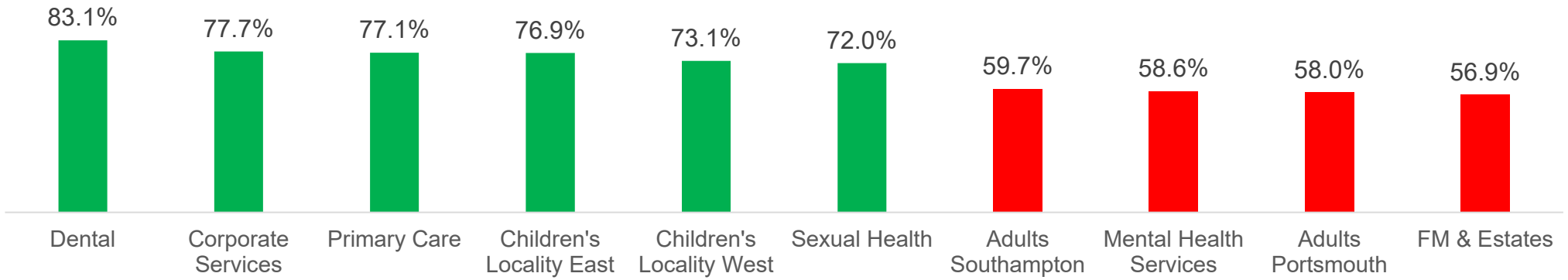
NHS Solent NHS Trust



Great response rate, but need to improve on postal surveys next year

68.4% response rate

Small increase from last year's 67.7%
Still significantly ahead our peers* average response rate of 50%



Postal survey response rate low with only 1 in 3 responding

Facilities Management (FM) and Estates (57% of staff receiving a postal survey)
ADS (28% of staff)
Mental health (24%)
ADPS (17%)

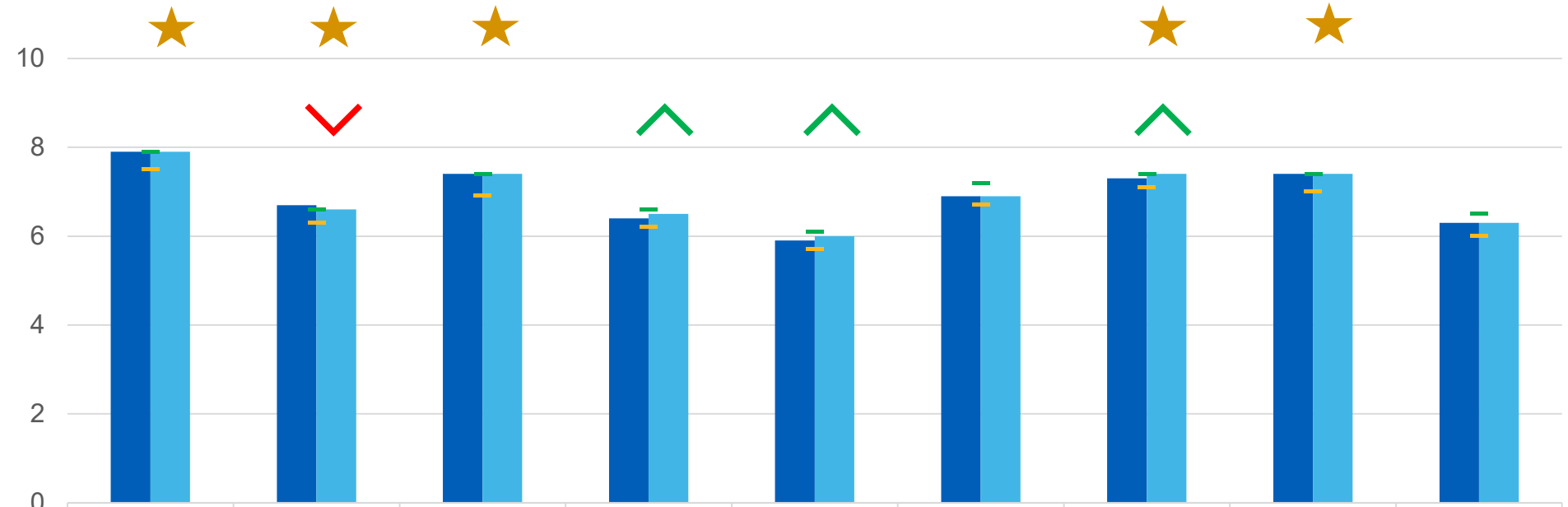
** Benchmarked against other mental health & learning disability and mental health, learning disability & community trusts*

In 2021 the NHS Staff Survey was redeveloped in line with the People Promise

Two previous themes remained: **staff engagement** and **staff morale**

After setting the bar high in 2021, Solent has maintained last year's standard with some minor improvements

And our relative position against our peers has strengthened, with Solent now ranked top for 5 of the 9 key metrics, an improvement from 3 last year



	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Solent 2021	7.9	6.7	7.4	6.4	5.9	6.9	7.3	7.4	6.3
Solent 2022	7.9	6.6	7.4	6.5	6.0	6.9	7.4	7.4	6.3
Best 2022	7.9	6.6	7.4	6.6	6.1	7.2	7.4	7.4	6.5
Average 2022	7.5	6.3	6.9	6.2	5.7	6.7	7.1	7.0	6.0

Some key variations in each metric by service line

Need to understand both the trends compared to last year, as well as influence of individual teams

Facilities and Estates notable with a rating lower than all other service lines

Sexual Health Services receives the worst rating, somewhat out of line for their other feedback whilst MHS score well

Not too much variety on this element – in-line with other scores

Trust appears split in half with Adults Portsmouth, Facilities and Estates, Primary care, Sexual Health Services SHS & Dental below average

This is the area with the greatest variety across service lines - Dental particularly poor & Corporate score well

Despite low score for a number of the People Promise elements, Facilities and Estates score well for morale

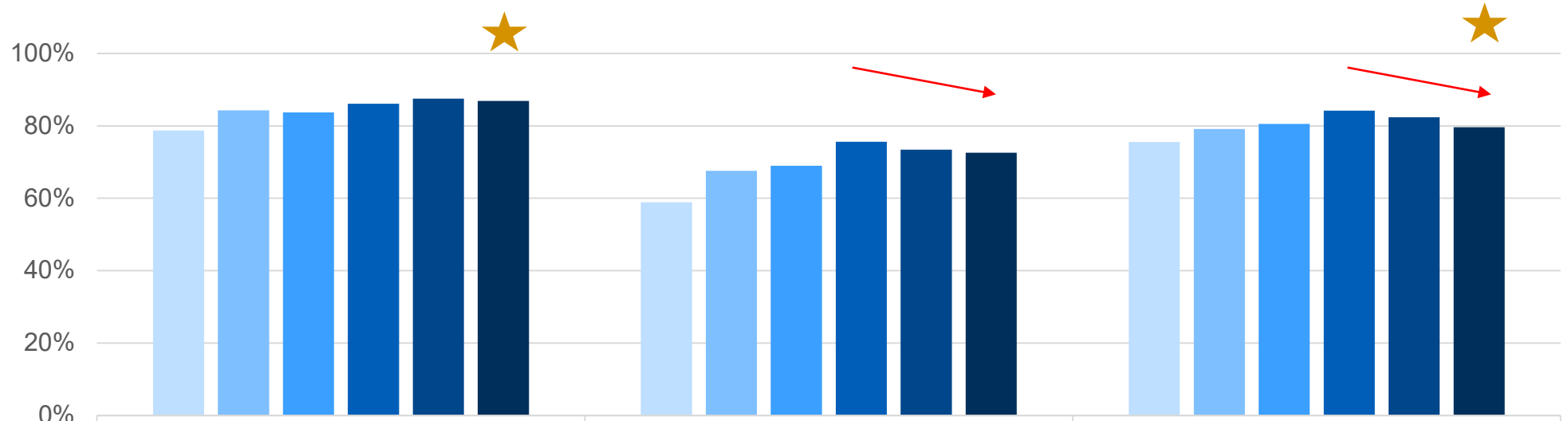
Not too much variety on this element – in-line with other scores

Facilities and Estates and Dental both have relatively low ratings compared to other service lines

This is one area where Facilities and Estates stands out as performing well, along with corporate

Despite remaining above average compared to other trusts, Solent is declining in terms of staff advocacy (three key questions for us as a Trust). We must not be complacent.

National trends are also declining, so Solent remains best in class for two of these measures. However, that doesn't mean that these shouldn't be areas of focus to see what more we could do.



	Care of patients/service users is organisation's top priority	Would recommend organisation as place to work	If friend/relative needed treatment would be happy with standard of care provided by organisation
Solent 2017	78.7%	58.9%	75.5%
Solent 2018	84.3%	67.6%	79.1%
Solent 2019	83.7%	69.0%	80.5%
Solent 2020	86.1%	75.6%	84.2%
Solent 2021	87.5%	73.4%	82.4%
Solent 2022	86.9%	72.6%	79.6%
Best 2022	86.9%	73.0%	79.6%
Average 2022	78.3%	62.8%	63.6%

ADP , FME & PRI below average

ADP & FME below average

ADP , FME & CHS below average

And there are some key things to celebrate this year

1. We have seen an improvement in the **fair treatment of staff** involved in errors, near misses or incidents

2. We have also rated the trust better this year as an organisation that **offers us challenging work**

3. And improvement in three areas that suggest **empowerment of our staff** to make the most of their opportunities:

   - **Teams** working well together to achieve objectives
   - Access to right **learning & development** opportunities
   - The ability to **make improvements happen** in my area of work

And a few areas for us to work on this year

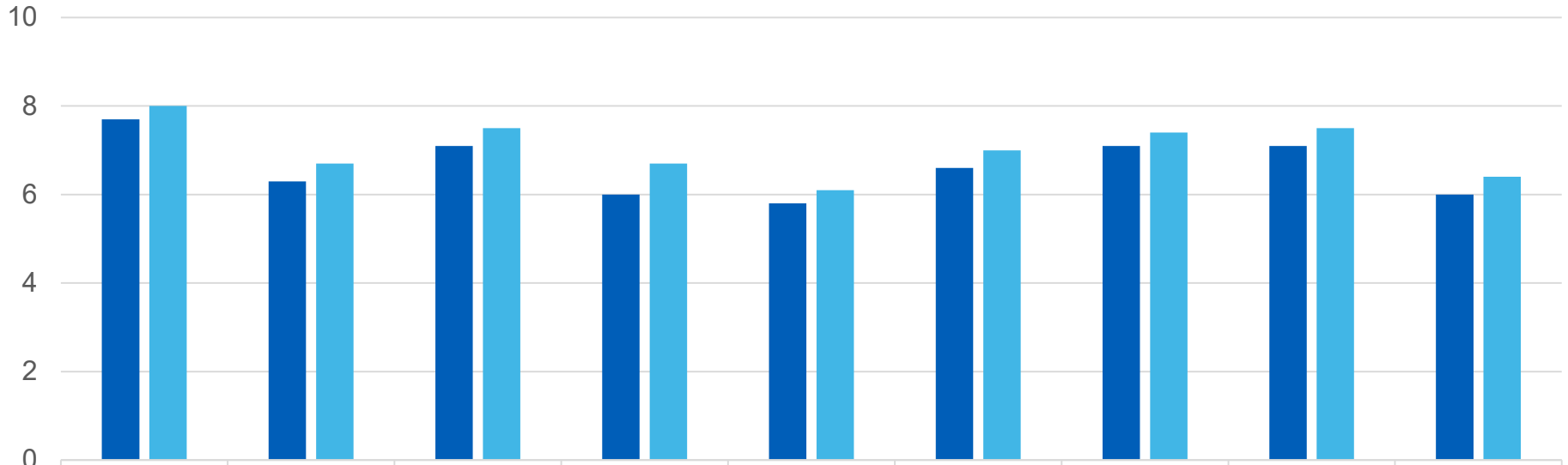
1. Our single biggest decline this year is for **satisfaction with pay**, but the expectation in that this trend will be seen across the NHS

2. Confidence in the trust to **address concerns raised by staff or patients AND unsafe clinical practices** all remain high compared to other trusts, but are amongst the biggest declines in our scores compared to last year

3. Another area of concern based on our score being low compared to other trusts is the **use/ability of appraisals** to help us to do our job

This years survey suggests we have work to do in meeting the needs of people with disabilities

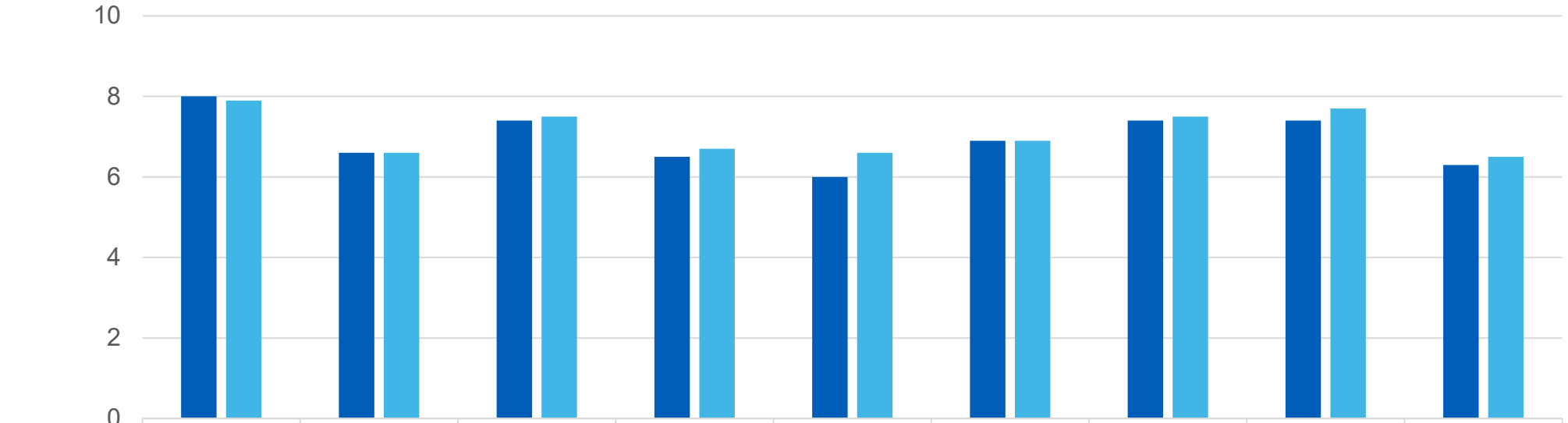
People with a disability rate Solent lower for all 9 measures, with the biggest discrepancy for ‘we are safe and healthy’. This is driven by dissatisfaction with both burnout and negative experience with the trust.



	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Disability 2022	7.7	6.3	7.1	6.0	5.8	6.6	7.1	7.1	6.0
No Disability 2022	8.0	6.7	7.5	6.7	6.1	7.0	7.4	7.5	6.4

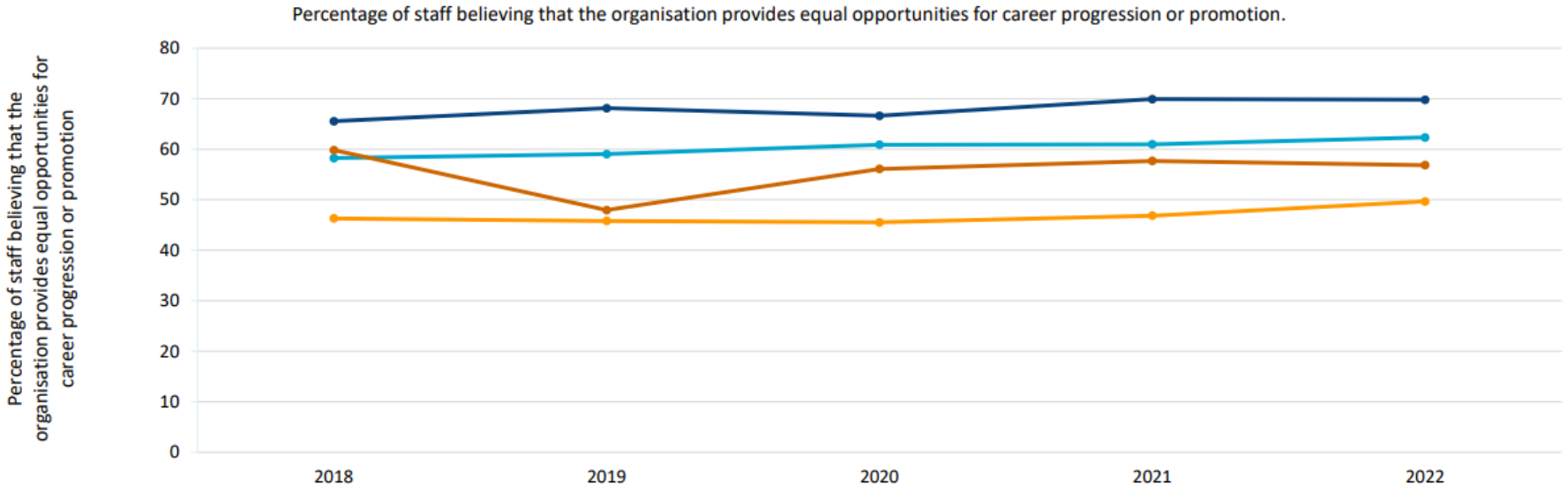
Staff satisfaction levels are comparable across both white and people from a BAME background

Two exceptions are people from a BAME background rating the Trust higher for both 'we are always learning' and 'staff engagement' – recognition for all the great work done by the trust over the last year.



	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
White 2022	8.0	6.6	7.4	6.5	6.0	6.9	7.4	7.4	6.3
BAME 2022	7.9	6.6	7.5	6.7	6.6	6.9	7.5	7.7	6.5

Slightly larger increase in difference between the positive responses.

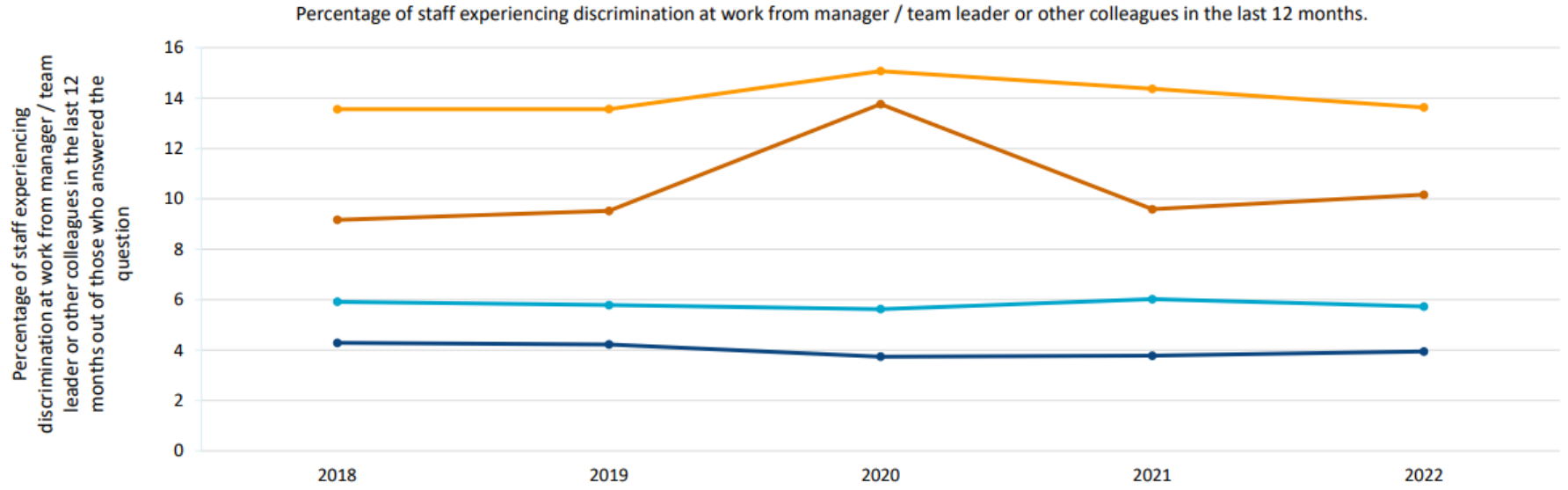


	2018	2019	2020	2021	2022
White staff: Your org	65.5%	68.1%	66.6%	69.9%	69.8%
All other ethnic groups*: Your org	59.8%	47.9%	56.1%	57.7%	56.9%
White staff: Average	58.3%	59.0%	60.9%	61.0%	62.3%
All other ethnic groups*: Average	46.3%	45.8%	45.5%	46.8%	49.6%
White staff: Responses	1854	1936	2136	2336	2470
All other ethnic groups*: Responses	117	146	189	215	248

*Staff from all other ethnic groups combined

Average calculated as the median for the benchmark group

Slightly larger increase in difference between the positive responses.

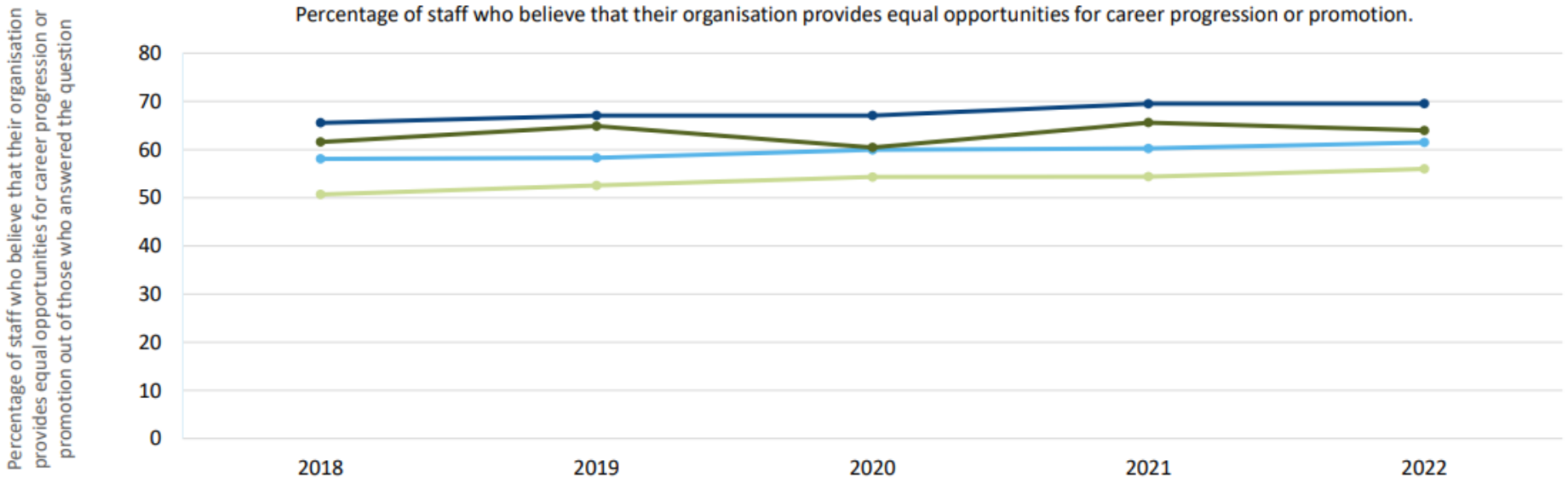


	2018	2019	2020	2021	2022
White staff: Your org	4.3%	4.2%	3.7%	3.8%	3.9%
All other ethnic groups*: Your org	9.2%	9.5%	13.8%	9.6%	10.2%
White staff: Average	5.9%	5.8%	5.6%	6.0%	5.7%
All other ethnic groups*: Average	13.6%	13.6%	15.1%	14.4%	13.6%
White staff: Responses	1842	1917	2111	2355	2483
All other ethnic groups*: Responses	120	147	189	219	246

Staff from all other ethnic groups combined

verage calculated as the median for the benchmark group

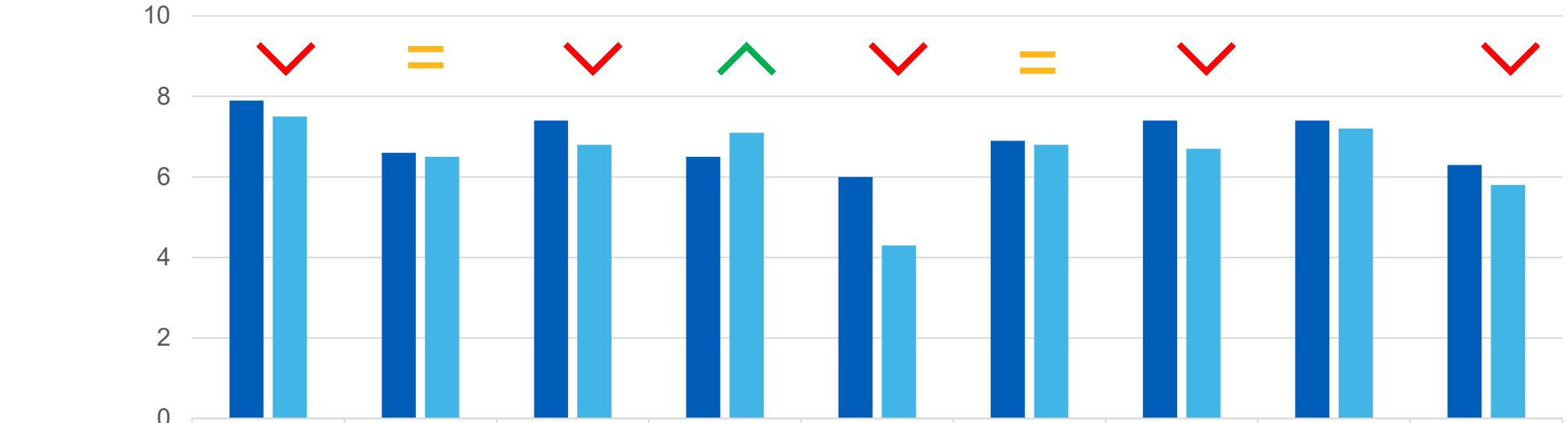
Slightly larger increase in difference between the positive responses.



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	61.6%	64.9%	60.4%	65.6%	64.0%
Staff without a LTC or illness: Your org	65.6%	67.1%	67.1%	69.5%	69.5%
Staff with a LTC or illness: Average	50.7%	52.5%	54.3%	54.4%	56.0%
Staff without a LTC or illness: Average	58.1%	58.3%	60.0%	60.2%	61.5%
Staff with a LTC or illness: Responses	354	407	508	602	641
Staff without a LTC or illness: Responses	1632	1677	1828	1974	2097

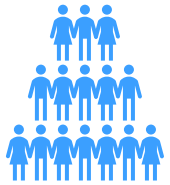
A bank survey was included for the first time this year

As expected, staff satisfaction is lower amongst bank workers with the exception of ‘recognised and rewarded’ and ‘work flexible’. But more surprising perhaps is the higher rating for ‘we are safe and healthy’.



	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Substantive 2022	7.9	6.6	7.4	6.5	6.0	6.9	7.4	7.4	6.3
Bank 2022	7.5	6.5	6.8	7.1	4.3	6.8	6.7	7.2	5.8

Next steps



This year we are ready to release pre-prepared result packs for each service line on the same day as the national embargo is lifted. This pack will provide the key insights from their results in a ready format to start sharing with staff. Along with this they will also receive the Pickers results tables for the whole Trust to benchmark themselves against.

The People Partnering Team are scheduling workshops for each service line and sub-teams where appropriate to begin quality discussions on what the results are saying.

A template to record this narrative and next step actions will be produced from each of these workshops, these will be reviewed on-going in PRMs and quarterly Workforce Summits.

This bottom-up approach will support an overall Trust level plan for focused areas of improvement activities.

NHS
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NHS Trust

Q&A

Board and Committees

NHS Solent NHS Trust

Item No.	8			Presentation to	Trust Board – In Public		
Date of paper	24 March 2023			Author	Sarah Earl - Head of Performance		
Title of paper	Trust Board Performance Report						
Purpose of the paper	The report describes the key operational issues facing the organisation, including the services connected with Urgent and Emergency Care and the increasing demand on our services. It triangulates workforce and other issues and describes the actions that the organisation is taking to mitigate the issues.						
Committees /Groups previous presented and outputs	N/A						
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X	
Action required	For decision		For assurance	X			
Summary of Recommendations and actions required by the author	The In-Public Trust Board is asked to: • Note the report						

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	Andrew Strevens, Chief Executive Officer.			Exec Sponsor signature:			

Table of Contents

Trust Board Integrated Performance Report (IPR)
January – February 2023

Solent NHS Trust continues to move through a period of development with our Trust Board Performance Report, in line with the CQC Well-Led recommendations. We continue to use the utilise the NHS Improvement 'Making Data Count' methodology (where relevant and applicable) to add context to variation and trends seen within our data.

Our performance is summarised within this report using the following indicators. A more detailed explanation of the methodologies can be found in Annex A.

Key

In-month Performance Indicator

- Metric is achieving the target
- Metric is failing the target

Trending Performance Indicator

Target has been consistently achieved, for more than 6 months

Target has been consistently failed, for more than 6 months

There is a variable and inconsistent performance against the target

Variance Indicator

Special Cause Variation, for improved performance. The trend is either:
- Above the mean for 6 or more data points
- An increasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the upper control limit

Special Cause Variation, for poor performance. The trend is either:
- Above the mean for 6 or more data points
- An increasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the upper control limit

Special Cause Variation, for improved performance. The trend is either:
- Below the mean for 6 or more data points
- An decreasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the lower control limit

Special Cause Variation, for poor performance. The trend is either:
- Below the mean for 6 or more data points
- An decreasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the lower control limit

Common Cause Variation, the information is fluctuating with no special cause variation.

1. Safe

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-23 Current Performance		Feb-23 Trending Performance	Feb-23 Variance	Jan-23 Current Performance		Jan-23 Trending Performance	Jan-23 Variance
Safe	Occurrence of any Never Event	E	0	0		P		0		P	
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	E	0	0		P	L	0		P	L
	VTE Risk Assessment	E	95.0%	89.0%		?		96.0%		?	
	Clostridium Difficile - variance from plan	E	0	0		?		0		?	
	Clostridium Difficile - infection rate	E	0	0		?		0		?	
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	E	0	0		P		0		P	
	Escherichia coli (E.coli) bacteraemia bloodstream infection	E	0	0		P		0		P	
	MRSA bacteraemias	E	0	0		P		0		P	
	Admissions to adult facilities of patients who are under 16 yrs old	E	0	0		P	L	0		P	L

VTE Risk Assessments

Solent's compliance with the National Standards for VTE Risk Assessments increased in January following low performance in November/December on the new Jubilee Unit. Unfortunately, performance declined again in February as a result of the Junior Doctor changeover on Lower Brambles, where only 62% of assessments were completed on time. The Chief Medical Officer and Chief Nurse are working with the service line Clinical Directors to identify leads for VTE on each of the ward to be accountable for maintaining performance above the target level. A deep dive on the delivery of VTE risk assessments and review of the policy is being undertaken by the Pharmacy team and findings will be reported into QIR in June.

b. Key Performance Challenges

Incident Reporting

The number of incidents reported continues to be above the upper control limit. There is a 20.8% increase in incidents reported in January/February 2023 compared with the same period in 2022. Incidents per 1,000 contacts has also increased compared to 2022, with an apparent upward shift from April 2022. Although the rates have stabilised over the past few months, the Head of Patient Safety is investigating what caused this shift, and whether the control limits need to be reset if this was as a result of a known change.

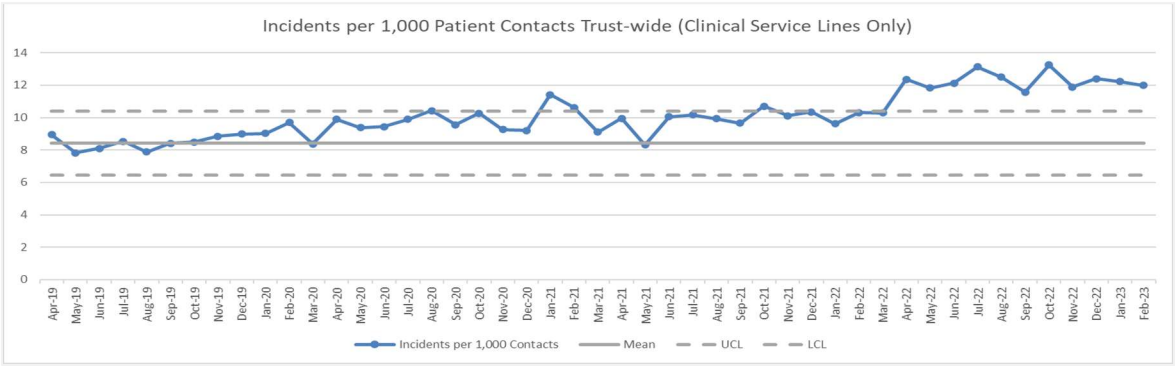

Figure 1: Incidents per 1,000 patient contacts

Following a review of internal guidance, the grading of harm in incident reporting is now judged on the impact to the individual concerned and a new category has been introduced to include incidents reporting the death (expected or unexpected) of a patient. As the outcome of the review has become embedded, we are starting to see an anticipated shift, increasing the number of incidents graded as Low Harm or above, and reducing the number of No Harm or Near Miss, as shown in Figure 2 below. There has been no increase in Serious or High Risk incidents during the same period, indicating that the change in categories is not masking an increase in actual harm.

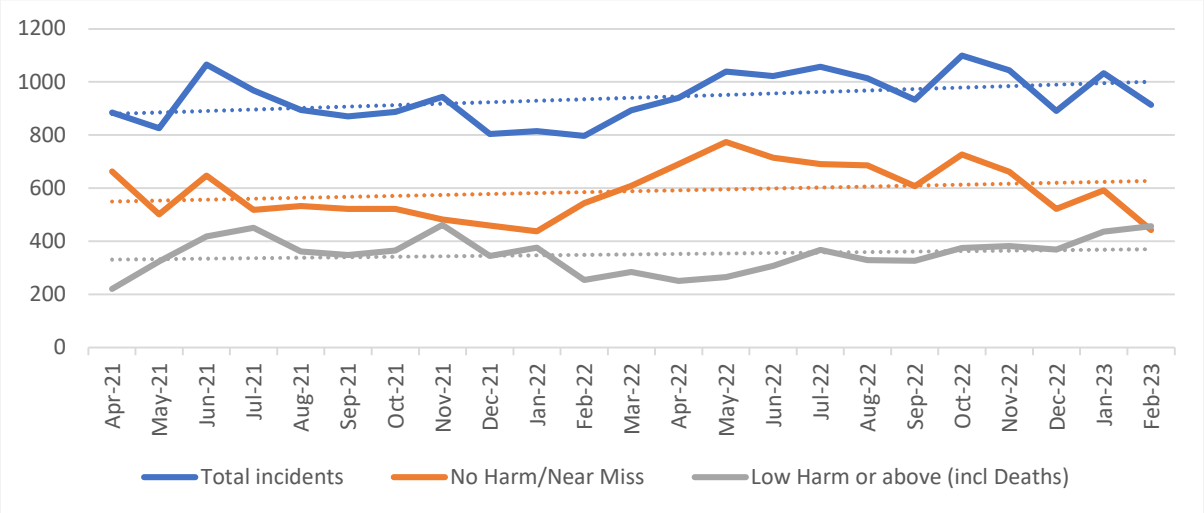

Figure 2: Number of incidents reported by category

The largest increases have been seen in 8 distinct Cause Groups as shown below.

Cause Group	No. of incidents reported in Jan/Feb 2022	No. of incidents reported in Jan/Feb 2023
Accidental Injury	18	31
Clinical Delay	5	31
Emergency (Medical)	32	58
HR & Staffing Issues	1	17
ICT & Digital Info/Systems	1	14
Patient deterioration/sepsis	10	35
Self-harming behaviour	16	34
Slips, Trips & Falls	34	58

Whilst the increases are in most cases spread across multiple teams, the following are of particular note:

- 17 Assault (Physical) incidents have been reported at The Orchards PICU compared with 1 in 2022. Two patients account for 8 of these incidents.
- A high number of Slips, Trips & Falls continue to be reported at the new Jubilee Unit, with 19 in 2023 compared with none at the old Jubilee Ward in 2022. As outlined in the last report, the change in environment and bed base at the new unit is a factor in this trend. The Solent Falls Lead is working with the Unit to implement changes designed to reduce the number of incidents occurring.
- 27 incidents have been reported by Spinnaker Ward/Jubilee Unit where a patient required escalation to Portsmouth Hospitals University Trust for tests, monitoring, or treatment. This compares to 5 in the same period of 2022. 22 incidents have been reported by Lower Brambles/Fanshawe Wards where, again, patients had to be escalated to the acute hospital for treatment. This compares with 10 in 2022. It is recognised that the increase could be attributable to the increased volume/acuity of patients on the Jubilee and Fanshawe/Brambles wards, however as there are known issues with the accessibility of DART training, these incidents are being further investigated to ensure the increase is not linked to training around the identification of deteriorating patients. The Quality & Safety Team are working with the Trust Resuscitation Lead to triangulate the acute escalation incidents with the Deteriorating Patients and Resuscitation quarterly report to identify any emerging trends and actions required.

We are also applying the NHSE guidance on harm levels more consistently so that any patient that has needed or is likely to need extra healthcare due to an incident beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond simple dressing changes or short courses of medication, is now graded as a Moderate harm or above. This has resulted in an anticipated increase in the number of Moderate incidents from 47 in January/February 2022 to 108 in 2023.

c. Spotlight On: Quality Reporting

A new Quality Library has been published within Power BI which draws together a wealth of data collected from the Incident Reporting system into a series of easy-to-use reports and dashboards. Over the coming months the team will work with each service line to develop this further and link it to other metrics to enable a greater level of analysis and insight to improve Patient Safety across the Trust.

The Quality & Safety Team have been monitoring incidents relating to staffing and impact on either patient care or staff wellbeing. Figure 3 is taken from the Quality Library and shows a significant increase in the last 12 months, following the addition of a new cause group to capture staffing issues.

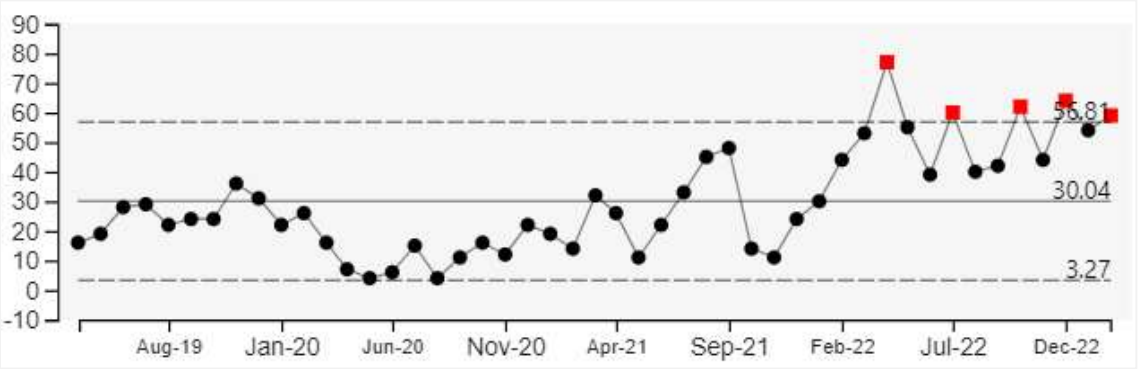

Figure 3: SPC Chart showing staffing level/workforce incidents by month

In addition to monitoring incidents relating to staffing/workforce, it was also agreed at QIR that risks relating to staffing levels and/or workforce should be escalated to the Clinical Executive Group for in-depth discussion. To support and inform these discussions, the Clinical Governance team will undertake a full review of the staffing/workforce risks to pinpoint any common themes and mitigations followed by the identification of actions to escalate to the Clinical Executive Group. This will enable a review of individual risks, thematic and interdependencies across similar risk groups.

2. Caring

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-23 Current Performance		Feb-23 Trending Performance	Feb-23 Variance	Jan-23 Current Performance		Jan-23 Trending Performance	Jan-23 Variance
Caring	Community FFT % positive*	E	95.0%	98.8%		P		98.6%		P	
	Mental Health FFT % positive*	E	95.0%	98.1%		?		98.7%		?	
	People Pulse Survey - Advocacy Theme (Recommended for Care & Employment)	E	0	-				-			
	Mixed Sex breaches* (Submission recommenced October 20221)	E	0	0		P		0		P	
	Plaudits	I	-	46				84			

b. Key Performance Exceptions

Nothing of note.

c. Spotlight On: Sexual Health Service Concerns

The past year has seen significant growth in the number of concerns the PALS & Complaints team have received in relation to the accessibility of the Sexual Health Service. The demand for this service exceeds capacity, and this is putting pressure on the workforce in the Single Point of Access (SPA) where telephone calls are received.

The concerns raised relate to two main issues, the ability to get through to the SPA, and then once through, the ability to get an appointment with the service.

- The first issue is comprised of two factors:
    - A new telephony provider was implemented in September 2022. A 2 hour 'cut-off' was put in place which disconnected calls if a patient had been waiting on hold for 2 hours. This affected a very small proportion of calls, as patients do have the option to opt for a 'call-back', however it does equate for a number of the complaints received. The 'cut-off' has now been extended to 4 hours, with the intention of no caller being on hold for that duration.
    - There are vacancies and high sickness rates within the SPA team which are impacting service delivery. The staff managing Sexual Health calls are experiencing low morale as the volume of frustrated callers has increased, which in-turn is increasing staff absence. The SPA management team have offered staff the option to work remotely for 25% of their working hours, which has increased attendance to work in recent weeks.

Figure 4: SPA in-month absence rate

- The second issue relates to availability of appointments within the Sexual Health service. The SPA team are receiving an average of 680 calls per day, but only have access to an average of 28 'on the day' appointments to offer callers, which are also available for booking via the website.

The chart below demonstrates contacts received by the PALS and Complaints Service have, at times, exceeded the normal control limits. The position is beginning to reduce and stabilise following some Sexual Health clinics moving their telephony support in-service.

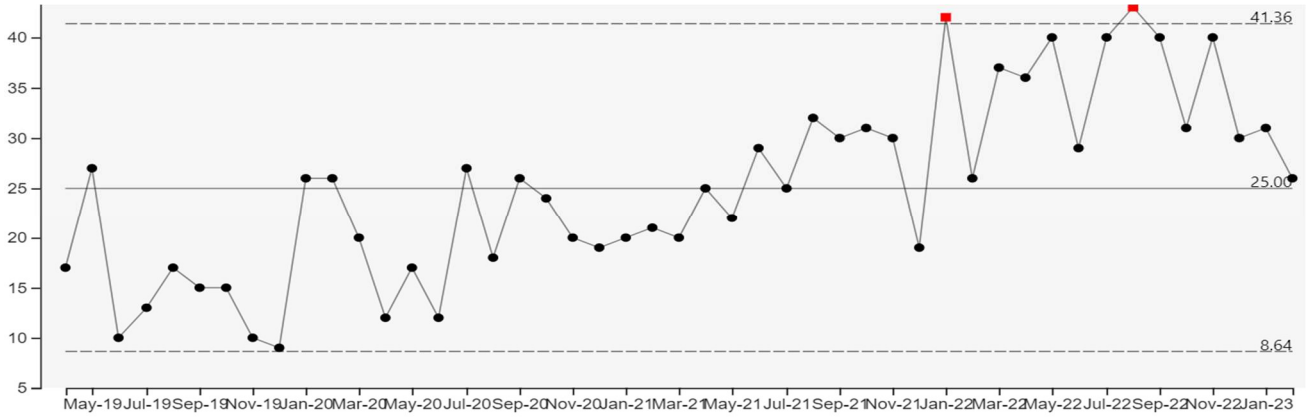

Figure 5: PALS and Complaints team contacts for Sexual Health related concerns

Actions are required to improve this situation, and the Chief Operating Officer is implementing additional monthly performance meetings with the Sexual Health service to manage this, along with a number of other challenges they are facing at present. The new Systems Thinking approach to service access has been rolled out across some of the smaller Sexual Health clinics and is planned to be implemented in Portsmouth in the coming weeks. This is hoped to reduce the pressure on SPA, and the subsequent concerns being raised, as it is the geographical area where the service demand is most pressured.

3. Effective

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-23 Current Performance		Feb-23 Trending Performance	Feb-23 Variance	Jan-23 Current Performance		Jan-23 Trending Performance	Jan-23 Variance
Effective	Bed Occupancy - Brambles	I	92.0%	95.1%				93.4%			
	Bed Occupancy - Fanshawe	I	92.0%	93.6%				103.2%			
	Bed Occupancy - Jubilee	I	92.0%	125.7%				126.8%			
	Bed Occupancy - Spinnaker	I	92.0%	115.2%				127.0%			
	Bed Occupancy - Brooker	I	87.0%	56.8%				57.5%			
	Bed Occupancy - Hawthorns	I	93.0%	104.6%				105.2%			
	Bed Occupancy - Maples	I	89.0%	87.5%				91.3%			
	Bed Occupancy - Kite	I	92.0%	64.6%				80.0%			
	Bed Occupancy - Snowdon	I	92.0%	94.0%				100.9%			
	Length of Stay - Brambles	I	24.0	25.4				27.8			
	Length of Stay - Fanshawe	I	24.0	22.0				26.7			
	Length of Stay - Jubilee	I	24.0	36.7				43.0			
	Length of Stay - Spinnaker	I	24.0	18.2				17.1			
	Length of Stay - Brooker	I	78.5	15.9				25.6			
	Length of Stay - Hawthorns	I	34.9	18.5				14.4			
	Length of Stay - Maples	I	48.6	24.9				30.1			
	Length of Stay - Kite	-	-	76.7				277.0			
	Length of Stay - Snowdon	-	-	28.4				53.3			
	Non-Criteria to Reside (NCtR) [patient count]	-	-	23				23			
	% clients in settled accommodation	E	59.0%	63.8%				68.0%			

Bed Occupancy and Length of Stay Reporting

Bed occupancy and length of stay information is now being reported for each individual ward, to avoid masking performance concerns within the previously reported Community, Mental Health, and Neurological categories. As reported last period, bed occupancy rates will now be calculated using the core bed base as the denominator, showing a percentage higher than 10% if additional surge beds are in operation.

Bed Occupancy – Brambles, Fanshawe, Jubilee, Spinnaker

All four of Solent's community wards are showing as having a high special cause variation for bed occupancy, as the rates have consistently been above the 92% internal target. 92% is widely thought to be a 'safe' level of occupancy, maintaining available beds for new admissions at any given time. The high occupancy rates across these wards reflect the continued pressures across the system and the flex our community wards are giving to take additional patients from our acute partners who are outside the scope of our usual admission criteria.

Length of Stay – Brambles, Fanshawe, Jubilee, Spinnaker

Non-Criteria to Reside (NCTR) *(previously known as Delayed Transfers of Care)*

The out-of-scope patients referenced above often have more complex needs whilst they are on the ward or require more complex support upon discharge. This causes not only an increase in the reported average length of stay, but also the number of patients that do not meet the Criteria to Reside being reported. This is particularly an issue in the Jubilee Unit, where the cohort of patients being treated has expanded with the transfer to the new Harry Sotnick House estate.

b. Key Performance Exceptions

Urgent Community Response (UCR) – Data Quality

There continues to be a discrepancy between the nationally published UCR figures to the locally reported figures. Solent have fed back their findings on the discrepancies to NHS Digital but have had little engagement to achieve a resolution. It is worth noting that other local provider organisations are also experiencing issues with recognising the data published nationally.

Locally, a number of actions have been undertaken/identified to resolve the known data quality issues. Additional checks have been put in place to ensure the data extract is full and complete prior to sharing with services, and a process whereby services approve the data for wider sharing has been implemented. Services have also agreed to focus efforts on validating and assuring the data reported from SystmOne, rather than keeping manual records.

There is, at present, one known issue which continues to be investigated/resolved. There are instances where the waiting time clock stop is not always recorded accurately in the report. This impacts the reported compliance rates for some 2 hour contacts. The service, Analytics Lead and Information Systems team are investigating what is causing this. The volume of this issue can be seen in the difference between the 'contacts' (completed 2 hour pathways) and '2 hour referral' (opened 2 hour pathways) data reported in figures 5 and 6 below.

Urgent Community Response (UCR) – 2-Hour Performance

Compliance for February was at 68% in Portsmouth. The service was operating at 65% staffing during this period, so being able to maintain compliance just below the target level (70%) is a positive achievement.

In Southampton, performance has declined in-month in February, however the 12-month rolling performance is still maintaining above the target (70%) at 74%.

School Aged Immunisations

The Contractual Performance Notice (CPN) for our School Aged Immunisation Service will run until the end of the academic year. The service is having fortnightly meetings with NHS England and are being very closely scrutinised.

Elective Recovery Framework (ERF)

The ICB announced plans to include community and mental health trusts in the 2023/24 Elective Recovery Framework, which had previously not been passed down to provider organisations. The Framework aims to increase productivity in elective services, reducing the number of patients waiting, and the length of time patients wait, to have an initial assessment/treatment.

Funding will be removed from the block element of the contracts for applicable services, and first contacts delivered in 2023/24 will be paid at national tariff price, on a cost per case basis. There is a financial incentive available to trusts who achieve 103% of the equivalent activity delivered in 2019/20. Solent have submitted a request to adjust the baselines where there has been material change to service provision or coding since 2019/20, and we are awaiting the outcome of this submission before being able to share targets with the relevant services. The original 2019/20 baseline would see circa £6.2million removed from the block contract, however the adjusted plan reduces this to around £5.4million.

Performance against the ERF will be monitored frequently and shared as part of this report moving forwards.

c. Corporate Business Review Meetings (CBRMs) – Key Areas of Exception

Corporate Business Review Meetings were stood down during January-February as the trust focussed on Business Planning for 2023/24. Following the retirement of the CBRM chair, Solent's Chief Financial Officer will be taking over this role and refocussing the meetings on delivery of business objectives, workforce, and finance.

4. Responsive

a. Performance Summary

	Indicator Description	Internal /External	Target	Feb-23 Current Performance		Feb-23 Trending Performance	Feb-23 Variance	Jan-23 Current Performance		Jan-23 Trending Performance	Jan-23 Variance
Responsive	Patients waiting > 18 weeks	-	-	4435			H	4303			H
	Accepted Referrals	-	-	26122				28453			
	Formal complaints per 1000 WTE	-	-	4.1				3.0			
	Number of complaints	I	15	12	●	?		9	●	?	
	Number of complaint breaches	-	-	7			H	0			
	RTT incomplete pathways*	E	92.0%	82.6%	●	?	L	81.7%	●	?	
	Maximum 6-week wait for diagnostic procedures	E	99.0%	100.0%	●	P	H	99.0%	●	?	
	Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	24	●	?		73	●	?	
	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	E	50.0%	67.0%	●	P		83.0%	●	?	
	IAPT - Proportion of people completing treatment moving to recovery	E	50.0%	53.9%	●	?	L	54.1%	●	?	
	IAPT - Waiting time to begin treatment - within 6 weeks	E	75.0%	92.0%	●	P		85.0%	●	?	
	IAPT - Waiting time to begin treatment - within 18 weeks	E	95.0%	100.0%	●	P		100.0%	●	?	
	Data Quality Maturity Index (DQMI) - MHSDS dataset score*	E	90.0%	89.9%	●	?		90.6%	●	?	

*DQMI Measured 3 months in arrears in line with national reporting

b. Key Performance Exceptions

Patients waiting > 18 weeks

Waiting lists, for patients waiting for a first contact, continue to have special cause variation showing an increasing trend, reflecting the continued pressure on our services. Referrals continue to be high across most services and capacity is stretched, making it challenging for services to gain traction on the growing waiting lists. It is recognised that the impact of the COVID-19 pandemic and current financial constraints have contributed to the waiting list growth, however at present, there is no consistent approach to monitoring any potential harm this may cause our patients across the organisation. A plan is in place to progress this when the new Associate Director for Quality joins the trust shortly.

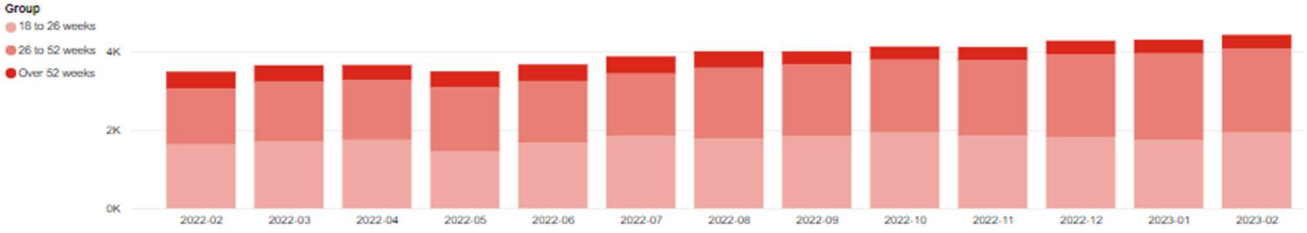

Figure 6: Monthly snapshot of the number of clocks running (>18 weeks) – Trust-wide (excluding Dental Services)

At a trust-wide level, the proportion of patients waiting over 52 weeks is gradually reducing, however we are now seeing an increase in the number of patients waiting between 28 and 52 weeks.

Adults Southampton, Adults Portsmouth and MPP services are all seeing an increasing trend in the size of their waiting lists, reflecting the trust-wide pattern of an increasing backlog of patients waiting between 28 and 52 weeks.

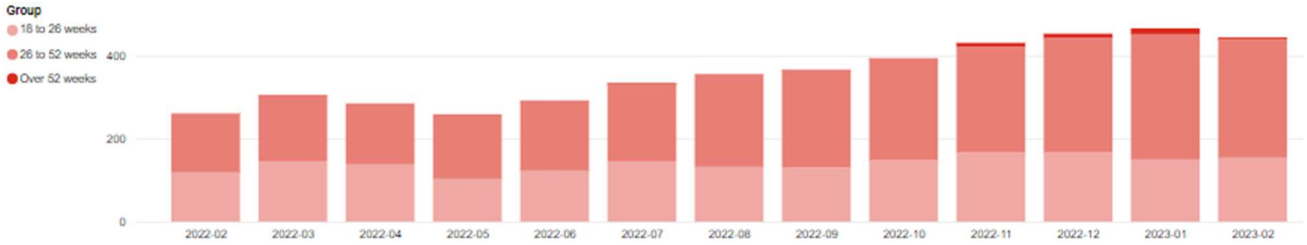

Figure 7: Monthly snapshot of the number of clocks running (>18 weeks) – Adults Portsmouth

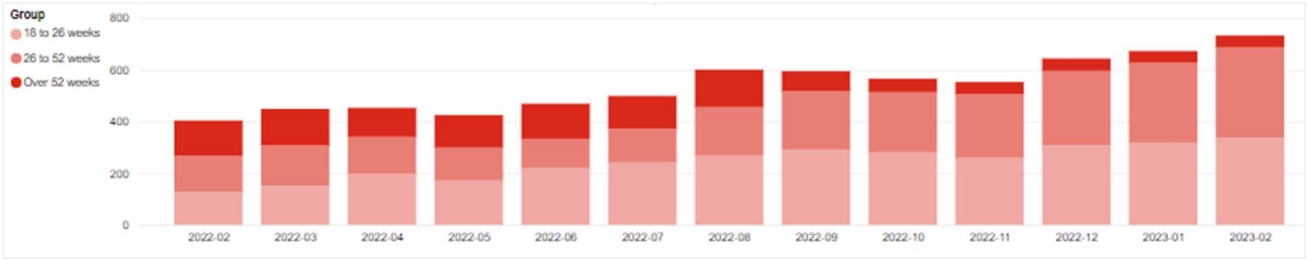

Figure 8: Monthly snapshot of the number of clocks running (>18 weeks) – Adults Southampton

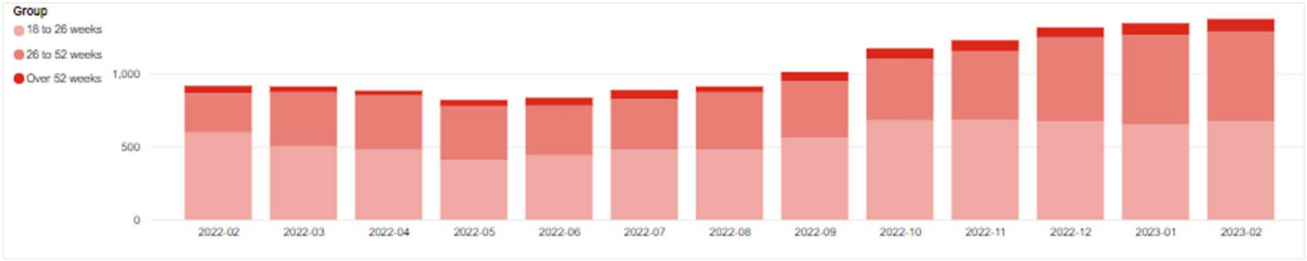

Figure 9: Monthly snapshot of the number of clocks running (>18 weeks) – MPP services

Number of Complaint Breaches

During February, 7 complaints breached the agreed timeframes out of 19 with an agreed response date scheduled in this period. Four of these have now been concluded and 3 are still ongoing. It should be noted that in all instances when a complaint is about to be breached the PALS team contact the person who has made the complaint to ensure they are kept updated and agree new dates were appropriate. The reasons for the breached complaints are:

- 2 – Delays caused by the Service awaiting sign off
- 1 - Complex Case –often take longer to progress due to the complexity and having to involve a wide number of people or organisations.
- 1 – Delays caused during the Exec Review/information request

RTT Incomplete Pathways

Patients waiting for an RTT eligible service continue to breach the 92% target to be seen within 18 weeks. Those patients on an incomplete pathway (still waiting to be seen) continue to be below the lower control

limit, however a slight increase in performance was seen during February. As previously reported, most of the RTT pathway breaches are from our Community Paediatrics Medical service (CPMS), and the small increase this month is reflective of recent recruitment and the expected start of a slow recovery of the waiting list backlog.

As the CPMS service is part of the Elective Recovery Framework for 2023/24, this should focus efforts of the service on delivery of first contacts, seeing patients move off the waiting list and onto the ongoing caseload more quickly.

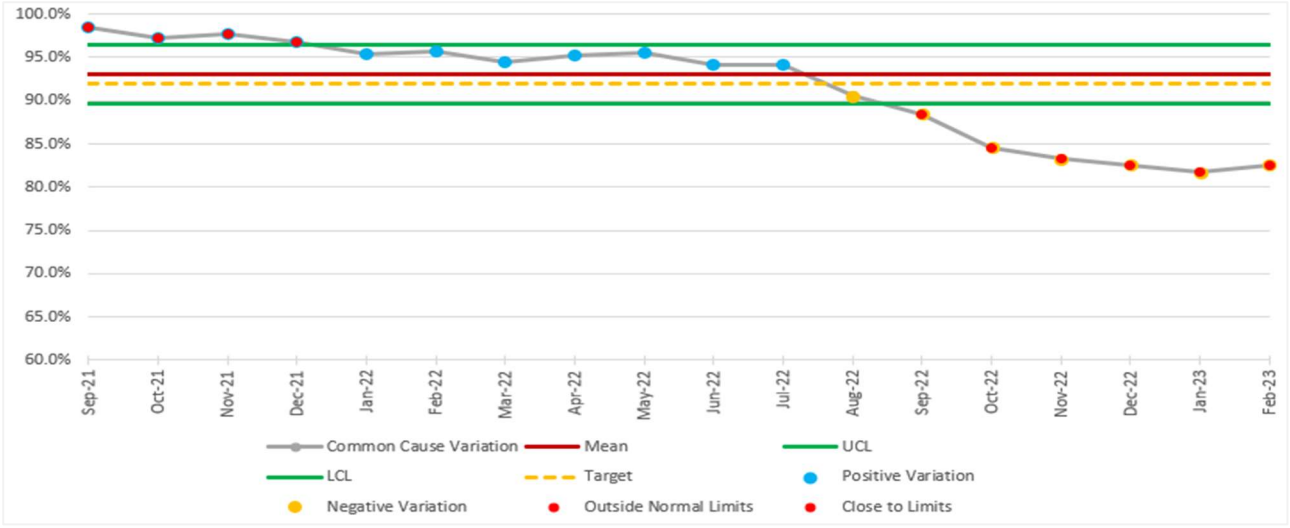

Figure 10: RTT Incomplete Pathways with significant variation highlighted

Inappropriate Out of Area Placements

The use of inappropriate out of area placements for mental health patients has continued in January and February. Additional in-area beds were sourced from the Priory in Southampton to support the time-limited reduction in beds on the Hawthorns Ward, however these beds were not suitable for all patients that required our services. As a result, 4 patients in January and 2 patients in February had to be placed out of area.

Data Quality Maturity Index (DQMI for the Mental Health Services Dataset (MHSDS)

The latest published DQMI score shows overall performance at 89.9% against the current 90% target. The target is due to increase to 95% as of April 2023.

The DQMI is made up of 36 data items which are each scored on their completeness. The table below shows areas of non-compliance using our local data. A data working group is being established with the Analytics Lead, service line Data Manager, and Data Assurance Officer to fully understand the issues with each measure and identify where changes can be implemented to improve completeness in time for quarter 2 reporting. The majority of these measures can be resolved with improvements to operational processes and more robust data quality validation. There is a potential option to apply a technical fix to the Ethnicity measure, however this requires further investigation to scope out the benefits as it would likely have a cost implication and would require delivery by the already stretched Data Warehouse team.

Measure name	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023
Estimated discharge date %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Primary reason for referral (mental health) %	7.46%	7.21%	6.92%	7.56%	7.24%	6.81%	6.06%	6.00%	5.89%	5.25%
Primary diagnosis date %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	99.70%	99.68%	100.00%
Activity location type code %	61.22%	61.36%	61.59%	60.67%	62.27%	63.39%	62.90%	60.79%	62.83%	62.04%
Referral closure reason %	80.71%	75.96%	77.64%	81.30%	80.03%	81.12%	75.95%	77.98%	75.65%	74.57%
Treatment function code (Mental Health) %	77.14%	83.33%	77.14%	77.78%	79.73%	74.03%	70.59%	63.16%	76.56%	64.62%
Ethnicity %	83.56%	83.50%	83.01%	82.85%	83.57%	83.59%	87.10%	86.98%	87.58%	87.38%
Hospital bed type %	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	76.24%	74.44%	86.08%

Figure 11: Summary of DQMI metrics with sub-optimal performance

c. Service Line Performance Review Meetings (PRMs) – Key Areas of Exception

This period has seen the trust focussed on Business Planning for 2023/24. As part of this process, support and challenge panels were held by the trust Executives with each service line and corporate teams, focussing on their workforce, finance, and business objectives for the year ahead. Subsequently, the Performance Review Meetings for January-February were focused on Quality and escalations from Service Lines to avoid duplication and discussion on plans which are awaiting approval.

Adults Community Services (Portsmouth)

Staffing Challenges and Agency Usage

Staffing continues to be a challenge across all services within Adults Portsmouth, with high levels of clinical and administrative vacancies and high sickness rates, meaning a great proportion of temporary staffing is being utilised, putting pressure on teams. This coincides with an increasing trend of incidents being reported.

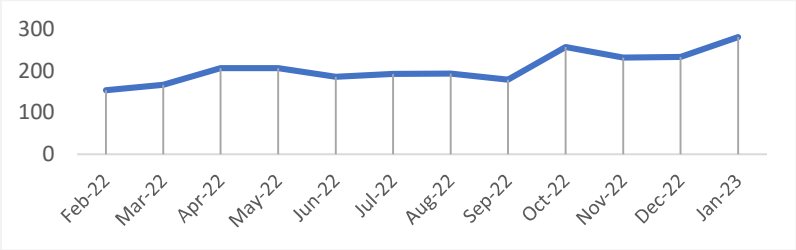

Figure 12: Adults Portsmouth Incidents per month

Figure 13: Adults Portsmouth in-month absence rate for the past 2 years

Analysis of bank, agency and additional staffing usage over the past two years shows a similar trend. Whilst both years (as show below in figures 15 and 16) follow the same seasonal trend, with an increase in Winter coinciding with Winter Pressures, the overall volume in 2022/23 starts at around the peak level seen in 2021/22 and continues to rise.

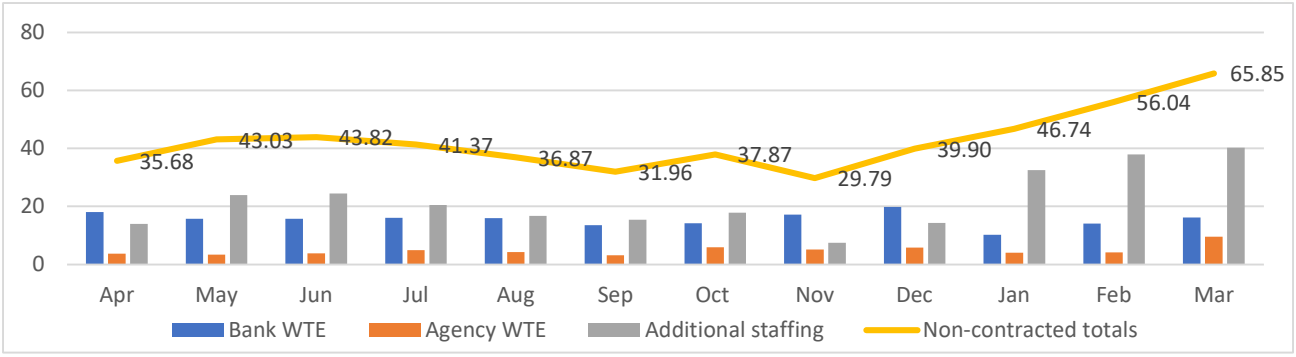

Figure 14: Adults Portsmouth WTE usage of bank, agency, and additional staffing in 2021/22

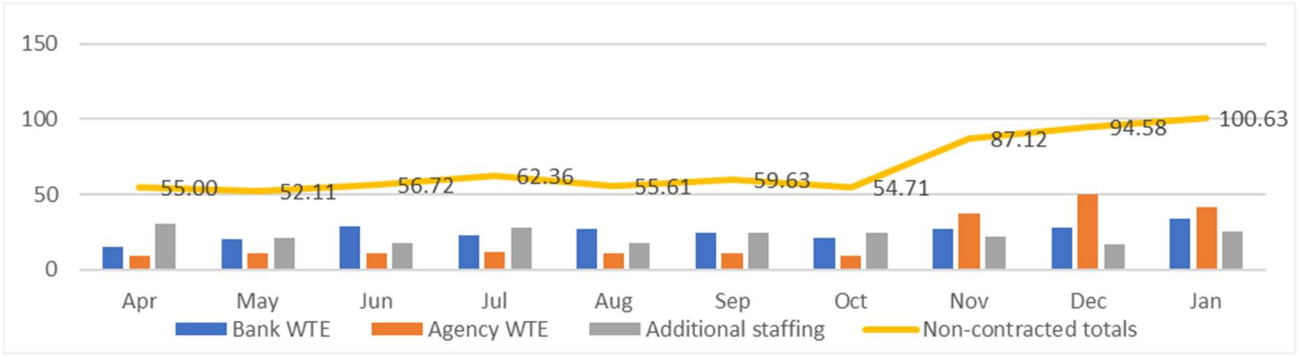

Figure 15: Adults Portsmouth WTE usage of bank, agency, and additional staffing in 2022/23

Bladder and Bowel Waiting List Reduction

Following successful recruitment to vacancies, the Bladder and Bowel service have modelled an improvement trajectory accounting for new starters, with a view to eradicating the waiting list backlog by November 2023, shown in figure 17 below.

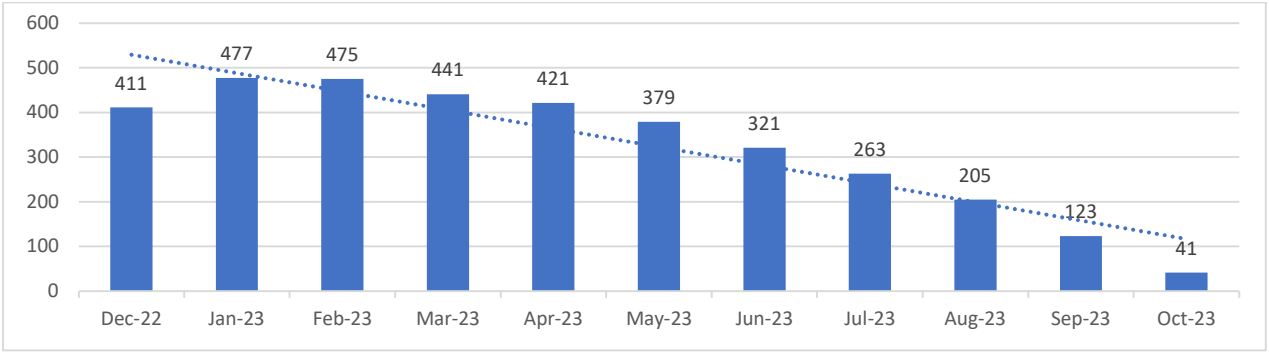

Figure 16: Bladder and Bowel service waiting list trajectory

The longest waiters and most urgent cases all have appointments booked in, as shown in yellow in figure 18, and a process has been implemented to send appointment reminders to reduce DNA rates across the service.

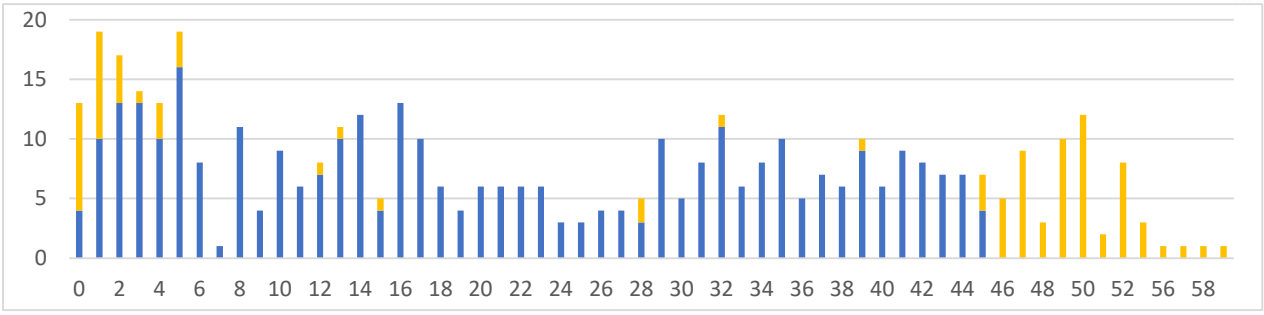

Figure 17: Bladder and Bowel service – number of patients waiting, but length of wait (weeks) showing patients with booked appointments in yellow

Mental Health Services

Data Quality

There are a number of areas where the quality of reported data for Mental Health services is sub-standard, causing challenges in reporting accurate data for key mental health metrics. The service has recruited a Data Manager, and together with the Data Assurance Officer and Analytics Lead they will focus on improving data input and reporting practices across the service line, alongside the work to improve the trust's Mental Health DQMI score (as referenced in section 4b).

As an example, one of the key national metrics 'Number of users followed up within 72 hours of discharge from inpatient care' is reporting around 80% compliance in the past 2 months, however the service has confirmed 100% of patients were followed up within 48 hours, well below the 72-hour target.

Figure 18: Percentage of users followed up within 72 hours of discharge from inpatient care – as reported from SystmOne

Specialist Dental Service (HIOW)

UDA Delivery and Staff Absence

The Specialist Dental Service continue to have high vacancy rates in dental officer posts and high sickness rates across the teams, resulting in delays and reduced throughput of patients in clinics. Clinic waits continue to be challenging, with the longest waiters at 27 months for appointments at Bitterne and 23 months at Somerstown. This has had a direct impact on the achievement of the UDA target, with delivery currently at 50% of the year-end target. The year-end forecast has improved as a result of actions taken by the service line and is at around 60%.

The service continues to be on a block contract arrangement, therefore there is no direct financial impact of underperforming against the UDA target this year. This is, however, an area of concern as it is unknown whether this will be maintained in the forthcoming tender for the Special Care Dental service.

Musculoskeletal, Pain and Podiatry (MPP) Services

Podiatry

The Podiatry service have initiated positive steps to reducing domiciliary contacts, to use the workforce more effectively in clinics where the throughput of patients is 50% greater. This has been achieved through successful joint case discussions with community nursing teams in Portsmouth, allowing face-to-face contacts to be reduced, releasing capacity. The domiciliary caseloads are being cleansed and discharge criteria reviewed. The impact of this released capacity is in the early stages, but the service waiting list has decreased marginally over the past four months. Urgent patients are being prioritised, pushing routine patients waiting times further and further.

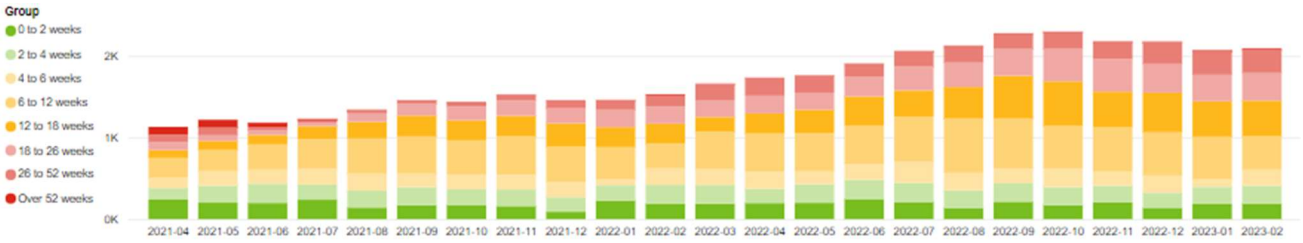

Figure 19: Monthly snapshot of the number of clocks running – Podiatry Service

SPA Workforce

Children and Family Services

IT & Estates Issues

Contemporaneous verbal update to be given at Exec PRM.

Safeguarding workload in Public Health services

There is an increasing demand on the Public Health workforce to undertake safeguarding meetings, which is resulting in diminished capacity to undertake commissioned work. There is no identified workforce to facilitate these meetings and options to continue to meet the need but reduce burden on the PH workforce are required. Discussions are ongoing within service on this matter.

Sexual Health Services

SNOMED Reporting

Reporting of activity data relating to the local authority Sexual Health contract will be shared with commissioners on 21 March 2023 following several months of focussed work to implement the new national SNOMED coding requirements. All audits are now complete, and with the exception of one outstanding issue, all data has been confirmed to be accurate through multiple audits. The outstanding issue will continue to be resolved in the background and commissioners will be made aware that this may increase reported activity by up to 5%.

This work has also enabled the GUMCAD (one of the national reporting datasets for Sexual Health activity) submissions for calendar year 2022 to be submitted this week. This is positive as it means our data will be included in the national STI surveillance publications, which we had previously thought would be unachievable.

Laboratory Information Management System Upgrade

The Southern Counties Pathology Network have procured a new laboratory information management system, Winpath, which will be deployed to Portsmouth Hospitals University Trust, Hampshire Hospitals Trust and University Hospitals Southampton laboratories from October 2023. This will require a new process to be setup to transfer test results into all the Trust's electronic patient record (EPR) systems. For Sexual Health, this has larger implications due to the volume of testing undertaken by the service. This means all data feeds containing the electronic results need to be re-written and tested, and this will need to be completed in collaboration with each individual laboratory and Inform (the service's EPR provider), taking time and resource from clinical staff away from service delivery. There is also a risk that if the testing is not complete before the cut off period, the flow of results into the EPR will cease, impacting patient safety and public health outcomes.

5. People

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-23 Current Performance		Feb-23 Trending Performance	Feb-23 Variance	Jan-23 Current Performance		Jan-23 Trending Performance	Jan-23 Variance
People	Sickness (annual)*	I	4.5%	5.7%				5.7%			
	Sickness (in month)	I	4.5%	5.8%				7.4%			
	Turnover (annual)*	I	14.0%	13.9%				14.5%			
	Turnover (in month)	I	1.2%	0.7%				1.1%			
	New starters (FTE)	-	-	50				82.1			
	Proportion of Temporary Staff (in month)	E	6.0%	4.3%				5.1%			

b. Key Performance Exceptions

Workforce Stability

January and February saw a positive downward trend in in-month sickness rates, staff turnover – which is now below the trust target – and the percentage of temporary staff used in month. It is anticipated that these trends will continue over the next few months. Annual staff sickness rates remain consistent, but we forecast this will reduce as we move into the warmer months. This winter has been one of the coldest the UK has recently had, and this has contributed to increased levels of colds and flu. Based on these figures, we anticipate the stability index will rise steadily over the coming months.

Industrial Action

Throughout January and February 2023 there has been focus on industrial strike action, with the RCN nurses strike having taken place and the Junior Doctor strikes in early March 2023 planned. The RCN strike action was managed sensitively and efficiently, ensuring derogations were in place where risk to life was greatest, with strong partnership collaboration with our Southern Health colleagues, our Solent staff side representatives, to ensure we managed the needs of our patients whilst respecting the nurses' rights to strike.

Statutory and Mandatory Training

February 2023 saw the highest rate of achievement for statutory and mandatory training across the trust at 92.6%, exceeding the 90% target. Appraisal rates reached 79% in February, also the highest rate in 22/23.

c. Spotlight On: Vacancy Rate

New starters are increasingly being onboarded and Solent's headcount is rising, demonstrating the results of the Recruitment Team's efforts to fill vacancies. At the end of February, the Trust vacancy rate was 4.4%, a reduction from the 5.9% seen at the end of December 2022. Positively the same trend was seen in nurse and midwives (11.5% > 11%) and medical and dental (15.9% > 14.4%) vacancy rates reducing from December 2022 to February 2023. Agency usage has also seen a significant reduction over the last 2 months, from 2.6% to 1.8%, reflecting the Recruitment and Bank teams' targeted interventions to support Solent's financial sustainability.

6. Finance

a. Performance Summary

	Indicator Description	Internal /External	Target	Feb-23 Current Performance		Feb-23 Trending Performance	Feb-23 Variance	Jan-23 Current Performance		Jan-23 Trending Performance	Jan-23 Variance
Finance	Year to date surplus/(deficit) Actual v budget	-	-	0%			L	0%			
	Agency spend % pay	I	3.5%	5.0%	●	?		4.3%	●	?	
	Cash balance	-	-	£30.5			L	£23.4			
	Aged debt (over 90 days)	-	-	190			H	189			
	Use of Resources Score	-	-	2				3			

b. Spotlight On: Month 11 Results

The Trust is reporting an in month adjusted deficit of £181k, £109k favourable to plan, with a year-to-date adjusted deficit of £10k, which is £25k favourable to plan.

Forecast

At the end of February, the Trust is forecasting an adjusted deficit of £1.8m, against a plan of breakeven. The position is predominately driven by the continuation of current spending levels, plus c£2.5m inflationary pressures unknown at the time of planning.

The Trust is planning on mitigating this deficit with non-recurrent adjustments in year to deliver a surplus of £0.4m.

Workforce

Pay savings targets of £5.2m have been allocated to operational and corporate service lines to support delivery of our year-end forecast. As at M11, savings of £5.4m have been delivered, exceeding the year to date plan of £4.8m.

The main contributors to the over-delivery of these savings are: Childrens, Dental and Adults Southampton Services, along with Covid savings.

Covid-19 Expenditure

The Trust continues to incur additional expenditure related to Covid-19 however this expenditure has dropped significantly since last year. Year to date expenditure is £1.5m, which is in line with the forecast.

Capital

The Trust's CDEL for 2022/23 of £15.1m consists of £5.5m of internally generated funding and £9.6m PDC funding.

In month expenditure was £0.4m, £0.2m lower than forecast. Year to date expenditure is £3.0m, with March 2023 spend forecast at £2.4m, fully utilising the capital allocation for the year.

Cash

The cash balance was £29.0m as at 28 February 2023, £5.7m higher than January driven by receipt of Public Dividend Capital for the Western Community Hospital bed optimisation and digital projects.

Aged Debt

The Trust's total debt was £6.0m, £0.6m debt 91+ days overdue, with no material movement from January.

Better Payment Practice Code

The trust aims to pay its creditors on receipt of undisputed, valid invoices within 30 days. Performance against this metric is monitored nationally by NHS England against a target of 95% achievement.

A review of performance to date has indicated that the trust is unable to meet the 95% target for 22/23 due to relatively poor performance in the first half of the year. The finance team are working with services where performance is lower than the target to provide additional training and support to strengthen performance into 23/24. Performance for 22/23 is anticipated to be circa 80% on volume of invoices or £90% based on value.

7. Research & Improvement

a. Performance Summary

This financial year, we have recruited 1170 participants into 44 studies, with a further 4 studies expected to open in the next few weeks.

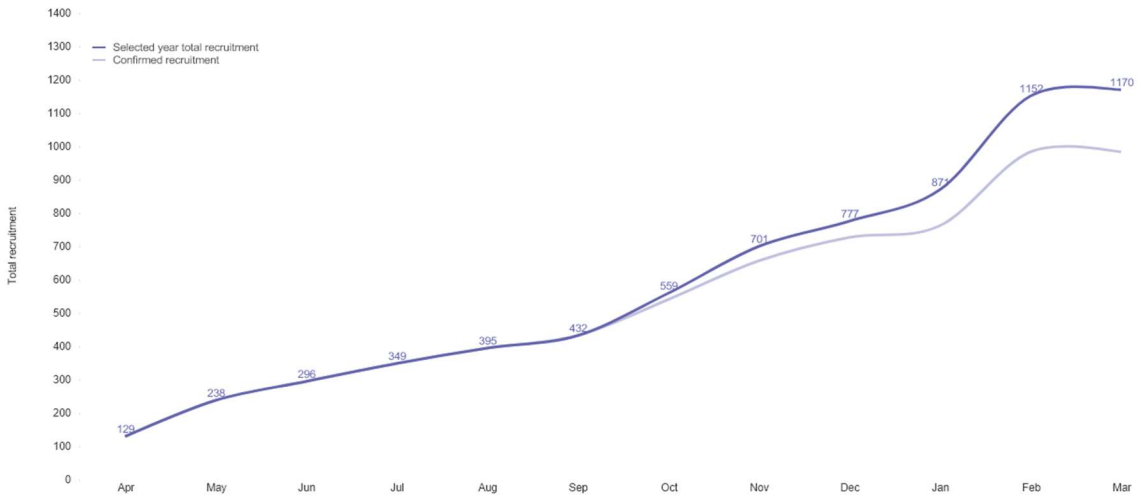

Figure 20: Research Participant Recruitment, 2022/23

There continues to be recruitment across all service lines, with Children and Family services being the most research active.

b. Spotlight On: Core Areas of Work

Solent recruits 2000th participant to The Prevenar Study

Becky Hocknell, Clinical Trials Assistants, recruited the 2000th participant to the Prevenar Study on 24 February, at Cutbush Children's Centre, Southampton. The Prevenar vaccine was introduced into the routine childhood vaccination programme in 2006. Prevenar protects us against bacteria called Streptococcus pneumoniae (S.pneumoniae). These bacteria are normally harmless but can cause illnesses such as ear infections, pneumonia or meningitis. This research study monitors the changes in the bacteria that are currently carried in children's noses to help us to develop and improve the vaccine for the future.

First Patient Recruited to The Open Study

The first participant has been recruited to The Open Study. The study is investigating the acceptance of Olanzapine in people with Anorexia Nervosa; seeing if participants take their Olanzapine regularly; for how long; their experience of the treatment; and collecting evidence on the effects of Olanzapine on anxiety, depressed mood, sleepiness, quality of life and physical/psychological consequences of Anorexia Nervosa.

Dental Teams Delivering Weight Interventions

A new study opened in partnership with the University of Portsmouth Dental Academy, exploring patients views about whether dental teams should be involved in helping people manage their weight. They would like to know whether patients feel comfortable having their height and weight measured at dental practices and whether discussing their weight at a dental appointment would be acceptable. There have already been over 200 patients recruited into the study, from both Solent Dental Services and The University of Portsmouth Dental Academy.

Annex A: Making Data Count Icon Crib Sheet

Process control	Variation Indicator	Trending Performance Indicator	Recommended action
In control			**Do nothing** *your process is working perfectly!*
In control		 Capability within acceptable levels	**Do nothing** *Your process is working well enough*
In control		 Capability outside of acceptable levels	**Consider process redesign** *If no other areas to prioritise*
In control			**Process redesign** *Your current process is designed to fail*
Out of control	 Cause unknown		**Investigate special cause origins BEFORE tackling process capability** *Try to understand what is happening before responding* *redesigning out of control processes is not advisable*
Out of control	 Cause known		**Root cause corrective action BEFORE tackling process capability** *Seek to restore process control* *redesigning out of control processes is not advisable*
Out of control	 Cause unknown		**Investigate special cause origins** *Try to understand what is happening before responding*
Out of control	 Cause known		**Consider root cause corrective action** *Seek to restore process control*
Out of control	 Cause unknown		**Investigate special cause origins** *Try to understand what is happening before responding*
Out of control	 Cause known		**Celebrate achievement (if intentional) and share learning** *Seek to restore process control*
Out of control	 Cause unknown		**Investigate special cause origins BEFORE tackling process capability** *Try to understand what is happening before responding* *redesigning out of control processes is not advisable*
Out of control	 Cause known		**Celebrate achievement in improvement (if intentional) and share learning** *Seek to restore process control - redesigning out of control processes is not advisable*

Solent NHS Trust - System Oversight Framework

The NHS System Oversight Framework is aligned with the ambitions set out in the NHS Long Term Plan and the 2022/23 NHS operational planning and contracting guidance. The framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate. This supports our ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: next steps to building strong and effective integrated care systems across England and the government's white paper on integration – Joining up care for people, places and populations.

A set of oversight metrics are used to support the implementation of the framework at a system level. The metrics listed below are those which Solent contribute towards. It is worth noting that nationally a number of these metrics are linked to the provision of additional funding to support performance improvement, however, as a Community and Mental Health provider, Solent is not always eligible for these funding streams.

Metrics which have incentive funding for other providers are highlighted in blue below. We continue to monitor our contribution towards these targets, as a member of the local system, but acknowledge we are not given financial support to invest in additional improvements for this activity.

	Indicator Description	Internal /External Target	Target	Feb-23 Current Performance		Feb-23 Trending Performance	Feb-23 Variance	Jan-23 Current Performance		Jan-23 Trending Performance	Jan-23 Variance
Quality, Access & Outcomes	S038a: Potential under-reporting of patient safety incidents	E	100.0%	100.0%				100.0%			
	S039a: National Patient Safety Alerts not completed by deadline	E	0	0				0			
	S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	E	0	0				0			
	S041a: Clostridium difficile infections	E	0	0				0			
	S042a: E. coli blood stream infections	E	0	0				0			
	S081a: IAPT access (total numbers accessing services)	E	366	470				590			
	S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (3 months rolling)	E	0	179				194			
	S086b: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only)	-	-	100.0%				100.0%			
	S107a. Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	E	70.0%	56.5%				60.9%			
	S007a: Total Elective Spells	-	-	Currently awaiting provision of guidance for measurements from NHS I&E							
	S009a: Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment	E	0	0				0			
	S013a: Diagnostic activity levels - Imaging	E	545	417				324			
	S013b: Diagnostic activity levels - Physiological measurement	E	77	84				53			
Looking after our people	S071a: Proportion of staff in senior leadership roles who are from a BME background	-	12.0%	6.9%				6.8%			
	S071b: Proportion of staff in senior leadership roles who are women	-	62.0%	75.3%				73.8%			
	S071c: Proportion of staff in senior leadership roles who are disabled	-	3.2%	4.5%				4.4%			
	S067a: Leaver rate	I	14.0%	13.9%				14.5%			
	S068a: Sickness absence (working days lost to sickness)	I	5.0%	5.8%				7.4%			
Finance and Use of Resources	S118a: Financial Stability	E	-	Data not currently available							
	S119a: Financial Efficiency	E	-	1.9%				2.1%			
	120a: Finance – Agency Spend vs agency ceiling	E	100.0%	Data not currently available							
	120b: Agency spend price cap compliance	E	100.0%								

Solent NHS Trust - System Oversight Framework

Performance Summary:

The majority of metrics showing a negative trend or variance are covered within the Trust Board Integrated Board Report. Other areas of exception worth noting are as follows:

Diagnostics Performance

Diagnostic performance levels are below target. This is an area where acute trusts are receiving additional investment to increase diagnostics capacity, but this is not applicable to Solent. There are no concerns about the levels of diagnostic activity being undertaken by Solent or our sub-contractors as all referrals are being managed within the nationally set timeframe of 6 weeks. Therefore, underperformance on this metric does not reflect any concerns about capacity within this service.

Key

In-month Performance Indicator

- Metric is achieving the target
- Metric is not achieving the target

Trending Performance Indicator

Target has been consistently achieved, for more than 6 months

There is a variable and inconsistent performance against the target

Target has been consistently failed, for more than 6 months

Variance Indicator

Special Cause Variation, for improved performance. The trend is either:
- Above the mean for 6 or more data points
- An increasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the upper control limit

Special Cause Variation, for poor performance. The trend is either:
- Above the mean for 6 or more data points
- An increasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the upper control limit

Special Cause Variation, for improved performance. The trend is either:
- Below the mean for 6 or more data points
- An decreasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the lower control limit

Special Cause Variation, for poor performance. The trend is either:
- Below the mean for 6 or more data points
- An decreasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the lower control limit

Common Cause Variation, the information is fluctuating with no special cause variation.

NHS Provider Licence – Self Certification 2022/23 – March 2023

Condition G6 – Systems for compliance with licence conditions:

Requirement

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Response

The effectiveness of internal control systems and processes are reviewed on an annual basis and documented within the Annual Governance Statement as presented to the Audit & Risk Committee and incorporated within the Annual Report. In addition, assurance to the Board is supported by opinions from Internal Auditors and External Auditors.

Annually the Trust declares compliance against the requirements of the NHS Constitution.

Condition FT4 – Governance Arrangements:

Requirement

1 The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Response

The Board considers and adopts corporate governance standards, guidance and best practice as appropriate.

We regularly review our governance processes including our Board Code of Conduct and associated protocols.

Requirement

2 The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time.

Response

The Board considers and adopts corporate governance standards, guidance and best practice as appropriate, including that issued by NHSE.

Requirement

3 The Board is satisfied that the Licensee has established and implements:

(a) Effective board and committee structures;

(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

(c) Clear reporting lines and accountabilities throughout its organisation

Response

On an annual basis the Trust has implemented a process of governance reviews (via the Remuneration and Nominations Committee) including;

- Reviewing composition, skill and balance of the Board and its Committees
- Reviewing Terms of Reference
- The completion of an Annual Report for each Board Committee incorporating a reflection on the achievement of objectives and business conducted in year. A mid-year review of each Committee is also conducted.

The Composition of Committees is also kept under constant review to take into consideration and periods of unscheduled /planned leave, the impact of vacancies effecting quoracy as well as any recommendations made following Internal Auditors (or other external review). The Executive Team Portfolios are continuously reviewed.

The Trust's wider governance structure is also regularly considered and refreshed to ensure efficiency and clear lines of reporting.

The Chair of the Audit and Risk Committee will be leaving on 31 March 2023. Active conversations are being held with NHSE regarding a replacement with the requisite skills.

Requirement

4 The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;

(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) To ensure compliance with all applicable legal requirements.

Response

We regularly review our governance processes including our Board Code of Conduct and associated protocols. The Trust ended the financial year 2021/22 with a small surplus.

The Trust has submitted a break-even plan for 2022/23.

Internal control processes have been established and are embedded across the organisation as outlined within the Annual Governance Statement. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls.

Requirement

5 The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Response

The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do.

The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors.

There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief of Nursing & Allied Health Professionals working with the Deputy CEO & Chief Medical Officer.

The Composition of Committees is also kept under constant review to take into consideration and periods of unscheduled /planned leave, the impact of vacancies effecting quoracy as well as any recommendations made following Internal Auditors (or other external review).

The Executive Team Portfolios are continuously reviewed.

Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies. Established escalation processes allow staff to raise concerns as appropriate.

Solent NHS Trust

Requirement

6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Response

Details of the composition of the Board can be found within the public website.

Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.

Item No.	**9**	Presentation to	**In Public Board**
Date of paper	7 March 2023	Author	Sandra Glaister, Head of Corporate Assurance
Title of paper	Annual Audit Timetable and Delegations		
Purpose of the paper	The aims of this paper are; • to present the timeline of the Audit and Risk Committee and in public Board meetings due to receive and approve the Trust's Annual Report and Annual Accounts. • request approval of alternate Board meeting chairing arrangements, and co-opted NED membership of the Audit & Risk Committee for the 21 June 2022 meetings • to agree and approve signing arrangements for documents that require the Chairs' signature at the in public Board on 21 June 2022.		

Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	**X**	
Action required	For decision	**X**	For assurance				
Summary of Recommendations and actions required by the author	The Board is asked to: • acknowledge the timeline for the meetings to approve the Annual Report and Annual Accounts, and in doing so; ○ Agree co-opted NED membership to the Audit & Risk Committee on 21 June 2022. ○ Designate a NED colleague to Chair the In Public Board meeting on 21 June 2022. ○ Agree that the Trust Chair pre-agrees to sign (via e-signature) the Annual Report (opening statement), subject to approval of the annual report content at the meeting on 21 June.						

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant	x	Sufficient		Limited		None	
Exec Sponsor name:	Rachel Goldsworthy			Exec Sponsor signature:			

Due to the accounting timetable and planned absence of the Trust's Chair, and in consideration of the reduced NED cohort, it is necessary to consider governance arrangements associated with the approval of the Trust's Annual Report and Annual Accounts.

This paper provides a timeline for meetings, and associated paper release, to approve the Trust's Annual Report and Annual Accounts, attendees at these meetings and details of the documentation that will require authorised signatures (Appendix 1), via e-signature, subject to Board approval at the In Public meeting on 21 June.

In summary the proposal is as outlined below.

Regarding the Audit and Risk Committee (A&RC) - 21 June;

- it should be noted that the A&RC Chair position is currently vacant – active discussions are being held to consider how best to fill this role[1]
- due to the reduced NED cohort, it is necessary for the Board to approve co-opted NED membership for the meeting to ensure quoracy (and in consideration of business continuity in the event of unschedueld absences) – as summarised in Appendix 1.
- the full Board are invited to the Public Disclosure section of the meeting (as is normal practice, to allow scrutiny and queries to be raised in the presence of the Trust's external and internal auditors),

[1] Should the appointed Audit Committee Chair be unable to make the 21 June date, it will be necessary to reconsider the approval timetable with the Board and Auditors

The A&RC will be followed by the In Public Board meeting on 21 June and in doing so:

- it is necessary to designate a Chair for this meeting due to the planned absence of the Trust's Acting Chair.
- approval is sought for agreement in advance from the Chair to sign the Annual Report (opening statement) via e-signature, subject to Board approval on 21 June.

Annual Audit Timetable and Delegations

Appendix 1

Documents for Signing	
Statement of Financial Position	CEO
Statement of Accountable Officer's Responsibilities	CEO
TAC schedules – 'Confirmations' tab	CEO
Annual Governance Statement	CEO
Events after the reporting period (not due until later in the year)	CEO
Statement of director's responsibilities in respect of the accounts	CEO & CFO
Certificate on the summarisation schedules (TAC schedules)	CEO & CFO
Annual Letter of Representation	Chair A&RC & CFO
Auditor ISA 260 Report	EY
Audit Report	EY
Auditor report in the summarisation schedules (TAC schedule)	EY
Annual Report Statement from Chair and CEO	CEO & Acting Board Chair* (Via prior agreement)

A&RC Paper release 14 June Midday

A&RC Public Disclosure paper release 16 June by 3pm

A&RC Meeting Wednesday 21 June 9.00 – 12.00

Attendees	Quoracy: 2 NEDs
9.00 – 10.00	Vanessa Avlonitis (member)
All Board Members	Gaurav Kumar (co-opted)
10.00 – 12.00	Chair to be confirmed
Andrew Strevens CEO	
Nikki Burnett CFO	
Rachel Cheal COS	
Alasdair Snell COO	
Angela Anderson CN	**Scheduled Apologies**
Dan Baylis CMO	Stephanie Elsy (co-opted)
Debbie James CSIO	Mike Watts, Acting Board Chair

EO in Public Board paper release 16 June after 3pm

EO in Public Board Meeting Wednesday 21 June 12.00-12.30

Quoracy	
2 Executive Directors	**2 NEDS**
Andrew Strevens CEO	Vanessa Avlonitis
Nikki Burnett CFO	Gaurav Kumar
Rachel Cheal COS	Chair to be confirmed
Alasdair Snell COO	
Angela Anderson CN	**Scheduled Apologies**
Dan Baylis CMO	Stephanie Elsy
Debbie James CSIO	Mike Watts, Acting Board Chair

Report template- Board and Committees

Item No.	10			Presentation to	Board		
Date of paper	3 April 2023			Author	Katy Cox, Programme Director		
Title of paper	Project Fusion approved Strategic Case, Update on Next Phase of the Programme and Communications & Engagement Plan for approval						
Purpose of the paper	This paper comprises the Project Fusion approved Strategic Case, a paper with an update on the next phase of the Programme and the Communications & Engagement Plan for approval						
Committees /Groups previous presented and outputs	The Communications & Engagement Plan, approved Strategic Case and Update on Next Phase of the Programme is also going to the Southern Trust Boards on 4 April for approval. The Communications & Engagement Plan is recommended to the Trust Boards for approval by the Programme Board.						
Statement on impact on inequalities	Positive impact (inc. details below)	X	Negative Impact (inc. details below)		No impact (neutral)		
Positive / negative inequalities	The Communications & Engagement Plan, which is a live document, describes the principles, approach and activities that will be undertaken to ensure a coordinated approach to communication and engagement with staff and stakeholders.						
Action required	For decision	X	For assurance				
Summary of Recommendations and actions required by the author	The Board is asked to approve the Communications & Engagement Plan for the Fusion programme and to note the next steps for the next phase of the Programme.						

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient		Limited		None	
Exec Sponsor name:				Exec Sponsor signature:			

Key messages /findings – Communication & Engagement Plan

- The Communications & Engagement Plan is presented to the Board for approval. The Communications & Engagement Plan is part of the Strategic Case which was approved by all four Trust Boards (Solent, Sussex Partnership, Southern and Isle of Wight) at the March 2023 boards. Given the importance of the communications and engagement plan and approach to the overall success of the Fusion programme, Board is asked to approve this document.

PROJECT FUSION

Bringing together community, mental health and learning disability services

Strategic Case for the creation of a new Trust for community, mental health and learning disability services across Hampshire and the Isle of Wight Integrated Care System

CONFIDENTIAL

21 February 2023

Contents

PROJECT FUSION

Glossary

ABBREVIATION	MEANING
ADHD	Attention deficit hyperactivity disorder
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CF	Carnall Farrar
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
Dorset HealthCare	Dorset HealthCare University NHS Foundation Trust
ECT	Electro-convulsive therapy
ED	Emergency Department
EUPD	Emotionally Unstable Personality Disorder
FTE	Full-time equivalents
HIOW	Hampshire and the Isle of Wight
ICB (the)	Hampshire and Isle of Wight Integrated Care Board
ICS (the)	Hampshire and Isle of Wight Integrated Care System
ICP	Integrated Care Partnership
IoW	Isle of Wight NHS Trust
JFP	Joint Forward Plan
LDS	Local Delivery System
LTP	NHS Long Term Plan
MSK	Musculoskeletal
MoHHS	Modernising our Hospitals and Health Services
OPMH	Older People's Mental Health Services
PCN	Primary Care Network
PTIP	Post Transaction Integration Plan
SDEC	Same Day Emergency Care
Solent	Solent NHS Trust
Southern	Southern Health NHS Foundation Trust
Sussex Partnership	Sussex Partnership NHS Foundation Trust
Trusts (the)	Collectively, Southern Health NHS Foundation Trust, Solent NHS Trust, Isle of Wight NHS Trust and Sussex Partnership NHS Foundation Trust
UCR	Urgent Community Response
VCSE	Voluntary Community and Social Enterprise

1. Executive summary

Summary

1.1 Southern Health NHS Foundation Trust (Southern), Solent NHS Trust (Solent), Isle of Wight NHS Trust (IoW) and Sussex Partnership NHS Foundation Trust (Sussex Partnership) (collectively, the Trusts) provide NHS community, mental health and learning disability services for the Hampshire and Isle of Wight population.

1.2 We have been working together for a number of years to improve services for the people and communities we serve. In each Trust there are multiple examples of superb services providing excellent care, including areas of national excellence. However, further significant change is needed in order to deliver sustainable improvements in access, care and outcomes for the people and communities we serve. Services are struggling to meet unprecedented increases in demand which means people are not getting the care they need at the right time and in the right setting; there is unwarranted variation in practice and fragmentation in service delivery; workforce shortages, particularly in mental health services, impact on the effectiveness and quality of services; and the Trusts, as well as the wider Hampshire and Isle of Wight Integrated Care System (the ICS), face a very substantial financial challenge.

1.3 We want all people in Hampshire and Isle of Wight to have equitable access to integrated, safe, consistent community and mental health care. We will be more likely to achieve this future by joining up the disparate, often inconsistent services and pathways delivered by four different community and mental health providers.

1.4 We have concluded that the best way to enable our vision is by working together to establish a new, single community and mental health provider, while, at the same time, accelerating collaboration and transformation, led by our clinical experts, to reduce the significant pressures in our system.

1.5 The new organisation will be an NHS Foundation Trust and will provide community, mental health and learning disability services across the whole ICS, as well as specialist services to a larger regional and national population. It will bring together our expertise and resources to manage increasing demand and complexity and deliver meaningful, long-lasting change for the benefit of patients, communities, staff and the wider health and care system:

- **Patients and communities will benefit from there being a strong voice of lived experience in all we do and improved patient experience, outcomes and safety.** It will enable us to deliver services that are less fragmented, across clinical pathways and geographic areas, providing the right care first time more often.
- **Staff will benefit because we will be able to create a better place to work.** By creating a single organisation we expect to reduce vacancies by developing a single approach to tackle recruitment and retention challenges, improving career progression and development opportunities, improving job satisfaction, continuing to develop an inclusive, open culture, improving service resilience and reducing professional isolation.
- **The wider health and care system will benefit because we will make it easier for partners to work with us effectively and in a seamless and integrated way.** Working in neighbourhoods, places and across the ICS as a

whole we will simplify and integrate our care pathways and make it easier for primary, social care, hospitals and other partner colleagues to signpost to and work with our services to support people in the community.

1.6 These proposals have been developed over the last twelve months as part of a whole system approach across the ICS and have the support of the Hampshire and Isle of Wight Integrated Care Board (the ICB). The proposals are also a core component of the ICS strategy to resolve the challenges of delivering sustainable health services for the Isle of Wight population.

1.7 Our target date for the establishment of the new organisation is 1 April 2024. Preparing a Strategic Case is the first step to achieving this objective. Subject to approval by the four Trust Boards, the Strategic Case will be submitted to NHS England (NHSE) in March 2023 for formal review, with work beginning in parallel to develop a Full Business Case and detailed integration plans.

1.8 The Strategic Case describes why we want to bring services together, the options we considered, the emerging strategy for our clinical services and why we are confident that the benefits of bringing services together into a new organisation outweigh the potential risks and costs. It also sets out how we are approaching the next phase of the programme to develop the Full Business Case.

Context: Mental health, learning disability and community services in the Hampshire and Isle of Wight Integrated Care System

1.9 The ICS covers a population of 1.9 million people across Southampton, Portsmouth, Isle of Wight and Hampshire. The area comprises substantial urban settlements (including Southampton, Portsmouth, Winchester and Basingstoke), large rural areas interspersed with market towns and villages and coastal communities in southern Hampshire and the Isle of Wight. There are significant variations in health needs across the ICS.

1.10 The four main providers of NHS community, mental health and learning disability services in the ICS are summarised in the table overleaf. In addition, services are delivered by primary care, local authorities and the voluntary, community and social enterprise sector and Dorset HealthCare University NHS Foundation Trust (Dorset HealthCare) provides NHS Talking Therapies for anxiety and depression in Southampton.

Provider	Services provided for Hampshire and Isle of Wight population
Solent NHS Trust	• Community, mental health and learning disability services in Portsmouth. • Community services in Southampton City. • 0-19 services, sexual health and dental services for Isle of Wight. • Some specialist services across Hampshire and Isle of Wight. Solent is rated 'good' by the CQC and reported operating income of £258m in 2021/22.
Southern Health NHS Foundation Trust	• Community, mental health, learning disability and 0-19 services across Hampshire. • Mental health and learning disability services in Southampton. • Specialised and forensic mental health services for a regional and national population. Southern is rated 'requires improvement' by the CQC and reported operating income of £402m in 2021/22.
Isle of Wight NHS Trust	IoW provides acute, community, mental health and ambulance services for the Isle of Wight population. The Trust is rated good by the CQC. Only the community services and mental health services provided by IoW are in scope for this Strategic Case. The IoW costs related to these services were £55m in 2021/22.
Sussex Partnership NHS Foundation Trust	Sussex Partnership NHS FT provides services for people with mental health problems and learning disabilities across Sussex, and a range of specialist services across south-east England. The Trust provides Child and Adolescent Mental Health Services (CAMHS) for Hampshire and it is these services that are in scope for this Strategic Case. Sussex Partnership is rated good by the CQC. The contract value for Hampshire CAMHS provided by Sussex Partnership was c. £23m in 2021/22.

The rationale for creating a new Trust for community, learning disability and mental health services across Hampshire and Isle of Wight Integrated Care System

1.11 Solent, Southern, IoW and Sussex Partnership share an ambition to deliver the best possible care and outcomes for people in Hampshire and Isle of Wight. In each Trust there are multiple examples of superb services providing excellent care, including areas of national excellence. The four Trusts are already collaborating to address the most significant clinical risks in community and mental health services.

1.12 However, and notwithstanding this, there is a compelling case for further change. In Hampshire and Isle of Wight:

1) **Community and mental health services are struggling to meet unprecedented increases in demand and there are rising numbers of people with complex or long-term physical and mental health conditions.** This is putting complex models under greater pressure and people are not getting the care they need at the right time and in the right setting. The NHS Long Term Plan (LTP), published in 2019, sets out the

strategic priorities for the NHS and makes specific commitments in respect of mental health, learning disabilities, autism and community services. These are not being met consistently across the system.

2) **There is unwarranted variation in practice, and fragmented pathways and services with multiple hand-offs** across Hampshire and Isle of Wight. As a result, people who use our services don't consistently experience high-quality person-centred care that meets their needs. This adversely impacts health and wellbeing outcomes.

3) **The Trusts are experiencing challenges in recruitment and retention resulting in workforce shortages which impact on the effectiveness and quality of services.** These are particularly visible in mental health services. Due to the fragmentation of services across multiple providers, there are low volume specialist services in each Trust which lack the scale to provide resilient workforce models, such as specialist nursing in the community. In our current model these smaller services also provide limited opportunity for career progression.

4) **The financial challenge is very significant.** The revised financial regime that was implemented in the NHS during COVID-19 resulted in the Trusts delivering breakeven positions or small surpluses in 2020/21 and 2021/22. However, the cost of delivering NHS services exceeds the available resources. Southern, Solent and the services proposed to transfer from Isle of Wight and Sussex Partnership are forecasting underlying deficits in 2022/23 that total £46.0m and this gap is projected to grow over the next five years. In addition, whilst pressures are felt across the whole system, there is a particular issue that Isle of Wight services are not financially sustainable because the population served by the Trust is too small to provide the critical mass needed to sustain high quality, efficient services.

1.13 These challenges cannot be addressed by any one organisation in isolation. We have concluded that it is not possible to fully respond to these challenges, overcome the fragmentation of care delivery and ensure greater consistency of outcomes across the Hampshire and Isle of Wight system within the current organisational model and that organisational changes are required to exploit the opportunities for better care.

Options for the future and our preferred option

1.14 A long list of eleven possible organisational options was generated, ranging from extending informal collaboration through to changes to organisations. Hurdle criteria were developed setting out the minimum, essential criteria to be met for an option to be short-listed for more detailed evaluation. Applying the hurdle criteria resulted in eight options being eliminated.

1.15 Three options remained for more detailed appraisal:

- the development of a lead provider model;
- the establishment of an NHS Group; and
- bringing all services together into a single Trust.

1.16 Evaluation criteria were developed to assess the three short-listed options, reflecting the case for change and implementation challenges. The options appraisal process concluded that:

- Whilst a lead provider model could harness and co-ordinate the expertise of existing providers to redesign pathways and standardise care, it provides less potential to deliver the transformational change needed to overcome the challenges being faced in Hampshire and Isle of Wight of organisational boundaries, would not deliver the benefits sought for people and communities, nor address the case for change. A lead provider model would also not resolve the sustainability of Isle of Wight community and mental health services.

- Whilst creating an NHS group could enable improved strategic alignment at Board level across community and mental health service providers, this model maintains separate organisations, which means that there are still multiple Trusts involved in providing care for individuals which fragments care, with at least two providers of community and mental health services in each local delivery system in the ICS. This model also maintains the current complexity, requires complex governance and falls short of creating the fully shared vision, values, strategy, culture and accountability that will be needed to deliver consistent care models and the required transformation. There isn't a practical or deliverable arrangement through which the in-scope services provided by IoW and Sussex Partnership (which are only a small part of the portfolio of those Trusts) can be included in a group model and so this model does not resolve the sustainability of Isle of Wight community and mental health services. For these reasons the conclusion was reached that the benefits of establishing a group model do not outweigh the risks and that this does not offer a viable long term model for community and mental health services for Hampshire and Isle of Wight.

- Bringing services together into a single Trust offers the greatest opportunity to create the alignment, leadership and governance arrangements needed to respond to the case for change. This option allows for the coordination of resources to manage capacity according to need, respond to system pressures and enable smaller services to operate at the appropriate scale. This also provides the critical mass needed to support the sustainability of Isle of Wight community and mental health services.

- Whilst this option takes longer to deliver (18 months rather than, for example, the 12 months estimated to create a group) and involves additional transaction costs, the additional benefits that can be realised as a result significantly outweigh these implementation factors. The additional costs of delivering the transaction are in the context of an ICB budget for all mental health and community services of c.£800m.

1.17 The preferred way forward is therefore to bring NHS community, mental health and learning disability services together through the creation of a new Trust. Combining the expertise, experience and resources from all four organisations will enable us to provide better community and mental health services for the population we serve whilst also achieving the benefits of scale.

1.18 The proposal to create the new Trust has the full support of the ICB. It is consistent with and flows from the outcome of an independent review of community and mental health services commissioned by the ICS in 2022. The creation of the new Trust is one

of the key strategic programmes that the ICS is progressing as part of its Partnership Strategy and to achieve its strategic goals.

Clinical strategy

1.19 Responding to the case for change, the four Trusts have come together to accelerate clinical collaboration to address the most significant clinical risks in our community and mental health services. Ten initial clinical priorities have been identified, informed by system priorities, joint strategic needs assessments, equality impact assessments, community requirements and workforce, performance and quality data. Each has an identified executive director who takes system-wide responsibility for leading the workstream, supported by senior clinical and operational leads, and reporting into a Clinical Delivery Group.

Mental health and learning disabilities priorities	Community service priorities
• Children and young people's mental health services • Neurodiversity pathways • Older people's mental health services (OPMH) • Adult mental health acute and crisis services • Community mental health framework ('no wrong door' programme)	• Community rapid response services • Community hospitals and community inpatient rehabilitation • Community frailty • Community health specialist services and long-term conditions • Supporting the sustainability and integration of primary care

1.20 To support these and future priorities, the following principles for clinical transformation have been agreed:

- Our primary goal is to deliver safe and effective mental health, learning disabilities and community services to all people across HIOW
- Our communities are at the heart of what we do, and we will work in, and with our communities to improve the way we deliver care
- We will seek to endeavour equitable voice of service users and professionals delivering our services
- Our success must be measured by outcomes that matter, co-created with the people who know our services the best
- We will adopt a life course approach across both community and mental health services which removes barriers, provides greater emphasis on prevention, and enables a pro-active approach
- We will work collaboratively at the appropriate scale as one health and care team, within the HIOW integrated care system and will recognise each other's leadership capabilities
- We will respect and value the interconnectivity of delivery with our partners, including primary care, local authority and voluntary services
- We will embrace innovation, research and new models of care

- Clinical and professional leadership is at the core of our success and must be appropriately resourced and supported

1.21 Each of the four Places in the ICS (Hampshire, Isle of Wight, Portsmouth and Southampton) identified priority areas for their populations, which form part of the system Partnership Strategy. Most work undertaken to tackle health inequalities and improve service delivery and health outcomes is delivered locally.

1.22 A clinical strategy for the new Trust will be developed which encompasses the principles for clinical transformation, reflects the emerging thinking from the clinical priority workstreams and responds to the Place and system priorities across the ICS. It will be ambitious and transformational to respond to the challenges facing the Trusts and the wider system. The clinical strategy will optimise patient safety, quality and experience through a consistent set of standards.

1.23 Building on the evolving work of the Clinical Delivery Group, the clinical strategy will continue to be developed by the Trusts alongside the ICB and other partners at system, place and local delivery system level including primary care, local authorities, acute providers and voluntary community and social enterprise (VCSE) partners. People with lived experience will be actively involved in coproducing our clinical strategy.

Benefits

1.24 Working with stakeholders including staff, patient groups and the ICB, we have identified the benefits that can be achieved through the creation of a new Trust for community and mental health services:

We will deliver **benefits for patients and communities** through the provision of better care	• **Improving patient experience** by creating services that are less fragmented, across both clinical pathways and geographic areas • **Improving patient safety and outcomes**, providing the right care first time, through a single approach to service improvement, innovation and transformation that utilises our combined transformation expertise and recognises the importance of both standardisation to reduce unwarranted variation and adaptation to meet the needs of place • **People with lived experience will have a strong voice in all we do**. This will include an enhanced voice through our membership and the Council of Governors and our approach to community engagement which will enable the new Trust to work in coproduction with people who use our services and to respond more effectively to the needs of the populations that we serve • Increasing **research opportunities** which provide benefits for patients
We will deliver **benefits for staff and create a better place to work**	• **Reducing vacancies** by developing a single approach to tackle recruitment and retention challenges • **Improved career progression** and development opportunities through the increased scale of the new Trust • **Improved job satisfaction** by sharing resources more effectively to maintain safe staffing levels, out-of-hours

	medical rosters and reducing gaps in specialist clinical knowledge, and aligning operational, clinical and management processes, job descriptions and terms and conditions • Continuing to develop an **inclusive, open culture** that promotes learning and continuous improvement • **Improved service resilience** and reduced professional isolation • **Attracting and retaining strong leadership**
We will deliver **benefits for our partners** by making it easier to work with us effectively, delivering benefits to the wider health and social care system	• Working closely with **neighbourhoods and places to simplify our care pathways** and make it easier for primary, social care and other partner colleagues to signpost to and work with our services to support people in the community • **Reducing Emergency Department (ED) attendances and avoidable admissions** to secondary care through reducing the complexity and duplication of our care pathways to care for patients in community settings when appropriate • Being a **strong and consistent voice for community and mental health services** across the ICS, working with partners at neighbourhood, place and system levels to achieve the system's aims

Financial context and plan

1.25 The revised financial regime that was implemented during the pandemic resulted in the Trusts delivering breakeven or small surplus positions in 2020/21 and 2021/22. However, in previous years both Southern and IoW reported deficits.

1.26 In 2022/23 both Southern and Solent planned to achieve breakeven and the Trusts are currently forecasting surpluses of £1.5m and £0.4m respectively. The community and mental health services on the Isle of Wight form part of an integrated NHS Trust that also provides acute and ambulance services. The Trust planned for a deficit of £13.1m in 2022/23, with the community and mental health segment planning for a deficit of £0.7m. The deteriorating financial performance has resulted in a segment deficit of £2.9m now being forecast. It has not yet been agreed how the historic financial deficit of the Trust will be managed following the transfer of services and this will be an important part of the Full Business Case. Hampshire CAMHS has worked within its budget over the past five years. However, the service is forecasting a deficit of £0.4m in 2022/23.

1.27 Achievement of the current year's forecast outturn for Southern, Solent and the services proposed to transfer from IoW and Sussex Partnership relies on non-recurrent benefits and the underlying cumulative forecast deficit for 2022/23 is £46.0m. All Trusts are currently reviewing their underlying financial position as part of planning for 2023/24 and are developing recovery plans to reduce these underlying deficits. This level of financial challenge is being experienced across Hampshire and Isle of Wight and the system will need to deliver unprecedented savings to achieve a balanced position in future years.

1.28 Although the primary driver for the transaction is the significant benefits that can be realised for patients, as described above, the Trusts have identified savings of between £2m and £2.5m per annum relating to economies of scale from bringing the Trusts and services together. We have not assumed any financial benefits from reductions in the cost base for clinical services. We anticipate there will be opportunities to streamline corporate services and the scale of these opportunities will be explored and quantified during the development of the Full Business Case. We also anticipate that the creation of a more sustainable workforce through the removal of barriers around workforce mobility and creating a single, shared workforce plan and vision will improve recruitment and retention, thereby reducing temporary staffing costs and deliver a further financial benefit.

1.29 Although, in and of itself, the transaction will not provide a solution to the underlying financial position, bringing together mental health and community services across the system will provide a platform to improve the financial resilience and sustainability of these services. Creation of the new Trust provides an opportunity to better use our collective resources to meet the needs of the population.

Integration Planning

1.30 The new Trust will be created through a merger of Solent and Southern (executed as an acquisition of Solent by Southern) and the transfer of the contracts for Isle of Wight community and mental health services and for Hampshire CAMHS from IoW and Sussex Partnership respectively to this enlarged organisation. The transfer of services from IoW is subject to a separate Joint Strategic Case, commissioner decision and regulatory approval; the transfer of services from Sussex Partnership is subject to ICB decision.

1.31 The new community and mental health provider will be one of the biggest in the country, with the potential to become a national role model in sustainable, transformative, local care models which make a real difference to patients, communities and systems. The new Trust will seek to respond to the contemporary and future needs of our communities. It will have a new vision, strategy, values, name, constitution and operating model which recognises and enables our collective ambition.

1.32 We will work together to embed a new, shared, empowering culture, where staff are engaged and have a sense of belonging. In doing so we will create the conditions whereby everyone in our workforce can look to the future with optimism and enthusiasm for improvement.

1.33 In the coming months, we will consider options for the operating model that are aligned with our key principles, informed by engagement with stakeholders including staff and place-based partners and learning from other models.

1.34 The intended ‘go-live’ date for the new Trust is 1 April 2024. It has been assumed that all transactions happen on 1 April 2024, however the Trusts are working closely with the ICB to mitigate any risks arising from timing changes and are confident these could be accommodated safely.

1.35 Robust programme governance arrangements are in place including a Programme Board, Programme Team and Steering Groups. Following approval of the Strategic Case the Trusts intend to review the governance arrangements and agree any changes required for Full Business Case stage. A Programme Director and Programme Manager are in place and the Trusts have identified the resources required to develop the Full Business Case and Post-Transaction Integration Plan

(PTIP). The important interdependencies with the wider programme to achieve sustainable services for the Isle of Wight population are being managed.

1.36 A risk management approach is in place and programme risks and mitigations have been identified. The most significant risks to the programme are loss of staff during the period of transition destabilising services and the timing of transfer of services from IoW and Sussex Partnership not aligning with creation of the new Trust.

1.37 A due diligence approach has been developed with plans to undertake the majority of due diligence internally to retain knowledge in the new Trust and ensure ownership of risks identified through due diligence.

1.38 A communications and engagement plan has been developed which describes the principles, approach and activity to ensure a co-ordinated approach with people who use our services and partners. The plan includes a programme of engagement with people who use our services, their families and carers and with our communities to develop a comprehensive understanding of what matters most to people about their local community and mental health services to influence the development, delivery and design of the new Trust.

2 Introduction

Chapter summary

- This chapter provides an overview of mental health, learning disability and community services in the Hampshire and Isle of Wight Integrated Care System and the organisations currently providing these services.
- The Hampshire and Isle of Wight Integrated Care System covers a population of 1.9 million people across Hampshire (except north-east Hampshire which is part of the Frimley Integrated Care System), Southampton, the Isle of Wight and Portsmouth. There are significant variations in health needs across Hampshire and the Isle of Wight.
- There are three main NHS providers of mental health and community services in the Integrated Care System: Solent NHS Trust, Southern Health NHS Foundation Trust and Isle of Wight NHS Trust. Sussex Partnership NHS Foundation Trust provides child and adolescent mental health services and children's eating disorder services in Hampshire and Dorset HealthCare University NHS Foundation Trust provides NHS Talking Therapies for Anxiety and Depression in Southampton. Alongside these NHS providers, services are also delivered by primary care, local authorities and the voluntary, community and social enterprise sector.
- Service provision is fragmented across care pathways and across geographies, resulting in multiple hand-offs and different access requirements.
- Solent NHS Trust provides community, learning disability and mental health services in Portsmouth, community services in Southampton and a range of specialist services across the Hampshire and Isle of Wight geography. The Trust is rated 'good' by the Care Quality Commission and reported operating income of £258.1m and a surplus of £0.1m in 2021/22.
- Southern Health NHS Foundation Trust provides community, mental health and learning disabilities services across Hampshire, mental health services in Southampton and specialist and forensic mental health services regionally and nationally. The Trust is rated 'requires improvement' by the Care Quality Commission and reported operating income of £401.7m and a surplus of £0.1m in 2021/22.
- Isle of Wight NHS Trust is the only integrated provider of acute, community, mental health, learning disability and ambulance services in England. Only the Trust's mental health, learning disability and community services are in scope for this Strategic Case. The Trust is rated 'good' by the Care Quality Commission and reported operating income of £285.1m and an overall breakeven position in 2021/22. Costs related to community, learning disability and mental health services were £55.4m in 2021/22.

Chapter summary (continued)

- Sussex Partnership NHS Foundation Trust provides services for people with mental health needs and learning disabilities across Sussex and a range of specialist services across southeast England. Only the Trust's child and adolescent mental health services in Hampshire are in scope for this Strategic Case. The Trust is rated 'good' by the Care Quality Commission and reported operating income of £431.4m and a surplus of £0.5m in 2021/22. The contract value for the Hampshire child and adolescent mental health services was c. £23m in 2021/22.
- The revised financial regime that was implemented during the COVID-19 pandemic resulted in the Trusts delivering breakeven or small surplus positions in 2020/21 and 2021/22. However, Southern, Solent and the services proposed to transfer from IoW and Sussex Partnership are forecasting underlying deficits in 2022/23 that total £46.0m and all providers are currently reviewing their underlying financial positions as part of planning for 2023/24. Further details on the financial position of the Trusts and the HIOW system are set out in chapter 7.
- The four Trusts are already collaborating to address the most significant clinical risks in community and mental health services, building on historic and existing collaboration including informal mutual support, development of shared pathways and membership of provider collaboratives.

Hampshire and Isle of Wight system

2.1 The ICS is one of the largest health and care systems in the country covering a resident population of 1.9 million people across Hampshire (except north-east Hampshire which is part of the Frimley ICS), Southampton, the Isle of Wight and Portsmouth. The ICB was formed in July 2022 from two Clinical Commissioning Groups (CCGs): Hampshire, Southampton and the Isle of Wight CCG[1] and Portsmouth CCG.

2.2 The area comprises substantial urban settlements (including Southampton, Portsmouth, Winchester and Basingstoke) as well as large rural areas interspersed with market towns and villages. It also includes the relatively isolated island population of the Isle of Wight with no fixed link to the mainland and at times limited, or no, access by ferry. Delivering services to a geographically isolated and sub-scale population of 140,400 island residents has led to significant challenges providing clinically and financially sustainable services.

2.3 Ethnic diversity varies across the HIOW footprint with a significantly more diverse population in Southampton and Portsmouth. Like many areas across the UK, there are significant variations in health needs across Hampshire and Isle of Wight, with the most vulnerable people typically suffering poorer health, dying younger and experiencing poorer access to health and care services.

2.4 There are also coastal communities in southern Hampshire and the Isle of Wight. National data shows that life expectancy, healthy life expectancy and disability-free life

[1] Hampshire, Southampton and the Isle of Wight CCG was created in 2021 following a merger of six CCGs: Southampton City, West Hampshire, South East Hampshire, Fareham and Gosport, the Isle of Wight and North Hampshire.

expectancy are all lower in coastal areas. Coastal communities face a disproportionately high burden of ill health, particularly heart disease, diabetes, cancer, chronic obstructive pulmonary disease and mental health.

2.5 Health and care services in Hampshire and Isle of Wight are struggling to meet unprecedented increases in demand and the needs of a rising number of people of all ages with complex or long-term physical and mental health conditions and learning disabilities. The challenges facing services are exacerbated by difficulties recruiting sufficient numbers of people into the health and care workforce. In addition, the ICS is operating with a financial deficit. All partners recognise that neither the quality, service or financial challenges will be resolved through stretching organisationally based plans and there is a need to change the way that services are delivered to the local population in order to support healthier lives and deliver high quality care in a sustainable way.

Overview of mental health, learning disability and community services in Hampshire and Isle of Wight Integrated Care System

2.6 There are three main NHS providers of community[2], mental health and learning disability services in the ICS: Solent, Southern and IoW. There are also providers of specific services from outside the ICS, including Sussex Partnership which provides community CAMHS and children's eating disorder services in Hampshire and Dorset HealthCare which provides NHS Talking Therapies for Anxiety and Depression[3] in Southampton (with an annual contract value of c.£2m).

2.7 The ICS covers four upper tier local authorities, 10 district and borough councils, three acute trusts, one ambulance trust, two community and mental health trusts (Solent and Southern) and one integrated trust providing acute, mental health, community and ambulance services (IoW), as well as primary care and voluntary, community and social enterprise (VCSE) partners.

2.8 On average, there are over 450,000 referrals each year for community and mental health services in the ICS and the ICB budget for all mental health and community services in 2022/23 was £804m.

2.9 Alongside these NHS community, mental health and learning disability service providers, community-based services are also delivered by c.154 GP practices within 42 Primary Care Networks (PCNs), four large local authorities (Portsmouth City Council, Hampshire County Council, the Isle of Wight Council and Southampton City Council) and an active VCSE sector.

2.10 Mental health service provision is fragmented across care pathways, particularly CAMHS, eating disorders and learning disabilities, and across geographies. This fragmentation results in multiple hand-offs and different access requirements. Figure 1 below shows mental health services by NHS provider across the ICS:

[2] Throughout this strategic case the term 'community services' is used to refer to physical health community services (as opposed to mental health community services).
[3] In January 2023 Improving Access to Psychological Therapies (IAPT) services were renamed as NHS Talking Therapies for Anxiety and Depression, following a public consultation and are referred to by their new name throughout this document.

Figure 1: Mental health and learning disability services by NHS provider in Hampshire and Isle of Wight Integrated Care System

Mental health service	Isle of Wight	Portsmouth	South East Hampshire	Southampton	South West Hampshire	North and Mid Hampshire
CAMHS	IoW	Solent	Sussex	Solent	Sussex	Sussex
CAMHS inpatient	Southern					
Eating disorder OP (children's – 0-17)	IoW	Solent	Sussex	Solent	Sussex	Sussex
Perinatal	IoW	Southern				
Adult Inpatient	IoW	Solent	Southern			
Eating disorder IP (adult)	Southern					
Eating disorder OP (adult)	IoW	Southern				
IAPT	IoW (*Isle Talk*)	Solent (*Talking Change*)	Southern / Solent Mind (*italk*)	Dorset HealthCare – (*Steps2Wellbeing*)	Southern / Solent Mind (*italk*)	Southern / Solent Mind (*italk*)
Community MH / crisis teams	IoW	Solent	Southern	Southern	Southern	Southern
Older persons MH services	IoW	Solent	Southern	Southern	Southern	Southern
Acute liaison	IoW	Southern				
Specialist and forensic	Southern					
Learning Disabilities & Autism	IoW	Solent	Southern			
Complex adults MH Therapy	IoW - ECT	Southern – ECT and rTMS				
Crisis	IoW	Solent	Southern	Southern (*The Lighthouse*)	Southern	Southern
Urgent MH helpline (NHS 111)	IoW	Solent	Southern			
Place of safety	IoW	Solent	Southern (Parklands, Antelope and Elmleigh)			
EIP	IoW	Solent	Southern			

2.11 There are three main NHS providers of community services: Solent, Southern and IoW[4], alongside the wider landscape of community service provision in local authorities, primary care and VCSEs. Similarly to mental health, but to a lesser extent, there is fragmentation of service delivery across different providers, with the exception of children's services where there is significant fragmentation. Figure 2 below shows the community services by NHS provider across the ICS:

[4] In addition, Hampshire Hospitals NHS Foundation Trust provides inpatient rehabilitation at Andover War Memorial Hospital.

Figure 2: Community services by NHS provider in Hampshire and Isle of Wight Integrated Care System

Community health service	Isle of Wight	Portsmouth	South East Hampshire	Southampton	South West Hampshire	North and Mid Hampshire
Adult Physical Health						
Community inpatients	IoW	Solent	Southern	Solent	Southern	Southern
Community – Integrated teams • **Urgent care** • **Frailty**	IoW	Solent	Southern	Solent	Southern	Southern
• **Falls**	IoW	Solent	Southern	Solent	Southern	Southern
• **Pulmonary rehab**	IoW	Solent	Solent	Solent		Solent
• **Palliative and End of Life**	IoW	Solent	Southern	Solent	Southern	Southern
• **MSK and Pain management**	IoW	Solent	Solent	Solent	Southern	Southern / HHFT
• **Tissue Viability**	IoW	Solent	Southern	Solent	Southern	Southern
• **Long Covid**	IoW	Solent	Southern	Solent	Southern	Southern
• **Sexual health services**	Solent	Solent	Solent	Solent	Solent	Solent
• **Diagnostics**	IoW	Portsmouth	Southern	Solent	Southern	Southern
• **Speech and Language Therapy**	IoW	Solent	Solent	Solent	Hobbs	Hobbs
Children's Physical Health (excluding CAMHS & Learning Disabilities)						
Health visiting and School Nursing (LA funded)	Solent	Solent	Southern	Solent	Southern	Southern
Children's Health Information Service	Southern	Southern	Southern	Southern	Southern	Southern
School Immunisations	Solent	Solent	Southern	Solent	Southern	Southern
Children's Community Nursing	Solent	Solent	Solent	Solent	Solent	HHFT
Children's Continuing Care	N/A	Various providers – commissioned according to need				
Community paediatrics and Therapies	Solent	Solent	Solent	Solent	Solent	Solent
Specialist Children's Home Health – Swanwick lodge	N/A	N/A	Southern	N/A	Southern	Southern

2.12 This complex system has developed through decades of organisational change, fragmented commissioning[5] and competition resulting in services moving between providers over time.

System performance

2.13 Latest published performance against mental health trajectories and targets is as set out in Figure 3 with supporting commentary in Figure 4. Key performance and activity metrics for the Trusts are detailed in appendix 1.

[5] Mental health and community services for the population of HIOW ICS are commissioned by a number of bodies including NHSE, HIOW ICB and local authorities.

Figure 3: HIOW ICS latest published performance against mental health trajectories and targets as at January 2023

Programme	No Wrong Door				Crisis Care		Children and Young People			Other LTP Delivery Ambitions			
Metric	Physical Health Check for SMI	Early Intervention in Psychosis Access Rate	Individual Placement Support*	Access to core CMH Services for Adults and Older Adults with SMI	AMH Inpatients receiving a follow up within 72hrs of discharge	OAP bed days (inappropriate - month)*	Access to CYPMH Services	CYP Eating Disorder waiting times**		IAPT Access Rate	Perinatal Access	Dementia Diagnosis Rate	Data Quality Maturity Index Score
								Urgent	Routine				
Latest available period	Q3***	Oct-22	Jun-22	Oct-22 (rolling 12 months data)	Oct-22	Oct-22	Oct-22 (rolling 12 months data)	Nov-22 (rolling 12 months local data)		Oct-22	Nov-22*** (cumulative YTD)	Oct-22	Sep-22
National - Target	10,400 by Q4	60.0%	1,379 by end of Q4	14,634 by Q4	80.0%	0	21,870 by end Oct-22	95.0%	95.0%	27,856 by end Oct-22	1,273 by end Nov-22	66.7%	90.0%
HIOW ICS - Target	6,000 by end Q3	60.0%	119 by end of Q1	12,674 by end Oct-22	80.0%	0	21,870 by end Oct-22	92.5%	78.9%	27,856 by end Oct-22	992 by end Nov-22	61.7%	90.0%
HIOW ICS - Performance	5,977	78.3%	248	10,860	78.1%	0	21,970	72.6%	73.1%	19,650	895	61.5%	73.9%

**Local data used as reporting issue with NHS Digital* Data

***Percentages have been produced using local data submitted to the CCG by Providers with Solent providing data on a quarterly basis*

****Provisional data*

Figure 4: HIOW ICS Mental Health Performance Summary as at January 2023

Programme 1: No Wrong Door

- **Severe Mental Illness (SMI) – Physical Health Checks -** There was continued improvement across HIOW ICS in the number of people with a SMI receiving a physical health check through 2021/22. Primary care delivery 5,977 physical health checks in Q3 against a local target of 6,000. The project team continue to work on improving the efficiency of reporting to ensure all activity within primary care is captured, but also to raise awareness of the important benefits of health checks for people with a SMI.
- **Early Intervention in Psychosis (EIP) Access Rate -** The ICS has consistently exceeded the 60% target for people experiencing first episode psychosis to be treated with NICE recommended package of care within two weeks of referral.
- **Individual Placement Support -** At the end of June 2022, 248 people had accessed IPS services across the ICS cumulatively through 2022/23, as reported by all local providers, which delivered the Q2 trajectory. The local target for HIOW ICS is to reach 680 people this year, however there is some risk in achieving this year end target due to delays in mobilisation of the new Hampshire service. The performance team is also working with ICS colleagues to establish better reporting of IPS services.
- **Access to core CMH services –** This target was updated by NHSE in May 2022 to increase contacts expected by the ICS from 13,260 to 14,634. It is unlikely that this increased target will be met. Based on the original target given to the ICS, services are delivering 86% of expected contacts. We continue to work with our provider and PCN colleagues regarding reporting to NHS Digital as there are currently MHSDS data issues for this metric in relation to contacts seen in PCNs leading to an underreporting of activity.

Programme 3: Children and Young People

- **Access to CYPMH Services -** There had been steady improvement against the trajectory over the last 12 months, with 21,970 CYP accessing mental health services between November 2021- October 2022 against a target of 21,870.
- **Children and Young People Eating Disorder (CYP ED) - Urgent referrals -** There has been a slow but steady improvement in the number of CYP ED being seen within the 1 week target for an urgent referral over the last 12 months. November's performance was 72.6% against a local recovery trajectory target of 92.5% (to achieve by end of Q3.) Performance is reported as a 12 month rolling figure (November 2022 figure being December 2021 to November 2022) and therefore poor performance below 50% prior to February 2022 continues to impact on our performance score now.
- **Children and Young People Eating Disorder (CYP ED) - Routine referrals -** The number of CYP being seen within the 4 week timeframe for a routine referral was 73.1% at the end of November 22, this follows gradual recovery over recent months after a dip to 65.7% in May 22. Again, this metric is calculated as a rolling 12 month figure, but since performance has not fallen below 65% in the last year we are not fighting historic performance in the same way as for the Urgent measure.

Programme 2: Crisis Care

- **Adult Mental Health Inpatients receiving a follow up within 72hrs of discharge** - HIOW ICS has seen a small dip in performance to 78.1% against a target of 80% of patients receiving timely follow up. Solent NHS Trust are investigating this and confirmed that all patients are aimed to be called within 48 hours.
- **Out of Area bed days (inappropriate - month)** - Across HIOW ICS, Trust have reported 0 inappropriate OAP bed days for October 2022. We continue to work with our provider colleagues to ensure accurate reporting to NHS Digital as there are currently MHSDS data issues for this metric.

Programme 4: Other LTP delivery ambitions

- **IAPT Access Rate -** In October 2022, 2,780 people accessed IAPT services, 1,466 below target for the month. The monthly trajectory target is set in line with our commitment to provide access to 51,204 people by end of 2022/23. Referrals to the service are down which has been attributed to; early intervention in primary care settings and robust third sector partner support impact; workforce challenges across all services e.g. step 2 consultants training to be step 3 consultants and higher sickness levels. All Providers are carrying out actions to mitigate against challenges.
- **Perinatal Access -** HIOW ICS has consistently met or been on the cusp of local targets and by the end of November 2022, 895 women had accessed specialist community perinatal services, against a local target of 992 for November 2022. This can be attributed to the service increasing the number of face to face and video contacts and reducing the number of telephone contacts which are not counted against access targets.
- **Dementia Diagnosis Rate (DDR) -** In October 2022, 15,969 people received a dementia diagnosis across HSI ICS which was 214 people short of the planned target. Due to a change in the methodology of data construction, the prevalence and number of people diagnosed have dropped and the resulting performance is 61.5%, 0.2% short of our local target and marginally behind national performance of 62.6% for DDR.
- **Data Quality Maturity Index Score (DQMI) -** Against a 2021/22 target of 80%, HIOW ICS consistently scored circa 78-80% over the last 12 months. The target for 2022/23 increased to 90% from April 2022, so the ICS is now falling below target at 73.9% for September 2022. We are working closely with our service provider performance colleagues to understand reporting issues and improve the quality of data reported to NHS Digital.

2.14 An equivalent summary of ICS performance for community services does not currently exist. Benchmarking of community services performance is primarily between providers across the south east region. Appendix 1 details key performance and activity metrics for the Trusts.

Solent NHS Trust

2.15 Solent is the main community and mental health provider for the 230,000 people living in Portsmouth city and the main provider of community services for the 250,000 people living in Southampton. It also provides some specialist services across the Hampshire and Isle of Wight geography. Solent has 42 mental health, 113 community and 26 virtual ward beds. Solent's services are primarily commissioned by HIOW ICB, NHSE, Hampshire County Council, Southampton City Council and Portsmouth City Council. All services provided by Solent are in scope for this Strategic Case.

2.16 The Trust is in Segment 2 of the NHS Oversight Framework[6].

2.17 The Trust was inspected by the Care Quality Commission (CQC) in 2018 and was rated 'good' overall, including an 'outstanding' rating against the caring domain. The Trust was due to be re-inspected in early 2020/21, however, due to COVID-19 all routine inspections were suspended by the CQC.

2.18 As at 31 March 2022, the Trust employed 5,426 staff, equivalent to 3,527 full-time equivalents (FTEs). The Trust's 2021 Annual NHS Staff Survey results reflect the priority it has put on making Solent a place where everyone counts and with a compassionate culture at its core - it scored highest on the new compassionate and inclusive theme and sustained its employee engagement score of 7.4.

2.19 In 2021/22, the Trust reported operating income of £258.1m and a surplus of £0.1m. The Trust is forecasting delivery of a small surplus (£0.4m) in 2022/23, however the underlying position is a deficit of £13.9m[7].

Southern Health NHS Foundation Trust

2.20 Southern provides mental health and learning disability services to the 1.65 million people living in Southampton and Hampshire and a range of specialised mental health services (such as forensic mental health units) for a regional and national population. Southern also provides community services for 1.2 million people in Hampshire. It is one of the largest providers of mental health and community services in England. Southern has 459 mental health, 228 community and 140 virtual ward beds. Southern's services are primarily commissioned by HIOW ICB, NHSE, Adult Secure and CAMHS Provider Collaboratives and Hampshire County Council. All services provided by Southern are in scope for this Strategic Case.

2.21 The Trust is in Segment 3 of the NHS Oversight Framework. Enforcement undertakings relating to the CQC warning notice issued in 2016 (see paragraph 2.22 below) were accepted by NHS Improvement in 2018. In March 2023 NHS England

[6] Segments are defined in Table 2 on page 13 of the Oversight Framework at https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf.

[7] All providers are currently reviewing their underlying financial positions as part of planning for 2023/24.

issued a compliance certificate confirming that the Trust has demonstrated compliance against each component of the enforcement undertakings.

2.22 The Trust's current overall CQC rating is 'requires improvement'. In 2016 the CQC issued a warning notice to the Trust after the publication of a report which highlighted failures to investigate and learn from patient deaths. The report was commissioned by NHSE following the death of 18 year old Connor Sparrowhawk at Southern's short term assessment and treatment unit in Oxfordshire in July 2013.

2.23 In February 2020, NHS England/Improvement published an independent report into the care of five patients who died whilst under the care of Trust services between 2011 and 2015, as well as the subsequent investigations and liaison with the patients' families. The report, authored by Nigel Pascoe QC, found significant failings in the Trust's response at the time (prior to the changes in the leadership of the Trust from 2017) and recommended a public investigative process to determine the extent to which the Trust had improved to date.

2.24 A series of public hearings took place throughout March and April 2021, chaired by Nigel Pascoe QC, and a final report was published in September 2021. The report made a number of recommendations to help the Trust achieve the highest possible standards and get things 'right first time'. The Trust accepted these recommendations and developed an action plan. In September 2022 the ICB reviewed evidence submitted by the Trust and concluded that all recommendations were either on track to be delivered (25) or completed (12).

2.25 In February 2022, following a series of inspections, the CQC published a report and the Trust's overall rating changed from 'good'[8] to 'requires improvement'. However, inspectors did find evidence of progress and the Trust retained a rating of 'good' in the well-led, caring and responsive domains (three of the five domains).

2.26 As at 31 March 2022, the Trust employed 6,532 staff, equivalent to 5,591 FTEs. The Trust's Annual 2021 NHS Staff Survey results were in line with the national average (engagement score of 7.0) but the Trust has seen some deterioration in scores.

2.27 In 2021/2022, the Trust reported operating income of £401.7m and a surplus of £0.1m. In 2022/23 the Trust is forecasting delivery of a £1.5m surplus, however the underlying position is a deficit of £23.8m[9].

Isle of Wight NHS Trust

2.28 IoW provides acute, community, mental health, learning disability and ambulance services in England. The Trust provides services to an isolated, offshore population of 140,400, with no fixed link to the mainland. Compared to England, the Isle of Wight has an older population structure10 with a greater proportion of the population aged 50 years and over and a lower proportion of working age and young population groups. Only the Trust's mental health, learning disability and community services are in scope

[8] In January 2020 the CQC rated Southern as 'good' overall which demonstrated the significant progress made by the Trust and the level of care provided by the staff. At the time 90% of the Trust's services were rated as 'good' or 'outstanding'.
[9] All providers are currently reviewing their underlying financial positions as part of planning for 2023/24.
[10] The Isle of Wight has a significantly older population than England as a whole with 37% of residents are aged over 60 years compared to 24% nationally.

for this Strategic Case (for further detail on the broader changes proposed as part of the Isle of Wight sustainability programme refer to paragraph 8.17).

2.29 Community services are delivered in patients' homes, in a range of primary and community settings and from St Mary's Hospital (which has a 14 bed community unit). The Trust also has 26 virtual ward beds. The Trust's community services include district nursing, community nursing teams, musculoskeletal (MSK), podiatry, acute therapies, specialist nursing, prosthetics and orthotics, as well as inpatient rehabilitation and community post-acute stroke wards. The Trust's mental health services provide inpatient and community based mental health care. There are 34 mental health beds and the community mental health team supports a caseload of 900 patients. The Trust's portfolio also includes specialist community CAMHS, mental health support teams, early intervention in psychosis service, a memory service, community rehabilitation and reablement service, dementia outreach service, talking therapies for anxiety and depression and community learning disability service.

2.30 The small population and physical remoteness of the Isle of Wight means that the services provided by the Trust are sub-scale and this has led to significant challenges providing clinically and financially sustainable healthcare. In 2016 the CQC inspected the Trust and issued an overall rating of 'inadequate'. Mental health services were rated 'inadequate' and community services rated 'requires improvement'. The Trust was then placed in special measures for quality. In 2019, due to deterioration in financial performance, the Trust was also placed in special measures for finance. In 2018/19 reinspection by the CQC resulted in an overall Trust rating of 'requires improvement'.

2.31 As a result of significant internal improvements and the development of partnerships with mainland providers, including with Solent, in the most recent CQC inspection, in July 2021, further improvement was evident and the Trust received an overall rating of 'good'. Community services were rated 'good' overall and 'outstanding' for the caring domain. Mental health services were rated 'good' overall for all services inspected, although certain domains for individual mental health services were rated 'requires improvement', for example mental health crisis services were rated 'requires improvement' on the safe domain and the overall rating for these services remained 'requires improvement'.

2.32 Following a sustained period of service and financial improvement, including significant benefits from working in partnership with other NHS providers, the Trust was removed from quality special measures in September 2021 and financial special measures in May 2022 (and moved from Segment 4 of the NHS Oversight Framework to Segment 3).

2.33 The Mental Health and Learning Disabilities Division employs 490 staff on an FTE basis and reported a staff engagement score of 7.0 in the 2021 Annual NHS Staff Survey. The Community Division employs 502 staff on an FTE basis and reported a staff engagement score of 7.2 in the 2021 Annual NHS Staff Survey.

2.34 In 2021/2022, the Trust reported operating income of £285.1m and an overall breakeven position[11]. The Trust's costs related to community and mental health

[11] The revised financial regime that was implemented during COVID-19 resulted in the Trust delivering a breakeven position in 2020/21 and 2021/22. Further details on the financial position of the Trusts and the HIOW system are set out in chapter 7.

services were £55.4m in 2021/22. In 2022/23 the Trust's community and mental health services segment is forecasting a deficit of £2.9m and an underlying £6.0m deficit[12].

Sussex Partnership NHS Foundation Trust

2.35 Sussex Partnership is a large NHS organisation that provides services for people with mental health problems and learning difficulties across Sussex and a range of specialist services across southeast England. Only the Trust's CAMHS services in Hampshire are in scope for this Strategic Case.

2.36 The Trust is in Segment 2 of the NHS Oversight Framework.

2.37 The Trust's overall CQC rating is 'good', with an 'outstanding' rating in the caring domain, based on the most recent inspection in January/February 2019. The CAMHS service is rated in line with the overall Trust rating.

2.38 The Trust employs 5,651 staff on an FTE basis, of which 450 (394 FTEs) provide CAMHS services in Hampshire. The Trust's Annual 2021 NHS Staff Survey showed a score of 7.0 (7.3 for Hampshire CAMHS) on staff engagement.

2.39 In 2021/2022, the Trust reported operating income of £431.4m and a surplus of £0.5m. The contract value for the Hampshire CAMHS service provided by Sussex Partnership was c. £23m in 2021/22. In 2022/23 the Trust is forecasting a deficit of £0.4m and an underlying £2.4m deficit for the Hampshire CAMHS service[13].

2.40 The transferring services represent c. 5% of operating income and c. 7% of the workforce. The transfer of Hampshire CAMHS services is not expected to impact the clinical and financial sustainability of the Trust.

Existing collaboration

2.41 The four Trusts[14] are already collaborating to address the most significant clinical risks in community and mental health services. Ten clinical priorities have been identified, each with an executive director who takes system-wide responsibility for leading the workstream, supported by senior clinical and operational leads.

Mental health and learning disabilities priorities	Community services priorities
• Children and young people's mental health services • Neurodiversity pathways • Older people's mental health services • Adult mental health acute and crisis services	• Community rapid response services • Community hospitals and community inpatient rehabilitation • Community frailty • Community health specialist services and long-term conditions

[12] All providers are currently reviewing their underlying financial positions as part of planning for 2023/24.
[13] Sussex Partnership and the ICB are working to establish the recurrent financial position of the Hampshire CAMHS service. The underlying position cited here reflects Sussex Partnership's view of their position in 2022/23 after non-recurrent funding. The recurrent deficit from future years arising from cost inflation and other factors is expected to be significantly smaller.
[14] Solent, Southern, IoW and Sussex Partnership – hereafter referred to as 'the Trusts'.

• Community mental health framework ('no wrong door' programme)	• Supporting the sustainability and integration of primary care

2.42 These transformation workstreams are overseen by a Clinical Delivery Group which meets monthly and is jointly chaired by the Medical Directors of Solent and Southern. The outputs of each meeting are shared with each Trust and also widely cascaded throughout the ICS and ICB. Further detail on the work of the Clinical Delivery Group is set out in chapter 5.

2.43 The work of the Clinical Delivery Group builds on existing collaboration between the Trusts which includes:

- Informal mutual support such as provision of external investigators and peer support in senior roles.
- Joint work across Southern, Solent and primary care and acute partners to take on a struggling GP practice in Basingstoke to sustain local primary care.
- Strong partnership working during COVID-19, particularly on the Solent-led community vaccine programme and the urgent care and discharge work.
- Children's Health Information Service delivered by Southern as part of Hampshire Healthy Families in partnership with Barnados on behalf of the system.
- Development of shared pathways:
    - Specialist services delivered by Southern across the ICS including adult, LD and CAMHS secure services, perinatal service including mother and baby unit and CAMHS Tier 4;
    - Electro-convulsive therapy (ECT) services delivered by Southern across Southern and Solent services and recent development of new shared role across ECT services in Southern and IoW in order to develop a HIOW-wide service;
    - Community eating disorder services delivered by Southern across Southern and Solent geographies;
    - Shared community rehabilitation consultant role across Solent and IoW;
    - 111 mental health triage service delivered by Southern for all mental health trusts in the ICS; and
    - Shared psychiatry on call arrangements in some areas between Solent and Southern.
- Membership of provider collaboratives:
    - CAMHS Tier 4 – Sussex Partnership is the lead provider for services in HIOW and Dorset and the four Trusts are all members of the provider collaborative;
    - Adult eating disorder services – Dorset HealthCare is the lead provider for services in HIOW and Dorset and the four Trusts are all members of the provider collaborative; and

- Secure services – Oxford Health NHS Foundation Trust is the lead provider for services in HIOW and the Buckinghamshire, Oxfordshire and Berkshire West ICS and Southern, Solent and IoW are all members of the provider collaborative.

2.44 In addition, Solent and IoW have been working in partnership since September 2019, initially focussed on mental health and learning disability services, but later extended to include community services. Together the Trusts co-produced and commenced implementation of an Isle of Wight Mental Health and Learning Disability Strategy 'No Wrong Door, 2020-2025' which responded to the Community Mental Health Framework for Adults and Older Adults[15]. This partnership work provided opportunities for mutual learning and support, including through the development of staff peer networks, and provided a strong foundation for the joint work across the whole geography through the Clinical Delivery Group which is described in more detail in chapter 5.

2.45 There is also a long history of wider collaboration with other system partners. This includes:

- HIOW ICS Mental Health Partnership Board which has been in place since 2017/18 and brings together Solent, Southern, IoW, Sussex, the ICB, primary care and voluntary sector partners to determine the strategic funding and prioritisation of mental health services growth and improvement;
- work with Hampshire Constabulary and local authority partners in development of shared mental health crisis pathways; and
- collaborative working with people with lived experience and VCSE organisations in order to develop an ICB-wide approach to coproduction and to establish a peer worker network.

[15] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

3 Strategic rationale

Chapter summary

- This chapter describes the strategic context and the rationale for creating a new Trust for all community, learning disability and mental health services across Hampshire and Isle of Wight Integrated Care System.
- The NHS Long Term Plan, published in 2019, sets out the strategic priorities for the NHS and makes specific commitments in respect of mental health, learning disabilities, autism and community services.
- National policy has continued to focus on integration and collaboration across health and social care at both a system and place-based level. The Health and Social Care Act 2022 put Integrated Care Systems on a statutory footing and established Integrated Care Boards.
- Hampshire and Isle of Wight Integrated Care System brings together health, care, public sector and voluntary partners to keep people as healthy and independent as possible and provide swift access to efficient, high quality care for those who need it.
- The shared aims of the system are to: improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money; take a more community-centred approach to wellbeing; and support broader social and economic development.
- The Integrated Care Partnership published its Partnership Strategy in December 2022 and identified five priorities for joint strategic focus: children and young people, mental wellbeing, good health and proactive care, people/workforce and digital and data.
- Each of the four Places in the Integrated Care System (Hampshire, Isle of Wight, Portsmouth and Southampton) identified priority areas for their populations that informed the Partnership Strategy, in recognition of the fact that most work undertaken to tackle health inequalities and improve service delivery and health outcomes will be delivered locally.
- The Integrated Care Board is responsible for planning and delivering the NHS's contribution to the Partnership Strategy through the development of the five year Joint Forward Plan with system partners.
- Creation of the new Trust is one of the key strategic programmes that the Integrated Care System is progressing in order to achieve its strategic goals. The Integrated Care Board has confirmed its support for this programme.

Chapter summary (continued)

- In April 2022 an independent review of community and mental health services commissioned by the Integrated Care System made five key recommendations:
  - A new Trust should be established to oversee delivery of all community and mental health services across the HIOW system;
  - A review of community physical health beds should be undertaken;
  - A system-wide clinical strategy for community and mental health services should be developed;
  - A strategy for Place and Place-based leadership should be developed; and
  - Funding arrangements for community and mental health services should be approached from a more strategic level.

  The ICB formally endorsed these recommendations in October 2022.
- The Trusts have identified four key challenges (the 'case for change') that they believe cannot be addressed by any one organisation in isolation:
  - Variation in practice and fragmented pathways and services adversely impact health and wellbeing outcomes;
  - Significant increases in demand are putting complex models under greater pressure and people are not getting the care they need at the right time and in the right setting;
  - Recruitment and retention challenges are resulting in workforce gaps which impact on the effectiveness and quality of services; and
  - Financial challenges are expected to continue to increase and Isle of Wight services are not financially (or clinically) sustainable.
- Responding to the case for change will require significant transformation. The four Trusts have come together to accelerate the clinical collaboration to address the most significant clinical risks in our community and mental health services (this is described in more depth in chapter 5). However, the Trusts have concluded that it is not possible to fully tackle the issues identified in the case for change, overcome the fragmentation of care delivery and ensure greater consistency of outcomes across the Hampshire and Isle of Wight system within the current organisational model and that organisational changes are required to exploit the opportunities for better care.

National strategic context

3.1 Published in 2019, the LTP[16] sets out the strategic priorities for the NHS, aiming to address concerns with regards to funding, staffing, increasing inequalities and pressures from an ageing population.

3.2 The LTP defines key principles for mental health, learning disabilities and autism and community services across the whole NHS, including:

- increasing funding for mental health services by more than £2.3bn per annum;

[16] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

- supporting the development of ICSs to encourage collaboration between providers, particularly in primary and community care settings;
- focusing efforts on illness prevention and maintaining health and wellness;
- investing in workforce recruitment, training and retention; and
- delivering value for money through reducing duplication and improving procurement to direct more funding to the delivery of frontline mental health services.

The relevant commitments of the LTP are set out in appendix 2.

3.3 Since the publication of the LTP, national policy has continued to focus on integration across health and social care. The White Paper **Joining up care for people, places and populations**[17], published in February 2022, sets out the government's proposals for health and care integration in England. The paper proposes strengthening place-based partnerships and greater workforce integration.

3.4 The 2022 **Health and Social Care Act**[18] introduced new legislative measures in England that aim to deliver joined-up care for people who rely on multiple different services, underpinned by a 'duty to collaborate' on providers and commissioners. The measures in the Act follow three core themes. Firstly, the Act removes barriers which stop the system from being truly integrated, with different parts of the NHS working better together, alongside local government, to tackle the nation's health inequalities. Secondly, the Act reduces bureaucracy across the system, seeking to remove barriers which make sensible decision-making harder and distract staff from delivering what matters – the best possible care. Lastly, the Act aims to ensure appropriate accountability arrangements are in place so that the health and care system can be more responsive to both staff and the people who use it.

3.5 The Act put ICSs on a statutory footing from 1 July 2022 with the establishment of ICBs as legal entities and Integrated Care Partnerships (ICPs) as statutory committees of ICSs. ICSs bring together NHS commissioners and providers with local authorities, the voluntary sector and public representatives to collectively plan and co-ordinate health and care services for their respective populations.

3.6 ICSs need to respond to a shift from episodic treatment of acute illnesses towards joined-up support for an ageing population. The purpose of ICSs is, therefore, to deliver a quadruple aim of:

- Improving outcomes in population health and healthcare;
- Tackling inequalities in outcomes, experience and access;
- Enhancing productivity and value for money; and
- Supporting broader social and economic development.

3.7 ICBs have taken on the responsibilities previously held by CCGs, as well as wider integration roles.

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17 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1055687/joining-up-care-for-people-places-and-populations-web-accessible.pdf

18 https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted

3.8 **Next steps for integrating primary care: Fuller Stocktake report**[19] was published in May 2022 and describes a vision for integrating primary care, improving the access, experience and outcomes for our communities, centred around three essential offers:

- streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it;
- providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions; and
- helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

3.9 The policy frameworks also stipulate the development of **provider collaboratives** and set an expectation that all acute, specialist and mental health NHS trusts and foundation trusts would be part of at least one provider collaborative by April 2022. Further guidance[20] published in August 2021 outlines expectations for how providers should work together as provider collaboratives, principles to support local decision-making, and function and form options that systems may consider.

Hampshire and Isle of Wight Integrated Care Partnership Strategy

3.10 The ICS brings together health, care, public sector and voluntary partners to keep people as healthy and independent as possible and provide swift access to efficient, high-quality care for those who need it.

3.11 In December 2022, the Integrated Care Partnership (ICP) published its interim Partnership Strategy to codify strategic aims, priorities and areas of focus. The ICS worked with system partners, local communities, service users and public representatives and other stakeholders to develop the Partnership Strategy, using data and information and other available evidence.

3.12 Within the Partnership Strategy, the shared aims of the ICS are to:

- improve outcomes in population health and healthcare;
- tackle inequalities in outcomes, experience and access;
- enhance productivity and value for money;
- take a more community-centred approach to wellbeing; and
- support broader social and economic development.

[19] https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

[20] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf

3.13 To achieve these aims in the medium-term, the Partnership Strategy sets out five priorities and key areas of joint focus[21]:

- Children and young people
  - Improve access and mental health outcomes for children and adolescent mental health services
  - Co-locate services to enable a family-based approach
  - Work with schools and other key partners on prevention and early intervention
  - Further develop a joint children's digital strategy
- Mental wellbeing
  - Address inequalities in access and services
  - Better connect people to avoid loneliness and social isolation
  - Promote emotional wellbeing and prevent psychological harm
  - Improve mental health and emotional resilience for children and young people
  - Focused work on suicide prevention
  - Support the mental health and wellbeing of staff
- Good health and proactive care
  - Provide support in community settings for healthy behaviours and mental wellbeing
  - Ensure equal importance is given to mental wellbeing and physical health
  - Minimise the possible health and wellbeing impact of cost of living pressures
  - Provide proactive, integrated care for people with complex needs
  - Support healthy ageing and those people living with the impact of ageing
  - Combine resources around groups of greatest need
- People / workforce
  - Evolve workforce models to build capacity to meet demand
  - Ensure the availability of the right skills and capabilities
  - Ensure people who provide services are well supported and feel valued
- Digital and data

[21] This section presents the Partnership Strategy in summary form, in the context of mental health, learning disabilities and autism, and community services so may not include elements more relevant to other services.

- Empower people to use digital solutions
- Develop joint data, information and insights
- Improve information sharing
- Continue to improve digital solutions

3.14 Within the ICS, there are four local Places: Hampshire, Isle of Wight, Portsmouth and Southampton. Each Place has identified the needs and priorities for its population and this has informed the development of the Partnership Strategy.

3.15 Most of the work to tackle health inequalities and improve service delivery and health outcomes will be delivered locally. All four Places have common themes to their respective local health and wellbeing strategies:

- Children and young people
  - Work with parents, families, schools and early years settings
  - Improve emotional wellbeing and mental health
  - Reduce inequalities
- Living well and improving lifestyles
  - Encourage healthier lifestyle choices and healthy approaches in schools and organisations
  - Promote mental wellbeing and reduce mental ill health
  - Promote active travel and creating a greener, cleaner environment
- Connected communities
  - Promoting joined up approaches across providers
  - Building community networks
  - Building on social capital
- Housing
  - Ensure residents are able to live in healthy and safe homes
  - Ensure home environments enable people to stay well
  - Ensure that communities and families are not adversely impacted through poverty

3.16 The ICB and system partners (including NHS providers) are developing their first five year Joint Forward Plan (JFP). The JFP will build on the Partnership Strategy and the local health and wellbeing strategies for each Place. Consultation on the draft JFP will commence by the end of March 2023 and the JFP will be finalised and published by the end of June 2023.

3.17 There are three major strategic changes that the ICS is progressing:

- Creation of a new Trust for community and mental health services (as described in this Strategic Case);

- Isle of Wight sustainability programme – a programme to achieve sustainable health services for the Isle of Wight population; and
- Hampshire Together Modernising our Hospitals and Health Services (MoHHS) – a programme that has the opportunity to deliver a new hospital in Hampshire as part of the government's New Hospital Programme.

3.18 These programme are key enablers for the system to address the long-term challenges it is facing and share a number of common themes reflecting the overarching case for change across the ICS, notably:

- The population is growing and ageing. Improvements in life expectancy have stalled. Demand for services is outstripping supply;
- Different communities have different needs and requirements. Health inequalities are widening and driving poor outcomes. Vulnerable people experience poorer health and are dying younger than the general population. Care pathways are fragmented with inconsistent models of care and, in some areas clinical and operational vulnerabilities are leading to further variation in patient access and outcomes; and
- Financial and workforce challenges are significant resulting in workforce gaps and financial pressures which impact on service delivery and sustainability.

3.19 There are links between these three programmes with the Isle of Wight sustainability programme being a key inter-dependency for this Strategic Case (see paragraph 8.17).The success of the proposed new hospital in north and mid Hampshire is reliant on a sustainable model of proactive, integrated community and mental health provision which shifts the focus from cure to prevention, provides care closer to home and reduces the demand on acute services.

3.20 The ICB has confirmed its support for the creation of a new Trust in a letter of support (see appendix 3).

Independent Review of Community and Mental Health Services across the Hampshire and Isle of Wight Integrated Care System

3.21 In February 2022, Carnall Farrar (CF) was commissioned by the ICS to undertake an independent review of community and mental health services and to identify further opportunities for collaboration and integration (see appendix 4). The scope of this review was broader than the scope of this Strategic Case and a summary of this review is therefore included in this chapter as part of the context.

3.22 The review was conducted with significant engagement from system stakeholders - in total, 83 stakeholders were interviewed, of whom 60 were on an individual basis. These interviewees covered community, mental health, and acute providers, local authorities, and system leadership. Executive and Non-Executive directors as well as clinical leads were included in the interviews, exploring views on the achievements and challenges of existing arrangements and opportunities for community and mental health services in the future.

3.23 Concurrently with these interviews, a baseline analysis was conducted on how current and future population health needs were being met by existing services in community and mental health across the ICS. This considered population demographics and health profile, the modelling of future demand (factoring in demographic and non-

demographic growth and assumptions on COVID-19 impacts), service access, waiting times, patient outcomes and a mapping of service provision. The interviews and baseline analysis were used to build a case for change through a system workshop with managerial and clinical leaders.

3.24 A clinical summit was held with clinical leads across the system to identify priorities for community and mental health services. This looked at the ideal patient experience when engaging with community and mental health services in the ICS, the challenges to achieving this ideal and therefore what needs to be prioritised for future service delivery.

3.25 A long list of potential options for the future arrangements for mental health and community services was drafted and narrowed down to a short list via a structured, two-part appraisal process. This process first considered the viability of options via a simple hurdle test, with a second evaluation against a detailed set of criteria that focused on the extent to which the options addressed the case for change. A second clinical summit and a further system workshop were held with key stakeholders to align views on a preferred option.

3.26 The review was completed in April 2022 and concluded with five key recommendations:

- **A new Trust should be established** to oversee delivery of all community and mental health services across HIOW. This should include services currently provided by Solent, Southern, IoW and Sussex Partnership in HIOW Places. This new Trust should have a clear focus on local geographies, achieved in part, by having Place-based divisions and leadership. This recommendation forms the basis of this Strategic Case.

- **A review of community physical health beds** should be undertaken. This should be conducted as a partnership between community and acute providers, local authorities, and primary care, with the aim to explore how the bed capacity can be used to best effect to facilitate patient flow and meet the needs of the population.

- **A system-wide clinical strategy for community and mental health services** should be developed**.** This should focus on prevention, early intervention and patient-centred care. This strategy should be led by the community and mental health providers but will require input from key system partners and service users.

- **A strategy for Place and Place-based leadership** should be developed. This strategy is needed to identify how to establish Place-based integration across all health and care partners and wider supporting sectors (e.g. education). This should acknowledge that Place-based integration of services is essential to support the systemwide clinical strategy.

- **Funding arrangements for community and mental health services should be approached from a more strategic level.** A strategic approach will allow HIOW to address current health inequalities and should ensure that services are resourced in proportion to need, reflecting future demand.

3.27 The ICB formally endorsed these recommendations at a public meeting held in October 2022. This included supporting the creation of a new Trust to deliver all community and mental health services in the ICS, as described in this Strategic Case.

3.28 A briefing on the system response to the recommendations of the independent review is included in appendix 5.

Case for Change

3.29 The Trusts have identified four key challenges that they believe cannot be addressed by any one organisation in isolation:

- Unwarranted variation in practice and fragmented pathways and services adversely impact health and wellbeing outcomes;
- Significant increases and changes in demand are putting complex models under greater pressure and people are not getting the care they need at the right time and in the right setting;
- Recruitment and retention challenges are resulting in workforce gaps (to varying degrees across the four Trusts) which impact on the effectiveness and quality of services; and
- Financial challenges are expected to continue to increase and Isle of Wight services are not financially (or clinically) sustainable.

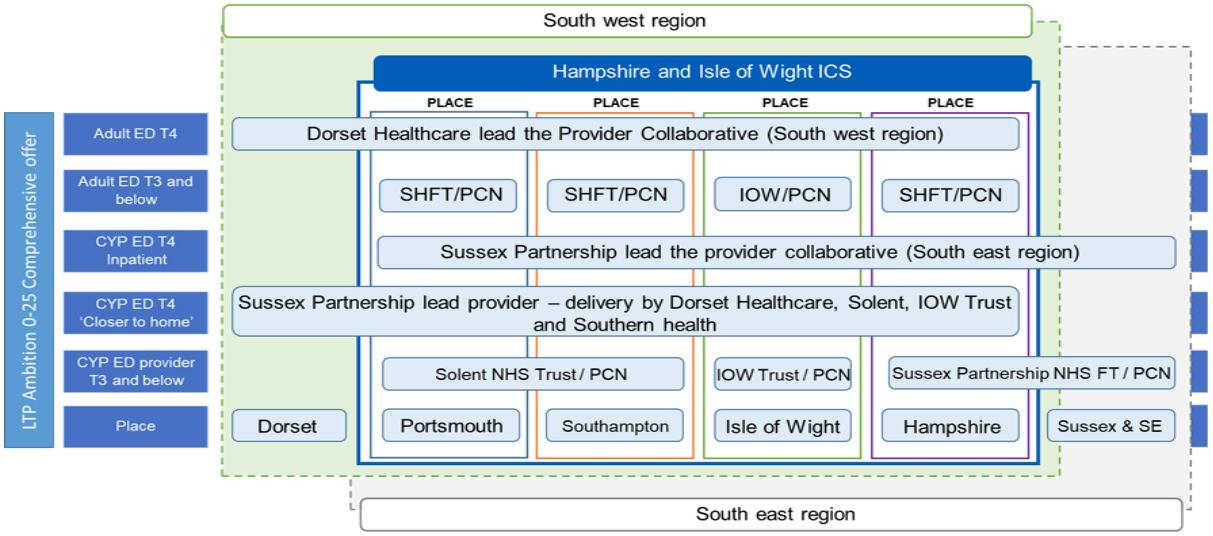
3.30 Although in each Trust there are multiple examples of superb services providing excellent care, including areas of national excellence, there is **unwarranted variation in practice and fragmented pathways and services** across HIOW. As a result people who use our services don't consistently experience high-quality person centred care that meets their needs and there is an opportunity to work collectively to deliver better care and health and wellbeing outcomes for the people of HIOW.

3.31 As a consequence of historic variations in commissioning and funding of services across the ICS, which have often been driven by historic contract value rather than population needs, and the evolution of the provider landscape, we have many pathways of care that are fragmented and difficult to navigate (as described in paragraphs 3.33 to 3.40 above). Clinical models of care in community mental and physical health services have developed in each provider organisation with little or no reference to developments across organisational boundaries, and have been built on over time often resulting in a widening gap between the models, clinical practices and ways of working. This is making information integration and joint working more challenging. There is a significant opportunity to develop a best practice approach across the system and to reduce unwarranted variation.

3.32 Fragmentation of clinical pathways impacts patients, as shown in the examples below. Fragmentation also makes it difficult to deliver the national priority regarding mental health transition pathways between CAMHS and adult pathways of care in a consistent and effective way. There is an opportunity to commission and provide less fragmented services.

3.33 The eating disorder pathway is described below, illustrating the highly complex pathway that young people with eating disorders need to navigate in order to get care. The lack of consistent 16-25 year pathways of care and delivery of differing models by multiple providers and commissioners at place, the ICS, and provider collaborative geography add to the complexity for all involved. Referral pathways, waiting times and access to services differ depending on where you live. There are opportunities to significantly simplify pathways of care, thereby improving access and outcomes.

Figure 5: Eating disorder pathway in HIOW ICS



3.34 There are similar examples of fragmentation across community services pathways. The management of back pain, for example, is delivered by multiple providers across Hampshire and the Isle of Wight.

3.35 In the south west of the county, physiotherapy, which includes provision by specialist spinal practitioners, is provided by both Solent and Southern, with Solent subcontracting diagnostic services to a private provider and Southern delivering diagnostics in-house. Psychological therapies input for people experiencing back pain is provided in part of this area by Dorset HealthCare, whereas patients experiencing the same symptoms elsewhere in south west Hampshire do not receive any physiological therapy input.

3.36 In the southeast of the county, physiotherapy is provided by Southern, specialist spinal practitioner input is provided by Solent, psychological therapies services are delivered by two different providers (iTalk, a partnership between Southern and Solent Mind) and Talking Change (provided by Solent), with diagnostics provided by Southern, Portsmouth Hospitals NHS Trust and a private provider.

3.37 On the Isle of Wight, physiotherapy is subcontracted to a private provider and specialist spinal practitioner input is delivered by IoW's acute services.

3.38 In the north of the county, physiotherapy is provided by multiple subcontractors and specialist physiotherapy by Circle Health. There is no psychological therapy input for people with back pain on the Isle of Wight or in north Hampshire.

3.39 This complexity and fragmentation means care is not always matched to need and patients often have to travel long distances to access diagnostics, treatment and support. The variability in access and provision has a negative impact on outcomes and experience for some people in Hampshire and the Isle of Wight and means it is very difficult to manage demand and capacity consistently and equitably across the county.

3.40 The complexity described in relation to eating disorder and management of back pain pathways above is replicated across many services including (but not limited to) CAMHS and community models of care such as frailty pathways, community rapid response and delivery of community hospital beds. As described in paragraph 5.36, there is currently no co-ordinated community bed and inpatient rehabilitation offer

across the ICS which means these beds are not being used to best meet the needs of the population. In relation to services for people with attention deficit hyperactivity disorder (ADHD) and autism, there are 25 distinct contracts with 11 providers across the ICS providing variable and disjointed pathways of care (for further detail see paragraph 5.21).

3.41 **Demand for community and mental health services is growing unsustainably** and outstrips capacity. Significant increases in demand are being driven by demographic changes and the impact of COVID-19, with further increases expected due to the current economic climate and operational pressures in acute services. Robust community services are needed in order to support more people closer to their homes and, in doing so, reduce dependency on acute hospital provision.

3.42 HIOW has an older population relative to the national average, with a higher proportion of over 65s in Hampshire and the Isle of Wight (24% of the west and south east Hampshire populations are aged over 65, 30% in Isle of Wight) in contrast to Southampton and Portsmouth at 14% and 15% respectively. Deprivation is markedly higher in Portsmouth, Southampton and the Isle of Wight and above the England average; and Southampton has the highest number of local areas in the three most deprived deciles.

3.43 Over the next ten years, the HIOW older population will grow faster than the national average, which will be the primary driver for the increase in demand for community services. As a result, demand for community services could grow by 11.3% by 2025 and will increase most significantly across Hampshire. The population is living longer with more long-term conditions and as a consequence there is an increasing prevalence of people living with frailty.

3.44 Demand for mental health services is set to increase slightly more than community services by 2025. The largest increase in absolute numbers will be seen in talking therapies for anxiety and depression.

3.45 Demand for mental health support has increased for children and young people across the pathway of care, from mental health and wellbeing services to the need for an inpatient psychiatric admission. Across England as a whole, rates of mental health problems for children and young people have increased since 2017. In 2020, one in six (16.0%) children aged 5 to 16 years were identified as having a probable mental disorder, increasing from one in nine (10.8%) in 2017[22]. The increase was evident in both boys and girls. The likelihood of a probable mental disorder increased with age with a noticeable difference in gender for the older age group (17 to 22 years); 27.2% of young women and 13.3% of young men were identified as having a probable mental disorder in 2020. 17.4% of children in the southeast of England have a probable mental health disorder – applying this figure to the HIOW population suggests over 42,000 children are likely to suffer from a diagnosable mental disorder in any given year. As described in more detailed in paragraph 5.17, we have experienced unprecedented demand for children and young people's mental health services and know we must do more to ensure care and support is available when and where young people need it and close to home.

3.46 There has also been an increase in the rate of self-harming behaviours affecting children and young people. It is estimated that around 10% of 15 to 16 year olds self-harm in any given year, with approximately 36% of 16 to 24 year olds having self-

[22] NHS Digital recently reported that the rate of probable mental health disorder increase to one in four for 17 to 19 year olds in 2022 - https://digital.nhs.uk/news/2022/rate-of-mental-disorders-among-17-to-19-year-olds-increased-in-2022-new-report-shows

harmed at some point. Rates of admission to hospital for young women are significantly higher than for young men, with even higher rates for those who identify as transgender or non-binary reported nationally. Conversely, young men are at significantly greater risk of death by suicide than young women, though less likely to report self-harming behaviour or to have attended hospital for medical attention following self-harm.

3.47 In 2021/22, 16,485 children and young people in HIOW accessed NHS funded mental health services. This exceeded the national target by 39% and is 4,450 (37%) more children than pre-pandemic in 2019/20. This trend has continued in 2022/23 with numbers of children and young people awaiting assessment, awaiting treatment and open to treatment all rising significantly compared to pre-pandemic levels.

3.48 There has been a 295% increase in referrals to children and young people inpatient services since the start of the pandemic (over 50% of this demand is for specialised eating disorder services). Children with eating disorders and disordered eating presentations continue to be the hardest to place with the most complex needs.

3.49 Within HIOW there are over 8,700 people (children and adults) waiting for an autism assessment with an average waiting time of 13.7 months (as of January 2022). While people are waiting for assessment, they are often not able to access ADHD medication and are generally not given sufficient support from health, education and social care.

3.50 Prevalence of different mental health conditions including dementia, depression and long-term mental health problems varies notably across geographies, creating different requirements for mental health services across the ICS.

3.51 Prevalence of physical health conditions also differs across geographies, meaning the requirements for community services will also vary by geography. Hypertension, heart failure and chronic heart disease appear to be most prevalent in the Isle of Wight and South East and South West Hampshire, whilst chronic obstructive pulmonary disorder (COPD) appears highest in Isle of Wight, Portsmouth, South East Hampshire and Southampton. Portsmouth and Southampton also have notably higher rates of smoking and overweight children.

3.52 Service provision is not aligned to need, for example community services delivery does not appear to align with different physical health needs across the geographies. This is partly driven by inequities in distribution of resources (as a result of historic funding and service commissioning across geographies), likely leading to some of the differences in quality of services.

3.53 Capacity issues result in patients not always being managed in the most appropriate care setting which impacts patient flows and outcomes. This can result in delayed discharges from acute care to community inpatient beds due to a lack of capacity (in community services and social care), leading to patient harm from remaining in hospital longer than necessary.

3.54 A mismatch is also seen in mental health which similarly has inequitable funding. Emergency readmissions for people with a mental health flag are growing, suggesting discharged patients are unable to access the community support needed to prevent readmission. Further detail is set out in the independent review of community and mental health services (see pages 18-19 of appendix 4).

3.55 The increase in significant mental health presentations along with an increase in self-harming behaviours requiring medical attention has meant that more young people are

in the wrong place often not being provided the best evidence based care for their condition.

3.56 The mismatch also results in variation in waiting times. Talking therapies for anxiety and depression access is much higher in the cities and waiting times for eating disorders consistently fall below national averages. Delayed access has the potential to cause 'harm' with severe consequences for those in need who may enter crisis as a result, particularly children with mental health needs.

3.57 There is an opportunity to create a united voice for community and mental health provision within the ICS and to target the investment in community and mental health services where it is needed most. Alignment of priorities would deliver better outcomes for our population by reducing the inefficiencies and ineffectiveness caused by current fragmentation, helping us to reinvest into better care.

3.58 All Trusts are experiencing **challenges in recruitment and retention resulting in workforce gaps** which impact on the effectiveness and quality of services. Workforce shortages are particularly visible in mental health, with vacancies of 483 full time roles (as at December 2022) for mental health services across the two main providers. The ICS's mental health inpatient services are also significantly affected by the nationwide shortage of mental health inpatient nurses.

3.59 Due to the fragmentation of services across multiple providers (as described above), there are a number of low volume high specialism services in each Trust which lack the scale to provide resilient workforce models, such as specialist nursing in the community. These smaller services also provide limited opportunity for career progression.

3.60 Training and development is duplicated across the multiple providers and staff are not trained to a consistent set of standards that would enable movement of the workforce within the system. An example of this is the variation of physical intervention training provided to inpatient mental health staff.

3.61 There is an opportunity to create a united community and mental health workforce which would improve staff satisfaction and career development and enable better care through more resilient workforce models.

3.62 **The financial challenge facing the NHS, both nationally and locally, is significant.** The total cost of delivering NHS services exceeds the available resources, and this gap is projected to grow over the next five years. ICS plans assume that growth in demand for health services is mitigated through a rebalancing of care with the enhancement of preventative, proactive and home or community-based care (rather than an expansion of acute service capacity). Community and mental health services play a key role in preventing ill health and supporting people in the community, and a coherent, co-ordinated approach is needed to deliver this.

3.63 The organisational landscape in HIOW with multiple providers of community and mental health services and the historical focus on competition rather than collaboration have limited the opportunity to deliver economies of scale, particularly in relation to back-office services. Mental health inpatient services are reliant on support from the private sector which creates a significant cost pressure which is not financially sustainable for the system (see paragraph 5.27 for further detail).

3.64 Whilst pressures are felt across the whole system, there is a particular issue that Isle of Wight services are not financially (or clinically) sustainable because the population served by the Trust is too small to provide the critical mass needed to sustain high quality, efficient services and the physical isolation of the Island creates clinical and

workforce challenges, for example the community specialist nurse service relies on individual practitioners. There is an opportunity to work collectively to support the Isle of Wight and create sustainable community and mental health care services that meet the needs of the residents of the Island.

Conclusion

3.65 Responding to the case for change will require significant transformation. The four Trusts have come together to accelerate the clinical collaboration to address the most significant clinical risks in our community and mental health services. Ten clinical priorities have been identified and a joint clinical strategy is being developed. Tackling the identified priorities together is our core objective and will lead to better care and outcomes for the populations we serve. This is described in more depth in chapter 5.

3.66 In addition to identifying these clinical priorities and accelerating clinical collaboration, the four Trusts have also concluded that it is not possible to fully tackle the issues identified in the case for change, overcome the fragmentation of care delivery and ensure greater consistency of outcomes across the Hampshire and Isle of Wight system within the current organisational model and that organisational changes are required to exploit the opportunities for better care.

4 Options assessment

Chapter summary

- This chapter describes the options the Trusts considered for the future of their collaboration and the justification for the selection of creation of a new Trust as the preferred option.
- An options appraisal process was undertaken as part of the independent review of community and mental health services and this has been refreshed to reflect the time that has elapsed, during which the Health and Social Care Act 2022 was passed and NHS England published new transactions guidance.
- A long list of the possible organisational options was generated, ranging from informal 'bottom up' collaboration through to more formal organisational structures requiring contractual changes and various forms of vertical and horizontal integration.
- A set of hurdle criteria was developed setting out the minimum, essential criteria that must be met for an option to be short-listed for more detailed evaluation. It was agreed to eliminate options that: increase fragmentation of community and mental health pathways; involve unclear accountabilities for care; don't respond to all aspects of the case for change (i.e. scope of option does not cover community and mental health services); or reduce integration of community and mental health services. Applying the hurdle criteria resulted in eight options being eliminated.
- Following application of the hurdle criteria, three options remained for more detailed appraisal: lead provider model, group model and single Trust for community and mental health services.
- A set of evaluation criteria was developed to assess the three short-listed options. The criteria reflect the case for change and implementation challenges. The evaluation criteria were applied to the three short-listed options. The new Trust option ranked higher than the lead provider and group model options for all evaluation criteria except implementation timescales and implementation costs.

Chapter summary (continued)

- The options appraisal process concluded that:
  - Whilst a lead provider model could harness and co-ordinate the expertise of existing providers to redesign pathways and standardise care, it provides less potential to deliver the transformational change needed to overcome the challenges faced by the HIOW system and address the case for change. A lead provider model would not resolve the sustainability of Isle of Wight community and mental health services.
  - Creating a group could enable improved strategic alignment at Board level across community and mental health services but maintains separate organisations, involves complex governance and does not enable delivery of consistent care models and the required transformation. There isn't a practicable or deliverable arrangement through which in scope services provided by IoW and Sussex Partnership can be easily accommodated in a group model and it does not resolve the sustainability of Isle of Wight community and mental health services.
  - Bringing services together into a single Trust offers the greatest opportunity to deliver the transformational change needed to respond to the case for change. This option allows for the coordination of resources to manage capacity according to need, respond to system pressures and enable smaller services to operate at the appropriate scale. This also provides the critical mass needed to support the sustainability of Isle of Wight community and mental health services.
- The preferred option is therefore to bring NHS community and mental health services for the Hampshire and Isle of Wight together through the creation of a new Trust.

Options appraisal process

4.1 An options appraisal process was undertaken as part of the CF review (see paragraphs 3.21 – 3.28) and this has been refreshed to reflect the time that has elapsed since the CF review, during which the Health and Social Care Act 2022 was passed and NHSE published new transactions guidance[23].

4.2 The Trusts built on the options appraisal process in the CF review through a workshop in December 2022 with representatives from across all Trusts (including Non-Executive Directors from Solent, Southern and IoW) and ensured that, as well as identifying a preferred option, the options appraisal process informed risk and benefits identification to support integration planning.

4.3 The options appraisal process accounted for risk in respect of two key areas. Firstly, the risk that an option would not address the factors which constituted the case for change, if implemented successfully. Secondly, the risk in respect of the implementation of each option (in terms of both timescale and cost), in which it was recognised that certain options were inherently more challenging to implement.

[23] https://www.england.nhs.uk/wp-content/uploads/2022/10/B1464_ii_Statutory-transactions-including-mergers-and-acquisitions.pdf

4.4 The options appraisal process focussed on the ultimate future state for community and mental health services in the ICS. For this reason, the options appraisal process did not include hybrid options which involved beginning with one model and moving over time to a different model. It was recognised this approach would extend implementation timescales, increase implementation costs, increase uncertainty for staff and reduce focus on transformational change.

4.5 Interdependencies and the potential phasing of the preferred options are considered as part of chapter 8 (see paragraphs 8.17 to 8.19).

Long list of options

4.6 A long list of the possible organisational options was generated, ranging from informal 'bottom up' collaboration through to more formal organisational structures requiring contractual changes and various forms of vertical and horizontal integration.

Figure 6: Long list of potential options proposed

Option	Description
No change	Maintain the status quo.
1	A single lead provider or an alliance is contracted to provide children and adult's mental health, eating disorder and learning disability services only.
2	Align provider arrangements for mental health through building out and formalising the developing mental health collaborative, with formal governance structures. Community services remain unchanged.
3	Lead provider arrangements contracted for agreed set of pathways and/or geographies as part of a provider alliance for community and mental health services with formal governance structures.
4	A group model is established for all community and mental health services across the ICS. This includes sharing central corporate and administrative functions, as well as shared leadership and governance.
5	A lead provider is contracted to provide mental health services and a different lead provider is contracted to provide community health services.
6	A new Trust for mental health services with the delivery of community services remaining unchanged across different providers.
7	A new Trust for mental health services with community services provided by each acute provider in a local delivery system, to become vertically integrated.
8	A new Trust for inpatient (bedded) mental health services only, with community services and community mental health services provided by each acute provider in a local delivery system, to become vertically integrated.
9	A new Trust is created providing community and mental health services across the ICS.
10	A new Trust for mental health services and a new Trust for community services.

4.7 It was noted at the workshop that one of the recommendations of the independent review of community and mental health services was a review of community physical health beds (see paragraph 3.26). It was recognised that the outcome of this review may result in a variant on option 9 (i.e. a new Trust for mental health and community services with inpatient community services provided by each acute provider in a local delivery system, to become vertically integrated) but as the community physical health beds review is ongoing it was agreed not to include this variant in the long list.

4.8 A set of hurdle criteria was developed setting out the minimum, essential criteria that must be met for an option to be short-listed for more detailed evaluation. If it was determined that the risk that an option would not be able to address the factors which constitute the case for change was too great, then the option was excluded from the short-list.

4.9 In that context, it was agreed to eliminate options that:

- Increase fragmentation of community and mental health pathways
- Involve unclear accountabilities for care
- Don't respond to all aspects of the case for change (i.e. scope of option does not cover community and mental health services)
- Reduce integration of community and mental health services

4.10 As set out in Figure 7 below, applying the hurdle criteria resulted in eight options being eliminated (highlighted in grey) due to the determination that the risk of not being able to address the factors which constitute the case for change was too high:

Figure 7: Application of hurdle criteria to long list of options (as compared to 'no change')

Long list of options	Is fragmentation reduced?	Are accountabilities for care clear?	Does the option aim to respond to all aspects of the case for change?	Does the option maintain or improve integration of community and mental health services?
Option 1: single lead provider or alliance for children and adult's mental health, eating disorder and learning disability services only.	Yes	Yes	No	No
Option 2: formalise mental health collaborative, community services remain unchanged.	Yes	No	No	Yes

Long list of options	Is fragmentation reduced?	Are accountabilities for care clear?	Does the option aim to respond to all aspects of the case for change?	Does the option maintain or improve integration of community and mental health services?
Option 3: lead provider arrangements for agreed set of pathways and/or geographies as part of a provider alliance for community and mental health services.	Yes	Yes	Yes/Neutral	Yes
Option 4: group model for all community and mental health services.	Yes	Yes	Yes	Yes
Option 5: lead provider for mental health services and a different lead provider for community services.	No	Yes	Yes	No
Option 6: A new Trust for mental health services with the delivery of community services remaining unchanged.	Yes	No	No	No
Option 7: A new Trust for mental health services with community services provided by each acute provider in a local delivery system (vertical integration).	Yes/Neutral	Yes	Yes	No
Option 8: A new Trust for inpatient mental health services only, with community services and community mental health services provided by each acute provider (vertical integration).	Yes	Yes	Yes	No
Option 9: A new Trust for community and mental health services.	Yes	Yes	Yes	Yes
Option 10: A new Trust for mental health services and a new Trust for community services.	Yes	Yes	Yes	No

Short list of options

4.11 Following application of the hurdle criteria, three options remained for more detailed appraisal:

- **Lead provider(s) model (option 3):** in this model a lead provider is contracted for an agreed set of pathways and/or geographies, as part of a provider alliance for community and mental health services with formal governance structures. The lead provider arrangements would involve all community and mental health providers and could involve different lead providers for different services.
- **Group model (option 4):** in this option a group model is established for community and mental health services across the ICS. The Boards of Solent, Southern, Sussex Partnership and IoW would have shared leadership and governance and would delegate most decision making for these services to a Group Board. There would also be shared corporate/ administrative functions.
- **Single Trust for community and mental health services (option 9):** A new Trust is created providing all community and mental health services across the ICS, including services currently provided by IoW and Sussex Partnership.

4.12 A set of evaluation criteria was developed to assess the three short-listed options. The criteria reflect the case for change set out in the previous chapter and implementation challenges. The agreed evaluation criteria were:

- Enables consistent care models and reduces fragmentation and hand-offs (thereby improving outcomes)
- Enables better alignment of capacity and need
- Positive impact on workforce challenges
- Supports delivery of transformational benefits
- Improves sustainability of Isle of Wight and the overall health and care system and focuses resources on frontline services
- Creates a single coherent voice for mental health and community services in the ICS
- Implementation timescales
- Implementation costs

4.13 The first six criteria assess the extent to which each option enables community and mental health services to respond to the case for change. The final two criteria take account of the risks relating to the implementation of each of the options.

4.14 An approach of weighting the evaluation criteria was not adopted as the majority of the criteria related to the case for change which the Trusts felt was the most important aspect of the appraisal process. Appendix 6 sets out the features of a strong and weak option for each criteria.

4.15 The evaluation criteria were applied to the three short-listed options (see Figure 8 below) with each option given a relative ranking (where 3 was the highest ranking and 1 was the lowest ranking). The new Trust option ranked higher than the lead provider

and group model options for all evaluation criteria except implementation timescales and implementation costs.

Figure 8: Application of evaluation criteria to short list of options

Evaluation criteria	Lead provider	Group model	New Trust
Enables consistent care models and reduces fragmentation and hand-offs (thereby improving outcomes)	Opportunity to agree consistent care models but retains organisational boundaries with multiple Trusts involved in an individual person's care and no overall leadership of services for HIOW 1	Provides shared leadership but retains separate Trusts with multiple Trusts involved in an individual person's care making it more difficult to deliver consistency 2	All care provided by one community and health provider - provides the greatest opportunity to agree and implement consistent care models across HIOW and reduce fragmentation 3
Enables better alignment of capacity and need	Retains current arrangements with five Trusts funded separately and doesn't create a mechanism to align capacity to need 1	Retains current arrangements with Trusts funded separately with weak mechanisms to align capacity to need 2	Single Trust has flexibility to allocate and align funding and capacity to local needs 3
Positive impact on workforce challenges	Enables joint workforce planning at service level but organisational barriers inhibit effective redeployment of staff to meet demand 1 - 2	Enables joint workforce planning at system level but organisational barriers inhibit effective redeployment of staff to meet demand 1 - 2	Enables whole system workforce planning and redeployment of staff to meet demand 3
Supports delivery of transformational benefits	Lack of centralised transformation resource and Trusts will also have their own priorities 1	Allows for creation of centralised transformation resource but Trusts will also have their own priorities 2	Centralised transformation resource to deliver single set of transformation priorities 3
Improves sustainability of Isle of Wight and the overall health and care system and focuses resources on frontline services	Does not resolve Isle of Wight sustainability 1 - 2	Does not resolve Isle of Wight sustainability and complexity from IoW being a member of another group for acute services, Group structures will limit opportunities to focus resources on frontline services 1 - 2	Creates best opportunity for sustainable IoW services and delivery of economies of scale to focus resources on frontline services 3
Creates a single coherent voice for mental health and community services in HIOW	Retains separate Trusts who may have different views 1	Creates some opportunity for a single voice depending on level of delegation to the Group 2	Creates best opportunity for a single coherent voice 3
Implementation timescales	Could be implemented in 6 months (although experience suggests it will likely take longer) 3	Likely to take 12 months to implement 2	Requires formal two-stage business case and regulatory approval following the NHSE transactions guidance, likely to take c. 18 months to implement 1
Implementation costs	Involves some limited legal, advisory and contracting costs to establish the lead provider arrangements 3	Involves some legal, advisory and business case development costs to establish the Group and create single leadership structures 2	Involves the greatest cost 1

Conclusion

4.16 The options appraisal process concluded that:

Lead provider(s) model (option 3)

4.17 Whilst a lead provider model could harness and co-ordinate the expertise of existing providers to redesign pathways and standardise care, these models provide less potential to deliver the transformational change needed to overcome the challenges being faced in Hampshire and the Isle of Wight of organisational boundaries, to deliver the benefits sought for people and communities, and to address the case for change.

4.18 Although a lead provider model may support establishment of a collective vision and single clinical strategy for mental health and community services across the ICS, the Trusts' experience of these models in practice is that organisational priorities would continue to overshadow collective responsibilities and organisational barriers to the development of consistent care models would remain. This would limit opportunities to implement system wide improvements, reduce fragmentation and improve outcomes.

4.19 Whilst a lead provider model may improve collaborative working and alignment of capacity and need, it would not maximise the opportunities to pool resources, proactively manage capacity to meet the population's changing needs and achieve economies of scale. A lead provider model would provide less opportunity to deliver savings which contribute to addressing the financial challenges across the ICS and would not resolve the sustainability of Isle of Wight community and mental health services.

4.20 It was not felt that the benefits of this option were sufficient to pursue a lead provider model as the preferred way forward for community and mental health services in Hampshire and the Isle of Wight.

Group model (option 4)

4.21 Creating a group could enable improved strategic alignment at Board level across community and mental health service providers. It was felt that a group model would provide more opportunity than a lead provider model to reduce fragmentation and develop consistent care models.

4.22 However, there are drawbacks to a group model. This model maintains separate organisations, which means that there are still multiple Trusts involved in providing care for individuals which fragments care, with at least two providers of community and mental health services in each local delivery system in the ICS. This would maintain the current complexity. It would require complex governance and fall short of creating the fully shared vision, values, strategy, culture and accountability that will be needed to deliver consistent care models and the required transformation.

4.23 There isn't a practical or deliverable arrangement through which the in-scope services provided by IoW and Sussex Partnership (which are only a small part of the portfolio of those Trusts) can be easily accommodated in a group model and so this model does not resolve the sustainability of Isle of Wight community and mental health services.

4.24 For these reasons the conclusion was reached that the benefits of establishing a group model do not outweigh the risks and that this does not offer a viable long term model for community and mental health services for Hampshire and Isle of Wight.

Single Trust for community and mental health services (option 9)

4.25 Bringing services together into a single Trust offers the greatest opportunity to create the alignment, leadership and governance arrangements needed to respond to the case for change. This option allows for the coordination of resources to manage capacity according to need, respond to system pressures and enable smaller services to operate at the appropriate scale. This also provides the critical mass needed to support the sustainability of Isle of Wight community and mental health services.

4.26 Whilst this option takes longer to deliver (18 months rather than, for example, the 12 months estimated to create a group) and involves additional transaction costs (as described in paragraphs 7.26 to 7.30), the additional benefits that can be realised as a result significantly outweigh these implementation factors. The additional costs of delivering the transaction are in the context of an ICB budget for all mental health and community services of c.£800m.

Overall conclusion

4.27 The preferred way forward is therefore to bring NHS community and mental health services together through the creation of a new Trust. Combining the expertise, experience and resources from all four organisations will enable us to provide better community and mental health services for the population we serve whilst also achieving the benefits of scale. The new Trust will be one of the largest community and mental health providers in the country with the potential to become a national role model for sustainable care models which make a real difference to patients, communities and systems.

4.28 The transfer of community and mental health services from IoW into a new provider for all community and mental health services for the ICS is consistent with the overall Trust and system strategy to resolve the long term challenges of delivering sustainable healthcare for the Isle of Wight population. In 2019 IoW established a strategic partnership with Portsmouth Hospitals University NHS Trust to support the delivery of acute services and this partnership, coupled with the delivery of the way forward described in this Strategic Case, provides a route to ensure the long term sustainability of IoW.

4.29 It is recognised that the creation of a new Trust will not, in and of itself, resolve all the challenges described in the case for the change, but the Trusts believe this option provides the best opportunity to respond positively and realise benefits for the population we serve.

5 Clinical strategy

Chapter summary

- This chapter sets out our developing clinical strategy for the new Trust.
- Each of the Trusts have been actively involved in developing clinical strategies aligned to the provision of high-quality mental health and community services. Existing strategies encourage and seek to optimise self care and self management and adopt the concepts of codesign, coproduction and codelivery.
- The Trusts have come together to address the most significant clinical risks in our system and a Clinical Delivery Group has been formed and ten clinical priorities have been identified. Each clinical priority workstream has an executive director who takes a system-wide responsibility for leading the workstream, supported by senior clinical and operational leads. The Clinical Delivery Group has agreed principles for clinical transformation and set these out in its Charter.
- The clinical leaders across the Trusts have commenced the development of a clinical strategy for the new Trust, overseen by the Clinical Steering Group.
- The clinical strategy for the new Trust will encompass the principles for clinical transformation and reflect the emerging thinking from the clinical priority workstreams, as well as relevant external strategies including the system Partnership Strategy and feedback from leaders across the Trusts.
- The clinical strategy will be ambitious and transformational. The clinical strategy will establish a holistic approach to patient needs and ensure care is delivered in the most appropriate setting for the patient. The clinical strategy will aim to keep people as healthy and independent as possible and provide swift access to efficient, high quality care for those who need it. The clinical strategy will optimise patient safety, quality and experience through a consistent set of standards.
- Implementation of the clinical strategy will support realisation of the benefits for patients, staff and the wider health and care system as set out in chapter 6.
- Building on the evolving work of the Clinical Delivery Group, the clinical strategy will continue to be developed by the Trusts alongside the ICB and other partners at system, place and local delivery system level including primary care, local authorities, acute providers and VCSE partners. The clinical strategy will be informed by place priorities and the five year Joint Forward Plan for HIOW ICS and people with lived experience will be actively involved in coproducing our clinical strategy.
- Our ambition is to create a new organisation with a new culture and common set of values that operates in line with key principles to enable sustainable change and address the challenges set out in the case for change (see chapter 3). We have an opportunity in the creation of the new Trust to be deliberate in our design of the culture, leadership and operational delivery model to realise the benefits we are setting out to achieve.
- We are at the early stages of considering the new Trust's operating model and associated management arrangements which will support delivery of the clinical strategy. In the coming months, we will consider options for the operating model that are aligned with our key principles, informed by engagement with colleagues and key external stakeholders (including place-based partners) and learning from other models.

Clinical strategy development to date

5.1 Each of the Trusts have been actively involved in developing clinical strategies aligned to the provision of high-quality mental health and community services. Existing strategies encourage and seek to optimise self care and self management and adopt the concepts of codesign, coproduction and codelivery.

5.2 The Trusts have worked collaboratively with wider ICS partners, both with local place-based teams in understanding the local needs, and with ICB leaders in understanding the strategic longer term requirements.

5.3 The Trusts have come together to address the most significant clinical risks in our system, as articulated in the case for change. This includes unwarranted variation in practice, fragmented pathways of care, difficulties in accessing services and significant increases in demand for clinical services. The aim of this work is to provide higher quality care, improve outcomes and experience, reduce inequalities and provide better value. This work has taken place at a time of significant operational pressure across the health and care system that has not been conducive to accelerated transformational change. Despite this, transformation has been prioritised by all Trusts, as each recognises that working together in this way is essential to addressing the pressures we face.

5.4 As described in paragraphs 2.42 to 2.43, a Clinical Delivery Group has been formed with membership comprising clinical and operational leads from across the Trusts and relevant ICB directors (see appendix 7 for the Terms of Reference for the Clinical Delivery Group). The work of the Clinical Delivery Group has been supported by each of the Trust Boards and endorsed by system partners.

5.5 Ten clinical priorities have been identified, informed by system priorities, joint strategic needs assessments, equality impact assessments, community requirements and workforce, performance and quality data. We sought feedback from clinical and operational colleagues across the four Trusts and the priorities were agreed by the clinical and operational executives of the Trusts in a provider joint executive meeting in June 2022. The clinical priorities include mental and physical health pathways and are brought together through and overseen by the Clinical Delivery Group to ensure an integrated approach to physical and mental health is adopted.

5.6 It is recognised that there are a significant number of services outside these ten priority areas, including, for example, children's and family services and sexual health services. These services are being encouraged and supported to work across the Trusts to develop or extend existing transformation programmes. It is intended that the Clinical Delivery Group will also have visibility of these transformation programmes, although it is not felt that these programmes require the same oversight as the ten clinical priorities at this stage. The Trusts recognise that there will be significant benefits in these areas, including in children's physical health services such as health visiting and school nursing.

5.7 Each clinical priority workstream has an executive director who takes a system-wide responsibility for leading the workstream, supported by senior clinical and operational leads and programme management resource. The 'triumvirate' workstream leadership teams are working across the system and engaging with other health and care providers, service users, families and carers, and other neighbourhood, local delivery system, place, and wider system partners.

5.8 The Clinical Delivery Group has agreed the following principles for clinical transformation as part of the Clinical Delivery Group Charter (see appendix 8):

- Our primary goal is to deliver safe and effective mental health, learning disabilities and community services to all people across HIOW
- Our communities are at the heart of what we do, and we will work in, and with our communities to improve the way we deliver care
- We will seek to endeavour equitable voice of service users and professionals delivering our services
- Our success must be measured by outcomes that matter, co-created with the people who know our services the best
- We will adopt a life course approach across both community and mental health services which removes barriers, provides greater emphasis on prevention, and enables a pro-active approach
- We will work collaboratively at the appropriate scale as one health and care team, within the HIOW integrated care system and will recognise each other's leadership capabilities
- We will respect and value the interconnectivity of delivery with our partners, including primary care, local authority and voluntary services
- We will embrace innovation, research and new models of care
- Clinical and professional leadership is at the core of our success and must be appropriately resourced and supported

Clinical strategy for the new Trust

5.9 The clinical leaders across the Trusts have commenced the development of a clinical strategy for the new Trust that will enable us to respond to the challenges facing the Trusts and the wider ICS, as described in the case for change in chapter 3. A Clinical Steering Group has been established that includes the Chief Medical Officers and Chief Nursing Officers and will oversee the production of the clinical strategy.

5.10 The clinical strategy for the new Trust will encompass the principles for clinical transformation detailed in paragraph 5.8 above and reflect the emerging thinking from the clinical priority workstreams which has been underpinned by a shared clinical vision of high quality services that are accessible, person-centred and outcome-focused. Collaboration is at the heart of this approach, including collaboration between the Trusts, the people who use our services and system partners.

5.11 The clinical strategy will also respond to relevant external strategies including the Partnership Strategy (see priorities described in paragraph 3.12) and feedback from the joint senior leaders events (see paragraph 8.40).

5.12 The clinical strategy will be ambitious and transformational and will continue to evolve according to the changing needs of the population. The clinical strategy will establish a holistic approach to patient needs and ensure care is delivered in the most appropriate setting for the patient. The clinical strategy will aim to keep people as healthy and independent as possible and provide swift access to efficient, high quality care for those who need it. The clinical strategy will optimise patient safety, quality and experience through a consistent set of standards.

5.13 The clinical strategy will reflect the opportunities that come with working in a consistent way at scale but also align with the strategy for place and place priorities to establish a holistic approach to patient needs and ensure care is delivered in the most appropriate setting for the patient. The clinical strategy will aim to keep people as healthy and independent as possible and provide swift access to efficient, high quality care for those who need it, consistent with the shared aims of the ICS.

5.14 Population health management and the consequent reduction in health inequalities is key to both the ICS approach to health and care and the new Trust's clinical strategy. We are engaging with wider ICS partners, including public health and local authority colleagues, and our local communities to co-design our approach to this.

5.15 An overview of the emerging thinking within each of the clinical priority workstreams is as follows:

Children and Young People's Mental Health Services

5.16 Children and young people are one of the five priorities identified in the system's Partnership Strategy, with improving access and mental health outcomes for children and adolescent mental health services specifically referenced.

5.17 We have experienced unprecedented growth in demand on services. Pressures have existed within services for many years, however, these have been exacerbated by COVID-19. Services across the ICS offer high quality care, with practitioners, clinicians and managers who are dedicated to improving access and supporting young people and their families. Despite this, all too often young people have gone into crisis while awaiting support in the community and admission to hospital has been necessary. Whilst rapid access to inpatient care for those few with the highest need is critical to avoiding harm and keeping people safe, the experience of young people and their families has told us that we must do much more to ensure care and support is available when and where they need it, and close to home.

5.18 Specific actions will be identified to deliver improvements in:

- Quality of care
- Quality of working life - workforce
- Understanding of the service offer and reducing unwarranted variation

5.19 To address immediate service pressures we will implement innovative solutions including:

- Providing a forum to own/share risks for the system decisions that need to be made in difficult or challenging circumstances
- Undertaking a rapid review of the children and young people crisis pathway to identify how we address/reallocate resources in the short-term to strengthen our offer and develop further alternatives to crisis pathways
- Developing new models of care, in collaboration with key stakeholders for the children and young people with the most complex needs which cannot be met by traditional hospital inpatient treatment or social care placements

Neurodiversity pathways

5.20 There are at least 8,746 people (both children and adults) waiting for an attention deficit hyperactivity (ADHD) and autism assessment across the ICS with an average waiting time of 13.7 months (as of January 2022). While people wait for assessment,

they are often unable to access ADHD medication and support from the NHS, education, and local authorities to meet their needs.

5.21 Due to legacy commissioning arrangements, there are 25 contracts with 11 providers for ADHD and autism assessments and this capacity is half of what would be needed to meet current referral demand. Current arrangements are not financially viable, nor are the required resources available to meet the population needs. As a result, we need a multi-faceted response and to consider innovative ways of tackling the waiting list and establishing a new resilient service that will meet the population's needs in the future. The ICS is not unique in this position and neurodiversity is one of seven strategic priority areas for mental health in the region.

5.22 The workstream aims to develop a single all-age NHS service offer in relation to autism assessment and ADHD assessment and prescribing, enabling patients and carers to easily navigate streamlined pathways which make the most efficient use of available resources. The workstream aims to improve post diagnosis support, including effective signposting to specific resources (e.g. utilising technology and community assets) that will improve outcomes and experience for service users. In addition the workstream aims to empower all our teams (not just those directly providing autism/ADHD services) to understand and adapt the delivery of care and to signpost individuals to appropriate help and support in a timely way.

5.23 The workstream aims to develop an 'inclusion focus' with system partners, enabling all health and care providers to be autism/ADHD aware/friendly, able to make reasonable adjustments and to provide a needs-led approach to all individuals within their care, irrespective of diagnosis. This work has the potential to transcend traditional health and care partnerships, impacting on how local communities recognise and support neurodivergence, for example in workplaces, leisure and retail facilities.

Older People's Mental Health Services

5.24 Over the next ten years, the ICS older population will grow faster than the national average, which will be the primary driver for the increase in demand for community services. As a result, demand for community health services could grow by 11.3% by 2025 and the associated impact upon OPMH services will be significant. We are already starting to see this come into fruition, as an ICS we continue to increase the number of people being diagnosed with dementia but continue to fall short of the target due to increasing prevalence in our area. Our ability to meet the needs of our older persons population is also challenged by workforce pressures, particularly the lack of substantive OPMH consultants in the IOW.

5.25 The workstream aims to:

- Set the direction and vision for OPMH services for the next decade for the ICS
- Ensure flexible health and care pathways from primary care (tier 1) to the most specialist mental health care (tier 4) for older people and people with Dementia in the ICS to meet the needs of the ageing population. Provision of care closer to home will be a key principle of the transformed pathways.
- Transform services across the OPMH pathway, reducing unwarranted variation and barriers to access, for example due to age, postcode, or diagnosis
- Ensure our services and workplaces are great places to train, work, innovate and research
- Support the broader ICB work to ensure the ICS is a healthy place to age well and support the work to reduce health inequalities

Adult Mental Health Acute and Crisis Services

5.26 Across the ICS there is variance in our crisis offer, ranging from the functionality of crisis and home treatment teams, to alternatives to crisis pathways. Whilst some of this variation is warranted due to local need much of this is unwarranted variance resulting from resource challenges. Our service delivery risks focus on workforce pressures; there are recruitment and retention challenges for all services, but in particular for nursing and psychiatry roles. We therefore need to think creatively about the skillsets we require to meet the needs of those in crisis. There are great areas of opportunity to learn from and support each other and adopt and scale up areas of best practice where this is appropriate to do so, to better meet the needs of our population.

5.27 Our region has one of the lowest adult mental health bed bases in the country relative to population size. Historically we have been reliant on additional support from the private sector to ensure our patients remain local for inpatient care. Over the last 18 months we have invested in two new inpatient wards (one adult acute ward and one female psychiatric intensive care unit) and reduced use of contracted private sector beds. We have done this alongside improvements to the therapeutic environment, including splitting larger ward areas into smaller single sex wards. The need for additional inpatient staff has led to increased use of agency which is a quality and cost pressure and is not financially sustainable to the system. There is an opportunity to look at our bed management model and system flow together as a system, to maximise bedded capacity and ensure that when our patients need admission this can be accessed in a timely way close to home.

Community Mental Health Framework ('No Wrong Door' programme)

5.28 The Community Mental Health Framework was published in 2019 and sets out the LTP's vision for a place-based community mental health model that will provide a whole-person, whole-population health approach aligned to primary care. The ICS-wide No Wrong Door programme was established in 2021 to ensure a strategic approach to implementation and shared learning. The programme works closely with people who use services, partners in mental health services, commissioning, primary care, adult social care, and voluntary sector. The workstream has coproduced the following priorities:

- Development of models for integrated working between all partners. Multiagency groups have been established in all LDSs, with strong primary care leadership and engagement. This infrastructure provides us with opportunities to further grow and develop our neighbourhood and local delivery system (LDS) mental health offer.
- To develop a framework for moving on from care programme approach (CPA). This work has been led by Southern, but has engaged all parts of the system, and is developing a shared approach to care planning and measurement of clinical outcomes. Our intention is to build on this work to collaboratively review the role of community mental health teams across the system.
- Workforce development, recruitment (including a 'grow our own' programme), and collaborative working across organisational boundaries. Extended primary care mental health teams are in place in all LDSs.
- Emotionally Unstable Personality Disorder (EUPD), emotional dysregulation and personality disorder framework is being developed collaboratively, led by the Heads of Psychology in Southern, Solent and IoW.

Community Rapid Response services

5.29 Being able to respond to people who are in crisis, close to home, is a critical cornerstone in delivering unscheduled care across the ICS. Currently, the crisis and rapid response service model across the ICS is highly variable in terms of access, staffing model, clinical model, and outcomes.

5.30 There is currently no common framework for Community Rapid Response services and variability in the services offered which include:

- Urgent Community Response (UCR)
- Virtual Wards
- Community Same Day Emergency Care (SDEC)
- Community hubs

5.31 There is the opportunity to further develop rapid response services to manage deterioration and prevent admission. Consideration will need to be given to local place need, PCN need, reduction of unwarranted variation (where appropriate), specific health outcomes we seek to improve along with scaling up areas of best practice (where appropriate) to better meet the needs of our population.

5.32 We will have oversight of how rapid response is delivered across the ICS, how we share learning, and we will develop a single language, with metrics that are outcome focussed. We will develop a common framework and work together to better understand variation in access and delivery and deliver effective, patient-led pathways. We will work to understand variation in staffing models and investment and look at how and why these impact on outcomes. We need to build a universal the ICS offer, whilst at the same time recognising the importance of variation to respond to local geography and demographic need.

5.33 The workstream will enable us to better articulate the community offer across the ICS, defining the key components which enable effective rapid response. These include the right number of staff with the right skill set to undertake rapid response assessment, differential diagnosis, treatment plan; multidisciplinary working to support decision-making and plans to support patients in their own homes, including consultant practice, advanced clinical practice, and medical support; IT infrastructure to maintain a caseload safely; admin support to ensure that plans are enacted, and communication with people who need to be updated.

5.34 There are clear opportunities to improve patient outcomes through this work, by providing care close to home and through the benefits of timely response. This will benefit acute partners in reducing demand, will support primary care and will avoid inappropriate hospital admissions for our patients.

Community Hospitals and Community Inpatient Rehabilitation

5.35 This workstream is taking forward the recommendation of the independent review of community and mental health services to undertake a review of community physical health beds (see paragraph 3.26).

5.36 The ICS has significant community hospital bedded capacity as well as access to temporary beds provided by social care (short term beds / discharge to assess beds). These have not been strategically designed to match demand across the LDSs and the ICS. There is a need to define the use of temporary non acute beds within our health and care system and determine how these best serve the needs of our

population in a co-ordinated way. This includes step up care, step down care, the interface with both community rapid response and same day emergency care and an emphasis on home-based optimisation as a priority. Currently, there is no coordinated community bed and inpatient rehabilitation offer across the ICS, this workstream will develop a coordinated approach by reviewing the:

- Community bed configuration
- Community rehabilitation models of care
- Home-based services

5.37 The workstream aims to:

- Identify and address unwarranted variation in services that is negatively impacting on patient care
- Improve outcomes and experiences for people
- Improve access and reduce duplication
- Improve staff experience

5.38 These improvements will contribute to improved flow across acute trusts.

Community Frailty

5.39 The population of the ICS is living longer with more long-term conditions. As a consequence there is an increasing prevalence of people living with frailty against the backdrop of a health and social care system with disparate models of care delivery. We plan to identify, and address, unwarranted variation in services supporting older people living with frailty that is impacting on patient care and outcomes. Understanding that there is limited ability to modify frailty, the scope of this workstream will focus on:

- Mild frailty - the goal is evidence-based management of long-term conditions, self-management and maintenance of fitness
- Moderate frailty - starting the process of anticipatory care planning to decide what success for that individual looks like and adaptation around the limits being introduced by frailty
- Severe frailty - the goal is detailed anticipatory care planning to outline limits of intervention, goals for the individual and anticipatory care planning

5.40 Working with subject matter experts (including experts by experience) and other stakeholders we will map service provision and develop a vision that supports the above aspirations, keeping people safe at home with a greater emphasis on wellness, supporting self-management, and maintaining independence (where possible) and reducing impacts on non-elective care provision. A key interdependency for this workstream is the community rapid response services workstream.

5.41 In addition to improvements in outcomes and experience, we anticipate wider system benefits from this work, particularly in the primary care and acute sectors.

Community Health Specialist Services and Long-Term Conditions

5.42 The ICS population is living longer with more long-term conditions. There is a need for a coordinated pathway approach to support primary care in the proactive management of long-term conditions across the life course, to improve the outcomes for the

population, to mitigate against unequitable service provision and ensure its sustainability.

5.43 Long term conditions make up a significant proportion of NHS care. Whilst many patients have more than one condition, especially as they approach the end of life, for those who develop these throughout the life cycle, optimisation of medical care and building resilience to manage conditions are essential to minimise deterioration in both physical and mental health.

5.44 Long term conditions as described in the LTP are multiple and include diabetes, respiratory conditions (asthma and chronic obstructive pulmonary disease (COPD)), heart failure, musculoskeletal conditions (osteoarthritis and chronic spinal pain) and neurological disorders.

5.45 Whilst monitoring and day-to-day management of long-term conditions are supported predominantly by general practice, specialist community services provide significant support to people with long term conditions. The role focuses largely on supporting people to self-manage and adjusting medication and there is less focus on diagnosis. The services play an important role in reducing the likelihood of patients deteriorating and attending acute hospitals with exacerbations.

5.46 Across the ICS there is wide variation in what has been commissioned, depending largely on historic contract value and less driven by patient need. Some populations will have significant barriers to self-management and so differing amounts of investment are justified, for example wound care funded for all long-term conditions and in other areas it is for diabetes care only. The impact on services can be both demoralising and frustrating and for patients causes utter confusion.

5.47 The aims of this workstream are to:

- Improve the outcomes and experiences of care
- Improve the experiences of colleagues working in long term condition services
- Develop community services for the advanced management of increased levels of acuity and complexity in the community
- Ensure community health specialist services are developed to meet demand

Integrating Primary Care

5.48 Primary care resilience is emerging as a theme in the Joint Forward Plan and the new Trust will be well-placed to contribute to the delivery of plans in this area, informed by the work of this workstream.

5.49 The role of this workstream is to co-ordinate an overall approach to primary care in reference to both GP practices (existing and new) and PCN development with a view to the establishment of a primary care function within the new Trust. This function will align with the ICB primary care strategy to support long-term sustainability of primary care services across the ICS.

5.50 Strong, sustainable primary care services are central to the functioning of the NHS however many GP practices are struggling to survive for a complex range of reasons. Southern and Solent currently run two large GP practices and a homeless healthcare service. Discussions are ongoing regarding other struggling practices.

5.51 The establishment of PCNs was intended to improve resilience of practices and help integration of primary care with other parts of the health and care system; this needs a strategic approach to maximise the advantages of working together. We have made

progress on this within Solent in the last 6 months, with improving relationships with both PCNs and GP practices and a better understanding of how we can work together in the future.

5.52 Bringing together our community primary care services under a single function will helps us to run our General Practices well, maximise economies of scale, innovate and integrate with PCNs. This puts us in a better position to support other struggling practices in the future and maximise the integration of our community and mental health services with primary care.

Benefits of the clinical strategy

5.53 The clinical strategy will bring together clinical teams and services and provide the catalyst to break down historical barriers and encourage ambitious, person-centred solutions. The clinical strategy will enable a life course approach to delivering both mental and physical health care in our communities, from childhood through to end of life.

5.54 Implementation of the clinical strategy will support realisation of the benefits for patients, staff and the wider health and care system as set out in chapter 6 with simplified and unified clinical pathways leading to earlier adoption of best practice and improvements in patient experience, development of a more resilient and agile workforce and better use of resources.

5.55 The new Trust will enable existing coproduction work to be strengthened through a more co-ordinated approach to service user and carer involvement. The new Trust will also be better placed to shift the dynamic and encourage service user and population groups to be commissioned to provide services directly, with the support of the Trust.

5.56 Development of the clinical strategy will include consideration of measures of success which are likely to include improved compliance with established best practice clinical care pathways, reduction in avoidable morbidity and mortality and improvements in quality of life and wellbeing for the population we serve.

How the clinical strategy will support the ICS strategy

5.57 The approach aligns with the system Partnership Strategy and emerging five year JFP, and will enable its delivery, particularly as the new Trust works more closely with ICB colleagues to develop a more joined up and clinically led approach to planning and transformation.

5.58 The aims of the Partnership Strategy are set out in paragraph 3.12. The emerging clinical strategy for the new Trust aligns with, and will support delivery against, the priority areas identified in the Partnership Strategy: children and young people; mental wellbeing; and promoting good health and providing proactive care.

Next steps in developing clinical strategy

5.59 Building on the evolving work of the Clinical Delivery Group, the clinical strategy will continue to be developed by the Trusts alongside the ICB and other partners at system, place and local delivery system level including primary care, local authorities, acute providers and VCSE partners.

5.60 The clinical strategy will be informed by place priorities and the 5 year Joint Forward Plan for the ICS and people with lived experience will be actively involved in coproducing our clinical strategy. Engagement with local communities is a key part of our communications and engagement approach as described in paragraphs 8.47 to 8.51.

5.61 If we receive approval to proceed we will set out the detail of our approach to implementing the clinical strategy in our Post Transaction Integration Plan (PTIP).

Operating model

5.62 The operating model covers our governance, systems and processes, organisation structures and roles and our capabilities, culture and behaviours. The operating model will be designed to support delivery of the clinical strategy.

5.63 Our ambition is to create a new organisation with a new culture and common set of values that operates in line with key principles to enable sustainable change and address the challenges set out in the case for change (see chapter 3) and respond to future changes in demand. These principles are not currently delivered in a consistent way across all Trusts, we therefore have an opportunity in the creation of the new Trust to be deliberate in our design of the culture, leadership and operational delivery model to realise the benefits we are setting out to achieve.

5.64 The key principles are:

- We will be open, transparent, and inclusive in designing all elements of the new organisation and operating model
- We will deliver consistent, high quality and compassionate care
- We will put our communities, and the people in them, at the heart of all we do, providing holistic, integrated and strengths-based care that is coproduced with the people who use our services, their families and carers, and our communities
- We will be an excellent employer and will develop a learning culture that strives for continuous improvement
- The people who are employed by us will experience inclusivity and equity, and will show loyalty to the organisation because of the many, and real opportunities to develop and thrive
- We will be good partners in our neighbourhoods, places, and wider systems, ensuring our services are highly accessible
- We will actively address health inequalities
- We will develop and deliver a clinical strategy that is designed in coproduction with the people who use services and our communities. It will be standardised across the trust, evidence based and always prioritised. This will be supported by a workforce strategy that enables delivery of the clinical strategy, is achievable and supports our people and local economy
- We will use our collective resources wisely and deliver value for money
- We will embrace the opportunities to align commissioning functions and deliver self-assurance

- We will embed population needs assessment, demand and capacity planning and align with strategic commissioning
- The new provider will form the core of the out of hospital model of care for the HIOW ICS, working closely with other health and care providers to ensure the needs of local communities and others are listened to and supported

5.65 We are at the early stages of considering the new Trust's operating model and associated management arrangements which will support delivery of the clinical strategy. In the coming months, we will consider options for the operating model that are aligned with the key principles, informed by engagement with colleagues and key external stakeholders (including place-based partners) and learning from other models, to enable us to describe our plans in the Full Business Case and PTIP.

5.66 In developing the new Trust's operating model we will be mindful of the geography covered by the Trust and the range of services in terms of both type (for example community based or inpatient) and scale (ranging from large services such as forensic psychiatry to small specialist services such as those for people living at home with complex long term neurological conditions).

Supporting strategies

5.67 The clinical strategy will be central to the corporate strategy of the new Trust, alongside the supporting strategies of the new Trust such as People, Digital, Estates and Finance which will be key enablers. In developing these supporting strategies and our plans for the new Trust will be mindful of NHSE's guidance on cultural integration and digital integration and ensure alignment with relevant system-wide strategies, in particular recognising that people/workforce and digital and data were identified as priorities for joint strategic focus in the system Partnership Strategy.

5.68 The Digital Strategy will explore opportunities for a provider working at scale to embrace innovative digital solutions to support service delivery and meet healthcare demands, address inter-operability challenges, use data to understand unwarranted variations and explore new ways of working.

6 Benefits

Chapter summary

- This chapter sets out the expected benefits for patients, staff and our health and care system. The financial benefits of the creation of the new Trust are set out in chapter 7.
- Working with stakeholders including staff, patient groups and the ICB, we have identified four main categories of benefits that can be achieved through the creation of a new Trust for community and mental health services across the HIOW ICS.
- We will deliver benefits for patients through the provision of better care by:
    - Improving patient experience by creating services that are less fragmented, across both clinical pathways and geographic areas;
    - Improving patient safety and outcomes;
    - Enhancing the patient voice through our membership and the Council of Governors and our approach to community engagement which will enable the new Trust to respond more effectively to the needs of the populations that we serve; and
    - Increasing research opportunities.
- We will deliver benefits for staff and create a better place to work by:
    - Reducing vacancies by developing a single approach to tackle recruitment and retention challenges;
    - Improving career progression and development opportunities;
    - Improving job satisfaction;
    - Continuing to develop an inclusive, open culture that promotes learning and continuous improvement;
    - Improving service resilience and reduced professional isolation; and
    - Attracting and retaining strong leadership.
- We will make it easier for our partners to work with us effectively, delivering benefits to the wider health and social care system, by:
    - Supporting our partners to provide more joined-up care across the health and social care system; and
    - Being a strong and consistent voice for community and mental health services across the ICS, working with partners at neighbourhood, place and system levels to achieve the system's aims.
- We will set out our detailed plans to realise these benefits in the Full Business Case and Post-Transaction Integration Plan.

6.1 The new Trust will be better placed to deliver the transformation of community and mental health services, building on the work of the Clinical Delivery Group described in the previous chapter. Working with stakeholders including staff, patient groups and the ICB, we have identified significant benefits that can be achieved through the creation of a new Trust for community and mental health services across the ICS.

6.2 These benefits are summarised into four main categories:

- Benefits for **patients and populations** through the provision of better care;

- Benefits for **staff** from creation of a better place to work;
- Benefits for the **wider health and care system** through being an effective partner; and
- Financial benefits.

6.3 Realising these benefits will enable us to make progress in addressing the case for change described in chapter 3.

6.4 It is recognised that the Trusts are already working to deliver some of these benefits but the creation of a new Trust will allow delivery of more benefits within a shorter timeframe.

Benefits for patients and populations

6.5 We will **improve the patient experience** by creating services that are less fragmented, across both clinical pathways and geographic areas. In particular, this will enable:

- Improved accessibility of our services by reducing the number of interfaces encountered by patients and their carers that can act as barriers to the provision of fast and easy access to care;
- Improved continuity of care by aligning the geographic coverage of our service teams and reducing the number of interfaces across care pathways;
- Improved patient experience by simplifying pathways and reducing hand-offs so that a single Trust can be the single point-of-contact across the ICS for a patient to interact with; and
- Improved communication with patients, their carers, and across clinical teams by reducing the inter-organisational boundaries along patient pathways that can act as barriers to the provision of consistent and complete information.

6.6 We will achieve **improvements to patient safety and outcomes** through:

- Providing the right care first time, through a tiered approach to service improvement, innovation and transformation that utilises our combined transformation expertise and recognises the importance of both standardisation to reduce unwarranted variation and adaptation to meet the needs of place, as set out in Figure 9 below;
- Supporting people more effectively at home and in the community, by strengthening links between mental and community services in local communities that services are tailored to specific local needs;
- Strengthening our ability to better align capacity and need and intervene earlier and support prevention, focusing our resources on frontline care by reducing duplication and expanding shared clinical systems and support services;
- Improving the quality of patient care by maintaining safe staffing levels, out-of-hours medical rosters and reducing gaps in specialist clinical knowledge by sharing resources more widely and improving knowledge transfer within teams; and

- Developing a culture that values the voice of lived experience in all we do, from every clinical interaction to the design and delivery of service. The culture will support recovery and coproduction resulting in improved safety, outcomes and experience for patients.

Figure 9: Tiered approach to service improvement, innovation and transformation

Design and deliver once across the ICS	For high complexity and low volume services that would benefit from a single approach across the ICS e.g. CAMHS approach to admission avoidance
Design once and deliver at place	This applies to the majority of improvement work with the intention of building in consistent standards and metrics but allowing for local variation according to population needs and local resources
Design and deliver at place and share learning	This will apply to local innovations and response to specific local circumstances e.g. the need for a merged out-of-hours mental health service in Isle of Wight due to the small scale of services
This will be a consistent approach to continuous improvement that will ensure improvements are sustained.	

6.7 The clinical strategy for the new Trust will aim to keep people as healthy and independent as possible and we anticipate this will contribute to improvements in health and wellbeing outcomes for our population and support delivery of the Partnership Strategy priority to promote healthy lifestyles.

6.8 Through the work of our Clinical Delivery Group (see chapter 5), we have already identified the following **service-level benefits** which demonstrate how these broad patient benefits will crystallise in specific services:

- Transformation of the eating disorder pathway to reduce fragmentation and provide consistency across all services;
- The No Wrong Door programme is delivering integration at neighbourhood and place between community mental health services and our partners in primary care, VCSE and local authority services. A consistent ICS-wide approach to this programme is enabling reduction in variation and shared learning; and
- Integrated working at neighbourhood, local delivery system and place levels with our partners in acute care, primary care, local authorities, VCSE and independent sector will enable a reduction in variation and shared learning in relation to the frailty and community rapid response pathway.

6.9 We expect to identify further service-level benefits (including in relation to children and young people, one of the priorities in the Partnership Strategy) as we evolve our clinical strategy and develop our detailed integration plans. We will also consider if there are benefits for particular population groups who experience inequalities, for example Gypsy, Roma and Traveller communities and coastal communities.

6.10 In developing our digital strategy we will explore opportunities for the new Trust to embrace digital developments, address inter-operability challenges, use data to understand unwarranted variation and explore new ways of working. Resulting benefits for patients will be articulated in the Full Business Case.

6.11 With a wider public constituency covering the entire population of Hampshire and the Isle of Wight, we will have an **enhanced patient voice** through our membership and the Council of Governors and our approach to community engagement (see paragraph 8.50). This will enable the new Trust to respond more effectively to the needs of the populations that we serve.

6.12 In addition, our **research** teams are excited about the opportunities which will arise from the creation of a new Trust which will ultimately result in benefits for patients:

- Conducting research across the ICS, increasing access to possible participants and generating economies of scale;
- Expansion of primary care research;
- Increasing the scope of the existing complementary research strategies in Southern and Solent and developing a bespoke community-based research strategy for the Isle of Wight; and
- Better aligning research approaches and strategy with other research infrastructure such as National Institute for Health and Care Research Clinical Research Network, Wessex Health Partners and the Academic Health Science Network.

Benefits for staff

6.13 We will reduce vacancies (which will reduce operational pressures on staff and improve staff satisfaction) by developing a single approach to **tackle recruitment and retention challenges** and fill 'hard to fill' posts (this will also have a financial benefit), including developing new innovative roles where traditional recruitment has been challenging. This will build on existing collaboration, including in international recruitment where Southern, Solent and IoW have been working together since 2022.

6.14 We will offer improved **career progression and development** opportunities (which will improve retention rates and staff satisfaction) including by:

- Using our greater scale to develop a more diverse range of opportunities, in particular by re-investing the time currently required for duplicated work across organisations into new and more specialist roles. For example, we will pool the Mental Health Act and Liberty Protection Safeguards expertise which will allow further development of specific areas of expertise for staff within the new function. There are likely to be similar opportunities in pharmacy services;
- Using our greater scale to reduce the need for staff to move between organisations to progress their careers and thereby improve talent retention; and
- Offering improved professional development and training opportunities (including strengthened access to support, advice and supervision) through the creation of a shared training function that provides high quality and consistent training.

6.15 We will improve **job satisfaction** by:

- Sharing resources more effectively to maintain safe staffing levels, out-of-hours medical rosters and reducing gaps in specialist clinical knowledge, particularly of smaller services;
- Removing inequity of roles across aligned services by aligning operational, clinical and management processes, job descriptions and terms and conditions; and
- Supporting staff more effectively with a people function that builds on the best of the existing ways of working across our people directorates and the existing wellbeing offers for staff.

6.16 We will ensure the continued development of an **inclusive, open culture** that promotes learning and continuous improvement by strengthening professional, clinical and operational peer networks and creating opportunities for shared learning wherever possible.

Case study: reverse mentoring programme

The Solent and Southern reverse mentoring programme 2023 is currently recruiting, with over 50 applications received in the first two weeks. The resources to support the promotion, attraction and ongoing support for this programme have been developed collaboratively to maximise their impact and return on investment of time and funding. The mentors and mentees will share their respective learning and reflection spaces, enabling them to build relationships and connections across organisational boundaries. This innovative approach to a shared programme demonstrates the opportunity we will have to support larger scale culture change through combined interventions in the new Trust.

6.17 We will improve **service resilience** and reduce professional isolation (particularly of smaller services and out-of-hours rotas) and allow service capacity to be better aligned with need by:

- Making it easier for staff to move around services across the ICS through common service models; and
- Investing in technology to reduce barriers presented by geography, in particular to the Isle of Wight.

6.18 We will **attract and retain strong leadership** by:

- Building an exciting shared purpose, vision, and people strategy for the new Trust that our people want to be a part of; and
- Developing a consistent matrix model of leadership that is aligned with professional development standards and supports operational and clinical delivery across innovative pathways of care.

Benefits for the health and care system

6.19 By bringing all community and mental health services together into one Trust we will make it easier for our partners to work with us effectively, delivering benefits to the

wider health and social care system. This will include the wide range of partners the Trust will need to work with in relation to the wider determinants of health including housing, education and the voluntary sector.

6.20 We will support our partners to **provide more joined-up care** across the health and social care system for those who need it by:

- Simplifying and integrating our care pathways and making it easier for primary, social care and other partner colleagues to signpost to and work with our services to support people in the community; and
- Reducing ED attendances and avoidable admissions to secondary care through reducing the complexity and duplication of our care pathways to care for patients in community settings when appropriate. Urgent and emergency care is emerging as a theme in the JFP and the new Trust will be well-placed to contribute to delivery of plans in this area.

6.21 The new Trust will be a **strong and consistent voice** for community and mental health services and work with partners at neighbourhood, place and across the wider ICS to:

- Inform and shape future system and place strategy development;
- Support delivery of the system Partnership Strategy, in particular contributing to the priorities for joint strategic focus) children and young people, mental wellbeing, good health and proactive care, people/workforce and digital and data);
- Work with neighbourhood teams to support key programmes such as the Fuller Stocktake implementation and work effectively with other members of the provider collaboratives across the system;
- Increase visibility of mental health and community services and needs within place-based partnerships, working with a range of partners to address the wider determinants of health and integrate services;
- Provide a platform to better support primary care through enhanced integrated community-primary care services in communities;
- Enable health inequalities to be more easily addressed with commissioners and provider collaborative partners through simplified commissioning of mental health and community services; and
- Simplify governance with the ICP and ICB with a single Trust being held accountable for the delivery of safe and high-quality mental health and community services and a reduction in the number of legal entities in the system.

Benefits realisation

6.22 We will set out our detailed plans to realise these benefits in the Full Business Case and PTIP, as described in paragraphs 8.28 to 8.30. This will include considering any potential disbenefits and identifying risks associated with specific benefits realisation plans to ensure these are mitigated appropriately. The programme risk register (see Figure 21 in chapter 8) includes strategic risks to realising benefits, such as leadership burnout.

7 Finance

Chapter summary

- This chapter sets out the financial performance of:
  - Southern;
  - Solent;
  - the community and mental health services of IoW which are proposed to transfer to the new Trust; and
  - the Hampshire CAMHS of Sussex Partnership which are proposed to transfer to the new Trust.
- It also sets out the expected incremental costs and savings from creation of the new Trust.
- The revised financial regime that was implemented during the COVID-19 pandemic resulted in the Trusts delivering breakeven or small surplus positions in 2020/21 and 2021/22. However, in previous years both Southern and IoW reported deficits.
- In 2022/23 both Southern and Solent planned to achieve breakeven and the Trusts are currently forecasting surpluses of £1.5m and £0.4m respectively.
- The community and mental health services on the Isle of Wight form part of an integrated NHS Trust that also provides acute and ambulance services. The Trust planned for a deficit of £13.1m in 2022/23, with the community and mental health segment planning for a deficit of £0.7m. The deteriorating financial performance has resulted in a segment deficit of £2.9m now being forecast.
- An analysis by segment has been completed for IoW 2021/22 outturn and 2022/23 plan with the intention of updating to reflect 2022/23 outturn to support preparation of the Full Business Case. Further work will be required to identify any stranded costs and agree how these will be managed. Similarly, it has not yet been agreed how the historic financial deficit of the Trust will be managed following the proposed transfer of services.
- The Hampshire CAMHS of Sussex Partnership has worked within its budget over the past five years. However, the service is forecasting a deficit of £0.4m in 2022/23.
- Achievement of the current year's forecast outturn for Southern, Solent and the services proposed to transfer from IoW and Sussex Partnership relies on non-recurrent benefits and the underlying cumulative forecast deficit for 2022/23 is £46.0m. All Trusts are currently reviewing their underlying financial position as part of planning for 2023/24 and are developing recovery plans to reduce these underlying deficits.
- This level of financial challenge is being experienced across the HIOW ICS and the system will need to deliver unprecedented savings to achieve a balanced position in future years.

Chapter summary (continued)

- Although the primary driver for the transaction is the significant benefits that can be realised for patients (as described in the previous chapter), the Trusts have identified savings of between £2m and £2.5m per annum relating to economies of scale from bringing the Trusts and services together. We have not assumed any financial benefits from reductions in the cost base for clinical services. We anticipate there will be opportunities to streamline corporate services and the scale of these opportunities will be explored and quantified during the development of the Full Business Case. We also anticipate that the creation of a more sustainable workforce through the removal of barriers around workforce mobility and creating a single, shared workforce plan and vision will improve recruitment and retention, thereby reducing temporary staffing costs and deliver a financial benefit.
- We are seeking to keep transaction costs low by minimising use of external advisers and using in-house resources (back-filled to ensure there is sufficient capacity) where we have the appropriate skills. The Trusts have developed a programme budget and an approach for sharing transaction costs has been agreed in principle.
- Although, in and of itself, the transaction will not provide a solution to the underlying financial position, bringing together mental health and community services across HIOW ICS will provide a platform to improve the financial resilience and sustainability of community and mental health services. Creation of the new Trust provides an opportunity to better use our collective resources to meet the needs of the population.

Southern Health NHS Foundation Trust financial performance

7.1 The revised financial regime that was implemented during COVID-19 resulted in the Trust being able to deliver a breakeven position in both 2020/21 and 2021/22 although the Trust reported deficits in previous years. Since 2019/20 there has been investment in the mental health investment standard and strengthening discharge planning, as well as additional income from the national financial regime during COVID-19 in 2020/21 and 2021/22. Securing adequate and sufficient workforce has become an increasing pressure, particularly around the medical workforce and mental health inpatient wards. The Trust has delivered an ambitious capital programme of £54m during this time including securing national funding to reduce dormitory accommodation and increase en suite facilities in mental health wards as well as invest in digital development.

7.2 In 2022/23 the Trust planned to achieve breakeven and is currently forecasting a marginally improved position of £1.5m surplus. There is significant risk in-year attributed to high temporary staffing costs, cost increases in non-pay linked to inflationary pressures and the ability to deliver meaningful levels of recurrent cost reduction alongside increasing demand and acuity. Achievement of the surplus this year will be reliant on non-recurrent benefits; when these are excluded the Trust is

forecasting a normalised underlying deficit of £23.8m[24] which is considered in paragraph 7.15 below.

7.3 Southern's recent and current financial performance is summarised in **Figure 10** below.

Figure 10: Southern Health NHS Foundation Trust financial performance

Southern Health Income and Expenditure	2020/21 Actual £000	2021/22 Actual £000	2022/23 Forecast £000
Clinical income	340,078	378,521	400,588
Other income	43,180	23,224	22,892
Pay	(277,414)	(291,421)	(317,119)
Non-pay	(103,303)	(111,675)	(98,830)
Operating Surplus/(Deficit)	**2,541**	**(1,351)**	**7,531**
Gain/(loss) on disposal of fixed assets	609	(496)	
Net finance costs	(1,231)	(1,175)	(1,059)
PDC dividend	(4,491)	(4,786)	(5,159)
Retained Surplus/(Deficit)	**(2,572)**	**(7,808)**	**1,313**
Revaluation (exceptional)	2,702	7,781	0
Donated assets and other impacts	3	109	187
Surplus/(Deficit) pre exceptional items	**133**	**82**	**1,500**
Plan	**0**	**0**	**0**
Variance from plan	**133**	**82**	**1,500**

7.4 Southern's balance sheets as at 31 March 2021, 31 March 2022 and forecast as at 31 March 2023 are set out in Figure 11 below. Cash balances within the Trust have remained high due to the system controls in place that have limited the use of capital.

[24] All providers are currently reviewing their underlying financial positions as part of planning for 2023/24.

Figure 11: Southern Health NHS Foundation Trust balance sheet

Southern Health Balance Sheet	As at 31/3/21 £000	As at 31/3/22 £000	Forecast as at 31/3/23 £000	
Non-current assets	207,364	223,885	309,175	*
Cash	46,752	58,654	44,718	
Current assets	8,758	11,005	16,822	
Current liabilities	(60,111)	(75,645)	(77,986)	
Assets less current liabilities	**202,763**	**217,899**	**292,729**	
Non-current liabilities	(16,203)	(15,874)	(85,000)	*
Total assets employed	**186,560**	**202,025**	**207,729**	
Financed by				
PDC	103,870	114,213	118,638	
Revaluation reserve	54,177	67,107	67,106	
Other reserves	(755)	(755)	(755)	
Income & expenditure reserve	29,268	21,460	22,740	
Charitable funds reserve	0	0	0	
Total taxpayer's equity	**186,560**	**202,025**	**207,729**	

* Impact of IFRS16

Solent NHS Trust financial performance

7.5 Over the past five years Solent has achieved a surplus financial position. Income growth since 2019/20 primarily relates to the mental health investment standard, strengthening discharge planning and, in 2020/21 and 2021/22, the national financial regime put in place during COVID-19. Securing adequate and sufficient workforce has become an increasing pressure particularly around the medical and nursing workforce and mental health inpatient wards. The Trust has delivered a significant capital programme of £32m during this time including securing national funding to improve facilities in mental health wards, replace the Trust wide network infrastructure and build a new 50 bed extension on the community hospital campus in Southampton (planned for completion in 2024/25).

7.6 In 2022/23 the Trust planned to achieve a breakeven position and is currently forecasting delivery of a small surplus (£0.4m). There is significant risk in-year attributed to high temporary staffing costs, cost increases in non-pay linked to inflationary pressures and the ability to deliver meaningful levels of recurrent cost reduction alongside increasing demand and acuity. Achievement of a small surplus this year will be delivered by utilising non-recurrent benefits. The underlying position for 2022/23 is considered in 7.15 below[25].

7.7 Solent's recent and current financial performance is summarised in **Figure 12** below.

[25] All providers are currently reviewing their underlying financial positions as part of planning for 2023/24.

Figure 12: Solent NHS Trust financial performance

Solent Income and Expenditure	2020/21 Actual £000	2021/22 Actual £000	2022/23 Forecast £000
Clinical income	202,946	227,989	230,732
Other income	35,631	30,108	23,650
Pay	(156,064)	(178,619)	(182,438)
Non-pay	(79,485)	(76,713)	(68,964)
Operating Surplus/(Deficit)	**3,028**	**2,765**	**2,980**
Gain/(loss) on disposal of fixed assets	6	(12)	(9)
Net finance costs	3	20	178
PDC dividend	(2,080)	(2,437)	(2,796)
Retained Surplus/(Deficit)	**957**	**336**	**353**
Revaluation (exceptional)	(364)	(136)	0
Donated assets and other impacts	(505)	(133)	80
Surplus/(Deficit) pre exceptional items	**88**	**67**	**433**

Plan	**(2,955)**	**(1,544)**	**0**
Variance from plan	**3,043**	**1,611**	**433**

7.8 Solent's balance sheets as at 31 March 2021, 31 March 2022 and forecast as at 31 March 2023 are set out in Figure 13 below. Cash balances remain high within the Trust due to the system controls in place for the use of capital.

Figure 13: Solent NHS Trust balance sheet

Solent Balance Sheet	As at 31/3/21 £000	As at 31/3/22 £000	Forecast as at 31/3/23 £000	
Non-current assets	102,827	111,268	174,348	*
Cash	36,356	36,832	22,774	
Current assets	13,500	14,137	13,180	
Current liabilities	(47,475)	(49,337)	(48,564)	
Assets less current liabilities	**105,208**	**112,900**	**161,738**	
Non-current liabilities	(128)	(147)	(41,848)	*
Total assets employed	**105,080**	**112,753**	**119,890**	
Financed by				
PDC	32,875	35,545	42,249	
Revaluation reserve	5,080	9,601	9,354	
Other reserves	0	0	0	
Income & expenditure reserve	67,125	67,607	68,288	
Charitable funds reserve	0	0	0	
Total taxpayer's equity	**105,080**	**112,753**	**119,890**	

* Impact of IFRS16

Isle of Wight NHS Trust community and mental health services financial performance

7.9 The community and mental health services form part of an integrated trust on the Isle of Wight. The Trust also provides acute and ambulance services. During 2020/21 and

2021/22 the Trust achieved a breakeven position (and it has been assumed that each segment achieved a breakeven position) due to the financial regime in COVID-19, however in previous years the Trust reported deficits (£30.1m in 2018/19 and £17.7m in 2019/20).

7.10 The Trust submitted a deficit plan for 2022/23 of £13.1m, with the community and mental health segment planning for a deficit of £0.7m. The deteriorating financial performance has resulted in a segment deficit £2.9m now being forecast, mainly due to unfunded pay award pressures and unfunded non pay inflation.

7.11 As part of the Isle of Wight sustainability programme, the Trust is using Service Line Reporting information as appropriate, supplemented with local intelligence to inform accurate apportionment between segments. This analysis has been completed for 2021/22 outturn and 2022/23 plan with the intention of updating to reflect 2022/23 outturn to support preparation of the Full Business Case. Following analysis of the 2022/23 outturn by segment, further work will be required to identify any stranded costs and agree how these will be managed.

7.12 Similarly, it has not yet been agreed how the historic financial deficit of the Trust will be managed following the transfer of services. The unique nature of delivering essential local NHS hospital services, 24/7, to a geographically isolated and sub-scale population of 140,000 island residents, without any boundary neighbours to provide mutual aid or support creates additional financial challenges referred to as the 'structural deficit'. The proportion of the structural deficit that relates to community and mental health services will be updated at Full Business Case stage. The changes proposed in the Isle of Wight sustainability programme (which is subject to a separate Joint Strategic Case) will reduce inefficiencies, allow better co-ordination of resources and increase the resilience of the services delivered on the Isle of Wight.

7.13 Growth in income in both community and mental health services is in relation to the LTP (e.g. Hospital Discharge Programme and Mental Health Investment standard). This investment has supported offering a wider range of services and has predominately resulted in increasing the workforce of each service, in more locations as well as offering more home-based services. Due to the nature of the Trust being island-based attracting staff across all professions is a continual cause for concern, over and above that experienced by mainland providers.

Figure 14: Isle of Wight NHS Trust mental health and community services financial performance

IOW Income and Expenditure	2020/21 Actual £000	2021/22 Actual £000	2022/23 Forecast £000
Clinical income	44,564	51,068	54,435
Other income	10,169	4,372	2,442
Pay	(37,485)	(41,679)	(44,365)
Non-pay	(17,248)	(13,761)	(15,423)
Operating Surplus/(Deficit)	**0**	**(0)**	**(2,911)**
Gain/(loss) on disposal of fixed assets	0	0	0
Net finance costs	0	0	0
PDC dividend	0	0	0
Retained Surplus/(Deficit)	**0**	**(0)**	**(2,911)**
Revaluation (exceptional)	0	0	0
Donated assets and other impacts	0	0	0
Surplus/(Deficit) pre exceptional items	**0**	**(0)**	**(2,911)**

Plan	**0**	**0**	**(2,271)**
Variance from plan	**0**	**(0)**	**(640)**

Sussex Partnership NHS Foundation Trust Hampshire CAMHS financial performance

7.14 Hampshire CAMHS has worked within its budget over the past five years. Investment of almost £11m (67%) over the past three years has increased staffing and increased service delivery to better support the demands in this area. Key investments have been in the areas of psychiatric liaison in acute hospitals, eating disorder community services, increased capacity in crisis teams, increased capacity in community teams and the introduction of Mental Health in Schools teams. The challenge of securing adequate workforce has become an increasing pressure particularly around the medical and nursing workforce.

Figure 15: Sussex Partnership Foundation Trust Hampshire CAMHS financial performance

Sussex Income and Expenditure	2020/21 Actual £000	2021/22 Actual £000	2022/23 Forecast £000
Clinical income	15,825	23,198	26,358
Other income	1,225	517	581
Pay	(13,387)	(16,438)	(20,398)
Non-pay	(3,975)	(5,420)	(6,449)
Operating Surplus/(Deficit)	**(312)**	**1,857**	**92**
Gain/(loss) on disposal of fixed assets	0	0	0
Net finance costs	0	0	0
PDC dividend	(342)	(1,407)	(511)
Retained Surplus/(Deficit)	**(654)**	**450**	**(419)**
Revaluation (exceptional)	0	0	0
Donated assets and other impacts	0	0	0
Surplus/(Deficit) pre exceptional items	**(654)**	**450**	**(419)**
Plan	**0**	**0**	**0**
Variance from plan	**(654)**	**450**	**(419)**

Underlying position of Southern, Solent and services proposed to transfer from IoW and Sussex Partnership

7.15 Achievement of the current year's forecast outturn for Southern, Solent and the transferring services from IoW and Sussex Partnership relies on non-recurrent benefits and an analysis of the underlying position is presented in Figure 16 below. This presents a position which includes the full year effects of in-year pressures and removes the non-recurrent benefits which have supported all Trusts in 2022/23. This moves the position from a cumulative forecast outturn of £1.4m deficit to an underlying deficit of £46.0m[26]. The main movements relate to non-recurrent efficiencies, recruitment slippage, release of mitigated provisions and the full year effect of in-year service changes and energy prices.

Figure 16: 2022/23 Forecast outturn underlying position for Southern, Solent and services proposed to transfer from IoW and Sussex Partnership

2022/23 Forecast Outturn Underlying Positon	Southern Health £000	Solent £000	IOW £000	Sussex Partnership £000	Total £000
Forecast Outturn	1,500	433	(2,911)	(419)	(1,398)
Adjust for:					
Non recurent and balance to full year effect	(25,264)	(14,308)	(3,075)	(1,954)	(44,601)
Forecast Underlying Outturn	**(23,764)**	**(13,875)**	**(5,986)**	**(2,373)**	**(45,999)**

[26] Sussex Partnership and the ICB are working to establish the recurrent financial position of the Hampshire CAMHS service. The underlying position included in this figure and in the figure below reflects Sussex Partnership's view of their position in 2022/23 after non-recurrent funding. The recurrent deficit from future years arising from cost inflation and other factors is expected to be significantly smaller.

7.16 All Trusts are currently reviewing their underlying financial positions as part of planning for 2023/24 and developing recovery plans to reduce these underlying deficits. The impact of these plans will be considered as part of the financial due diligence and reflected in the Full Business Case.

7.17 At the time of writing this Strategic Case, the national and local planning process for 2023/24 and beyond has only just commenced. Projections for the new Trust in the Full Business Case will reflect future funding levels, efficiency requirements and recovery plans which will be confirmed over the next two months.

7.18 As described in paragraphs 7.19 to 7.20 below, this level of financial challenge is being experienced across the ICS (and the wider NHS) and is not unique to the Trusts who are part of this Strategic Case.

Historical system performance and ICS context

7.19 The ICS faces a significant financial challenge to live within its means, in part due to structural factors (particularly the higher costs of providing care to the geographically isolated Isle of Wight population) as well as non-elective pressures and a productivity challenge. The system, including the providers of community and mental health services, has been working collaboratively to improve the forecast outturn for 2022/23 and clarify and improve the underlying deficit position. The system will need to deliver unprecedented savings to achieve a balanced position in future years.

7.20 As set out in paragraph 3.26, the independent review of community and mental health services across the ICS included a recommendation to approach funding arrangements for community and mental health services from a more strategic level. The proposed system approach to addressing this recommendation is detailed in appendix 5.

Expected savings from the transaction

7.21 In the short term, the most significant savings relate to economies of scale from bringing the Trusts and services together, such as the reduction in Boards and rationalisation of processes, systems and licences. These are expected to be in the region of between £2m and £2.5m per annum.

7.22 We have not assumed any financial benefits from reductions in the cost base for clinical services. We recognise that there will be a need for enhanced leadership to ensure the successful implementation of the PTIP and that this will support talent retention.

7.23 Support services, such as corporate services, will be provided once across the organisation at scale. Developing plans to ensure effective and efficient services will be the priority of the Steering Groups as we progress the due diligence and integration planning for the new Trust and develop the Full Business Case. We anticipate there will be opportunities to streamline corporate services and the scale of these opportunities will be explored and quantified during the development of the Full Business Case.

7.24 We also anticipate that the creation of a more sustainable workforce through the removal of barriers around workforce mobility and creating a single, shared workforce plan and vision will improve recruitment and retention, thereby reducing temporary

staffing costs and deliver a financial benefit. We will scope this benefit during the development of the Full Business Case.

Other financial benefits from the transaction

7.25 Enhancing research and innovation, as described in paragraph 6.12, is expected to offer opportunities to generate additional income and deliver efficiencies.

Transaction Costs

7.26 We are seeking to keep transaction costs low by minimising use of external advisers and using in-house resources (back-filled to ensure there is sufficient capacity) where we have the appropriate skills. This approach has the additional advantage of ensuring ownership and retention of the developing thinking and planning.

7.27 The Trusts are developing their 2023/24 plans collaboratively to allow prioritisation of any capital investment (e.g. in digital or estates) required to support the transaction in advance of 1 April 2024.

7.28 The Trusts have developed a programme budget with input from Steering Groups based on their expected resource requirements. This budget identifies transaction costs of c. £4m to be incurred in 2023/24. This includes due diligence costs, legal advice and project and programme management costs. This programme budget will be monitored by the Programme Board.

7.29 An approach for sharing transaction costs has been agreed in principle and transaction costs to be incurred in 2023/24 will be reflected in the Trusts' 2023/24 plans as appropriate.

7.30 Based on the initial savings identified in paragraph 7.21 above, the payback period is expected to be within two years.

Conclusion

7.31 The primary driver for the transaction is the significant benefits that can be realised for patients, as described in chapter 6. However, the Trusts recognise that the ICS faces significant financial challenge. Although, in and of itself, the transaction will not provide a solution to the underlying financial position, bringing together mental health and community services across the ICS will provide a platform to improve the financial resilience and sustainability of these services. Creation of the new Trust provides an opportunity to better use our collective resources to meet the needs of the population. As set out in paragraph 7.30 above, savings from the transaction are expected to outweigh the transaction costs within two years.

8 Transaction execution

Chapter summary

- This chapter outlines our plans to deliver the transactions which will result in the creation of the new organisation.
- The Trusts are working together to establish a new Trust for community and mental health services with a new vision, strategy, values, name and operating model.
- From a legal perspective, the new Trust will be created through a merger of Solent and Southern (executed as an acquisition of Solent by Southern) and the transfer of the contracts for Isle of Wight community and mental health services and for Hampshire CAMHS from IoW and Sussex Partnership respectively to this enlarged organisation. The transfer of services from IoW is subject to a separate Joint Strategic Case, commissioner decision and regulatory approval; the transfer of services from Sussex Partnership is subject to ICB decision.
- The constitution of Southern will be updated to reflect the revised population served, service portfolio and shared future ambitions and the new Trust will have a new name.
- The Trusts are working closely with NHS England and the ICB to agree the detailed process by which the Board (of Southern) will evolve to ensure it has the necessary skills and experience to enable it to provide effective leadership and oversight of the enlarged Trust.
- The intended 'go-live' date for the new Trust is 1 April 2024. It has been assumed that all transactions happen on 1 April 2024, however the Trusts are working closely with the ICB to mitigate any risks arising from timing changes and are confident these could be accommodated safely.
- Robust programme governance arrangements are in place including a Programme Board, Programme Team and Steering Groups. Following approval of the Strategic Case the Trusts intend to review the governance arrangements and agree any changes required for Full Business Case stage.
- A Programme Director and Programme Manager are in place and the Trusts have identified the resources required to develop the Full Business Case and Post-Transaction Integration Plan.
- The Trusts have developed a plan to understand the cultures of the four Trusts which will inform an organisational development programme to develop the desired culture of the new Trust.
- A risk management approach is in place and programme risks and mitigations have been identified. The most significant risks to the programme are loss of staff during the period of transition destabilising services and the timing of transfer of services from IoW and Sussex Partnership not aligning with creation of the new Trust.
- A due diligence approach has been developed with plans to undertake the majority of due diligence internally to retain knowledge in the new Trust and ensure ownership of risks identified through due diligence.

Chapter summary (continued)

- A communications and engagement plan has been developed which describes the principles, approach and activity to ensure a co-ordinated approach with people who use our services and partners. The plan includes a programme of engagement with people who use our services, their families and carers and with our communities to develop a comprehensive understanding of what matters most to people about their local community and mental health services to influence the development, delivery and design of the new Trust.

Approach to creating a new Trust

8.1 We want all people in Hampshire and the Isle of Wight to have equitable access to integrated, safe, consistent community and mental health care. Working alongside our communities, we will design a model of community and mental health care which ensures the right focus is given to proactive care and healthy behaviours, where children and young people are properly supported to get the best start in life. We must enable a future where equal importance is given to mental wellbeing and physical health; where care is delivered closer to home, and hospital and urgent care services are only used when they are absolutely needed.

8.2 We will be more likely to achieve this future by joining up the disparate, often inconsistent services and pathways delivered by four different community and mental health providers. We need to bring our expertise and resources together to manage increasing demand and complexity and deliver meaningful, long-lasting change. Partners have agreed that the best way to enable our vision is by working together to establish a new, single community and mental health provider, while, at the same time, accelerating collaboration and transformation, led by our clinical experts, to reduce the significant pressures in our system.

8.3 The new community and mental health provider will be one of the biggest in the country, with the potential to become a national role model in sustainable, transformative, local care models which make a real difference to patients, communities and systems. In order to realise the opportunity and deliver benefits which outweigh the risks and costs, we must be brave and forward looking. The new organisation must be able to respond to the contemporary and future needs of our communities. It will have a new vision, strategy, values, name and operating model which recognises and enables our collective ambition.

8.4 The process to establish the new organisation must enable everyone to feel that we are genuinely creating a partnership of equals, which recognises and builds on each other's strengths to create a new and exciting future. We need the best leaders at all levels of the organisation to drive the transformational change needed, and in establishing the new organisation, we will need to demonstrate transparency, equity and ambition, in order to bring our teams with us and retain talent. We must work together to embed a new, shared, empowering culture, where staff are engaged and have a sense of belonging. In doing so we will create the conditions whereby everyone in our workforce can look to the future with optimism and enthusiasm for improvement.

Legal form of transaction

8.5 From a legal and technical perspective, the least complex and costly approach (and the one that has regulatory support) is to bring services together into one of our existing NHS Foundation Trusts. The plan is therefore to create the new Trust through:

- a merger of Solent and Southern, executed as an acquisition of Solent by Southern under section 56 of the NHS Act 2006; and
- the transfer of the contracts for Isle of Wight community and mental health services and for the Hampshire CAMHS service from IoW and Sussex Partnership respectively to this enlarged organisation. The transfer of services from IoW is subject to a separate Joint Strategic Case, commissioner decision and regulatory approval; the transfer of services from Sussex Partnership is subject to ICB decision.

8.6 Although technically the new Trust will be created through a merger by acquisition, it is the intention of the Trusts that this feels like a 'new' organisation (and hence it is described as such throughout this Strategic Case).

8.7 The constitution of Southern will be updated to reflect the revised population served, service portfolio and shared future ambitions.

New Trust's name

8.8 As part of the approach to ensuring that the new Trust feels like a new organisation, the new Trust will have a new name (as well as a new vision, strategy, values and desired culture). If we secure approval to move to Full Business Case stage, the Trusts will decide at that stage about the name of the new Trust, informed by the views of local communities (including people who use our services, their families and carers), staff, the governors of Southern and other key stakeholders. We will ensure we comply with the NHS naming conventions.

Planning for Board and Council composition of new Trust

8.9 The current composition of the Boards of Southern, Solent and IoW are detailed in appendix 9. There is relevant transaction experience across all three organisations including several Executive Directors who were involved in the creation of Solent from the provider arms of Southampton City Primary Care Trust and Portsmouth City Primary Care Trust in 2011. Non-Executive Directors bring a wealth of transaction experience, both commercial and NHS.

8.10 The Trusts are working closely with NHS England and the ICB to agree the detailed process by which the Board (of Southern) will evolve to ensure it has the necessary skills and experience to enable it to provide effective leadership and oversight of the enlarged Trust. The Trusts have agreed the following principles:

- While the technical vehicle to forming a new organisation is an acquisition (of Solent by Southern) and the transfer of Isle of Wight community, mental health and learning disability services and Hampshire CAMHS from IoW and Sussex Partnership respectively, the new Trust will be created through a partnership of equals;

- Form should follow function starting with the diversity of skills, knowledge and experience the Board of the new Trust will need to realise the identified benefits and what this in turn means for Board roles. Delivering well on integration of care pathways, services, and clinical and corporate services will be a key priority for the new Trust, enabled by organisational development, continuous improvement and integrated governance, and the wider contribution the new organisation will make to the health, wellbeing and prospects for people across Hampshire and the Isle of Wight;
- The process to evolve the Board must recognise foundation trust requirements including the role of Governors in Board appointments;
- The new Board will bring together the expertise and resources of the Trust. There are talented, experienced individuals on the Boards of Southern, Solent and IoW and the process will therefore start from 'ringfenced' pools to best retain leadership talent and minimise the risk of redundancy costs. This will not extend to open competition unless it is not possible to appoint to a particular position from within this ringfence;
- Retaining and developing leadership talent through the process will be essential and the leadership group supporting the Board of the new Trust will also have a vital role in the success of the new organisation and driving the transformational change that is needed; and
- The process will include appropriate consultation with stakeholders.

8.11 The current composition of Southern's Council of Governors is as follows:

- 13 Public Governors (elected by the members within their constituency);
- 4 Staff Governors (elected by the members within their constituency);
- 2 Local Authority Governors – Hampshire County Council and Southampton City Council (appointed by the relevant local authority); and
- 4 Partnership Governors – Age Concern Hampshire, Carers Together, University of Southampton and Unloc (appointed by the relevant partner organisation).

8.12 The current public and staff constituencies are set out in Figures 17 and 18 below.

Figure 17: Public Constituencies

Constituency	Area	Number of Governors
Southampton	The Electoral Wards of Southampton City Council	3
South West Hampshire	The Electoral Wards of: • Eastleigh Borough Council • New Forest District Council • Test Valley Borough Council • Winchester City Council	3
South East Hampshire	The Electoral Wards of: • Fareham Borough Council • Gosport Borough Council • Havant Borough Council	3

North Hampshire	The Electoral Wards of: • East Hampshire District Council • Basingstoke and Deane Borough Council • Hart District Council • Rushmoor Borough Council	3
Rest of England	All the Electoral Wards of England save those set out in the Public Constituency areas listed above	1
TOTAL		**13**

Figure 18: Staff Constituencies

Name of Class	Description of Members	Number of Governors
Southampton	Staff employed within the Southampton Public Constituency	1
South West Hampshire	Staff employed within the South West Hampshire Public Constituency	1
North Hampshire	Staff employed within the North Hampshire Public Constituency	1
South East Hampshire	Staff employed within the South East Hampshire Public Constituency	1
TOTAL		**4**

8.13 Following approval of the Strategic Case a Governor Working Group will be formed to:

- consider the future composition of the Council of Governors (both elected and appointed governors) and potential expanded constituencies to reflect the new Trust's service portfolio, workforce and population served;
- develop a plan for future Council of Governor elections and representation, including current vacancies in the existing Council of Governors; and
- consider how best to communicate with the future membership of the new Trust.

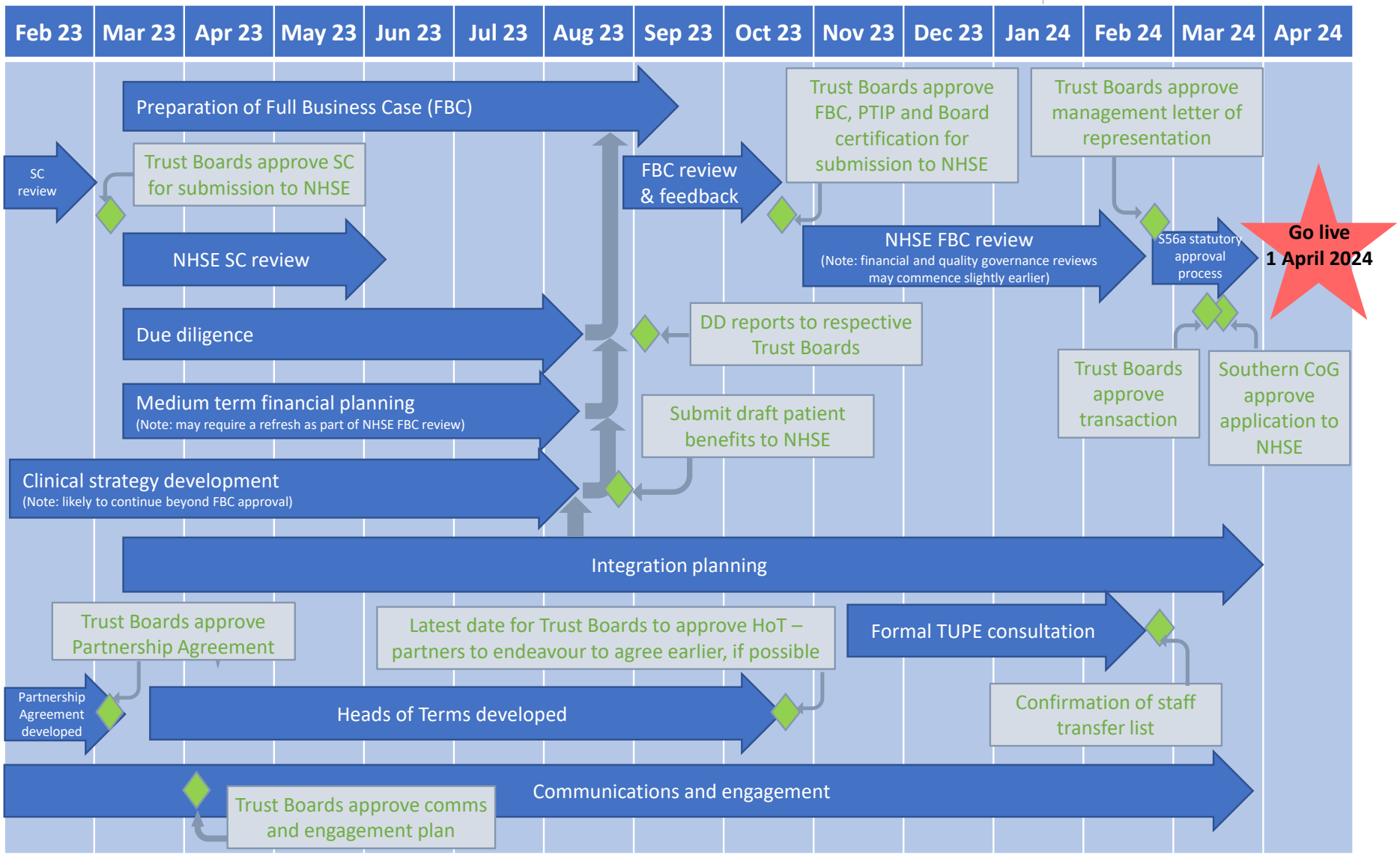
8.14 The Working Group is expected to include the Lead Governor, additional Governor representatives and representatives from the Corporate Governance and Communications and Engagement Steering Groups.

Plan to deliver transaction

8.15 We have developed an initial plan to create the new Trust. Key milestones in the programme plan are set out in Figure 19 on the next page. Provided we secure the necessary support and approvals from our Boards, the governors of Southern, stakeholders and regulator, our intended 'go-live' date for the new Trust is 1 April 2024.

8.16 The programme plan assumes there are no service changes requiring formal public consultation. The Programme Manager is maintaining a more detailed programme plan.

Figure 19: High-level programme plan as at February 2023



Interdependencies

8.17 There are two key interdependencies with the creation of the new Trust:

- Isle of Wight sustainability programme – the proposed transfer of mental health and community services to the new Trust is part of a new strategic approach for achieving sustainable health services for the Isle of Wight population. Ambulance services will transfer from IoW to South Central Ambulance Services NHS Foundation Trust. Acute services will form a group with Portsmouth Hospitals University NHS Trust. These inter-related changes are subject to a separate Joint Strategic Case and subject to commissioner decision (and regulatory approval); and
- Commissioning decision to transfer CAMHS contract from Sussex Partnership to the new Trust.

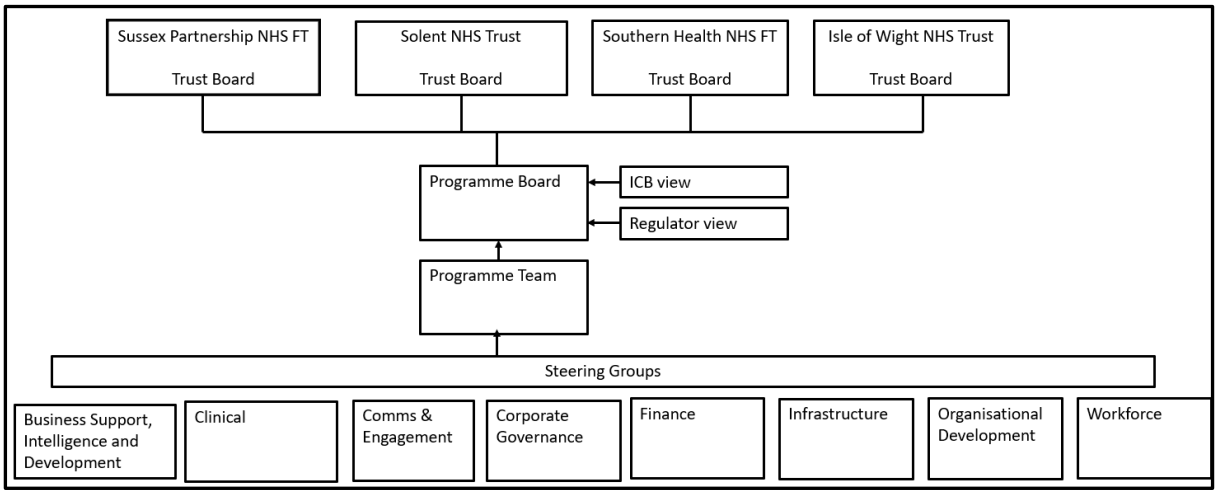
8.18 This Strategic Case has been prepared assuming that all transactions happen on 1 April 2024. However, there is a risk that the timing of either, or both, of these interdependencies do not align with the creation of the new Trust on 1 April 2024. In order to mitigate any risks arising from timing changes, the Trusts are working closely with the ICB to adapt plans as required.

8.19 Notwithstanding these interdependencies, the Trusts preferred option for the future end state is the creation of the new Trust (as set out in chapter 4) and therefore these interdependencies will be managed appropriately to achieve this goal. The Trusts are confident that any changes to timing of the interdependencies can be accommodated safely.

Transaction governance

8.20 The partners have established programme governance arrangements, set out in Figure 20 below.

Figure 20: Programme governance structure



PROJECT FUSION

8.21 The Programme Board meets on a monthly basis and is chaired by the Non-Executive members on a rotational basis. The membership of the Programme Board comprises a maximum of two Executive Directors from each of the Trusts, a maximum of one Non-Executive Director from each of the Trusts and the Programme Director. The Programme Board directs the work of the programme, ensuring a robust programme plan, governance and resources are in place. It receives progress reports and escalations from the Programme Team, ensuring that risks and issues are identified and managed and the required assurance regarding the delivery of the programme is given to the partners' Trust Boards, the ICB and NHSE. The Programme Board will operate until the new Trust is established and will ensure appropriate governance is in place thereafter.

8.22 The Programme Team meets on a fortnightly basis and is chaired by the CEO Lead (the CEO of Solent). The membership of the Programme Team comprises the Lead CEO, a representative from each of the Steering Groups, the Programme Director and the Programme Manager. The Programme Team oversees the work of the Steering Groups and receives progress reports and escalations from the Steering Groups. The Programme Team provides assurance and reports progress to the Programme Board, escalating any key risks and issues.

8.23 Eight Steering Groups report into the Programme Team. Each Steering Group has an executive sponsor and an agreed scope setting out the deliverables and milestones (see appendix 10). The Steering Group scopes will be refreshed following approval of the Strategic Case. Each Steering Group meets regularly (at least monthly) with a standard agenda to ensure continuity and capture actions for follow up.

8.24 Following approval of the Strategic Case the Trusts intend to review the governance arrangements and agree any changes required to the programme for Full Business Case stage.

Resources and programme management

8.25 The programme is being led by a Programme Director, supported by a Programme Manager. The Programme Director oversees the programme, coordinating the work of the Steering Groups and ensuring interdependencies are managed. The Programme Director lead on the drafting of the Strategic Case using content provided by the Steering Groups. The Programme Director also liaises with key external stakeholders including the ICB and NHSE to ensure the agreed timetable is met. The Programme Manager supports the Programme Director and coordinates the agenda and papers for the Programme Board and Programme Team meeting, including collating and quality assuring Steering Group highlight reports and maintaining the programme risk register and detailed programme plan.

8.26 We have used a workstream approach (with each workstream led by a Steering Group) to develop this Strategic Case. If we receive approval to move to Full Business Case stage, we will require increased internal resources and external support to develop the Full Business Case. We will continue to use the existing Steering Group structure, supplemented where necessary with additional resources, to develop the Full Business Case and support planning for Day 1 and beyond. Each Steering Group has identified the resources it needs at Full Business Case stage.

8.27 We will use in-house resources as far as possible, to maintain ownership, retain skills, and keep costs down. However, we do not have sufficient in-house capacity and capability to complete the Full Business Case on our own. Alongside expert legal

advice (see paragraph 7.28 above) we also intend to procure specialist consultancy support to help us prepare the Full Business Case and develop the PTIP.

Approach to benefits realisation

8.28 A detailed benefits realisation plan will be developed as part of the PTIP. The benefits realisation plan will be developed in conjunction with Steering Groups and will reflect the benefits identified in the Full Business Case setting out how and when they will be realised. An Executive Sponsor will take ownership of the benefits realisation plan to ensure senior level focus and progress against the plan will be monitored via the Programme Board.

8.29 There is much evidence of the direct relationship between the culture of an organisation, the engagement of staff and the ability to provide outstanding care. It is recognised that realising the benefits being sought for patients, communities and staff will require a change not just in the structures and boundaries between services but also a huge cultural change. The organisational development programme (see below) will therefore be critical to benefits realisation through determining a shared vision and embedding a culture to deliver that vision.

8.30 A suitable tool will be used to capture the plan and track the realisation of benefits (for example, Solent currently utilises Verto 365, Work Collaboration Platform, to track and manage projects and programmes and Southern uses a PRINCE2 programme management approach and internally developed tools).

Organisational development

8.31 Culture is about how people think, behave and feel. The Trusts recognise that there will be a multitude of live cultures across the services which will come together to form the new Trusts. There is broad consensus amongst the Trusts that, in order to effectively rise to the challenges set out in the case for change, the culture of the new organisation will need to create an environment for staff and people who use services to flourish.

8.32 We have engaged with staff, people who use our services, stakeholders and leaders regarding this and the following themes have emerged from these discussions about the culture that will be required in the new Trust:

- We will deliver consistent, high quality and compassionate care that is highly accessible;
- We will put people at the heart of all we do, providing holistic, integrated and strengths based care that is co-produced with the people who use our services, their families and carers;
- We will value the voice of lived experience in all we do, from every clinical interaction to the design and delivery of services;
- We will be an excellent employer and the people who are employed by us will experience inclusivity and equity and will show loyalty to the organisation because of the many and real opportunities to develop and thrive;
- We will develop a learning culture that strives for continuous improvement; and

- We will be good partners in our neighbourhoods, places and wider systems, delivering seamless integrated care with our partners in primary care, acute care, local authorities and VCSEs that is designed around the needs of individuals.

8.33 These themes align with the charter developed by the Clinical Delivery Group (see paragraph 5.8 and appendix 8) and will underpin all aspects of the work to develop the new Trust, including the organisational design, organisational development and communications and engagement.

8.34 An Organisational Development Steering Group has been established to support the culture change. It has started by seeking to understand the existing cultures across the Trusts, as well as those which are intra- organisational and vary within Trust boundaries, in order to shape the organisational development programme. The programme will also be informed by NHSE's guidance on culture and staff engagement that was published in April 2022. Specifically the Organisational Development Steering Group plans to:

- Agree upon a way in which cultures across the Trusts will be understood in a consistent way, including considering the use of the NHS Staff Survey, results from existing cultural tools used by the Trust and external support (for further detail see appendix 11; and
- Understand the similarities and differences between the cultures of the four Trusts.

The Steering Group will consider the cultural ambitions that are emerging through the programme and will:

- Identify what cultural elements should be retained from each Trust;
- Ascertain what is not to be accommodated in the new Trust; and
- Consider what the risks relating to culture are which include the possible disconnect between current state cultures and desirable future state.

8.35 The aim is to complete the initial understanding of the cultures of the four Trusts by the end of May 2023.

8.36 The Organisational Development Steering Group will then agree plans to develop the desired culture of the new Trust, working closely with the Clinical Delivery Group and Communications and Engagement Steering Group. These plans will be set out in the Full Business Case.

8.37 The Trusts are committed to building on the strengths of all four Trusts and creating a Trust that looks, feels and operates differently to (and has greater impact than) any of its predecessors.

8.38 The plans for developing culture are expected to include:

- Interventions which enable staff to describe the future of our new Trust, including identifying our shared values, behaviours, ways of working, principles and expectations;
- Interventions which engage and enable our people to be part of the change and part of creating and delivering their vision for the future;
- Interventions which equip our people with the skills, capabilities and tools that are needed to bring the values of the new organisation to life; and

- Supporting peer Steering Groups as required.

8.39 Indicative details of these interventions is set out in appendix 12.

Risk assessment and management

8.40 Changing organisational arrangements brings some risks, which need to be carefully managed. A programme risk register has been developed which incorporates both strategic risks and specific risks identified by individual Steering Groups. Risks have been categorised as either transaction risks (risks to creation of the new Trust on 1 April 2024) or integration risks (risks arising from bringing the Trusts and services together). Steering Groups report risks to the Programme Team and the most significant risks are reviewed at monthly Programme Board meetings. As at 14 February 2023, the following risks with a mitigated score of 10 or above have been identified:

Figure 21: Programme risk register

Risk Category	Risk Description. (inc reason and outcome)	Residual Risk Score			Controls in Place/Planned Mitigating Action
		Impact Score	Probability Score	Risk Score	
Integration	Reduced staff morale leads to loss of staff during the period of transition (up to and beyond 1 April 2024), through staff leaving and/or sickness absence and/or impact on productivity, could destabilise services and lead to incidents (and ultimately patient harm) and reputational damage.	4	4	16	Comms and eng plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Joint senior leaders event in Oct 22 and event planned for 22/2. Clinical Delivery Group workstreams mobilised to deliver clinical transformation.
Transaction	Timing of transfer of services from IoW and/or Sussex does not align with creation of new organisation.	3	5	15	Regular engagement with ICB and partners to understand timescales and reflect in programme planning. Strategic case narrative will focus on ultimate end state. Monthly CEOs meetings including Southern, Solent, IoW, PUH and Programme Director in place to ensure alignment of programmes.

Risk Category	Risk Description. (inc reason and outcome)	Residual Risk Score			Controls in Place/Planned Mitigating Action
		Impact Score	Probability Score	Risk Score	
Transaction	IoW does not have resource to support the programme given other demands on time from strategic programmes.	3	4	12	Programme Director has advised on minimum requirements at strategic case stage. Monthly CEOs meetings including Southern, Solent, IoW, PUH and Programme Director in place to ensure alignment of programmes.
Integration	Leadership burn out or distraction of integration activities results in detrimental impact on performance/quality of the new Trust and benefits not being realised (and ultimately patient harm).	4	3	12	In FBC the Trusts will articulate plans and resources to deliver integration beyond 1 April 2024 and an operational model that ensures sufficient leadership focus on BAU activities. Benefits realisation approach to be developed in SC and inform plans for the new organisation, including resource requirements.
Transaction	ICS financial position puts pressure on programme budget resulting in sub-standard programme and/or delay to the programme and ultimately benefits not being realised.	4	3	12	Continued engagement with the ICB regarding the strategic importance of the programme.
Transaction	Scrutiny committees determine that the creation of a new organisation is a substantial service change resulting in need for formal public consultation which would lead to delay.	4	3	12	Engagement with scrutiny committees. Clear articulation in strategic case (and FBC) and communications that new organisation creates a platform for, but is not in and of itself, service change.
Transaction	Identified benefits do not outweigh risks and or the SC contains insufficient detail on senior leadership appointment process to assure Boards and the SC is not approved by Trust Boards	5	2	10	Robust approach to benefit identification and risk management. CEO/Chair discussions regarding senior leadership appointment process are ongoing.

Risk Category	Risk Description. (inc reason and outcome)	Residual Risk Score			Controls in Place/Planned Mitigating Action
		Impact Score	Probability Score	Risk Score	
Transaction	Proposals are not supported by ICB and/or NHSE (potentially as a result of Project Fusion not delivering significant system financial benefits)	5	2	10	Regular engagement with ICB and NHSE to agree approach and ensure requirements are met. Joint letter sent to NHSE with ICB in Dec 22.

8.41 The programme risk register is a live document which will be kept updated as we move through the process, including to take account of risks identified through due diligence and additional risks identified as we develop our detailed integration plans.

Legal advice sought

8.42 If we receive approval to move to Full Business Case stage, we would expect to take legal advice on matters including TUPE transfer of staff, Heads of Terms, appointment processes to Boards, any agreements or contracts relating to transfer of services from IoW or Sussex Partnership, the revised Constitution for the new Trust, property leases and licences and contracts, sub-contracts and procurements. A single legal advisor is being sought to ensure consistency in advice across all areas. All requests for legal advice will be approved by the Programme Board.

Due diligence

8.43 The Trusts have adopted a two-phased approach to due diligence. At Strategic Case stage the Trusts carried out an indicative risk assessment to understand the areas where detailed due diligence needs to be performed (with reference to NHSE's indicative scopes for due diligence) for each Trust and which elements should be undertaken internally and externally. The initial due diligence findings were documented in a summary report (see appendix 13) for Trust Boards in February 2023. Risks identified as part of the indicative risk assessment have been reflected in the programme risk register and this Strategic Case as appropriate.

8.44 The Trusts have identified the resources (both internal and external) required to undertake the due diligence at Full Business Case stage and this is reflected in the programme budget (see paragraph 7.28). Where due diligence will be undertaken externally, the Trusts will follow relevant procurement processes to appoint an appropriate provider.

8.45 The timings for due diligence are reflected in the programme timeline (see Figure 19 above). Final due diligence reports will be approved by Trust Boards in summer 2023 and the findings will be incorporated into the Full Business Case and PTIP which will be approved by Trust Boards in October 2023.

8.46 The due diligence processes are being managed via the relevant Steering Groups (with co-ordination by the Programme Manager) as follows:

Due diligence area	Steering Group
Clinical	Clinical governance
HR and pensions	Workforce
Financial	Finance
Contract	Business support
Legal	Corporate governance
Commercial	Business Support

Due diligence area	Steering Group
Estates / property	Infrastructure
IT	Infrastructure
Taxation	Finance
Environmental	Infrastructure
Health and safety	Infrastructure

Stakeholder communications and engagement

8.47 All organisations involved in this programme are committed to effective, meaningful and joined up communications and engagement throughout. The Communications and Engagement Steering Group leads on communications and engagement activity associated with Project Fusion.

8.48 The Communications and Engagement Steering Group reports to the Programme Team and is attended by communications and engagement representatives from the Trusts as well as colleagues from the ICB.

8.49 The Steering Group oversees all communications and engagement activity related to Project Fusion, including 'community engagement'. Community engagement is the activity of reaching out to local people to understand what really matters most to them, to build long term, trusting relationships and to work as equal partners. This partnership enables the active involvement in the cocreation of solutions to local issues with care and treatment, and in the design, development and delivery of those services. The approach to community engagement is based on the principles of a strengths-based approach; that is recognising our communities as being an asset, with strengths, knowledge, experience and skills to offer this programme of change.

8.50 The community engagement approach is designed to ensure that the voice of local communities actively informs the development of the new Trust. This includes being equal partners in the design and development of new clinical pathways, and the implementation of a strengths based approach to service design and delivery.

8.51 This approach is aligned to the principles set out in the most recent NHSE statutory guidance on working in partnership with people and communities[27] and to the co-designed Hampshire and Isle of Wight ICB Community Involvement Approach which was published in July 2022. It is recognised that there is no one size fits all approach to effectively inform, involve, and work alongside our wide range of stakeholders and partners. Our approach can be viewed as a scale ranging from giving information to full participation and coproduction, as described in Figure 22 below.

[27] https://www.england.nhs.uk/wp-content/uploads/2022/07/B1762-guidance-on-working-in-partnership-with-people-and-communities.pdf

Figure 22:

8.52 The communications and engagement plan (see appendix 14) describes the principles, approach and activity to ensure a coordinated approach with partners. It includes a programme of communications and engagement work to develop a comprehensive understanding of what matters most to people about their local community and mental health services to influence the development, delivery and design of the new Trust. The plan is a live document that is regularly updated and reviewed at the Communications and Engagement Steering Group.

8.53 The aims of the communications and engagement plan are to:

- Deliver co-ordinated communications and engagement activity;
- Support the delivery of timely and meaningful community and employee engagement programmes, led by each Trust's community engagement and HR and Organisational Development leads respectively;
- Shape key messages and ensure these are communicated and understood by all audiences; and
- As far as possible ensure that media reporting is factual and accurate.

8.54 The communications and engagement activities are guided by the following strategic principles:

- **Person-centred** – Front and centre of our approach should be a focus on the people who use services and their carers, as well as those who may not access our services and are most profoundly affected by health inequalities. The driving force behind the recommendation is centred around delivering joined-up, high quality and equitable services. Our approach will be to focus our narrative on the benefit to the people who use our services and their carers and ensure meaningful opportunities to engage and co-produce.

- **Clinically led** – Clinical leadership, and peer to peer engagement, is central to our communications and engagement approach – leaders should be highly visible through our communications and engagement activities. Clinical input, alongside the voice of lived experience, is also fundamental in order to articulate the positive impact of any changes on patients, service users and their carers.

- **Honest and transparent** – We will be open, honest, and transparent in our communications about the way forward. Where there may be an impact on staff members or on how people access services, we will ensure this is fully understood. We will also be clear about the aspects of the proposals that can be influenced, and what particularly we are seeking views on.

- **Two-way local engagement** – Engagement with stakeholders, staff and partners will be timely, to allow adequate opportunity for queries and clarification. We want to deliver changes that our stakeholders, staff and communities can co-produce, support and endorse. We will build upon existing relationships we have based around places, local delivery systems and neighbourhoods.

8.55 The plan also sets out the guiding principles to engaging with communities:

- We recognise our communities as people with exceptional strengths, knowledge, experience and skills. We want to uncover those often-untapped talents, assets and abilities. We build on what's strong not what's wrong.

- Conversations with our community are based on the principles of discovery; always a question to be asked and not answering a question before we ask it!

- Our aim is to work in a way that enables communities to create their own wellbeing and health. We are moving from "doing to" people, to "done by" people in our communities.

- We focus our work on the answers to three key questions:

  - What do our communities do best and therefore what they should be enabled to do themselves?

  - What is it we could do to help communities do what they wish to do for themselves?

  - What is it our communities need us to do as providers of community and mental health services?

8.56 The communications and engagement plan identifies and maps internal and external stakeholders using an interest and influence grid. This will be regularly reviewed

throughout the course of the programme. The position of each stakeholder group determines the communication and engagement tactics.

8.57 Key stakeholder groups include:

- **Staff**, including volunteers, and their respective representatives across all Trusts will be regularly communicated with and kept up to date. They will also be asked to share their thoughts to help shape the programme via a range of engagement methods. The Communications and Engagement Steering Group will work closely with the Organisational Development Steering Group to provide communications and engagement support to the co-design of the values and culture of the proposed new Trust, bringing together what's best about each sovereign organisation.

- **People who use our services, their carers and the public** - all the Trusts have a range of ways and means of communicating and engaging with patient and carer groups and the wider public. We will use existing patient and public involvement networks to share information and gather feedback and insights. For those that would like to be more involved we will harness their interest to inform and increase the reach of our messages in local communities. We will also use our corporate channels – particularly our websites and social media – to ensure we keep those who are interested informed and up to date.

- **Scrutiny committees, councillors, and MPs** play an important role as representatives of their local communities, raising concerns and scrutinising plans and services on their behalf. They also act as opinion formers, both informing and reflecting public opinion and their ongoing support is important. We will provide regular updates to the scrutiny committees across our geography on the partnerships. This will take the form of written updates, informal meetings (collectively when it makes sense to do so) and specific briefings through existing statutory meetings. All of the Trusts have contact with these stakeholders and so it will be important to ensure that briefings are co-ordinated and attendees at meetings planned in advance.

- **Voluntary, community and patient groups** (including Patient Participation Groups (PPGs), patient and community partners and Healthwatch) – as representatives of their members, these groups will also have a keen interest in their local health services and any proposals that may impact on them. We will ensure these groups are regularly communicated with and have opportunities to engage.

- **Foundation Trust Council of Governors** – the governors of Southern have a statutory role to play and this group is being kept informed and involved through regular updates via regular and bespoke meetings and sessions.

- **Health and care system partners** – this group includes colleagues from the Integrated Care Board, partner NHS Trusts, local authorities, other statutory organisations and others who deliver care alongside us. These stakeholders will have a keen interest in how the new Trust will be shaped and how services will be delivered. Communications and engagement will primarily be maintained through existing forums and relationships, with key briefings as required.

- **Media** – the local media can be a powerful vehicle to help us to communicate key messages to the public and stakeholders. However, there is also inherent risk that information is leaked, and coverage is shaped by rumour and hearsay. We will aim to get fair coverage by taking a more proactive approach,

ensuring local press are aware of our plans, including providing background briefings as plans develop.

8.58 A wide range of communications and engagement methods are being used to ensure that each stakeholder group is reached effectively including (but not limited to) internal and external FAQs, websites, intranets, media and stakeholder briefings, staff engagement sessions, social media, internal bulletins and press releases. Methods are tailored to the purpose and audience in question.

8.59 We have established a set of key messages to ensure our messaging is consistent with staff and stakeholders. Each audience will have different needs and so our communications and engagement approach needs to be tailored and our messaging regularly reviewed to reflect the evolution of the programme. The current key messages are set out in the communications and engagement plan (appendix 14).

8.60 The communications and engagement plan reflects insights from engagement activity that has already taken place to inform the development of the Strategic Case and shape plans for the new Trust. These insights are captured in an engagement log (see appendix 14).

8.61 Engagement to date has included:

- In autumn 2022 representatives from the Trusts attended Overview and Scrutiny Panels in Southampton, Portsmouth, wider Hampshire and the Isle of Wight to present and discuss the recommendations of the CF review. All panels are broadly supportive of the proposals and requested ongoing updates. At the Hampshire panel, there was some discussion about whether the proposals constitute significant change in service, and the decision was made to consider this again in spring 2023;

- A stakeholder meeting in November 2022 was attended by around 70 people from a range of stakeholder organisations and community groups. At this event around two thirds of participants 'agreed' or 'strongly agreed' that the creation of a new Trust was the right direction of travel;

- A community engagement meeting took place on 25 November and was attended by community and voluntary sector partners, including by local Healthwatch representatives and people from some of our seldom heard communities. A strength-based approach to community engagement was supported and agreed. The group also agreed to ongoing meetings to work alongside us to co-design and deliver the community engagement required and met again in January 2023. The need for more public facing communications to keep people informed that are targeted at different parts of our communities was also discussed; and

- There have been a range of communications and engagement activity with staff from the Trusts involved. This includes at existing senior leader forums as well as bespoke events for senior leaders in October 2022 and February 2023, each attended by more than 150 members of staff from across all four Trusts. There have also been open sessions for staff to ask questions they have about the programme. Since September 2022 there have been regular internal communications with staff to provide updates about the programme and a set of Frequently Asked Questions (FAQs) have been published.

8.62 Audiences have generally been supportive of the concept of creating a new Trust, and in addition some specific hopes and concerns have emerged as themes for

consideration as we develop the detailed plans for the new Trust, detailed in Figure 23.

Figure 23:

Hopes	Concerns
• The voice of our community, those who use services, their families and carers, and the community as a whole, provides the foundation for the new Trust. • Improved / equitable access and more coproduction of services or • Addressing health inequalities with a focus on removing barriers (cultural, organisational and practical) to access for all. • That staff are supported / involved throughout • Improved partnership working with the voluntary and charitable sector • Reduced duplication of resources • Reduced competition for staffing • Joined up services with effective communication between teams and services. • Services based on what matters most to the local community. • Increased focus on prevention and people supported to look after themselves. • Services delivered close to home. • Improved support for unpaid family carers • System wide and effective use of digital solutions for those who can and wish to use them.	• New Trust too big / not sufficiently focused on local need • Disruption during transition • Losing staff / workforce capacity • Culture – concerns from staff about identity loss • Levelling down / will there be funding to truly deliver benefits

8.63 During the initial phase of the programme and the development of this Strategic Case, insights from staff engagement have primarily been used to help shape key messages and the communications and engagement approach that will be used going forwards. Key themes from staff engagement have been shared with the Programme Team and Programme Board. For example, although the transaction is likely to directly impact

only a relatively small number of people, staff fed back that the overall uncertainty about exactly what the future may hold has an indirect impact on a far greater number of people. Ensuring a range of opportunities for staff to stay informed, to get involved, and to hear how their inputs have been taken into account, is therefore important and has guided our proposed approach.

8.64 Staff also fed back that there wasn't a consistent and simple name for this work and different organisations were referring to the programme in different ways, which was confusing. In response some options for names for the programme were developed and shared with senior leaders, resulting in the name Project Fusion which is now consistently applied by all organisations.

8.65 Staff have shared hopes and concerns about the development of a new organisation, including through organisational staff drop-in events and joint senior leadership events. Staff wanted to ensure that the organisations involved would learn from previous transactions. Work has since been carried out to summarise this learning and share with the Programme Board to inform the development of the programme. Staff also fed back that it was important to ensure that the best of each organisation was taken forwards (in terms of service delivery, culture and existing collaboration) and this a key aspect of the way in which the programme is working.

8.66 The Clinical Delivery Group workstreams have engaged with staff to begin the process of understanding what future service delivery will look like. These events have included opportunities for colleagues to get to know each other and build relationships, as well as developing a shared vision, purpose, and priorities as they bring their services together.

8.67 As the programme progresses, the Communications and Engagement Steering Group will ensure that insights and feedback from staff (as well as other stakeholders) are shared via the programme governance structure (including the regular Programme Team meetings) to shape the planning for the new organisation.

Appendices

Appendix 1 – Trust performance

Key performance metrics – year to date as at 31 December 2022

Source	Area	Measure	Year to date 31/12/22 Southern	Solent	IoW
NHS Oversight Framework metrics for 2022/23	Primary care and community services	Proportion of Urgent Community Response referrals reached within two hours	88.4%	70% *	93.2%
NHS Oversight Framework metrics for 2022/23	Primary care and community services	Available virtual ward capacity per 100k head of population and occupancy	9.97	Portsmouth: 5.6 Southampton: 3.5	18.5
NHS Oversight Framework metrics for 2022/23	Mental health services	Number of people accessing IAPT services as a % of trajectory	61.7%	107%	16.2%
NHS Oversight Framework metrics for 2022/23	Mental health services	Inappropriate adult acute mental health placement out-of-area placement bed days	20	185	166
Targets	Elective care	RTT, 52 week waits	83.8% 0 patients waiting over 52 weeks	89.5% 0 patients waiting over 52 weeks	N/A (reported as part of acute performance)
Targets	Elective care	6-week waiting time diagnostics	98.3%	99%	N/A (reported as part of acute performance)
Targets	Mental Health	EIP 2-week access	89.5%	73%	95.8%
Targets	Mental Health	NHS Talking Therapies 6 weeks	95.4%	94.9%	76.7%
Targets	Mental Health	NHS Talking Therapies 18 weeks	99.2%	99.7%	99.9%
Targets	Mental Health	NHS Talking Therapies 1st/2nd appt	29.5%	10%	6 weeks or less to 1st appt: 80.3% 18 weeks or less to 1st appt: 99.7%
Targets	Mental Health	NHS Talking Therapies Recovery	50.6%	54.2%	48%

Source	Area	Measure	Year to date 31/12/22 Southern	Solent	IoW
Targets	Mental Health	Readmissions in 30 days	13.7%	7.2%	9.9%
Targets	Mental Health	Gatekeeping	98.4%	100%	91.5%
Targets	Mental Health	72 hr FU	91.7%	Not yet reporting this metric	78.9%
Targets	Mental Health	UTC attendances completed in 4 hours	97.6%	N/A	N/A

* Known data quality issue in December reported performance, true position actually higher

Activity data – 2021/22

	Solent		Southern		IoW	
	Community & Outpatient contacts	Inpatient Occupied Bed Days	Community & Outpatient contacts	Inpatient Occupied Bed Days	Community & Outpatient contacts	Inpatient Occupied Bed Days
Adults Community	532,337	30,526	886,011	67,305	147,054	3,612
Adults Outpatient	92,139		136,496		48,875	
Forensic - CAMHS			13	11,429	n/a	n/a
Learning Disabilities	4,413		23,635	N/A	2,616	n/a
Older Persons Mental Health	10,321	4,778	89,574	28,039	4,263	2,242
Forensic - Adult			6,284	31,501	n/a	n/a
Adults Mental Health	30,406	7,031	301,097	71,224	28,311	8,485
IAPT	27,914		98,813	N/A	13,158	n/a
Children and Families - Community	193,948		163,282	N/A	16,492	n/a
Children and Families - Outpatient	6,697					
Children and Families - CAMHS	33,199					
Diagnostics	3,026		54,412	N/A		

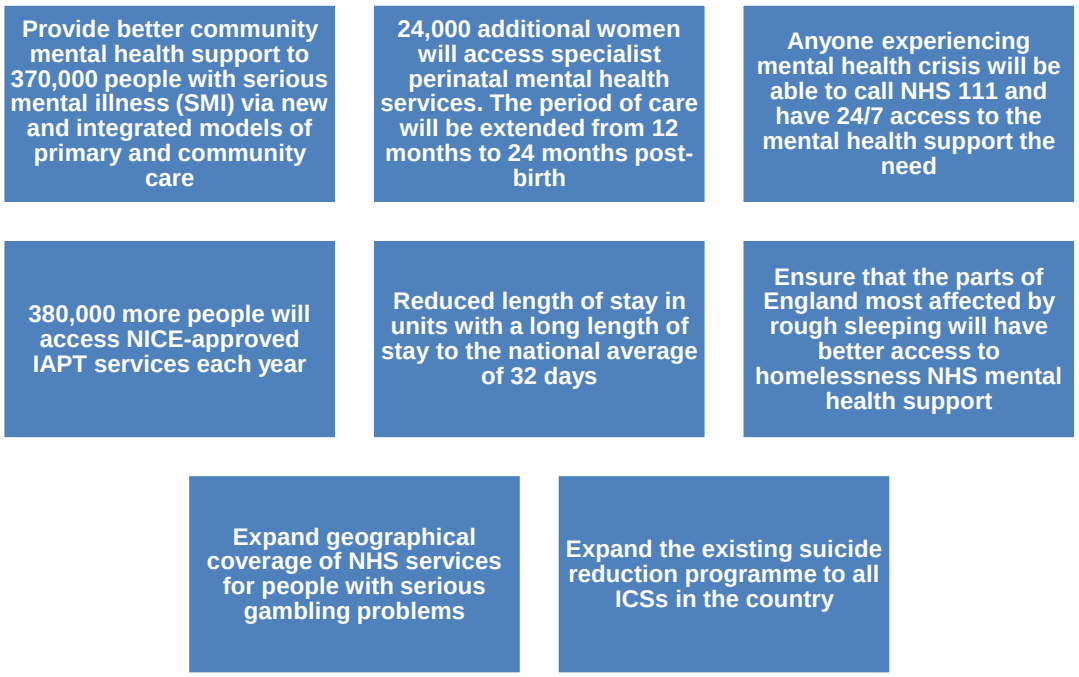
Appendix 2 – NHS Long Term Plan commitments

The LTP identifies specific issues regarding mental health services that it seeks to address:

- Poor mental health contributes to health inequalities, with people with severe mental health illnesses tending to die 15-20 years earlier than those without;
- People with mental health illnesses are more likely to face issues gaining and retaining employment. Similarly, people in stable employment are less likely to develop mental health problems; and
- Over 400,000 people in England have some form of gambling problem, with a further 2 million at risk of developing gambling addiction. Few people are able to access treatment through a single national clinic.

The LTP included the following specific ambitions in relation to mental health (by 2023/24):

Figure 24: Mental health ambitions in the LTP



COVID-19 has, nationally, had a major impact on ICSs' ability to make progress on some LTP objectives. In particular, the pandemic saw a significant reduction in talking therapies for anxiety and depression referrals, with a concomitant, albeit lesser magnitude, decline in treatments started, throughout early 2020. However, whilst improved access to remote consultations and the establishment of 24/7 mental health crisis hotlines allowed a partial recovery of talking therapies for anxiety and depression referrals and treatments by early 2021, numbers had not fully returned to their pre-pandemic levels by that time.

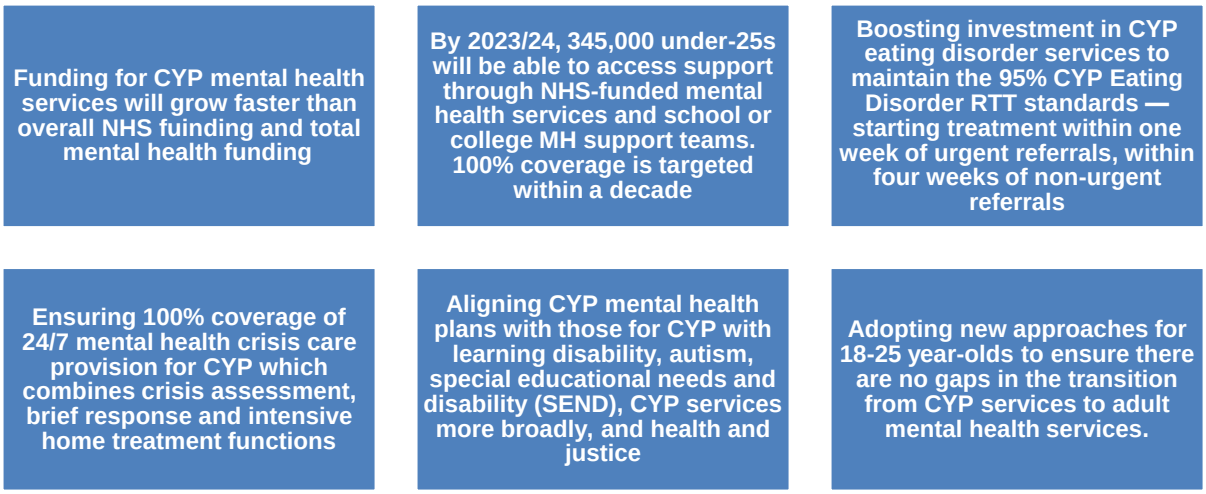
NHSE has confirmed that there is evidence that the pandemic has increased demand for mental health services nationally. It is likely that new mental health problems caused directly by the pandemic have arisen.[28]

This is supported by analysis performed in the HIOW system specifically - the impact of COVID-19, according to the NHSEI Strategy Unit will see mental health demand increase to 117% of 2019 levels, representing an increase of around 2.0% per year from 2019 to 2025. In absolute terms, the largest increases will be in talking therapies for anxiety and depression demand, with the largest proportional increases in older peoples' inpatient demand.[29]

COVID-19 created a significant increase in suppressed demand for community support and in people coming forward for dementia diagnosis.

The commitments for mental health of children and young people (CYP) in the LTP equate to the following in Hampshire and the Isle of Wight by 2023/24:

Figure 25: Children and young people ambitions in the LTP



The pandemic has undoubtedly had an impact on the LTP from a CYP Mental Health perspective. NHS Digital's national prevalence survey published in July 2020 showed an increase in children's ill health, with the Children's Commissioner concluding that the pandemic likely increased the gap between demand and services available. Indeed referrals data to March 2021 showed a year-on-year increase of 58% for urgent referrals and total referrals were the highest on record for a single month.[30]

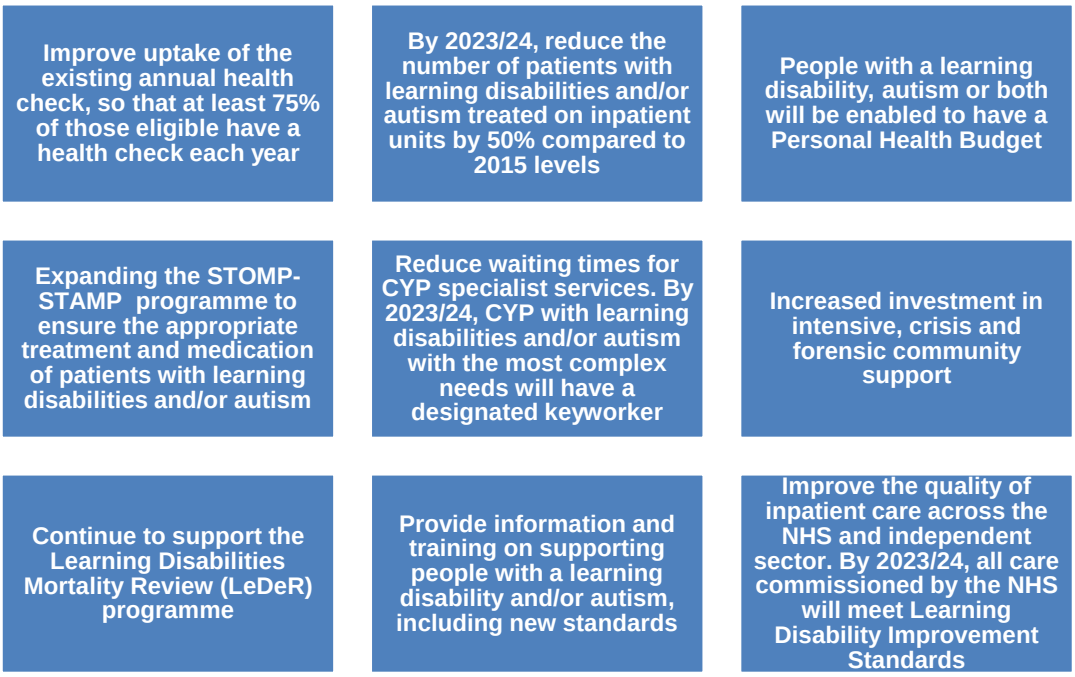
Whilst delivery of the LTP will see a shift from inpatient to community support and physical health checks rolled out to a significant proportion of people with learning disability and autistic people, there is still further to go, particularly reducing mortality, improving health outcomes and improving diagnosis and treatment for autistic people:

- In 2021, 49% people with a learning disability died from health problems that were 'avoidable', compared to 22% for the general population;

[28] The Health Foundation, *The NHS Long Term Plan and COVID-19*, September 2021 https://doi.org/10.37829/HF-2021-P08
[29] Carnall Farrar, *Independent Review of Community and Mental Health Services across the HIOW ICS: Report of findings,* April 2022
[30] The Health Foundation

- On average, males with a learning disability die 22 years younger than males from the general population, and females 26 years younger than females from the general population; and
- People of Black, Black British, Caribbean or African, mixed ethnic group and Asian or Asian British ethnicity died at a younger age in comparison to those of white ethnicity.

Figure 26: Learning disability and autism ambitions in the LTP



Prior to the pandemic, limited progress had been made nationally against the 50% reduction in inpatient care, with an interim target reduction of 35% missed in 2020; the actual number of inpatients reported in March 2020 was 27% lower than the baseline[31]. Data reported during the pandemic show significant declines in inpatient activity in March and April 2020 followed by an increase to August 2020.

Likewise, poor progress had been made against the 75% health check objective prior to the pandemic - by 2019/20, only 57.8% of eligible patients received a health check, down from the previous year. However, concerted efforts by NHSE showed that, nationally, 71.8% of eligible patients received a health check in 2021/22, although this was 3.4 percentage points lower than in 2020/21[32].

Specifically within the HIOW region, COVID-19 has had a greater impact on those with learning disabilities than those without, exacerbating existing inequalities within the region (e.g. 14-18 year lower life expectancy).

The LTP highlights three major initiatives to improve community care:

- A new NHS offer of urgent community response and recovery support: This is predominantly to improve care for people experiencing a sudden deterioration in their health and involves investing in and enhancing existing community response teams to prevent unnecessary emergency hospital admissions and

[31] The Health Foundation
[32] https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2021-to-2022

speed up discharges – with a specific target of people receiving services within two hours in a crisis and within two-days for reablement care. Also, it includes improving access via a single point of access for people requiring urgent care in the community;

- Enhanced care for people living in care homes: supporting timely access to out of hours support and end of life care, including supporting care homes to have easier and secure access for sharing information about their residents using NHSmail; and
- Enabling people to age well: this involves identifying older people with moderate frailty at particular risk of deterioration and offering them proactive personalised care and support.

The LTP also includes delivering a core model for the future care of people with complex needs. This will be delivered through PCNs, where general practices, community teams, social care, hospitals and the voluntary sector work together with the shared aims of enabling older people to stay well, better manage their own conditions and live independently at home for longer. Delivering these initiatives in an integrated, joined-up way will increase the effectiveness of community services to deliver prevention, crisis intervention, reablement, rehabilitation, end of life care and care for people living in care homes.

The impact of the pandemic on the ICS is that the demand for community services is likely to increase by c.11% between 2019 and 2025. This increase is particularly acute in Hampshire, owing to its older demographic.[33]

[33] Carnall Farrar

Appendix 3 – Letter of support from HIOW ICB

NHS
Hampshire and Isle of Wight

Hampshire and Isle of Wight Integrated Care Board
Hampshire Fire & Police Headquarters
Leigh Road,
Eastleigh
Hampshire
SO50 9SJ

10 March 2023

Sent via email
Melloney Poole, Chair, Isle of Wight NHS Trust
Darren Cattell, Chief Executive, Isle of Wight NHS Trust
Mike Watts, Acting Chair, Solent NHS Trust
Andrew Strevens, Chief Executive, Solent NHS Trust
Lynne Hunt, Chair, Southern Health NHS Foundation Trust
Ron Shields, Chief Executive, Southern Health NHS Foundation Trust
Peter Molyneux, Chair, Sussex Partnership NHS Foundation Trust
Dr Jane Padmore, Chief Executive, Sussex Partnership NHS Foundation Trust

Dear all,

Re: Strategic case for the creation of a new Trust

Thank you for sending the Strategic Case for the creation of a new Trust for all community, mental health and learning disability services across Hampshire and Isle of Wight Integrated Care System. As the main commissioner of these services for the Hampshire and Isle of Wight population, I am confirming the Integrated Care Board's support for the strategic direction and statutory transactions proposed in the Strategic Case.

The case contains each Trust's current estimates of their underlying financial position, which is important context for this transaction. The Integrated Care Board is currently working with all system providers to develop cost improvement and recovery plans that will help to mitigate the underlying financial challenge we face in 2023/24 and beyond. The new organisation has a crucial role in our recovery and transformation programmes, including through efficiency savings from the creation of a larger, single entity.

The new Trust will be a key system partner in the Integrated Care System and will play a pivotal role in achieving our collective goals. These include keeping people as healthy and independent as possible, providing swift access to efficient, high-quality care when required, and taking a population health management approach to the planning and delivery of services. The new organisation will also have a vital leadership role in delivering the ambitions of the Hampshire and Isle of Wight Integrated Care Partnership's strategy.

The creation of the new Trust responds to one of the five recommendations in the recent independent review of mental health and community services. In order to address the long-term challenges across Hampshire and Isle of Wight, we are committed to continue working together on our joint programme to ensure all the recommendations are achieved. These are reducing unwarranted variations in access, experience and outcomes, to integrate models of care, to right size services and to develop sustainable solutions for the future.

PROJECT FUSION

The future offers opportunities for the mental health and community health sector to reframe its role and style of working in relation to a variety of partners. This includes primary care services; neighbourhood teams that are developing in response to the Fuller recommendations and the system's local care strategy; and the place-based health and care partnerships in each local authority footprint.

I am encouraged by the work providers are undertaking together ahead of the establishment of the new Trust. We are also all committed to working alongside our communities, patients, services users and carers as we progress with the creation of the new organisation.

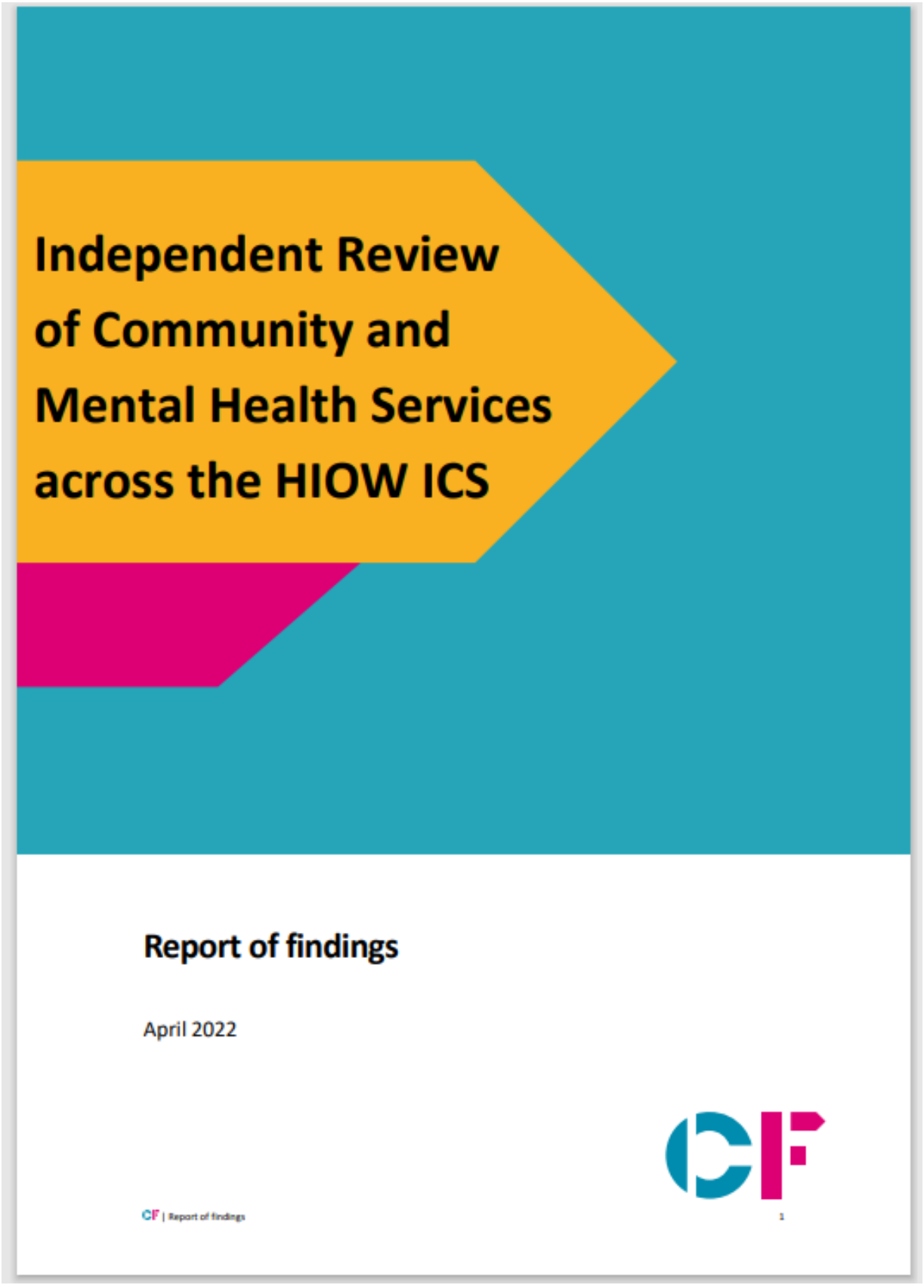
This crucial work on strengthening our community and mental health services is inextricably linked to the wider partnership work to guarantee clinical sustainability on the Isle of Wight. It is essential that we describe how all proposals for future service delivery on the Island fit together and the benefits they will bring. I know our collective communications and engagement teams are working together on this, and we will ensure we review our approach at regular intervals to ensure our population is at the heart of our progress and decision-making.

I look forward to continuing to work with you on this vitally important change programme and to seeing our collective progress unfold.

Best wishes,

Maggie MacIsaac
Chief Executive
Hampshire and Isle of Wight Integrated Care Board

Appendix 4 – Independent review of community and mental health services



PROJECT FUSION

Contents page

PROJECT FUSION

1. Executive summary

1.1 Introduction

With the evolution of Integrated Care Systems (ICS), provider collaboratives and place-based partnerships, Hampshire and the Isle of Wight (HIOW) ICS is seeking to develop its approach to integration of community and mental health services to best meet the needs of the population.

To support the ICS in developing its approach, Carnall Farrar (CF) were commissioned in February 2022 to undertake an independent strategic review of the potential future arrangements for community and mental health services.

The terms of reference for the scope of the Review are as summarised:

- Set out a high-level overview of current and future population needs for community and mental health services
- Map community and mental health services currently delivered in HIOW
- Understand strengths and weaknesses of the existing arrangements and their ability to meet future needs
- Produce options for future delivery of services to meet needs and improve outcomes
- Conduct an options appraisal exercise using evaluation criteria to explore relative pros and cons of each option
- Set out the preferred option in a report and consider the impact on future leadership arrangements

This document outlines the approach and findings of the Review. It includes findings from analysis and stakeholder engagement on current and future population needs and existing service provision, the 'case for change' which sets out why existing service arrangements are insufficient to meet future need, and the resulting strategic priorities for future services. It also summarises the process for, and outcomes of, evaluating different options for future service arrangements to address these priorities and the case for change.

The preferred option is recommended in the report alongside a set of supporting actions, following iteration with lead providers of community and mental health services and the designate ICB leadership. There are also principles for implementing the recommendations which were proposed by lead providers.

There was extensive engagement throughout the Review. Key leaders from across HIOW were involved at every stage of the process to develop, iterate, and align on the outputs, as well as to take ownership of the steps required to action the recommendations.

1.2 Case for change

There is a compelling case for change in the way that community and mental health services are resourced and delivered in HIOW to reduce the unwarranted variation that exists in access and outcomes across communities.

Firstly, demand for community and mental health services is high and will continue to grow, with a population that is older than the England average and ageing faster than most of the country. As a result, demand for community health services could grow by ~11% by 2025, and for mental health services could grow even further at ~13%.

There is misalignment between the needs of the population for services and the capacity of the NHS to respond. This discrepancy will be exacerbated by the rising demand. This results in unwarranted variation in access to care, differential quality of services and likely poorer patient outcomes in some geographies. Currently, the areas with the highest needs do not have the most resource. In particular, community health spend is disproportionately low compared to community health needs in Hampshire and the provision of care does not correspond to the prevalence of health conditions. In part, this is caused by historical inequities in the distribution of resource across HIOW meaning that some geographies have received less investment over several years.

The communities that have benefitted from higher investment in community health services also appear to spend proportionately less on acute care, demonstrating the health and financial benefits of redistributing resource into community physical health services. For example, reducing A&E presentations and non-elective hospital admissions as described later. This indicates an opportunity to improve care and value for money by delivering care in appropriate settings, in a context where the HIOW ICS does not have a balanced financial plan.

The lack of community health capacity relative to population needs also impedes effective pathways of care for patients. This results in delayed discharges from acute to community services which can lead to significant patient harm when remaining in hospital longer than necessary. In other cases, interventions are insufficient or not early enough in the care pathway to prevent health deteriorating and the subsequent hospital admissions. The knock-on consequence of these events for other patients is delays in accessing acute inpatient care.

Significant workforce shortages in mental health, particularly speciality inpatients, also constrain the ability of services to respond to population needs. Southern – the provider of most inpatient mental health services – has a 13% vacancy rate for mental health staff, largely driven by the national shortage of inpatient nurses. Staff shortages not only affect access and capacity to care for people but also risk the safety and quality of services.

Furthermore, care delivery is fragmented across multiple community and mental health providers, which makes services hard to navigate for patients and carers and leads to multiple hand-offs between providers. The fragmentation is particularly visible in mental health, notably in CAMHS, Eating Disorder and Learning Disability Services, and at the transition between children and adult's mental health. For example, CAMHS is delivered by three different providers and its referral waiting time subsequently differs by nearly four weeks depending on where you live. Again, fragmentation partly arises from past 'patchwork commissioning' with varied funding for community and mental health services across the historic seven CCG geographies; Hampshire has received the least funding overall.

Finally, multiple providers operating in the HIOW system has created inconsistencies in care models. This drives further variation in service quality, access to care and patient outcomes depending on where you live and which provider's service you interact with. The complexity of multiple providers can make it unclear who is accountable for individual patients and creates an imbalance of clinical risk where patients are escalated to high acuity settings rather than treated in the most appropriate care setting for their needs. It also creates wider confusion around leadership and ownership for improving systemwide provision of community and mental health services. This acts as a barrier to integrating across health and care services.

Taken together, these issues highlight a clear need for system change to create greater alignment and clearer leadership of community and mental health services, in order to improve patient care and outcomes and ensure they are equitable irrespective of where you

live. This requires better use of collective resources to meet the needs of the population, greater consistency and continuity of patient care, and a more holistic and preventative approach to care that meets all of a person's needs by joining up services within communities and beyond.

1.3 Strategic priorities for community and mental health services

To address the case for change and overcome existing variation, a set of strategic priorities for community and mental health services were agreed by clinical and system leaders:

- **Optimisation of patient safety, quality and experience by reducing variation;** consistent standards and treating patients in the most appropriate care setting
- **Alignment of care models and pathways to optimise patient access and ensure clear ownership of care**, by addressing the overlap in services, using consistent criteria, reducing the complexity of the provider landscape and aligning community physical health and mental health
- **Integration of local services across the life course and a more holistic approach to care** by reducing fragmentation of services, focusing on prevention and integrating across multiple community teams locally to meet all of a person's needs at once
- **Building a flexible, sustainable, and engaged workforce** and optimising systemwide use of staff and available skillsets
- **Improving resourcing of services according to local needs** and the required scale of delivery so generalist services are delivered locally and specialist services at scale

1.4 Future arrangements of community and mental health services

There is widespread agreement across HIOW that the current arrangements for delivering community and mental health services are not able to adequately to respond to the case for change or meet the strategic priorities outlined for services. There is an unwarranted variation in access to care, quality and experience of care, and type of care for people depending on where they live and which provider and service they interact with, which ultimately creates inequitable health outcomes.

This has arisen over time due to different investment and commissioning decisions made by seven separate predecessor CCGs. However, the issues persist because these decisions have led to fragmented service provision across multiple providers in the ICS and divergent care models operating across these providers who have differing levels of resources that are not aligned to population needs. This has created inconsistencies in access and care, complexity around who is accountable for individual patients at different points in their care and a lack of ownership for systemwide improvement of community and mental health services. These issues will only be exacerbated as demand for services continues to rise.

To overcome the fragmentation of care delivery and ensure more alignment and consistency, different organisational arrangements are required. Therefore, following an evaluation of possible arrangements, this Review recommends the creation of a new Trust for all community and mental health services across HIOW. This single organisation will bring together the best of community and mental health care from across HIOW and provides the most opportunity to benefit patients by reducing complexities in service delivery and supporting equity of access for all people in the ICS. Although it requires some of the highest level of change, the potential benefits for the population are significant. To maximise this potential, it needs to be delivered in a timeframe and at a pace of change that is sufficient to drive continued momentum and material progress in responding to the case for change and delivering on the opportunities for patients.

1.5 Recommendations and next steps

Whilst organisational change is an important component of addressing the case for change, it is not the only requirement if the system is to overcome the challenges outlined. While the Review's focus was on future arrangements for the delivery of services, four complementary recommendations are set out below that need to be implemented to ensure the ICS can fulfil all elements of the future strategic priorities. The recommendations are:

1. **A new Trust should be created for all community and mental health services across HIOW (including services provided by Solent, Southern, IoW and Sussex) with Local Delivery System/place-based divisions. The aim should be bringing together the best of community and mental health care from across HIOW.** This creates the greatest system alignment of any of the proposed organisational changes to reduce variation for patients across HIOW, overcoming the fragmentation across services and establishing consistency of care by bringing all NHS-provided community and mental health services into one organisation with a single leadership and clear accountability. It also provides an opportunity to create a more sustainable workforce by removing barriers around workforce mobility and creating a single, shared workforce plan and vision. Bringing all services into one Trust allows for the coordination of resources to manage capacity according to need, respond to system pressures and enable at-scale or fragile services to operate at the appropriate scale, as well as enhancing research and innovation. In creating this new Trust there is a need to:
    a. **Establish a shared leadership structure** early to coordinate across the Boards.
    b. **Co-develop a clear, structured roadmap and programme** for creating the new Trust including necessary organisational development, regulatory and assurance processes such as risk assessments and business cases in line with statutory transactions guidance. The roadmap should reflect timelines and processes that can drive change at a sufficient pace and demonstrate progress in responding to the case for change and delivering the opportunities for patients described.
    c. **Integrate the community and mental health elements of the IoW Trust Sustainability Programme** into this programme of work, and understand and mitigate how the existing IoW programme might be impacted by the establishment of a new Trust.
    d. **Closely engage Sussex Partnership and Dorset HealthCare** to discuss how and when to integrate these services into the Trust.
    e. **Identify where this change may affect other geographies** which provide services, including **Frimley**.
    f. **Ensure the Trust has a clear focus on local geographies**, in part through creating place-based divisions and leadership in the Trust.

2. **A review of community physical health beds should be undertaken.** This review should be conducted as a partnership between community providers, acute providers, local authorities and primary care. The scope of the review should be agreed between all parties, with the aim of exploring whether the bed capacity is being used to best effect to facilitate patient flow and meet the population needs for community inpatient care.

3. **Development of a systemwide clinical strategy for community and mental health services that focuses on prevention, early intervention and patient-centred care.** This should be led by the community and mental health providers but with input from key system partners including local authorities, primary care and the acute sector, as well as service users. This will optimise patient safety, quality and experience through a consistent set of standards. It should align with the strategy for place to establish a holistic approach

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to patient needs and ensure care is delivered in the most appropriate setting for the patient. It is essential to ensure that community and mental health clinical expertise, as well as the views of patients, is strongly represented on, and feeds into the strategy.

4. **A clear, systemwide strategy for place and place-based leadership** is needed that identifies how to accelerate place-based integration across all health and care actors and wider relevant sectors including education. Community and mental health care is deeply rooted in place, meaning that a strategy focused on place-based integration of services is essential to accompany the systemwide clinical strategy. In particular, it will need to understand and navigate the boundaries between place and Local Delivery Systems.

5. **Establishing a more strategic approach to the funding for community and mental health services** to address the current inequities. The approach should reflect on the overall system performance in communities that have historically had higher levels of investment in community and mental health services. The revised approach should ensure that community and mental health services are resourced proportionately to need with a response to the future demand.

Key stakeholders from across Solent, Southern and the Isle of Wight proposed a set of principles to guide the implementation of these recommendations, which can be found in Chapter 6.

2. Introduction

Increasing integration is central to the development of the ICS. To achieve this, it is essential to advance collaboration and place-based partnerships across providers of health and care services, including establishing provider collaboratives. Evolving national policy for ICSs brings further opportunities for integration through changes in commissioning responsibilities and removal of competition policy as ICSs move to a statutory footing from July 2022.

Building on this, HIOW ICS has sought to develop its approach to collaboration and integration in community and mental health services. In February 2022, Carnall Farrar (CF) were commissioned to undertake an independent review of community and mental health services in the ICS to identify further opportunities for collaboration and integration, building on an understanding of current and future population health needs and how these were being met through existing services.

The purpose of the review was to:

- Set out a high-level overview of current and future population needs for community and mental health services, drawing on existing ambitions of the HIOW ICS and highlighting differing needs at place level
- Document community and mental health services currently delivered in HIOW, including those provided by Solent NHS Trust ('Solent'), Southern Health NHS Foundation Trust ('Southern') and other NHS providers
- Understand the strengths and weaknesses of the existing arrangements and their ability to meet future needs
- Produce options for future delivery of services to meet population needs and improve outcomes
- Conduct an options appraisal exercise using evaluation criteria to frame evidence of the relative pros and cons of each option
- Set out a preferred option in a report agreed by relevant stakeholders
- Assess the impact on the potential future leadership arrangements for community and mental health services in HIOW

Senior leaders from across HIOW ICS (designate ICB leadership and CCGs), Southern and Solent were engaged closely in the process alongside other key stakeholders including Sussex Partnership, the four acute Trusts, local authorities and primary care. Engagement included regular governance meetings for the project as well as 1:1 interviews, group interviews, Solent and Southern Board context sessions, two clinical summits and two system-wide workshops.

This report sets out the strategic context for community and mental health services in HIOW and the findings and recommendations arising from the Review.

2.1 Methodology

Over an 11-week period, the CF team, in collaboration with key stakeholders, undertook a programme of work involving the following steps and core activities.

1. Developing the case for change

In total, 83 stakeholders were interviewed, including over 60 individual interviews with community and mental health providers, acute providers, local authorities and system leadership. Six group interviews were also conducted with Solent and Southern NEDs and clinical leads, the CCG Executive Group and the CCG Managing Directors group. The interviews

explored views on the successes and challenges of current arrangements, as well as future opportunities for community and mental health services and how evolving ICS policy was changing working practices.

In parallel, a baseline analysis was conducted on current and future population health needs and how these were being met by community and mental health services in HIOW. Analysis included population demographics and health profiles, modelling of future demand for community and mental health services (considering demographic growth, non-demographic growth and impact of Covid-19), service access and uptake, service spend, waiting times, patient outcomes and a detailed mapping of service provision.

The interviews and baseline analysis were used to build a case for change, which was reviewed and iterated at a workshop with HIOW system leaders (both managerial and clinical). There were also two sessions with Solent and Southern Boards to discuss the emerging findings.

2. Identifying future strategic priorities for the system
A clinical summit was held with clinical leads from across HIOW to identify priorities for community and mental health services. This session explored what good looks like for a patient engaging with community and mental health services in HIOW, the barriers to achieving this, and subsequently the priorities for future service delivery. The strategic priorities helped to identify additional requirements in response to the case for change, which were iterated with wider stakeholders.

3. Developing and appraising options for future organisational arrangements
From the interviews and in response to the case for change, a longlist of potential options for future arrangements of community and mental health services in HIOW was collated. A structured, two-part appraisal process was used to narrow these down to the most realistic options, and then to compare their relative merits. First, this involved the application of simple hurdle criteria to produce a shortlist of the most viable options. The longlist of options and application of the hurdle criteria was then reviewed at the first system workshop.

Subsequently, the shortlisted options were evaluated against a more detailed set of criteria which focused on how far they responded to the case for change and delivered against the future strategic priorities for the system. A second clinical summit and system workshop were held with key stakeholders to review the options and full appraisal process, align on a preferred option and outline the key steps of a roadmap to achieve the preferred option.

4. Outlining next steps
A roundtable discussion was held with Solent and Southern leaders to align on the recommendations that are needed in response to the case for change and the next steps for delivering them. This built upon initial discussions on next steps from the second clinical summit and system workshop.

Exhibits 1 and 2 provide an overview of the Review's methodology and engagement.

Methodology overview

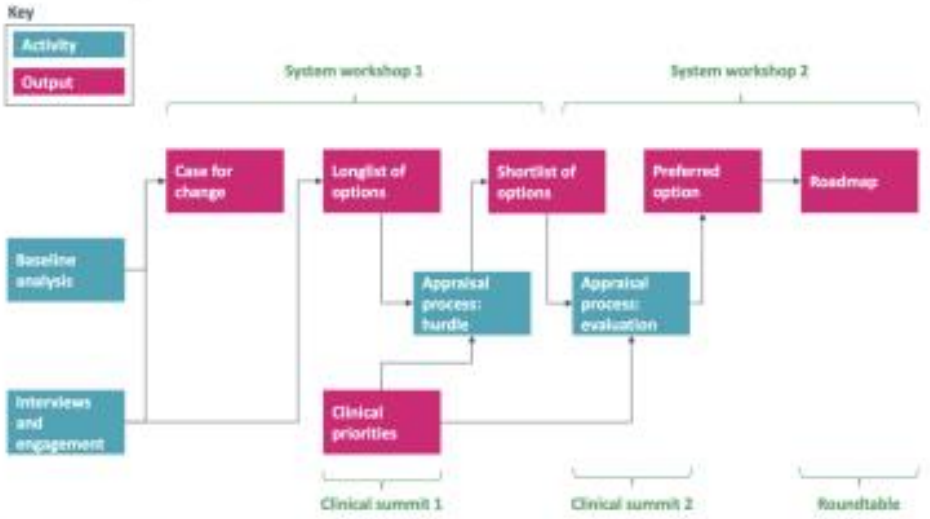


Exhibit 1: Infographic of the overall process for the Review

Engagement overview

	Meeting	Purpose	Dates	Attendees
Workshops	Context session for Solent (90 min)	• Provide update on the overall programme • Review emerging findings from interviews and baseline analysis	7 March 22	Solent Board members
	Context session for Southern (90 min)	• Consider future options for how community and mental health services are organised in HIOW	8 March 22	Southern Board members
	Clinical Summit 1	• Reflect and align on what good looks like for C&MH services in HIOW • Identify the barriers to achieving this • Outline future priorities for service delivery to address these barriers	2 March 22	Key clinical leads and C&MH experts from Solent, Southern, Acute Trusts, primary care and local authorities in HIOW
	System workshop 1	• Review findings of review of current state and future opportunities • Align on options to be appraised • Discuss and refine appraisal process for evaluating the options	16 March 22	Senior stakeholders and C&MH experts from Solent, Southern, Acute Trusts, primary care and local authorities in HIOW
	Clinical Summit 2	• Review shortlisted options following application of the hurdle criteria • Discuss pros and cons of shortlisted options from a clinical perspective • Begin developing a roadmap to achieving the agreed clinical priorities and future options	24 March 22	Key clinical leads and C&MH experts from Solent, Southern, Acute Trusts, primary care and local authorities in HIOW
	System workshop 2	• Review options against appraisal matrix and discuss relative merits and challenges of each • Align on preferred option for future delivery of C&MH services • Begin outlining the roadmap for implementing the preferred option • Identify additional requirements to respond to the case for change	28 March 22	Senior stakeholders and C&MH experts from Solent, Southern, Acute Trusts, primary care and local authorities in HIOW
	Roundtable Discussion	• Engage key stakeholders in recommendations of the report and the direction of travel to ensure they resonate with those delivering them • Review, build-out and co-develop the roadmap to safely and effectively establishing a new Trust	12 April 22	Solent and Southern Chairs, Chief Executives, CMOs and other key senior representatives including IoW

Exhibit 2: Summary of stakeholder engagement throughout the Review

2.2 Governance

Throughout the programme of work, weekly touchpoints were held with leads from across the ICS, Solent and Southern. These were used to provide progress updates, guide the work and test emerging findings. Touchpoints were complemented by fortnightly Steering Group meetings with the Chief Executives from the same three organisations. Finally, there were three meetings of the Chairs and Chief Executives from these organisations to review and sign off on materials and the direction of the programme.

A list of interviewees, workshop attendees and governance groups are provided in Annex 1.

3. Context

3.1 About the HIOW ICS

HIOW ICS covers a resident population of 1.9 million people across Hampshire, Southampton, the Isle of Wight and Portsmouth. It comprises two CCGs: Hampshire, Southampton and the Isle of Wight CCG – created in 2021 following a merger of six CCGs – and Portsmouth CCG.

On average, there are over 450,000 referrals each year for community and mental health services in HIOW, with a total ICS spend (pre-Covid-19) of ~£507m on these services. The three main providers of NHS community and mental health services in HIOW are Solent NHS Trust (Solent), Southern Health NHS Foundation Trust (Southern) and Isle Of Wight NHS Trust (IoW). Solent are the main community and mental health provider in Portsmouth city and the main provider of community services in Southampton. Southern are the main community and mental health provider across Hampshire and the main provider of mental health services in Southampton. Other providers include Dorset HealthCare University NHS Foundation Trust (Dorset), who provide talking therapies (IAPT) to Southampton City, and Sussex Partnership NHS Foundation Trust (Sussex), providing Children and Adolescent specialist mental health services (CAMHS) in Hampshire.

Alongside these NHS community and mental health service providers, community-based services are also delivered by ~154 GP practices and 42 PCNs, four large Local Authorities (Portsmouth City Council, Hampshire County Council, the Isle of Wight Council and Southampton City Council) and an active VCSE sector. Furthermore, there are four main acute providers: Hampshire Hospitals NHS Foundation Trust, Portsmouth Hospitals NHS Trust, University Hospitals Southampton NHS Foundation Trust and the Isle of Wight NHS Trust.

Core to the development of the ICS is the advancement of provider collaboratives; some of those already established in HIOW are described in 3.5. In addition to this, the senior leadership team at Solent is undergoing change which means this was an opportune moment to review how NHS providers of community and mental health services in HIOW can work most effectively together to meet future population needs.

3.2 National context

ICS policy continues to evolve at national level. The White Paper, *'Working together to improve health and social care for all'*, published 11 February 2021, focuses on the integration of health and care and proposes several legislative changes including the formation of statutory ICSs. The associated guidance outlines expectations that ICSs will be responsible for commissioning decisions. The removal of competition and the changing role of the ICS is focused on driving and stimulating integrated care across systems and these changes will bring renewed opportunities for development of place-based partnerships. Focus on strengthening place-based partnerships is reiterated through the White Paper published on 9 February 2022: *'Health and social care integration: joining up care for people, places and populations'*.

The policy frameworks also stipulate the development of provider collaboratives with the expectations that all NHS trusts will be part of at least one provider collaborative by April 2022. Further guidance (August 2021) outlines expectations for how providers should work together as provider collaboratives, principles to support local decision-making, and function and form options that systems may consider. A summary of the guidance is outlined in Exhibit 3.

In response to national guidance and building on its evolving provider collaboratives, HIOW ICS is seeking to develop its approach to collaboration in community and mental health services.

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area. Provider collaboratives will be a key component of system working, as a way in which providers work together to plan, deliver and transform services. By working effectively at scale, provider collaboratives provide opportunities to tackle unwarranted variation, making improvements and delivering the best care for patients and communities.

What are provider collaboratives?

- Partnership arrangements involving at least two trusts working at scale across multiple places
- Providers may also work in place-based partnerships to co-ordinate planning and delivery of integrated services
- Collaboratives may support other collaborations, networks, and Cancer Alliances

Why are they needed?

- Benefits of scale: reduce unwarranted variation and health inequalities; increase system resilience; improve recruitment, retention, and development; consolidate specialised services; utilise economies of scale
- Areas to consider are clinical services, clinical support services, corporate services

Expectations for NHS Providers

- All trusts providing acute and mental health services expected to be part of a provider collaborative by April 2022
- Ambulance, community and private providers should also join collaboratives where this would benefit patients
- ICS leaders, trusts and system partners are expected to identify shared goals, appropriate membership and governance, and ensure alignment with ICS priorities

The role of provider collaboratives in health and care systems

- Membership should be inclusive, evolutionary, purpose-driven
- May be at system, multi-system, regional, national scale
- Should involve voluntary sector, primary care, local authorities
- Health and Care Bill would allow Integrated Care Boards (ICBs) to delegate functions e.g., devolved budgets

Form and Governance

- Shared vision and commitment to collaborate
- Build on existing governance arrangements
- Mechanisms to hold each other to account
- Voices of local communities and clinical leadership embedded
- Clarity on how decisions are made
- Streamline ways of working within/across systems
- Resourcing should be proportional to benefits expected
- Potential for new governance forms following legislation

Accountabilities

- Mutual accountability between members is a key feature
- Providers expected to take action to improve delivery on shared priorities through strengthening provider collaboratives
- If legislation is passed, ICBs will hold provider collaboratives to account for services commissioned from or delegated to them

Source: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf, CF analysis

Exhibit 3: Summary of NHS England provider collaborative guidance – August 2021

3.3 Current mental health service arrangements in HIOW

There are three main NHS providers of mental health services: Solent, Southern and IoW. There are also providers of specific services from outside the ICS, including Sussex who provide community CAMHS and Children's Eating Disorder services in Hampshire, and Dorset who provide IAPT in Southampton. There is further non-NHS mental health service support through the four Local Authorities, primary care and the VCSE sector.

Mental health service	Isle of Wight	Portsmouth	South East Hampshire	Southampton	South West Hampshire	North and Mid Hampshire
CAMHS	IoW	Solent	Sussex	Solent	Sussex	Sussex
CAMHS inpatient	Southern					
Eating disorder OP (children's – 0-17)	IoW	Solent	Sussex	Solent	Sussex	Sussex
Perinatal	IoW	Southern				
Adult inpatient	IoW	Solent	Southern			
Adult inpatient (rehab)	*Not identified*	Solent	Southern			
Eating disorder IP (adult)	Southern					
Eating disorder OP (adult)	IoW	Southern				
IAPT	IoW (*Isle Talk*)	Solent (*Talking Change*)	Southern / Solent Mind (*Talk*)	Dorset HealthCare – (*Steps2Wellbeing*)	Southern / Solent Mind (*Talk*)	Southern / Solent Mind (*Talk*)
Community MH / crisis teams	IoW	Solent	Southern	Southern	Southern	Southern
Older persons MH services	IoW	Solent	Southern	Southern	Southern	Southern
Acute liaison	IoW	Southern				
Specialist and forensic	Southern					
Learning Disabilities & Autism	IoW	Solent	Southern			
Complex adults MH Therapy	IoW - ECT	Southern – ECT and rTMS				
Crisis	IoW	Solent	Southern	Southern (*The Lighthouse*)	Southern	Southern
Urgent MH helpline (NHS 111)	IoW	Solent	Southern			
Outreach	IoW (Dementia)	*Not identified*				
Place of safety	IoW	Solent	Southern (Parklands, Antelope and Elmleigh)			
EIS	*Not identified*	Southern				

Exhibit 4: Provider landscape for NHS mental health services in HIOW

Mental health service provision is particularly fragmented across care pathways and across geographies. Clinical pathways which are notably affected with multiple hand offs and different access requirements are CAMHS, Eating Disorders and Learning Disabilities. Exhibit 4 shows the NHS mental health service provider mapping across HIOW.

3.4 Current community health service arrangements in HIOW

Similarly, there are three main NHS providers of community health services: Solent, Southern and IoW, alongside the wider landscape of community service provision in local authorities (e.g. social care), primary care and VCSEs. Similarly to mental health but to a lesser extent, there is a complex, mixed delivery of services across different providers. Exhibit 5 shows the community health service provider mapping across HIOW.

Community health service	Isle of Wight	Portsmouth	South East Hampshire	Southampton	South West Hampshire	North and Mid Hampshire
Adult Physical Health						
Community inpatients	IoW	Solent	Southern	Solent	Southern	Southern
Community – integrated teams - Urgent care - Frailty	IoW	Solent	Southern	Solent	Southern	Southern
- Falls	IoW	Solent	Southern	Solent	Southern	Southern
- Pulmonary rehab	*Not identified*	Solent	Solent	Solent		Solent
- Palliative and End of Life	IoW	Solent	Southern	Solent	Southern	Southern
- MSK and Pain management	IoW	Solent	Solent	Solent	Southern	Southern / HHFT
- Tissue Viability	IoW	Solent	Southern	Solent	Southern	Southern
- Long Covid	IoW	Solent	Southern	Solent	Southern	Southern
- Sexual health services	Solent	Solent	Solent	Solent	Solent	Solent
- Diagnostics	IoW	Portsmouth	Southern	Solent	Southern	Southern
- Speech and Language Therapy	IoW	Solent	Solent	Solent	Hobbs	Hobbs
Children's Physical Health (excluding CAMHS & Learning Disabilities)						
Health visiting and School Nursing (LA funded)	Solent	Solent	Southern	Solent	Southern	Southern
Children's Health Information Service	Southern	Southern	Southern	Southern	Southern	Southern
School immunisations	Solent	Solent	Southern	Solent	Southern	Southern
Children's Community Nursing	Solent	Solent	Solent	Solent	Solent	HHFT
Children's Continuing Care	*Not identified*	Solent	Solent	*Not identified*	*Not identified*	*Not identified*
Community paediatrics and Therapies	Solent	Solent	Solent	Solent	Solent	Solent
Specialist Children's Home Health – Swanwick lodge	N/A	N/A	Southern	N/A	Southern	Southern

Exhibit 5: Provider landscape for NHS community health services in HIOW

3.5 Current collaboration in mental health and community services

The provider landscape for community and mental health services across HIOW is complex with multiple providers serving the same population. Despite the impact of historically fractured commissioning, the evolution of the ICS and merging of six of the CCGs provides an opportunity to improve collaboration and consistency of commissioning. Here, some of the existing and developing collaboration between providers is outlined.

Specialist services provider collaboratives have been in place for over a year. There is a newly formed mental health collaborative across the ICS with a steering group led by Southern, Solent and Sussex, which meets regularly to better coordinate mental health services. There is also a Clinical Leadership Forum.

Solent is in the process of developing a partnership with the IoW to provide a range of community and mental health services on the island. This has involved developing relationships at service line and clinicians joining together in peer review meetings to look at best practice across common services and develop a single collaborative model.

Between Solent and Southern, there are many examples of growing collaboration over recent years, which accelerated during the pandemic with strong partnerships around local planning.

There is a community and mental health partnership committee which provides a forum for joint problem-solving between executives. This has led to consistent IPC measures across the Trusts, a shared staff vaccination programme and flexible use of the bed base for community inpatient care across the two organisations. Collaboration also exists between physical health services in South East Hampshire, where Solent and Southern have worked on setting and delivering a combined vision for community physical health services.

There are also examples of growing collaboration across NHS community and mental health services and local authorities. For example, Southern co-developed 0-19 children's services and immediate integrated care teams with Hampshire County Council. Similarly, Solent is part of the Portsmouth Collaboration Team which enables integration between local authorities and NHS services, and where joint provision has proved very effective. This has led to weekly meetings between the Trusts and councils, regular progress checks and strong relationships.

Examples of mental health provider collaboratives across HIOW:

Provider Collaborative	HIOW Mental Health NHS Trusts Included
Adult ED T4 Provider Collaborative	Southern Health IoW Trust (silent partner/stakeholder) Solent (silent partner/stakeholder)
Wessex and Dorset CAMHS	Southern Health (Tier 4 Provider) Sussex Partnership (Lead Provider – Hampshire CAMHS) IoW Trust (Community Provider – IoW) Solent (Community Provider – Portsmouth & Southampton)
FOR ME – TVW Adult Secure Services	Southern Health (Service Provision) IoW Trust (Stakeholder) Solent (Stakeholder)
Veterans – South East Pilot	Solent (Service Provision) Sussex Partnership (Service Provision)

3.6 HIOW population needs

HIOW has an older population relative to the national average, with a higher proportion of over 65s in Hampshire and the IoW (24% of the historical CCG West Hampshire and South East Hampshire populations, 30% in IoW) in contrast to Southampton and Portsmouth (14% and 15% respectively). Deprivation is higher in Portsmouth, Southampton and the IoW, which are all above the England average. Deprivation varies across Hampshire with significant pockets of deprivation in the South East, although all areas are below the England average. Ethnic diversity also varies across HIOW with a more diverse population in Southampton.

Portsmouth and Southampton have the highest rates of lifestyle factors across HIOW that can contribute to greater physical and mental health needs, being above the national average in prevalence of smoking and overweight children.

Prevalence of different mental health conditions including dementia, depression and long-term mental health problems varies notably across geographies, creating different requirements for mental health services across HIOW. HIOW has high and growing rates of depression in over 18s, with levels significantly above the national average.

HIOW has higher than national average levels of physical needs, with 55% of its population living with a long-standing health condition. Prevalence of physical health conditions differs across geographies, meaning the requirements for community services will also vary by geography. Hypertension, heart failure and CHD appear most prevalent in the IoW and South East & South West Hampshire, whilst COPD appears highest in IoW, Portsmouth, South East

Hampshire and Southampton. Portsmouth and Southampton have notably higher rates of smoking and overweight children.

A summary of physical and mental health needs by HIOW ICS geography:

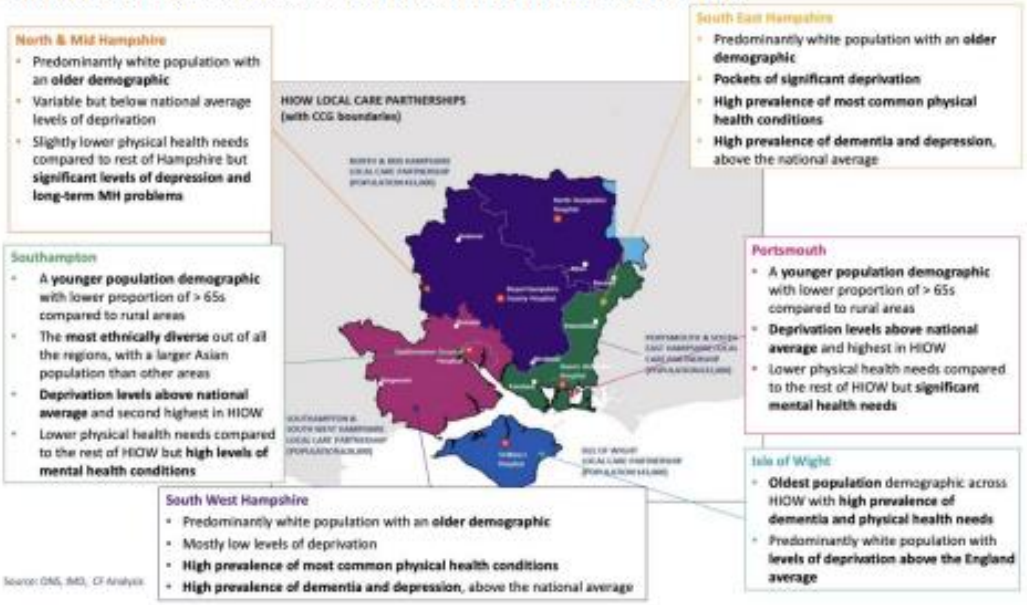


Exhibit 6: Summary of physical and mental health needs across HIOW ICS

4. The Case for Change

The Review found a compelling case for change in the way that community and mental health services are resourced and delivered in HIOW. This is centred around the need to reduce unwarranted variation in services which is subsequently causing variation in patient access, care, experience and outcomes. Significant system change is needed to create greater alignment and clearer leadership of these services, and to ensure that patient care and outcomes are equitable irrespective of where you live or how and when you access services. Details of the various challenges in the system that need to be addressed are outlined below.

4.1 Rising demand for community and mental health services

Demand for community and mental health services is high and will continue to grow over the next five years, with growth slightly higher for mental health services than community health.

The HIOW population is older than the England average and ageing faster than most of the country. This will be the primary driver for an increase in demand for community services over the next few years. As a result, demand for community health services could grow by ~11% by 2025 (see Exhibit 7) and will grow the most across Hampshire, reflecting its older demographic.

Mental health services could grow even further by ~13% by 2025. Demand for mental health services is predicted to peak in 2022 at 117% of 2019 levels due to the impact of COVID (estimates from NHSEI Strategy Unit), before continuing to rise at its original growth trajectory. The largest growth in demand is expected for older person's MH inpatient care and lower acuity MH community services – ~33 new beds will be needed to meet future inpatient demand. The largest increase in absolute patient numbers will be seen in IAPT.

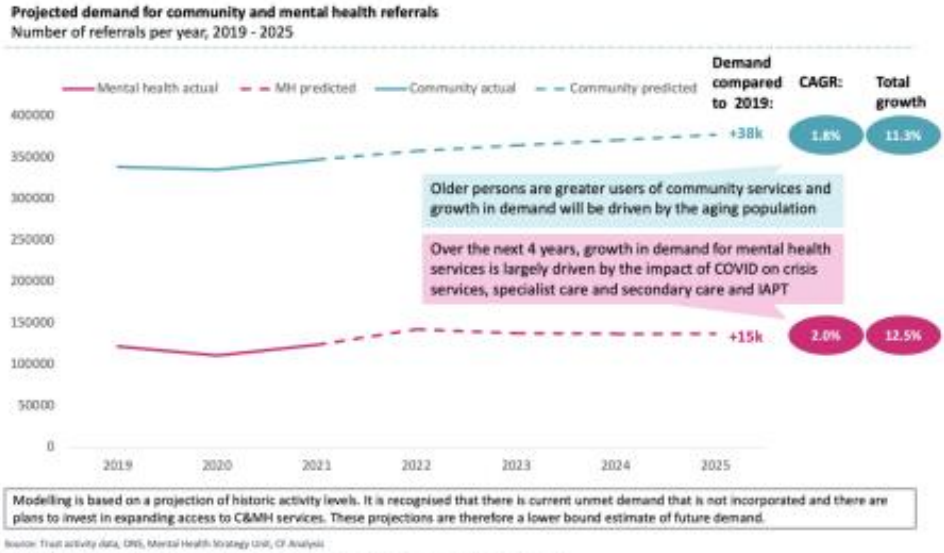
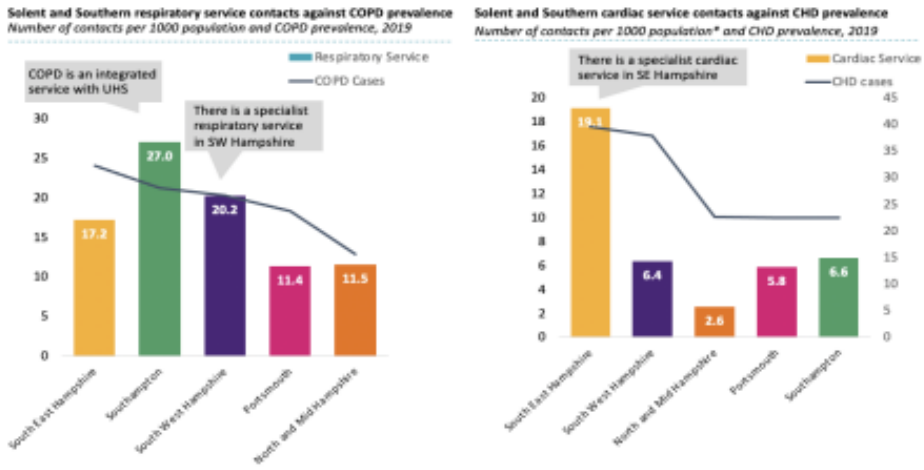


Exhibit 7: Projected demand for community and mental health referrals

4.2 Capacity-need mismatch and staff shortages in mental health

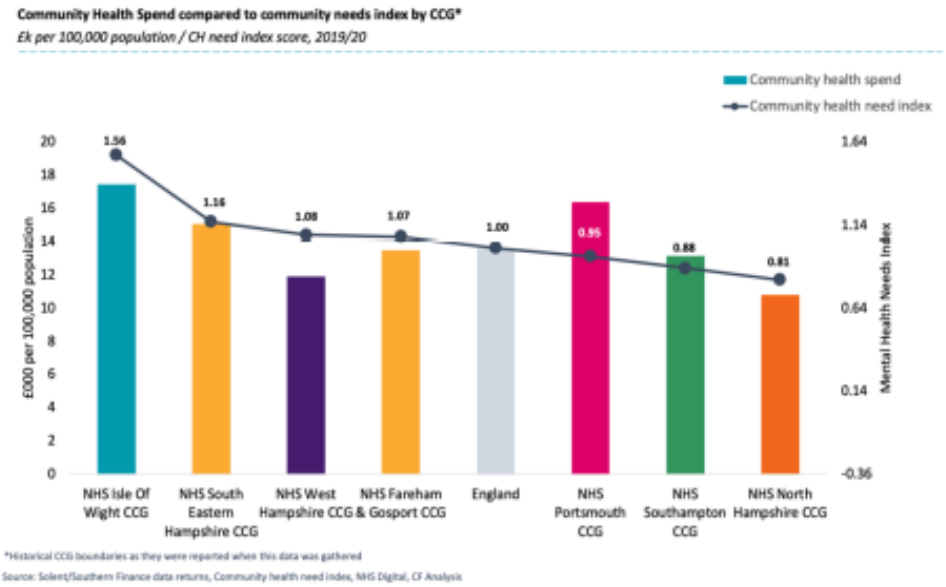
There is misalignment between the needs of the population for community and mental health services and the capacity of NHS services in HIOW to respond to this. This discrepancy will be exacerbated by the rising demand. As a result, there is unwarranted variation in access to care, differential quality of services and likely poorer patient outcomes in some geographies. The mismatch is particularly stark in community health where, for example, the number of contacts per 1,000 population does not appear to align with physical health needs across geographies (see Exhibit 8), suggesting a misalignment in capacity and population needs. Furthermore, there are differential levels of resource for community health services across HIOW which are not proportionate to need, partly due to historical inequitable funding for community health services across geographies, as shown in Exhibit 9. This likely leads to some differences in quality and effectiveness of services available to patients.



N.B. Contacts are mapped to area in which a patient is registered with a GP, not area in which care took place

Source: Southern and Solent activity data, Fingertips, CF analysis

Exhibit 8: Number of contacts compared to prevalence of relevant condition across HIOW



*Historical CCG boundaries as they were reported when this data was gathered

Source: Solent/Southern Finance data returns, Community health need index, NHS Digital, CF Analysis

Exhibit 9: Historical CCG Community Health spend compared to Community Health needs index

The communities that have benefited from higher investment in community health services also appear to spend proportionately less on acute care (as shown in Exhibit 10), demonstrating the health and financial benefits of redistributing resource into community and physical health services. For example, reducing A&E presentations and non-elective hospital admissions as described later. This indicates an opportunity to improve care and value for money, in a context where HIOW ICS does not have a balanced financial plan.

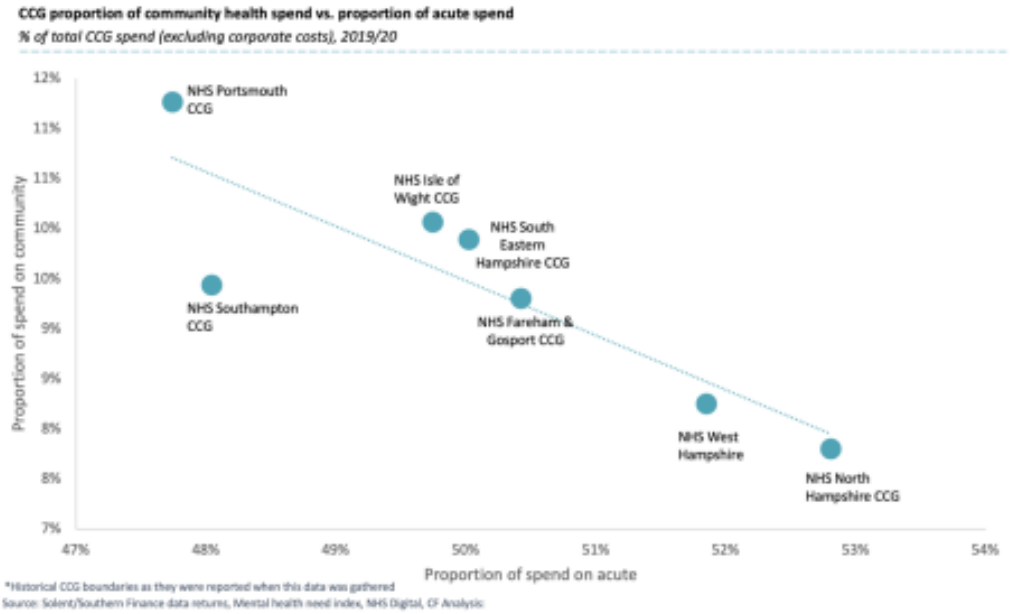
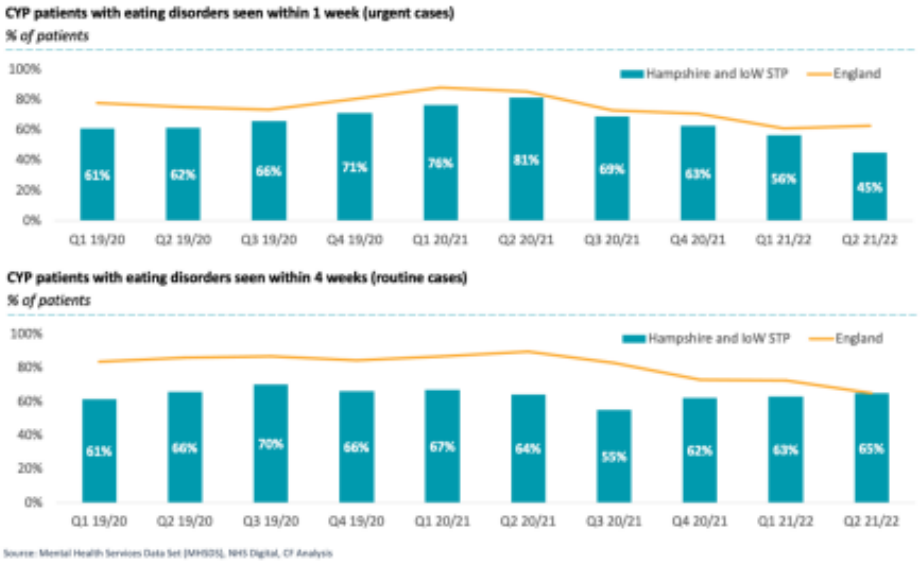


Exhibit 10: Historical CCG Community Health spend compared to Community Health needs index

The lack of community health capacity relative to population needs also impedes effective pathways of care for patients. Information shared in the interviews, especially from acute stakeholders, suggested that patients are not always managed in the most appropriate care setting for their needs (i.e. at a more intensive care setting than needed). This is often due to capacity issues in community and social care services which results in delayed discharges from acute to community services. Delayed discharges can lead to significant patient harm due to remaining in hospital longer than necessary (e.g. through development or deterioration of musculoskeletal conditions, patient frailty or loss of patient independence). In other cases, interventions were not sufficient or early enough to avoid health deteriorating and subsequent hospital admissions. The knock-on consequence of these events for other patients is delays in accessing acute inpatient care.

Mental health services also observe a capacity-need mismatch. In Southampton in particular, mental health spend is not proportionate to need. Emergency readmissions for people with a mental health flag are growing, suggesting discharged patients are unable to access the community support necessary to prevent their readmission. The mismatch also results in variation in patient access; rates of those with depression accessing IAPT services is much higher in the cities and adherence to waiting time targets in HIOW for eating disorders consistently falls below national averages for Children and Young People (CYP) (see Exhibit 11). Delayed access has the potential to cause harm with consequences for those in need who may enter crisis as a result.



Source: Mental Health Services Data Set (MHSDS), NHS Digital, CF Analysis

Exhibit 11: Waiting time breaches for Children and Young People (CYP) with eating disorders

Significant workforce shortages were also repeatedly highlighted, which could compromise the safety and quality of services by constraining capacity. These shortages are particularly visible in mental health with vacancies of 355 full time roles for mental health services across the two main providers. Southern – the provider of most MH inpatient services – has a 13% vacancy rate for mental health staff, largely driven by the national shortage of inpatient nurses. Furthermore, providers compete for workforce which has led to a strong desire for a system-wide workforce plan and spreading best practice on innovative ways to fill gaps.

4.3 Fragmentation of care delivery and inconsistencies in care models

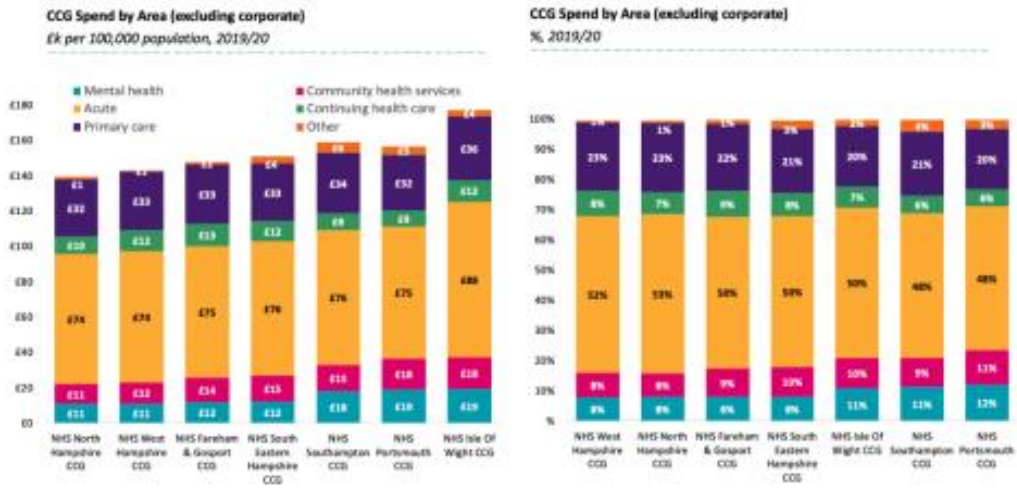
The landscape of community and mental health providers in HIOW is complex, with multiple providers in a single pathway or geography and fragmented care pathways that are hard to navigate for patients and carers.

Fragmentation across pathways and different providers is particularly visible in mental health, with many hand-offs, limited integration between services and patients being 'passed around' the system. This is most visible in Children and Adolescent Mental Health Services (CAMHS), Eating Disorder services and the transition between children and adult's mental health. For example, CAMHS community services are provided by two different providers and CAMHS referral waiting time subsequently differs by nearly four weeks depending on where you live. Additionally, CAMHS inpatient services are provided by another separate provider, contributing to further discontinuity when patients require hospital admission.

Again, provider and pathway fragmentation partly arises from historical "patchwork commissioning" across multiple CCGs. This has resulted in variation in funding for community and mental health services across historical CCG geographies (see Exhibit 12); with Hampshire receiving the least in overall terms.

There are also differing levels of integration across health and broader community services in local geographies. Whilst Portsmouth is upheld as an exemplar for integration, in other places there is a need for more join up across services including acute, community and mental health services, social care and education, to provide a more holistic approach to a person's care.

Challenges with vertical and horizontal integration can also lead to differential access to research and innovation opportunities across different geographies.



The Isle of Wight CCG has a significantly higher spend compared to other areas due to the lack of economies of scale for healthcare provision.

*Historical CCG boundaries as they were reported when this data was gathered
Source: FD: 2019/20 CCG spend; NHSE CCG allocation 2019/20-23/24 weighted populations; CF analysis

Exhibit 12: Historical CCG spend across service groups in 19/20

Furthermore, inconsistencies in care models across different providers leads to variation in in patient access, experience, and quality of care across geographies. Combined with the misalignment of services delivered versus population needs, this may lead to variation in patient outcomes across HIOW (See Exhibit 13). For example:

- SE Hampshire and Southampton have higher under 75s mortality rates for all causes considered preventable
- IAPT recovery rates are 11% higher in Portsmouth than Southampton
- Major indicators of patient mental health outcomes are noticeably higher in Portsmouth compared to the rest of Hampshire

*Historical CCG boundaries as they were reported when this data was gathered
Source: Southern and Solent activity data, Fingertips, MHSDS, NHS Digital, CF Analysis

Exhibit 13: Variation in patient access and outcomes across HIOW

4.4 Lack of clarity around ownership and imbalance of clinical risk

The complexities of community and mental health service provision in HIOW has created confusion around accountability and ownership at different levels.

Firstly, there is confusion around accountability for individual patients and an imbalance of clinical risk which can result in inappropriate escalation of patient care to acute hospitals rather than patients being treated in the right care setting for their needs. Secondly, the complexity of multiple different providers operating in a delivery system means that there are uncertainties around where to discharge and refer patients to, particularly for acute providers (as shown in Exhibit 14). This has potential for patients to fall between services, to cause delays in discharge and may impede integration across different services.

Overall, the confusion around accountability creates a lack of ownership and leadership for systemwide alignment and improvements across all community and mental health services.

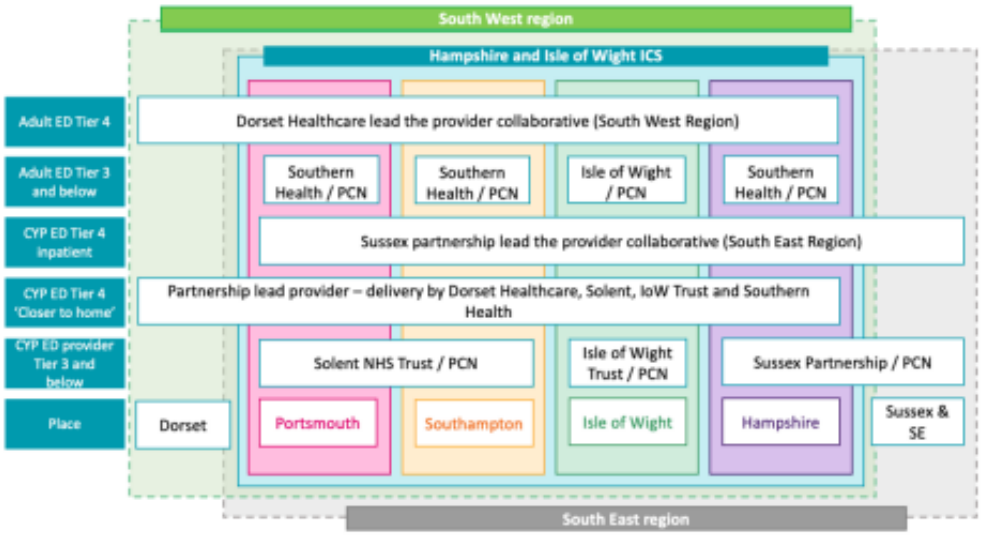


Exhibit 14: Pathway showing the complexity of all-age Eating Disorder pathways across different providers in HIOW

5. Strategic priorities for community and mental health services

5.1 Strategic priorities for future services

To respond to this case for change and overcome the variation experienced by people accessing community and mental health services in HIOW, five strategic priorities were agreed (see Exhibit 15). These were based on the views of clinicians, system managers and community and mental health experts from across the system.

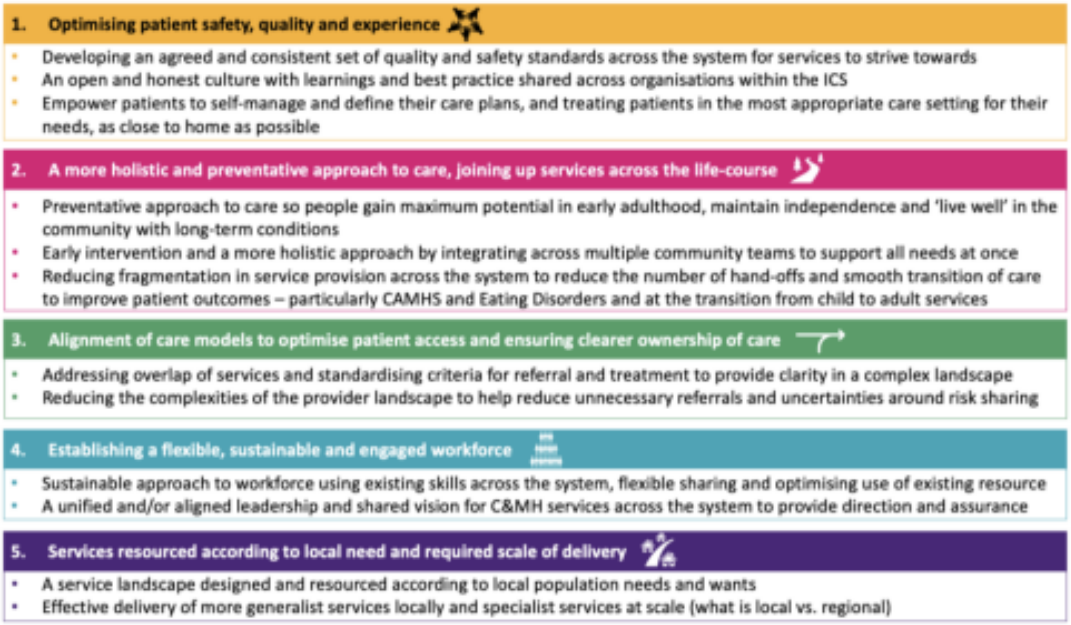


Exhibit 15: Five strategic priorities for future delivery of community and mental health services, in response to the case for change

5.2 Future arrangements of community and mental health services

There is widespread agreement across HIOW that current arrangements for delivering community and mental health services are not able to adequately respond to the case for change or meet the strategic priorities for services. There is an unwarranted variation in access to care, quality and experience of care, and type of care for people depending on where they live and which provider they interact with, ultimately creating inequitable health outcomes. This has arisen over a period of time due to different investment and commissioning decisions made by seven separate predecessor CCGs. However, the issues persist because these decisions led to fragmented service provision across multiple providers in the ICS, and divergent care models operating across the providers who have differing levels of resources that are not aligned to population needs. This has created inconsistencies in access and care, complexity around who is accountable for individual patients at different points in their care and a lack of ownership for systemwide improvement of community and mental health services. These issues will only be exacerbated as demand for services continues to rise.

Therefore, different organisational arrangements are required to overcome the fragmentation of care delivery and embed more consistency. Various options for future arrangements were considered by this Review and a longlist of possible options suggested during interviews is shown in Exhibit 16. These ranged from informal 'bottom up' collaboration through to more formal organisational structures requiring contractual changes, and various forms of vertical and horizontal integration.

A two-part appraisal process was used to evaluate the options and align on a lead arrangement, as outlined in Exhibit 17 (Annex 2 providers further detail on the appraisal process and evaluation outputs):

1. Applying a set of three clear hurdle criteria based on essential elements of the future strategic priorities and case for change, which eliminated five of the options
2. Reviewing the shortlisted options against a set of detailed evaluation criteria that draw on the Case for Change, national priorities, and the ICS five-year plan, as well as considering the deliverability and feasibility of these changes

Option	Full longlist of possible options proposed
No change	*Maintain the status quo.*
1	A single **lead provider or an alliance** is contracted to provide **children and adult's mental health, eating disorder and learning disability services** only.
2	**Align provider arrangements for MH** through **building out and formalising the developing MH collaborative**, with formal governance structures. Community services remain unchanged.
3	**Lead provider arrangements contracted for agreed set of pathways and/or geographies**, including those services currently provided by Sussex, as part of a provider alliance for community and mental health services with formal governance structures.
4	A **group model** is established for all community and mental health services across the HIOW ICS. This includes sharing central corporate and administrative functions, as well as a shared leadership and governance.
5	A **lead provider is contracted to provide mental health services** including services currently provided by Sussex, and a **different lead provider is contracted to provide community health services.**
6	A **new Trust for mental health services** including services currently provided by Sussex, with the **delivery of community services remaining unchanged** across different providers.
7	A **new Trust for mental health and community services** including services currently provided by Sussex, with inpatient (bedded) **community services provided by each acute provider in a local delivery system,** to become vertically integrated.
8	A **new Trust for mental health services** including services currently provided by Sussex, with **community services provided by each acute provider in a local delivery system,** to become vertically integrated.
9	A **new Trust for inpatient (bedded) mental health services only**, with **community services and community mental health services provided by each acute provider in a local delivery system,** to become vertically integrated
10	**A new Trust** is created providing community and mental health services across HIOW, including services currently provided by Sussex, with **place-based/LDS divisions**

Exhibit 16: Full longlist of possible structural options for community and mental health services considered by the

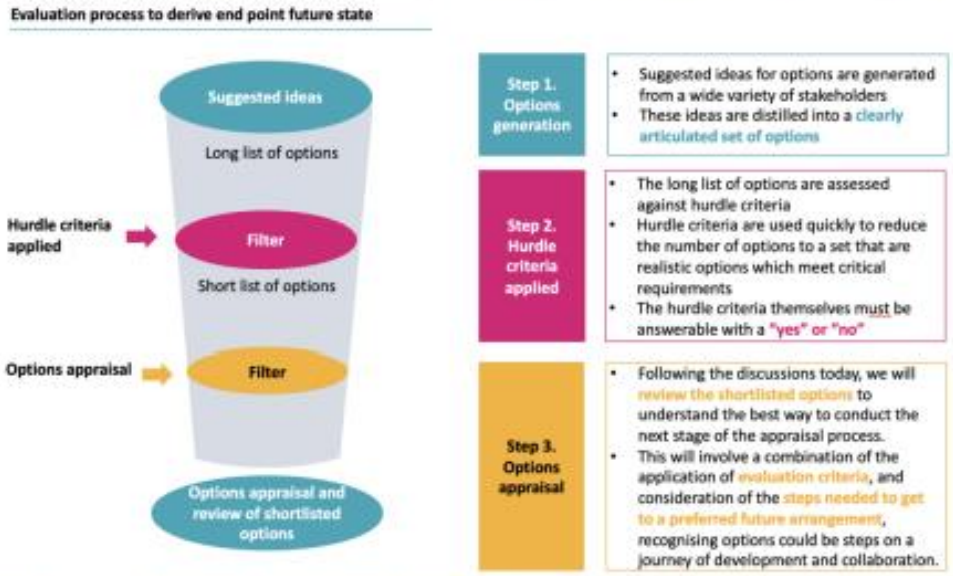


Exhibit 17: The clear, two-part options appraisal process that was used to shortlist and evaluate options

Through this process, the creation of a new Trust for all community and mental health services across HIOW with Local Delivery System/place-based divisions (Option 10) was agreed to provide the most opportunity to benefit patients by delivering the change needed to overcome the variation. This single organisation will bring together the best of community and mental health care from across HIOW. It should be implemented in a timeframe and at a pace that allows for continued momentum and material progress in responding to the case for change and delivering on the opportunities identified for patients.

Of the possible arrangements, it creates the most alignment and integration by bringing together all community and mental health services including those from Solent, Southern, the Isle of Wight and Sussex. This ensures more equitable service access for patients by enabling

more consistent care (e.g. waiting times) and more continuity and fluidity of care, preventing patients from getting lost between different providers. By housing community and mental health services in one organisation, a person's physical and mental health needs can all be met at once, supporting joined up care for those 11.4k patients who required both physical and mental health services in HIOW in 2022 (see Exhibit 22 in Annex 2) – a larger number of people than may benefit from vertical integration of physical health services into acutes.

Furthermore, Option 10 establishes a single leadership and clear accountability. This not only drives the consistency outlined above but enables better management of clinical risk and a systemwide approach to managing capacity so that patients are treated in the right care setting for their needs. This bears both patient and financial benefit. A single Trust can also coordinate resource more equitably across geographies to manage capacity according to local need, helping to overcome misalignment between services delivered and local needs.

Finally, a single Trust with geographical divisions provides the best economies of scale. First, by enabling delivery of local services according to local needs, and at-scale services to a larger geography such as forensic mental health and specialist community services. Secondly, it creates a more sustainable workforce by reducing competition for staff, removing barriers to workforce mobility and facilitating a single workforce plan. In turn, this improves capacity of services to respond to population needs and ensure the safety and quality of patient care. It also supports research and innovation and more equitable access to these by overcoming geographical boundaries, covering a larger population and providing the necessary infrastructure at scale such as digital systems, whilst bringing together the best of research from across different organisations. Although it appears large, the new Trust's turnover would still be exceeded by the smallest acute Trust in HIOW.

Overall, the greater integration of service delivery and focus on reducing inequalities, alongside shared workforce planning and digital alignment, are in line with the national direction for ICSs and integration.

The other options considered were agreed to be less able to overcome the variation that exists and support the ICS to meet the future needs of the population:

- **Separation of community physical health and community mental health services** was agreed to be adverse by clinicians as it is where there is the largest overlap in service users. It also creates significant barriers to delivering at-scale specialist services.
- **Lead provider arrangements,** although focused on localised delivery of care, fails to significantly improve fragmentation between physical and mental health services, has potential to create additional complexity and will not sufficiently reduce variation in access and outcomes. Stakeholders cautioned against viewing this as an 'easy option' as it may require more effort and time to implement than the other options.
- **A group model** would not achieve full accountability, alignment of care or workforce mobility as separate organisations remain, and so it would not go far enough to reducing fragmentation, misalignment and variation. Some noted that it may be beneficial to move through a group model as an intermediate step to reach a new Trust, but only if it did not create an extra step or lengthen the timeline.
- **Integration of community inpatient services into acute Trusts** had some support from the acute sector but it was felt that a one size fits all approach does not adequately account for different types of bedded services and the variable situation in different geographies. It was agreed that a more thorough, tailored review should be carried out of community inpatient services as a partnership between community providers, acute providers, local authorities and primary care (as detailed in recommendation 2).

Whilst Option 10 is an important component of addressing the case for change, it is not the only requirement if the system is to overcome the challenges outlined. Therefore, whilst the Review focused on future arrangements for the delivery of services, four complementary recommendations are set out below that need to be implemented to ensure the ICS can fulfil all elements of the future strategic priorities.

6. Recommendations and next steps

A roundtable was held with key stakeholders from Solent, Southern and the IoW to align on the recommendations and ensure clear ownership going forward, as well as to agree a set of immediate next steps for progressing them. This discussion also agreed two sets of principles: those to underpin the recommended actions and those necessary for their implementation.

6.1 Recommendations

A set of recommendations have been developed to deliver on the strategic priorities for community and mental health services a recommendation on future organisational arrangements and further complementary actions to respond to all elements of the case for change.

The roundtable agreed the following principles – that the recommendations put forward should:

- **Focus on improving health outcomes** for the people which these organisations serve, as well as delivering benefits for staff wellbeing and experience
- **Be clinically led,** with representation from across all relevant care settings, to ensure that future organisational functions and processes are informed by a clinical perspective and prioritise delivering patient benefits
- **Not be one provider taking over another but focus on the elements of four organisations (Solent, Southern, IoW and Sussex) coming together** into one new organisation to determine collectively how services are delivered across HIOW
- **Ensure benefits of the programme, particularly patient outcomes, are identified and its progress against these and responding to the case for change is monitored** early and throughout the transition to demonstrate the effectiveness of these changes
- **Harness the expertise of community and mental health service providers** to allow commissioning functions and responsibilities to be reframed and owned by the provider

Recommendations

1. **A new Trust should be created for all community and mental health services across HIOW (including services provided by Solent, Southern, IoW and Sussex) with Local Delivery System/place-based divisions. The aim should be bringing together the best of community and mental health care from across HIOW**. This creates the greatest system alignment of any of the proposed organisational changes to reduce variation for patients across HIOW, overcoming the fragmentation across services and establishing consistency of care by bringing all NHS-provided community and mental health services into one organisation with a single leadership and clear accountability. It also provides an opportunity to create a more sustainable workforce by removing barriers around workforce mobility and creating a single, shared workforce plan and vision. Bringing all

services into one Trust allows for the coordination of resources to manage capacity according to need, respond to system pressures and enable at-scale or fragile services to operate at the appropriate scale, as well as enhancing research and innovation. In creating this new Trust there is a need to:

a. **Establish a shared leadership structure** early to coordinate across the Boards.
b. **Co-develop a clear, structured roadmap and programme** for creating the new Trust including necessary organisational development, regulatory and assurance processes such as risk assessments and business cases in line with statutory transactions guidance. The roadmap should reflect timelines and processes that can drive change at a sufficient pace and demonstrate progress in responding to the case for change and delivering the opportunities for patients described.
c. **Integrate the community and mental health elements of the IoW Trust Sustainability Programme** into this programme of work, and understand and mitigate how the existing IoW programme might be impacted by the establishment of a new Trust.
d. **Closely engage Sussex Partnership and Dorset HealthCare** to discuss how and when to integrate these services into the Trust.
e. **Identify where this change may affect other geographies** which provide services, including **Frimley**.
f. **Ensure the Trust has a clear focus on local geographies**, in part through creating place-based divisions and leadership in the Trust.

2. **A review of community physical health beds should be undertaken.** This review should be conducted as a partnership between community providers, acute providers, local authorities and primary care. The scope of the review should be agreed between all parties, with the aim of exploring whether the bed capacity is being used to best effect to facilitate patient flow and meet the population needs for community inpatient care.

3. **Development of a systemwide clinical strategy for community and mental health services that focuses on prevention, early intervention and patient-centred care.** This should be led by the community and mental health providers but with input from key system partners including local authorities, primary care and the acute sector, as well as service users. This will optimise patient safety, quality and experience through a consistent set of standards. It should align with the strategy for place to establish a holistic approach to patient needs and ensure care is delivered in the most appropriate setting for the patient. It is essential to ensure that community and mental health clinical expertise, as well as the views of patients, is strongly represented on, and feeds into the strategy.

4. **A clear, systemwide strategy for place and place-based leadership** is needed that identifies how to accelerate place-based integration across all health and care actors and wider relevant sectors including education. Community and mental health care is deeply rooted in place, meaning that a strategy focused on place-based integration of services is essential to accompany the systemwide clinical strategy. In particular, it will need to understand and navigate the boundaries between place and Local Delivery Systems.

5. **Establishing a more strategic approach to the funding for community and mental health services** to address the current inequities. The approach should reflect on the overall system performance in communities that have historically had higher levels of investment in community and mental health services. The revised approach should ensure that community and mental health services are resourced proportionately to need with a response to the future demand.

6.2 Next steps to developing a new Trust

To effectively deliver on these recommendations and support the creation of a roadmap to forming a new Trust, the following principles and requirements were agreed:

- **A planned approach for establishing a new Trust safely and effectively that guides a more detailed programme of work.** This should follow a pace of change that is sufficient to continue driving momentum across the programme and be accompanied by an **overarching governance structure and clear leads for respective workstreams.**
- **Careful consideration of the key interdependencies** when developing the programme, such as interdependencies with the IoW Sustainability programme.
- **Accounting for risks and ways to mitigate these.** There should be continual monitoring of risks throughout the programme, whilst avoiding unnecessary processes that impede progress. For example, the impact to staff should be limited.
- **Demonstrating progress in response to the case for change and the benefits for patients throughout the programme.** This can be driven partly through acting early on tangible steps that will deliver significant benefit to staff and patients.
- **Inclusive of all partners** in planning and delivering the programme. Including shared, transparent communications to relevant groups including staff, patients, local communities and the wider health and care system.
- **Transparency about the costs of the programme with funding mechanisms agreed from the outset**. There will be considerable costs associated with the transaction and integration of digital systems across Trusts to ensure that the programme is a success. It is vital that these costs and associated funding mechanisms are determined and agreed upfront.
- **Utilising skills and talents already in the current workforce and system wherever possible** to support the transformation programme. It is also important to ensure the necessary support and resource is available for those involved in delivery of the programme, recognising the additional commitment this entails.

These requirements and principles are key to building an effective roadmap to a new Trust, but the programme's success also relies on the alignment and engagement of system partners on all five of the recommendations detailed in this report. This is critical to building a shared, systemwide vision for improving and integrating community and mental health services across HIOW, and ultimately meeting the ambitions outlined to enhance patient care, experience and outcomes.

Annex 1: List of interviewees and workshop attendees

A1.1 Governance

	Meeting	Purpose	Dates	Invitees
Governance Groups	Client touchpoint	• Ensure coordination and engagement with key organisational stakeholders • Summarise project updates and flag identified risks	• Weekly	• Paul Gray, project SRO (HIOW ICS) • Andrew Strevens, Chief Executive (Solent) • Rachel Cheal, Chief of staff (Solent) • Paula Anderson, Deputy CEO and Finance Director (Southern)
	Steering Group	• Input to develop, test and refine materials	• 17 Feb 22 • 28 Feb 22	• Paul Gray, project SRO (HIOW ICS) • Andrew Strevens, Chief Executive (Solent) • Ron Shields, Chief Executive (Southern) • Rachel Cheal, Chief of staff (Solent) • Paula Anderson, Deputy CEO and Finance Director (Southern)
	Chairs / Chief exec. forum	• Appraise and Sign-off outputs	• 18 March 22 • 30 March 22 • 22 April 22	• David Radbourne, Regional Director of Strategy and Transformation (NHSE South East) • Lena Samuels, Chair Designate (HIOW ICB) • Maggie MacIsaac, Chief Executive Designate (HIOW ICB) • Catherine Mason, Chair (Solent) • Lynne Hunt, Chair (Southern) • Andrew Strevens, Chief Executive (Solent) • Ron Shields, Chief Executive (Southern)

Exhibit 18: Summary of the governance for the review including purpose, dates and invitees for each group

A1.2 List of interviewees

Interviewee Name	Role	Organisation
David Radbourne	Regional Director Strategy and Transformation	NHSE/I South East
Acosia Nyanin	Chief Nurse	NHSE/I South East
Lena Samuels	Chair Designate	HIOW ICB
Maggie MacIsaac	Chief Executive Designate	HIOW ICB
Roshan Patel	Chief Finance Officer	HIOW CCG/ICS
Derek Sandeman	Chief Medical Officer	HIOW CCG/ICS
Julie Dawes	Chief Nursing Officer	HIOW CCG/ICS
Nicola Decker	Clinical Lead	HIOW CCG/ICS
Jenny Erwin	Director of Mental Health Transformation and Delivery	HIOW CCG/ICS
Sara Tiller	Director of Primary care development	HIOW CCG/ICS
Paul Gray	Director of Strategy	HIOW CCG/ICS
Tessa Harvey	Executive Director of Performance	HIOW CCG/ICS
Alison Smith	Managing Director	HIOW CCG/ICS
Ruth Jackson-Colburn	Managing Director	HIOW CCG/ICS
Ros Hartley	Clinical lead	HIOW CCG/ICS
Ciara Rogers	Deputy Director Mental Health Transformation and Delivery	HIOW CCG/ICS
Ian Corless	Board Secretary/Head of Business Services	HIOW ICS / HIOW ICB
Jo York	Managing Director	Portsmouth CCG (Health and Care Portsmouth)
Catherine Mason	Chair	Solent NHS Trust
Andrew Strevens	Acting CEO	Solent NHS Trust
Jackie Munro	Acting Deputy Chief Executive & Chief Nurse	Solent NHS Trust
Dan Baylis	Chief Medical Officer	Solent NHS Trust
Gordon Fowler	Acting Chief Finance Officer	Solent NHS Trust
Sarah Balchin	Associate Director Community Engagement	Solent NHS Trust
Sarah Williams	Associate Director Research and Improvement	Solent NHS Trust
Mark Kelsey	Associate Medical Director Primary Care	Solent NHS Trust

Rachel Cheal	Chief of Staff	Solent NHS Trust
Suzannah Rosenberg	Chief Operating Officer	Solent NHS Trust
Jas Sohal	Chief People Officer	Solent NHS Trust
Claire Robinson	Clinical Director of Child and Family Services	Solent NHS Trust
Ian McCafferty	Clinical Director of Mental Health	Solent NHS Trust
Cathy Price	Clinical Director of Primary Care	Solent NHS Trust
Calum Mercer	NED	Solent NHS Trust
Gaurav Kumar	NED	Solent NHS Trust
Michael Watts	NED	Solent NHS Trust
Stephanie Elsy	NED	Solent NHS Trust
Lynne Hunt	Chair	Southern Health NHS Foundation Trust
Ron Shields	Chief Executive	Southern Health NHS Foundation Trust
Steve Tomkins	Chief Medical Officer	Southern Health NHS Foundation Trust
Grant Macdonald	Chief Operating Officer	Southern Health NHS Foundation Trust
Paul Draycott	Chief People Officer	Southern Health NHS Foundation Trust
Paula Anderson	Finance Director and Deputy Chief Executive	Southern Health NHS Foundation Trust
Paula Hull	Director of Nursing and Allied Health Professionals	Southern Health NHS Foundation Trust
Heather Mitchell	Director of Strategy and Infrastructure Transformation	Southern Health NHS Foundation Trust
Nicky Macdonald	Divisional Director of Operations	Southern Health NHS Foundation Trust
Sarah Olley	Divisional Director of Operations	Southern Health NHS Foundation Trust
Riaz Dharamshi	Deputy Chief Medical Officer (Physical Health) and Clinical Director (Portsmouth and SE Hampshire)	Southern Health NHS Foundation Trust
Nicky Creighton-Young	Divisional Director of Operations (Portsmouth and SE Hampshire)	Southern Health NHS Foundation Trust
Rachel Anderson	Clinical Director / Deputy CMO for physical health (SW Hampshire Division)	Southern Health NHS Foundation Trust
Laura Rothery	Divisional Director of Operations (SW Hampshire Division)	Southern Health NHS Foundation Trust
Rob Guile	Divisional Director of Operations - Specialist Services	Southern Health NHS Foundation Trust
Ade Williams	NED	Southern Health NHS Foundation Trust
David Hicks	NED	Southern Health NHS Foundation Trust
David Kelham	NED	Southern Health NHS Foundation Trust
Subashini M	NED	Southern Health NHS Foundation Trust
Jeni Bremner	NED	Southern Health NHS Foundation Trust
Kate FitzGerald	NED	Southern Health NHS Foundation Trust
Michael Bernard	NED	Southern Health NHS Foundation Trust
Victoria Osman-Hicks	Clinical Director (Mid & North Hampshire Division)	Southern Health NHS Foundation Trust
Graham Allen	Director of Adults' Health and Care	Hampshire County Council
Simon Nightingale	Assistant Director for Health & Care Partnerships	Portsmouth City Council
David Williams	Chief Executive	Portsmouth City Council
Jonathan Lake	Clinical Director for Adult Services Portsmouth	Portsmouth City Council
Andy Biddle	Director of Adult Services	Portsmouth City Council
Helen Atkinson	Director of Public Health	Portsmouth City Council
Hayden Ginns	Commissioning and Partnerships Manager (Children's)	Portsmouth City Council
Robert Henderson	Director of Children's Services	Southampton City Council
Guy van Dichele	Executive Director of Wellbeing (Health and Adults DASS)	Southampton City Council
Jennifer Dolman	Public Health Service Lead Officer	Southampton Council
Stephanie Ramsey	Director of Quality and Integration	Southampton City Council / Southampton City CCG

Debbie Chase	Director of Quality and Integration	Southampton City Council / Southampton City CCG
Laura Gaudion	Directors of Adult's Services and Social Care	IoW Council
Kim Goode	Directors of Children's Services	IoW Council
Simon Bryant	Director of Public Health	IoW Council and Hampshire County Council
Steve Erskine	Chair	Hampshire Hospitals NHS Foundation Trust
Alex Whitfield	Chief Executive	Hampshire Hospitals NHS Foundation Trust
Darren Cattell	Chief Executive	Isle of Wight NHS Trust
Lesley Stevens	Director of Community, Mental Health and Learning Disabilities	Isle of Wight NHS Trust
Melloney Poole	Chair	Portsmouth Hospitals University NHS Trust / Isle of Wight NHS Trust
Penny Emerit	Chief Executive	Portsmouth Hospitals University NHS Trust
Jane Padmore	Interim Chief Executive	Sussex Partnership NHS Foundation Trust
Peter Hollins	Chair	University Hospital Southampton NHS Foundation Trust
David French	Chief Executive	University Hospital Southampton NHS Foundation Trust

A1.3 Attendees at First System Workshop – Wednesday 16 March

Name	Role	Organisation
Alex Whitfield	Chief Executive	Hampshire Hospitals NHS Foundation Trust
Andrew Strevens	Chief Executive	Solent NHS Trust
Charlotte O'Brien	Director, Strategic Partnerships	Sussex Partnership NHS Foundation Trust
Chris Ainsworth	Clinical Director and Head of Psychology	Isle of Wight Trust
Christine McGrath	Director of Strategy and Partnerships	University Hospital Southampton NHS Foundation Trust
Dan Baylis	Chief Medical Officer	Solent NHS Trust
David French	Chief Executive	University Hospital Southampton NHS Foundation Trust
Derek Sandeman	Chief Medical Officer	HIOW CCG/ICS
Hayden Ginns	Commissioning and Partnerships Manager (Children's)	Portsmouth City Council
Jackie Munro	Acting Deputy Chief Executive & Chief Nurse	Solent NHS Trust
Jason Brandon	Head of Mental Health	Hampshire County Council
Jessica Hutchinson	Director of Transformation	Hampshire County Council
Julie Dawes	Chief Nurse	Hampshire Hospitals NHS Foundation Trust
Lao Cooper	Head of Hampshire CAMHS	Sussex Partnership NHS Foundation Trust
Lesley Stevens	Director of Community, Mental Health and Learning Disabilities	Isle of Wight Trust
Maggie MacIsaac	Chief Executive Designate	HIOW ICB
Paul Gray	Director of Strategy	HIOW CCG/ICS
Paula Hull	Director of Nursing and Allied Health Professionals	Southern Health NHS Foundation Trust
Penny Emerit	Chief Executive	Portsmouth Hospitals University NHS Trust
Ron Shields	Chief Executive	Southern Health NHS Foundation Trust
Simon Bryant	Director of Public Health	Hampshire County Council and Isle of Wight Council
Simon Nightingale	Assistant Director for Health & Care Partnerships	Portsmouth City Council
Steve Tomkins	Chief Medical Officer	Southern Health NHS Foundation Trust
Suzannah Rosenberg	Chief Operating Officer	Solent NHS Trust
Vernon Nosal	Director of Operations	Southampton City Council
Victoria Osman-Hicks	Clinical Director of Mid and North Hampshire Division	Southern Health NHS Foundation Trust

A1.4 Attendees at Second System Workshop – Monday 28 March

Name	Role	Organisation
Andrew Strevens	Chief Executive	Solent NHS Trust

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Andy Biddle	Director of Adult Social Care	Portsmouth City Council
Charlotte O'Brien	Director, Strategic Partnerships	Sussex Partnership NHS Foundation Trust
Christine McGrath	Director of Strategy and Partnerships	University Hospital Southampton NHS Foundation Trust
Dan Baylis	Chief Medical Officer	Solent NHS Trust
David French	Chief Executive	University Hospital Southampton NHS Foundation Trust
Debbie Chase	Public Health Service Lead Officer	Southampton City Council
Lesley Stevens	Director of Community, Mental Health and Learning Disabilities	Isle of Wight NHS Trust
Graham Terry	Director Strategy and Performance	Portsmouth Hospitals University NHS Trust
Hayden Ginns	Commissioning and Partnerships Manager	Portsmouth City Council
Jackie Munro	Acting Deputy Chief Executive & Chief Nurse	Solent NHS Trust
Jason Brandon	Head of Mental Health	Hampshire County Council
Jenny Erwin	Director of Mental Health Transformation and Delivery	HIOW CCG/ICS
Jeremy Rowland	Deputy Chief Medical Officer	Southern Health NHS Foundation Trust
Jessica Hutchinson	Director of Transformation	Hampshire County Council
Julie Dawes	Chief Nurse	Hampshire Hospitals NHS Foundation Trust
Lao Cooper	Head of CAMHS	Sussex Partnership NHS Foundation Trust
Linda Collie	Clinical Leader	Portsmouth CCG
Maggie McIsaac	Chief Executive Designate	HIOW ICB
Paul Gray	Director of strategy	HIOW CCG/ICS
Penny Emerit	Chief Executive	Portsmouth Hospitals University NHS Trust
Rachael Walker	Director, CYP & LD services	Sussex Partnership NHS Foundation Trust
Ron Shields	Chief Executive	Southern Health NHS Foundation Trust
Steve Tompkins	Chief Medical Officer	Southern Health NHS Foundation Trust
Sue Cochrane	Director of Public Health	Hampshire County Council
Suzannah Rosenberg	Chief Operating Officer	Solent NHS Trust
Trevor Smith	Deputy Chief Medical Officer	University Hospital Southampton NHS Foundation Trust
Vernon Nosal	Director of Operations	Southampton City Council

A1.5 Attendees at First Clinical Summit – Wednesday 2 March

Name	Role	Organisation
Derek Sandeman (Chair)	Chief Medical Officer	HIOW CCG/ICS
Charlotte Hutchings	Clinical Director for North and Mid Hampshire	HIOW CCG/ICS
Claire Robinson	Clinical Director for Child and Family Services	Solent NHS Trust
Daisy Mudoni	Deputy Director of Nursing and Allied Health Professionals	Southern Health NHS Foundation Trust
Dan Baylis	Chief Medical Officer	Solent NHS Trust
Nicola Decker	Clinical Leader	HIOW CCG/ICS
Graham Allen	Director of Adults' Health and Care	Hampshire County Council
Hana Burgess	GP Board Member & Clinical Lead for Mental Health	HIOW CCG/ICS
Hayden Kirk	Clinical Director for Adult Services Southampton	Solent NHS Trust
Helen Atkinson	Director of Public Health	Portsmouth City Council
Ian McCafferty	Clinical Director for Mental Health Services	Solent NHS Trust
Jackie Munro	Acting Deputy Chief Executive & Chief Nurse	Solent NHS Trust
Jenny Erwin	Director of Mental Health Transformation and Delivery	HIOW CCG/ICS
Jeremy Rowland	Deputy Chief Medical Officer	Southern Health NHS Foundation Trust
Laura Edwards	Medical Director	Wessex Local Medical Committee
Mark Kelsey	Deputy Chief Medical Officer	Solent NHS Trust
Naomi Ratcliffe	Associate Director, Clinical Integration and Strategy	Hampshire Hospitals NHS Foundation Trust

Paula Hull	Director of Nursing and Allied Health Professionals	Southern Health NHS Foundation Trust
Riaz Dharamshi	Deputy Chief Medical Officer and Clinical Director of South East Division	Southern Health NHS Foundation Trust
Simon Bryant	Director of Public Health	Hampshire County Council and Isle of Wight Council
Simon Nightingale	Assistant Director for Health & Care Partnerships	Portsmouth City Council
Steve Tomkins	Chief Medical Officer	Southern Health NHS Foundation Trust
Trevor Smith	Deputy Chief Medical Officer	University Hospital Southampton NHS Foundation Trust

A1.6 Attendees at Second Clinical Summit – Thursday 24 March

Name	Role	Organisation
Derek Sandeman (Chair)	Chief Medical Officer	HIOW ICS/CCG
Cheryl Spencer	Service Manager	Southampton City Council
Claire Robinson	Clinical Director for Child and Family Services	Solent NHS Trust
Daisy Mudoni	Deputy Director of Nursing and Allied Health Professionals	Southern Health NHS Foundation Trust
Dan Baylis	Chief Medical Officer	Solent NHS Trust
Graham Allen	Director of Adults' Health and Care	Hampshire County Council
Ian McCafferty	Clinical Director for Mental Health Services	Solent NHS Trust
Jackie Munro	Acting Deputy Chief Executive & Chief Nurse	Solent NHS Trust
Jenny Erwin	Director of Mental Health Transformation and Delivery	HIOW ICS/CCG
Jeremy Rowland	Deputy Chief Medical Officer	Southern Health NHS Foundation Trust
Lara Alloway	Chief Medical Officer	Hampshire Hospitals NHS Foundation Trust
Laura Edwards	Medical Director	Wessex Local Medical Committee
Lesley Stevens	Director of Community, Mental Health and Learning Disabilities	Isle of Wight NHS Trust
Mark Kelsey	Deputy Chief Medical Officer	Solent NHS Trust
Mark Roland	Deputy Medical Director	Portsmouth Hospitals University NHS Trust
Naomi Ratcliffe	Associate Director, Clinical Integration and Strategy	Hampshire Hospitals NHS Foundation Trust
Paula Hull	Director of Nursing and Allied Health Professionals	Southern Health NHS Foundation Trust
Riaz Dharamshi	Deputy Chief Medical Officer and Clinical Director of South East Division	Southern Health NHS Foundation Trust
Sarah Daly	Children's Services	Portsmouth City Council
Steve Tomkins	Chief Medical Officer	Southern Health NHS Foundation Trust
Trevor Smith	Deputy Chief Medical Officer	University Hospital Southampton NHS Foundation Trust

Annex 2: Options appraisal process

A2.1 Options appraisal process

An iterative two-part appraisal process was conducted. First, to narrow down the longlist of possible arrangements for future mental health and community services to a shortlist of those most realistic for the system. Second, to then assess the relative merits of the shortlisted options in detail. Exhibit 19 details the process taken to the appraisal.

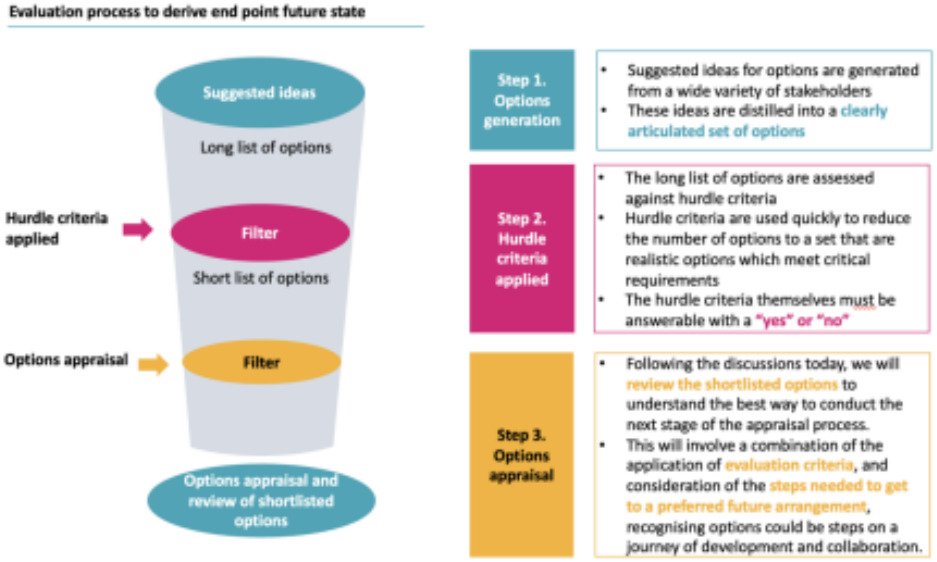


Exhibit 19: Clear and transparent options appraisal process to shortlist and evaluate options

A2.2 Options appraisal: hurdle criteria

First, the longlist of options was assessed against a set of clear, simple hurdle criteria. These were used to quickly narrow down the number of options to leave those most realistic for the system that meet the hurdle requirements. The hurdle criteria were based on the strategic priorities identified at the Clinical Summit and the system 'must haves' articulated during the interviews. Following iteration with the Steering Group and at the first system workshop, three hurdle criteria were applied:

1. Is pathway fragmentation reduced?
2. Are there clearer accountabilities for care?
3. Does the option aim to respond to all aspects of the Case for Change?

When compared to 'no change', those options where any one of the answers is 'no' are removed to leave a shortlist. This eliminated five options for the following reasons:

Option Description	Rationale for elimination
Option 1: Single lead provider or alliance contracted to provide children and adult's mental health, ED & LD services only	Did not aim to respond to all aspects of the case for change as only focused on one part of mental health services. In particular, did not address any of the challenges in community health such as the capacity-need mismatch.
Option 2: Align provider arrangements for MH through the developing MH collaborative; CH services remain unchanged	Did not provide clearer accountabilities for care; did not aim to respond to all aspects of the case for change, in particular the capacity-need mismatch in community health.

Option 5: Lead provider contracted to provide MH services and a different lead provider contracted to provide CH services.	Did not reduce fragmentation as community and mental health remain fragmented, and acute and community physical care remain fragmented.
Option 6: New Trust for MH services with delivery of CH services unchanged across different providers	Did not provide clearer accountabilities for care; did not aim to respond to all aspects of the case for change, in particular the capacity-need mismatch in community health.
Option 9: New Trust for bedded MH services only; CH services and community MH services provided by each acute provider	Did not reduce fragmentation as inpatient mental health services are separated from community mental health services.

A2.3 Shortlisted options

Following the application of the hurdle criteria, a shortlist of options remained which can be shown on a matrix of level of alignment and level of change (See Exhibit 20). Level of change ranged from lead provider arrangements through to the creation of a new Trust, and level of alignment ranged across full vertical physical care alignment into acutes with separation of mental health, vertical integration of inpatient community services only, and full integration of community and mental health services into a single Trust.

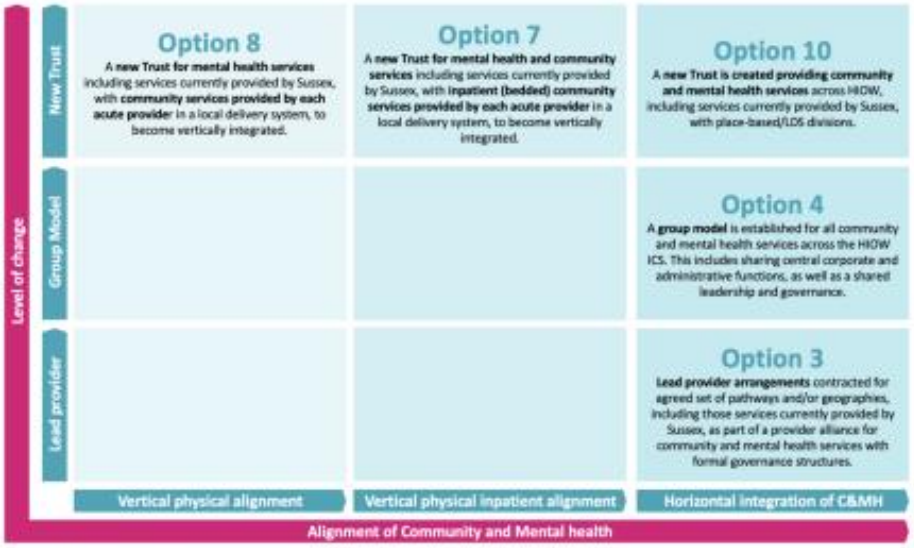


Exhibit 20: Shortlisted options shown on a matrix of alignment and level of change

A2.4 Options appraisal – detailed evaluation criteria

A set of specific and measurable evaluation criteria were used to explore the relative merits of the remaining options. These criteria were co-developed and iterated based on stakeholder interview, baseline analysis, future strategic priorities and feedback from the Steering Group. The criteria related to the case for change, national priorities for ICSs and integration, and the ICS five-year plan, and were added to an appraisal matrix to allow for a comparison of the relative pros and cons of the five remaining options.

The rationale for the criteria selected and the resulting appraisal matrix can be found in Exhibits 21 and 22. Further detail on the scoring methodology can be found in the Annex.

Criterion	Sub-criteria	Rationale
ICS strategic alignment	Alignment with national policy	The preferred option should be in line with the national direction for ICSs and integration
	Alignment with HIOW Strategic Objectives	The preferred option should be in line with the ICS strategic priorities
	Provider catchment coterminosity with the ICS	To the greatest extent possible, (non-specialist) patient pathways should be coterminous with the ICS and delivered by providers within the ICS of a patient's residence
Workforce sustainability	Ease of recruitment	The preferred option should reduce competition for new recruits and support system-wide planning
	Workforce mobility	The ability for workforce to move between services and local areas across the system will increase resilience
Consistency of care	Accountability for consistency of care	Accountability for alignment of services should increase the consistency of quality and safety of services
	Alignment of services to need: patients crossing organisations per year	Services that are most used in conjunction with one another should be joined up to provide a single front door
	Maximum number of handoffs between organisations across CAMHS pathways	Fewer providers will increase the clarity of accountability for the patient
Deliverability	Timelines for change	It is important to understand the timelines for any new structure
	Digital alignment: maximum number of EPR systems per organisation present at the start of the change	There is a need for digital join up to improve care fluidity but EPR systems are difficult to integrate
	Provider strategic alignment: ability to create shared vision	Organisations joining together should be able to align around a shared set of priorities
Financial impact	Number of providers receiving funding for C&MH	Fewer providers will be better able to deliver resources according to need across their geographies
	Economies of scale: minimum spend on community services by provider	Provision of community services requires a sufficient size to provide expertise and economies of scale

Exhibit 21: Rationale for the detailed evaluation criteria selected

			Alternative options				
Criterion	Sub-criteria	Current	Option 8	Option 7	Option 3	Option 4	Option 10
ICS strategic alignment	Alignment with national policy	1.5 /5	2 /5	3 /5	2.5 /5	3 /5	4 /5
	Alignment with HIOW Strategic Objectives	5 /12	9 /12	9.5 /12	6 /12	10 /12	11 /12
	Provider catchment coterminousity with the ICS	75%	86%	86%	75%	75%	86%
Workforce sustainability	Ease of recruitment	◔	○	◕	◔	◕	●
	Workforce mobility	○	○	◕	○	◑	●
Consistency of care	Accountability for consistency of care	◔	◑	◕	◑	◕	●
	Alignment of services to need: patients crossing organisations per year	3027 Acute to CH inpatient	11483 MH referral to CH referral	2358 CH inpatient to CH referral	3027 Acute to CH inpatient	3027 Acute to CH inpatient	3027 Acute to CH inpatient
	Maximum number of handoffs between organisations across CAMHS pathways	4	0	0	4	4	0
Deliverability	Timelines for change	n/a	24 months	24 months	12 months	9 months	24 months
	Digital alignment: maximum number of EPR systems per organisation present at the start of the change	1	3	3	1	1	2
	Provider strategic alignment: ability to create shared vision	n/a	◑	○	◑	◕	◕
Financial impact	Number of providers receiving funding for C&MH**	5	6	6	5	5	2
	Economies of scale: minimum spend on community services by provider	£97m	£53m	£8m* / £175m	£97m	£97m	£207m

*Option 7 first minimum spend only includes the cost of physical inpatient services at the Trust with the lowest spend
**Assumes Dorset remains as a provider of IAPT services

Exhibit 22: Detailed evaluation matrix used to assess the shortlist of options

A2.5 Outcomes of the options evaluation

The evaluation matrix was used to inform discussions at the second Clinical Summit and System Workshop around the relative pros and cons of the shortlisted options. Based on these discussions, a clear picture was formed of the relative merits and trade-offs of different options.

At the start of the second system workshop, a vote was taken at the beginning to test attendees' incoming preference of the shortlisted options, shown below in Exhibit 23.

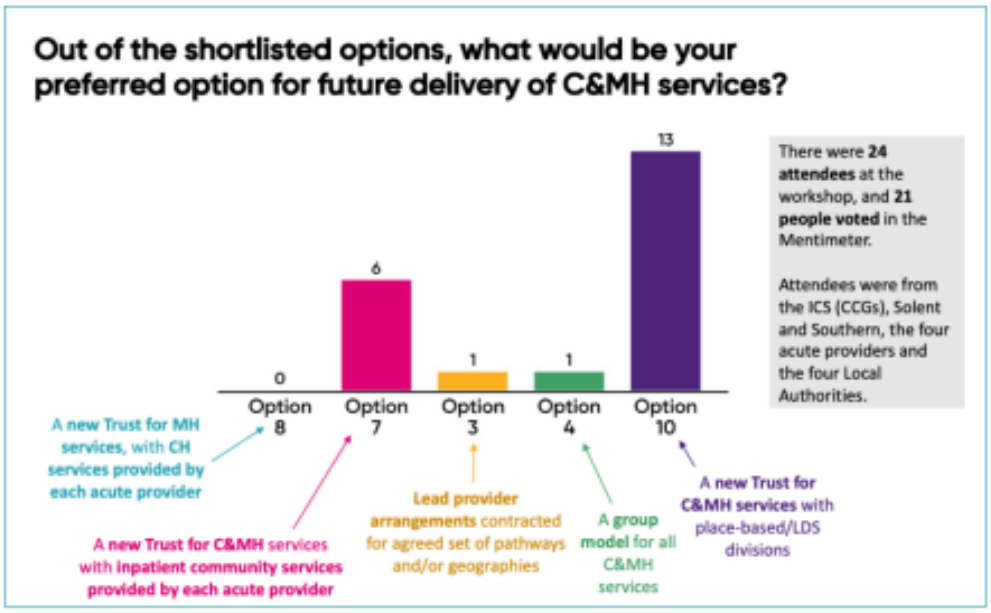


Exhibit 23: Results of a vote at the second system workshop on the preferred option for future services

By the end of both the second Clinical Summit and System Workshop, clinical and system leads were generally aligned on Option 10 delivering the most patient benefit. However, it was agreed there needed to be a further review of community health inpatient services in light of option 7 to find a more tailored solution for these across each geography. There was discussion around cycling through option 4 to reach option 10, however, it was felt that the process should not be delayed by doing this unless it was a natural step.

A summary of the appraised options:

	Pros	Cons
Option 8: A new Trust for MH services, with CH services provided by each acute provider	• Improves integration between acute and physical services to address some of the issues in patient flows between acute and community services	• Splits out physical and mental health which was deemed by clinicians to be detrimental for patients and is where there is the largest overlap in service users • Creates significant challenges for delivery of at-scale services such as specialist community services.
Option 3: Lead provider arrangements contracted for agreed set of pathways and/or geographies	• Focuses on localised delivery of care and supports more coordination across providers • Requires the least organisational change	• Fails to significantly improve fragmentation between clinical pathways and between physical and mental health services • Potential to cause great additional complexity in the system and confuse accountability and risk • Requires more effort and time than other options

		• Insufficient in how certain it will reduce variation
Option 7: A new Trust for C&MH services with inpatient community services provided by each acute provider	• Received some support from the acute sector as improves patient flow between acutes and community beds	• Carries risk by not considering the nuances of different bedded community services and geographies – agreed to a more case-by-case review of services rather than a one size fits all approach
Option 4: A group model for all C&MH services.	• Helps reduce some of the complexities observed across the system • Preserves what is working well • Creates an aligned leadership and clearer accountability. However, it does not achieve full accountability or alignment of care as separate organisations would remain.	• Does not achieve full accountability or alignment of care as separate organisations remain • This also means that workforce cannot be shared as fluidly across boundaries
Option 10: A new Trust for C&MH services with place-based/LDS divisions.	Identified to have the most benefits for patients including by: • Ability to reduce variation most significantly in patient access and care by reducing provider fragmentation • Reduces fragmentation between physical and mental health services where there is the greatest overlap of service users • Ensuring consistency across clinical models • Full clarity of accountability	• Requires a set of complementary actions to address all elements of the future system priorities and Case for Change (detailed later)

Appendix 5 – Briefing on system response to recommendations of the independent review

Hampshire and Isle of Wight

Review of mental health and community services

Improving services to reduce unwarranted variation in access and outcomes

Briefing on our joint response to the review recommendations

1 Introduction

In 2022, the Hampshire and Isle of Wight integrated care system commissioned a review of mental health and community services, to understand how to best meet the current and future demands of our local populations and how organisations might work together.

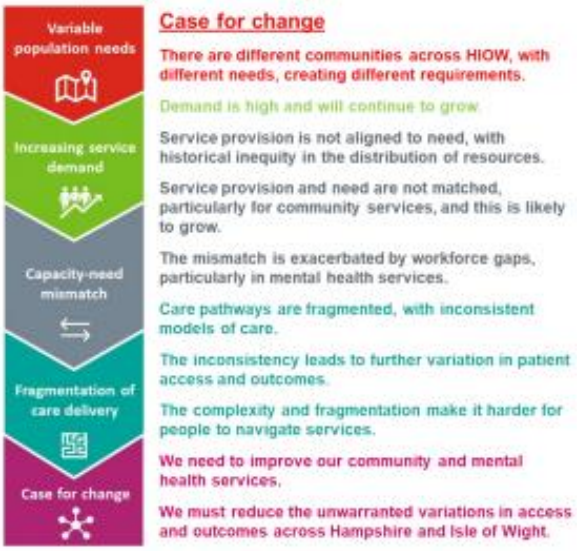
This paper provides an update on our joint response to the five recommendations.

2 Independent review and recommendations

2.1 Case for change

The current arrangements for mental health and community services evolved over many years, with multiple providers and fragmented commissioning across Hampshire and Isle of Wight. These arrangements are outlined in attachment A.

The review found a compelling case for change, as summarised below.



2.2 Recommendations

The review concluded with five recommendations, which are summarised below:

1. To develop a shared system-wide clinical strategy for mental health and community services, focussing on prevention, early intervention and user-centred care
2. To develop a clear, system-wide strategy for place and place-based leadership

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3. To undertake a review of the use of community physical health beds
4. To establish a more strategic approach to funding mental health and community services
5. To create a new Trust, bringing together all mental health and community services across the Hampshire and Isle of Wight integrated care system.

The remainder of this paper describes our approach in response to each of these recommendations, outlines the work so far and our proposed next steps.

3 System-wide clinical strategy

3.1 Recommendation from independent review

To develop a system-wide clinical strategy for community and mental health services that focuses on prevention, early intervention and patient-centred care.

This should be led by the community and mental health providers but with input from key system partners including local authorities, primary care and the acute sector, as well as service users.

This will optimise patient safety, quality and experience through a consistent set of standards. It should align with the strategy for place to establish a holistic approach to patient needs and ensure care is delivered in the most appropriate setting for the patient.

It is essential to ensure that community and mental health clinical expertise, as well as the views of patients, is strongly represented on, and feeds into the strategy.

3.2 Our approach

The strategic priorities for mental health and community services are closely aligned to the core goals for any integrated care system, including Hampshire and Isle of Wight.

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

Therefore, we are linking our work in response to the review with the development of our wider partnership strategy, place-based health and care strategies, the creation of neighbourhood teams and the emerging clinical models for all services across Hampshire and Isle of Wight (rather than treating the development of a clinical strategy for mental health and community services as a separate isolated activity). Please see attachment B for an overview of our system-wide approach to strategy and planning.

Another review recommendation (described in section 7) is to bring mental health and community services together into a single provider organisation. In preparation for the new Trust in April 2024, providers are developing a strategy for mental health and community services that will align with the wider system strategy.

3.3 Achieved so far

The priorities and ambitions identified for mental health and community services are informing the development of our partnership strategy for the integrated care system, plus the joint forward plan for NHS services.

The clinical leaders across mental health and community services are working together through a 'Clinical Delivery Group' as though they are already in a single combined provider. This group also includes system partners.

Clinicians, system leaders and other stakeholders prioritised the following activities:

- Optimise patient safety, quality of care and experience
- Reduce unwarranted variation in access and outcomes
- Align care models, reducing inconsistencies and complexity of service provision
- Integrate services along pathways of care
- Optimise access and ensure clear ownership of care
- Integrate local services across the life course
- Offer a more holistic approach to care
- Build a flexible, sustainable, and engaged workforce
- Improve resourcing of services according to local needs.

3.4 Current work

To take this approach forward, the Clinical Delivery Group has identified ten priorities for their initial focus. They are currently working together to understand unwarranted variations, share best practice and align service models across providers in these areas:

- Child and adolescent mental health
- Older people's mental health
- Neurodiversity
- Crisis services
- 'No wrong door'
- Frailty
- Rapid response and virtual wards
- Specialist services for long term conditions
- Community hospitals and rehabilitation
- Primary care

The workstreams involve clinicians, system partners and people with lived experience in the relevant service. Arrangements vary according to the specific workstream.

We are also developing a system-wide workforce strategy, as an enabler to our service strategies and the work described above to align care models. Workforce development is one of five areas that have been prioritised by system partners for joint work and a more strategic focus. It is also critical to the successful delivery of the work described above to align care models and improve pathways.

3.5 Next steps

- To use the work so far to inform the emerging clinical strategy outlined in the strategic case for the new Trust, bringing mental health and community services together across the Hampshire and Isle of Wight system
- To work with local authorities and other partners to develop an aligned vision for well-being and associated ambition for health services
- To articulate 'what good looks like' for mental health and community services, to inform the outcome metrics and success measures in our joint forward plan for Hampshire and Isle of Wight.
- To continue to build on existing collaboration across partners, work towards the NHS Long Term Plan and use available benchmarking such as GIRFT (get it right first time).

4 Place-based strategy and place leadership

4.1 Recommendation from independent review

A clear, system-wide strategy for place and place-based leadership is needed that identifies how to accelerate place-based integration across all health and care partners and wider relevant sectors including education.

Community and mental health care is deeply rooted in place, meaning that a strategy focused on place-based integration of services is essential to accompany the system-wide clinical strategy.

In particular, it will need to understand and navigate the boundaries between place and local delivery systems.

4.2 Our approach

This recommendation is also very closely aligned with the wider developments across the integrated care system.

The Hampshire and Isle of Wight integrated care system is committed to making decisions as local as possible. Our four place partnerships are the cornerstones of our integrated care system: Hampshire, Isle of Wight, Portsmouth and Southampton.

Similarly, we are developing neighbourhood teams as part of a local care strategy. The development of multi-disciplinary teams in neighbourhoods would enable us to enhance the input of mental health professionals, as well as other community-based clinicians.

Therefore, we are linking our work in response to the review with our wider development of place-based health and care partnerships and neighbourhood teams, rather than creating a separate place-based strategy for these services.

4.3 Achieved so far

Each of our four places has a Health and Wellbeing Board, which has set the health and care strategy for its population.

We have also established a Health and Care Partnership Board in each place, bringing together local authority, health service and voluntary sector partners to understand the population needs, agree joined up local health and care plans to meet those needs, develop strong broad local partnerships and implement local solutions.

4.4 Current work

Some of these partnerships were newly established in 2022 and there is ongoing work to develop them through the system-wide Place Development Focus Group.

This group has identified the work in response to the review of mental health and community services as a priority area of focus, as these services are an ideal example where a range of partners need to work together at scale, as well as in each place and in neighbourhoods.

The group is having a series of discussions about how best to work together in respond to people's needs, embracing the benefits of specialist expertise in mental health and community services, whilst also providing care as close to home as possible.

4.5 Next steps

Review the health and care strategies and plans for each place, and to collate the priorities and ambitions that are pertinent to mental health and community services.

Engage place leads in a workshop to inform the plans for the creation of the new Trust

To continue working together across system partners to consider the best way to:

- involve health and care partnerships in shaping and developing our plans for mental health and community services
- design the new Trust so that it engages effectively with places, local delivery systems, communities and neighbourhoods

5 Strategic approach to funding these services

5.1 Recommendation from independent review

Establish a more strategic approach to the funding for community and mental health services to address the current inequities.

The approach should reflect on the overall system performance in communities that have historically had higher levels of investment in community and mental health services. The revised approach should ensure that community and mental health services are resourced appropriate to need with a response to the future demand.

5.2 Our approach

In keeping with the early recommendations, this is very closely aligned with other developments across the integrated care system.

Our strategic approach to funding for mental health and community services must arise from and enable the emerging clinical strategy for community and mental health services, as well as linking to our wider approach to system funding and our system financial recovery strategy.

5.3 Current work

We have established a series of system-wide workstreams to support our overall system planning for 2023/24

Workstream	*Focus*
- Setting the framework for working together	To establish system principles for the sustainability planning process and what good collective working looks like
- Establishing the baseline	To develop a shared view of system activity and the financial baseline (income and expenditure) on a cost basis, as well as projected five year forecasts
- Establishing our objectives	To triangulate and prioritise objectives across the system
- Identifying opportunities	To identify areas of opportunity to reduce or avoid cost, improve efficiency and generate income
- Clinically led review	To agree the priority system transformation programmes to significantly impact sustainability and outcomes
- Cross-referencing to test proposals	To establish alignment of objectives and principles to the opportunities and priorities identified.

Each of these workstreams will incorporate community and mental health funding and the intention is that these workstreams will establish a shared and jointly understood view that all parties in the system can sign up to.

This then establishes a shared version of the current underlying position, key challenges and key ambitions for our population, our organisations and our system as a whole.

Please see the diagram in attachment C, outlining the timeframes for this work.

5.5 Next steps

The work will then feed into coordinated planning, both for the next year and feeding into the NHS Five Year Joint Forward Plan.

Any adjustments to the funding approach for mental health and community services in 2023/24 will be undertaken as part of this wider approach to system funding and strategic recovery.

Following this, the priority will be for the integrated care board and providers to work together on the following:

- Carry out any further baselining or benchmarking necessary to review spending on mental health and community services by place, population groups etc, to fully understand any existing inequalities or mismatches between need and spending
- Draw out the financial implications of the emerging clinical strategy for community and mental health services
- Identify options for any longer-term changes to funding community and mental health services that may be required and agree a phased transition process.

6 Review the use of community physical health beds

6.1 Recommendation from independent review

A review of community physical health beds should be undertaken.

This review should be conducted as a partnership between community providers, acute providers, local authorities and primary care. The scope of the review should be agreed between all parties, with the aim of exploring whether the bed capacity is being used to best effect to facilitate patient flow and meet the population needs for community inpatient care.

6.2 Our approach

This is being taken forward by the Clinical Delivery Group and incorporated into the workstream on 'community hospitals and rehabilitation'.

The proposal is to undertake a six month review with recommendations into a Clinical Summit. It will involve many people from different organisations, with groups who then seek views from wider partners and stakeholders, as this affects the whole population and total health and care system.

We will also consider the learning from a recent review in Swindon, Wiltshire and Bath.

7 Bring services together into single Trust for Hampshire and Isle of Wight system

7.1 Recommendation from independent review

A new Trust should be created for all community and mental health services across Hampshire and Isle of Wight.

The aim should be bringing together the best of the community and mental health care across Hampshire and Isle of Wight.

7.2 Our approach

The Trusts that are directly affected by this recommendation are working together to create a new Trust, in accordance with NHS England's Transaction Guidance.

This work is closely linked with the Isle of Wight sustainability programme, which is exploring the best way of responding to the clinical and financial challenges associated with delivering health services on a small and physically isolated island. As part of the Isle of Wight sustainability programme it is proposed to transfer responsibility for the delivery of mental health and community services to the new Trust for the whole of the Hampshire and Isle of Wight system.

7.3 Achieved so far

'Project Fusion' has been launched jointly by the four Trusts: Isle of Wight NHS Trust, Solent NHS Trust, Southern Health NHS Foundation Trust and Sussex Partnership NHS Foundation Trust. Please see the timeline for Project Fusion in attachment D.

Significant engagement has been undertaken to date including a senior leaders' event in October 2022 attended by around 150 people from across the four Trusts and a stakeholder meeting in November 2022 attended by around 70 people where around two thirds of participants 'agreed' or 'strongly agreed' that the creation of a new Trust was the right direction of travel.

The Trusts and the ICB jointly wrote to NHS England in December 2022 setting out their intention to submit a strategic case for review in March 2023.

7.4 Current work

As part of the plans to create a new Trust, providers are currently preparing for the next engagement workshop in February 2023. This will involve staff from mental health and community service providers and other services (such as primary care, acute services, local authorities, and voluntary sector partners), plus people with lived experience and colleagues from the integrated care board.

Work is on track to develop a Strategic Case by February for the transactions to form the Trust, and for Trust Boards to approve it in March 2023.

We are also reviewing our ICB procurement strategy, as it is critical that we can align our contracts with our strategic direction, as well as creating the new Trust. Please see attached tables with current providers by area.

Frimley Integrated Care Board also aim to create a combined all-age mental health provider for the Frimley system. We are liaising with Frimley to ensure that there is a well-managed interface between providers to ensure integrated service delivery for the people living in the north east Hampshire area.

7.5 Next steps

- To prepare a strategic case for the formation of the new Trust during January, for consideration by Trust Boards in February 2023 and approval in March 2023
- To submit the strategic case to NHS England in March 2023
- The next stage will then be to develop the full business case and post-transaction integration plan, with the aim of creating the new Trust in April 2024.

Isobel Wroe
Transformation Director
Integrated Care System

On behalf of system partners
9 February 2023

Providers by service and by area (A)

Extract from independent review, information collected in Spring 2022

Community health service	Isle of Wight	Portsmouth	South East Hampshire	Southampton	South West Hampshire	North and Mid Hampshire
Adult Physical Health						
Community inpatients	IoW	Solent	Southern	Solent	Southern	Southern
Community – Integrated teams • Urgent care • Frailty	IoW	Solent	Southern	Solent	Southern	Southern
• Falls	IoW	Solent	Southern	Solent	Southern	Southern
• Pulmonary rehab	*Not identified*	Solent	Solent	Solent		Solent
• Palliative and End of Life	IoW	Solent	Southern	Solent	Southern	Southern
• MSK and Pain management	IoW	Solent	Solent	Solent	Southern	Southern / HHFT
• Tissue Viability	IoW	Solent	Southern	Solent	Southern	Southern
• Long Covid	IoW	Solent	Southern	Solent	Southern	Southern
• Sexual health services	Solent	Solent	Solent	Solent	Solent	Solent
• Diagnostics	IoW	Portsmouth	Southern	Solent	Southern	Southern
• Speech and Language Therapy	IoW	Solent	Solent	Solent	Hobbs	Hobbs
Children's Physical Health (excluding CAMHS & Learning Disabilities)						
Health visiting and School Nursing (LA funded)	Solent	Solent	Southern	Solent	Southern	Southern
Children's Health Information Service	Southern	Southern	Southern	Southern	Southern	Southern
School Immunisations	Solent	Solent	Southern	Solent	Southern	Southern
Children's Community Nursing	Solent	Solent	Solent	Solent	Solent	HHFT
Children's Continuing Care	*Not identified*	Solent	Solent	*Not identified*	*Not identified*	*Not identified*
Community paediatrics and Therapies	Solent	Solent	Solent	Solent	Solent	Solent
Specialist Children's Home Health – Swanwick lodge	N/A	N/A	Southern	N/A	Southern	Southern

Key

- Solent
- Southern
- IoW
- Sussex
- Other / mixed
- x Not identified or not provided

Source: Solent and Southern Websites, CCG register and leadership teams 2022

Plus Hampshire Hospitals as a provider for community beds in North and Mid Hampshire geography

PROJECT FUSION

Mental health service	Isle of Wight	Portsmouth	South East Hampshire	Southampton	South West Hampshire	North and Mid Hampshire
CAMHS	IoW	Solent	Sussex	Solent	Sussex	Sussex
CAMHS inpatient	Southern					
Eating disorder OP (children's – 0-17)	IoW	Solent	Sussex	Solent	Sussex	Sussex
Perinatal	IoW	Southern				
Adult inpatient	IoW	Solent	Southern			
Adult inpatient (rehab)	*Not identified*	Solent	Southern			
Eating disorder IP (adult)	Southern					
Eating disorder OP (adult)	IoW	Southern				
IAPT	IoW (*Isle Talk*)	Solent (*Talking Change*)	Southern / Solent Mind (*iTalk*)	Dorset HealthCare – (*Steps2Wellbeing*)	Southern / Solent Mind (*iTalk*)	Southern / Solent Mind (*iTalk*)
Community MH / crisis teams	IoW	Solent	Southern	Southern	Southern	Southern
Older persons MH services	IoW	Solent	Southern	Southern	Southern	Southern
Acute liaison	IoW	Southern				
Specialist and forensic	Southern					
Learning Disabilities & Autism	IoW	Solent	Southern			
Complex adults MH Therapy	IoW - ECT	Southern – ECT and rTMS				
Crisis	IoW	Solent	Southern	Southern (*The Lighthouse*)	Southern	Southern
Urgent MH helpline (NHS 111)	IoW	Solent	Southern			
Outreach	IoW (Dementia)	*Not identified*				
Place of safety	IoW	Solent	Southern (Parklands, Antelope and Elmleigh)			
EIS	*Not identified*		Southern			

Key

- Solent
- Southern
- IoW
- Sussex
- Other / mixed
- X Not identified or not provided

Source: Solent and Southern Websites, CCG register and leadership teams 2022

Urgent mental health crisis line via NHS111 – now provided by Southern Health for Isle of Wight geography

Mental health and community services

Mental health service	Isle of Wight	Portsmouth	South East Hampshire	Southampton	South West Hampshire	North and Mid Hampshire
CAMHS	IoW	Solent	Sussex	Solent	Sussex	Sussex
CAMHS inpatient	Southern					
Eating disorder OP (children's – 0-17)	IoW	Solent	Sussex	Solent	Sussex	Sussex
Perinatal	IoW	Southern				
Adult Inpatient	IoW	Solent	Southern			
Adult inpatient (rehab)	*Not identified*	Solent	Southern			
Eating disorder IP (adult)	Southern					
Eating disorder OP (adult)	IoW	Southern				
IAPT	IoW (*Isle Talk*)	Solent (*Talking Change*)	Southern / Solent Mind (*iTalk*)	Dorset HealthCare – (*Steps2Wellbeing*)	Southern / Solent Mind (*iTalk*)	Southern / Solent Mind (*iTalk*)
Community MH / crisis teams	IoW	Solent	Southern	Southern	Southern	Southern
Older persons MH services	IoW	Solent	Southern	Southern	Southern	Southern
Acute liaison	IoW	Southern				
Specialist and forensic	Southern					
Learning Disabilities & Autism	IoW	Solent	Southern			
Complex adults MH Therapy	IoW - ECT	Southern – ECT and rTMS				
Crisis	IoW	Solent	Southern	Southern (*The Lighthouse*)	Southern	Southern
Urgent MH helpline (NHS 111)	IoW	Solent	Southern			
Outreach	IoW (Dementia)	*Not identified*				
Place of safety	IoW	Solent	Southern (Parklands, Antelope and Elmleigh)			
EIS	*Not identified*	Southern				

Key

- Solent
- Southern
- IoW
- Sussex
- Other / mixed
- X Not identified or not provided

Source: Solent and Southern Websites, CCG register and leadership teams 2022

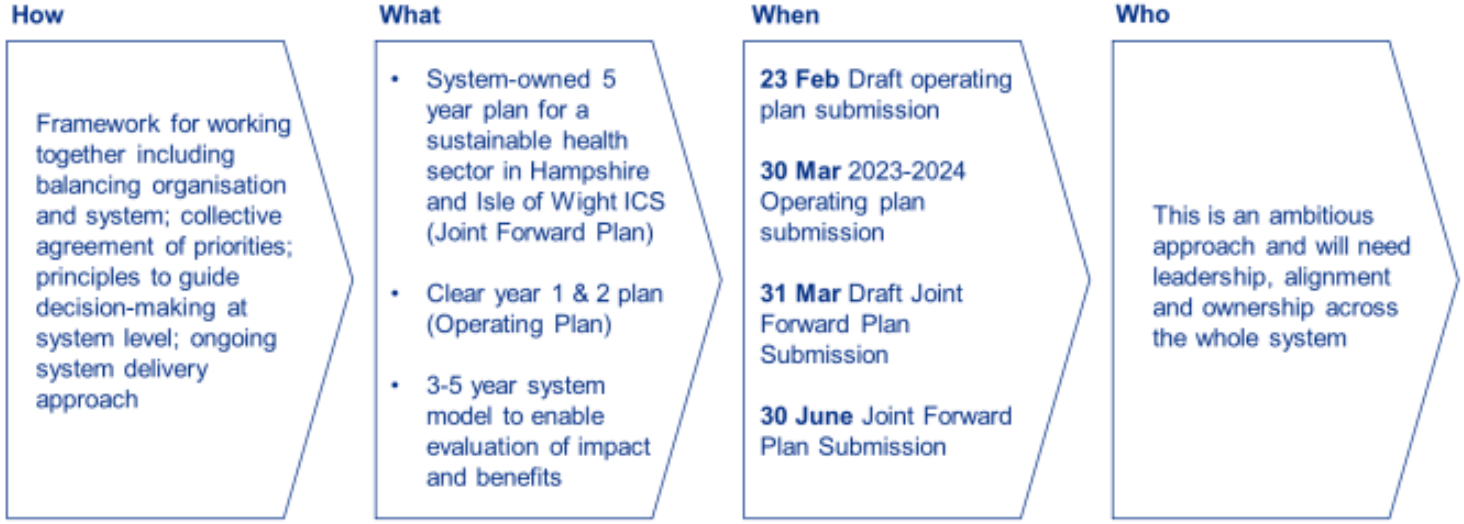
Urgent mental health crisis line via NHS111 – now provided by Southern Health for Isle of Wight geography

PROJECT FUSION

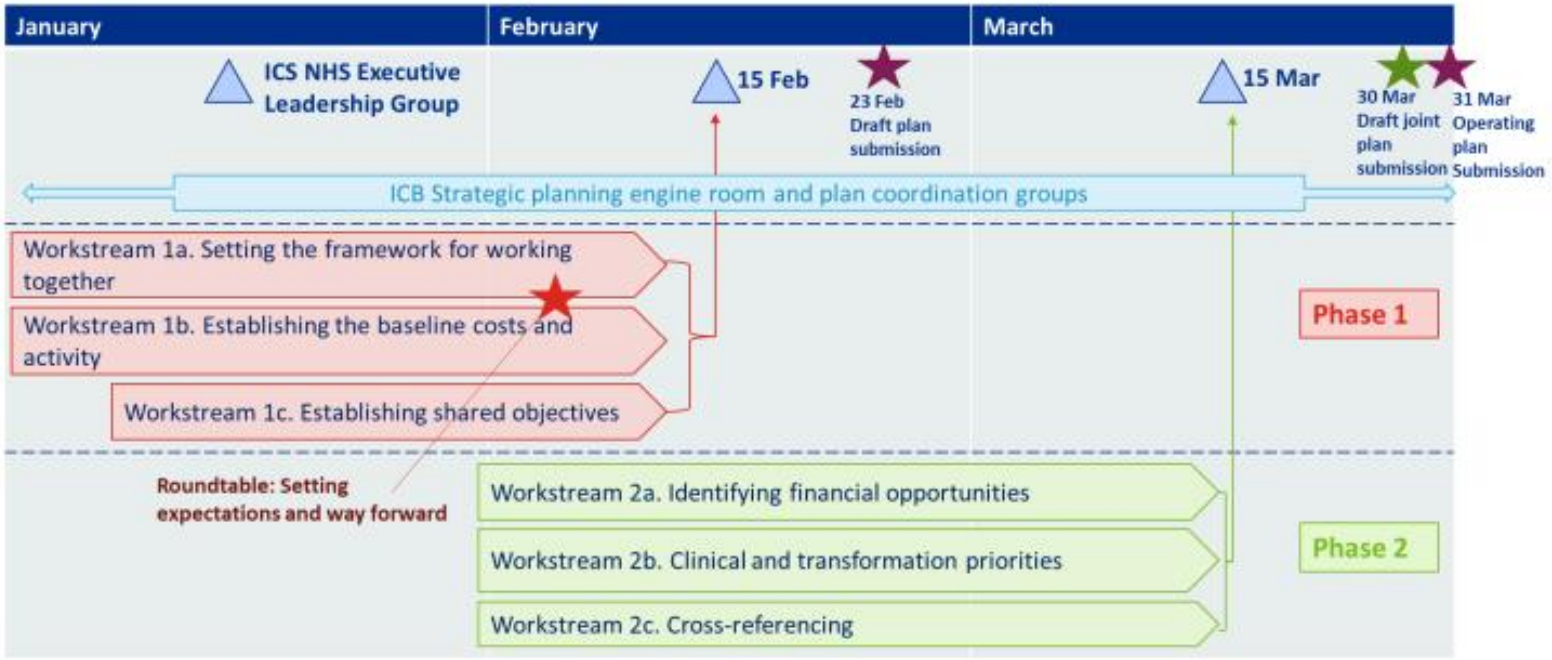
Overview of our system-wide approach to strategy and planning (B)

Integrated Care System
The Hampshire and Isle of Wight integrated care system was formed in July 2022, bringing together NHS organisations, local authorities and other agencies to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. We agreed our Partnership Strategy in December 2022.

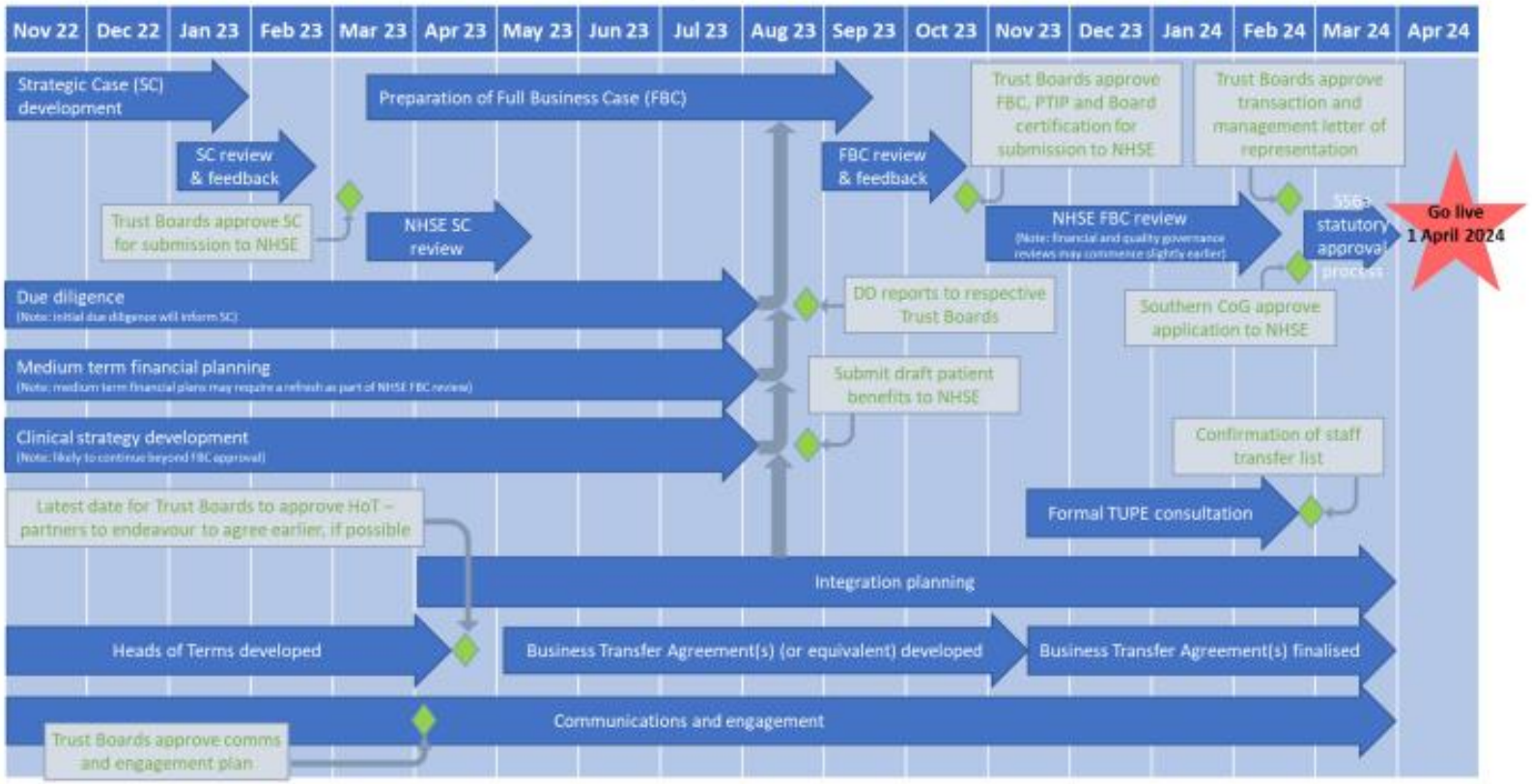
NHS Hampshire and Isle of Wight
We are now developing our plans for the health service in response to the partnership strategy. Working together is our best opportunity to address the long-term challenges that we are facing - but it requires a new approach across NHS partners.



Timeline for establishing a more strategic approach to funding (C)



Timeline for Project Fusion, bringing providers together into a new Trust (D)



Note: A detailed programme plan has been developed and is maintained by the programme team.

PROJECT FUSION

Appendix 6 – Evaluation criteria: features of a strong and weak option

Evaluation criteria	Features of a strong option	Features of a weak option
Enables consistent care models and reduces fragmentation and hand-offs (thereby improving outcomes)	Supports delivery of consistent care by enabling the implementation of consistent clinical pathways across the ICS, the utilisation of consistent processes across pathways and the provision of consistent and patient / carer information. Reduces fragmentation and hand-offs by reducing the number of different organisations involved in clinical pathways.	Organisational barriers exist to the development of consistent care models resulting inpatients experiencing hand-offs between different organisations, poorly co-ordinated care plans and a lack of informational continuity resulting in poor patient experience and outcomes.
Enables better alignment of capacity and need	Provides equity of access regardless of location by enabling more effective pooling of resources to allow patients to access treatment more quickly, proactive management of capacity to meet the population's changing needs and the coordination of resources to more effectively manage demand at bottlenecks. Facilitates more effective allocation of resources by enabling a more holistic assessment of the local population's care needs, health inequalities, interdependencies and capacity constraints to direct resources to the area of most impact for the long-term health outcomes of the local population. Facilitates collaborative working at neighbourhood, place and system level including the tailoring of services to meet the needs of the local population where appropriate.	Access to care varies by location. Organisational barriers exist to patient-centred capacity planning and management. Organisational barriers to allocating existing resources where they can most effectively meet the needs of the population. Organisational barriers to investing in additional resources where they are most needed (e.g. to create new services in areas where there are gaps in provision).

Evaluation criteria	Features of a strong option	Features of a weak option
Positive impact on workforce challenges	Provides greater opportunities for career progression thus improving retention. Enables greater access to workforce resources including training and development, wellbeing and occupational health. Provides an opportunity to engage the entire workforce in the development of a shared vision and culture. Enables the redeployment of staff to meet demand and support fragile services, including at times of high operational pressure across the geography. Provides the ability to improve long-term resilience by sharing rotas or combining services to reduce reliance on single/few individuals. Improves opportunities for effective succession planning for leadership roles, supported by a compelling clinical strategy.	Organisational barriers exist to the development of a single approach to tackling recruitment and retention issues. Workforce resources are limited to the resources available within existing organisations. Continued workforce challenges and professional isolation in subscale services arising from the fragmentation of clinical teams and expertise. Organisational barriers limit the rapid redirection of combined resources during periods of operational pressure. Succession planning is largely limited to individual organisations, lack of talent retention risks destabilising services.
Supports delivery of transformational benefits	Increases the deliverability of transformational benefits through the establishment of a centralised transformation resource to develop benefit plans and manage implementation processes. Increases the volume and value of potential benefits by expanding the opportunities for economies of scale, reducing duplication and enabling targeted investment. Increases the deliverability of potential benefits through the establishment of a collective vision and shared ownership for a single clinical strategy for mental health and community services in the ICS.	Transformation resources are limited to the resources available within existing resources. Differing organisational priorities limit opportunities to implement system wide transformational changes.

Evaluation criteria	Features of a strong option	Features of a weak option
Improves sustainability of Isle of Wight and the overall health and care system and focuses resources on frontline services	Supports delivery of the Isle of Wight sustainability programme to achieve sustainable health services for the Isle of Wight population by contributing to improved clinical and financial sustainability. Contributes positively to the financial challenges facing the ICS. Enables the reduction of duplication and expansion of shared systems and services to focus resources on frontline services.	Is not aligned to changes proposed as part of the Isle of Wight sustainability programme. Does not contribute to addressing the financial challenges facing the ICS. Organisational barriers constrain ability to focus resources on frontline services.
Creates a single coherent voice for mental health and community services in the ICS	Enables the establishment of a collective vision and single clinical strategy for mental health and community services in the ICS. Enables more effective engagement with key stakeholders to support collaborative working at neighbourhood, place and system level. Enables increased visibility of mental health and community services through consistent messaging and proposals. Simplifies governance arrangements with the ICP and ICB with a single Trust being held accountable for the delivery of safe and high-quality mental health and community services.	Different voices and contradictory priorities reduce ability to create consensus. Ineffective and inconsistent engagement with key stakeholders frustrates collaborative working. Complex governance arrangements with multiple organisations represented in ICP and ICB structures.
Implementation timescales	Regulatory and legal requirements enable short implementation timescales. Low complexity enables short implementation timescales and minimises risk of delay.	Long timescales associated with complying with regulatory and legal requirements prior to the commencement of integration activities. Complex implementation model drives extended timescales and risk of significant delays.
Implementation costs	Implementation costs are low.	High costs of implementation associated with complying with regulatory and legal requirements. Risk of additional costs being incurred due to the complexity of implementation process.

Appendix 7 – Terms of Reference for the Clinical Delivery Group

Hampshire and Isle of Wight NHS | Sussex Partnership NHS Foundation Trust | Southern Health NHS Foundation Trust | Isle of Wight NHS Trust | Solent NHS Trust

Mental Health & Learning Disabilities and Community Health

Clinical Delivery Group

Terms of Reference

1 Constitution

1.1 Mental Health (MH) and Community Health (CH) Providers in the Hampshire and Isle of Wight Integrated Care System (ICS) have established a Mental Health & Learning Disabilities and Community Health Clinical Delivery Group (the Group). Providers include:

- IOW NHS Trust
- Sussex Partnership NHS Foundation Trust
- Solent NHS Trust
- Southern Health NHS Foundation Trust

1.2 The Group will operate as Committees in Common and discuss MH and CH service redesign, set and monitor trajectories, as per described under section 3. Governance arrangements will be reviewed on a 6-monthly basis in recognition of the following:

- the HIOW Strategic Review and associate recommendations
- the maturing ICS and associated infrastructure

1.3 The Group reports into the Board of each sovereign provider organisation

2. Standing

2.1 Members shall only exercise functions and powers to the extent that they are permitted to as determined by individual organisations established internal governance.

3 Purpose

3.1 The role of the Group is to provide strategic leadership and a collaborative approach to strategic planning, assurance and delivery of MH & CH NHS services across the HIOW geography.

3.2 The Group will:

- act as the engine room for driving clinical change to improve the outcomes of service users
- develop an overarching charter to describe purpose, ambition and principles (including ensuring proposals and solutions are coproduced)
- act as a voice for NHS MH and CH services across all providers and, provide a forum for commissioners to equality speak collectively to providers
- support the development of peer networks
- act an advisory body to the wider strategic design of MH and CH services

- address issues once, collectively, at scale where it is the right thing to do

- identify 'quick wins' as well as agree priority clinical workstreams – and in doing so
    - ensure each workstream is supported by a triumvirate comprising of an Executive Sponsor, Senior Responsible Officer and Operational Lead, with project support to be sought from the ICS
    - ensure workstream infrastructure is aligned to the developing Place Based Health & Care Partnerships
    - receive assurance that identified workstreams are:
        - delivering to the agreed coproduced plan
        - identifying and managing risks, and, escalating as appropriate
        - engaging with stakeholders, and service users as appropriate
- collectively oversee risks, seeking to mitigate these and escalating as appropriate
- seek assurance that clinical and professional standards are consistently met across NHS providers
- encourage innovation, new roles and ways of working across partners
- share intelligence and lessons learnt in respect of enhancing patient safety and quality (including for example, CQC inspections)
- seek to resolve any matter referred to it via constituent members, Senior Responsible Officers or workstreams – where matters cannot be resolved they will be escalated to the respective CEOs for discussion.
- recommend, review and approve the adoption of joint policies and procedures across organisations that will benefit the work of the collaborative

3.5 A business cycle will be agreed by the Group

3.6 The Group will review continuously review its' effectiveness and function, set against a backdrop of maturing ICS and organisational changes.

4 Membership

4.1 Membership comprises

- Representatives -Solent NHST – including:
    - Chief Medical Officer
    - Chief Nurse Officer
    - Chief Operating Officer
- Representatives – Southern NHSFT - including:
    - Chief Medical Officer
    - Director of Nursing and AHPs
    - Chief Operating Officer
- Representatives – IOW NHST - including:
    - Director of Community, Mental Health and Learning Disabilities
    - Director of Governance and Risk
- Representatives – Sussex NHSFT – including:
    - Director of Integration and Partnerships
    - Clinical Director – CAMHS and Specialist Services

4.2 The following will be invited to attend:

- HIOW ICS Director of Mental Health Transformation and Delivery
- HIOW ICS Director of Mental Health Transformation and Delivery programme support
- HIOW ICS Community Programme Director
- HIOW ICS Community Programme Director programme support
- Workstream SROs
- Chief of Staff -Solent NHS Trust
- Clinical Delivery Group Programme Lead

5 Attendees

5.1 The Board will invite attendees according to the agenda

6 Chair

6.1 The Group will be clinically chaired by a clinical executive from a provider organisation.

7 Secretary

7.1 The administration of the meeting shall be supported by the Corporate Affairs Administrator, Solent NHS Trust, who will arrange to take minutes of the meeting and provide appropriate support to the Chair and members.

7.2 The agenda and any working papers shall be circulated to members five working days before the date of the meeting.

8 Quorum

8.1 No business shall be transacted at the meeting unless the following are present;

- a representative from Southern, Solent and the IOW and
- the Chair (Chief Medical Officers on a rotational basis -however, in their absence a designated deputy will be appointed)

9 Frequency

9.1 The Board will meet monthly. Additional meetings can be called by the Chair.

10 Minutes of meetings

10.1 Minutes of the meeting will be shared with the members following agreement by the Chair.

11 Authority

11.1 The Group will not have any statutory legal responsibilities for partner organisations and will not affect or replace the statutory responsibilities and accountabilities of each partner sovereign organisation.

11.2 The Group has delegated powers from each sovereign organisation for setting the strategic direction for MH and CH services across HIOW and oversight of the design and delivery of associated work programmes.

11.3 It is acknowledged that the remit of the Group will expand in consideration of the maturing ICS and relationships between partners. As such the TORs will be reviewed every six months and sovereign Boards will be consulted, and agreement sought.

12 Reporting

12.1 An exception/summary report will be provided from the Group via the chair to each partner organisation's Board and shared for information with the HIOW Partnership Board – highlighting business transacted, associated risks and making any recommendations as deemed appropriate within the remit of the Group.

Appendix 8 – Clinical Delivery Group Charter

NHS Provider Clinical Delivery Group Charter

Community Health - Mental Health & Learning Disabilities

Background

The Provider Clinical Delivery Groups (CDG) brings organisations together to enable the delivery or higher quality care, closer to people's homes, across Hampshire and the Isle of Wight (HIOW). It is formed from senior clinical and operational executives across the IOW Trust, Solent NHS Trust, Southern Health NHS FT, Sussex Partnership NHS FT plus other organisations where and when appropriate.

The CDG has the authority from independent Trust Boards, and works closely with the HIOW Integrated Care Board, to ensure alignment within clinical workstreams and to facilitate transformative progress.

Priority workstreams are identified by the CDG and resourced with a clinical and operational lead plus an executive sponsor from the CDG (the workstream triumvirate). The workstream triumvirate will describe their workstream with timelines and outcomes; they will develop a delivery group to include all stakeholders and community engagement and report progress back into the CDG for assurance, facilitation and to support learning and direction setting.

Charter

1. Our primary goal is to deliver safe and effective mental health, learning disabilities and community services to all people across HIOW
2. Our communities are at the heart of what we do, and we will work in our communities to improve the way we deliver care
3. We will seek to endeavour equitable voice of service users and professionals delivering our services
4. Our success must be measured by outcomes that matter, co-created with the people who know our services the best
5. We will adopt a lifecourse approach which removes barriers and providers greater emphasis on prevention and a pro-active approach
6. We work collaboratively at the appropriate scale as one health and care team, within the HIOW integrated care system and recognise each other's leadership capabilities.
7. We will respect and value the interconnectivity of delivery with our partners – including primary care, local authority and local voluntary services
8. We will embrace innovation, research and new models of care
9. Clinical and professional leadership is at the core of our success and must be appropriately resourced and supported

Signed

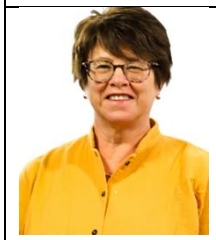
Steve Tomkins, Southern- Chief Medical Officer
Paula Hull, Southern- Director of Nursing and AHPs
Eugene Jones, Southern- Chief Operating Officer
Charlotte O'Brien, Sussex Partnership - Director of Integration and Partnerships
Rachel Walker, Sussex Partnership- Operations Director- CAMHS, Specialist, LD/Neurodevelopmental Services

Dan Baylis, Solent – Chief Medical Officer
Jackie Munro, Solent- Deputy CEO & Chief of Nursing and AHP
Suzannah Rosenberg, Solent- Chief Operating Officer
Lesley Stevens, IOW - Dir of Comm, MH and LD
Lois Howell, IOW - Director of Governance & Risk

NHS Sussex Partnership NHS Foundation Trust
NHS Southern Health NHS Foundation Trust
NHS Isle of Wight NHS Trust
NHS Solent NHS Trust

Appendix 9 – Trust Board compositions: Solent, IoW, Southern

Solent NHS Trust Board

Acting Chair	**Mike Watts**
	Mike grew up and went to school in Southampton. He is a Hampshire resident and current President and Chair of Board for the Trojans Club Ltd and has an extensive and wide ranging track record in organisational design and development that has driven business performance. Mike is currently the lead consultant with Capability and Performance Improvement Ltd of which he is a co-owner. He has previously held senior HR roles at Southampton City Council, and the Chartered Institute of Professional Development; Cabinet Office; Lloyds TSB and Scottish Widows. During his time in the Cabinet Office, Mike was recognised by HR Magazine as one of top 30 influencers of HR practice. He has also held a previous Non-executive Director role with the Scottish Executive. Mike was appointed in October 2016.
Non-Executive Director	**Stephanie Elsy**
	Stephanie has worked in the delivery of public services for over 30 years. She was a CEO in the charity sector for 15 years managing community and residential services for people recovering from substance misuse, people with disabilities and people living with HIV and AIDS. She then entered local politics as a Councillor in the London Borough of Southwark in 1995, becoming Chair of Education in 1998 and then Leader of the Council in 1999. After retiring from local government in 2002 Stephanie served on the Board of Southwark Primary Care Trust which had pooled its resources with the Social Services Department and had a joint Director. She also started a consultancy business providing services in health, local and regional government. Serco Group PLC became one of her clients, and in 2004 she was invited to join the company as a senior Director to support its Board and Senior Executives in raising the company's profile in government and business. She was a member of the company's Global Management Team and helped shape the company's business strategy and supported new market entry in the UK and internationally. Stephanie left Serco in 2012 to establish a new consultancy business, Stephanie Elsy Associates, an advisory consultancy specialising in public sector services and the government contracting markets. She lives in Emsworth where she is Chair of the local Neighbourhood Forum which is developing a Neighbourhood Plan for the town. Stephanie is also the Chair of Bath and North East Somerset, Swindon and Wiltshire STP/ICS. Stephanie joined Solent NHS Trust in September 2017.

Non-Executive Director	Gaurav Kumar
	Gaurav is a Hampshire resident with extensive international experience. During his career he has worked and lived in India, New Zealand, Australia, U.A.E and the UK. He is presently employed in the private sector as the Global Chief Information Officer / Senior VP of IT with ASSA ABLOY Entrance Systems where is also an Executive Board member and a member of the ASSA ABLOY IT Board. Gaurav has a strong background in strategy development, digital transformation, operations management and enterprise performance improvement. His professional experience consists of working in the areas of Engineering, Supply Chain, Information Technology and Major Program Management. Gaurav holds a bachelor's degree in Chemical Engineering and Masters in Business IT.
Non-Executive Director	**Calum Mercer**
	Calum was appointed from 1 April 2021 as a substantive Non-executive Director. Calum has several years of experience as an executive and Non-executive Director in health and social care and a range of other sectors. Calum is the Finance and Operations Director at the Royal College of Psychiatrists and a Non-executive Director at the Legal Aid Agency (an agency of the Ministry of Justice that manages the legal aid service), Treasurer and Member of Council at the University of Bath and the Housing and Finance Institute (which supports the delivery of more homes and good homes across the country). Calum chairs the Audit and Risk Committees at Dimensions and the Legal Aid Agency. He was previously a governor of Manchester Metropolitan University. Previous executive roles were in social care sector as Finance Director of one the largest behaviour change charities and previously in infrastructure and utilities. In his roles he has helped transform and improve organisations, helping them deliver better outcomes for people and has raised over £4 billion in funding.
Non-Executive Director	**Vanessa Avlonitis**
	Vanessa was appointed as a substantive Non-Executive Director in February 2022. Vanessa is a registered nurse who has a breadth of experience within the NHS Acute sector, Clinical Commissioning Group, in regulation at Monitor as a Quality Governance Associate and within the charitable sector supporting and developing sound clinical governance structures and compliance to CQC standards. She has served as Clinical Non-Executive Director for North Hants Urgent Care. Vanessa was also the Registered Nurse member for Dorset CCG where she sat on the Governing Body. Within this role she was the Freedom to Speak up Guardian. She currently holds a Clinical Trustee Board position for a Hospice in North West London. Vanessa is passionate about nursing and the quality of care that patients receive. She is also committed to the wellbeing of staff who work at Solent. She has an MSc in Nursing Leadership.

Chief Executive Officer	Andrew Strevens
	Andrew is the Chief Executive Officer and joined the Solent NHS Trust in August 2015 (as Chief Finance Officer). Andrew's formative years were in Southampton, being educated in local state schools. He has worked within the health service since 2009 and brings a whole system view, having worked in senior positions for providers (Hampshire Community Health Care and Southern Health NHS FT) and as a commissioner (NHSE South Region). He also has a commercial background, having worked for KPMG and B&Q Plc. Andrew is a passionate believer in delivering value by treating patients as individuals and in trusting the judgement of frontline staff. Andrew is a values-based leader who believes deeply in developing a culture where people can thrive and be at their best. He previously stepped into the role of Acting Chief Executive from October 2020 to March 2021 whilst the Trust's Chief Executive was seconded to the national COVID-19 vaccination programme. During this time, Andrew led the organisation's response to the second wave of the COVID-19 pandemic which included the creation and operation of four COVID-19 mass vaccination sites across Hampshire and the Isle of Wight. Andrew has a real passion for working in partnership with health, social care and the voluntary sector to deliver joined up, patient-centred care for the benefit of local people.
Chief Medical Officer and Deputy CEO	**Dan Baylis**
	Dan studied medicine in London and graduated with distinctions in surgery and medicine before moving to the south coast to complete his postgraduate specialty training in general and geriatric medicine. He took time out of clinical training when he was awarded and NIHR fellowship to undertake a PhD where he studied the role of the immune system in accelerating age related processes and, separately, was also able to spend some time working in a field hospital on the Thai-Myanmar boarder. Since qualification he has been appointed as a consultant geriatrician in Southampton which has seen him work across both community and hospital settings. Currently Dan works clinically in the Older Persons assessment unit within the Emergency Department at University Hospital Southampton and within community services in Solent. Dan has had a number of management roles within healthcare which has included leading the UHS department of medicine for older people where the team were awarded BMJ Older Persons Team of the Year and also the department of emergency medicine. Dan has also had system wide roles in patient flow and worked as a clinical leader within the Solent Adults Southampton service line. In addition to his duties as CMO for Solent NHS Trust, Dan will also provide leadership to UHS via his role as associate medical director for integrated care and thereby step across community and acute organisations which is aligned with his values of partnership working to provide high quality care in the most appropriate settings.

Chief of Nursing and Allied Health Professionals	Angela Anderson
	Angela was appointed as Chief of Nursing and Allied Health Professionals in March 2023. Angela moved from the West of Ireland in 1985 to pursue her ambition to become a nurse, qualifying as a Registered General Nurse (adults) in Epsom District Hospital. From there Angela moved to London to specialise in sick children's nursing, achieving her Registered Sick Children's Nursing qualification at Westminster Children's Hospital. From there she worked in West London before moving to Hampshire where she has held several leadership roles, both clinical and operational, across acute and community services within the NHS. She was part of a team who were national leaders in developing and delivering community children's nursing services including the development of excellent end of life care for children in their own home. She also led the development of one of the first ambulatory care units for children in the area, championing the role nurses have in advancing practice within a multidisciplinary, integrated team. On completion of her Master's in Business Administration, Angela took up a role with the Strategic Health Authority, establishing a clinical network for children, young people and maternity services across Hampshire and Isle of Wight before joining Portsmouth Community and Mental Health services in 2008. Angela has worked for Solent since its inception firstly within the children's service line before taking up an opportunity within the Chief Nurse Directorate in 2016. She is passionate about providing care, which is compassionate and respectful of the individual, is high quality and safe. Angela describes being a nurse as the greatest privilege, being able to care for people at a time when they are most vulnerable. Angela was the Clinical Director for the successful set up and roll out of four Mass Vaccinations Centres across Hampshire and Isle of Wight in 2021 and continued to lead the service clinically until it ceased in December 2023. She was shortlisted for the Nursing Times, Nurse Leader of the Year in 2021 and was part of the team shortlisted for an HSJ award in 2022 for the successful COVID-19 Vaccination Service.

Chief Financial Officer	**Nikki Burnett**
	Nikki joined Solent NHS Trust as Chief Financial Officer and Director of Estates in August 2022. Nikki is an advocate for system learning and actively participates in the NHS Future Focused Finance and One Finance programmes acting a as peer reviewer for the national Towards Excellence Accreditation programme. Having started her career with the NHS at Hull PCT in 2008 studying towards AAT, Nikki has continued to combine hands on experience with formal qualifications, and is currently a Fellow of the Association of Chartered Certified Accountants, Master of Business Administration and holds a Masters in Forensic Accounting. Since moving to the area in 2010 with her husband, a serving member of the Royal Navy, she has been working across the South East system providing financial leadership and support in roles including Assistant Head of Finance for NHSE covering Dorset, Hampshire and the Isle of Wight, Finance Lead for the Hampshire and Isle of Wight ICS and most recently Deputy Chief Finance Officer at Portsmouth CCG where her dedication to system integration and process improvements resulted in being shortlisted for the national HFMA Deputy Finance Director of the Year award.
Chief People Officer	**Shahana Ramsden**
	Shahana joined Solent NHS Trust as Chief People Officer on 1st July 2022. She has 35 years' experience in a range of public sector roles and has consistently demonstrated an authentic commitment to improving the life experiences of staff and patients. Shahana has held national leadership roles as Director of NHS Employer's Positively Diverse programme and as Deputy Director of the Department of Health's National Delivering Race Equality in Mental Health program. As part of her role with the Social Care Institute for Excellence, Shahana developed the ground-breaking Making it Real programme which generated practical solutions to implementation of personalised and community-based support. More recently, Shahana led the successful Vaccination Workforce programme in the South East Region and co-chaired the Regional Turning the Tide Transformation and Oversight Board which focused on addressing racial inequalities across our workforce and population. The positive impact of Shahana's work has been recognised by the Health Service Journal (HSJ) where she was listed as a BME pioneer and she was highlighted as one of 100 virtual change activists for health and social care through NHS Improving Quality (The Edge) and was nominated for an NHS70 Windrush award. More recently the impact of the Turning the Tide Transformation programme co-chaired by Shahana has been recognised through a high commendation for the HSJ NHS Race Equality award.

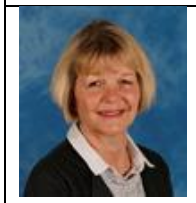
Chief Operating Officer [non-voting]	Suzannah Rosenberg
	Suzannah returned to full time work after being a full time mum in 1995 and took a job as administrator at a supported housing project for young people with mental health and substance misuse issues. Her passion to support young people led her to apply for a support worker role in that same project which led to a 25 year career in health and social care. She quickly stepped into a management role as deputy manager of a registered hostel for homeless young people. In 1999 she led the development of one of the first one stop shops for young people, turning an empty butchers shop in a highly deprived area into a vibrant drop-in with multi agency support. She went on to manage the new service and its sister drop-in, in Portsmouth. In 2001, Suzannah took up her first joint commissioning role in substance misuse and since then has held a number of senior management and director roles across health and social care spearheading the integration of both services and commissioning. Suzannah has been a strong advocate of breaking down the barriers between providers and commissioners which facilitated her joining Solent NHS Trust in 2019 as Deputy Chief Operating Officer whilst retaining a role in Portsmouth CCG.
Chief of Staff, Governance and Corporate Affairs [non-voting]	**Rachel Goldsworthy**
	Rachel joined the NHS in 2002 to support the establishment of the Patient Advice and Liaison Service. Prior to this she worked in a number of corporate sector industries including banking, recruitment and IT. Whilst in the NHS, Rachel has worked in a variety of corporate support and management roles and was heavily involved in the programme bringing the provider arms of both Southampton City PCT and Portsmouth City PCT together prior to the establishment of Solent NHS Trust in 2011. In her current role, Rachel provides support to the CEO and wider Board including the Chair and Non-executive Directors, manages corporate affairs, corporate governance and is accountable for Communications, Information Governance and Freedom to Speak Up. Rachel is also the Senior Information Risk Officer (SIRO) and exec sponsor for the Carers Network.

Director of Strategic Transformation - Advisor to the Board [non-voting]	Debbie James
	Debbie joined Solent NHS Trust's Executive team as Director of Strategic Transformation in September 2022. She has 20 years' experience in the Hampshire and Isle of Wight health and care system. Prior to this role, Debbie worked with the Hampshire and Isle of Wight ICS as Associate Director for the Hampshire Together programme, which has the opportunity to build a new hospital in North and Mid Hampshire. Debbie has held previous leadership roles in strategy, planning, service development, project and change management, contracting and procurement. Debbie is responsible for advising the Trust Board and providing assurance in the development of strategic projects and partnerships, ensuring decision making is centred around patients and enabling our people to thrive. She leads on development and implementation of the Trust's strategy and transformation agenda, ensuring the organisation is best-placed to contribute to national and local priorities and the changing NHS architecture. Debbie is also Executive lead for the Trust's contracting, procurement, business planning and business development activities.

Isle of Wight NHS Trust Board

Role	Name
Trust Chair	**Melloney Poole OBE**
	Melloney joined the Isle of Wight NHS Trust on 5 October 2020. She is also Chair of Portsmouth Hospitals NHS Trust which she joined in May 2017 and was appointed Chair on 1 November 2017. Since June 2015, she has been the head of the Armed Forces Covenant Fund and the other grant programmes funded by LIBOR (London Inter-bank Offered Rate) fines which directly supports the delivery of the Armed Forces Covenant across the UK. Melloney is a corporate, charity and administrative law solicitor with 25 years of private sector commercial and corporate experience before becoming the head of the legal department for the Big Lottery Fund in 2013. She developed the combined legal service department which now supports all the legal and governance matters for the Arts Council England, the Heritage Lottery Fund and the Big Lottery Fund. In addition, Melloney had had a parallel career as a Non-Executive Director in the NHS, serving on the boards of 3 NHS trusts, and as the Vice Chair of the Health Foundation. She has also been a volunteer and fundraiser for various charities and a magistrate on the Preston Bench. Melloney was awarded an OBE in the 2010 New Year Honours for legal and governance services.
Non-Executive Director	**Debbie Beaven**
	Debbie joined the Isle of Wight NHS Trust as a Non-Executive Director in January 2022. She is a qualified accountant and an experienced senior executive and board director. Debbie joins us as we launch the next phase of our financial improvement journey on our drive to financial sustainability. Experience in financial leadership roles across different market sectors, business models and structures as well as leading change programmes and improving performance outcomes are all skills and experience that we welcome to the Board.
Non-Executive Director	**Dr Tim Peachey**
	Tim joined the Isle of Wight NHS Trust as a Non-Executive Director in April 2018. He qualified as a doctor in 1983 and worked as a consultant anaesthetist. Tim has held medical management roles at all levels in a number of acute hospital Trusts including as Medical Director of the Royal free Hospital, and Chief Executive of Barnet and Chase Farm Hospitals. Tim has also worked as an Improvement Director helping NHS Trusts and is currently the Deputy Chief Executive of Barts Health NHS Trust in London.

Non-Executive Director	Dr Christopher Tibbs
	Christopher joined the Isle of Wight NHS Trust as a Non-Executive Director in January 2022. He brings a long history of clinical practice and clinical leadership to the Trust having previously been a Deputy Chief Executive and Medical Director. He also brings not only extensive clinical and managerial experience but also recent experience as a CQC inspection chair and he now works in the Regional and National Commissioning team and Regional Medical Directorate. Christopher also has long and strong links to the Island having had a home here for a number of years. Christopher has significant transaction experience including the south London reconfiguration which brought together St Georges, Kingston and Queen Mary's Roehampton, proposed acute Trust mergers and the integration of community services into an acute Trust.
Non-Executive Director	**Inga Kennedy CBE**
	Inga joined the Isle of Wight NHS Trust on 1 April 2022 as a Non-Executive Director. She has had a life-long career in healthcare, combining time in the NHS with service in the Royal Navy. Born in Aberdeen, she studied nursing at Queen Margaret College in Edinburgh followed by postgraduate studies in Edinburgh and London. A registered nurse, midwife and lecturer, she worked in the National Health Service between 1980 and 1998. Having joined the Royal Navy Reserve in 1987, she undertook full-time reserve service between 1998 and 2000 as a senior midwife in the Royal Naval Hospital Gibraltar. In 2000, she joined the Queen Alexandra's Royal Naval Nursing Service (QARNNS). After being promoted to Commander in 2005, she served in Afghanistan in 2011 and was made Captain in November of that year. She was promoted to Commodore in 2015 and began serving as Inspector General of the Defence Medical Services the same year. In 2017, Commodore Kennedy was appointed Head of the Royal Navy Medical Service, a position she relinquished only recently. Currently, Inga is still a registered and validated nurse and undertakes a portfolio of work focusing on healthcare. She is also a NHS Non-Executive Director and Trustee of an Independent Hospital in London and Trustee of the White Ensign Association.

Non-Executive Director	Phil Berrington
	Phil joined the Trust as an Associate Non-Executive Director in January 2019 and was made a Non-Executive Director in January 2022. He is also an Executive Partner in IBM Consulting and leads accounts where clients are undergoing large and complex transformation journeys. In his consulting work Phil has experience of working in the public sector, notably with a large central government department helping them transform back-office functions and processes. He currently leads IBM's relationship with a quasi-public sector organisation. Phil is a Chartered Management Accountant (FCMA), a Chartered Management Consultant, and holds a post graduate diploma in Strategy and Innovation from Said Business School.
Non-Executive Director	**Sara Weech**
	Sara joined the Trust as an Associate Non-Executive Director in January 2018. She is an experienced public sector executive director having spent 25 years working in complex health and social care systems including East and West Sussex, Hampshire and the Isle of Wight. Sara has worked for both local authority and NHS organisations and since 2013 has been Trustee and Chair of Earl Mountbatten Hospice.

Chief Executive	Darren Cattell
	Darren is a highly capable and compassionate NHS leader with more than 20 years of experience in the health service. Darren joined the Isle of Wight NHS Trust in 2017 and has held Executive-level roles on the Isle of Wight in Estates, Finance, and Information Management and Technology (IM&T) and earlier in his career in a number of other NHS organisations across the country. As Deputy Chief Executive until November 2021, he played a leading role in the quality and financial improvement which saw the trust received a Good rating overall from the Care Quality Commission (CQC). As Chief Executive he is committed to improving the experience of staff and the people who use the Trust's services even further. Darren's transaction experience includes the acquisition of Heatherwood and Wexham Park Hospitals by Frimley, bringing together organisations in Birmingham and the disaggregation of Mid Staffordshire NHS Foundation Trust.

Medical Director	**Steve Parker**
	Steve joined the Isle of Wight NHS Trust in January 2015 as a Consultant General Surgeon who specialised in Breast and General Paediatric Surgery. During his time at the Trust, he has held a number of clinical leadership roles and was appointed as the Medical Director in November 2020. Prior to relocating to the island, he was a consultant at University Hospitals Coventry and Warwickshire Hospitals NHS Trust and also served in the Royal Navy for 16 years, including 4 years in the submarine service. Steve has provided clinical leadership to a number of transformation projects and is committed to the delivery of safe and effective clinically-led services.
Director of Nursing, Midwifery and Allied Health Professions	**Juliet Pearce**
	Juliet joined the Isle of Wight NHS Trust in October 2021. Previously Juliet was the Deputy Chief Nursing Officer at University Hospital Southampton NHS Foundation Trust and has extensive NHS leadership experience. Juliet is a senior registered nursing professional with a Masters degree in Management and Leadership in Health and Social Care. Throughout her career she has held governance, safety and transformation roles.
Director of Governance and Risk	**Lois Howell**
	Lois joined the Isle of Wight NHS Trust in July 2020, and works in the same role at Portsmouth Hospitals University NHS Trust on a shared basis. Lois is a solicitor by background and has held a range of board level positions in public sector bodies including NHS trusts and local authorities, specialising in corporate and clinical governance, compliance, and regulation. Lois is also the Senior Information Risk Owner for the Trust, and the Nominated Individual for the CQC. Lois also leads on Freedom to Speak Up, Volunteers Service and the Trust's charity.

Director of Finance	Jo Gooch
	Jo Gooch joined the Isle of Wight NHS Trust in December 2021 from Portsmouth Hospitals University NHS Trust where she worked as Finance Director. Jo joined the NHS in 1990 and has extensive NHS finance experience, having held several senior finance roles across Hampshire and Isle of Wight, spanning various sectors of the NHS, including that as Chief Finance Officer at Portsmouth CCG. Jo is a Chartered Management Accountant (ACMA) and has a Masters in Leadership in Health and Wellbeing.
Director of People and Organisational Development [non-voting]	**Julie Pennycook**
	Julie Pennycook is the Director of People and Organisational Development and was appointed in September 2017. Julie has over 25 years experience as an Human Resources (HR) professional working in both private and public healthcare sectors. She joined the NHS in 2003 and prior to joining the Isle of Wight NHS Trust held the position of Director of HR and OD at Solent NHS Trust. Julie leads a multi-disciplinary team which includes human resource management, organisational development, recruitment and resourcing, workforce information and systems, learning and development and occupational health and wellbeing. Julie is CIPD qualified and has a Masters in Human Capital Management.
Director of Strategy, Partnerships and Digital [non-voting]	**Nikki Turner**
	Nikki has worked in the NHS for 25 years and started her career on the Isle of Wight in 1998 as a Project Manager. Nikki has worked for Portsmouth and SE Hampshire Health Authority (and was involved in bringing organisations together and the creation of all the Primary Care Trusts in that region) as well as for the Isle of Wight Council and the Isle of Wight Primary Care Trust. Nikki has held several roles within the Isle of Wight NHS Trust covering service and system transformation and has led operational areas across acute, mental health, ambulance and community services including as a Deputy Chief Operating Officer and also as the executive Director of Acute and Ambulance Services. She has a doctorate and is a Prince 2 practitioner in programme management and also has experience in creating care trusts.

Director of Community, Mental Health and Learning Disabilities [non-voting]	**Lesley Stevens**
	Lesley joined the Isle of Wight NHS Trust Board in July 2018, originally as the Director of Mental Health and Learning Disabilities, and since 2021 she has also been the Director of Community services. Lesley became a consultant psychiatrist in 1999, and has 15 years' experience in of senior leadership roles in mental health, learning disability and community services. She is a Health Foundation QI Fellow, and is committed to working alongside people who use and work in our services, and our partners, to provide high quality integrated care that wraps around the needs of individuals
Chief Operating Officer (Acute and Ambulance) and Director of Estates [non-voting]	**Joe Smyth**
	Joe joined the Isle of Wight NHS Trust in October 2019, in his previous role he worked with 8 CCG's and 4 acute Trusts to develop an acute clinical site strategy for North West London. Prior to that, Joe was the Chief Operating Officer at Hillingdon Hospitals for seven years and led on the creation of their Integrated Care Partnership including the set up of Care Connection Teams and transformation of reablement services. He was also the Director of Service Improvement at Epsom and St Helier in South London and spent 3 years at the Royal Bournemouth NHS Trust as their Deputy COO where he led the reconfiguration of their hospital sites.
Director of Communications and Engagement [non-voting]	**Kirk Millis-Ward**
	Kirk was appointed to lead Communications and Engagement for the Isle of Wight NHS Trust and Isle of Wight Council in May 2019. Kirk has worked in a range of senior communications roles for national and local NHS organisations, most recently as Head of News for NHS Improvement and Head of Communications and Engagement for Sussex Community NHS Foundation Trust. Having originally trained as a physiotherapist, Kirk went on to study and work in journalism writing for a number of national, regional and local news publications.

Southern Health NHS Foundation Trust Board

Role	Name
Chair	**Lynne Hunt**
	Lynne has a track record of over 40 years public service, working in the NHS within mental health and learning disabilities services. She began her career as a nurse in Dorset, before moving to London and has held a number of clinical and Board level roles. Most recently she was Non-Executive Director and Vice Chair of Dorset HealthCare University NHS Foundation Trust. Lynne is Co-Chair of Unloc, a leading not for profit organisation in Hampshire that helps to empower young people. She is also the Mental Health Trust Chair lead on the Mental Health Board for NHS Confederation. Lynne has NHS transaction experience (as Director of Nursing) from the merger of two community and mental health trusts in west London and the merger of a high secure hospital with an NHS trust. Lynne also led and supported the transfer of an entire mental health services contract between providers as an independent consultant.
Non Executive Director	**Michael Bernard**
	Michael's career has been in IT, with spells in Sales and Marketing leadership, culminating in a role as an International Marketing Director. His particular areas of expertise are around strategy, communications, IT and sustainability. He is on the Board of the Royal Humane Society and sits on the Advisory Board for Exeter University Business School. He has previously chaired the board of governors for a secondary school. He supports Arctic Base Camp as an Executive Volunteer. Michael is the author of *Creating Strategy: A Practical Guide*, published in 2021. Exposure to mental health problems close to him have given him a long- standing interest in this area and motivated him to apply to the Trust. He hopes to be able to help the Trust with his experience in leadership in a large, complex organisation, as well as a background in strategy and communications. Michael has commercial transaction experience from his time at IBM.

Non Executive Director	Jeni Bremner
	Jeni has worked in public service for over 25 years in the NHS and Local Government and has over 30 years experience at board level both as an executive and non-executive. A nurse by background, Jeni is also a health economist and was a member of the Board as a Health Economist then Policy Analyst at Newcastle City Health Trust, a community and mental health trust, in the mid 90s. She then joined the Local Government Association to lead their public health and health agenda in the late 90s. Her remit expanded to include social care and community safety. She joined the Local Government Associate Board in the early 2000s. In 2007, she became Chief Executive of an international health charity, the European Health Management Association, focusing on policy and practice to improve health management and the delivery of high quality patient focussed healthcare. She worked extensively across the European Region with a wide range of partners both in country at provider / payer level and with government and other non-governmental bodies including the World Health Organisation, European Union and other pan-national organisations. Her particular focus was on Public Health, Patient Involvement / Community Engagement and Health Workforce. Since 2016 Jeni has focussed primarily on her non executive career and is currently Deputy Chair at Southern Health NHS Foundation Trust and Chair of AECC University College.
Non Executive Director	**Dr Kevin Cleary**
	Kevin was previously Deputy Chief Inspector of Hospitals and lead for mental health at the Care Quality Commission (CQC), where he was responsible for the regulation of all mental health providers in England. Kevin has held posts as Medical Director at the NPSA, Chief Medical Officer at East London NHS Foundation Trust (rated outstanding by the CQC) and Chief Medical Officer and Deputy Chief Executive a the North Middlesex Hospital University Trust. Kevin has transaction experience including the merger of Hammersmith and Fulham and Broadmoor Hospitals and East London NHS Foundation Trust's acquisition of Luton and Bedfordshire services (from South Essex).

Non Executive Director	Kate FitzGerald
	Kate was in the City for over 30 years, becoming a senior lawyer in a globally significant, highly regulated financial institution where her role included risk, working with regulators, industry groups and understanding the dynamics of and challenges faced by individuals and complex organisations. Kate has personal experience of dealing with disability and terminal conditions as well as the profound effects and outcomes on carers and families. Kate was Co-Chair of Access Ability, a business resource group at the financial institution where she worked, she identified risk and compliance issues relating to the Equalities Act and worked with the Head of the Legal to address these. Kate was previously a governor at Barncroft School Leigh Park where she was the Special Educational Needs lead governor.
Non Executive Director	**Dr David Hicks**
	David has over 30 years' experience in senior clinical and management leadership posts. Most recently he has been interim Medical Director at Great Ormond Street, where he was the trust's lead for patient and staff safety and clinical quality with responsibility for the legal team and medical workforce and their education and development. He has held a range of Board Level clinical leadership posts during his career, as well as being Acting Chief Executive at Barnsley Hospital from 2006 to 2007. David held a number of roles with Mid Yorkshire Hospitals NHS Trust, advising on the Trust's clinical reorganisation and Chairing the Quality Committee, leading on safeguarding and End-of-Life Care. In addition to his role at Great Ormond Street, he was also a Clinical and Professional Advisor to the Care Quality Commission and a Medical Appraiser to NHSE, supporting a number of GPs across the South of England. He is also an Honorary Senior Lecturer at the University of Sheffield and an Assistant Professor at the University of St. Matthew's in Miami. His other roles have included: Consultant in GenitoUrinary Medicine and Sexual Health, Non-Executive Director in two other NHS Trusts, Medical Director (Transfusion) for NHS Blood and Transplant Service, Medical Director for the Cromwell Hospital, Advisor to the NHS COVID-19 Behaviour Change Unit and Trustee for Horder Healthcare.

Non Executive Director	David Kelham
	David is a Fellow of the Institute of Chartered Accountants in England and Wales and held Chief Financial Officer (CFO) roles in major UK based companies for 24 of his 34 year executive career covering 48 different countries. During that period David completed 25 acquisitions for companies including Shell, P&O, NTL (Virgin Media) and Cable and Wireless, integrating the acquired organisations into their new parent and continuing to transform the combined businesses to deliver outstanding customer service and strong financial performance. He also sold companies for the benefit of the shareholders, customers and staff and, on one occasion, after the disposal was re-employed by the acquiring company to integrate and transform the enlarged international business. Since retiring from executive roles David has held four non-executive / Trustee positions with three of them (including Southern) involved in health care in the UK and internationally. He was Chair of a technology company for two years. David's mother lived with Alzheimer's for 10 years before her death in 2011. His mother-in-law died in January 2021, again after a long period of dementia. David was honorary Treasurer and Trustee of the Alzheimer's Society from September 2015 to March 2017. David was a member of the Scout Association for 40 years, rising to Explorer Scout Commissioner before retiring. He is also a past member and Chairman in the Round Table organisation, and a member and past Chairman of the Ex-Round Tablers' Association.
Non Executive Director	**Dr Subashini M**
	Subashini is a surgical doctor by background and now works as Medical Director at Aviva Health, implementing value-based healthcare, delivering data-driven solutions and championing workplace wellbeing, She previously worked as Director of Science, Health and Wellness at Holland and Barrett where she provides expertise powering the delivery of science-backed in-store and digital products and services, to cement Holland and Barrett's status as a trusted health and wellness destination. Subashini Chairs is the Wellbeing Guardian for the trust. She is also a Non-Executive Director at Healthwatch Hampshire, and a faculty member at Good Governance Institute. Subashini has commercial transactions experience from Holland and Barrett, providing subject matter expertise in validating and reviewing the valuation of potential opportunities, specific to science-based ventures, and supporting post-acquisition integration plans.

Non Executive Director	Ade Williams
	Ade is the Director and Superintendent Pharmacist of the MJ Williams Pharmacy Group. He is the Lead prescribing Pharmacist at the multi-award-winning Bedminster Pharmacy in South Bristol. He was an Associate Non-Executive Director at the North Bristol NHS Trust also worked as part of a GP Clinical Team. Ade is the Royal Pharmaceutical Society's Patient Champion. For distinction in the practice of pharmacy, he received a Fellowship of the Royal Pharmaceutical Society. He maintains ongoing research and clinical design interest in population health management and addressing health inequalities. Further recognition for his work through national awards include the 2019 NHS Parliamentary Award for Excellence in Primary Care, GP-Pharmacist of the Year 2019 and NHS Pharmacist of the Year 2018. As part of the 2018 NHS70 Parliamentary Awards, he was nominated as the Person-Centred Care Champion. Ade received an MBE in the New Year's Honours list 2022 for his services to the NHS and the community in South Bristol, particularly during COVID-19. Ade is a Board Member and Trustee of the Self Care Forum Charity responsible for the NHS Self Care Week and ongoing Self Care Strategy and is also Director of a Business Improvement District responsible for aligning the delivery of commercial, communal and wellbeing objectives.
Chief Executive	**Ron Shields**
	Ron has extensive leadership experience with over 20 years as a successful NHS Chief Executive. His 40-year NHS career spans varied roles across physical and mental health, inpatient and community settings. Prior to joining Southern Health, Ron was Chief Executive at Dorset Healthcare University NHS Foundation Trust, where he led the organisation to achieve an overall Care Quality Commission rating of Outstanding. Ron has also led NHS organisations in London and Northampton. He has a track record of successful and sustainable transformation and integration of services to improve patient outcomes.

Deputy Chief Executive and Finance Director	**Paula Anderson**
	Paula joined Southern Health NHS Foundation Trust in 2009 and was appointed as Deputy Director of Finance in 2014, Finance Director in September 2016 and in addition the Deputy Chief Executive from October 2021. Paula has therefore been involved in both Southern's previous transactions. Prior to this, Paula's finance experience was within commissioning, including the Finance Director for Mid-Hampshire PCT between 2001 and 2006. As part of her role at Southern Health, Paula leads on finance and procurement as well as a broader remit within the Deputy Chief Executive role. Paula attained her MBA from Cranfield University in 2001 and is also a member of the Chartered Institute of Management Accountants.
Director of Nursing and Allied Health Professionals	**Paula Hull**
	Paula qualified as a registered nurse at Southampton Hospital in 1991. She worked at Southampton Hospital in acute and respiratory medicine and rehabilitation for older people specialties for eight years. She then transitioned into community and practice nursing, working in primary care for over 10 years. After several years as the first Matron for Primary Care, she joined Southern and continued her career in a range of nursing and allied health professional leadership positions. She also worked at South Central Strategic Health Authority as a Patient Safety Manager within the Patient Safety Federation. Paula attained a Masters in Leadership and Management from the University of Southampton in 2013 and became the Associate Director of Nursing and Allied Health Professionals in the Integrated Services Division in 2014. In 2018 Paula became the Director of Nursing and Allied Health Professionals for Southern, with responsibility for all Nurses and Allied Health Professionals and accountability for ensuring patients, service users and families are at the heart of our services. Paula is a member of the National Mental Health Director of Nursing Council.
Acting Chief People Officer	**Kerry Salmon**
	Kerry is a highly experienced HR professional who has worked in the local healthcare system since 1999. Previously Deputy Chief People Officer, Kerry is acting Chief People Officer during the period until this post has been filled substantively.

Chief Operating Officer	Eugene Jones
	Eugene Jones joined Southern Health NHS Foundation Trust as Chief Operating Officer on 1 April 2022. A highly experienced and capable director, Eugene joined from East London NHS Foundation Trust, an outstanding rated organisation, where he led on successful operational service delivery and transformation of services across North East London. Eugene is a compassionate and inclusive leader, and a clinician by background, who puts patients, carers and colleagues first. He has held Director-level posts across health and social care since 2013 including Clinical Director and Borough Director roles in mental health and community health services. Eugene holds a Masters Degree in Healthcare Leadership (University of Manchester) and a PGDip in Forensic Mental Health (Kings College London). Eugene was also awarded the role of Honorary Lecturer at the Institute of Psychiatry in the field of Dual Diagnosis. Eugene has transaction experience including community and mental health Trust mergers involving South West London and St George's and also East London NHS Foundation Trust's acquisition of Luton and Bedfordshire services (from South Essex Partnership Trust).
Director of Strategy and Infrastructure Transformation	**Heather Mitchell**
	Heather has held NHS Executive Director posts with a broad portfolio for over 12 years. Within Southern Health NHS Foundation Trust, Heather leads on strategic planning, digital estates and sustainability. Prior to joining the Trust, Heather was Director of Strategy and Partnerships for West Hampshire Clinical Commissioning Group, where she held the responsibility for Clinical Commissioning Group strategy and business planning, mental health commissioning, children's commissioning and digital transformation. She previously worked with Hounslow and Richmond Community Healthcare (HRCH) NHS Trust, where she was the Director of Planning and Performance with responsibility for strategy, business development, performance, digital and estates. Heather holds a Master's Degree and PhD in Civil Engineering and prior to joining the NHS she worked in engineering consultancy and project management with responsibility for business development. Heather joined Hounslow and Richmond Community Healthcare just after the Trust had formed (bringing together two community organisations) and supported the post-merger cultural alignment. Heather also led a pioneering outcome-based commissioning approach developing a lead provider model within Richmond, working in partnership with two acute providers.

Chief Medical Officer	Dr Steve Tomkins
	Steve joined the Trust as Chief Medical Officer in May 2021 and is a GP by training. Whilst developing a family based primary care service in Christchurch, Steve enjoyed a varied career including, at different times, various roles for Dorset Clinical Commissioning Group. These roles included being the lead for education, primary care estates, integration, self-care and self-management and locality clinical lead. Steve was also Programme Director for the Wessex GP day release course. Steve was formerly Medical Director at Dorset Healthcare NHS Foundation Trust, helping the organisation achieve outstanding status. Steve has transactions experience in primary care and was previously a Board member at Dorset CCG when Poole Hospital and Royal Bournemouth and Christchurch Hospitals initially proposed a merger.

Appendix 10 – Steering Group Scopes

Business Support, Intelligence and Development

Steering Group work programme summary

Scope		Inter-dependencies (with other workstreams
Strategic Case stage	**Full Business Case stage (draft)**	
• Identification of expected / potential financial and non -financial benefits • Identification of expected / potential transaction and integration costs • Agree scope and manage delivery of initial contract and commercial due diligence to support indicative risk assessment	• Detailed assessment of financial and non-financial benefits • Detailed calculation of expected / potential transaction and integration costs • Agree scope and manage delivery of contract and commercial due diligence • Plan integration for relevant functions (e.g. commercial, business intelligence) • Develop performance reporting for new Trust • Provide content for full business case as required	Finance Clinical Infrastructure (Digital)

Key deliverables at Strategic Case stage	Milestones	Target Date	Owner
SC content: Articulation of: • Expected / potential financial and non -financial benefits, transaction and integration costs	• Financial benefits, transaction and integration costs provided to Finance Steering Group • Non-financial benefits provided to programme team	• 16 Dec 22 • 6 Jan 23	D James/S Errock
Initial due diligence reports: • Contract due diligence on Southern • Contract due diligence on Solent • Contract due diligence on IoW • Commercial due diligence on Southern • Commercial due diligence on Solent • Commercial due diligence on IoW	• Initial due diligence reports to programme team for incorporation in SC • Initial due diligence reports to Programme Board • Initial due diligence reports to Trust Boards	• 6 Jan 23 • 16 Jan 23 • Early Feb 23	D James/S Errock

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PROJECT FUSION

Clinical

Steering Group work programme summary

Scope		Inter-dependencies (with other workstreams
Strategic Case stage	**Full Business Case stage (draft)**	
• Develop the clinical strategy for the new Trust, ensuring alignment with relevant ICS strategies • Identify key issues to be considered in developing the clinical operating model for the new Trust • Identification of expected / potential financial and non -financial benefits, particularly benefits for patients and staff • Identification of expected / potential transaction and integration costs • Ensure the requirements of NHSE's quality governance assessment are understood and incorporated into plans for the FBC stage • Agree scope and manage delivery of initial clinical due diligence to support indicative risk assessment	• Articulation of clinical operating model for delivery of the new Trust's clinical strategy • Identification of enablers of delivery of the clinical strategy and clinical operating model, for inclusion in other Steering Groups' plans • Detailed assessment of financial and non-financial benefits, particularly benefits for patients and staff • Detailed calculation of expected / potential transaction and integration costs • Agree scope and manage delivery of clinical due diligence • Plan integration of clinical functions and clinical support services and document in integration plan, including any changes to clinical governance • Provide assurance to NHSE in respect of its quality governance assessment	Infrastructure Comms & Engagement Workforce Organisational Development Finance Corporate Governance

Key deliverables at Strategic Case stage	Milestones	Target Date	Owner
SC content: Articulation of: • Process to date to develop clinical strategy and any design principles that have been agreed for designing service models • Clinical strategy for the new Trust, including expected benefits and how it will support the ICS strategy, and proposed next steps • Key issues to be considered in developing the clinical operating model	• Content provided to programme team	• 6 Jan 23	L Stevens
Articulation of expected / potential financial and non -financial benefits, transaction and integration costs	• Financial benefits, transaction and integration costs provided to Finance Steering Group • Non-financial benefits provided to programme team	• 16 Dec 22 • 6 Jan 23	S Malcolm
Initial due diligence reports: • Clinical due diligence on Southern • Clinical due diligence on Solent • Clinical due diligence on IoW	• Initial due diligence reports to programme team for incorporation in SC • Initial due diligence reports to Programme Board • Initial due diligence reports to Trust Boards	• 6 Jan 23 • 16 Jan 23 • Early Feb 23	S Malcolm

Communications and Engagement

Steering Group work programme summary

Scope		Inter-dependencies (with other workstreams
Strategic Case stage	**Full Business Case stage (draft)**	
• Identification of expected / potential financial and non -financial benefits • Identification of expected / potential transaction and integration costs • Develop a communications and engagement plan tailored to each type of stakeholder, including a community engagement plan to be co-produced with local communities	• Detailed assessment of financial and non-financial benefits • Detailed calculation of expected / potential transaction and integration costs • Delivery of the communications and engagement plan • Plan integration for relevant functions (e.g. communications) and document in integration plan • Plan integration for relevant corporate materials (e.g. branding, naming considerations)	Corporate Governance Workforce Organisational Development Clinical Infrastructure Finance

Key deliverables at Strategic Case stage	Milestones	Target Date	Owner
SC content: Articulation of: • Key elements of communications and engagement plan	• Content provided to programme team	• 6 Jan 23	A Hewitt/T Westbury
Articulation of expected / potential financial and non -financial benefits, transaction and integration costs	• Financial benefits, transaction and integration costs provided to Finance Steering Group • Non-financial benefits provided to programme team	• 16 Dec 22 • 6 Jan 23	A Hewitt/T Westbury
Communications and engagement plan	• Plan to Programme Board for approval • Plan to Trust Boards for approval	• 13 Feb 23 • Early March 23	A Hewitt/T Westbury

Corporate Governance

Steering Group work programme summary

Scope		Inter-dependencies (with other workstreams
Strategic Case stage	**Full Business Case stage (draft)**	
• Identification of expected / potential financial and non -financial benefits • Identification of expected / potential transaction and integration costs • Agree scope and manage delivery of initial legal due diligence to support indicative risk assessment • Engagement of joint legal advisors as required	• Detailed assessment of financial and non-financial benefits • Detailed calculation of expected / potential transaction and integration costs • Agree scope and manage delivery of legal due diligence • Support development of Board statements and certifications required by Trust Boards or NHSE • Develop plans to establish a Council of Governors, Trust Board and sub-committees for the new Trust • Plan integration for relevant functions (e.g. corporate governance) and document in integration plan • Support development of Transaction Agreements as required • Develop constitution for the new Trust • Ensure CQC and NHS Resolution registrations in place for the new Trust	Finance Comms & Engagement Workforce Clinical

Key deliverables at Strategic Case stage	Milestones	Target Date	Owner
SC content: Articulation of: • Proposed plan to establish a Council of Governors, Trust Board and sub-committees for the new Trust	• Content provided to programme team	• 6 Jan 23	R Goldsworthy/A Williams
Articulation of expected / potential financial and non-financial benefits, transaction and integration costs	• Financial benefits, transaction and integration costs provided to Finance Steering Group • Non-financial benefits provided to programme team	• 16 Dec 22 • 6 Jan 23	R Goldsworthy/A Williams
Initial due diligence reports: • Legal due diligence on Southern • Legal due diligence on Solent • Legal due diligence on IoW	• Initial due diligence reports to programme team for incorporation in SC • Initial due diligence reports to Programme Board • Initial due diligence reports to Trust Boards	• 6 Jan 23 • 16 Jan 23 • Early Feb 23	R Goldsworthy/A Williams

Finance

Steering Group work programme summary

Scope		Inter-dependencies (with other workstreams
Strategic Case stage	**Full Business Case stage (draft)**	
• Identification of expected / potential financial and non -financial benefits • Identification of expected / potential transaction and integration costs • Support other Steering Groups to quantify the potential / expected financial benefits and costs for the SC • Agree scope and manage delivery of initial financial and taxation due diligence to support indicative risk assessment • Develop a plan to calculate and evidence the detailed financial benefits and costs identified by all Steering Groups for the FBC • Ensure the requirements of NHSE's financial governance assessment are understood and incorporated into plans for the FBC stage	• Detailed assessment of financial and non-financial benefits • Detailed calculation of expected / potential transaction and integration costs • Develop financial reporting for new Trust • Agree scope and manage delivery of financial and taxation due diligence • Ensure the requirements of NHSE's financial governance assessment are understood and incorporated into plans for the FBC stage • Calculate and evidence the detailed financial benefits and costs identified by all Steering Groups for the FBC • Plan integration for relevant functions (e.g. finance) and document in integration plan • Provide assurance to NHSE in respect of its quality governance assessment	Business Support, Intelligence and Development Infrastructure Comms & Engagement Workforce Clinical Corporate Governance Organisational Development

Key deliverables at Strategic Case stage	Milestones	Target Date	Owner
SC content: • Articulation of expected / potential financial and non -financial benefits, transaction and integration costs • Quantification of the potential / expected financial benefits and costs (as identified by all Steering Groups) • Current financial performance information	• Non-financial benefits provided to programme team • Financial benefits, transaction and integration costs received from other Steering Groups • Finance chapter content provided to programme team	• 6 Jan 23 • 16 Dec 22 • 6 Jan 23	P Anderson
Initial due diligence reports: • Financial due diligence on Southern • Financial due diligence on Solent • Financial due diligence on IoW • Taxation due diligence on Southern • Taxation due diligence on Solent • Taxation due diligence on IoW	• Initial due diligence reports to programme team for incorporation in SC • Initial due diligence reports to Programme Board • Initial due diligence reports to Trust Boards	• 6 Jan 23 • 16 Jan 23 • Early Feb 23	N Burnett

Infrastructure [Estates and Digital]

Steering Group work programme summary

Scope		Inter-dependencies (with other workstreams
Strategic Case stage	**Full Business Case stage (draft)**	
• Identification of expected / potential financial and non -financial benefits • Identification of expected / potential transaction and integration costs • Agree scope and manage delivery of initial estates / property, IT, environmental, and health & safety due diligence to support indicative risk assessment	• Detailed assessment of financial and non-financial benefits • Detailed calculation of expected / potential transaction and integration costs • Agree scope and manage delivery of estates / property, IT, environmental, and health & safety due diligence • Develop Digital and Estates strategies to support delivery of the new Trust's clinical strategy and relevant ICS strategies • Provide support on relevant matters (e.g. digital) to the development of integration plans by other Steering Groups • Plan integration for relevant functions (e.g. digital and estates) and document in integration plan	Finance Workforce Clinical Communications & Engagement

Key deliverables at Strategic Case stage	Milestones	Target Date	Owner
Articulation of expected / potential financial and non -financial benefits, transaction and integration costs	• Financial benefits, transaction and integration costs provided to Finance Steering Group • Non-financial benefits provided to programme team	• 16 Dec 22 • 6 Jan 23	H Mitchell
Initial due diligence reports: • Estates / property due diligence on Southern • Estates / property due diligence on Solent • Estates / property due diligence on IoW • IT due diligence on Southern • IT due diligence on Solent • IT due diligence on IoW • Environmental due diligence on Southern • Environmental due diligence on Solent • Environmental due diligence on IoW • Health & safety due diligence on Southern • Health & safety due diligence on Solent • Health & safety due diligence on IoW	• Initial due diligence reports to programme team for incorporation in SC • Initial due diligence reports to Programme Board • Initial due diligence reports to Trust Boards	• 6 Jan 23 • 16 Jan 23 • Early Feb 23	H Mitchell

Organisational Development

Steering Group work programme summary

Scope		Inter-dependencies (with other workstreams
Strategic Case stage	**Full Business Case stage (draft)**	
• Identification of expected / potential financial and non -financial benefits • Identification of expected / potential transaction and integration costs • Develop an approach to cultural alignment and organisational development, informed by an understanding of existing cultures in partners, to support design of the new Trust and delivery of the clinical strategy	• Detailed assessment of financial and non-financial benefits • Detailed calculation of expected / potential transaction and integration costs • Delivery of planned approach to cultural alignment and organisational development (expected to continue beyond transaction date and to be documented in integration plan) • Provide support on relevant matters (e.g. culture) to the development of integration plans by other Steering Groups	Workforce Finance Comms & Engagement Clinical Infrastructure

Key deliverables at Strategic Case stage	Milestones	Target Date	Owner
SC content: articulation of: • Approach to cultural alignment and organisational development	• Content provided to programme team	• 6 Jan 23	S Ramsden/F Acton
Articulation of expected / potential financial and non -financial benefits, transaction and integration costs	• Financial benefits, transaction and integration costs provided to Finance Steering Group • Non-financial benefits provided to programme team	• 16 Dec 22 • 6 Jan 23	S Ramsden/S Acton

Workforce Steering Group work programme summary

Scope		Inter-dependencies (with other workstreams
Strategic Case stage	**Full Business Case stage (draft)**	
• Identification of expected / potential financial and non -financial benefits • Identification of expected / potential transaction and integration costs • Agree scope and manage delivery of initial HR and pensions due diligence to support indicative risk assessment • Develop an employee engagement / consultation plan (specifically related to TUPE) • Ensure early discussions with staff side/union representatives are carried out, feeding back any potential issues or concerns to be addressed to the Programme Board	• Detailed assessment of financial and non-financial benefits • Detailed calculation of expected / potential transaction and integration costs • Agree scope and manage delivery of HR and pensions due diligence • Plan and implement staff transfer plan, including all TUPErelated activities • Plan integration for relevant functions (e.g. HR) and document in integration plan	Finance Comms & Engagement Clinical Corporate Governance Infrastructure OD

Key deliverables at Strategic Case stage	Milestones	Target Date	Owner
Articulation of expected / potential financial and non -financial benefits, transaction and integration costs	• Financial benefits, transaction and integration costs provided to Finance Steering Group • Non-financial benefits provided to programme team	• 16 Dec 22 • 6 Jan 23	K Salmon/S Davies
Initial due diligence reports: • HR and pensions due diligence on Southern, Solent, IOW	• Initial due diligence reports to programme team for incorporation in SC • Initial due diligence reports to Programme Board • Initial due diligence reports to Trust Boards	• 6 Jan 23 • 16 Jan 23 • Early Feb 23	K Salmon/S Davies

Appendix 11: Ways in which the existing cultures of the Trusts could be understood

1. The NHS Staff Survey is an agreed measure of workplace experience which is conducted across all NHS Trusts each year. Since it's alignment to the seven elements of the NHS People Promise, it is easier for Trusts to understand their performance and progress in different domains of staff experience. The National Quarterly Pulse Survey in which all trusts providing acute, specialist, ambulance and mental health services in England have been required to participate in since April 2022, also provides consistent insights of the working experience of our people. This happens in quarters 1, 2 and 4.

2. With the publication of the 2022 annual results due on 31st January 2023 the Staff Survey will provide one way for the culture of each merging organisation to be understood. The Organisational Development Steering Group will discuss how best the results of each representative organisation could be shared, analysed and used to inform the development of the organisational development programme including benchmarking data over the last 3-4 years to provide a meaningful baseline.

3. In addition to the annual NHS Staff Survey, there are several ways in which the Trusts measure their internal cultures, which are described below.

Organisation	Method for Measuring / Understanding Workplace Culture
Southern	Cultural Insights Cultural Insights Lite (until 2022) Bespoke Cultural Insights National Quarterly Pulse Survey National Staff Survey
Solent	National Quarterly Pulse Survey National Staff Survey
IoW	National Quarterly Pulse Survey National Staff Survey
Sussex Partnership	National Quarterly Pulse Survey National Staff Survey
N/A	Model Hospital Data, which allows for comparisons of organisations across a range of measures, including productivity and culture

4. The Trusts will consider what more is needed, if anything, to provide a measurable way of understanding the future state culture and, if useful, conducting a gap analysis against current position. If a new tool is required, it would be prudent to ensure that this is the one likely to serve the new Trust in the longer term.

5. The Organisational Development Steering Group intends to arrange a workshop to explore different approaches and agree actions and leads.

Factors which may support using a cultural tool in existence	Factors which may support procuring external support to measure culture
Tried and tested	New, objective and an opportunity for all to learn
Internally managed / led	Externally led
Knowledge that we can identify the 'hearts' or 'pearls' of our culture	Risk it could miss the heart of what drives the positive cultures
Costs likely to be only associated with IT infrastructure	Costs associated; the group have sought funds of £40k from the Finance Steering Group to allow for this.

Appendix 12: Indicative detail of proposed organisational development interventions

1. Based on the new operating model, interventions which enable staff to design and describe the future of our new Trust, including identifying our shared values, behaviours, ways of working, principles and expectations. This could include:

    - Values - What is in place for each organisation – the current values, understanding the engagement process, what is the duration of their existence, how embedded are they – and what could the future state in relation to values be? Scope of work needs to consider when new values need to be in place by (e.g., April '24 or before) and work back accordingly.

    - Opportunity to clarify expectations around leaders and ensure these are embedded through appraisal / feedback tools / relevant policies, job descriptions and recruitment comms and meaningfully link to workstreams such as Just Culture.

2. Interventions which engage and enable our people to be part of the change and part of creating and delivering their vision for the future. This could include:

    - Leader's skills focus – the importance of compelling narrative. Uniting all leaders around compelling vision for a new Trust where teams are aligned around new unified and regularly measured culture; helping leaders to set own cultural priorities with the capability to make cultural uplifts.

    - Culture / change champion roles which could include staff feeling connected to the change, able to influence it and get updates at a local level. Ambassadors for change. Vehicle for feedback about how change is being experienced.

    - Support for leaders who will be leading teams directly affected by Project Fusion, such as bringing together a new team across previous org. boundaries / broadening their new clinical focus / changing clinical pathways (input from Clinical Delivery Groups.)

3. Interventions which equip colleagues with the skills, capabilities and tools that are needed to bring the values of the new organisation to life. This could include:

    - Support teams to network, build trust and develop capacity and capability to embrace and embed cultural aspirations and values through development of a self-service toolkit / and access to facilitation when needed

    - A coaching and mentoring offer which spans the breadth of roles across all organisations and incorporates reverse mentoring

    - Skills sessions on topics such as:

Building an understanding of Trust (ABCD model of trust) including the power of forgiveness and letting go	Equipping our people to realise the benefits of change : How to meaningfully empower teams and be an adaptive leader	The Curious Leader – Exploring the importance of curiosity in the workplace and at times of change	Models to understand change and how we can support our teams to navigate it	Exploring Positive Personality Difference with Myers Briggs
Giving feedback and having candid conversations	How can our mindset impact on how we develop talent in our teams?	Situational Leadership – how can we adapt our approach around the context?	What does being an inclusive leader mean and how can we reduce our own biases?	Compassionate leadership – what does it mean and how can you make it a reality?
Understanding conflict and how to adapt conflict styles (Thomas Kilmann)	The Power of appreciation and how this simple behaviour can uplift team culture	Staff engagement and how team leaders can better engage their staff with organisational values	Coaching as a leadership skill set	
Failing Brilliantly – How we can innovate and why failure can help us	Quality Improvement and how to embed the approach through leadership			

3. An offer describes how can the OD Steering Group can support the other workstreams to consider how their work is being undertaken, the relationships. This could include:

    - Workshops to enable steering groups to consider where culture features in their workplans / project plans.
    - Workshops / tools to enable steering groups to reflect on whether ways of working align to suggested guiding principles developed by the OD SG

Appendix 13 – Initial due diligence summary report

Purpose of due diligence

The purpose of due diligence is to identify areas of risk so that the risks the new Trust will inherit are understood and, where possible, these risks are mitigated through integration planning. The risks identified through due diligence will be documented in a report for Trust Boards and reflected in the Full Business Case.

It should be noted that, alongside the formal due diligence process, the Trusts will share a range of information that will inform integration planning for the new Trust (but will not be documented in a formal due diligence report for Boards). This will support the development of robust plans that draw on the best from each of the Trusts.

Approach to initial due diligence

As agreed by the Programme Board at its meeting on 14 November 2022, Steering Groups have undertaken an indicative risk assessment to understand where detailed due diligence needs to be performed (at Full Business Case stage) and which elements should be undertaken internally and externally. Steering Groups have reviewed the indicative scopes for due diligence in NHSE's Transaction Guidance[34]. The risks identified through the initial due diligence exercise have been reflected in the programme risk register as appropriate.

Sussex Partnership due diligence at Full Business Case stage

The decision to transfer Hampshire CAMHS services from Sussex Partnership is a decision for commissioners (HIOW ICB and Frimley ICB). Once that decision has been taken, there would then be a six month mobilisation period at which point information about transferring services would be shared with the new provider. Sussex Partnership has therefore been excluded from the summary table overleaf and will not be asked share any commercially sensitive information in advance of any decision by the ICB. The exception to this is information Sussex Partnership shares as part of the transformation workstreams being overseen by the Clinical Delivery Group.

Southern, Solent and IoW due diligence at Full Business Case stage

The table below summarises for each area of due diligence, by Trust:

- the proposed scope of detailed due diligence based on the indicative scopes in NHSE's Transaction Guidance i.e. full scope or amended scope (the appendix sets out the detailed scopes for each area of due diligence); and
- the proposed approach to undertaking detailed due diligence i.e. use of internal, external or hybrid resource.

Detailed scopes have been developed by each Steering Group based on the NHSE indicative scopes.

Where the skills are available internally, the preferred approach is to undertake due diligence internally to build knowledge across teams and to ensure accountability for mitigating identified risks and delivering integration plans. Where it is proposed to undertake detailed due diligence internally, in order to ensure a level of 'check and challenge' and consistent

[34] https://www.england.nhs.uk/wp-content/uploads/2022/10/B1464_ii_Statutory-transactions-including-mergers-and-acquisitions.pdf

quality across the due diligence output reports, it is proposed that an external 'critical friend' function is engaged to fulfil this role.

Next steps

Following approval of the Strategic Case by Trust Boards in early March resources will be mobilised to support detailed due diligence. The findings of due diligence will be reported to Trust Boards and incorporated in the Full Business Case for approval in October 2023.

Due Diligence Area (assigned Steering Group)	Solent		Southern		IoW	
	Scope	Approach	Scope	Approach	Scope	Approach
Legal (Corporate Governance Steering Group)	Full	Hybrid	Full	Hybrid	Full	Hybrid
Clinical (Clinical Steering Group)	Full +	Hybrid	Full +	Hybrid	Full +	Hybrid
Commercial (Business Support Steering Group)	Full	Internal	Full	Internal	Full	Internal
Contracts (Business Support Steering Group)	Full	Internal	Full	Internal	Full	Internal
Finance (Finance Steering Group)	Full	Hybrid	Full	Hybrid	Full	Hybrid
Taxation (Finance Steering Group)	Full	Hybrid	Full	Hybrid	Full	Hybrid
IT (Infrastructure Steering Group)	Full +	Internal	Full +	Internal	Full +	Internal
Estates and Property (Infrastructure Steering Group)	Full +	Hybrid	Full +	Hybrid	Full +	Hybrid
Environmental (Infrastructure Steering Group)	Full +	Hybrid	Full +	Hybrid	Full +	Hybrid
Health and Safety (Infrastructure Steering Group)	Full +	Hybrid	Full +	Hybrid	Full +	Hybrid
HR and Pensions (Workforce Steering Group)	Full	Internal	Full	Internal	Full	Internal

Note: Full + means the full scope of the NHSE indicative scopes plus some specific, additional elements of due diligence which the Steering Group considers are necessary to ensure all significant risks are identified to be mitigated through integration planning.

Appendix 14 – Communications and engagement plan as at 9 February 2023

Background

1. Across Hampshire and Isle of Wight community and mental health services are provided by several organisations working closely together: Solent NHS Trust, Southern Health NHS Foundation Trust, Isle of Wight NHS Trust and Sussex Partnership NHS Foundation Trust as well as a range of other NHS, local authority and voluntary and independent sector organisations.

2. A key priority for the NHS in Hampshire and the Isle of Wight is ensuring that communities have equal access to services and experience the same outcomes. We know that over the coming years the demand for community and mental health services will increase. Our physical and mental health services are already responding to increasing need, both in terms of the number being referred and the complexity of issues they present with. Against this backdrop, continuing to improve and transform service provision as well as having an even greater focus on integration between mental and physical health is vitally important.

3. In January 2022 the Hampshire and Isle of Wight ICS commissioned a review of community and mental health services. The purpose of the review was to understand how to best meet the current and future demands of our local populations. The review looked carefully at the evidence and involved a number of partners. A range of different options were put forward and the review made recommendations for us to consider as a system.

4. The work, which took place during March and April, was led by an independent organisation and involved a range of clinicians, partners and stakeholders. It considered a wide range of data and information, including patient experience and insight, as well as feedback from one-to-one interviews and roundtable discussions.

5. One of the review's key recommendations is that a new organisation be formed, to bring together all NHS community and mental health services provided in Hampshire and the Isle of Wight by Solent NHS Trust, Southern Health NHS Foundation Trust, Isle of Wight NHS Trust and Sussex Partnership NHS Foundation Trust, that delivers Child and Adolescent Mental Health Services (CAMHS).

6. These organisations (the providers) are now taking forward this recommendation working closely with the Integrated Care Board (ICB).

7. This document describes the principles, approach and initial activity we will undertake to ensure a coordinated approach to communication and engagement across partners. It will be refreshed as the programme develops and moves through different phases:

- **Phase 1** – Development of Strategic case – Sharing case for change and developing plans for engagement in development of full business case

- **Phase 2** – Strategic case approval – Ensuring stakeholders are fully aware of the outcome, next steps and opportunities for involvement

- **Phase 3** – Full business case development – More targeted, specific communications
- **Phase 4** – Full business case approval – Communicating outcome and next steps
- **Phase 5** – Mobilisation
- **Phase 6** – Go live – Launching new organisation and describing next steps for ongoing communications and engagement, e.g. first 100 days
- This plan links to the overall strategic communications priorities for the Integrated Care Board which includes the acute services partnership between Isle of Wight NHS Trust and Portsmouth Hospitals NHS Trust. There are clear links between this ICB strategic priority and Project Fusion.

Aims

- Deliver co-ordinated communications and engagement activity
- Support the delivery of timely and meaningful community and employee engagement programmes, led by each provider engagement and HR and OD leads respectively
- Shape key messages and ensure these are communicated and understood by all audiences.
- As far as possible ensure that media reporting is factual and accurate

Principles

8. Our communications and engagement activities will be guided by the following strategic principles:

Patient-centred:

- Front and centre of our approach should be a focus on the patient and their carers. The driving force behind the recommendation is centred around delivering joined-up, high quality and equitable services. Our approach will be to focus our narrative on the benefit to the people who use of our services and their carers and ensure meaningful opportunities to engage and co-produce.

Clinically led:

- Clinical leadership, and peer to peer engagement, is central to our communications and engagement approach – leaders should be highly visible through our communications and engagement activities. Clinical input is also fundamental in order to articulate the positive impact of any changes on patients and service users.

Honest and transparent:

- We will be open, honest, and transparent in our communications about the way forward. Where there may be an impact on staff members or on how people access services, we will ensure this is fully understood. We will also be clear

about the aspects of the proposals that can be influenced, and what particularly we are seeking views on.

Two-way local engagement:

- The engagement we undertake with stakeholders, staff and partners will be timely, to allow adequate opportunity for queries and clarification. We want to deliver changes that our stakeholders, staff and communities can co-produce, support and endorse. We will build upon existing relationships we have based around place.

Approach to collaborative communications and engagement

Provider-led:

- Communications and engagement activity relating specifically to the recommendation to create a new organisation will be led by the providers' communication and engagement leads, supported by colleagues from the Integrated Care Board.
- Communications and engagement activity relating to the overarching community and mental health review, and wider set of recommendations, will be led by the Integrated Care Board, supported by colleagues from the provider organisations.

Co-ordinated

- All the organisations involved in the transformation will work together to ensure key messages are agreed and signed off by each respective organisation. These will be updated regularly via the Communications and Engagement Steering Group.
- Organisations can create their own communications and engagement activity aligned to the agreed messaging without the need for additional sign off. However, partners will update one another on activity regularly (see oversight and assurance).
- Feedback and outcomes from communications and engagement activity will be shared via the Communications and Engagement Steering Group, as well as logged in the engagement log, to inform the programme.

Oversight and assurance

- Communications and engagement colleagues are experienced at working across organisational boundaries.
- The provider organisations have established a dedicated provider Communications and Engagement Steering Group which reports to the Provider Programme Team and onto the Programme Board. This is attended by communications and engagement representatives from all provider organisations involved, as well as colleagues from the ICB. It provides an update into the ICB CMH Review Communications Group and the Project Fusion Programme Team meeting.

Sign off

- All the organisations involved in the programme will agree and sign off key messages and any updates to these and agree any joint communications when there are significant milestones.
- Individual organisations can undertake communications and engagement activity using the agreed narrative without group sign off. However, outcomes of engagement should be shared for information and logged in the engagement log.

Media protocol

- On receipt of a media query regarding the recommendation to create a new organisation, all partner communications leads should be notified, and draft responses shared for comment.
- Signed off statements should be shared with partner CEOs and cleared with the ICB before issuing. Response times should be in line with media deadline and all partners should be advised on this to allow for comments.
- Sign off is also subject to existing national media handling protocols.
- Media coverage should be monitored and shared with partner communications leads and any correction, clarification or rebuttal handled jointly.
- Spokespeople will be agreed between organisations depending on the line of enquiry. The preference would be for clinical spokespeople.

Approach to engagement

9. We describe ‘communications and engagement’ and ‘community engagement’ as two different and complementary types of activity.
10. All partners are committed to ensuring patients are front and centre of our approach, which will be clinically-led, transparent, and inclusive. The engagement we undertake with local communities, staff and stakeholders will be two-way, to ensure that everyone’s voices are heard and the changes put in place are widely endorsed.
11. Our approach is aligned to the principles set out in the most recent NHSE statutory guidance on working in partnership with people and communities. We recognise that there is no one size fits all approach to effectively inform, involve, and work alongside our wide range of stakeholders and partners. Our approach can be viewed as a scale ranging from giving information to full participation and coproduction, as described in the image below.

12. Community engagement is the activity of reaching out to local people to understand what really matters most to them, to build long term, trusting relationships and to work as equal partners. This partnership enables the active involvement in the cocreation of solutions to local issues with care and treatment, and in the design, development and delivery of those services. Our approach to community engagement is based on the principles of a strengths-based approach; that is recognising our communities as being an asset, with strengths, knowledge, experience and skills to offer this programme of change

13. The community engagement approach is designed to ensure that the voice of our local communities actively informs the development of the new organisation. This includes being equal partners in the design and development of new clinical pathways, and the implementation of a strengths based approach to service design and delivery.

14. An engagement steering group has been established to oversee and support the engagement programme which includes Healthwatch, representatives of currently unrepresented communities and partner community engagement leads. Engagement will continue through the preparation of the strategic case, full business case, to day one of the new organisation and beyond. We will seek to understand more about what a great community and mental health organisation looks like for both current users of our services, their families and carers and prospective users for the future.

Audiences

15. Audiences have been categorised into the following groups.

Staff

16. Staff, including volunteers, and their respective representatives across all organisations will be regularly communicated with and kept up to date. The key messages will ensure messaging and communications activity are consistent.

Stakeholders

- **Scrutiny committees, councillors, and MPs** play an important role as representatives of their local communities, raising concerns and scrutinising plans and services on their behalf. They also act as opinion formers, both informing and reflecting public opinion and their ongoing support is important. We will provide regular updates to the scrutiny committees across our geography on the partnerships. This will take the form of written updates, informal meetings (collectively when it makes sense to do so) and specific briefings through existing statutory meetings. All of our organisations have contact with these stakeholders and so it will be important to ensure that briefings are co-ordinated and attendees at meetings planned in advance.

- **People who use our services, their carers and the public.** All our organisations have a range of ways and means of communicating and engaging with patient and carer groups and the wider public. We will use existing patient and public involvement networks to share information and gather feedback and insights. For those that would like to be more involved we will harness their interest to inform and increase the reach of our messages through local communities. We will also use our corporate channels – particularly our websites and social media – to ensure we keep those who are interested informed and up to date.

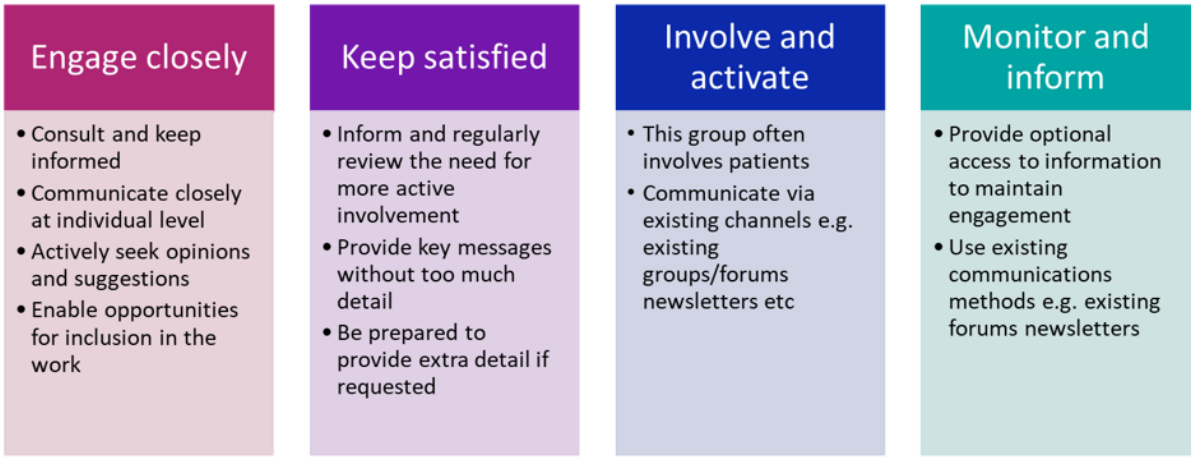
- **Voluntary, community and patient groups (including PPGs, FT governors and patient and community partners) and Healthwatch.** As representatives of their members, these groups will also have a keen interest in their local health services and any proposals that may impact on them. We will ensure these groups are regularly communicated with and have opportunities to engage. Any communications and engagement will reflect the statutory role of FT governors.

- **Health and care system partners.** This group includes colleagues from partner NHS Trusts, local authorities, other statutory organisations and others who deliver care alongside us. These stakeholders will have a keen interest in how the proposed organisation will be shaped and how services will be delivered. As key stakeholders, communications and engagement will primarily be maintained through existing forums and relationships, with key briefings as required.

- **Media.** The local media can be a powerful vehicle to help us to communicate key messages to the public and stakeholders. However, there is also inherent risk that information is leaked, and coverage is shaped by rumour and hearsay.

- We will aim to get fair coverage by taking a more proactive approach, ensuring local press are aware of our plans, including providing background briefings as plans develop.
- At all key milestones, all partner organisations will agree an approach to proactive/ reactive media handling.
- A stakeholder mapping has been undertaken, outlining the influence and interest of each stakeholder group. This will be regularly reviewed throughout the course of the programme. The position of each stakeholder group determines the tactics we will undertake, as shown in figure 27 below:

Figure 27: Stakeholder tactics



17. The stakeholder mapping is further broken down into a comprehensive stakeholder list. A lead organisation has been identified for each stakeholder.

Key messages (as of 8 December)

Context:

18. Across Hampshire and Isle of Wight community and mental health services are provided by several organisations.
19. Care is fragmented, with inequitable patient outcomes and often people are cared for by many different organisations during their healthcare journey. With so many providers, it is difficult to make positive changes across a big geography, and the same changes across all organisations.
20. It is important that services are set up to meet the needs of the people we serve now and in the future.
21. We want to ensure that people have equitable access, experience and outcomes from the care they receive.
22. We are proud of the dedication, compassion and expertise of staff and want to enable them to work even more closely to benefit the people they support.
23. Provider organisations have already been taking steps to further join up services and work even closer across organisation boundaries.

The review:

24. In January 2022 the Hampshire and Isle of Wight ICS commissioned a review of community and mental health services.

25. The purpose of the review was to understand how to best meet the current and future demands of our local populations.

26. The review looked carefully at the evidence, including clinical evidence and patient experience and insight, and involved a number of partners. A range of different options were put forward and the review made recommendations for us to consider as a system.

The recommendations from the review:

27. The review resulted in the following five recommendations:

1. **A new Trust should be created for all community and mental health services across Hampshire and Isle of Wight, with local divisions to focus on our communities.** All existing providers are being engaged and are coordinating this work with the ICB, and identifying a roadmap on developing this work further, the risks and mitigations required.
2. **A review of community physical health beds should be undertaken, in a partnership between community, acute and primary care providers and local authorities.** This is required to ensure the highest possible levels of patient safety, quality and experience are in place and that patients are receiving care in the most appropriate setting for their needs.
3. **Develop a systemwide clinical strategy for community and mental health services that focuses on prevention, early intervention and patient centred care.** This will be led by our community and mental health providers with input from service users and key system partners, such as primary care and local authorities.
4. **A clear, systemwide strategy for place and local leadership is needed.** This will help to identify local integration across health and care and wider determinants such as education.
5. **Establishing a more strategic approach to the funding for community and mental health services to address the current inequities.** The approach should acknowledge financial complexities to date and reflect on the overall system performance in communities that have historically had higher levels of investment in community and mental health services, considering how the overall health spend available can be better utilised.

28. One of the review's key recommendations is that a new organisation be formed, to bring together all NHS community and mental health services provided in Hampshire and the Isle of Wight.

29. Bringing together services would improve consistency of care between these services which are currently responsible for different parts of the care pathway. It would also improve equity of access to care.

30. Local services will continue to be delivered: this recommendation is about improving the way these services work together.

31. There is no risk to the delivery of local services as a direct result of this work.

32. The ICB has formally accepted the recommendations made within the review. These are now being taken forward.

Our response to the recommendation:

33. Working even closer together is the right approach to take for the benefit of the people who use our services, their carers and families and local communities.

Next steps / governance / process

34. Each of the provider organisations, and their respective Boards, will need to formally consider the review's recommendations.

35. The providers are developing a strategic case which will describe in more detail the recommendation to create a new organisation alongside other potential options that the review considered.

36. The strategic case will be presented to each provider organisation's Board with a preferred option on how best we can work together.

37. With support from each Board, the case will then be presented to NHSE.

38. If the strategic case is approved, we will move to full business case.

39. We have established an internal provider programme governance structure to take forward the recommendation. The Programme Board includes members from executive teams and a Programme Team is made up of representatives from different workstreams, each led by a steering group.

40. Our ambition is to have created a new organisation, pending the necessary approvals, on 1 April 2024.

Commitment to ongoing communication and engagement:

41. We are committed to working with our staff, people who use our services, their families and/carers, and the organisations with which we work, throughout this process.

42. We are working with Healthwatch and others to help shape our engagement and communication plans.

Supporting materials

43. To support our communications and engagement activity a range of channels will be used, and materials developed. We will be flexible enough to adapt and change to the needs of the audience.

44. These include:

- Core narrative and key messages document
- Internal and external frequently asked questions
- Copy for websites and intranet sites
- Media and stakeholder briefings, including one to one meetings
- Staff engagement sessions
- Virtual calls and Q&As
- Video content for internal communications

- Social media as needed e.g. to promote opportunities for engagement
- Engagement and coproduction platforms
- Content for internally managed bulletins
- Syndicate articles for partner communication channels
- Press releases and briefings for key announcements/milestones/activity

Risks and mitigations

Risks and mitigations have been noted as part of the programme of work.

Resources

45. The delivery of this strategy will be jointly led by the Provider Communications and Engagement Steering Group. It will be delivered in partnership with communication and engagement leads from all organisations.

46. The delivery is dependent upon sufficient resource to backfill current workloads within Solent, Southern, the Isle of Wight NHS Trust and Sussex Partnership communication and engagement teams, as well as additional roles. Non-pay budget will also be required for each provider organisation to develop communication and engagement materials and activities.

Evaluation

47. Evaluation will be measured through:

- Level of support from stakeholders
- Balanced media coverage
- Support from staff for direction of travel
- Broad engagement and participations activity

Activity plan (Updated: 9 February 2022)

- Key phases in communications and engagement which will be reflected in the plan going forwards
    - **Phase 1** – Development of Strategic case – Sharing case for change and developing plans for engagement in development of full business case
    - **Phase 2 –** Strategic case approval – Ensuring stakeholders are fully aware of the outcome, next steps and opportunities for involvement
    - **Phase 3 –** Full business case development – More targeted, specific communications
    - **Phase 4 –** Full business case approval – Communicating outcome and next steps
    - **Phase 5 -** Mobilisation
    - **Phase 6 -** Go live – Launching new organisation and describing next steps for ongoing communications and engagement, e.g. first 100 days

Date	Audience	Activity	Responsible	Progress
Set up				
31 August	Provider staff	Intranet pages with FAQs section and details of engagement opportunities	Provider comms	Complete – Solent, Southern
31 August	N/A	Develop feedback logging tool and process for account managers to use	Provider engagement leads	Complete
30 September	Provider staff FAQs	Shared question and answer document for provider staff, with HR input	Provider comms and HR	Available, continual update needed
N/A	External audiences	Strategic narrative and FAQs	Provider Comms	Comments received from partners. Developing further.

Date	Audience	Activity	Responsible	Progress
Set up				
30 September	N/A	Develop programme design identity	Provider comms	Complete – Project Fusion
October	Communities – the people who use our services, carers and families	Co-design, with Healthwatch and others, a comprehensive plan for the engagement of the people who use our services	Provider engagement leads with support from provider comms	Steering group established
November	External audiences	Create area on provider websites with narrative and FAQs and link to ICB report	Provider communication leads	Complete and comments received from Healthwatch to develop lines
November	Managers	Managers guide including key messages etc to help with staff briefings	Comms leads	

Date	Audience	Activity	Responsible	Progress
Phase 1: Development of strategic case				
Ongoing	Stakeholders	Conversations with stakeholders to gain support for strategic outline case	Provider orgs – local organisations to carry out own engagement	Monitoring responses to stakeholder letter and virtual session
Ongoing	'Engage closely' stakeholders	Proactively approach 'engage closely' stakeholders we haven't heard from	Provider orgs – local organisations to carry out own engagement	Monitoring responses to stakeholder letter and virtual session
7 June 2022	Provider staff	Letter from ICB and Provider CEOs to share recommendations from review	Provider/ ICB comms	Complete
7 June 2022	Stakeholders	Letter from ICB and Provider CEOs to share recommendations from review	Provider/ ICB comms	Complete
17 July 2022	IOW Healthwatch	Meeting with representatives to talk about review	IOW comms	Complete
22 July 2022	Healthwatch organisations	Letter from ICB in response to letter from collective Healthwatch organisations	ICB comms	Complete
27 July 2022	IOW Integrated Partnership Board	Paper presented to Board	IOW comms	Complete
28 July 2022	Provider staff	Letter from Provider CEOs to staff confirming next steps (SOC) and rough timelines	Provider comms	Complete
1 September 2022	Southampton HOSP	Briefing to Panel on the recommendations and	Provider and ICB comms	Complete

Date	Audience	Activity	Responsible	Progress
Phase 1: Development of strategic case				
		next steps. Southern/ Solent/ICB CEOs to attend		
During September	Provider staff	Staff engagement sessions	Provider comms	Ongoing
5 September 2022	Staff, public, partners	Mention of recommendations as part of conversation around looking to the future at Solent AGM	Solent comms	Complete
w/c 6 September	Senior leaders	Email to senior leaders asking for expressions of interest for clinical workstream leads	All comms	Complete – Solent, Southern, IOW TBC - Sussex
6 September	IOW staff – division engagement	Update to leaders	IOW comms	Complete
12 September	IWC Policy and Scrutiny Committee	Briefing to Panel on the recommendations and next steps.	IOW comms	Complete
20 September	Staff, public, partners, members, governors	Mention of recommendations as part of conversation around looking to the future at Solent AMM	Southern comms	Complete
22 September	Portsmouth HOSP	Update to panel included as part of Solent update	Solent comms	Complete
During September/ October	Provider staff	Ongoing staff engagement opportunities and capturing feedback/ FAQs	Provider orgs	Ongoing
w/c 3 October	Provider staff	Start of weekly communication with latest update to provider staff – every Monday	Provider comms	Ongoing

Date	Audience	Activity	Responsible	Progress
Phase 1: Development of strategic case				
w/c 3 October	Provider staff	Ongoing stories of partnership work in Friday comms (Friday Focus and Feel Good Friday)	Provider comms	Ongoing
19 October	Provider staff leadership team	Joint leadership event	Provider organisations	Complete
w/c 24 October	Stakeholders	Letter from Provider CEOs confirming next steps (SOC) and offering opportunity for virtual conversation, feeding into Strategic Outline Case	Provider comms	Complete
During Oct	Provider staff	Opinion pieces from leaders	Provider comms	Lesley Stevens, IOW w/c 14 November
25 November	Healthwatch	Meeting with Healthwatch to coproduce engagement plan	Provider engagement leads	Complete
8 November	Solent Mind	Meeting with partners, Solent Mind	Ron Shields and Andrew Strevens	To be added to engagement log
10 November	Stephen Morgan MP	Conversation as part of visit to St Mary's, Portsmouth	Andrew Strevens	Complete
22 November	Interested stakeholders	Virtual stakeholder engagement event	Provider Communication teams	Complete
23 November	Southern governors	Session with Southern governors	Southern engagement lead	Complete
25 November	Solent senior leaders	Update at Senior leaders event	Solent Communications	Complete
29 November	Hampshire HASC	Briefing to Panel on the recommendations and next steps	Southern and Solent comms, with ICB	Complete

Date	Audience	Activity	Responsible	Progress
Phase 1: Development of strategic case				
5 December	IOW Scrutiny panel	Briefing to Panel on the recommendations and next steps	IOW NHS Trust	Complete
15 December	Portsmouth HOSP	Briefing as part of wider Southern update to HOSP	Southern Comms	Complete
10 January	Healthwatch and community partners	Meeting with engagement working group to agree approach and plan bigger engagement event	Engagement leads	Complete
TBC	Meeting with Penny Mordant MP	Andrew Strevens meeting Penny Mordaunt MP	Solent Comms	Being scheduled by AS PA
19 January	Southern stakeholder newsletter	Update on the programme and current position	Southern Comms	Complete
18 January	Public Health leads, PCC, SCC, HCC	Briefing from Clinical Delivery Group leads	Southern and Solent Comms	Complete
26 January	Portsmouth HOSP	Briefing to HOSP on Project Fusion and engagement activities to date	Solent Comms	
2 February	Healthwatch partners	Meeting with Healthwatch Chairs and Officers to explain how the project works – Andrew Strevens, Paula Anderson and Lesley Stevens	Comms and engagement leads	
2 February	Meeting with Royston Smith MP	Andrew Strevens meeting Royston Smith MP	Solent Comms	
7 February	Meeting with Stephen Morgan MP	Andrew Strevens meeting Stephen Morgan MP	Solent Comms	
20 February	Provider partner staff meeting	Virtual meeting with partner employees for update and Q&A	Comms leads	

Date	Audience	Activity	Responsible	Progress
Phase 1: Development of strategic case				
22 February	Senior staff and partners (two partner meeting)	Face to face event with senior leaders in the morning and partners in the afternoon	Comms and OD leads	Communication sent to partners with invite.
XXX	Southern Health working in partnership committee	Meeting with engagement working group	Engagement leads	
Prior to strategic case approval	OSC briefing	Written briefing to all Scrutiny Panels on Project Fusion	Comms leads	
Prior to strategic case approval	MP briefing	Written briefing to all MPs on Project Fusion, with offer of opportunity to meet to discuss further	Comms leads	
TBC March	Solent stakeholder newsletter	Update on the strategic case and current situation	Solent Comms	
Milestone: Strategic Case approval (March Board review)				

Date	Audience	Activity	Responsible	Progress
Phase 2: Strategic case approval				
TBC April	Interested stakeholders	Virtual stakeholder engagement event	Comms leads	
TBC June	Joint SLT	Face to face SLT event	Comms and OD leads	
To be planned: Internal announcement of approval. Proactive media briefings, stakeholder communication to all stakeholders, increase engagement with 'engage closely stakeholders' including account handling approach				
Phase 3: Development of full business case				
To be developed				
Phase 4: Full business case approval				
Milestone: Business Case approval (August 2023) – Joint communication to be agreed when Business Case approved				
To be developed				
Phase 5: Mobilisation comms				
To be developed				
Phase 6: Go live comms				
To be developed				
Milestone: Go live (April 2024)				
To be developed				

Item 10.3

Communications and engagement approach

Version	Date	Author	Comments	Approval
V1	August 2022	Tom Westbury and Andrea Hewitt		Solent, Southern, Sussex, IOW and ICB
V1.1	September 2022	Andrew Hewitt and Tom Westbury	Communications messaging updated and action plan amended	
V1.2	November 2022	Andrew Hewitt and Tom Westbury	Communications messaging updated and action plan amended. Update to communications assurance and sign off process.	
V1.3	December 2022	Andrea Hewitt and Tom Westbury	Updated following comments from Katy Cox, Programme Director and from Sussex NHS Partnership Foundation Trust	
V1.4	January 2023	Andrea Hewitt and Tom Westbury	Updates to key messages following feedback from Healthwatch	
V1.5	March 2023	Andrea Hewitt and Tom Westbury	Update to messaging, communications plan etc	

Background

Across Hampshire and Isle of Wight community and mental health services are provided by several organisations working closely together: Solent NHS Trust, Southern Health NHS Foundation Trust, Isle of Wight NHS Trust and Sussex Partnership NHS Foundation Trust as well as a range of other NHS, local authority and voluntary and independent sector organisations.

A key priority for the NHS in Hampshire and the Isle of Wight is ensuring that communities have equal access to services and experience the same outcomes. We know that over the coming years the demand for community and mental health services will increase. Our physical and mental health services are already responding to increasing need, both in terms of the number being referred and the complexity of issues they present with. Against this backdrop, continuing to improve and transform service provision as well as having an even greater focus on integration between mental and physical health is vitally important.

In January 2022 the Hampshire and Isle of Wight Integrated Care System commissioned a review of community and mental health services. The purpose of the review was to understand how to best meet the current and future demands of our local populations. The review looked carefully at the evidence and involved a number of partners. A range of different options were put forward and the review made recommendations for us to consider as a system.

The work, which took place during March and April, was led by an independent organisation and involved a range of clinicians, partners and stakeholders. It considered a wide range of data and information, including patient experience and insight, as well as feedback from one-to-one interviews and roundtable discussions.

One of the review's key recommendations is that a new organisation be formed, to bring together all NHS community and mental health services provided in Hampshire and the Isle of Wight by Solent NHS Trust, Southern Health NHS Foundation Trust, Isle of Wight NHS Trust and Sussex Partnership NHS Foundation Trust, that delivers Child and Adolescent Mental Health Services (CAMHS).

These organisations (the providers) are now taking forward this recommendation working closely with the Integrated Care Board (ICB). This work is known as Project Fusion.

This document describes the principles, approach and initial activity (shown in appendix 2) we will undertake to ensure a coordinated approach to communication and engagement across partners. It will be refreshed as the programme develops and moves through different phases:

- **Phase 1** – Development of Strategic case – Sharing case for change and developing plans for engagement in development of full business case
- **Phase 2** – Strategic case approval – Ensuring stakeholders are fully aware of the outcome, next steps and opportunities for involvement
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PROJECT FUSION
Bringing together community, mental health and learning disability services

This plan links to the overall strategic communications priorities for the Integrated Care Board which includes the acute services partnership between Isle of Wight NHS Trust and Portsmouth Hospitals NHS Trust. There are clear links between this ICB strategic priority and Project Fusion.

Aims

- Deliver co-ordinated communications and engagement activity
- Support the delivery of timely and meaningful community and employee engagement programmes, led by each provider engagement and HR and OD leads respectively
- Shape key messages and ensure these are communicated and understood by all audiences.
- As far as possible ensure that media reporting is factual and accurate.

Principles

Our communications and engagement activities will be guided by the following strategic principles:

- **Patient-centred**
  Front and centre of our approach should be a focus on the patient and their carers. The driving force behind the recommendation is centred around delivering joined-up, high quality and equitable services. Our approach will be to focus our narrative on the benefit to the people who use of our services and their carers and ensure meaningful opportunities to engage and co-produce.

- **Clinically led**
  Clinical leadership, and peer to peer engagement, is central to our communications and engagement approach – leaders should be highly visible through our communications and engagement activities. Clinical input is also fundamental in order to articulate the positive impact of any changes on patients and service users.

- **Honest and transparent**
  We will be open, honest, and transparent in our communications about the way forward. Where there may be an impact on staff members or on how people access services, we will ensure this is fully understood. We will also be clear about the aspects of the proposals that can be influenced, and what particularly we are seeking views on.

- **Two-way local engagement**
  The engagement we undertake with stakeholders, staff and partners will be timely, to allow adequate opportunity for queries and clarification. We want to deliver changes that our stakeholders, staff and communities can co-produce, support and endorse. We will build upon existing relationships we have based around place.

Approach to collaborative communications and engagement

- **Provider-led**

  Communications and engagement activity relating specifically to the recommendation to create a new organisation will be led by the providers' communication and engagement leads, supported by colleagues from the Integrated Care Board.

Communications and engagement activity relating to the overarching community and mental health review, and wider set of recommendations, will be led by the Integrated Care Board, supported by colleagues from the provider organisations.

- **Co-ordinated**
  All the organisations involved in the transformation will work together to ensure key messages are agreed and signed off by each respective organisation. These will be updated regularly via the Communications and Engagement Steering Group.

  Organisations can create their own communications and engagement activity aligned to the agreed messaging without the need for additional sign off. However, partners will update one another on activity regularly (see oversight and assurance).

  Feedback and outcomes from communications and engagement activity will be shared via the Communications and Engagement Steering Group, as well as logged in the engagement log, to inform the programme.

- **Oversight and assurance**
  Communications and engagement colleagues are experienced at working across organisational boundaries.

  The provider organisations have established a dedicated provider Communications and Engagement Steering Group which reports to the Provider Programme Team and onto the Programme Board. This is attended by communications and engagement representatives from all provider organisations involved, as well as colleagues from the ICB. It provides an update into the ICB CMH Review Communications Group and the Project Fusion Programme Team meeting.

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  Sign off is also subject to existing national media handling protocols.

  Media coverage should be monitored and shared with partner communications leads and any correction, clarification or rebuttal handled jointly.

Spokespeople will be agreed between organisations depending on the line of enquiry. The preference would be for clinical spokespeople.

Approach to engagement

We describe 'communications and engagement' and 'community engagement' as two different and complementary types of activity.

All partners are committed to ensuring patients are front and centre of our approach, which will be clinically-led, transparent, and inclusive. The engagement we undertake with local communities, staff and stakeholders will be two-way, to ensure that everyone's voices are heard and the changes put in place are widely endorsed.

Our approach is aligned to the principles set out in the most recent NHS England statutory guidance on working in partnership with people and communities. We recognise that there is no one size fits all approach to effectively inform, involve, and work alongside our wide range of stakeholders and partners. Our approach can be viewed as a scale ranging from giving information to full participation and coproduction, as described in the image below.

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partnership enables the active involvement in the cocreation of solutions to local issues with care and treatment, and in the design, development and delivery of those services. Our approach to community engagement is based on the principles of a strengths-based approach; that is recognising our communities as being an asset, with strengths, knowledge, experience and skills to offer this programme of change

The community engagement approach is designed to ensure that the voice of our local communities actively informs the development of the new organisation. This includes being equal partners in the design and development of new clinical pathways, and the implementation of a strengths based approach to service design and delivery.

A community engagement working group has been established to oversee and support the engagement programme which includes Healthwatch, representatives of currently unrepresented communities and partner community engagement leads. Engagement will continue through the preparation of the strategic case, full business case, to day one of the new organisation and beyond. We will seek to understand more about what a great community and mental health organisation looks like for both current users of our services, their families and carers and prospective users for the future. A community engagement delivery plan can be seen in appendix 2.

Audiences

Audiences have been categorised into the following groups.

Staff

Staff, including volunteers, and their respective representatives across all organisations will be regularly communicated with and kept up to date. The key messages will ensure messaging and communications activity are consistent.

Stakeholders

- **Scrutiny committees, councillors, and MPs** play an important role as representatives of their local communities, raising concerns and scrutinising plans and services on their behalf. They also act as opinion formers, both informing and reflecting public opinion and their ongoing support is important. We will provide regular updates to the scrutiny committees across our geography on the partnerships. This will take the form of written updates, informal meetings (collectively when it makes sense to do so) and specific briefings through existing statutory meetings. All of our organisations have contact with these stakeholders and so it will be important to ensure that briefings are co-ordinated and attendees at meetings planned in advance.

- **People who use our services, their carers and the public.** All our organisations have a range of ways and means of communicating and engaging with patient and carer groups and the wider public. We will use existing patient and public involvement networks to share information and gather feedback and insights. For those that would like to be more involved we will harness their interest to inform and increase the reach of our messages through local communities. We will also use our corporate channels – particularly our websites and social media – to ensure we keep those who are interested informed and up to date.

- **Voluntary, community and patient groups (including PPGs, FT governors and patient and community partners) and Healthwatch**

As representatives of their members, these groups will also have a keen interest in their local health services and any proposals that may impact on them. We will ensure these groups are regularly communicated with and have opportunities to engage. Any communications and engagement will reflect the statutory role of FT governors.

- **Health and care system partners**

  This group includes colleagues from partner NHS Trusts, local authorities, other statutory organisations and others who deliver care alongside us. These stakeholders will have a keen interest in how the proposed organisation will be shaped and how services will be delivered. As key stakeholders, communications and engagement will primarily be maintained through existing forums and relationships, with key briefings as required.

- **Media**

  The local media can be a powerful vehicle to help us to communicate key messages to the public and stakeholders. However, there is also inherent risk that information is leaked, and coverage is shaped by rumour and hearsay.

  We will aim to get fair coverage by taking a more proactive approach, ensuring local press are aware of our plans, including providing background briefings as plans develop.

  At all key milestones, all partner organisations will agree an approach to proactive/ reactive media handling.

A stakeholder mapping has been undertaken, outlining the influence and interest of each stakeholder group. This will be regularly reviewed throughout the course of the programme. The position of each stakeholder group determines the tactics we will undertake.

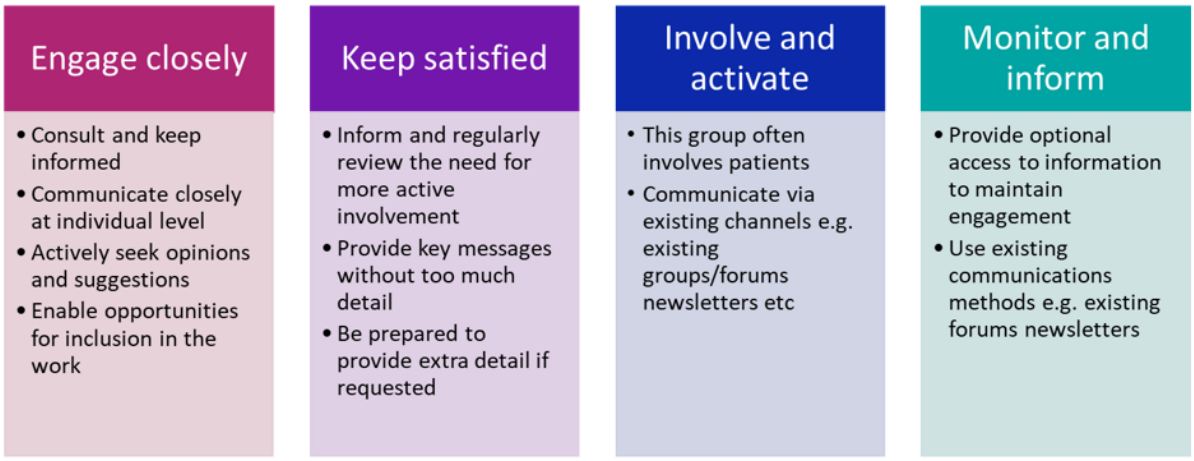


Figure 1: Stakeholder tactics

The stakeholder mapping is further broken down into a comprehensive stakeholder list which is available on request. A lead organisation has been identified for each stakeholder.

Key messages (as of March 2023)

Context:

- Across Hampshire and Isle of Wight community and mental health services are provided by several organisations.
- Care is fragmented, with inequitable patient outcomes and often people are cared for by many different organisations during their healthcare journey. With so many providers, it is difficult to make positive changes across a big geography, and the same changes across all organisations.
- It is important that services are set up to meet the needs of the people we serve now and in the future.
- We want to ensure that people have equitable access, experience and outcomes from the care they receive.
- We are proud of the dedication, compassion and expertise of staff and want to enable them to work even more closely to benefit the people they support.
- Provider organisations have already been taking steps to further join up services and work even closer across organisation boundaries.

The review:

- In January 2022 the Hampshire and Isle of Wight Integrated Care System commissioned a review of community and mental health services.
- The purpose of the review was to understand how to best meet the current and future demands of our local populations.
- The review looked carefully at the evidence, including clinical evidence and patient experience and insight, and involved a number of partners. A range of different options were put forward and the review made recommendations for us to consider as a system.

The recommendations from the review:

- The review resulted in the following five recommendations:
    1. **A new Trust should be created for all community and mental health services across Hampshire and Isle of Wight, with local divisions to focus on our communities**. All existing providers are being engaged and are coordinating this work with the ICB, and identifying a roadmap on developing this work further, the risks and mitigations required.
    2. **A review of community physical health beds should be undertaken, in a partnership between community, acute and primary care providers and local authorities.** This is required to ensure the highest possible levels of patient safety, quality and experience are in place and that patients are receiving care in the most appropriate setting for their needs.
    3. **Develop a systemwide clinical strategy for community and mental health services that focuses on prevention, early intervention and patient centred care.** This will be led by our community and mental health providers with input from service users and key system partners, such as primary care and local authorities.

4. **A clear, systemwide strategy for place and local leadership is needed.** This will help to identify local integration across health and care and wider determinants such as education.
5. **Establishing a more strategic approach to the funding for community and mental health services to address the current inequities.** The approach should acknowledge financial complexities to date and reflect on the overall system performance in communities that have historically had higher levels of investment in community and mental health services, considering how the overall health spend available can be better utilised.

- One of the review's key recommendations is that a new organisation be formed, to bring together all NHS community and mental health services provided in Hampshire and the Isle of Wight.
- Bringing together services would improve consistency of care between these services which are currently responsible for different parts of the care pathway. It would also improve equity of access to care.
- Local services will continue to be delivered: this recommendation is about improving the way these services work together.
- Solent NHS Trust, Southern Health NHS Foundation Trust, Sussex Partnership and Isle of Wight NHS Trust are now taking forward the work to create a new community, mental health and learning disability provider. This work is called Project Fusion.
- The bringing together of existing services of the four organisations does not in itself change services. Bringing the organisations into one Hampshire and Isle of Wight-wide organisation will provide the platform from which services can be improved or changed. Any emerging proposals to change services will be engaged and consulted upon as appropriate.

Next steps / governance / process

- The strategic case describes why we want to bring services together, the options we considered, the emerging strategy for our clinical services and why we are confident that the benefits of bringing services together into a new organisation outweigh the potential risks and costs. It also sets out how we are approaching the next phase of the programme to develop the full business case.
- The strategic case has been approved by each provider organisation's Board.
- The case will be presented to NHS England for regulatory review.
- We have established an internal provider programme governance structure.
- The Programme Board includes members from executive teams and a Programme Team is made up of representatives from different workstreams, each led by a steering group.
- Our ambition is to have created a new organisation, pending the necessary approvals, on 1 April 2024.

Commitment to ongoing communication and engagement:

- We are committed to working with our staff, people who use our services, their families and/carers, and the organisations with which we work, throughout this process.
- We are working with Healthwatch and others to help shape our engagement and communication plans.

Supporting materials

To support our communications and engagement activity a range of channels will be used, and materials developed. We will be flexible enough to adapt and change to the needs of the audience.

These include:

- Core narrative and key messages document
- Internal and external frequently asked questions
- Copy for websites and intranet sites
- Media and stakeholder briefings, including one to one meetings
- Staff engagement sessions
- Virtual calls and Q&As
- Video content for internal communications
- Social media as needed e.g. to promote opportunities for engagement
- Engagement and co-production platforms
- Content for internally managed bulletins
- Syndicate articles for partner communication channels
- Press releases and briefings for key announcements/milestones/activity

Risks and mitigations

Risks and mitigations have been noted as part of the programme of work.

Resources

The delivery of this strategy will be jointly led by the Provider Communications and Engagement Steering Group. It will be delivered in partnership with communication and engagement leads from all organisations.

The delivery is dependent upon sufficient resource to backfill current workloads within Solent, Southern Health, the Isle of Wight NHS Trust and Sussex Partnership communication and engagement teams, as well as additional roles. Non-pay budget will also be required for each provider organisation to develop communication and engagement materials and activities.

Evaluation

Evaluation will be measured through:

- Level of support from stakeholders
- Balanced media coverage
- Support from staff for direction of travel
- Broad engagement and participation activity

Activity plan (March 2022)

Key phases in communications and engagement which will be reflected in the plan going forwards

- **Phase 1** – Development of Strategic case – Sharing case for change and developing plans for engagement in development of full business case
- **Phase 2** – Strategic case approval – Ensuring stakeholders are fully aware of the outcome, next steps and opportunities for involvement
- **Phase 3** – Full business case development – More targeted, specific communications
- **Phase 4** – Full business case approval – Communicating outcome and next steps
- **Phase 5** - Mobilisation
- **Phase 6** - Go live – Launching new organisation and describing next steps for ongoing communications and engagement, eg first 100 days

Date	Audience	Activity	Responsible	Progress
Set up				
31 August	Provider staff	Intranet pages with FAQs section and details of engagement opportunities	Provider comms	Complete – Solent, Southern
31 August	N/A	Develop feedback logging tool and process for account managers to use	Provider engagement leads	Complete
30 September	Provider staff FAQs	Shared question and answer document for provider staff, with HR input	Provider comms and HR	Available, continual update needed
N/A	External audiences	Strategic narrative and FAQs	Provider Comms	Comments received from partners. Developing further.
30 September	N/A	Develop programme design identity	Provider comms	Complete – Project Fusion

October	Communities – the people who use our services, carers and families	Co-design, with Healthwatch and others, a comprehensive plan for the engagement of the people who use our services	Provider engagement leads with support from provider comms	Steering group established
November	External audiences	Create area on provider websites with narrative and FAQs and link to ICB report	Provider communication leads	Complete and comments received from Healthwatch to develop lines
November	Managers	Managers guide including key messages etc to help with staff briefings	Comms leads	
Phase 1: Development of strategic case				
Ongoing	Stakeholders	Conversations with stakeholders to gain support for strategic outline case	Provider orgs – local organisations to carry out own engagement	Ongoing
Ongoing	Provider SLT	Regular meetings and updates	Provider orgs	Ongoing
Ongoing	Southern Health working in partnership committee	Meeting with engagement working group	Southern engagement lead	Ongoing
Ongoing	Provider staff	Regular communication through internal channels to update on programme and how to get involved	Provider comms	Ongoing
7 June 2022	Provider staff	Letter from ICB and Provider CEOs to share	Provider/ ICB comms	Complete

		recommendations from review		
7 June 2022	Stakeholders	Letter from ICB and Provider CEOs to share recommendations from review	Provider/ ICB comms	Complete
17 July 2022	IOW Healthwatch	Meeting with representatives to talk about review	IOW comms	Complete
22 July 2022	Healthwatch organisations	Letter from ICB in response to letter from collective Healthwatch organisations	ICB comms	Complete
27 July 2022	IOW Integrated Partnership Board	Paper presented to Board	IOW comms	Complete
28 July 2022	Provider staff	Letter from Provider CEOs to staff confirming next steps (SOC) and rough timelines	Provider comms	Complete
1 September 2022	Southampton HOSP	Briefing to Panel on the recommendations and next steps. Southern/ Solent/ICB CEOs to attend	Provider and ICB comms	Complete
During September	Provider staff	Staff engagement sessions	Provider comms	Ongoing
5 September 2022	Staff, public, partners	Mention of recommendations as part of conversation around looking to the future at Solent AGM	Solent comms	Complete

w/c 6 September	Senior leaders	Email to senior leaders asking for expressions of interest for clinical workstream leads	All comms	Complete – Solent, Southern, IOW TBC - Sussex
6 September	IOW staff – division engagement	Update to leaders	IOW comms	Complete
12 September	IWC Policy and Scrutiny Committee	Briefing to Panel on the recommendations and next steps.	IOW comms	Complete
25 September	Hampshire CAMHS staff	Comms to Hampshire Comms staff	Sussex	Complete and then ongoing
20 September	Staff, public, partners, members, governors	Mention of recommendations as part of conversation around looking to the future at Solent AMM	Southern comms	Complete
22 September	Portsmouth HOSP	Update to panel included as part of Solent update	Solent comms	Complete
During September/ October	Provider staff	Ongoing staff engagement opportunities and capturing feedback/ FAQs	Provider orgs	Ongoing
w/c 3 October	Provider staff	Start of weekly communication with latest update to provider staff – every Monday	Provider comms	Ongoing
w/c 3 October	Provider staff	Ongoing stories of partnership work in Friday comms (Friday Focus and Feel Good Friday)	Provider comms	Ongoing
13 October	Southampton Healthwatch	Update about programme as part of	Southern engagement	Complete

		wider face-to-face meeting		
19 October	Provider staff leadership team	Joint leadership event	Provider organisations	Complete
w/c 24 October	Stakeholders	Letter from Provider CEOs confirming next steps (SOC) and offering opportunity for virtual conversation, feeding into Strategic Outline Case	Provider comms	Complete
During Oct	Provider staff	Opinion pieces from leaders	Provider comms	Lesley Stevens, IOW w/c 14 November
25 November	Healthwatch	Meeting with Healthwatch to coproduce engagement plan	Provider engagement leads	Complete
8 November	Solent Mind	Meeting with partners, Solent Mind	Paula Anderson and Andrew Strevens	Complete
10 November	Stephen Morgan MP	Conversation as part of visit to St Mary's, Portsmouth	Andrew Strevens	Complete
22 November	Interested stakeholders	Virtual stakeholder engagement event	Provider Communication teams	Complete
23 November	Southern governors	Session with Southern governors	Southern engagement lead	Complete
25 November	Solent senior leaders	Update at Senior leaders event	Solent Communications	Complete
25 November	Healthwatch and community partners	Face to face update re programme and next steps	Provider engagement leads	Complete

29 November	Hampshire HASC	Briefing to Panel on the recommendations and next steps	Southern and Solent comms, with ICB	Complete
5 December	IOW Scrutiny panel	Briefing to Panel on the recommendations and next steps	IOW NHS Trust	Complete
15 December	Portsmouth HOSP	Briefing as part of wider Southern update to HOSP	Southern Comms	Complete
15 December	Healthwatch Chairs and Leads Officers quarterly meeting	Face to face briefing	Solent engagement	Complete
6 January	Steve Brine MP	Update as part of wider face-to-face meeting	Southern CEO	Complete
10 January	Fusion working group	Meeting with engagement working group to agree approach and plan bigger engagement event	Engagement leads	Complete
17 January	South West community engagement group	Face to face meeting	ICB with Solent engagement	Complete
18 January	Southampton community engagement group	Face to face meeting	ICB with Solent engagement	Complete
19 January	Southern stakeholder newsletter	Update on the programme and current position	Southern Comms	Complete
18 January	Public Health leads, PCC, SCC, HCC	Briefing from Clinical Delivery Group leads	Southern and Solent Comms	Complete
19 January	Southern stakeholder newsletter	Update on Project Fusion	Southern comms	Complete
24 January	Southampton East engagement group	Face to face meeting	ICB with Solent engagement	Complete
26 January	Portsmouth HOSP	Briefing to HOSP on Project Fusion and	Solent Comms	Complete

		engagement activities to date		
26 January	North and mid engagement group	Face to face meeting	ICB with Solent engagement	Complete
During February	Hampshire CAMHS staff	Leadership meeting with teams to discuss opps and concerns	Sussex NHS	Complete
During February/ March	Southern membership and Solent past members	Information regarding Project Fusion	Solent and Southern Comms	Complete
1 February	Hampshire CAMHS staff	Face to face meeting	Sussex NHS	Complete
2 February	Healthwatch partners	Meeting with Healthwatch Chairs and Officers to explain how the project works – Andrew Strevens, Paula Anderson and Lesley Stevens	Comms and engagement leads	Complete
2 February	Meeting with Royston Smith MP	Andrew Strevens meeting Royston Smith MP	CEO Solent	Complete
7 February	Meeting with Stephen Morgan MP	Andrew Strevens meeting for verbal briefing	CEO Solent	Complete
10 February	Meeting with Penny Mordaunt MP	Andrew Strevens meeting for verbal briefing	CEO Solent	Complete
20 February	Provider partner staff meeting	Virtual meeting with partner employees for update and Q&A	Comms leads	Complete
21 February	Future communities event	Community conversation	Solent engagement	Complete
22 February	Senior staff and partners (two partner meeting)	Face to face event with senior leaders in the morning and partners in the afternoon	Comms and OD leads	Complete

26 February	Gurdwara Temple Southampton	Information sharing event	Solent engagement	Complete
26 February	Inclusion and Diversity Event Portsmouth	Information sharing event	Solent engagement	Complete
27 February	VCSE IOW	Community conversation	Solent engagement	Complete
28 February	VCSE IOW	Community conversation	Solent engagement	Complete
6 March	IWC Policy & Scrutiny Committee for Health and Social Care	IOW Strategic Partnerships update including both Project Fusion and Acute Partnership	IOW NHS Trust	Complete
7 March	Community engagement leads, Southampton	Community conversation	Solent engagement	Complete
8 March	IOW MHLD Transformation Programme Launch event	Information sharing and engagement (includes Project Fusion update)	IOW NHS Trust	Complete
Milestone: Strategic Case approval (March Board review)				
14 March	Hampshire HASC	Face to face event with latest Fusion update and discussion around whether Fusion is a substantial variation to services	Comms leads	Complete
16 March (tbc)	Ryde Town Council (Community Development Group)	Information sharing, community conversation	IOW NHS Trust	
w/c 20 March	Provider staff and key players	Written communication of strategic case approval and next steps	Comms leads	
w/c 20 March	OSC briefing	Written briefing to all Scrutiny Panels on Project Fusion	Comms leads	

27 March	IOW Safeguarding Children's Partnership	Information sharing - update on Project Fusion	IOW NHS Trust	
During March	Sussex staff	Survey to highlight opportunities and concerns	Sussex NHS	
During March	Solent stakeholder newsletter	Update on the strategic case and current situation	Solent Comms	
Pre-election period (27 March - 4 May)				
17 April	Southern membership	Update on Programme Fusion	Southern Comms leads	
25 April	Public Health leads, PCC, SCC, HCC	Briefing from Clinical Delivery Group leads	Southern and Solent Comms	
During May (following pre-election period	Stakeholders	Send letter to stakeholders with update and offer opportunity to meet and opportunity to join virtual event		
TBC June	Stakeholder	Virtual event		
TBC June	Joint SLT	Face to face SLT event	Comms and OD leads	
Phase 3: Development of full business case				
Phase 4: Full business case approval				
Milestone: Business Case approval (August 2023) – Joint communication to be agreed when Business Case approved				
To be planned: Internal announcement of approval. Proactive media briefings, stakeholder communication to all stakeholders, increase engagement with 'engage closely stakeholders' including account handling approach				
Phase 5: Mobilisation comms				
Phase 6: Go live comms				
Milestone: Go live (April 2024)				

Community engagement delivery plan

Community Engagement Plan fo


NHS

Item 10.4

PROJECT FUSION

Bringing together community, mental health and learning disability services

Next phase

21 March 2023

Executive summary

- Following approval by the four Trust Boards, the Strategic Case and supporting submissions were submitted to NHS England on 13 March to commence their review. The review is expected to include interviews with individual Execs and Chairs (in late March/April) and an “Exec to Exec” meeting in early May. The decision on the risk rating is expected to be taken at NHSE’s RSG meeting on 25 May.
- In parallel to NHSE’s review of the Strategic Case we are progressing with the next phase of the programme – due diligence and development of the Full Business Case, Patient Benefits Case and Post-Transaction Integration Plan. Further details on the key elements of the next phase of the programme are set out on slide X.
- Outline structures for the Full Business Case and Post-Transaction Integration Plan have been developed and shared with the Programme Board and Steering Groups. The structures reflect the requirements of NHS England’s Transactions Guidance.
- Steering Group scopes have been refreshed reflecting the key deliverables of this phase of the programme. These scopes are being reviewed by Steering Groups for approval at the Programme Team meeting on 18 April.
- The proposed go-live date for the new Trust remains 1 April 2024 and the latest programme timeline is set out on slide X.
- The Programme Board has reviewed the programme governance and made a number of enhancements for the next phase of the programme, as set out on slide X.
- Community and patient communications and engagement will be central throughout the next phase of the programme and the Communications and Engagement Plan is shared with Boards as a separate paper.

Key elements of the next phase of Project Fusion

Full Business Case

- Sets out how the transaction will be executed, what the benefits will be and how they will be delivered
- Programme timeline – Trust Boards approve in Oct 2023
- Likely chapters – vision for the new Trust, clinical strategy, operating model, enabling strategies (e.g. estates, digital , people), benefits, finances, transaction execution, comms and engagement

Example FBC (Yeovil-Somerset): https://yeovilhospital.co.uk/wp-content/uploads/2022/11/Full-Business-Case-for-merger-YDHFT_SFT-public.pdf

Detailed due diligence

- Reports set out findings as per scopes the Steering Groups have developed
- Programme timeline – Trust Boards approve in early Sept 2023

Patients Benefits Case

- Sets out the expected benefits for patients focusing on 4-6 “case studies” (service-level or cross-cutting)
- Programme timeline – submit drafts to NHSE in July 2023

Example PBC (Yeovil-Somerset): https://yeovilhospital.co.uk/wp-content/uploads/2022/12/Final-Patient-Benefits-Case-YDHFT_SFT-public-1.pdf

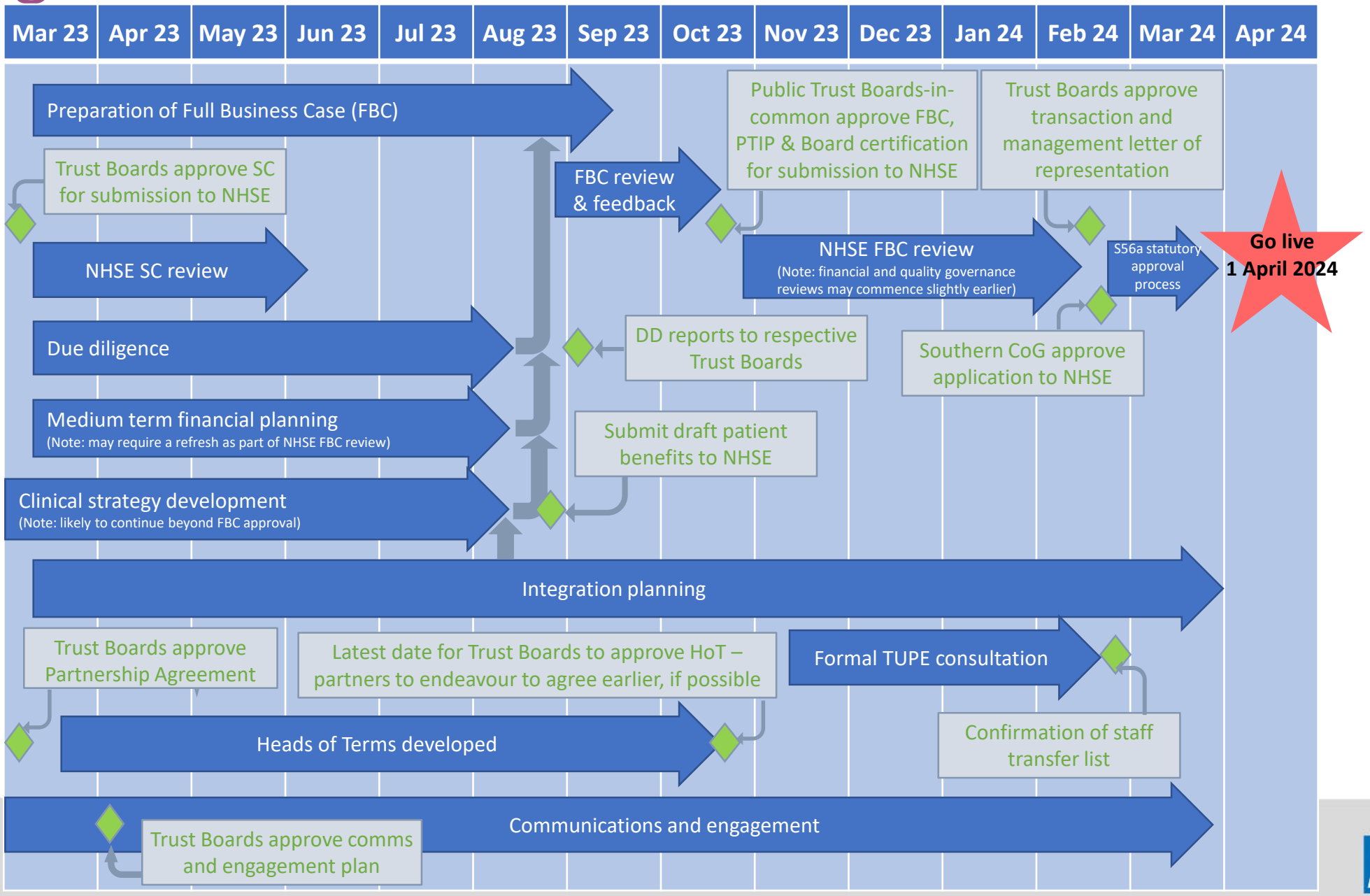
Post-Transaction Integration Plan (PTIP)

- Sets out programmes of work to integrate the Trusts – narrative with accompanying project plans (likely excel)
- Project plans are live document but Boards will approve latest version in Oct 2023 for submission to NHSE
- Activities generally categorised into Day 1, Day 100, Year 1, Years 2-3/5

PROJECT FUSION

NHS

Programme timeline as at March 2023



PROJECT FUSION

NHS

Timeline assumptions

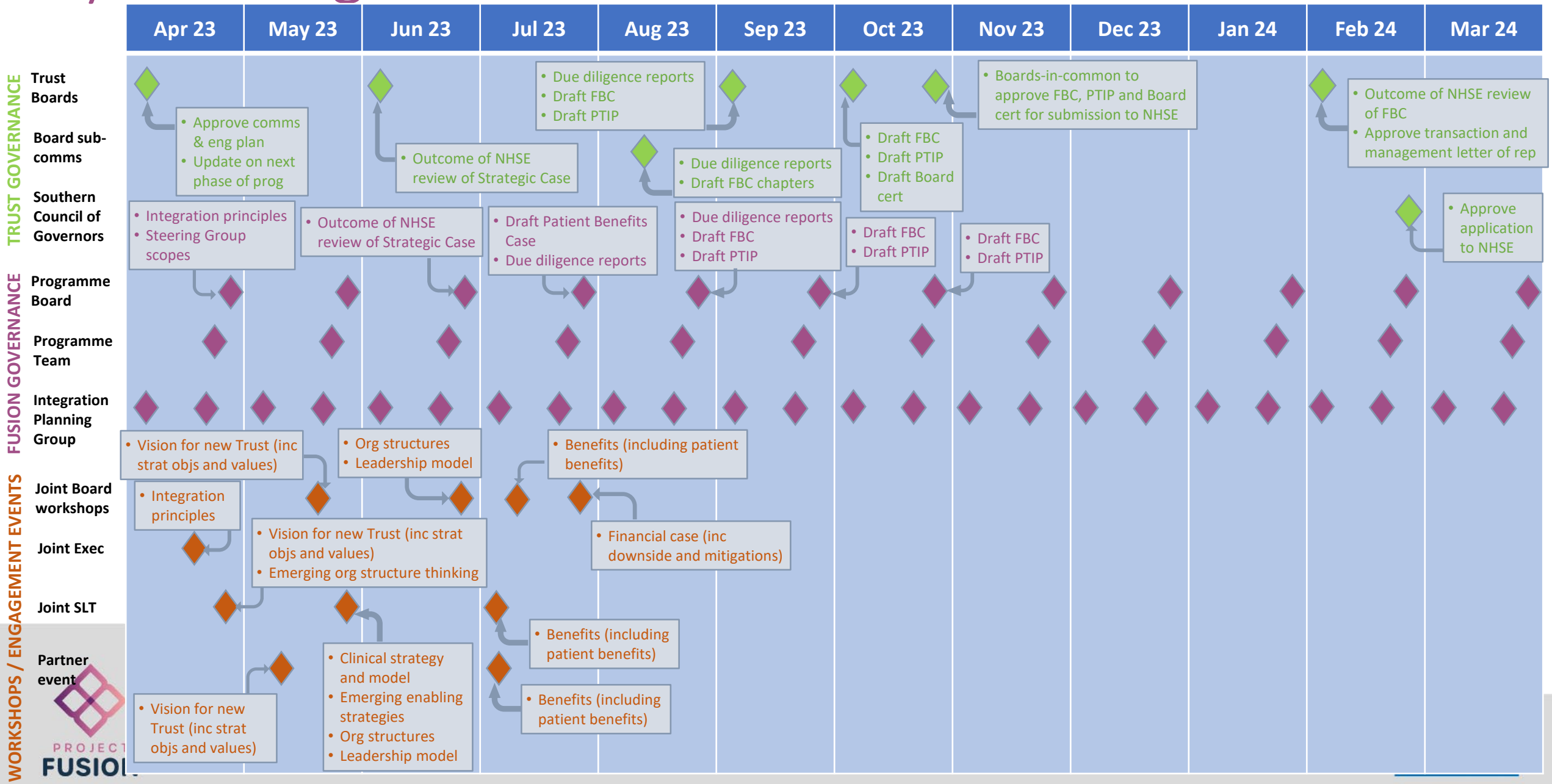
The timeline on the previous slide is based on the following assumptions:

- Services from Southern, Solent, Isle of Wight and Sussex Partnership (Hampshire CAMHS) will come together on the same day (1 April 2024), subject to commissioning decisions in respect of IoW and Sussex Partnership services;
- Formal public consultation is not required for the new Trust to be created;
- Creation of the new Trust is a significant transaction subject to detailed review by NHSE and the timeline assumes 4 months for NHSE's review at FBC stage (the Transactions Guidance states this typically takes 3-4 months; and
- The ICB is engaged and has oversight throughout the development of the FBC and a formal standalone review process is not required.

A detailed programme plan has been developed and is maintained by the programme team.

Key meetings

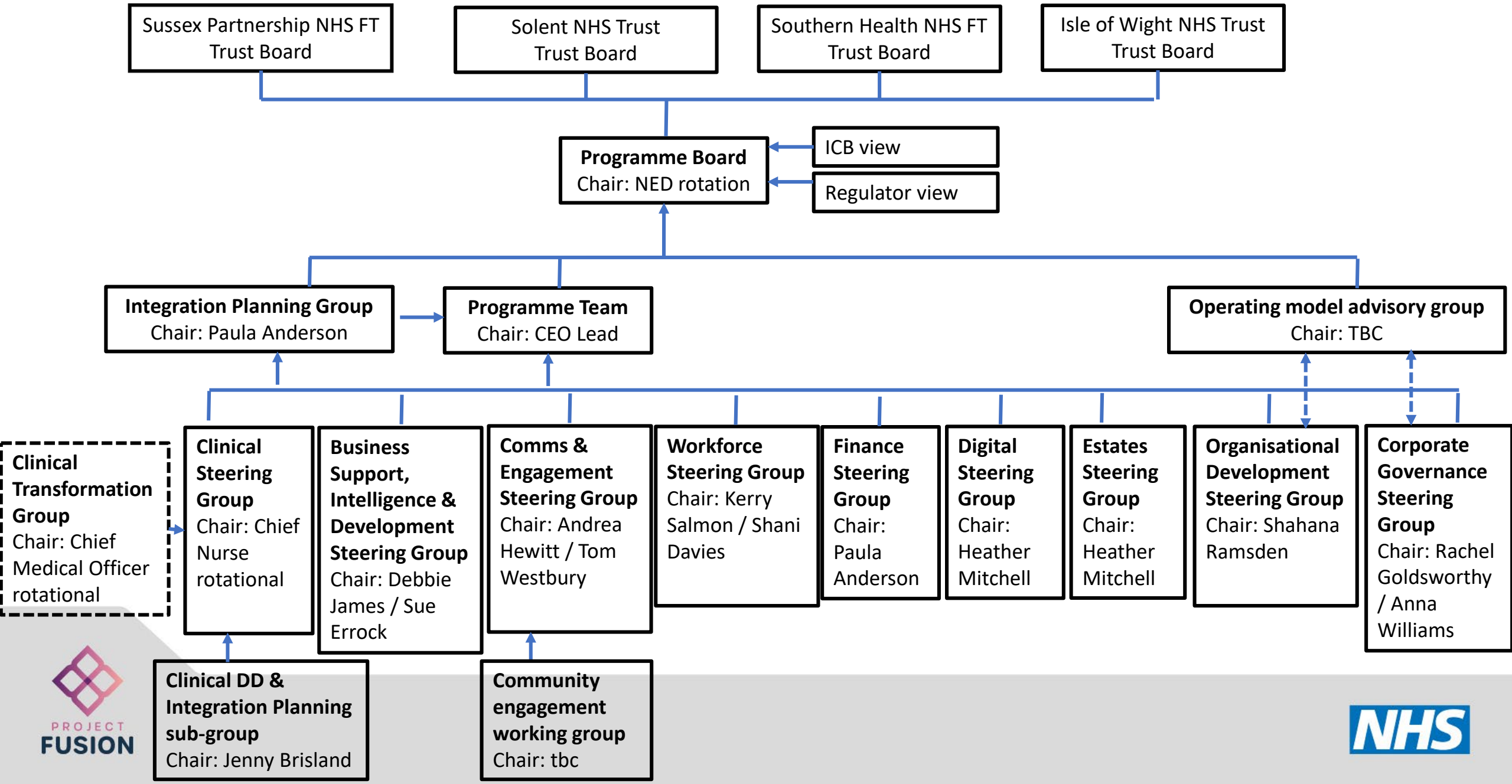
Note: this diagram is intended to show the key meetings at which key items will be considered, it is not exhaustive and will continue to evolve (for example, need to agree with the Governors their involvement in advance of formal approval of the application to NHSE to include development days and a governor working group)



Programme governance

- A programme governance structure is in place, as set out on the next slide.
- The Programme Board meets monthly. Since February 2023 the membership of the Programme Board has included Non-Executive Directors from Southern, Solent and IoW.
- It was agreed at the February Programme Board meeting that an Operating Model Advisory Group would be established to lead on the process to develop the vision and values for the new Trust and the organisational structures and leadership model. The Group will be informed by the work of and provide direction to Steering Groups as required (most notably the Organisational Development and Corporate Governance Steering Groups) and build on work to date which has included engagement at Joint SLT meetings and partner events. The membership of the Group will initially comprise the executive members of the Programme Board and the Group will report directly to the Programme Board.
- The Programme Team meets monthly and provides assurance to the Programme Board on progress of the Steering Groups against their agreed scopes. The nine Steering Groups report progress and risks to the Programme Team in highlight reports.
- It was agreed at the February Programme Board meeting that an Integration Planning Group (IPG) would be established to support collaboration in integration planning and manage inter-dependencies between Steering Groups. The IPG will meet fortnightly, include representatives from each of the Steering Groups and report to the Programme Team.
- Steering Groups have identified the additional resources needed to deliver their scopes and a process is in place for approval of resource requests.

Programme governance



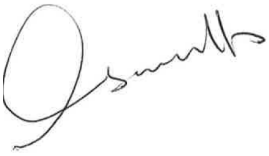
PROJECT FUSION

NHS

Report: In-Public Board Meeting

Item No.	11.1			Presentation to	In-Public Board Meeting		
Title of paper	People Committee Exception Report			Author	Tina King, Business Manager		
Purpose of the paper	To summarise the business transacted at the People Committee held on 16 March 2023						
Committees /Groups previous presented and outputs	N/A						
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X	
Action required	For decision		For assurance	X			
Summary of Recommendations and actions required by the author	The following reports were noted by the Committee: **Sub-Committee Exception Reports:** • The committee noted and discussed the received **People Forum** exception report. • **Joint Consultative Negotiating Committee Report –** No meeting held to report • **Wellbeing Oversight Meeting Exception Report -**No meeting held to report • **Joint Local Negotiating Committee (formerly DDNC) Exception Report** -No meeting held to report. **Equality Delivery System Update:** • The draft EDS Report was reviewed, and the Committee agreed that further discussion with stakeholders should take place to potentially change the overall status from 'developing' to 'achieving'. It was felt there was enough evidence to improve on this. The report will then go to Board in April for review. **Chief People Officer Report:** • A verbal update on current strategic matters including the People team update, Industrial action, an upcoming Support Staff recognition event, and project fusion. **Workforce Performance and Workforce Metrics Report:** • A revised report was presented, and feedback was received for further development and correlation with other data, trends and benchmarking to be included. **Board Assurance Framework:** • The BAF and its commentary was agreed. **Internal Audit and HR Self Audit:** • Timeline of audits completed so far was presented. Head of Recruitment team is auditing 100% of employment checks on a monthly basis and second review is completed to assess 50% of the employment checks. • PWC are completing an external audit to provide an independent review of the quality.							

	Health and Wellbeing Plan update: • The Committee was assured that all is on track and going to plan. • G2 go live (the new Occupational Health Records System) will go live in April. • The joint service model was discussed. **Employee Relations Assurance report:** • Amendments to the report were suggested to include commentary and learning from closed cases. • 'Improving People Practices' has been rolled out. **Staff Survey:** • Solent's results were pleasing. • Survey results and supporting information were shared with all services as soon as the Embargo was lifted on 9th March. **People Operations Update:** • Solent and Southern Health have merged the international recruitment teams. • International Recruitment and retention figures were shared. • Oleeo will enable more reporting on recruitment. **Workforce Planning Update:** • Workforce and Finance Plans will be submitted to ICB 16 March 2023.

To be completed by Exec Sponsor - Level of assurance this report provides:							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	Mike Watts, Non-Executive Director			Exec Sponsor signature:			

Item 11.2

Solent NHS Trust People Committee

TERMS OF REFERENCE

1 Constitution

1.1 The People Committee (the Committee) is a formal committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. The Committee is accountable to the Trust Board.

2 Purpose

2.1 The Committee is responsible for providing assurances to the Trust Board on all aspects of workforce and organisational development supporting the provision of patient care and the NHS people plan. In particular, ensuring the strategic objectives and trust ambitions are being delivered.

3 Duties

3.1 The Committee is the primary Board committee for providing assurance and raising any concerns to the Trust Board about delivery of the People & Organisational Development strategy, Communications Strategy, Diversity & Inclusion, Occupational Health & Wellbeing, Workforce Plans and the recruitment, retention, deployment and development of the Trust's workforce.

It is chaired by a Non-Executive Director of the Board.

3.2 The duties of the Committee will be to provide the Trust Board with an independent and objective review of, and assurances in relation to:

- Workforce & OD risks recorded on the Board Assurance Framework
- The development and delivery of a people and organisational development strategy that supports the Trust plans and ensures an appropriate culture is in place.
- Assurance that a robust organisational development and workforce programme is developed to support creation of a new organisation through the Fusion Programme).
- The creation and delivery of workforce plans aligned to Trust strategies and financial envelope to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the current and future needs of patients and service users. We have the right people, in the right job, with the right skills, at the right place, in the right time and for the right cost (the 6Rs).
- The effectiveness of the Trust Communication strategy and workplans.
- The Trust's workforce performance and sustainability indicators, including but not limited to, sickness absence, training, appraisal, employee relations, people practices and bank and agency usage and expenditure and monitor any necessary corrective plans and actions.
- Effectiveness of recruitment and retention processes to ensure that the Trust has the people to deliver its strategy.

- Meeting legal and regulatory requirements in relation to the workforce, to include Diversity & Inclusion such as Workforce Race Equality Standard, Workforce Disability Standard, Gender Pay Gap and the Equality Delivery System
- Effectiveness of arrangements to understand and improve health and wellbeing.
- The effective identification and mitigation of workforce and organisational development risks within the supporting infrastructure of the Board Assurance Framework and Risk Register.
- Succession planning options to be developed to support retention of internal skills and expertise.
- Employee engagement and experience, reviewing staff surveys (national & local) and delivery plans to achieve a highly motivated and engaged workforce.
- The effectiveness of learning, development, training and education of the workforce in all professions.
- National reports and best practice relating to workforce and organisational development.
- Receive assurance on the HR aspects of any external/internal compliance reviews that have raised concerns at Board and/or Executive Team.
- Development of effective and compassionate people practices and a just and inclusive culture.

The Committee will be supported in executing its responsibilities through the People Forum which will be supported by delivery forums.

4 Membership

4.1 The membership of the committee shall comprise the following:

Members	**In attendance**
Non-Executive Director (Chair)	Deputy Chief Executive Officer and Chief Finance Officer
2 Non-Executive Directors	Strategic Transformation Director and Director of Estates
Chief People Officer (Lead Executive)	Associate Directors/Heads of People & OD
Chief Nurse	Service/Corporate reps as required
One Chief Operating Officer	
Chief Executive Officer	

4.2 If any member is unable to attend a meeting, they are to designate another suitable officer to attend as an alternate in their place. Members are expected to attend at least 75% of meetings annually. An annual register of attendance of members will be published by the Committee.

4.3 Other organisational managers and colleagues invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

5 Chair

5.1 The Committee will be chaired by a Non-Executive Director. In the absence of the Chair, another NED colleague will be nominated.

6 Secretary

6.1 The administration of the meeting shall be supported by the PA to the Chief People Officer or alternative member of Business Support who will arrange to take minutes of the meeting and provide appropriate support to the Chair and committee members.

6.2 The agenda and any working papers shall be circulated to members five working days before the date of the meeting.

7 Quorum

7.1 A quorum shall be two of the non exec members and two other members.

8 Frequency

8.1 The Committee will meet bi-monthly.

9 Notice of meetings

9.1 Meetings shall be summoned by the secretary of the Committee at the request of the Chair.

10 Minutes of meetings

10.1 The minutes of Committee meetings shall be formally recorded and will be shared with the members following agreement by the Chair.

11 Authority

11.1 The Committee shall be accountable to the Trust Board. The committee is authorised to:

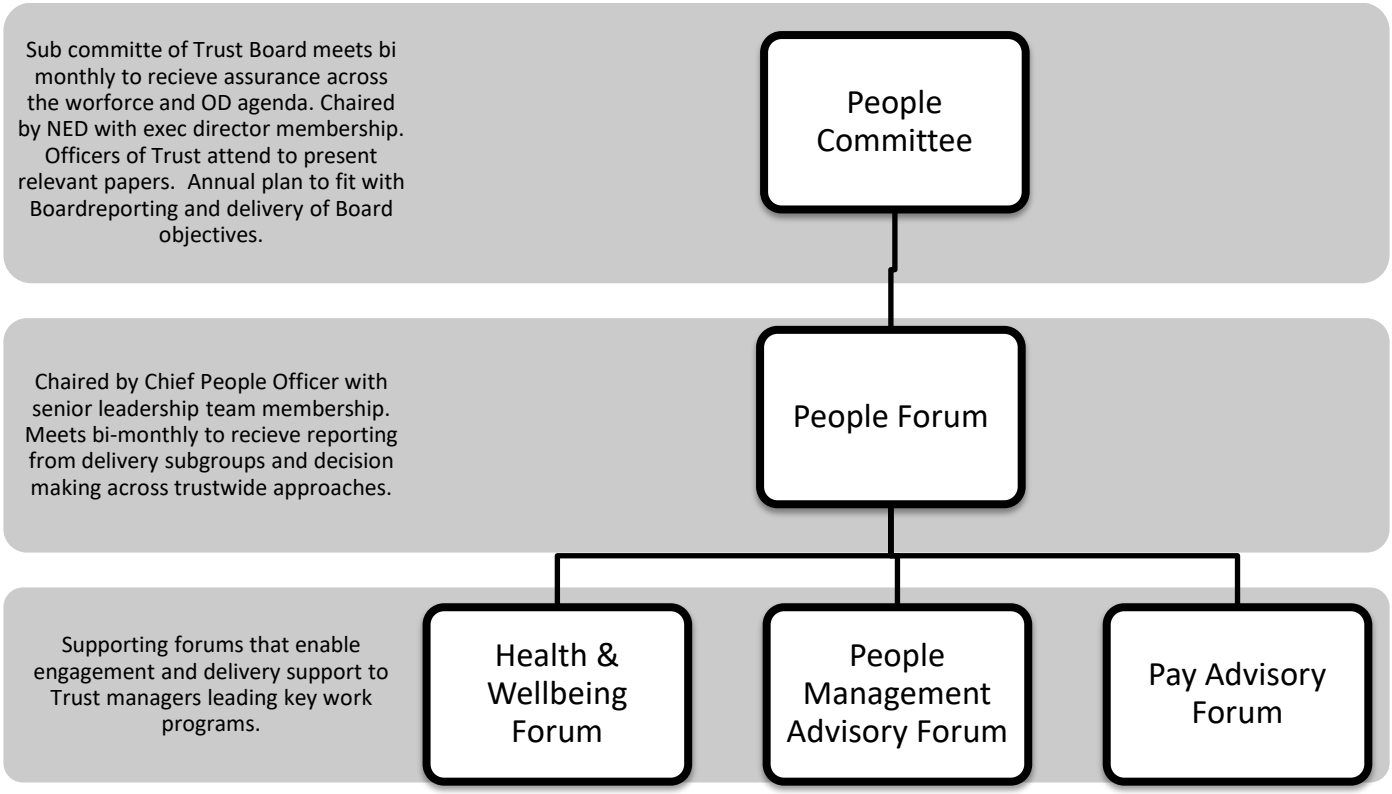
- To seek any information, it requires from any employee of the Trust in order to perform its duties
- To call any employee to attend a meeting as and when required
- Seek external expertise where required

12 Reporting

12.1 The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

12.2 The Committee will review effectiveness annually as well as preparing an annual report and future work plan for the Board that will demonstrate the Committee's discharge of its duties. This report should be produced as required according to the Board's Annual Work Plan.

Appendix 1 – Committee Structure



Version	9
Agreed at	People Committee Date: 18 Nov 2021
Date of Next Review	Date: Jan 2022

Report template- Board and Committees

Item No.	**12**	Presentation to	In Public Board		
Title of paper	Mental Health Act Scrutiny Committee Exception Report				
Purpose of the paper	To summarise the business transacted at the Mental Health Act Scrutiny Committee held on 16 February 2023.				
Committees/Groups previously presented	N/A				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)	No impact (neutral)	X
Action required	For decision		For assurance	X	
Summary of Recommendations and actions required by the author	The In Public Board is asked to: • To note the report from the Committee				

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Non- Exec Sponsor name:	Vanessa Avlonitis, Non-Executive Director Committee Chair		Exec Sponsor signature:	V.Avlonitis			

Summary of business transacted:

- The **Mental Health Act Report** was noted and exceptions/comments shared.
  - It was reported that the use of s2 had remained stable during this reporting period.
  - The Committee were informed of Extra Contractual Referral (ECR) beds purchased and were assured of progress made.
  - It was confirmed that all cases of Community Treatment Orders and Long-Term Home Leave were within necessary criteria.
  - Review of s5(2) cases was held, with decrease reported due to grading. It was confirmed that issues had been addressed.
  - Extensive discussions were held in relation to continued monitoring of ethnic minority data.
  - An update regarding the new Draft Mental Health Bill pre-legislative scrutiny report published by the Joint Committee was provided. Ongoing monitoring of requirements was confirmed.
- Standard scrutiny of the **Restraint and Seclusion Assurance Report** took place. An increase in restraints was reported, following relocation of Maples Ward from a larger ward environment to its original 10 bedded environment (after refurbishment of the ward at the beginning of August 2022). It was confirmed that cases had since reduced. The Committee were briefed on continued work to enhance training and skill slots with the prevention and management of violence and aggression (PMVA) team.
- The Mental Health Act and Mental Capacity Act Lead provided an **Associate Hospital Managers (AHM) Update**. It was agreed to include the update within the main Mental Health Act Report going forward.
- There were no open **Internal Audit Recommendations** relating to mental health. There were no risks to report in relation to the **Board Assurance Framework (BAF).**

Decisions made at the meeting:

No other decisions were made at the meeting - reports were received as referenced above.

Recommendations (not previously mentioned):

There are no specific recommendations to note.

Other risks to highlight (not previously mentioned):

There are no risks to highlight.

Item No.	13		Presentation to	In Public Board		
Title of paper	Audit & Risk Committee Exception Report					
Purpose of the paper	To summarise the business transacted at the Audit & Risk Committee held on 9th February 2023.					
Committees /Groups previous presented and outputs	N/A					
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X
Action required	For decision		For assurance	X		
Summary of Recommendations and actions required by the author	The In Public Board is asked to: • Note the report from the Committee					
To be completed by Exec Sponsor - Level of assurance this report provides :						
Significant		Sufficient	X	Limited		None	
Non- Exec Sponsor name:	Calum Mercer, Non-Executive Director		Non-Exec Sponsor signature:			

Key messages /findings

- The Chief Finance Officer presented a report outlining the **Single Tender Waivers** and **Losses and Special Payments** processed since the last meeting. Rationales were provided, which were noted by the Committee.
- An **Accounting Standards** Update was and relevance assurance was provided. The report was noted by the Committee.
- A review of **Financial Timetable & Plans** was shared. It was agreed to amend the existing date of the June Audit & Risk Committee and EO Board to accommodate timescales.
- The Committee noted the **Solent NHS Charity Annual Report and Accounts** and confirmed that audit had taken place with no issues identified.
- Highlights from the **Internal Audit Progress Report** were provided. Ongoing field work was explained and progress noted. A **High level Risk Assessment and Audit Plan 2023-24** and **HFMA NHS Financial Sustainability Benchmarking** was presented and upoming reviews explained.
- An **External Audit Progress Report** was noted, including start of detailed planning.
- The following **Counter Fraud, Bribery & Corruption updates** were provided:
    - **Counter Fraud, Bribery and Corruption Progress Report-** key highlights were shared, including overview of proactive work and assurance regarding case matters.

    - **Benchmarking Report**- An overview of current position across providers was shared.
- There were no updates to provide in relation to **external reviews / (un)announced visits**.
- The **Litigation Six Monthly Report** was received and an overview of ongoing activity was shared.
- The following Committee governance items were **noted**:
    - **Committee Mid Year Review of Annual Objectives**
    - **Committee Annual Effectiveness Review**
- The **Well Led Progress Report** was presented and continued work highlighted. The Committee noted continued assurance.
- A **Trust Assurance Report on Internal Audit Recommendations** was shared and current status noted.

Decisions made at the meeting:

No other decisions were made at the meeting - reports were received as referenced above.

Recommendations (not previously mentioned):

There are no specific recommendations to note.

Other risks to highlight (not previously mentioned):

There are no risks to highlight.

Board and Committees- In Public Board Exception Report

Item No.	14.1		Presentation to	In Public Board	
Title of paper	Quality Assurance Committee Exception Report				
Purpose of the paper	To summarise the business transacted at the Quality Assurance Committee held on Thursday 23 March 2023.				
Committees /Groups previous presented and outputs	N/A				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) X
Action required	For decision		For assurance	X	
Summary of Recommendations and actions required by the author	The Board is asked: • To note the report from the Committee				

To be completed by Exec Sponsor - Level of assurance this report provides:							
Significant		Sufficient	X	Limited		None	
Sponsor name:	Vanessa Avlonitis, Non-Executive Director Committee Chair			Exec Sponsor signature:	*V.Avlonitis*		

Summary of business transacted:

- There were no **Freedom to Speak Up Concerns, Urgent Matters of Safety or Partnership Governance Arrangements** to report.
- The Committee **noted** the following standard reports presented:
  - **Patient Safety Quarter 3 Report**- Review of ongoing activity was shared, including focus on sharing learning, proposed structure for new quality governance arrangements and feedback from the 'Safety Chats' model. Continued positive utilisation of the RIPPLE Model was reported. The Committee were briefed on introduction of the Quality Library, with consideration of how to triangulate information/data to ensure improvements going forward. *(included as Board paper item 14.2)*
  - **Safeguarding Quarter 3 Report**- Continued high level of safeguarding activity and pressures within the team were highlighted. Investment to manage demand was reported in Portsmouth, with business case being submitted for Southampton. Increase in the audit activity was explained and challenges regarding training compliance noted.
  - **Infection Prevention & Control Q3 Report-** The Committee were informed of continued challenges in relation to training compliance and FIT testing requirements. Ongoing considerations, together with services, was confirmed.
  - **Experience of Care Quarter 3 Insights Report**- An overview of professional activity was provided, including an update on inclusion of demographic data. Continued work in relation to the complaints process was shared and increased complexity was noted. Ongoing work to understand incident trends were discussed.
- The **Performance & Quality Exception Report** was **noted**.
  - Contemporary feedback in relation to recent Industrial Action was provided.
  - Continued challenges in relation to demand and capacity was reported, particularly with the Single Point of Access (SPA) service.
  - The Committee discussed continued mitigations in terms of security and ensuring full support provided to staff.

- The Committee received an update from the recent **Mental Health Act Scrutiny Committee.**
- There were no **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items)** to report. An update regarding CQC engagement and Mental Health Act visits were shared. An overview of Fresh Eyes Visits were also provided.
- **Ethics and Caldicott Panel Exception Report**- There was no panel held since the last meeting.
- The **Board Assurance Framework (BAF) consideration and oversight of risks Report** was presented. No comments were raised and the report was **noted** by the Committee.

Decisions made at the meeting:

No other decisions were made at the meeting - reports were received as referenced above.

Recommendations (not previously mentioned):

There are no specific recommendations to note.

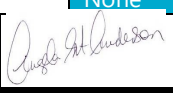
Other risks to highlight (not previously mentioned):

There are no risks to highlight.

Item 14.2

Patient Safety Quarterly Report

Item No.	14.2			Presentation to	Quality Assurance Committee		
Title of paper	**Quarter 3 2022/23 Patient Safety Quarterly Report**						
Purpose of the paper	The aim of this report is to update the Quality, Improvement and Risk Group on the management of Patient and Staff Safety within the Solent and the areas of focus for Quarter 4 2022/23.						
Committees /Groups previous presented and outputs	Presented at Quality, Improvement and Risk Group December 2022. The group asked for additional information to be included with regards to moderate level incidents and further data for learning from deaths.						
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X	
Action required	For decision		For assurance	X			
Summary of Recommendations and actions required by the author	The Quality Assurance Committee is asked to note the following: • The focus of quarter 3 was sharing patient safety learning, with two events taking place to celebrate World Patient Safety day • The implementation of the Learn from Patient Safety Events System is on target for 3rd April, with staff support plans in place. • The proposed Quality Governance arrangements for the existing Quality, Improvement and Risk Group have been agreed and will commence in Q1 2023/24 • The 'Safety Chats' model has been adopted by the Freedom to Speak up Lead • The RIPPLE model continues to be a good source of support for Service Lines, which includes some services receiving facilitated peer support sessions. • In line with PSIRF, our current Serious Incident Investigators commenced the HSIB System based approach to investigations training, which replaces the root cause analysis approach.						

To be completed by Exec Sponsor - Level of assurance this report provides:							
Significant		Sufficient				None	
Exec Sponsor name:	**Angela Anderson - Chief Of Nursing and Allied Health Professionals.**			Exec Sponsor signature:			

Patient Safety Report Quarter 3 2022

This report provides information on the following:

- Incidents
- Serious Incidents
- Learning from Deaths
- Safety Chats
- RIPPLE model
- Quality Governance arrangements
- Medication without Harm Conference
- Safety, Excellence, and Improvement Forum
- Patient Safety Strategy

THE REPORT COVERS THE PERIOD 01/10/2022 – 31/12/2022

1.0 Introduction

1.1 Quarter 3 was a busy time for sharing patient safety learning. To celebrate World Patient Safety Day, Solent held two events, an extended Safety, Excellence and Improvement Forum and a Medication without Harm Conference.

1.2 The proposed Quality Governance arrangements for the existing Quality, Improvement and Risk Group have been agreed and will commence in Q1 2023/24.

2.0 Insight

2.1 Incidents

2.1.1 Incidents reported across the trust in Quarter 3 2022/23 are up 14.8% compared with Q3 2021/22 and 21.5% compared with Q3 2020/21. This is shown below in figure 1.

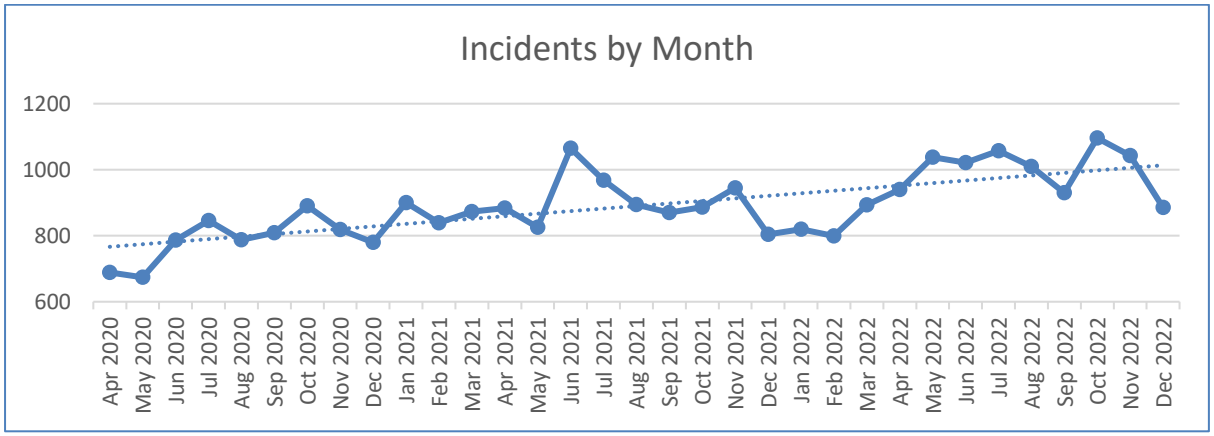


Figure 1 - Incident Reporting Trend – Trust Wide

2.1.2 The SPC chart below also shows an upward trajectory in the number of incidents reported. Whilst data in November and December 2022 shows a potential movement down, when compared with previous years the number of incidents reported is showing an increase (as shown in figure 2).

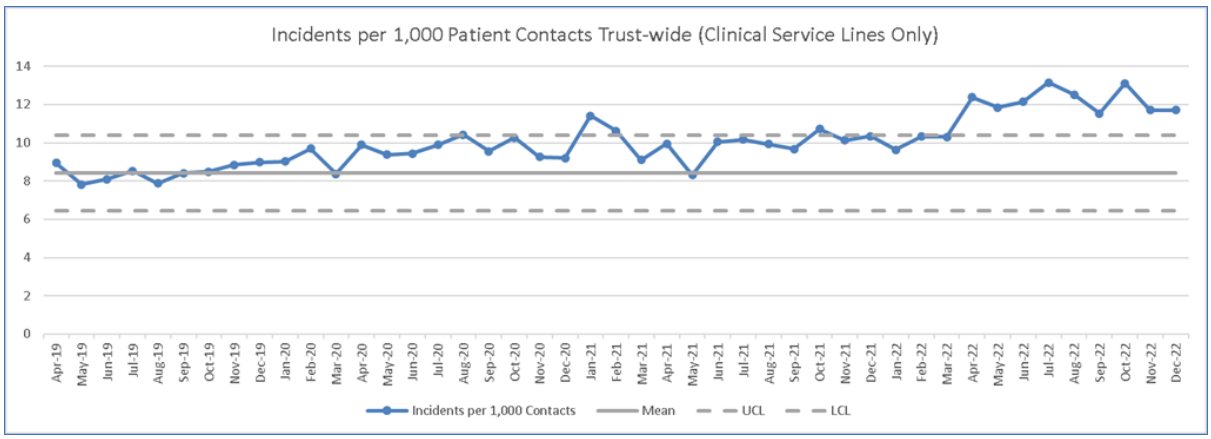


Figure 2 – Incidents reported per 1,000 Patient Contacts

2.1.3 Figure 3 below provides further evidence that the overall number of incidents reported does continue to increase. However, the upward trend is related to incidents of No Harm/Near Miss with instances of Low Harm or above continuing to show a steady reduction.

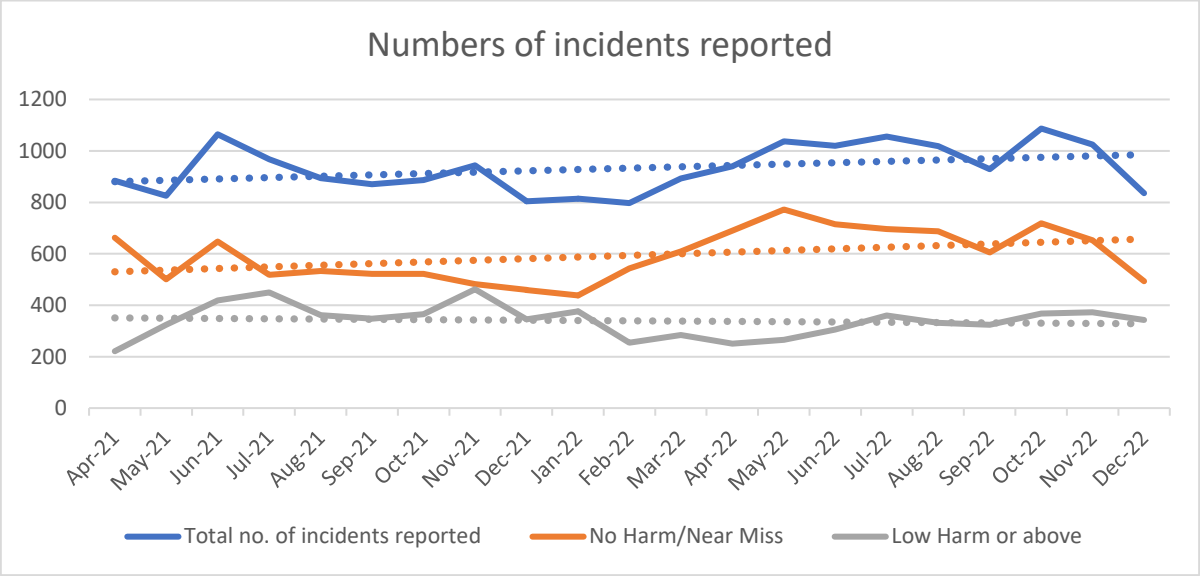


Figure 3 – Number of incidents split by Harm

2.1.4 This shift towards an increase in incidents of No Harm/Near miss being reported was particularly noticeable in Q3 2022/23 where there was a 14.8% increase in the overall number of incidents reported alongside a 4.5% reduction in the number of incidents resulting in Harm. Demonstrated in Figure 4 below.

	Q3 2019/20	Q3 2020/21	Q3 2021/22	Q3 2022/23
No Harm/Near Miss	**1,371**	**1,453**	**1,463**	**1,905**
Low Harm or above (incl Death/Fatality)	**1,231**	**1,036**	**1,173**	**1,120**
Total number of incidents	**2,602**	**2,489**	**2,636**	**3,025**

Figure 4 – Number of incidents split by Harm

2.1.5 The top ten incident cause groups is largely unchanged from quarter 2 therefore these are not included in the report, however they will feature in the Q4 report.

2.2 Levels of Harm

2.2.1 As a result of a review of internal guidance, harm is now judged on the impact to the individual concerned. We also introduced a new category to include incident reporting the death (expected or unexpected) of a patient. Whilst the number of incidents resulting in Moderate Harm, Severe Harm or reporting a Death have increased, the overall number of incidents of Minor Harm or above continues to fall – see Figure 5 below.

Year (Q3)	Number of incidents reported	No Harm or Near Miss		Minor or Low Harm		Moderate or above Harm	
		% of overall incidents	Total	% of overall incidents	Total	% of overall incidents	Total
2020/21	2489	58.4%	1453	38.7%	963	2.9%	73
2021/22	2636	55.5%	1463	41.9%	1105	2.6%	68
2022/23	3025	63%	1905	21.9%	661	15.1%	459

Figure 5 - Incidents breakdown by Actual Impact

2.2.2 As a result of the review we are now applying the NHSE guidance more consistently so that any patient that has needed or is likely to need extra healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond simple dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention is now graded as a moderate harm or above.

2.2.3 It is important to understand that before the internal review, incidents graded as minor harm or below were still reviewed and consideration given to undertake any further investigation.

2.2.4 The incidents reported as moderate and above consists of deaths, medical emergencies, deteriorating patients, self-harming, and pressure ulcers.

2.3 Incidents in Community Mental Health

2.3.1 In September and October 2022 there was a significant increase in the number of deaths relating to suspected suicide in our Community Mental Health Teams. A thematic review of the cases has been completed which included a comparison of Solent's cases against the 13 themes from the National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2022.

2.3.2 The headline findings of the Solent commissioned report are:

- In all cases the Clinical Risk & Management Policy was complied with.
- No acts, omissions or errors in care were identified.
- The carers and family members of patients would benefit from better communication with services and information on how to support their loved one.
- Streamlining the access to services by creating a single point of contact would be beneficial for patients and reduce the length and impact of delays.
- No single theme or root cause was identified

The full report will be shared at the January 2023 Learning from Incidents and Deaths panel.

2.4 Slips, Trips & Falls in Adult Services Portsmouth In-Patients

2.4.1 At the December Quality Evidence Meeting an increase in the number of Slips, Trips & Falls reported on the Jubilee Unit was noted, from an average of 3 incidents per month to 17 in October and 19 in November (see Figure 6 below). Two formal complaints as a result of patients experiencing a fall were also noted. Both complaints were received directly from

the Ward Service Manager on 8th December, enquirers will have the opportunity to discuss their concerns at a Local Resolution Meeting.

2.4.2 Adult Services Portsmouth have confirmed that the increase in falls coincides with the move from Jubilee House in Cosham to the Southsea Unit. This move resulted in an increase in the number of beds, a change in the type of patient being cared for and a change in the environment for staff to adapt to. Mel Chawner, Solent Falls Lead, is working with the service to understand the increase in falls and the measures that can be put in place in the new unit to reduce them. The Quality & Safety Team in collaboration with the Patient Advice & Liaison Service continue to monitor incident reports and complaints.

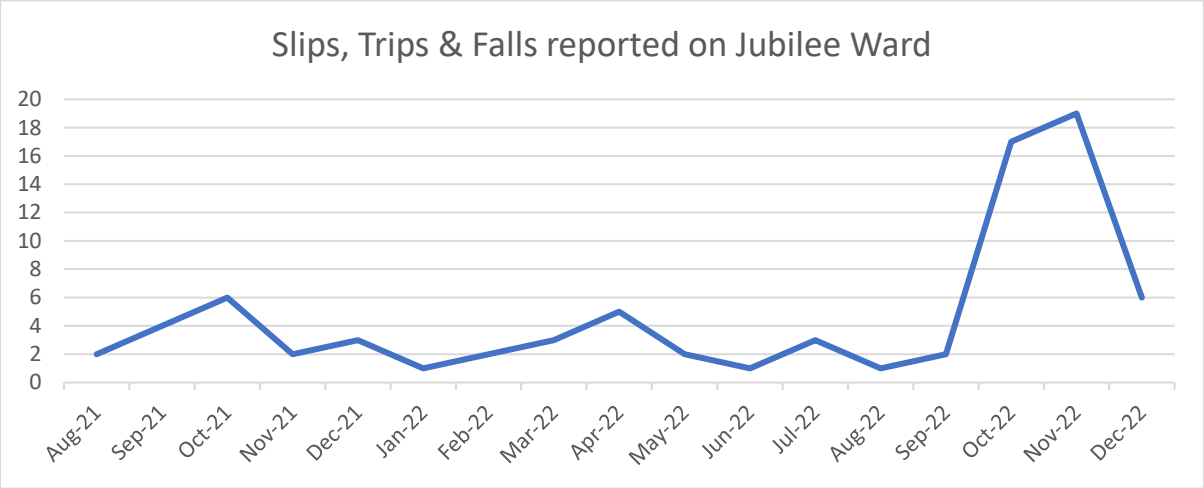


Figure 6 – Slips, Trips & Falls

2.5 Serious Incidents

2.5.1 Six Serious Incidents were declared in Q3. These are being investigated and the learning from them will be discussed at future Learning from Incidents and Deaths Panels. See figure 7.

Service	Description
Adult Services Portsmouth	A patient of the Community Heart Failure Service developed an Acute Kidney Infection and required surgical intervention.
Adult Services Southampton	A patient on Fanshawe ward at the Royal South Hants Hospital deteriorated overnight and passed away.
Mental Health Services	A patient of the Crisis Resolution Home Treatment Team is suspected to have committed homicide before taking their own life.
	A patient passed away whilst an in-patient on Hawthorn Ward.
Special Care Dental	Missed opportunities to diagnose dental caries in patients have been identified.
Covid Vaccination and Health Inequalities	A pop-up COVID-19 vaccination clinic gave an incorrect dose of the vaccine to multiple young people.

Figure 7 – Serious Incidents declared in Q3 2022/22

2.6 High-risk Incidents

2.6.1 High-risk incidents are investigated by the Service lines and the learning presented as a poster at future Learning from Incidents and Deaths panel. See figure 8.

Service	Description	Cause Group
Mental Health Services	South Coast Ambulance Service raised concerns over the quality of handover for a patient requiring escalation to Queen Alexandra Hospital (QAH).	Emergency Medical
	The family of a patient raised concerns about communication and discharge planning between Solent services and an outside provider.	Self-harming behaviour
Adult Services Portsmouth	A patient admitted to Jubilee House for rehabilitation following a fall deteriorated, was escalated to QAH, and passed away.	Deaths – Expected, Unexpected and Homicide
Adult Services Southampton	A patient admitted to Snowdon Ward developed a Deep Vein Thrombosis and a Pulmonary Embolism.	Venous Thromboembolism

Figure 8 – High-risk Incidents declared in Q3 2022/23

2.7 Learning from Deaths

2.7.1 During Quarter 3 of 2022/23, 447 people in receipt of services provided by Solent NHS Trust have died. In 59 cases the patient's death was reviewed using a Structured Judgement Tool (SJT), Investigation or a Multi-Disciplinary Team (MDT) discussion. The breakdown by Service Line is shown in Figure 9.

Service line	Number of deaths reported	Reviewed via SJT, MDT, or Serious Incident Investigation	Reviewed by another provider	Total Reviewed (% of cases reviewed)
Adult Services Portsmouth	177	20	0	20 (11.3%)
Adult Services Southampton	195	11	8	19 (9.7%)
Child & Family Services	7	0	0	0 (0%)
Mental Health Services	43	18	1	19 (44.2%)
Primary Care	24	0	0	0 (0%)
Sexual Health	1	1	0	1 (100%)
Total	447	50	9	59 (13.2%)

Figure 9 – Reviews of patient deaths completed in Q3 2022/23

2.7.2 Of the reviews undertaken by **Solent**, 96% of cases were either Not Preventable or there was only Slight Evidence of Preventability whilst 93.2% rated the Quality of Care provided either Good or Excellent.

3.0 Involvement

3.1 Quality Governance arrangement changes

3.1.1. A review of quality governance arrangements has taken place by the Head of Quality and Safety with the Heads of Quality and Professions across all service lines. This was initiated in response to concerns raised around duplication of escalation and report writing and has resulted in a proposal for change to the Quality, Improvement and Risk (QIR) structure. The proposal was presented to the QIR group and agreed for implementation in Q1 2023/24.

3.1.2 The new structure will consist of alternating meetings, month one being 'Safety and Risk Group' and month two being 'Learning and Improvement Group'. The escalation reports have also been reviewed and a new template developed. This change in structure should lead to efficient and timely escalation of key risks and issues for discussion and allow the opportunity for follow up of actions to provide assurance. The proposal details are in the process of being finalised and discussed with key members of the senior leadership team. See Figure 10.

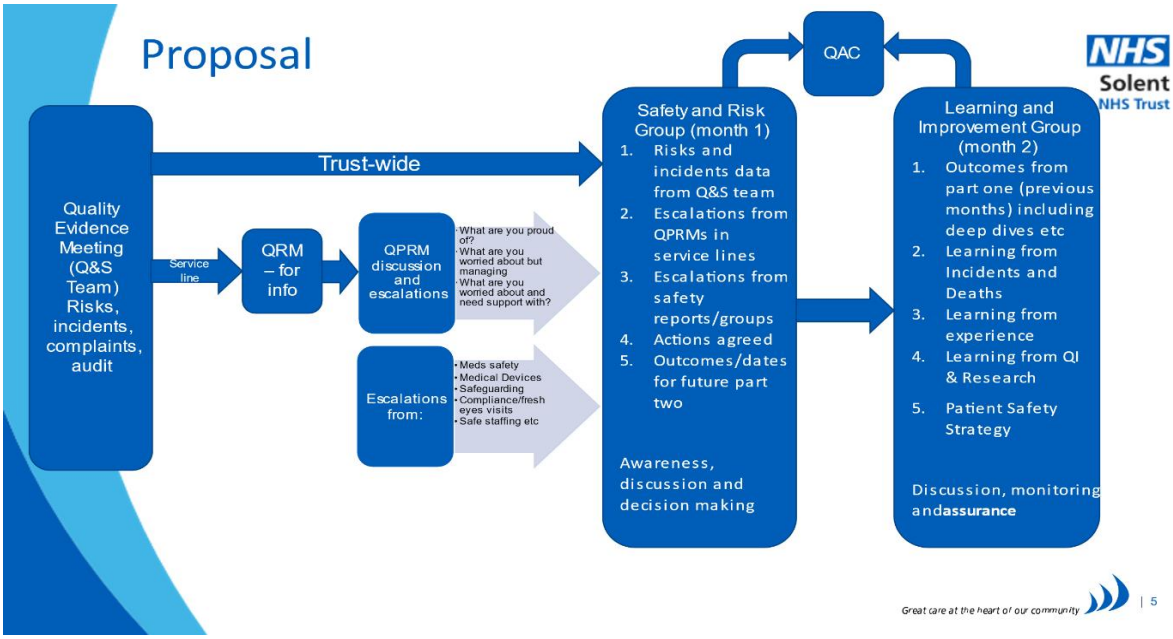


Figure 10 Proposed Governance Arrangements

3.1.3 The monthly Quality Evidence meetings continue to be developed and from Quarter 1 2023/24 will include representatives from Clinical and Organisational Assurance and Audit.

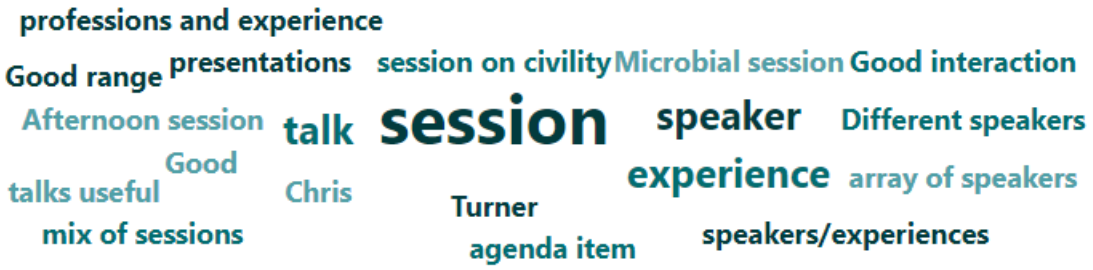
3.2 Medication without Harm Conference November 2022

3.2.1 Each year the World Health Organisation hold a themed World Patient Safety Day. This year it was planned for the 17th September and the theme was Medication without Harm. Solent planned a virtual conference to be held on the 14th September but due to the passing of the late Queen it was rescheduled to 30th November.

3.2.2 The conference was fantastic opportunity to share the great work of the Solent Pharmacy team, along with our Learning Disability Service. The keynote speaker was Chris Turner from Civility Saves Lives, providing an important message in line with our Just Culture and Safer Culture work in Solent. Figure 10 is the agenda.

Figure 11 Medication Without Harm Conference agenda

3.2.3 The conference was attended by over 80 staff and recorded for those unable to attend. Examples of the feedback received by staff, when asked what they liked most about the conference are below.



3.3. Safety, Excellence, and Improvement Forum Nov 2022

3.3.1 The Solent Safety, Excellence and Improvement Forum is usually held as a quarterly half day event. To mark World Patient Safety day, a whole day event had been planned for the 15th September. This was rescheduled for the 15th November and for the first time the forum was held on a ward. Making it accessible to patients and staff. It was also available to all Solent staff via Zoom and as per usual it was recorded.

3.3.2 The forum provided an opportunity for our Patient Safety Partners to present their role and engage in the whole day. The forum provided the opportunity to share learning from events such as case reviews, incidents, research, and audits. In addition, Safety Chats, and the Solent Ripple Model sessions were provided by the Quality and Safety Team.

3.3.3 The feedback from the forum was very positive with staff reporting how they will use the learning in their Service Lines and a patient attending a specific session related to their work in social care. Over 30 people attended. Figure 12 is the agenda.

Figure 12 Safety, Excellence, and Improvement Forum agenda.

3.4. Safety Chats

3.4.1 The successful implementation of the 'safety chat' project has been expanded upon and is now being undertaken in collaboration with the Lead Freedom to Speak Up Guardian who will lead on these going forward. This will now be the route to access safety chats across the organisation.

3.5 The RIPPLE model

3.5.1 In the period 1st April 2022 to 31st December 2022 there have been 113 incidents reported where additional support has been requested under the RIPPLE Model. The top Cause Groups are shown in Figure 13 below:

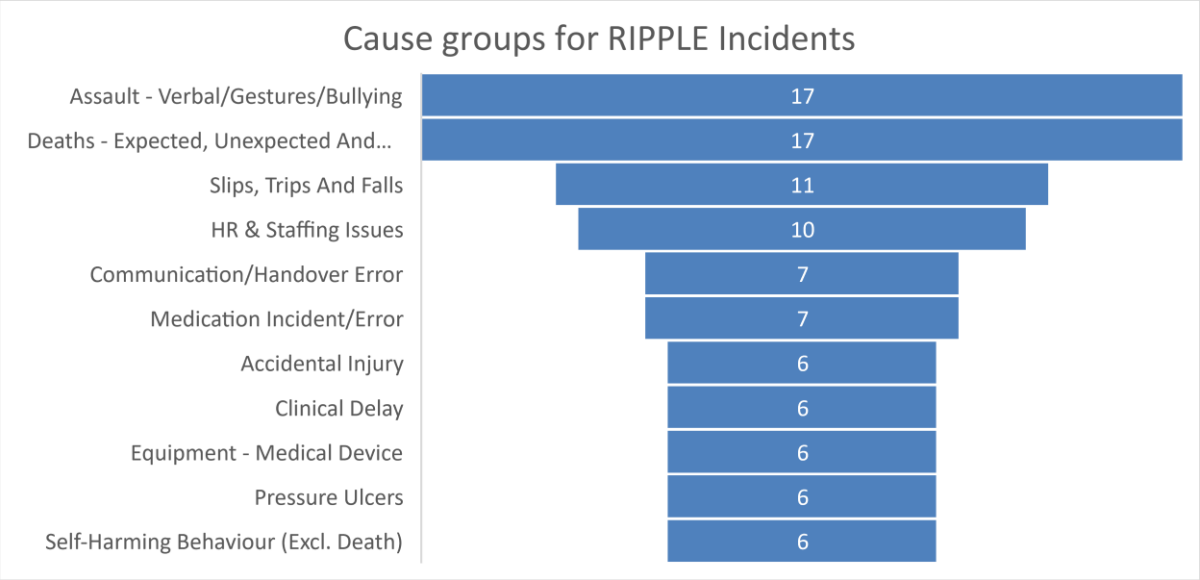


Figure 13 – RIPPLE Incidents by Cause Group

3.5.2 In Q3 RIPPLE support was requested on 8 occasions following the death of a patient. Following these requests facilitated peer support sessions were provided by the Quality & Safety Team to the End-of-Life Support Services Team in Adult Services Portsmouth, the Public Health Nursing 0-5 Team in Child & Family Services, and the High Intensity Veterans Team in Mental Health Services.

3.6. Patient Safety Strategy update

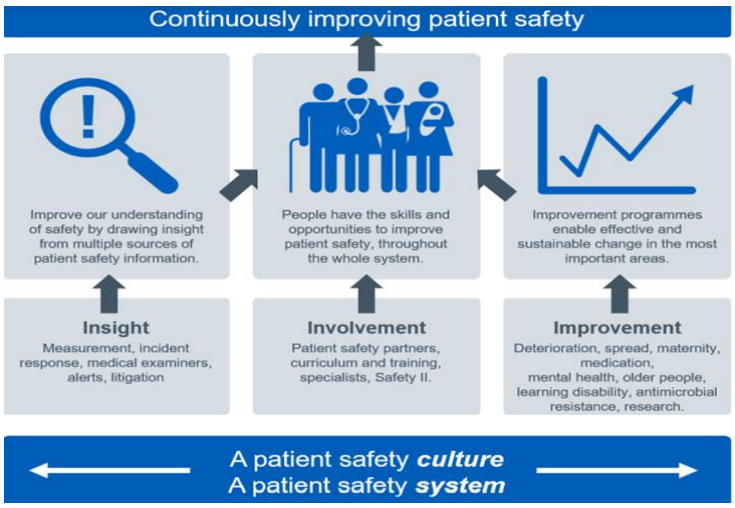


Figure 13 Patient Safety Strategy elements

3.6.1. The implementation of the Patient Safety Incident Response Framework requires a system-based approach to patient safety events. In quarter 3 the patient safety investigators (employed on the bank) commenced the *Healthcare Safety Investigation Branch (HSIB) Level 2 System approach to learning from patient safety incidents.* This virtual training will support the new approach to investigation. The Root Cause Analysis approach to investigation along with the Serious Incident Framework will cease in Autumn 2023.

3.6.2 In addition, the patient safety Investigators are also required to complete the HSIB Investigative Interviewing, Demystifying Thematic Analysis and Involving those affected by patient safety incidents in the learning process training.

3.6.3 The Patient Safety Specialist, Operational lead, and the Quality Safety Manager also commenced the HSIB training along with the Medical Devices Safety Officer and the Medication Safety Officer. It is anticipated other key Patient Safety leads will complete this training in Quarter 1 2023/24 onwards.

3.6.4 Compliance with the NHSE level 1 and level 2 Patient Safety training on LMS continues to be monitored. Following increased publicity of the Access to Practice training it is on target to be over 85% by 1st April 2023. There is a plan for the board to be 100% compliant with their Level 1 by the end of Q4.

3.6.5 The Q3 compliance is detailed below.

Training	Q3 Level of Compliance	Q2 Level of Compliance
Level 1 – Essentials of Patient Safety	87%	87%
Level 1 – Essentials of Patient Safety for Boards	61%	89%
Level 2 – Access to Practice – Patient Safety	79%	68%

3.6.6 The Safety, Excellence, and Improvement Forum in November provided an excellent opportunity for the Patient Safety Partners to promote their role. A platform held each month provides a mix of touching base and education sessions. In this quarter the PSP's received sessions from the PALS and Complaints Manager, the Freedom to Speak Up Lead and the Falls Lead. They continue to be involved in the Ward Environmental Falls Audits and the next phase of recruitment of the PSP's in Q4.

3.6.7 Following the release of the Patient Safety Incident Response Framework in August 2022 Solent moved from the Orientation phase to the start of the Diagnostic and Discovery phase. The orientation phase has been spent digesting a variety of patient safety tools, planning the training requirements and how Solent works collaboratively with Southern, the Isle of Wight and Sussex Partnership in line with Project Fusion.

3.6.8 PSIRF will change the way we currently review patient safety events. Providers are required to write a plan and a policy which will include what patient safety events will be subject to a patient safety II approach, along with details on how we will learn from other patient safety events for example Pressure Ulcers and Falls using the tools in the framework.

3.6.9 As the framework will supersede the Serious Incident Framework and our local process for high-risk incidents, it will be necessary to review our Incidents Reporting, Investigation and Learning Policy and our Learning from Deaths Policy. This will be done in collaboration with our Project Fusion colleagues.

3.6.10 As detailed in the Q2 report, the implementation of LFPSE is on target for implementation on 3rd April 2023. The Quality and Safety Team have been preparing posters, power point slides and a staff briefing for services. There are also plans for Q&A drop-in sessions. Further information will follow in the Q4 report.

4.0 Next Steps

4.1 Quarter 4 report will provide Information on the following.

- An annual review of the RIPPLE model
- Organisational learning from Serious Incidents
- An update on the implementation of the Learn from Patient Safety Events (LFPSE)
- Patient Safety Partners recruitment
- An update on the implementation of the Patient Safety Incident Response Framework
- An annual review of incidents.

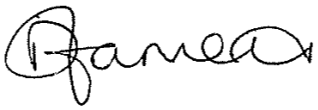
Board and Committee Cover Sheet

Item No.	16

Presentation to	Solent NHS Trust Board		
Title of Paper	Charitable Funds Committee Exception Report		
Purpose of the Paper	To summarise the key business transacted at the recent Charitable Funds Committee meeting, 09 February 2023		
Author(s)	Belinda Brown, Executive Assistant to Chief Executive	Sponsor	Gaurav Kumar, NED – Committee Chair Debbie James – Executive Sponsor
Date of Paper	16 February 2023	Committees/Groups previously presented	----
Summary of key issues/messages	The committee: - • **Discussed** Project Fusion and implications for the charity. • **Received** the **Quarter 3 (Q3)** Finance Report covering the period 01 October 2022 to 31 December 2023. • was **informed** that the charity reported a deficit in Q3 of **£33,531.00** and a YTD deficit of **£43,214** • **Discussed** the use of the charity's restricted funds • was **informed** of public donations made within Q3 totalling **£4,245.00** • was **updated** on spend within Q3, including **£33,006.00** on the staff memorial garden at St James' Hospital, **£3,384.00** costs associated to the Solent Striders event (September 2022), and **£1,250.00** of costs associated to branding and artwork for charity's relaunch • **Agreed** for all current unused designated funds be transferred to general funds if not used by June 2023. Communication to staff to be made. • **Received** an update on the stage 3 NHS Charities Together recovery grant (application deadline 30 June 2023), grant available £80K. • **Received** an update on the future planning of the charity and **discussed** options to share resources internally • **Received** an update from the Communications team and **discussed** the draft charity communications plan. • **Discussed** future charity opportunities, including a charity cycle ride to Paris, the NHS Big Tea, and the NHS 75th Birthday (05 July 2023) and Heart Awards event. • **Received** an update from the Estates team and **supported** the proposal to hold a charity lunch, cooked by the Trust's NHS chef competition finalists 2022, on **Wednesday 07 June 2023, 1.00pm to 3.00pm, St Mary's Hospital**.		

Action Required	For decision?	N	For assurance?	Y
Recommendation	The Board is asked to receive the above summary of business transacted.			

For presentation to Board and its Committees: - To be completed by Exec Sponsor

Level of Assurance *(tick one)*	Sigificant		Sufficient	X	Limited		None	
Assurance Level	Concerning the overall level of assurance the Trust In Public Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature								

Board and Committees

Item No.	18	Presentation to	Trust In Public Board		
Title of paper	Trust Board Effectiveness Review/Appraisal - 2022				
Purpose of the paper	To summarise the results of the recent Effectiveness Review survey.				
Committees /Groups previous presented and outputs	N/A				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)	No impact (neutral)	X
Action required	For decision		For assurance	X	
Summary of Recommendations and actions required by the author	The Board is asked to: • Review the results presented and • Consider any recommendations made for improvement / areas to address				

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient		Limited		None	
Non- Exec Sponsor name:	Mike Watts, Acting Trust Chair		Exec Sponsor signature:				

Key messages

On an annual basis, as well as reviewing the Terms of Reference, it is good governance for each Committee and the Board to consider its effectiveness (against the agreed Terms of Reference) and to highlight any areas for improvement.

The results of the recent survey, completed by Board members, are presented on the following pages.

General responsibilities:

1. To maintain and improve quality of care

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

2. To ensure that the trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

3. To foster positive and productive external relationships with partners and stakeholders in the local health economy, in particular with patient/user groups and forums; Local Authorities, Health and Wellbeing Boards, Hampshire & Isle of Wight Integrated Care System partners, Healthwatch and Primary Care Networks

More Details

Strongly agree	3
Agree	4
Disagree	1
Strongly disagree	0

4. To exercise collective responsibility for adding value to the trust by promoting its success through direction and supervision of its affairs in a cost effective manner

More Details

Strongly agree	3
Agree	5
Disagree	0
Strongly disagree	0

5. To ensure compliance with all applicable law, regulation and statutory guidance. In fulfilling its duties, the trust board will work in a way that makes the best use of the skills of non-executive and executive directors.

More Details

Strongly agree	6
Agree	2
Disagree	0
Strongly disagree	0

Leadership:

6. The Board provides active leadership to the organisation by ensuring there is a clear vision and strategy for the trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed

More Details

Strongly agree	3
Agree	5
Disagree	0
Strongly disagree	0

7. The board provides active leadership to the organisation by ensuring the trust is a good employer by the development of a workforce strategy/plan and its appropriate implementation and operation

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

8. The board provides active leadership to the organisation by promoting the health and wellbeing of staff

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

9. The board provides active leadership to the organisation by implementing effective board and committee structures and clear lines of reporting and accountability throughout the organisation

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

Quality:

10. The board ensures that the trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

11. The board has an intolerance of poor standards, and fosters a culture that puts patients first

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

12. The board ensures that it engages with all its stakeholders, including patients and staff on quality issues

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

13. The board ensures that issues are escalated appropriately and dealt with

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

Strategy:

14. The board sets and maintains the trust's strategic vision, aims and objectives, being cognisant of the Hampshire and the Isle of Wight Integrated Care System for, ensuring the necessary financial, workforce and physical resources are in place for it to meet its objectives

More Details

Strongly agree	2
Agree	6
Disagree	0
Strongly disagree	0

15. The board determines the nature and extent of the risk it is willing to take in achieving its strategic objectives

More Details

Strongly agree	2
Agree	6
Disagree	0
Strongly disagree	0

16. The Board monitors and reviews management performance to ensure the trust's objectives are met;

More Details

Strongly agree	3
Agree	5
Disagree	0
Strongly disagree	0

17. The board oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;

More Details

Strongly agree	1
Agree	6
Disagree	1
Strongly disagree	0

18. The board develops and maintains an annual business plan, and ensures its delivery as a means of taking forward the strategy of the trust to meet the expectations and requirements of stakeholders

More Details

Strongly agree	2
Agree	6
Disagree	0
Strongly disagree	0

19. The board ensures that national policies and strategies are effectively addressed and implemented within the trust

More Details

Strongly agree	3
Agree	5
Disagree	0
Strongly disagree	0

Culture, ethics and integrity:

20. The board is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the board is entirely consistent with those values

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

21. The board promotes a patient-centred culture of openness, transparency and candour

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

22. The board ensures that high standards of corporate governance and personal integrity are maintained in the conduct of trust business

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

23. The board ensures the application of appropriate ethical standards in sensitive areas such as research and development

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

24. The board ensures fairness and continuity to improve people practices

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

25. The board embeds the Learning Organisation and Quality Improvement ethos into all activities

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

26. The board ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

27. The board promotes diversity and inclusion

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

28. The board is responsible for maintaining a Freedom to Speak Up Culture

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

Governance and Compliance:

29. The board ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHS provider organisations

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

30. The board ensures that all licence conditions relating to the trust's governance arrangements are complied with

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

31. The board ensures that the trust has comprehensive governance arrangements in place that guarantee that the resources vested in the trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the trust fulfils its accountability requirements

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

32. The board ensures that the trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

33. The board ensures that all the required returns and disclosures are made to the regulators

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

34. The board formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of trust business

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

35. The board agrees the schedule of matters reserved for decision by the board of directors

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

36. The board ensures the proper management of and compliance with the Mental Health Act and other statutory requirements of the trust

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

37. The Board approves the Annual Report, Quality Account and Annual Accounts

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

38. The board considers directives, comments and recommendations from its committees and takes the appropriate action

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

39. The board ensures there are appropriately constituted appointment and evaluation arrangements for senior positions

More Details

Strongly agree	3
Agree	5
Disagree	0
Strongly disagree	0

40. The board ensures that the statutory duties of the trust are effectively discharged

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

41. The board acts as corporate trustee for the trust's charitable funds

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

42. The board will conduct an annual appraisal of the Board's effectiveness

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

Risk:

43. The board ensures an effective system of integrated governance, risk management and internal control across the whole of the trust's clinical and corporate activities

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

44. The board ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

Finance:

45. The board ensures that the trust operates effectively, efficiently, economically

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

46. The board oversees the achievement of the Trust's Control Total

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

47. The board ensures the continuing financial viability of the organisation

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

48. The board ensures the proper management of resources and that financial responsibilities are fulfilled

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

49. The board ensures that the trust achieves the targets and requirements of stakeholders within the available resources

More Details

Strongly agree	4
Agree	4
Disagree	0
Strongly disagree	0

50. The board reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken

More Details

Strongly agree	5
Agree	3
Disagree	0
Strongly disagree	0

Board behaviours and competencies:

51. Honesty

More Details

Strongly demonstrates	7
Demonstrates sometimes	1
Rarely demonstrates	0
Never demonstrates	0

52. Everyone counts

More Details

Strongly demonstrates	6
Demonstrates sometimes	2
Rarely demonstrates	0
Never demonstrates	0

53. Accountable

More Details

Strongly demonstrates	6
Demonstrates sometimes	2
Rarely demonstrates	0
Never demonstrates	0

54. Respectful

More Details

Strongly demonstrates	8
Demonstrates sometimes	0
Rarely demonstrates	0
Never demonstrates	0

55. Teamwork

More Details

Strongly demonstrates	8
Demonstrates sometimes	0
Rarely demonstates	0
Never demonstrates	0

56. Board competency - Judgment

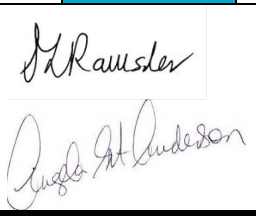
More Details

Strongly demonstrates	6
Demonstrates sometimes	2
Rarely demonstrates	0
Never demonstrates	0

57. Any other comments (including any suggested areas of focus for the Board during the year ahead)

Question 3 – not technically disagreeing but don't believe we have actively enacting this responsibility and may be something we wish to pursue moving forward Question 17 – need more oversight of delivery against strategic objectives and key priorities, especially via performance report

There have been times when Ive been surprised that there has been no challenge on a particularly item - thats the danger of so many papers and taking reports as read. When staff attend the board to present we should ensure that they feel valued and that the agenda item they are presenting is given due consideration

Item No.	**20**			Presentation to	Trust Board		
Date of paper	March 2023			Author	Angela Anderson, CNO and AHP Shahana Ramsden, CPO		
Title of paper	Reflection on Patient and Staff Stories, joint summary						
Purpose of the paper	This paper provides a summary of the Staff Stories presented this year, what we heard, what we learnt and an opportunity for Board to consider future format.						
Committees /Groups previous presented and outputs	Nil						
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)		
Positive / negative inequalities							
Action required	For decision		For assurance	x			
Summary of Recommendations and actions required by the author	The Board is asked to: • Note report • Consider the recommendations included within						
To be completed by Exec Sponsor - Level of assurance this report provides:							
Significant		Sufficient		Limited		None	
Exec Sponsor name:	Angela Anderson, CNO & AHP Shahana Ramsden, CPO		Exec Sponsor signature:				

1.0 Introduction

Hearing the voice of people who work in Solent and those who access our services is an essential component of a learning organisation as it enables us to respond and improve our services for patients and the working environment for our people. This report provides a summary of the patient and staff stories which have been shared with Board over the past twelve months and the impact they have had on individuals and the organisation. It also includes some recommendations to generate discussion.

2.0 Patient stories:

Five patient stories were shared with the Board between April 2022 and February 2023 and those presenting have been supported by colleagues from the Community Engagement and Experience team and the Chief of Nursing & AHPs.

April 2022: The Board heard from local community members of Asian heritage who established 'Chat over Chai' and they described the benefits this was having both in terms of improving women's physical and mental health through physical activities, educational sessions supported by clinicians and discussion groups.

June 2022: There was a powerful story from one of the Trust's clinicians demonstrating the positive impact a new service she established had on a teenage girl. It demonstrated the dedication and commitment to have a positive impact and what can be achieved with tenacity and vision. The young person described the difference the physiotherapist had made to her life and how it helped her to reintegrate into school and to participate in activities again.

August 2022: The Board were introduced to the concept of storytelling and how it can impact on people with learning disabilities. The tools and techniques described were used to improve information and support and provided an open space for natural and honest discussions. There was a reflection from a service user of their experience accessing a vaccination at one of our vaccination centres. They described how they felt uncomfortable and treated differently due to their race. The individual described the response from the team which enabled them to be listened to and this led to improvements within the service. They described the way the Trust responded as being positive and emphasised the importance of working collaboratively to improve patient experience.

December 2022: The Board heard about the experience of a person attending the Covid-19 vaccination centre at Oakley Road. They described how they were specifically asked to provide ID although non-BAME people who were in the queue were not asked for the same information. She concluded that she was targeted due to her ethnic origin. This led to an uncomfortable and demeaning altercation with a member of staff. AWU shared the impact of her experience, particularly her feeling that there was differentiation of treatment due to her race. Following a meeting with OW and EP she had the opportunity to share her concerns and felt she was actively listened to. She was able to use her experiences to work with the team to address some of the issues – such as developing posters to clarify when and why ID might be requested and communications to remind staff about the language and tone of communication with people.

February 2023: 'Busy People' a community partner with the Trust described the work they do to support people with learning difficulties, improving services and accessibility of information. She described how she is currently working with our Experience of Care teams to improve how we respond to complaints and concerns, including being a member of virtual panels and providing advice on projects, inputting to the complaints and communication checker's panel.

3.0 Staff Stories

Six staff stories were presented to the Board between April 2022 and February 2023, generated through collaboration between People Partners and the Communications team and supported by the Chief People Officer.

April 2022: A summary of the Preceptorship Programme was shared with the Board. An International Nurse shared her personal experience of the support provided by Solent within the Preceptorship Plus programme when joining the Trust from India. One area for improvement highlighted was that, in some cases, services find it hard to release staff to attend the programme. Feedback suggested that staff feel guilty about leaving their busy colleagues and are often told at short notice that they cannot be released from clinical areas due to staffing issues. This highlighted the need to review and understand what the challenges are and work with services to address them.

June 2022: KS briefed the Board on her experience and journey within the NHS, of her various roles as a Mental Health nurse and current role within CAMHS. Despite limited careers advice received at school, KS informed the Board of the self-confidence she developed over the years and confirmed that she has completed a Master's degree that was funded by the Trust. The presentation highlighted staff fragility and continuing pressures faced in CAMHS. KS shared inspiring projects achieved during lockdown within the CAMHS team to support the wellbeing of staff - such as actively encouraging breaks, 3-minute discos and mirroring positive messages to staff that are shared with patients. Assurance was provided that action plans are in place to continue this support.

August 2022: CW provided an overview of her background, and challenges within other NHS Trust roles and described her experience of excellent care received as a service user through the Talking Change service. CW confirmed that she was appointed to a role in this service via the Trust IAPT employment team and confirmed that she was able to have open and honest discussions of her mental health needs and background during the

appointment process. The board reflected on the unique skills and perspectives that people with lived experience can bring to Solent Trust.

October 2022: Background to the new Remote Working Consultant Psychiatrist roles were explained and their ground-breaking work was highlighted. The team described how positive clinical outcomes can be achieved using virtual platforms. They experienced initial challenges in integrating within the hybrid team and described how they developed daily connections with staff to address this. Improvements in the experience of patients and their outcomes and the value of this innovation was highlighted. Although this work is piloted within adult services, there is potential effectiveness for both CAMHS and Older Persons Mental Health (OPMH). From a workforce perspective, the benefits of remote working were highlighted – as the approach enabled Solent to access skills and expertise across a large geographical area, and also enabled professionals who wanted more flexible working to provide a valuable service to the NHS.

December 2022: PO shared her personal background with the Mental Health Crisis Team and the high standard of care she received as a patient. She explained her journey of recovery with the support of mental health services, including Solent MIND. The Board were briefed on exemplary support from a care coordinator to challenge and empower PO to re-enter employment. She described her initial role as a peer support worker which encouraged her to re-enter nursing. The high level of learning and support was highlighted which led to progression to a developmental Band 6 role within the Crisis Team. The story highlighted another example of a former user of our services taking up in employment in the Trust and the benefits that this brings to Solent.

February 2023: KL briefed the Board on the Trust apprenticeship offer for both clinical and non-clinical apprentices of all age ranges and noted retention of 90% of apprentices to date. LG and ZS shared their background and individual experiences of completing apprenticeships with the Trust. Management support was shared and the importance of investing in staff and the value of apprenticeships emphasised. The importance of strong leadership and line management to support apprenticeship roles was highlighted. One area of challenge was the ability to release apprentices for the 20% off the job training element. The benefits of apprenticeships to support career progression of staff who may otherwise not be able to fund further qualifications was highlighted.

4.0 Learning from patient and staff stories

The stories:

- Highlight the human factors that impact on the way policies are implemented – bridging the gap between our strategic plans and the reality of people's day to day experiences.
- Acknowledge the work that still needs to be done to ensure we treat all people accessing our services with dignity and respect irrespective of their protected characteristics
- Demonstrate that there is not a clear dividing line between patients and staff – as in some cases people who work at Solent are former and current users of our services and the insights that they bring due to their lived experience are valuable.
- Emphasise the power of storytelling and create an opportunity for people to connect with and feel heard by Board members, which in turn sends the message that their experiences are valued. (Which also supports elements of the CQC well-led framework).
- Support Board awareness about areas for improvement generated through the lens of both patients and staff.

- Demonstrate the impact on positive outcomes when we empower clinicians to develop innovative services and remove barriers to creativity

5.0 Analysis of impact

Below is a reflection provided by one of those who shared their story:

"Thank you for supporting me and taking this matter seriously. I really appreciate everything you have done and taken on board and in a timely fashioned manner. You have been open minded, taken ownership and accountability of the concern I raised. I feel the matter was dealt with efficiently and effectively. You have maintained great communication, high standard of integrity and respect. When you say you will do something you have done so."

People invited to tell their stories have valued the opportunity to share their perspectives with the Board. In some cases, changes have been made as a result of the discussions, including introduction of a debrief process post complaint for services, working with an individual who presented about storytelling to see how poetry could be used as a means of getting patient feedback, another individual is considering applying for a role within the organisation as their experience of working with us as a community partner has been so positive.

6.0 Recommendations to improve the impact further include

- We need to get better at answering the 'so what' question when generating and responding to personal accounts and develop a more consistent way of translating these into improvements across the whole organisation.
- It would be beneficial to link the selection of stories more closely to strategic priorities of the Trust. For example – invite people to share their personal experiences of one of the 6 People Priorities in the People Plan and the impact of improvements we are making, or challenges that people face in accessing support.
- It is important to consider whether inviting people into our space, at our convenience generates the most honest or impactful accounts. Is there an opportunity to enhance the Board to Floor visits to create a space for more open conversations to provide another opportunity to learn from people's experiences?
- Whilst taking into account that every individual's experience is unique, we need to determine the purpose of stories more clearly, identify what difference it has made and discuss what are we doing differently. This could be achieved through a simple "People Story" template to allow a consistent format for selecting, hearing and tracking progress as a result of the board stories.