Isle of Wight NHS Trust, Solent NHS Trust, Southern Health NHS Foundation Trust

Meeting of the Boards in Common

Agenda

Monday 13 November 2023
Time 15:00 – 17:00
Cedar Hall, King's Conference Centre, Upper Northam Road, Hedge End, Southampton, SO30 4BZ

Item	Time	Southern Health NHS Foundation Trust	Solent NHS Trust	Isle of Wight NHS Trust
1.	09:00	**Introduction to the Boards in Common and context for Boards in Common meeting** *Chair, Southern Health NHS Foundation Trust and designate Chair, Hampshire & Isle of Wight Healthcare NHS Foundation Trust*		
2.	09:10	**Welcome, Apologies and Declaration of Interests** *Chair, Southern Health NHS Foundation Trust*		
3.	09:15		**Welcome, Apologies and Declaration of Interests** *Chair, Solent NHS Trust*	
4.	09:20			**Welcome, Apologies and Declaration of Interests** *Chair, Isle of Wight NHS Trust*
6.	09:25	**Presentation of Project Fusion documents for approval:** • **Full Business Case** • **Post-Transaction Integration Plan** • **Patient Benefits Case** • **Board Certification** *Ron Shields, Chief Executive, Southern Health NHS Foundation Trust and designate Chief Executive, Hampshire & Isle of Wight Healthcare NHS Foundation Trust* *Andrew Strevens, Chief Executive, Solent NHS Trust* *Penny Emerit, Chief Executive, Isle of Wight NHS Trust*		
7.	09:50	**General discussion in relation to the Project Fusion documents for approval**		

Item	Time	Southern Health NHS Foundation Trust	Solent NHS Trust	Isle of Wight NHS Trust
8.	10:10	**Discussion of any issues specific to Southern and approval of the documents for submission to NHS England** *Chair, Southern Health NHS Foundation Trust*		
9.	10:25		**Discussion of any issues specific to Solent and approval of the documents for submission to NHS England** *Chair, Solent NHS Trust*	
10.	10:40			**Discussion of any issues specific to Isle of Wight and approval of the documents for submission to NHS England** *Chair, Isle of Wight NHS Trust*
11.	10:55	**Questions from the public**		
12.	11:00	**Meeting close and thanks**		

Report template- Board and Committees

<table>
<tr><td>Item No.</td><td colspan="3">To be inserted by meeting administrator</td><td colspan="2">Presentation to</td><td colspan="3">Board</td></tr>
<tr><td>Date of paper</td><td colspan="3">23rd November 2023</td><td colspan="2">Author</td><td colspan="3">Katy Cox, Fusion Programme Director</td></tr>
<tr><td>Title of paper</td><td colspan="8">Project Fusion
• Full Business Case
• Post-Transaction Integration Plan
• Patient Benefits Case
• Board Certification</td></tr>
<tr><td>Purpose of the paper</td><td colspan="8">This paper comprises the Patient Benefits Case, Full Business Case, Post-Transaction Integration Plan and Board Certification for approval by the Board.</td></tr>
<tr><td>Committees /Groups previous presented and outputs</td><td colspan="8">The Trust Board reviewed the final drafts of the Full Business Case, Post-Transaction Integration Plan, Patient Benefits Case and Board Certification at its meeting on 6th November.</td></tr>
<tr><td>Statement on impact on inequalities</td><td>Positive impact (inc. details below)</td><td colspan="2">X</td><td colspan="2">Negative Impact (inc. details below)</td><td></td><td>No impact (neutral)</td><td></td></tr>
<tr><td>Positive / negative inequalities</td><td colspan="8">The Full Business Case and Patient Benefits Case set out the case for change and expected patient benefits which will be achieved through creation of the new Trust.</td></tr>
<tr><td>Action required</td><td>For decision</td><td colspan="3">X</td><td colspan="2">For assurance</td><td colspan="2"></td></tr>
<tr><td>Summary of Recommendations and actions required by the author</td><td colspan="8">The Board is asked to approve the Full Business Case, Post Transaction Integration Plan, Patient Benefits Case and Board Certification for submission to NHS England.</td></tr>
<tr><td colspan="9">To be completed by Exec Sponsor - Level of assurance this report provides :</td></tr>
<tr><td>Significant</td><td></td><td>Sufficient</td><td></td><td>Limited</td><td></td><td>None</td><td colspan="2"></td></tr>
<tr><td>Exec Sponsor name:</td><td colspan="3">Debbie James</td><td colspan="2">Exec Sponsor signature:</td><td colspan="3"></td></tr>
</table>

Key messages /findings

- The Full Business Case proposes the statutory acquisition of Solent NHS Trust by Southern Health NHS Foundation Trust under s. 56A and s.56AA NHS Act 2006.
- Since the Board reviewed the final draft of the Full Business Case:
  - Risk 88 has increased in score from 12 to 16 and the summary of risks (Figure 80) and narrative in the executive summary (paragraph 1.41) have been updated to reflect this. This change has also been made in the Post Transaction Integration Plan (Figure 9).
  - The narrative around integration costs and financial benefits in the executive summary (1.44 and 1.45) have been updated to match the latest figures in the finance chapter.
  - The executive board structure has been updated to include the Deputy Chief Executive roles and interaction with directorates/divisions (Figure 31). The same change has been made in the Post Transaction Integration Plan (Figure 38)
- The following minor changes have been made to the Post Transaction Integration Plan since the Board reviewed the final draft:
  - The date of the Boards-in-common meeting has been corrected, from 23 October to 13 November 2023, in paragraphs 2.6, 6.2, 6.4 and 6.10;
  - The wording relating to standing down OMAG at the end of October has been changed from the future to the past tense in paragraph 6.30; and
  - Erroneous cross-references have been corrected in paragraphs 6.2 and 7.119.

Appendices

Appendix 1 – Final Full Business Case

Appendix 2 – Final Patient Benefits Case

Appendix 3 – Final Post-Transaction Integration Plan

Appendix 4 – Final Board Certification

Full Business Case for the creation of a new Trust for community, mental health and learning disability services across Hampshire and Isle of Wight

9 November 2023

Contents

1 Executive summary 5
2 Introduction 20
3 Strategic rationale 40
4 Vision for the new Trust 59
5 Clinical strategy 65
6 Operating model 91
7 Quality governance 112
8 Enabling strategies and support functions 123
9 Benefits 148
10 Financial case 163
11 Transaction execution 191
12 Communication and stakeholder engagement 207
Appendices 221

Glossary

Abbreviation	Meaning
ADHD	Attention deficit hyperactivity disorder
AHP	Allied Health Professionals
AMH	Adult Mental Health
ARFID	Avoidant restrictive food intake disorder
BAF	Board Assurance Framework
BAU	Business as usual
CAMHS	Childrens and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CCIO	Chief Clinical Information Officer
CF	Carnall Farrar
CIP	Cost improvement plan
CMHT	Community Mental Health Team
CMHLD	Community, mental health and learning disability services
CMO	Chief Medical Officer
CNIO	Chief Nursing Information Officer
CNO	Chief Nursing Officer
CoG	Council of Governors
COO	Chief Operating Officer
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CYP	Children and Young People
CYPMH	Children and Young People Mental Health
Day 1	1 April 2024
ECT	Electro-convulsive therapy
EDIB	Equality, Diversity, Inclusion and Belonging
EDS	Equality Delivery System
EIA	Equality Impact Assessments
EPR	Electronic Patient Record
FBC	Full Business Case
FRP	Financial Recovery Plan
FTE	Full Time Equivalent
FTSU	Freedom to Speak Up
GP	General Practitioner
HDP	Hospital Discharge Programme
HIOW	Hampshire and Isle of Wight
HQP	Heads of Quality and Professions
I&E	Income and expenditure
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IoW	Isle of Wight NHS Trust

Abbreviation	Meaning
IPG	Integration Planning Group
IPR	Integrated Performance Report
ITIL	Information Technology Infrastructure Library
JFP	Joint Forward Plan
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer and others
LMS	Learning Management System
MHIS	Mental Health Investment Standard
MoHHS	Modernising our Hospitals and Health Services
MSK	Musculoskeletal
MWRES	Medical Workforce Race Equality Standard
NED	Non-Executive Director
NHSE	NHS England
NHS LTP	The NHS Long Term Plan
NICE	National Institute for Health and Care Excellence
OMAG	Operating Model Advisory Group
OPE	One Public Estate
OPMH	Older Person's Mental Health
PBC	Patient Benefits Case
PCN	Primary Care Network
PHU	Portsmouth Hospitals University NHS Trust
PoS	Place of Safety
PRM	Performance Review Meeting
PSW	Peer Support Worker
PTIP	Post Transaction Integration Plan
QIR	Quality Improvement and Risk Group
RTT	Referral to Treatment
SLA	Service Level Agreement
SMI	Severe Mental Illnesses
Solent	Solent NHS Trust
Southern	Southern Health NHS Foundation Trust
STEAG	Service Transfer Executive Advisory Group
Strategic Case	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
STP	Sustainability and Transformation Plan
Sussex Partnership	Sussex Partnership NHS Foundation Trust
The Trusts	Solent, Southern, IoW and Sussex Partnership
The three Trusts	Solent, Southern and IoW
TUPE	Transfer of Undertakings (Protection of Employment)
UTC	Urgent Treatment Centre
VCSE	Voluntary Community and Social Enterprise
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

1 Executive summary

Introduction

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 The Trusts 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 services providing excellent care, including areas of national excellence. However, significant further change is needed 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 (HIOW ICS), face a very substantial financial challenge.

1.3 The four Trusts worked together with system partners to develop the Strategic Case for the creation of a new Trust for community, mental health and learning disability services across the HIOW ICS. This Strategic Case was approved by the Trust Boards in March 2023 and NHS England supported the Trusts proceeding to develop this Full Business Case (FBC).

1.4 The Trusts want all people in Hampshire and Isle of Wight to have equitable access to integrated, safe, consistent community and mental health care. This FBC describes the challenges faced by the Trusts and the system, the options to address these challenges and the plan to bring the Trusts together to deliver improved access, services and outcomes for patients and local communities.

Context

1.5 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.

1.6 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 the 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 employs 5,335 staff (at March 2023), is rated 'good' by the CQC and reported operating income of £274.8m in 2022/23.
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 employs 6,908 staff (at March 2023), is rated 'requires improvement' by the CQC and reported operating income of £455.0m in 2022/23.
Isle of Wight NHS Trust	• 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 FBC. The IoW income related to these services totalled £56.9m in 2022/23.
Sussex Partnership NHS Foundation Trust	• Services for people with mental health problems and learning disabilities across Sussex, and a range of specialist services across south-east England. The Trust is rated 'good' by the CQC. Only the Child and Adolescent Mental Health Services (CAMHS) for Hampshire provided by Sussex Partnership are in scope for FBC. This service employs 440 staff (as at September 2023) and the income associated with this service was £28.6m in 2022/23.

Strategic rationale

1.7 There is a compelling case for change in the Hampshire and Isle of Wight system, driven by four main factors:

- **Community and mental health services are struggling to meet unprecedented increases in demand**. 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 (NHS 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.
- **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 the Trusts' services don't consistently experience high-

quality person-centred care that meets their needs. This adversely impacts health and wellbeing outcomes.

- **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 the current model these smaller services also provide limited opportunity for career progression.

- **The financial challenge is very significant.** the cost of delivering NHS services exceeds the available resources. Southern, Solent and the services proposed to transfer from IoW and Sussex Partnership are forecasting underlying deficits in 2023/24 that total £25.8m. 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.

1.8 In February 2022 the HIOW ICS commissioned an independent review of community and mental health services to understand how best to meet the current and future demands of local populations and how organisations might work together. The review concluded with the following recommendations, which were formally endorsed by the HIOW Integrated Care Board (ICB) in October 2022:

- 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.

1.9 An options appraisal was conducted as part of the independent review to determine the preferred options for the future arrangements of community and mental health services in HIOW. This process concluded that the preferred way forward was to bring NHS community and mental health services together by creating a new Trust. This options appraisal was refreshed during the development of the Strategic Case, which was approved by Boards in March 2023, and the process followed and conclusions reached remain valid for this FBC.

Vision for the new Trust

1.10 The emerging vision for the new Trust has been developed through engagement with staff and partners, in particular through the 'Shape Our New Trust' programme::

"Together we deliver outstanding care that supports people to live their best and healthiest lives."

1.11 The Trusts have developed a set of emerging strategic objectives that are designed to deliver the vision for the new Trust:

- Deliver high quality, safe and effective services to all people to improve health and wellbeing and reduce health inequalities
- Leverage the strategic benefits of working at scale to deliver in local communities
- Embed and sustain an inclusive culture of coproduction, collaboration and continuous improvement
- Facilitate change within the system, working collaboratively to transform clinical pathways for the benefit of our population
- Be a great pace to work, supporting and providing opportunities for staff
- Improve value for money

1.12 Embedding values and cultural change across the new Trust will be critical to the successful delivery of the strategic objectives. The Trusts have therefore undertaken a programme of work, engaging with staff and communities throughout, to understand existing cultures, to articulate the values and culture to be embedded in the new Trust and to plan the programme of interventions that will deliver this. The emerging values for the new Trust are:

- **People first:** we are kind, caring and compassionate;
- **Creative:** we empower and innovate to constantly improve;
- **Accountable:** we are open, we act with integrity and take responsibility;
- **Respectful:** we are inclusive and treat people as they want to be treated; and
- **Working together:** we work in partnership with our patients, staff and communities.

Clinical strategy

1.13 The clinical strategy for the new Trust has been developed to respond to the case for change. 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 clinical priority 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 Transformation Group.

- Mental health and learning disabilities:
    - Children and young people
    - Older people's mental health
    - Acute and crisis care
    - Community mental health services (No Wrong Door)
    - Neurodiversity services
- Community:
    - Frailty
    - Community beds and rehabilitation
    - Long term conditions
    - Urgent community response
- Primary care

In addition, lived experience is a cross-cutting workstream of the clinical strategy.

1.14 The principles that will underpin the delivery of the clinical strategy are:

1. Embed a culture and practice of continuous improvement, innovation and research.
2. Ensure that all clinical decisions benefit from both lived and learned experience.
3. Adopt a life course approach which removes barriers and provides greater emphasis on prevention and a pro-active approach.
4. Work alongside our communities ensuring that we collaborate effectively to wrap services around the needs of individuals and measure ourselves according to outcomes that matter.
5. Provide effective clinical and professional leadership.
6. The clinical strategy will be underpinned by a sustainable workforce.

1.15 The clinical strategy for the new Trust is summarised in the following figure, which shows how the core objective of providing "sustained high quality care for the people of Hampshire and the Isle of Wight" is underpinned by the principles and supported by key enabling strategies of workforce, digital and estates.

Clinical and Professional Leadership and Workforce equipped to deliver high quality care

Collaborative working with people with lived experience of using services, their families and carers, our communities and with system partners

Sustained high quality care for the people of Hampshire and the Isle of Wight

Continuous improvement, innovation and research

Life course approach, including prevention and early intervention

Workforce

Digital

Estates

1.16 The new Trust will adopt a phased and prioritised approach to the integration of clinical services. The ten clinical priority areas will be the initial priorities for the new Trust, focusing on the areas where there are significant risks that need to be addressed and where significant patient and workforce benefits can be delivered.

1.17 The clinical strategy has been designed to provide a framework for service improvement and will be developed further over the first two years of the new Trust to ensure it reflects the evolving needs of patients and staff, progress and challenges arising from implementation and any changes to system or national priorities.

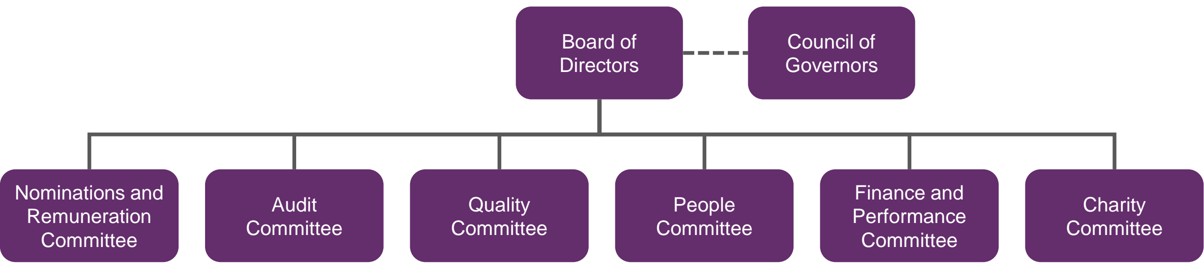
Operating model

1.18 As the new Trust will also be a foundation trust, the operating model will include a CoG. A Constitution Review Group was established to look at how the Southern constitution needs to change to reflect the broader geography of services provided. This work involved developing proposed amendments to the constituencies and appointed governors and making recommendations on the composition of the CoG. A

key change will be the addition of the service user and carer constituency to help embed the voice of lived experience at the heart of the Trust.

1.19 The process to appoint designate members of the new Trust's Board was developed based on the Partnership Agreement and to comply with Southern's constitution and the Code of Governance. As at the date of this FBC, the designate chair, designate Non-Executive Directors and designate chief executive have been appointed. Executive directors will be appointed by the end of December 2023.

1.20 The Corporate Governance Steering Group has reviewed the committee structures within Solent, Southern and the IoW to support the development of the committee structure for the new Trust, which is shown below. Once the Board composition has been finalised, including the executive portfolios, a process will be agreed with the Chair designate to review the skills matrix for Board members to inform the membership of committees and appointment of committee chairs.



1.21 The operational management structure that will sit below the Board and committees is under development. An options appraisal was undertaken to inform the design of the operational management structure and to establish principles for its development. This options appraisal involved staff from across the Trusts and took into account what already works well in each Trust. Work is underway on detailed service mapping and engagement with clinical teams where there are different options to consider. The operational management structure is due to be agreed by the end of December 2023.

Quality governance

1.22 The quality governance strategy has been developed to support the principles of the clinical strategy. The new Trust will build upon best practice from each Trust to embed a 'just culture' that learns from incidents and concerns.

1.23 The new Trust's reporting mechanisms from floor to Board will support assurance and good governance. A Quality Oversight Group will report into the Quality Committee which will report directly to the Trust Board where matters require escalation.

1.24 The new Trust will adopt a quality management system based on the 'learning health system' approach, comprised of:

- Quality planning: understanding of the needs of the population and co-designing an approach that meets these needs with measurable outcomes;

- Quality control: measuring quality outcomes and using this information to identify and address emerging problems. Standardisation is an important quality control measure; and
- Quality improvement: using evidence-based methodologies to address improvement priorities.

1.25 The new Trust will embrace patient experience and coproduction and a Lived Experience Steering Group is leading the development of the approach the new Trust will take in order to ensure it is it representative of the people who use its services.

People, digital and estates

1.26 People, digital and estates strategies will help enable the successful delivery of the clinical strategy of the new Trust. Development of these strategies depends on a clear understanding of the principles and guidelines set out in the clinical strategy. Development of these enabling strategies is underway, with completion planned within the first year of the new Trust. Work to date has focused on the requirements for Day 1, the structure of each function within the new Trust, integration planning and the key aims for the new Trust.

People

1.27 A four phase approach to organisational development has been adopted to understand the cultures of the Trusts and develop plans for the new Trust: scoping, discovery, design and delivery. Staff and senior leadership were engaged with throughout.

1.28 The approach to embedding cultural change in the new Trust includes building the culture into everyday ways of working, leadership commitment, visible changes and combining interventions to deliver the desired culture.

1.29 An initial set of priorities of the emerging people strategy have been articulated, along with associated measures and metrics to monitor. The people strategy is in development, with further engagement activities planned before it is finalised.

1.30 The structure of the people function for the new Trust has been determined, which includes a single Occupational Health and Wellbeing service for all staff groups, based on the recently implemented Solent model.

Digital

1.31 The HIOW ICB has recently developed a Digital, Data and Technology Transformation Plan for the system. This plan includes a series of objectives designed to deliver the vision, which have been considered in the development of the emerging digital strategy for the new Trust.

1.32 Each of the four Trusts operate a number of different Electronic Patient Record systems. £1.3m of national EPR funding has been secured to transfer Hampshire CAMHS from Carenotes to Rio by 1 March 2024, with the remaining £0.1m cost to be

funded from existing Trust capital budgets. An options assessment to develop a roadmap for the convergence or rationalisation of EPR systems will be undertaken as part of the ongoing development of the digital strategy. Any significant investment will be subject to a separate business case.

1.33 Digital transition involves a number of changes to be made ahead of Day 1 to ensure access to appropriate software and systems, alignment of networks and infrastructure and consolidation of corporate systems where essential.

1.34 For digital services relating to IoW, a service level agreement is planned for an initial period of two years.

Estates

1.35 The existing estates strategy for the HIOW ICS was developed by the HIOW STP in 2018. A new Estates Infrastructure Strategy for the ICS will be developed by the end of 2023/24, with the new Trust expected to play a significant role in its development.

1.36 The existing estates strategies of each of the four Trusts identify specific areas of focus. These will be aggregated, reviewed and consolidated under the emerging estates strategy for the new Trust. This emerging estates strategy articulates a vision for estates and facilities and outlines the ways in which it will support existing national and regional strategies to deliver place-based care by integrating technologies that support the elimination of geographic boundaries.

Benefits

1.37 Working with stakeholders including staff, patient groups and the ICB, we have identified significant benefits that will be achieved through the creation of a new Trust. This has been done alongside the integration planning process to ensure that potential opportunities are incorporated into the Post Transaction Integration Plan, along with the approach for benefits realisation.

Benefits for patients and carers	• **Improving accessibility of 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; • **Improving continuity of care** by aligning the geographic coverage of service teams and reducing the number of interfaces across care pathways; • **Simplifying pathways** and reducing hand-offs so that a single Trust will be the single point-of-contact across the ICS for a patient to contact; • **Providing the right care first time** by adopting a tiered approach to service improvement, innovation and transformation that recognises the importance of standardisation to reduce unwarranted variation and adaptation to meet the needs of place; • **Providing integrated care and supporting people more effectively at home and in the community** by bringing physical and mental health services together as well as strengthening links with system partners; • **Strengthening the alignment of capacity and need** through better matching capacity of services to the level of need in different geographies and patient cohorts; • **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; • **Developing a culture that values the voice of lived experience** from every clinical interaction to the design and delivery of services. The culture will support recovery and coproduction resulting in improved safety, outcomes and experience for patients; and • **Expanding opportunities for research activities**, which will ultimately support improvements in patient care.
Benefits for staff	• **Tackling recruitment and retention challenges** to reduce vacancies, which will also help reduce operational pressures on staff and improve staff satisfaction. • **Improving career progression and development**, reducing the need for staff to move between organisations to progress their careers and thereby will improving talent retention; • **Improving job satisfaction,** thereby improving staff health and wellbeing; • **Development of an inclusive, open culture,** which will help managers to feel supported to navigate employee relation matters compassionately, helping to reduce employee relation cases such as formal resolution cases; and • **Improving service resilience** by reducing professional isolation, particularly of smaller services.

Benefits for the wider health and care system	• **Tackling health inequalities** as the new Trust will be better placed to work with system partners to address health inequalities; • **Responding better to local communities,** by joining up services, involving communities in determining how care is delivered and improving constancy of access across geographic areas; • **Supporting the delivery of health and wellbeing strategies** by being an active partner in each of the place-based partnerships and facilitating delivery of these strategies; • **Aligned operational planning** by working closely with commissioners to ensure plans are aligned to system priorities; • **Enabling the streamlining of system assurance processes,** working collaboratively to design system governance and increasing opportunities to share learnings and spread innovation; • **Supporting large-scale transformation of models of care** to improve services with potential benefits across the system; • **Enhancing the focus on population health** by working more effectively with system partners, thereby helping to improve the health and care for the population across HIOW; and • **Being a strong and consistent voice for community and mental health and learning disability services across the ICS,** working with partners at neighbourhood, place and system levels to achieve the system's aims.

1.38 There are additional benefits specific to the population of the Isle of Wight, including strengthening the resilience of sub-scale services, helping to address the highest risks in service delivery, enabling opportunities for training and development for IoW staff and reducing the professional isolation associated with delivering sub-scale services is a geographically isolated location.

1.39 Four case studies have been developed in the Patient Benefits Case to illustrate the patient benefits expected to be realised through creation of the new Trust

Integration risks

1.40 Robust risk assessment and management processes have been in place throughout the programme. Risks have been identified from a range of sources including the due diligence process, Steering Groups, the Programme Board and external sources. Risks and mitigations are managed through the programme governance structure.

1.41 The key integration risks, which are the risks arising from the creation of the new Trust have been identified as:

- **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, which could destabilise services and lead to incidents (and ultimately patient harm) and reputational damage.

  Mitigation: Communications and engagement plan in place and key messages issued weekly. An Organisational Development plan is being developed.

Frequently asked questions developed and available. A programme of joint senior leaders events has been in place since October 2022. Clinical Transformation Group workstreams have been mobilised to deliver clinical transformation. Staff survey and senior staff surveys have been planned for autumn 2023 to monitor staff engagement.

- **Culture, behaviours and values:** if the creation of the new Trust's culture, behaviours and values is not co-designed and embedded with staff and supported by managers to address concerns raised, there is a risk that acceptance of the transition will be poor, and that the positive conditions for a healthy culture are not be created, leading to increased staff turnover.

  Mitigation: Further to the Shape Our New Trust staff engagement programme and Manager's Change Support pack and training offer, activities are planned around values, new Trust strategy and operational management structure. A series of pulse check surveys will measure how staff feel specifically in relation to the Fusion change programme.

- **Post-Day 1 senior leadership arrangements:** there is a risk that uncertainty over organisational form and senior leadership team including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.

  Mitigation: The executive structure and high level portfolios for the new Trust have been developed and further engagement on operational management structure is planned.

- **Disparity in remuneration** approaches for staff across the existing Trusts could result in inequities and variations that could negatively impact staff morale if not dealt with in a timely and agreed way.

  Mitigation: TUPE measures and evaluation of salaries, with any risks to be worked through with options appraisals presented to the new Trust Board to determine fair and equitable arrangements.

- **ICS financial position risks pressure on programme budget**, resulting in sub-standard delivery or delay, ultimately leading to benefits not being realised.

  Mitigation: Continued engagement with the ICB regarding the strategic importance of the programme.

1.42 The Trusts carry significant business as usual (BAU) risks, particularly relating to the delivery of medium term financial plans. Bringing the Trusts together will create further opportunities for cost reductions, which helps to reduce the level of financial risk that exists in the standalone organisations.

Financial context and plan

1.43 The HIOW system reported a £83.2m deficit in 2022/23 which comprised of £12.6m for the ICB and £70.6m for providers. For the 2023/24 plan the ICB initially submitted a £7.1m deficit and the providers a £111.3m deficit. Clearly this was not a position that

was compliant with the organisations' statutory responsibilities and as a result the system moved into the Recovery Support Programme and moved to segment 4 of the NHS Oversight Framework. In month 2, NHSE notified a change in allocations for the ICB on the condition it was reflected in a change to the financial position. As a result, the ICB plan moved to a surplus of £5.9m and the system overall moved to a plan of £105.4m deficit. The HIOW system partners have identified several key strategic changes that constitute the system's Financial Recovery Plan (FRP). Bringing together community, mental health, learning disability and autism services into a single entity is a fundamental element of this FRP.

1.44 Although the primary driver for the transaction is the significant benefits that can be realised for patients, the Trusts have identified annual corporate and agency premium savings of £2.4m in 2024/25, increasing to £4.1m by 2026/27. There are also further indirect financial benefits to system partners.

1.45 Transaction and integration costs have been quantified and total £3.5m in 2024/25. These costs are principally non-recurrent costs of integration and implementing the clinical strategy.

1.46 The financial position for the relevant services of the four Trusts in aggregate is forecast as a deficit of £7.4m in 2023/24. Under the new Trust, this is projected to reduce to a deficit of £1.7m in 2026/27 after the reinvestment in clinical services to benefit patients and staff. The £1.7m forecast deficit represents the current view of the IoW structural deficit.

1.47 Financial risk has been quantified through a sensitivity analysis which considers a range of potential downside risks, mitigations and upside opportunities. This analysis highlights the level of risk that exists within the counterfactual case, as well as the potential impact of the creation of the new Trust on risks of increased activity growth, CIP delivery and integration costs.

Delivering the transaction

1.48 A timeline has been developed, showing the key activities and milestones required to create the new Trust on 1 April 2024. This includes Trust Board approvals, regulatory review and approval by NHSE, Transfer of Undertakings (Protection of Employment) (TUPE) consultation and ongoing communications and engagement activities.

1.49 Robust programme governance arrangements were put in place to develop this FBC, including a Programme Board, Programme Team and Steering Groups. The Segmentation and Service Transfer Executive Advisory Group (SSTEAG) was established to advise the IoW Board and Fusion Programme Board on the approach to segmentation and the transfer of community and mental health services from IoW. These programme governance arrangements will remain in place following the creation of the new Trust to oversee the integration process.

1.50 The process for determining the name for the new Trust involved extensive engagement with stakeholders including staff, system partners and communities. Based on this engagement and following NHS guidance, options for potential names

were agreed at Programme Board and shared with NHSE. The geographical descriptor was agreed as "Hampshire and Isle of Wight" and a poll was conducted to assess options for the additional descriptor required to differentiate the new Trust from other providers in the system. The resulting proposed name of the new Trust is **Hampshire and Isle of Wight Healthcare NHS Foundation Trust**.

1.51 The legal form of the transaction is to bring services together into Southern, as the existing NHS Foundation 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
- a statutory transfer under section 69A of the NHS Act 2006 of the Isle of Wight community, mental health and learning disabilities services from IoW to this enlarged organisation.

1.52 The transfer of CAMHS from Sussex Partnership to Southern is planned for 1 February 2024, subject to commissioner decision.

1.53 Prior to Day 1, the priority is to ensure that any patient safety risks arising from the integration are mitigated appropriately, to ensure the new Trust can operate legally, and for there to be no adverse impact on delivery of clinical and corporate services. Work will have commenced to develop clinical transformation plans on a phased basis, and to establish integrated clinical and corporate services.

1.54 The focus for the first 100 days will be to deliver the initial benefits from creating the new Trust and maintain momentum in the immediate post-Day 1 period. Integration of the four of the clinical service priorities and the implementation of integrated team structures for the majority of corporate services will begin during this phase.

1.55 During year 1, the focus will be on delivering the benefits that do not require complex and/or transformational change, which are planned for years 2 and 3.

1.56 The new Trust will undertake post transaction evaluations to learn from successes and challenges of the integration as it progresses. These will be conducted one month after Day 1 and annually thereafter for three years.

Communications and stakeholder engagement

1.57 The Communications and Engagement Steering Group has developed a strategy that aims to:

- deliver coordinated communications and engagement activity;
- support the delivery of timely and meaningful community and employee engagement programmes;
- shape key messages and ensure these are communicated and understood by all audience; and
- as far as possible, ensure that media reporting is factual and accurate.

1.58 The Shape Our New Trust engagement programme was developed in order to engage with patients, communities, staff and partners on key matters relating to the development of the new Trust. The programme ran for six weeks in May and June 2023 and involved a series of surveys, meetings and events. Feedback from the programme was shared with the senior leaders from across all four Trusts at the end of June at a joint senior leaders' event. Key themes have also been shared with staff through the monthly e-newsletter.

1.59 Key themes arising from engagement to date are:

- Concerns regarding the potential impact of the new Trust on accessibility of services, particularly regarding the Isle of Wight;
- Ensuring equitable access to all services across the region along with clear information about how to access services;
- The need to see the new Trust address inequalities between different groups so that diverse communities have equal access;
- A desire to see improvements in identifying clear pathways for diagnosis, treatment and support of mental health for people of all ages and for those with dementia;
- Services should work more effectively to address waiting lists;
- Concerns about communities across the area having an equal voice in developing services and a desire to see services improved in line with the best available provision; and
- A desire to ensure that voluntary sector providers were recognised as an important and equal part of overall service provision.

1.60 Feedback from engagement is provided to the Communications and Engagement Steering Group and where responses are required these are being actioned by the group or through local contact. Specific feedback relating to clinical priority workstreams is fed back through the Clinical Transformation Group.

1.61 The frequency and reach of engagement with staff and external stakeholders, including people in local communities, will increase in the approach to Day 1. A communications and engagement strategy for the new Trust will be developed to deliver an enhanced programme of activity in the first year of the new Trust. The emerging strategy sets out the planned aims, approach, audiences and channels of communication.

2 Introduction

Chapter summary

- This chapter provides background on the Hampshire and Isle of Wight (HIOW) system, the Trusts involved in this proposed transaction and the challenges facing them in respect of mental health, learning disability and community services.
- The HIOW Integrated Care System (ICS) 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 ICS: 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 (CQC) and reported operating income of £274.8m and a surplus of £0.4m in 2022/23.
- 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 CQC and reported operating income of £455.0m and a surplus of £1.5m in 2022/23.
- 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 Full Business Case. The Trust is rated 'good' by the CQC and reported operating income of £284.9m and an overall deficit of £24.8m in 2021/22. Income related to community, learning disability and mental health services was £59.6m in 2022/23.
- In June 2023 HIOW Integrated Care Board (ICB) and all seven of its member Trusts were moved to Segment 4 of the NHS Oversight Framework after declaring a deficit plan for the system for 2023/24. Further details on the financial position of the Trusts and the HIOW system are set out in chapter 10.
- 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 Integrated Care System

2.1 The Hampshire and Isle of Wight (HIOW) Integrated Care System (ICS) is the tenth largest of the 42 health and care systems in England, covering a resident population of 1.9 million people across Hampshire (excluding north-east Hampshire, which forms part of the Frimley ICS), Southampton, the Isle of Wight and Portsmouth. The ICS has an annual health and care budget of £3.9 billion.

2.2 The ICS includes four upper tier local authorities (Portsmouth City Council, Hampshire County Council, the Isle of Wight Council and Southampton City Council), ten 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.

2.3 The HIOW Integrated Care Board (ICB) was established in July 2022 from two Clinical Commissioning Groups (CCGs): Hampshire, Southampton and the Isle of Wight CCG (which was itself established in 2021 following the merger of six CCGs: Southampton City, West Hampshire, South Eastern Hampshire, Fareham and Gosport, North Hampshire and Isle of Wight) and Portsmouth CCG.

2.4 The area comprises the substantial urban settlements of Southampton, Portsmouth, Winchester and Basingstoke, as well as large rural areas interspersed with market towns and villages. It also includes the relatively geographically isolated island population of 143,000 on the Isle of Wight, with no fixed transport link to the mainland and, at times, limited or no access via ferry. There are significant challenges to providing clinically and financially sustainable services to this isolated and small scale population.

2.5 Demographically, there is variation across the HIOW system. For example, whilst the population of the whole system is ageing and living with increasing associated mental health needs, rural areas, west Hampshire, and the Isle of Wight are experiencing this to a greater extent. On the Isle of Wight the age profile of the population is similar to that of other areas popular with retirees, but more people live alone on the Isle of Wight.

2.6 92.7% of Isle of Wight residents live in areas defined as coastal and there are also coastal communities in southern Hampshire. These communities have lower life expectancy and higher rates of several diseases – including heart disease, diabetes, cancer, chronic obstructive pulmonary disease (COPD) – and poor mental health in comparison to non-coastal areas.

2.7 The population of the ICS is ethnically diverse, with urban areas such as Portsmouth, Southampton and north-east Hampshire being more diverse than the predominantly white rest of the system. These urban areas are also associated with higher levels of social deprivation and mental health vulnerability.

2.8 The HIOW system experiences areas of health inequality that manifest in various ways:

- Higher levels of emergency care compared to the rest of England, but this is especially true in more deprived areas where access to primary care is poorer
- Prevalence of heart disease, diabetes, COPD and mental health issues is higher in more deprived areas of the system, with these contributing to higher mortality compared to the least deprived areas of the ICS
- There is also a significant inequality in life expectancy at birth between the most- and least-deprived areas. Male life expectancy is between 6.1 and 9.1 years lower in more deprived areas, with female life expectancy being between 2.3 to 5.5 years lower
- The impact of COVID-19 has disproportionately affected, and created additional health needs relative to the rest of the HIOW population, residents of more deprived areas and densely populated centres, those with learning disabilities, males, older people, certain ethnic minority groups, and those with pre-existing conditions
- People with severe mental illness experience higher rates of premature mortality (under the age of 75) on the Isle of Wight, in Southampton and in Portsmouth than the national average

2.9 The ICS has identified a number of key challenges that it is seeking to address as a system, as set out in the Interim ICS strategy published in December 2022:

- **Demand:** in general, the ICS is facing increasing demand for services, including an increase in complexity in both physical and mental health needs. There are unprecedented pressures in urgent care that – if left unabated – will result in a 15-20% increase in non-elective admissions by 2025. The number of patients waiting for operations has increased but issues with flow through hospitals and workforce availability have limited the rate with which services can treat people;
- **Workforce:** the system faces ongoing recruitment and retention challenges, coupled with higher rates of sickness absence due to COVID-19, stress and other physical illnesses. This is exacerbated by staff shortages nationally and lower levels of volunteering caused by cost-of-living hardship;
- **Budget:** The ICS is operating with a financial deficit. Local authority budgets have decreased across all services, particularly social care. Whilst NHS budgets have increased in real terms, these increases have been outstripped by increased service demand. The voluntary sector has seen funding challenges due to the cost-of-living crisis. Rising cost inflation, particularly in energy, adds additional pressure to the system's budgetary position. All system partners acknowledge the need to change the way that services are delivered to the local population to promote healthier lives and deliver high-quality,

sustainable care, rather than simply stretching individual organisations' plans; and

- **Pressure on people's lives:** Across the HIOW system, cost-of-living pressures have had an impact on people's physical and mental health and health inequalities.

2.10 In relation to mental health, HIOW has below-national average performance in waiting times for children and young people and people living with a serious mental illness who have not had their physical health check in primary care, and below national targets for waiting times talking therapies for anxiety and depression[1] and dementia diagnosis.

2.11 The ICS also recognises the increased risk of children in lower income households, children in a family with unhealthy family functioning, and/or whose parents have a mental health disorder developing a mental health disorder themselves. The significant pressures on our core community child and adolescent mental health services remain. New referrals into these services continue to far exceed planned capacity, and together with increasing acuity levels, numbers awaiting assessment, awaiting treatment and open to treatment have continued to rise.

Overview of mental health, learning disabilities and community services in HIOW

2.12 There are three main NHS providers of community[2], mental health and learning disability services in the ICS: Solent, Southern and IoW[3]. There are also providers of specific services from outside the ICS, including Sussex Partnership which provides community Children and Adolescents Mental Health Services (CAMHS) and children's eating disorder services in Hampshire, Dorset HealthCare which provides talking therapies for anxiety and depression in Southampton (with an annual contract value of c.£2m) and Surrey and Borders Partnership NHS Foundation Trust which provides attention deficit hyperactivity disorder (ADHD) and autism services in Hampshire and Portsmouth.

2.13 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), the four local authorities and the VCSE sector.

2.14 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. The

[1] 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.

[2] Throughout this FBC the term 'community services' is used to refer to physical health community services (as opposed to mental health community services).

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

figure below shows the main mental health services by main NHS provider across the ICS.

Figure 1: Main mental health and learning disability services by main NHS provider in the HIOW ICS

<table>
<tr><th>Mental health service</th><th>Isle of Wight</th><th>Portsmouth</th><th>South East Hampshire</th><th>Southampton</th><th>South West Hampshire</th><th>North and Mid Hampshire</th></tr>
<tr><td>CAMHS</td><td>IoW</td><td>Solent</td><td>Sussex</td><td>Solent</td><td colspan="2">Sussex</td></tr>
<tr><td>CAMHS inpatient</td><td colspan="6">Southern</td></tr>
<tr><td>Eating disorder OP (children's 0-17)</td><td>IoW</td><td>Solent</td><td>Sussex</td><td>Solent</td><td colspan="2">Sussex</td></tr>
<tr><td>Perinatal</td><td colspan="6">Southern</td></tr>
<tr><td>Adult inpatient</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Eating disorder IP (adult)</td><td colspan="6">Southern</td></tr>
<tr><td>Eating disorder OP (adult)</td><td>IoW</td><td colspan="5">Southern</td></tr>
<tr><td>IAPT</td><td>IoW (Isle Talk)</td><td>Solent (Talking Change)</td><td>Southern / Solent Mind (italk)</td><td>Dorset HealthCare (Steps2Wellbeing)</td><td colspan="2">Southern / Solent Mind (italk)</td></tr>
<tr><td>Community MH / crisis teams</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Older persons MH services</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Acute liaison</td><td>IoW</td><td colspan="5">Southern</td></tr>
<tr><td>Specialist and forensic</td><td colspan="6">Southern</td></tr>
<tr><td>Learning disabilities & autism</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Complex adults MH therapy</td><td>IoW - ECT</td><td colspan="5">Southern – ECT and rTMS</td></tr>
<tr><td>Crisis</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Southern (The Lighthouse)</td><td colspan="2">Southern</td></tr>
<tr><td>Urgent MH helpline (NHS 111)</td><td>South Central Ambulance Service</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Place of safety</td><td>IoW</td><td>Solent</td><td colspan="4">Southern (Parklands, Antelope and Elmleigh)</td></tr>
<tr><td>EIP</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
</table>

2.15 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. The figure below shows the main community services by main NHS provider across the ICS.

Figure 2: Main community services by main NHS provider in the HIOW ICS

<table>
<tr><th>Community health service</th><th>Isle of Wight</th><th>Portsmouth</th><th>South East Hampshire</th><th>Southampton</th><th>South West Hampshire</th><th>North and Mid Hampshire</th></tr>
<tr><td colspan="7">Adult physical health</td></tr>
<tr><td>Community inpatients</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>Community – Integrated teams
• Urgent care
• Frailty</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Falls</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Pulmonary Rehab</td><td>IoW</td><td colspan="3">Solent</td><td></td><td>Solent</td></tr>
<tr><td>• Palliative and End of Life</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• MSK and Pain management</td><td>IoW</td><td colspan="3">Solent</td><td>Southern</td><td>Southern / HHFT</td></tr>
<tr><td>• Tissue Viability</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Long Covid</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Sexual health services</td><td colspan="6">Solent</td></tr>
<tr><td>• Diagnostics</td><td>IoW</td><td>Portsmouth</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Speech and Language Therapy</td><td>IoW</td><td colspan="3">Solent</td><td colspan="2">Hobbs</td></tr>
<tr><td colspan="7">Children's physical health (excluding CAMHS and Learning Disabilities)</td></tr>
<tr><td>Health Visiting and School Nursing (LA funded)</td><td colspan="2">Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>Children's Health Information Service</td><td colspan="6">Southern</td></tr>
<tr><td>School Immunisations</td><td colspan="2">Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>Children's Community Nursing</td><td>IoW</td><td colspan="4">Solent</td><td>HHFT</td></tr>
<tr><td>Children's Continuing Care</td><td>N/A</td><td colspan="5">Various providers – commissioned according to need</td></tr>
<tr><td>Community Paediatrics and Therapies</td><td>IoW</td><td colspan="5">Solent</td></tr>
<tr><td>Specialist Children's Home Health – Swanwick lodge</td><td>N/A</td><td>N/A</td><td>Southern</td><td>N/A</td><td colspan="2">Southern</td></tr>
</table>

2.16 This complex system has developed through decades of organisational change, fragmented commissioning[4] and competition resulting in services moving between providers over time. Examples of the impact this fragmentation has had on services are provided in paragraph 3.45.

[4] Historically, the commissioning across HIOW was split across 7 CCGs: Fareham and Gosport, Isle of Wight, North Hampshire, Portsmouth City, Southampton City, South Eastern Hampshire and West Hampshire.

Figure 3: The main sites from which community, mental health and learning disabilities services are delivered by the Trusts

System performance

2.17 The latest published performance against mental health trajectories and targets is as set out in figure 4 with supporting commentary in figure 5. Key performance and activity metrics for the three Trusts are detailed in appendix 1.

Figure 4: HIOW ICS latest published performance against mental health trajectories and targets as at August 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**		NHS Talking Therapies Access Rate (previously IAPT)	Perinatal Access	Dementia Diagnosis Rate	Data Quality Maturity Index Score
								Urgent	Routine				
Latest available period	Q4	Apr-23 (rolling 3 months data)	Q4	Apr-23 (rolling 12 months data)	Apr-23	Apr-23	Apr-23 (rolling 12 months data)	Apr-23 (rolling 12 months data)		Apr-23	May-23 (rolling 12 months data)	Jun-23	Apr-23
National - Target	10,400 by end of Q4	60.0%	1,379 by end of Q4	121,466 by end Q1 23/24	80.0%	0	23,374 by end of Q1	95.0%	95.0%	3,333 by end Apr-23	1,439 by end Mar-24	66.7%	90.0%
HIOW ICS - Target	7,000 by end of Q4	60.0%	565 by end of Q4	11,814 by end Apr-23	80.0%	0	22,922 by end Apr-23	95.0%	82.5%	3,333 by end Apr-23	1,534 by end Mar-24	61.4%	90.0%
HIOW ICS - Performance	**6,740**	**77.8%**	**572**	**11,125**	**80.0%**	**35**	**22,045**	**85.1%**	**75.2%**	**2,855**	**1,120**	**60.9%**	**82.2%**

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

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

Figure 5: HIOW ICS Mental Health Performance Summary as at August 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 and into 2022/23. Primary care delivered 6,740 physical health checks by the end of Q4 against a local target of 7,000. This equates to 45.3% of SMI patients on the GP register receiving a complete annual physical health check.
- **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 March 2023, 572 people had accessed IPS services across the ICS cumulatively through 2022/23, as reported by all local providers, which is 7 higher than the Q4 local trajectory of 565 despite experiencing delays in mobilisation of the new Hampshire service. The performance team is also working closely with ICS colleagues to establish better reporting of IPS services.
- **Access to core CMH services** – Based on the Q1 2023/24 National target given to the ICS, services were delivering 89.2% of expected contacts by the end of April (month one of the quarter) and were therefore 689 contacts adrift of the local target for April. We continue to work with our provider and PCN colleagues on 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** – rolling 12 month position at the end of April 2023 was that 22,045 CYP had been supported by NHS funded MH services with at least one contact, 877 contacts adrift of target and the third month running that performance has slipped back. This is disappointing after steady improvement and above target performance May-Dec 2022.
- **Children and Young People Eating Disorder (CYP ED) - Urgent referrals** – Following consistent improvement, performance for the 12 months to April 23 was the highest we have seen since reporting of this metric with 85.1% of CYP ED being seen within the 1 week target for an urgent referral.
- **Children and Young People Eating Disorder (CYP ED) - Routine referrals** – The number of CYP seen within the 4 week timeframe for a routine referral at the end of April 2023 was 75.2%. Although in a better position that at this point last year, (65.1% April 2022) recovery of this metric has been challenging. This is largely due to a higher level of breaches within the Hampshire CAMHS ED service where performance in the 12 months to end of April 23 was 66.5%. The service has experienced an increase in Urgent ED referrals comparing year on year, and a high proportion of ARFID referrals continue to hinder the service's ability to assess and treat all routine referrals on this pathway within the 4 week target.

Programme 2: Crisis Care

- **Adult Mental Health Inpatients receiving a follow up within 72hrs of discharge –** April performance remains on target with 80% of HIOW Adult MH Inpatients reported as receiving a timely follow up post discharge, against a target of 80%. This is a consistent picture for 5 months of the target being achieved.
- **Out of Area bed days (inappropriate - month)** - Across HIOW ICS, 35 inappropriate OAP bed days were reported for April 2023. These were for two patients registered with HIOW GPs but sent by non HIOW Trusts to out of area private providers.

Programme 4: Other LTP delivery ambitions

- **NHS Talking Therapies* Access Rate** - In April 2023, 2,855 people accessed NHS Talking Therapies services, a decrease from March and 478 below target for the month. The monthly trajectory target is set in line with our commitment to provide access to 42,553 people by end of 2023/24. The Talking Therapies service has been identified as a priority service area for review during 23/24. A deep dive will be undertaken to get a better understanding of the barrier to entry and the necessary work required to meet the standard.
- **Perinatal Access** – Rolling 12 month position at the end of May 2023 was that 1,120 women had accessed specialist community perinatal mental health services against an end of year target of 1,534. NHS Digital note that figures may be low due to new data items to be completed this year.
- **Dementia Diagnosis Rate (DDR)** - In June 2023, 16,257 people received a dementia diagnosis across HSI ICS which was 283 above our 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 60.9%, 0.5% short of our local target and behind national performance of 63.5% for DDR.
- **Data Quality Maturity Index Score (DQMI)** - The target for 2023/24 has increased to 95%, so the ICS performance is below target at 82.2% for April 2023, however, this is a significant improvement from 64.3% in January due to all HIOW registered Providers now making a successful MHSDS submission. We continue to work with our service provider performance colleagues to understand reporting issues and improve the quality of data reported to NHS Digital.

*Previously Improving Access to Psychological Therapies (IAPT)

2.18 A summary of ICS performance for community services is provided in the figure below. Benchmarking of community services performance is primarily between providers across the south-east region. Appendix 1 details key performance and activity metrics for the three Trusts.

Figure 6: key performance metrics for community services across the ICS

	Current year performance				
	Apr-23	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**
UCR					
Total referrals	985	1,110	1,080	1,015	985
Compliance %	87%	87%	84%	84%	87%
National target %	70%	70%	70%	70%	70%
Virtual wards					
Expected admissions	497	510	523	534	557
Actual admissions	709	689	413	651	666
Waiting lists (top 5)					
MSK services	10,813	11,842	12,370	12,581	12,682
Podiatry services	3,994	3,956	3,863	3,745	3,572
Integrated rehab services	2,883	2,811	2,864	2,777	2,914
Nursing and therapy for LTCs continence/colostomy	2,425	2,754	2,874	2,870	2,495
CYP speech and language	2,374	1,614	1,787	1,628	1,682

Solent NHS Trust

2.19 Solent is the main community and mental health provider for the 230,000 people living in Portsmouth and the main provider of community services for the 250,000 people living in Southampton. It also provides services in south-east Hampshire, south-west Hampshire and some Hampshire-wide specialist services, as well as to the Isle of Wight. Solent has 42 mental health, 113 community and 26 virtual ward beds. All services provided by Solent are in scope for this Full Business Case (FBC).

2.20 Solent provides primary care services across Southampton and Portsmouth. GP and homeless healthcare services are provided in Southampton across three sites. Specialist primary care services, including rheumatology, are provided across both Southampton and Portsmouth.

2.21 The Trust delivers community, inpatient, nursing, therapies and specialist services – including tuberculosis – to adults in Southampton. Inpatient services are delivered through a Neuropsychiatric and Neuro Behavioural Rehabilitation unit, a 14 bed ward specialising in adults with physical and cognitive limitations, and two inpatient wards for adults receiving rehabilitation from the community or acute sectors.

2.22 Similarly in Portsmouth, Solent provides community, inpatient, nursing, therapies and specialist services to adults, including a range of integrated services with Portsmouth

City Council. In addition to learning disability and behavioural services, the Trust has two inpatient units: a 30 bed continuing healthcare unit and a 16 bed inpatient rehabilitation ward for those with complex physical disabilities.

2.23 The Trust provides community-based nursing, therapies and mental health services to children and their families across HIOW. CAMHS caters to 5-to-18-year-olds living in Portsmouth and Southampton who experience acute, chromic and severe mental health disorders.

2.24 Solent's general mental health services are provided across the community and three adult wards – based at St James Hospital – for Portsmouth residents. A 22-bed ward provides older people's accommodation for those with acute illness and/or severely challenging behaviour. A ten bed secure ward provides psychiatric intensive care and a 20-bed non-secure ward provides care to adults experiencing acute episodes of mental illness.

2.25 The Trust also provides specialised dental services to patients with special needs and sexual health services across all of HIOW.

2.26 The Trust is in Segment 4 of the NHS Oversight Framework[5].

2.27 An overview of the Trust's operational performance for the year to 31 August 2023 is provided in appendix 1.

2.28 The Trust was last inspected by the Care Quality Commission (CQC) in October 2018 and was rated 'good' overall, including an 'outstanding' rating against the caring domain. No domain was rated as being lower than 'good' during the latest inspection. One regulatory action was taken during this inspection, in respect of ensuring that the Trust make medication management safe for all patients.

2.29 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.

2.30 As at 31 March 2023 the Trust employed 5,335 staff, equating to 3,908 full-time equivalents (FTEs). In the 2022 Annual Staff Survey[6] the Trust achieved the best scores in its peer group for the 'compassionate and inclusive', 'recognised and rewarded', 'having a voice that counts' and 'being a team' themes and sustained its employee engagement score of 7.4.

2.31 In 2022/23 the Trust reported operating income of £274.8m (sources detailed in the figure below) and a surplus of £0.4m. In 2023/24 the Trust planned for operating

[5] In June 2023 HIOW ICB and all seven of its member Trusts were moved to Segment 4 of the NHS Oversight Framework after declaring a deficit plan for the system for 2023/24. Prior to this, Solent was in Segment 2. 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

[6] https://www.solent.nhs.uk/media/4276/nss22-benchmark-reports_r1c.pdf

income of £251.2m (a decrease of 8.6%) and a deficit of £2.2m. As at month five, the Trust is forecasting delivery of a £2.2m deficit, in line with plan.

Figure 7: Sources of income for Solent in 2022/23

	£000
NHS income	220,769
Local authorities	26,815
Other sources	27,218
Total income	**274,802**

Southern Health NHS Foundation Trust

2.32 Southern is one of the largest providers of mental health and community services in England with 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 FBC.

2.33 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) for a regional and national population. Southern also provides community services for 1.2 million people in Hampshire.

2.34 Southern's mental health services include adult inpatient and older people inpatient wards, the former being located at six hospitals across Hampshire and the latter at four hospital sites. As well as supporting patients with functional and organic mental illnesses, specialist inpatient wards are also available for military personnel, as well as a mother and baby unit in Winchester. Adult and older people's community mental health services provide psychological interventions for functional (e.g. depression, anxiety, mood disorders) and organic (e.g. Alzheimer's) illnesses. The Trust also provides specialist dementia services, early intervention in psychosis, crisis resolution teams, talking therapies, eating disorder service, psychiatric liaison across Hampshire general hospitals' emergency departments, and rehabilitation services. Southern also has a forensic mental health service catering to both adults and children across six inpatient units (low and medium secure) and the community.

2.35 Southern provides learning disability services to adults in Hampshire and Southampton to support them with unmet health needs, including their physical health, epilepsy, challenging behaviours, autism, mental health (including dementia) and forensic health needs.

2.36 The Trust's children and family services are delivered by specialist teams, covering areas such as health visiting, school age immunisations, school nursing, ChatHealth services to allow young people and their families to text health visitors or school nurses about health and wellbeing concerns and services for children in care. Since

2020 the Trust has delivered the Healthy Child Programme across Hampshire in partnership with children's charity Barnardo's.

2.37 Southern's physical health services cover a variety of services, including 13 inpatient wards at six hospitals across Hampshire. Inpatient services aim to support patients in becoming well enough to return to the community, be that their own homes or in nursing or care homes. These wards also provide some end-of-life services. Integrated care teams deliver physical health services in the community, comprising nurses, therapists, practitioners, and support workers to provide care to patients in their homes and local communities. The care provided includes hospital step-down, a falls service, living support, support with managing chronic conditions and tissue viability support. Other services covered by physical health at the Trust include endoscopy, radiology, occupational therapy, physiotherapy, podiatry, continence and Urgent Treatment Centres (UTCs).

2.38 The Trust is in Segment 4[7] of the NHS Oversight Framework. An overview of the Trust performance for the year to 31 August 2023 is provided in appendix 1.

2.39 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.

2.40 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 KC, 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.

2.41 A series of public hearings took place throughout March and April 2021, chaired by Nigel Pascoe KC, 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).

[7] In June 2023 HIOW ICB and all seven of its member Trusts were moved to Segment 4 of the NHS Oversight Framework after declaring a deficit plan for the system for 2023/24. Prior to this, Southern was in Segment 3.

2.42 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).

2.43 Enforcement undertakings relating to the CQC warning notice issued in 2016 (see paragraph 2.39 above) were accepted by NHS Improvement in 2018. In March 2023 NHS England (NHSE) issued a compliance certificate confirming that the Trust has demonstrated compliance against each component of the enforcement undertakings.

2.44 As of March 2023, the Trust employed 6,908 staff, equating to 5,999 FTEs. In the NHS Staff Survey 2022, the Trust typically scored at or slightly above average in each of the domains surveyed, with the Trust seeing slight improvements in most domains. The 'staff engagement' score was 7.1, a slight improvement from the previous year's score of 7.0.

2.45 In 2022/23 the Trust reported operating income of £455.0m and a surplus of £1.5m. In 2023/24 the Trust planned for operating income of £443.8m (a decrease of 2.5%) and a breakeven position. As at month five, the Trust is forecasting delivery of a breakeven position, in line with plan.

Figure 8: Sources of income for Southern in 2022/23

	£000
NHS income	402,456
Local authorities	18,702
Other sources	33,846
Total income	**455,004**

Isle of Wight NHS Trust

2.46 Isle of Wight NHS Trust provides acute, community, mental health, learning disability and ambulance services to the population of the Isle of Wight. The Trust serves an isolated, offshore population of 140,400, with no fixed link to the mainland. Compared to the rest of England, the Isle of Wight has an older population[9] with a greater proportion of the population aged 50 years and older and a lower proportion of working age and younger population groups. Only the Trust's mental health, learning disability and community services are in scope for this FBC.

2.47 Community services are delivered in patients' homes, in a range of primary and community settings, and from St Mary's Hospital, within which there is a 14-bed

[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] The Isle of Wight has a significantly older population than England as a whole, with 37% of residents being aged over 60 years, compared to 24% nationally

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.

2.48 The Trust's mental health services provide inpatient and community-based mental health care. The Trust has 34 mental health beds and its community mental health team supports a caseload of 900 patients. The Trust's mental health services cover speciality 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.

2.49 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'.

2.50 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. All mental health services inspected were rated 'good', including the Community Mental Health Team, where the rating moved from 'inadequate' to 'good', although the overall rating remained 'requires improvement'.

2.51 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. The Trust was also moved from Segment 4 of the NHS Oversight Framework to Segment 3 (although returned to Segment 4 in June 2023 alongside the ICB and all seven member Trusts[10]).

2.52 As of March 2023, the Mental Health and Learning Disabilities Division employs 390 staff on an FTE basis and reported a staff engagement score of 7.0 in the 2022 Annual NHS Staff Survey (unchanged from 2021). Divisional staff survey scores were at or above peer average across all domains, with the 'learning' domain reporting the best in the peer group. As of March 2023, the Community Division employs 547 staff on an FTE basis and reported a staff engagement score of 7.1 in the 2022 Annual

[10] In June 2023 HIOW ICB and all seven of its member Trusts were moved to Segment 4 of the NHS Oversight Framework after declaring a deficit plan for the system for 2023/24.

NHS Staff Survey (down from 7.2 in 2021). As with the Mental Health division, the divisional staff survey scores were at or above peer average, with the 'learning' domain scoring the best of the Trust peer group.

2.53 In 2022/23 the whole Trust reported operating income of £284.9m (sources detailed in the figure below) and a deficit of £24.8m. In 2023/24 the Trust planned for operating income of £280.8m and a deficit of £24.8m. As at month five, the Trust is forecasting delivery of a £24.8m deficit, in line with plan.

Figure 9: Sources of income for IoW in 2022/23

	£000
NHS income	264,383
Local authorities	-
Other sources	20,475
Total income	**284,858**

2.54 In 2022/23, mental health and community services income was £56.9m and a deficit of £2.9m was delivered. For 2023/24, the planned mental health and community services income was £58.4m, with an identified deficit of £5.2m.

2.55 The transfer of mental health and community services from the Isle of Wight NHS Trust 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 strengthen their partnership with South Central Ambulance Services NHS Foundation Trust. In February 2023 Portsmouth Hospitals University NHS Trust (PHU) and the Isle of Wight NHS Trust announced plans to strengthen the Acute Services Partnership through the formation of an NHS Group, with a single Chief Executive, Executive Team and single clinical leadership across our two organisations. On 1 June 2023 Penny Emerit became Chief Executive Officer of both PHU and IoW and appointments were made to a single Executive Team in August 2023.

Sussex Partnership NHS Foundation Trust

2.56 Sussex Partnership is a large NHS Foundation Trust that provides services for people with mental health problems and learning difficulties across Sussex and a range of specialist services across south-east England. Only the Trust's Hampshire CAMHS that are provided to the HIOW ICS population are in scope for this FBC. At the time of writing, these services are expected to transfer from Sussex Partnership to Southern on 1 February 2024, subject to relevant commissioner and Trust Board approvals.

2.57 Hampshire CAMHS provides services to young people aged 5-18 years and their families who are experiencing difficulties with their mental health. The service employs psychiatrists, psychologists, mental health nurses, a range of therapists, dieticians and support staff to support young people with mental health concerns including

eating disorders, ADHD, depression, psychosis, substance misuse and mental health crises.

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

2.59 The CQC last undertook an inspection of the Trust in early 2019, with the Trust being rated as 'good' overall. The CQC rated the Trust as 'outstanding' for its services being caring, with all other domains rated as 'good'. During this inspection, CAMHS was not directly inspected. However, the CQC did note an area of outstanding practice whereby the Trust's CAMHS community teams were commended by the mental health collaborative judges in October 2018, having been shortlisted for two awards: Hampshire CAMHS specialist eating disorder team and Hampshire CAMHS New Forest team were both commended in their respective categories. CAMHS inpatient services were rated 'good' at CQC's September 2016 inspection of the Trust and CAMHS community services were rated 'good' in November 2017.

2.60 As of September 2023, the Trust employed 6,031 staff, equating to 5,318 FTEs, of which 440 staff (equating to 390 FTEs) relate to Hampshire CAMHS. In the 2022 NHS Staff Survey, the Trust typically scored at or close to the average for their peer group. For 'staff engagement' Sussex scored 6.9, a slight decline on the 7.0 scored in the 2021 survey.

2.61 The transferring services represent approximately 5% of operating income and 7% of the workforce as at February 2023. The transfer of Hampshire CAMHS is not expected to impact the clinical and financial sustainability of the Trust.

Existing collaboration

2.62 In advance of the Fusion programme commencing, the four Trusts were 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.

Figure 10: Clinical priority areas

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

2.63 The Trusts have subsequently added 'lived experience' as an additional, cross-cutting workstream as it has emerged as a key theme in the development of the clinical strategy for the new Trust (see chapter 5).

2.64 These transformation workstreams are overseen by a Clinical Transformation 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.

2.65 The work of the Clinical Transformation Group informed the development of the clinical strategy for the new Trust (see chapter 5) and four[11] of the workstreams developed case studies within the Patient Benefits Case (PBC).

2.66 The work of the Clinical Transformation 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 Barnardo's 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;

[11] Children and young people's mental health services, older people's mental health services, lived experience and urgent response and frailty.

  - 111 mental health triage service delivered by Southern for all mental health trusts in the ICS;
  - Shared psychiatry on call arrangements in some areas between Solent and Southern; and
  - Mental Health Act governance across Solent and IoW has shared leadership.
- Membership of provider collaboratives:
  - CAMHS Tier 4 – Sussex Partnership is currently 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.

2.67 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 coproduced and commenced implementation of an Isle of Wight Mental Health and Learning Disability Strategy 'No Wrong Door, 2020-2025' which supports the Community Mental Health Framework for Adults and Older Adults[12]. 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 Transformation Group which is described in more detail in chapter 5.

2.68 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, local authorities 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

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

- collaborative working with people with lived experience and VCSE organisations to develop an ICS-wide approach to coproduction and to establish a peer worker network.

2.69 Since autumn 2022, the Trusts have been collaborating formally as part of the Fusion programme. The Fusion governance arrangements are described in chapter 11. The Strategic Case, which had the support of the ICB, was approved by all four Trust Boards in March 2023 and submitted to NHSE. In June 2023 NHSE confirmed it was supportive of the Trusts progressing to develop this FBC.

3 Strategic rationale

Chapter summary

- This chapter provides an overview of the challenges that the HIOW system and Trusts are seeking to address, and the reasons that the creation of a new Trust is proposed as the preferred option.
- 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 HIOW Integrated Care Partnership Strategy sets out five strategic aims for the system. The HIOW ICB along with system partners have developed the five-year Joint Forward Plan, which builds on the strategy by developing local priorities with key actions and enablers. 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.
- In February 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 case for change for the creation of the new Trust is driven by four main factors:
    - Community and mental health services are struggling to meet unprecedented increases in demand;
    - There is unwarranted variation in practice, and fragmented pathways and services with multiple hand-offs;
    - The Trusts are experiencing challenges in recruitment and retention resulting in workforce shortages which impact on the effectiveness and quality of services; and
    - The financial challenge is very significant.
- An options appraisal process was initially undertaken as part of the independent review of community and mental health services and was refreshed in the Strategic Case that was approved in March 2023. This process, criteria, scoring and conclusions remain valid for this Full Business Case.

National strategic context

3.1 Published in 2019, the NHS Long Term Plan (NHS LTP)[13] 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 NHS 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;
- 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.

3.3 The relevant commitments of the NHS LTP are set out in paragraphs 5.29 to 5.34.

3.4 Since the publication of the NHS 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**[14], 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.

3.5 The 2022 **Health and Social Care Act**[15] 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.

3.6 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.

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

[14] 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

[15] https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted

3.7 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 coordinate health and care services for their respective populations.

3.8 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.

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

3.10 In April 2023 the **Hewitt Review: an independent review of integrated care systems**[16] was published. The review identified six key principles to create the context in which ICSs can thrive and deliver: collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the space and time to lead; the right support; balancing freedom with accountability; and enabling access to timely, transparent and high-quality data. The review also describes the tendency of ICSs to prioritise waits for surgery over waits for community, mental health and learning disability services (CMHLD).

3.11 **Next steps for integrating primary care: Fuller Stocktake report**[17] 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

[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1148568/the-hewitt-review.pdf

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

- helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

3.12 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[18] 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.

3.13 The ICB has confirmed its support for the creation of the new Trust in a letter of support (see appendix 2 – [to be provided by ICB once finance chapter is finalised]).

Hampshire and Isle of Wight Integrated Care Partnership Strategy

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

3.15 The aims of the HIOW ICP Strategy are summarised in the figure below. These aims will be delivered across five priority areas: children and wellbeing; mental wellbeing; good health and proactive care; our people and digital solutions, data and insights. Specific areas of focus have been identified for each of these priority areas. More detail is provided in paragraphs 5.41 to 5.44.

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

Figure 11: Aims of the Hampshire and Isle of Wight Integrated Care Partnership Strategy

3.16 The HIOW ICB and system partners (including NHS providers) have developed their first five-year Joint Forward Plan (JFP)[19]. This builds on the Partnership Strategy and the health and wellbeing strategies for each Place. The JFP was developed by system partners in April and May 2023 prior to publication at the end of June. Further detail on the JFP is provided in paragraphs 5.46 to 5.48.

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

3.17 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 3). The scope of this review was broader than the scope of this FBC and a summary of this review is therefore included in this chapter as part of the context.

[19] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.hantsiowhealthandcare.org.uk%2Fapplication%2Ffiles%2F5716%2F8814%2F6151%2FHampshire_and_Isle_of_Wight___Joint_Forward_Plan_2023.pptx

3.18 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 (NEDs) 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.

3.19 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.

3.20 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.

3.21 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.

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

1. **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.

2. **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.

3. **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.

4. **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.

5. **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.

3.23 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 FBC. The new Trust will serve as an enabler for the other four recommendations and the success of this new Trust (and the realisation of the benefits) will be predicated on the system delivery of the other recommendations of the independent review.

3.24 A briefing on the system response to the recommendations of the independent review is included in appendix 4.

3.25 The new Trust will be a key partner in the review of community physical health beds (recommendation 2 above) which will need to include the number, location, function and purpose of beds. This will require a parallel assessment of acute hospital beds.

The case for change

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

- Significant increases in demand and are putting complex models under greater pressure, resulting in people not getting the care they need at the right time and in the right setting;
- Unwarranted variation in practice and fragmented pathways and services adversely affect health and wellbeing outcomes;
- Recruitment and retention challenges are resulting in workforce gaps (to varying degrees across the four Trusts) which impact the effectiveness and quality of services; and

- Financial challenges are expected to continue to increase. Since the whole system is in segment 4 of the NHS Oversight Framework, financial sustainability is an issue across all services in the system, including the Isle of Wight's services which are not financially or clinically sustainable.

Community and mental health services are struggling to meet unprecedented increases in demand

3.27 Across the HIOW system there have been significant increases in demand for community and mental health services. These have been driven by demographic changes and the impact of COVID-19. This is expected to be further exacerbated by the current adverse economic climate as well as operational pressure in the acute healthcare sector. Robust community services are needed to support more people closer to their homes and, in so doing, reduce dependency on acute hospital provision.

3.28 Prevalence of physical health conditions 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 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.

3.29 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 (because of historic funding and service commissioning across geographies), likely leading to some of the differences in quality of services.

3.30 Capacity issues in community services 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. A REAL Centre report published in July 2023[20] found that the prevalence of anxiety and depression are expected to increase in the period to 2040, reinforcing the need for greater capacity in community-based services.

3.31 HIOW has an older population relative to the rest of England, 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, and 30% are in Isle of Wight. By contrast, in Southampton and Portsmouth the proportion of over-65s is 14% and 15% respectively. Over the next ten years, the HIOW older population will grow faster than the national average, increasing demand for community services. The population is

[20] https://www.health.org.uk/news-and-comment/news/25-million-more-people-in-england-projected-to-be-living-with-major-illness-by-2040

living longer with more long-term conditions and therefore there is an increasing prevalence of people living with frailty.

3.32 Demand for mental health services is forecast to increase by slightly more than for community services by 2025. The largest increase, in absolute numbers, will be seen in talking therapies for anxiety and depression. It will therefore be key for HIOW to meet this increased demand to prevent the mental health of the HIOW population declining to the extent that demand for more complex inpatient and longer-term care then increases and strains the system further.

3.33 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.[21] 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 south-east 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. HIOW has 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.

3.34 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-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.

3.35 In 2022/23, 22,280 children and young people in HIOW accessed NHS funded mental health services. This is 10,245 (85%) more children than in 2019/20, before the COVID-19 pandemic.

3.36 There has been a 295% increase in referrals to children and young people inpatient services since the start of the COVID-19 pandemic (over 50% of this demand is for

[21] NHS Digital recently reported that the rate of probable mental health disorder increased 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

specialised eating disorder services). Children with eating disorders and disordered eating presentations continue to be the hardest to place with the most complex needs.

3.37 Across HIOW ICB there are over 10,000 adults and children waiting for an ADHD and/or Autism assessment. The current average wait across the ICB is 13.7 months with some people waiting up to 28.5 months. Whilst waiting for assessments, patients continue to attempt to seek help and support, placing significant pressure on other services such as A&E, secondary mental healthcare and primary care. Adults with autism are at least 6sixtimes more likely to attempt suicide with rates as high as 13 times more likely in women. Children with a neurodevelopmental condition are at least twice as likely to consider suicide than those without. 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.

3.38 Emergency readmissions for people with a mental health flag are growing, suggesting discharged patients are unable to access the community support needed to prevent such readmission. Further detail is set out in the independent review of community and mental health services (see appendix 3).

3.39 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.

3.40 The mismatch also results in variation in waiting times. Demand for 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.

There is unwarranted variation in practice, and fragmented pathways and services with multiple hand-offs

3.41 Whilst 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. Consequently some people are not able to access the services they need and therefore don't consistently experience high-quality, person-centred care that meets their needs. There is an opportunity to work collectively to deliver better care and health and wellbeing outcomes for the people of HIOW.

3.42 Historic variations in commissioning and funding of services across the ICS (driven by historic contract value rather than population needs) along with the evolution of the provider landscape has resulted in many pathways of care that are fragmented and difficult to navigate. 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 evolved over time. This often results 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 significant opportunity to develop a best-practice approach across the system to reduce unwarranted variation.

3.43 Fragmentation of clinical pathways negatively impacts patients. It 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.

3.44 The Strategic Case demonstrated how fragmented pathways are highly complex and difficult to navigate. The examples of the complex pathway for eating disorders showed that the differing provider models and referral pathways contribute to variation in waiting times to access services and the outcomes delivered, based on where patients are resident within HIOW. Care is not always matched to need, with patients often having to travel long distances to access diagnostics, treatment or support. The opportunity to simplify pathways of care will allow better alignment of demand and capacity across the system, improving access to services and therefore improving outcomes.

3.45 Examples of fragmentation in community physical health pathways include:

- Neuro-rehab: patients in both Southampton and Portsmouth have access to specialist community neuro-rehabilitation teams. In other parts of Hampshire, patients with complex neurological conditions are under the care of generic community teams. These teams sometimes have staff with specialist skills and knowledge, but this is not consistent and on many occasions patients miss out on appropriate rehabilitation, get referred to Portsmouth and Southampton services or are increasingly referred to private providers commissioned directly by the ICB. This fragmentation of services and inequity of access denies patients treatments and create inefficient and unnecessary delays in treatment.

- Bladder and bowel services: community bladder and bowel services in Southampton both assess and issue products to their patients. In south-west Hampshire, patients have their assessments undertaken by a different provider (Southern) from the service which delivers the product (Solent). This has historically created a number of issues and frustrations for south-west Hampshire patients who perceive that they should receive a different product from those that are available on the commissioned formulary.

The Trusts are experiencing challenges in recruitment and retention resulting in workforce shortages which impact on the effectiveness and quality of services

3.46 All Trusts are facing challenges in filling staff vacancies. Workforce shortages are particularly visible in mental health, with vacancies of 563 full time roles (as of September 2023) 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.

3.47 The fragmentation of services across multiple providers, as described previously, means there is a low volume of high specialism services in each Trust. These 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, making it harder to retain staff.

3.48 Training and development are 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 to where capacity is needed. An example of this is the variation of physical intervention training provided to mental health inpatient staff.

3.49 The opportunity to create a united community and mental health workforce within a single Trust would improve staff satisfaction and career development whilst enabling better care through more resilient workforce models.

The financial challenge is very significant

3.50 The total cost of delivering NHS services in HIOW currently exceeds the available resources. 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; this is as opposed to through 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, coordinated approach is needed to deliver this.

3.51 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.

3.52 Whilst there are pressures across the whole system, there is a particular issue that the Isle of Wight services are both financially and clinically unsustainable, since the population served by the Trust is too small to provide the critical mass needed to sustain high quality, efficient services. 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.

Options appraisal

3.53 In developing the Strategic Case an options appraisal was undertaken. A long list of ten options, plus a counterfactual status quo option, to address the case for change were identified. These were on a continuum from maintaining the current ways of working through closer collaboration between providers to creating a new, merged Trust for mental health services and a new Trust for community services.

3.54 Hurdle criteria were agreed that set out the minimum, essential conditions that an option needed to meet to be shortlisted for more detailed evaluation. If the Trusts determined that if the risk an option would not be able to adequately address the case for change, then it was excluded from the short-list.

3.55 In this context, it was agreed to eliminate options which:

- Increased fragmentation of community and mental health pathways;
- Involved unclear accountabilities for care; or
- Did not respond to all aspects of the case for change (i.e. scope of the option does not cover community and mental health services).

3.56 Applying these hurdle criteria led to the Trusts eliminating eight options. This left a short list of three options taken forward for more detailed appraisal:

- **Lead provider(s) model (option 3):** in this model a lead provider would be 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 would be 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 would be created providing all community and mental health services across the ICS, including services currently provided by IoW and Sussex Partnership.

3.57 A set of eight evaluation criteria were agreed to assess the three short-listed options. These reflected the case for change previously outlined as well as the challenges of implementing the options (timescale and cost). These criteria were:

- Enabling consistent care morels and reducing fragmentation and hand-offs, thereby improving patient outcomes

- Enabling better alignment of capacity and demand
- Positively impacting workforce challenges
- Supporting delivery of transformational benefits
- Improving the sustainability of Isle of Wight and the overall health and care system, and focusing on frontline services
- Creating a single coherent voice for mental health and community services in the ICS
- Implementation timescales
- Implementation costs

3.58 The first six criteria explicitly assess the extent to which each of the options enabled mental health and community services to respond to the case for change. The final two criteria consider the risks associated with the implementation of the options. No weighting was applied to the criteria, since most criteria related to the case for change, which the Trusts felt was the most important aspect of the appraisal process. The Trusts did, however, define what a strong and weak option would look like in respect of each of the criteria.

3.59 The evaluation of the short-listed options gave each a relative ranking for the extent to which it meets the specified criteria: a score of 3 was given to the best option and a score of 1 given to the poorest option. The single Trust option ranked above both the lead provider and group model options for all of the criteria save for the implementation timescales and implementation costs.

Figure 12: 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	❶	Provides shared leadership but retains separate Trusts, with multiple Trusts involved in an individual person's care making it more difficult to deliver consistency	❷	All care provided by pone community and health provider – provides the greatest opportunity to agree and implement consistent care models across HIOW and reduce fragmentation	❸
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	❶	Retains current arrangement with Trusts funded separately with weak mechanisms to align capacity to need	❷	Single Trust has flexibility to allocate and align funding and capacity to local needs	❸
Positive impact on workforce challenges	Enables joint workforce planning at service level but organisational barriers inhibit effective redeployment of staff to meet demand	❶-❷	Enables joint workforce planning at service level but organisational barriers inhibit effective redeployment of staff to meet demand	❶-❷	Enables whole system workforce planning and redeployment of staff to meet demand	❸
Supports delivery of transformational benefits	Lack of centralised transformation resources and Trusts will also have their own priorities	❶	Allows for creation of centralised transformation resource but Trusts will also have their own priorities	❷	Centralised transformation resource to deliver single set of transformation priorities	❸
Improves sustainability of Isle of Wight and the overall health and care system and focuses resources on frontline services	Does not solve Isle of Wight sustainability	❶-❷	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	❶-❷	Creates best opportunity for a sustainable IoW services and delivery of economies of scale to focus resources on frontline services	❸
Creates a single coherent voice for mental health and community services in the ICS	Retains separate Trusts who may have different views	❶	Creates some opportunity for a single voice depending on level of delegation to the Group	❷	Creates best opportunity for a single coherent voice	❸
Implementation timescales	Could be implemented in 6 months (although experience suggests it will likely take longer)	❸	Likely to take 12 months to implement	❷	Requires formal two-stage business case and regulatory approval following the NHSE transactions guidance, likely to take c.18 months to implement	❶
Implementation costs	Involves some limited legal, advisory and contracting costs to establish the lead provider arrangements	❸	Involves some legal, advisory and business case development costs to establish the Group and create single leadership structures	❷	Involves the greatest cost	❶

3.60 The options appraisal process allowed the Trusts to conclude that:

Lead provider(s) model (option 3)

3.61 Whilst a lead provider model could harness and coordinate 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.

3.62 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.

3.63 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.

3.64 The Trusts felt that the benefits of this option were insufficient 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)

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

3.66 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 have maintained 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.

3.67 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.

3.68 For these reasons the Trusts concluded that the benefits of establishing a group model did not outweigh the risks and that this did 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)

3.69 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.

3.70 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 paragraph 10.57), 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

3.71 The Trusts concluded that the preferred way forward was 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.

3.72 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 FBC, provides a route to ensure the long-term sustainability of IoW.

3.73 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. However, the Trusts believe this option provides the best opportunity to respond positively and realise benefits for the population we serve.

3.74 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 FBC);
- 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 can deliver a new hospital in Hampshire as part of the government's New Hospital Programme. 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.

3.75 These programmes 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.

3.76 There are links between these three programmes, in particular there is an inter-dependency between the Isle of Wight sustainability and the creation of the new Trust.

3.77 IoW is the only integrated acute, community, mental health, and ambulance health care provider in England. Established in April 2012, the Trust provides a full range of health services to an isolated offshore population of circa 143,000 people. The combination of the wide breadth of responsibility and the sub-scale nature of the services, alongside the geographic isolation and island demographics, results in clinical, financial and operational challenges.

3.78 IoW has developed partnerships with mainland providers to help mitigate these risks, and this approach has achieved demonstrable improvements in the quality of services. A strategic review of the Trust's requirements to create a resilient approach

to these partnerships, and the best organisational form has been completed in order to achieve the following strategic objectives:

- Clinical sustainability: ensure that the quality, accessibility, and comprehensiveness of services available to the island population can be sustained into the future; and
- Financial sustainability: ensure that IoW achieves and sustains financial balance, while improving the quality of care through the sustainability programme.

3.79 As a consequence of this work, the transfer of IoW community, mental health and learning disabilities services to the new Trust was agreed alongside the following strategic changes as part of the Isle of Wight sustainability programme:

- Creation of a Group across PHU and IoW in order to develop and implement plans that deliver sustainable acute services;
- Development and implementation of plans that establish single corporate services across PHU and IoW with common policies, processes, and control systems;
- Strengthening the partnership work between the IoW ambulance services and South Central Ambulance Service; and
- Supporting the development of place arrangements on the Island through the Isle of Wight Health and Care Partnership to ensure partners can deliver integrated care.

3.80 In order to achieve these changes it is necessary to ‘segment’ the existing Trust. The approach to segmentation is described in paragraph 10.30 and is designed to mitigate the clinical, financial and workforce risks that may arise as a consequence of the transferring the accountability for community, mental health and learning disabilities services from IoW to the new Trust.

3.81 In June 2023, the IoW Executive Team considered options for the timing of the transfer of community, mental health and learning disabilities services from the IoW to the new Trust and recommended that the transfer take place no later than 1 April 2024. This position was supported by the Fusion Programme Board. Due to the required segmentation work and regulatory processes the Trusts are planning for transfer on 1 April 2024.

4 Vision for the new Trust

Chapter summary

- This chapter sets out the emerging vision for the new Trust and outlines how this will be delivered through the new Trust's strategic objectives.
- The emerging vision and strategic objectives for the new Trust have been developed through engagement with staff and partners. The emerging vision for the new Trust is: "Together we deliver outstanding care that supports people to live their best and healthiest lives."
- The emerging strategic objectives for the new Trust are:
  - Deliver high quality, safe and effective services to all people to improve health and wellbeing and reduce health inequalities;
  - Leverage the strategic benefits of working at scale to deliver in local communities;
  - Embed and sustain an inclusive culture of coproduction, collaboration and continuous improvement;
  - Facilitate change within the system, working collaboratively to transform clinical pathways for the benefit of our population;
  - Be a great pace to work, supporting and providing opportunities for staff; and
  - Improve value for money.
- Developing and embedding values and cultural change across the new Trust will be critical to the successful delivery of strategic objectives. An initial set of values for the new Trust has been developed through engagement with staff and communities:
  - People first: we are kind, caring and compassionate;
  - Creative: we empower and innovate to constantly improve;
  - Accountable: we are open, we act with integrity and take responsibility;
  - Respectful: we are inclusive and treat people as they want to be treated; and
  - Working together: we work in partnership with our patients, staff and communities.
- The desired culture of the new Trust is summarised in this chapter, with further detail on the "as is" culture and development of the "to be" culture described in chapter 8.

4.1 This chapter sets out the emerging vision for the new Trust and outlines how this will be delivered through the new Trust's strategic objectives.

Development of the vision and strategic objectives

4.2 The emerging vision and strategic objectives for the new Trust have been developed through engagement with staff and partners, in particular through the 'Shape Our New Trust' programme (described in chapter 12). The overarching ambition that is shared by staff and partners is for the new Trust to provide consistently high quality, safe and effective mental health, learning disability and community services to all people across HIOW. The way the new Trust delivers its ambition will be characterised by working in

partnership: partnership with people who use services, with communities, with staff and with NHS, local government and third sector partners.

4.3 The emerging vision and strategic objectives have been developed to respond to the case for change set out in chapter 3 and reflect the national and local strategic context as described in chapter 2. The emerging vision and strategic objectives were discussed at a Fusion Programme Board meeting which included ICB representation. The strategic objectives align with the clinical strategy (see chapter 5), with the first strategic objective being mirrored in the clinical strategy.

4.4 Further work is required to refine the vision and strategic objectives and develop these into the strategy for the new Trust. This will commence following the approval of the FBC and will include:

- Further engagement to share, test and listen to feedback on the emerging vision and strategic objectives;
- Refine the emerging vision and strategic objectives to ensure they are comprehensive, accessible, measurable and reflective of the benefit priorities. This includes demonstrating how they are fully aligned with system plans and strategy;
- Considering how the objectives will be measured and progress demonstrated; and
- Development of a strategy for the new Trust to deliver the vision and strategic objectives.

Vision and strategic objectives for the new Trust

4.5 The emerging vision statement for the new Trust is as follows:

“Together we deliver outstanding care that supports people to live their best and healthiest lives.”

4.6 The emerging strategic objectives for the new Trust are:

- Deliver high quality, safe and effective services to all people to improve health and wellbeing and reduce health inequalities
- Leverage the strategic benefits of working at scale to deliver in local communities
- Embed and sustain an inclusive culture of coproduction, collaboration and continuous improvement
- Facilitate change within the system, working collaboratively to transform clinical pathways for the benefit of our population

- Be a great pace to work, supporting and providing opportunities for staff
- Improve value for money

Patient story – Katie's story

Katie is a woman in her late 20s. She has diagnoses of emotionally unstable personality disorder, anxiety, depression and a history of substance misuse. She was struggling with managing thoughts of self-harm associated with grief and ongoing low mood/anxiety. She had previously been supported by the CMHT.

She self-enrolled into the local voluntary sector wellbeing service and was assessed within three working days. Shortly after starting the Wellbeing Programme, a wellbeing coach became concerned about some of the comments Katie had made about her partner and their relationship and approached Katie to talk through these concerns in a sensitive way. Katie opened up and described what was an emotionally abusive, financially coercive relationship. After discussions, and with Katie in agreement, a safeguarding referral was submitted. Katie was given a supportive police intervention, she has been relocated, and is now thriving in her new environment and has described the other women as a huge support for her.

As a result of these timely interventions, Katie:

- Now feels supported;
- Has an entirely new perspective on life;
- Is setting weekly goals to continue to move forward;
- Is actively using the tools shed gained from the Wellbeing service to manage her emotions, and to great effect;
- Has rediscovered their meaning and purpose for helping people and has now applied for a volunteer post with Saint John's Ambulance; and
- Has recently graduated from the Wellbeing service and continues to access top-up workshops as necessary to stay focused.

This approach to system working, with direct access to services meant that Katie:

- did not need to wait for an appointment with her already highly pressured GP surgery;
- did not need to return to the CMHT; and
- was empowered to take the first step herself.

She received life-changing support in a timely way which has led to Katie now living a life free from abuse and it has allowed Katie to re-discover herself, her meaning and purpose in life and prioritise her wellbeing.

4.7 The Organisational Development Steering Group has engaged with staff and partners (as described in section 8.3) to develop the desired culture, values and behaviours of the new Trust. This is an ongoing piece of work and the emerging outputs of this work are included in appendix 5 and described below.

4.8 The desired culture of the new Trust will:

- be compassionate and empowering;
- be anchored in having respect; and
- create unity and cultivate innovation.

Figure 13: How the culture of the new Trust will feel

Values that are actively embedded, socialised and role modelled by leaders and staff	Needs of the people we serve are at the heart of everyday working; decision-making, processes, communication, roles and responsibilities	Participative decision-making process, where staff feel their voice is heard and where they are actively invited to contribute to finding solutions
Leaders and teams recognise success is achieved through collaboration and partnerships across and beyond organisational boundaries	Psychologically safe environments for our staff and all those who engage with our services	Environment of open communication where agendas are transparent and new information is communicated in advance of major decisions across the organisation
Our people feel and see that action is taken in response to their feedback and issues about culture	Leaders committed to incremental innovation, seeking out different perspectives and testing new ideas to improve performance and delivery	Leaders who understand their respective roles in achieving organisational outcomes and who hold each other accountable
Lower turnover driven by enhanced staff satisfaction and engagement and a collective sense of impact	People are energised, compelled and empowered to bring their voice to the table	Every individual feels they 'belong' and valued for their unique background and lived experience

4.9 Chapter 8 describes how the desired culture will be embedded in the new Trust.

4.10 Based on the feedback from staff, patient groups and partners, the following emerging values for the new Trust have been developed:

Figure 14: Emerging values for the new Trust

People first
We are kind, caring and compassionate.

Creative
We empower and innovate to constantly improve.

Accountable
We are open, we act with integrity and take responsibility.

Respectful
We are inclusive and treat people as they want to be treated.

Working together
We work in partnership with our patients, staff and communities.

4.11 As with the emerging vision and strategic objectives, further work is needed and is underway to engage on and refine the emerging values. This includes creating opportunities for staff to talk about the behaviours that will be needed to underpin the values in the new organisation, and how the values are brought to life.

Lisa's Story: why culture, values and behaviours matters

I'd like to talk about culture, values and behaviours from the perspective of merging three child health teams from different organisations in April 2021, specifically, the very first day that all colleagues came together in the same office. This day marked the end of the merging process and the start of our cultural journey of learning how to work together successfully to deliver our service. Not many teams get the opportunity to set their cultures in this way and my story seems particularly relevant to the process that we find ourselves in now with regards to Fusion.

I believe that team culture comes from knowing that you are in a team. It sounds obvious but feeling that you belong, that you are sharing a purpose, is key to being engaged and influencing the collective culture you want to work in. It can be very lonely to feel outside of the collective. We all have the ability to influence culture, for good or bad. Cultures change all the time and as managers we have a unique opportunity to observe, to notice changes and to take steps to get things back on track.

Thinking about the particular Trust values of people, partnership and respect, I arrived on that first day with a deep respect for everyone in the team. Here they were, all 46 of them, each with their own perspective. They all knew their jobs inside out, the newness was the transition and the culture we could create together. They needed to collaborate and partner to create our new ways of working in the knowledge that what we started with, would not be what we ended up with and that by listening to, respecting and partnering with each other, we could make the transition as smooth as possible. A key element of our culture is that we all know each other well.

From my perspective, I tried to role model the behaviours I wanted to see in the team - honesty, sincerity, authenticity and appreciation. I gave space and time for everyone to adjust, time for people to find their feet. On that first day, we just found our place in the office and looked at our systems. No more was expected. I made sure I appreciated everyone and noticed and commented upon their successes.

My key takeaways from our merger that I'd like to share are to create a culture of kindness and behave kindly. Everyone is on their own journey, this is not your journey, it's theirs, be respectful and sincere.

5 Clinical strategy

Chapter summary

- This chapter describes the new Trust's clinical strategy and how this will support delivery of the new Trust's vision.
- The clinical strategy was developed through the following process, engaging with stakeholders throughout:
  - Developing a shared understanding of the HIOW clinical case for change
  - Identifying a set of clinical priorities
  - Agreeing the shared principles that will help address the clinical priorities
  - Drafting the clinical strategy document
- The clinical priorities of the new Trust's clinical strategy are:
  - Mental health and learning disabilities:
    - Children and young people
    - Older people's mental health
    - Acute and crisis care
    - Community mental health services (No Wrong Door)
    - Neurodiversity services
  - Community:
    - Frailty
    - Community beds and rehabilitation
    - Long term conditions
    - Urgent community response
  - Primary care

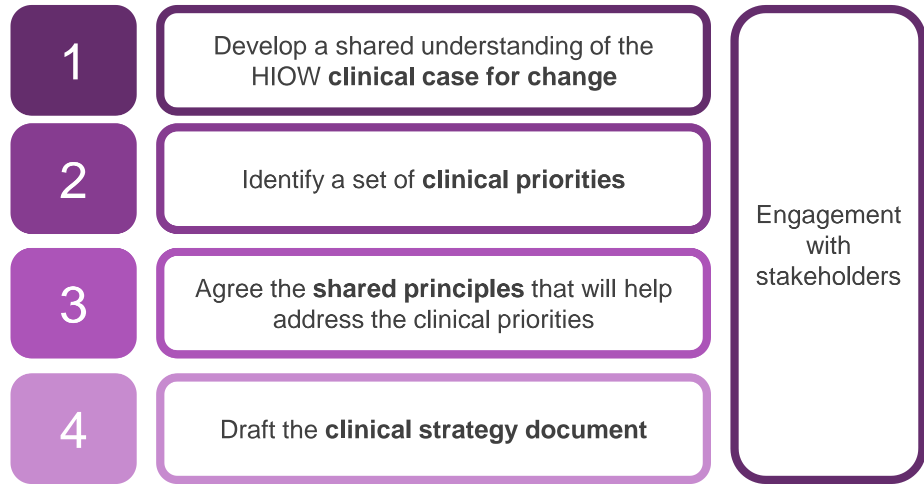
  In addition, lived experience is a cross-cutting workstream of the clinical strategy.
- The principles that will underpin the delivery of the clinical strategy are:
  1. Embed a culture and practice of continuous improvement, innovation and research.
  2. Ensure that all clinical decisions benefit from both lived and learned experience.
  3. Adopt a life course approach which removes barriers and provides greater emphasis on prevention and a pro-active approach.
  4. Work alongside our communities ensuring that we collaborate effectively to wrap services around the needs of individuals and measure ourselves according to outcomes that matter.
  5. Provide effective clinical and professional leadership.
  6. The clinical strategy will be underpinned by a sustainable workforce.
- The new Trust will adopt a phased and prioritised approach to the integration of clinical services. The ten clinical priority areas will be the initial priorities for the new Trust, focusing on the areas where there are significant risks that need to be addressed and where significant patient and workforce benefits can be delivered.

- Implementing the clinical strategy in a new Trust which brings together services from four different Trusts will be challenging, as each Trust has its own distinct culture, improvement journey and approach to quality improvement. The clinical strategy has been designed to provide a framework for service improvement and will be developed further over the first two years of the new Trust to ensure it reflects the evolving needs of patients and staff, progress and challenges arising from implementation and any changes to system or national priorities.
- The clinical strategy aligns with and supports the delivery of the NHS LTP, the HIOW ICS Partnership Strategy and the ICS Joint Forward Plan.

Development of the clinical strategy

5.1 The process to develop the clinical strategy is set out in the figure below.

Figure 15: An overview of the process followed to develop the clinical strategy



5.2 The starting point for the clinical strategy is the shared understanding of the HIOW clinical case for change, as described in chapter 3. There was broad clinical involvement in the development of the case for change, which built on the Independent Review of Community and Mental Health Services across the HIOW ICS (see appendix 3).

5.3 The Clinical Transformation Group[22] identified a set of clinical priorities to address the most significant clinical risks in the system.

[22] The Clinical Transformation Group was previously called the Clinical Delivery Group. The Clinical Transformation Group is co-chaired by the CMOs of Solent and Southern and its membership includes clinical and operational leads from across the four Trusts and relevant ICB directors.

Figure 16: Clinical Transformation Group workstreams[23]

Priority	Workstream
Mental health and learning disabilities	Children and young people
	Older people's mental health
	Acute and crisis care
	Community mental health services (No Wrong Door)
	Neurodiversity services
Community	Frailty
	Community beds and rehabilitation
	Long term conditions
	Urgent community response
Primary care	Primary care

5.4 Whilst the Primary care workstream primarily focuses on the direct delivery of primary care, it also considers some aspects of the interface between primary care and community and mental health services. It is important to note that the Community mental health services (No Wrong Door) workstream is coproduced with primary care colleagues and focusses on the development of the primary care and community mental health interface. Similarly, the Frailty and other community workstreams are working closely with primary care colleagues. The relationship with primary care (as well as VCSE and local authorities) is crucial to the success of all transformation programmes.

5.5 The Clinical Transformation Group agreed a set of guidelines to apply consistently across the workstreams. These guidelines are set out in the figure below and formed the starting point for the creation of the clinical strategy.

[23] The Trusts have subsequently added 'lived experience' as an additional, cross-cutting workstream as it has emerged as a key theme in the development of the clinical strategy for the new Trust (see paragraph 2.63).

Figure 17: The guidelines that underpin the development of the clinical strategy

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

5.6 The Clinical Steering Group was responsible for the development of the clinical strategy and engaged with relevant stakeholders throughout, ensuring that the voice of lived experience was heard and reflected in the clinical strategy. The principal stakeholders involved in developing the clinical strategy were:

- Trust staff from clinical, operational, and corporate teams;
- System partners including the ICB[24], local authorities, voluntary sector and primary care colleagues;
- People who use services, their families and carers; and
- Wider communities.

5.7 Staff engagement was primarily through the Shape Our New Trust engagement events in May and June 2023 which provided multiple opportunities for staff across the four Trusts to engage in development of the clinical strategy including:

- Participating in online interactive engagement sessions;

[24] The CMO and CNO of the ICB provided positive feedback on the content and clarity of the clinical strategy.

- A survey which gathered responses from both teams and individuals; and
- A face-to-face workshop, as part of the Shape Our New Trust engagement.

5.8 The Clinical and Professional Leadership Network, which includes leaders from across the Trusts, also provided comments on the draft clinical strategy. Further detail on the 'Shape Our New Trust' engagement programme is set out in chapter 12.

5.9 The outputs of these engagement events informed the development of the clinical strategy. For example, based on feedback gathered from these events, the objective that states that the clinical strategy must be underpinned by a sustainable workforce was added to the clinical strategy.

The clinical strategy for the new Trust

5.10 The aim of the clinical strategy is to provide a clear framework for integrating and transforming clinical services of the new Trust. It has been developed in preparation for the launch of the new Trust and is intended to form a foundation to be built on as the new Trust develops.

5.11 The strategy is structured around a clear ambition to deliver high quality, safe and effective services to all people across HIOW, balancing the benefits of working at a large scale to drive out unwarranted variation, and working locally in order to respond to the needs of different communities. In delivering safe services the new Trust will ensure it continues to address and learn from any quality reviews (e.g. CQC inspections). There are six key principles that will deliver this ambition:

1. **Embed a culture and practice of continuous improvement, innovation and research:** a culture of learning and continuous improvement will be embedded in the new Trust as a requirement to deliver sustainable high-quality care.

Figure 18: The elements of the approach to continuous improvement

The quality improvement approach will implement:

- **Quality planning:** understanding the needs of the population and codesigning an approach that meets their needs with measurable outcomes

- **Quality control:** measuring quality outcomes and using this information to identify and address emerging problems.

- **Evidence-based methodologies:** using methodologies based on evidence to ensure effective solutions based on the best available research.

2. **Ensure that all clinical decisions benefit from both lived and learned experience**, The term 'lived experience' describes people whose expertise is derived either wholly or primarily through the lens of living with a condition and/or receiving or accessing any of the Trusts' services, including as a family member or unpaid carer, rather than through delivering them. Lived experience is sometimes contrasted with 'learned experience', which is where a person's expertise around a condition or service provision is learned through training and workplace experience. However, many people working in NHS services will have both lived and learned experience of services and health conditions. 'Coproduction' is an equal partnership where people with lived and learnt

experience work together from start to finish. The new Trust's approach to lived experience and coproduction will include:

- Person-centred and coproduced assessment, care planning and treatment;
- Delivery of services including expansion of peer support worker roles, carer support worker roles and Recovery Colleges;
- Community engagement, ensuring the new Trust is responsive to the needs of the varied communities across HIOW; and
- Strategic leadership and organisational approach to lived experience and coproduction. This includes:
    - clinical, operational and financial governance;
    - quality improvement, transformation, innovation and research, through understanding the views and needs of staff and patients; and
    - strategic decision-making through ensuring engagement with relevant staff and patient groups.

3. **Adopt a life course approach which removes barriers and provides greater emphasis on prevention and a pro-active approach**. This will be achieved by:
    - focussing on maximising potential in childhood and early adulthood, providing seamless transitions from child to adult services, maintaining good health, living successfully with chronic disease and anticipating and responding to decline;
    - personalising care focusing on the question 'what matters to you?', ensuring people have choice and control over the way their care is planned and delivered;
    - seeking to make every contact we have with service users count, encouraging behaviour change, prioritising early intervention and enabling access to a range of services to help people to live well;
    - working with system partners to ensure the new Trust takes a population health management approach;
    - ensuring services are able to improve health equity by removing barriers; and
    - making our services inclusive, diverse, and accessible by design.
4. **Work alongside our communities ensuring that we collaborate effectively to wrap services around the needs of individuals and measure ourselves according to outcomes that matter**. Services will be delivered at the scale that best meets the needs of users. In determining whether services should be

delivered in local areas (e.g. 50,000 to 80,000 population), wider areas (e.g. 150,000 to 300,000 population), or across HIOW and beyond, the following will be considered:

- **Service demand**: high volume services are more likely to be appropriately delivered in local areas, enabling sustainable local service delivery that provides value for money. Low volume and more specialist services will generally be delivered at a wider or system-wide scale.
- **Effective and resilient partnership arrangements** will be developed at the appropriate scale to deliver seamless pathways of care that wrap around the needs of individuals. For example, integrated pathways with primary care are likely to be most effectively delivered in local areas, while those that involve national networks may be best delivered system-wide. Integrated services may benefit from joint leadership arrangements with partner organisations.

5. **Provide effective clinical and professional leadership.** Credible and strong clinical and professional leadership is necessary, working closely with operational leadership colleagues, to shape the culture of the organisation and enable delivery of high quality care. This means:

   - Inspiring and driving safe and effective change;
   - Clinical leaders with responsibility and accountability for the development and delivery of clinical services;
   - Supporting organisational development so that form follows clinical function;
   - Ensuring principles of continuous improvement underpin all service delivery;
   - Ensuring a clinical voice from floor to board via an effective and empowered clinical executive;
   - Providing visible leadership and having a central voice in the organisation;
   - Being supported to develop clinical and professional leadership skills;
   - Ensuring equity across all professions represented in the Trust; and
   - A leadership structure that is able to develop future senior clinical and professional leaders.

6. **The clinical strategy will be underpinned by a sustainable workforce.** The workforce will have:

   - opportunities for **training and development** that enable staff to maintain and grow their skills;

- a **working environment in which psychological safety is prioritised**, including effective team working, and an ability to admit and learn from mistakes. Embedding a trauma-informed approach is an important component of ensuring the physical, psychological and emotional safety of staff is prioritised. Trauma-informed practice requires safety, trust (transparent and open communication), choice and empowerment (giving staff a voice in decision-making and validating their feelings and concerns), collaboration (valuing the experience of staff in improving services) and cultural consideration (equality and diversity);
- opportunities for **reflective practice and supervision individually**, in a team and with wider system colleagues;
- the **resources required to deliver patient care safely**;
- **opportunities to participate in** service or professional specific **clinical networks**; and
- **services that have clear remits** and can deliver the fundamentals of excellent care at the capacity required.

5.12 The clinical strategy has been developed alongside the engagement about and development of the overall vision of the new Trust (see chapter 4) to ensure the language and approach is aligned.

5.13 The new Trust's clinical strategy has been designed to address the challenges described in the case for change, as set out in the figure below.

Figure 19: How the principles of the clinical strategy address the challenges described in the case for change

Challenges identified in the case for change	Principles of the clinical strategy for the new Trust
Community and mental health services are struggling to meet unprecedented increases in demand	Life course approach, including prevention and early intervention
There is unwarranted variation in practice, and fragmented pathways and services with multiple hand-offs	Collaborative working with people with lived experience of using services, their families and carers, our communities and with system partners
	Sustained high quality care for the people of Hampshire and the Isle of Wight
The Trusts are experiencing challenges in recruitment and retention resulting in workforce shortages which impact on the effectiveness and quality of services	Clinical and professional leadership and workforce equipped to deliver high quality care

Challenges identified in the case for change	Principles of the clinical strategy for the new Trust
The financial challenge is very significant.	Continuous improvement, innovation and research

5.14 The patient story below illustrates the impact the clinical strategy for the new Trust will have on patients.

Patient Story

Rose is 55 years old and has multiple long term physical and mental health problems that limit her ability to get out of the house.

She wrote her own care plan with the help of a nurse and is reassured by how kind and responsive the people who care for her are. She has a number to call to get her the help she needs, whether it is the GP, voluntary sector mental health peer support worker or community nurse.

She is learning about how to look after herself more effectively in the Recovery College and is enjoying the contact she has with other people whilst growing in confidence. She has been inspired by some of the volunteers in the Recovery College and is thinking about volunteering when her course ends.

Figure 20: Clinical strategy overview

5.15 A plain English version of the clinical strategy has been developed and is being finalised.

Implementing the clinical strategy

5.16 The content of the clinical strategy has been agreed by the Project Fusion Programme Board and by the Solent, Southern and IoW Boards. An exercise is underway to design a number of versions (e.g. long form, leaflet, poster) of the clinical strategy to present it in an engaging way, with jargon-free language, to staff, partners and people who use services. These versions are due to be published, with a supporting programme of communications and engagement, before the end of December 2023. The clinical strategy drives all key areas of the design of the new Trust, including the operating model and enabling strategies (workforce, digital, estates). Workforce, digital and estates strategies for the new Trust are being designed to support delivery

of the clinical strategy. These strategies are under development and are described in chapter 8.

5.17 In addition, the clinical strategy requires a significant and sustained change in culture. An organisational development programme has been developed to embed the culture change required from the Trust Board and through all parts of the new Trust. Further details of this programme are provided in chapter 8.

Approach to clinical service integration

5.18 Experience and learning from other healthcare systems that have undertaken large scale service transformation is that it takes many years to implement and embed. The new Trust will therefore adopt a phased and prioritised approach to the integration of clinical services. The ten clinical priority areas identified in the clinical strategy will be the initial priorities for the new Trust, focusing on the areas where there are significant risks that need to be addressed and where significant patient and workforce benefits can be delivered.

5.19 The design of clinical integration plans will involve:

- Identifying the optimum scale and setting for services to meet the needs of the local population;
- Agreeing the best service delivery model and pathways;
- Working with clinicians and operational leads to set priorities and the timeline for integration; and
- Where beneficial, integrating services into single pathways with a single waiting list. For example, a hub and spoke approach to specialist nursing services (e.g. for Parkinson's disease or multiple sclerosis) will help address current workforce pressures, whilst delivering services as close to home as possible.

5.20 Where services are best delivered in local communities, delivery will be integrated with community and voluntary sector partners to deliver care as close to home as is possible. For example, the integrated neighbourhood teams that are already in place deliver services in conjunction with adult social care services commissioned by local authorities and primary care.

5.21 Clinical leadership of clinical service integration is essential to deliver the potential benefits. Clinical integration work will therefore be driven by the clinical service teams themselves. Clinical integration guides will be developed to support these teams, helping them to document the vision for the service, clinical and operational leadership of the service, the patient pathway for the new service, the unified waiting list, the approach to waiting list management, unified policies and protocols and aligned budgets and reporting. Improvement specialists will support clinical and operational staff to develop and implement plans, as well as monitoring and reporting

on progress. The impact of any planned changes to services will be assessed using quality impact assessments and equality impact assessments as required.

Patient benefits case

5.22 The following services were selected as examples of how the clinical strategy will be implemented and how this will benefit patients. These benefits are summarised in chapter 9 of this FBC and are described in more detail in the PBC:

- Lived experience;
- CAMHS;
- Older person's mental health (OPMH); and
- Frailty and urgent response.

Challenges to delivery of the clinical strategy

5.23 The new Trust will bring together services from four different Trusts, each of which have their own distinct cultures, improvement journey and approach to quality improvement. This presents a risk of failure to implement the clinical strategy if the approach to engagement, integration plans and the clinical strategy itself are not designed to address these differences. The clinical strategy has been designed to provide a clear framework to support the creation of the new Trust, setting out ambitions and the direction of travel to achieve sustainable high-quality care for our population. The clinical strategy will be developed further over the first two years of the new Trust to reflect the evolving needs of patients and staff, progress and challenges arising from the implementation of the integration plan and the impact of any changes to system or national priorities.

5.24 Culture change is fundamental to the successful delivery of the clinical strategy and must be driven by Trust leadership. This will be particularly challenging with services being brought together from four Trusts. To mitigate this an organisation development programme is being developed to support delivery of the clinical strategy.

5.25 There is a risk that the implementation of the clinical strategy could be impaired due to competing priorities during the creation and integration of the new Trust. This risk has been mitigated through establishing sponsorship and accountability of the clinical strategy by the CMOs, CNOs and a peer network of clinical and professional leaders.

Fit with NHS Long Term Plan

5.26 Published in 2019, the NHS LTP[25] 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.

5.27 The NHS LTP sets out how the NHS will overcome the challenges facing the health and care sector through a new service model for the 21st century:

- **Boosting out-of-hospital care and dissolving the divide between primary and community health services:** this is the formation of PCNs – supported by £4.5bn of new investment – to facilitate greater collaboration between GPs and community teams, to give people more control over their health and the care they receive. This funding expands multidisciplinary community teams that align with neighbouring GP practices to create PCNs. The NHS LTP will deliver improved responsiveness of community health crisis response services.

- **Redesigning and reducing pressure on emergency hospital services:** the NHS LTP introduces a single, embedded multidisciplinary Clinical Assessment Service within integrated NHS 111, ambulance dispatch and GP out-of-hours services. This provides specialist advice, treatment and referral from a broad range of healthcare professionals incorporating both physical and mental health. The NHS LTP also implements the UTC model, working alongside other parts of the urgent care network to provide alternatives to A&E.

- **Giving people more control over their own health and more personalised care when they need it:** the NHS LTP will "ramp up support for people managing their own health", expanding the many health conditions for which people are already taking control of themselves, with supplemental expert advice from community and online sources. This starts with diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support, and online therapies for common mental health problems. The NHS LTP will roll out the NHS Personalised Care model across England, reaching 2.5 million people by 2023/24 and 5 million people within a decade of the NHS LTP launching. Personal Health Budgets (PHBs) will also give people greater choice and control over how their care is planned and delivered. These will support expanded offers in mental health and learning disability services, people receiving social care support and end-of-life care packages.

- **Digitally enabled primary and outpatient care:** the NHS LTP sets out how patients will be given more convenient access to services and health information, with the NHS App serving as the 'digital front door' to the NHS. Digital-first primary care becomes a new option for patients, with every patient eventually having the option to choose telephone or online consultations within five years. Outpatient services are being redesigned to allow technology to

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

reduce the demand for face-to-face outpatient appointments by 30 million annually within five years.

- **An increasing focus on population health and the creation of Integrated Care Systems:** the implementation of ICSs builds on the work undertaken by Sustainability and Transformation Partnerships (STPs). ICSs are working with Local Authorities at the 'place' level and will facilitate shared decision-making between commissioners and providers on how resources are used, services are designed and population health improved. Funding flows and contract reform support the move to ICSs by facilitating local service integration through collaborative arrangements between different providers, including local 'alliance' contracts and lead provider arrangements. Integrated Care Provider (ICP) contracts also allow contractual integration of primary medical services with other services, and creates greater flexibility to achieve full integration of care.

5.28 Specifically in relation to community, mental health and learning disabilities services, the NHS LTP sets out key ambitions to be delivered by 2023/24:

- increasing funding for mental health services by more than £2.3bn per annum;
- 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; and
- delivering value for money through reducing duplication and improving procurement to direct more funding to the delivery of frontline mental health services.

Mental health services

5.29 The NHS LTP lists the following mental health ambitions to be achieved by 2023/24:

Figure 21: Mental health ambitions in the NHS LTP

Provide better community mental health support to 370,000 people with SMI via new and integrated models of primary and community care	24,000 additional women will access specialist perinatal mental health services. The period of care will be extended from 12 months to 24 months post-birth	Anyone experiencing mental health crisis will be able to call NHS 111 and have 24/7 access to the mental health support the need
380,000 more people will access NICE-approved IAPT services each year	Reducedlength of stay in units with a long length of stay to the national average of 32 days	Ensure that the parts of England most affected by rough sleeping will have better access to homelessness NHS mental health support
Expand geographical coverage of NHS services for people with serious gambling problems	Expand the existing suicide reductionprogramme to all ICSs in the country	

5.30 COVID-19 has, nationally, had a major impact on ICSs' ability to make progress on some NHS LTP objectives. In particular, the COVID-19 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.

5.31 NHSE has confirmed that there is evidence that the COVID-19 pandemic has increased demand for mental health services nationally. It is likely that new mental health problems caused directly by the pandemic have arisen.[26]

[26] The Health Foundation, The NHS Long Term Plan and COVID-19, September 2021 https://doi.org/10.37829/HF-2021-P08

Children and young people

5.32 In relation to children and young people, the NHS LTP sets out the following commitments to be achieved by 2023/24:

Figure 22: Children and young people ambitions in the NHS LTP

Funding for CYP mental health services will grow faster than overall NHS fuinding and total mental health funding	**By 2023/24, 345,000 under-25s will be able to access support through NHS-funded mental health services and school or college MH support teams. 100% coverage is targeted within a decade**	**Boosting investment in CYP eating disorder services to maintain the 95% CYP Eating Disorder RTT standards — starting treatment within one week of urgent referrals, within four weeks of non-urgent referrals**
Ensuring 100% coverage of 24/7 mental health crisis care provision for CYP which combines crisis assessment, brief response and intensive home treatment functions	**Aligning CYP mental health plans with those for CYP with learning disability, autism, special educational needs and disability (SEND), CYP services more broadly, and health and justice**	**Adopting new approaches for 18-25 year-olds to ensure there are no gaps in the transition from CYP services to adult mental health services.**

5.33 The COVID-19 pandemic has undoubtedly had an impact on the NHS LTP from a Children and Young People Mental Health (CYPMH) 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.[27]

Learning disabilities and autism

5.34 Whilst delivery of the NHS 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;
- 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.

[27] The Health Foundation

Figure 23: Learning disabilities and autism ambitions in the NHS LTP

Improve uptake of the existing annual health check, so that at least 75% of those eligible have a health check each year	By 2023/24, reduce the number of patients with learning disabilities and/or autism treated on inpatient units by 50% compared to 2015 levels	People with a learning disability, autism or both will be enabled to have a Personal Health Budget
Expanding the STOMP-STAMP programme to ensure the appropriate treatment and medication of patients with learning disabilities and/or autism	Reduce waiting times for CYP specialist services. By 2023/24, CYP with learning disabilities and/or autism with the most complex needs will have a designated keyworker	Increased investment in intensive, crisis and forensic community support
Continue to support the Learning Disabilities Mortality Review (LeDeR) programme	Provide information and training on supporting people with a learning disability and/or autism, including new standards	Improve the quality of inpatient care across the NHS and independent sector. By 2023/24, all care commissioned by the NHS will meet Learning Disability Improvement Standards

5.35 Prior to the COVID-19 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[28]. Data reported during the pandemic show significant declines in inpatient activity in March and April 2020 followed by an increase to August 2020.

5.36 Likewise, poor progress had been made against the 75% health check objective prior to the COVID-19 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.[29]

5.37 HIOW performance against NHS LTP ambitions for mental health and children and young people are reviewed monthly with system partners. Good progress is being made against the ambitions, for example:

- **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 and into 2022/23. Primary care delivered 6,740 physical health checks by the end of Q4 against a local target of 7,000. This equates to 45.3% of SMI patients on the GP register receiving a complete annual physical health check;

[28] The Health Foundation

[29] https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2021-to-2022

- **Early Intervention in Psychosis Access Rate.** The ICS has consistently exceeded the 60% target for people experiencing first episode psychosis to be treated with National Institute for Health and Care Excellence (NICE) recommended package of care within two weeks of referral;

- **Adult Mental Health Inpatients receiving a follow up within 72hrs of discharge.** April 2023 performance is on target with 80.0% of HIOW adult mental health inpatients reported as receiving a timely follow up post discharge, against a target of 80%;

- **Perinatal Access.** HIOW ICS has consistently met or been on the cusp of local targets and by the end of May 2023 1,120 women had accessed specialist community perinatal services against a local target of 1,534 (73.0% of the target);

- **Children and Young People Eating Disorder (CYP ED) – Urgent referrals.** Following consistent improvement, performance for the 12 months to April 2023 was the highest the ICS has seen since reported for this metric with 85.1% of CYP ED being seen within the one week target for an urgent referral; and

- **Access to core Community Mental Health services.** The ICS has delivered access to 11,125 adults and older adults with SMI in the 12 months to April 2023. This represents 94% of the target of 11,814 expected contacts.

5.38 There are a number of areas that are more challenging including:

- **Access to CYPMH Services.** The rolling 12 month position at the end of April 2023 was that 22,045 CYP had been supported by NHS funded MH services with at least one contact (877 contacts below target). It is likely to be a challenge for the ICS to meet the full year target of 23,374 by end of March 2024; and

- **Children and Young People Eating Disorder (CYP ED) – Routine referrals.** The number of CYP seen within the four week timeframe for a routine referral at the end of April 2023 was 75.2% with a higher level of breaches within the Hampshire CAMHS ED service where performance in the year ending March 2023 was 63.4%. The service has experienced an increase in Urgent ED referrals and a high proportion of avoidant restrictive food intake disorder (ARFID) referrals continue to hinder the service's ability to assess and treat all routine referrals on this pathway within the four week target.

5.39 The COVID-19 pandemic has had a significant impact on demand for mental health services, seen most significantly in CAMHS and eating disorder services. There has also been an increase in acuity of presentations as a consequence of COVID-19.

5.40 The clinical strategy aligns closely to the NHS LTP. The NHS LTP was an important consideration in determining the system priorities for the Clinical Transformation Group workstreams (see figure 16). The broader principles of the clinical strategy are

also designed to align with the NHS LTP ambitions that require effective system working, person-centred care and improvements that are sustained.

Figure 24: Alignment of Clinical Transformation Group workstreams with NHS LTP ambitions

NHS LTP ambition	Clinical Transformation Group workstream
• Acute and Crisis - anyone experiencing mental health crisis will be able to call NHS 111 and have 24/7 access to the mental health support they need. • Reduced length of stay in units with a long length of stay to the national average of 32 days.	Acute and crisis care
• Provide better community mental health support to 370,000 people with SMI via new and integrated models of primary and community care. • Adopting new approaches for 18-25 year-olds to ensure there are no gaps in the transition from CYP services to adult mental health services.	Community mental health services (No Wrong Door)
• Boosting investment in CYP eating disorder services to maintain the 95% CYP Eating Disorder Referral to Treatment (RTT) standards —starting treatment within one week of urgent referrals, within four weeks of non-urgent referrals. • Ensuring 100% coverage of 24/7 mental health crisis care provision for CYP which combines crisis assessment, brief response and intensive home treatment functions.	Children and young people's mental health
• Ambitions for autism expressed in the Learning Disability and Autism NHS LTP.	Neurodiversity services

Fit with ICS Partnership Strategy

5.41 The ICP published its interim Partnership Strategy to codify strategic aims, priorities and areas of focus, as noted in chapter 3. 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.

5.42 To achieve these aims in the medium-term, the Partnership Strategy sets out five priorities and key areas of joint focus[30]:

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

[30] 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.

- Ensure people who provide services are well supported and feel valued

Digital and data

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

5.43 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, which has informed the development of the Partnership Strategy.

5.44 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 can 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

5.45 The following figure summarises how the clinical strategy will support the aims of the ICS partnership strategy.

Figure 25: The principles of the clinical strategy support the aims of the ICS partnership strategy

Aims of the ICS partnership strategy	Principles of the clinical strategy for the new Trust
Improve outcomes in population health and healthcare	Life course approach, including prevention and early intervention
Tackle inequalities in outcomes, experience and access	Sustained high quality care for the people of Hampshire and the Isle of Wight
Enhance productivity and value for money	Clinical and professional leadership and workforce equipped to deliver high quality care
	Continuous improvement, innovation and research
Take a more community-centred approach to wellbeing	Collaborative working with people with lived experience of using services, their families and carers, our communities and with system partners
Support broader social and economic development.	

Stakeholder story - working with system partners

A local mental health charitable organisation was reviewing its organisational strategy at the same time as the clinical strategy was in development. They invited Project Fusion representatives to a strategy workshop in order to share emerging thinking. The alignment was striking, particularly with regards to:

- valuing the voice of lived experience;
- being rooted in our communities; and
- a focus on development of a skilled and value led workforce.

This collaborative approach has strengthened the connections between the services and has opened up opportunities for developing the relationship with the Voluntary and Charitable sector and the new Trust for the benefit of the people we serve.

Fit with ICS Joint Forward Plan

5.46 The HIOW ICB and system partners have developed the five-year JFP, as noted in chapter 3. The key themes described in the JFP are:

- Tackling health inequalities;

- Ensuring the voices of local people and communities are heard;
- Transformation programmes to improve models of care;
- ICP priorities to improve population health;
- Improving end of life care, maternity care and cancer care; and
- Working together as a system to improve productivity and efficiency, grip and control and system working.

5.47 The JFP responds to the key themes identified in the health and wellbeing strategies for each place over the next five years:

Hampshire

- Improve physical, mental health and emotional resilience for children, young people and their families.
- Work collaboratively to support people to live healthier lives, focussing on coronary vascular disease and reduction of prevalence of risk factors including smoking, obesity, physical inactivity.
- Support people to stay healthier for longer and be more active and independent into old age by implementing the Live Longer Better model.
- Work together to address wider social and economic determinants of health, including housing, poverty, and air quality.
- Further the work on effective mental health and wellbeing services and interventions to meet the needs of the population.
- Ensuring synergies between health and care services are maximised.

Isle of Wight

- Further the strategic partnerships with NHS partners to ensure improvements in quality and outcomes of patient care in conjunction with financial sustainability of the island health system.
- Ensure the Home First model is embedded in all areas of work.
- Coordinate action and partnerships to improve mental health and wellbeing with a focus on the most vulnerable groups.
- Reduce inequalities that patients experience in accessing and experiencing health services focused on Coronary Vascular Disease working with communities to take action on tackling poverty, and the prevention of disease, and addressing the wider determinants of health.

- Work together to improve the outcomes where housing impacts on health, and prevent homelessness.
- Implement the family hubs model across the Island.

Portsmouth

- Work to improve health and reduce health inequalities by embedding the population health management approach.
- Develop Children's services 0-19, safeguarding children from harm.
- Support adults with the most complex lives by addressing the needs of our health inclusion groups.
- Embed an integrated community care model that drives early intervention and self-care.
- Provide Person-centred care by ensuring single, streamlined processes for assessing the needs of individuals requiring support.

Southampton

- Reducing childhood obesity
- Improving children's and young people's emotional and mental wellbeing
- Improving outcomes in the early years
- Improving mental health and tackling loneliness
- Improving lives for the most vulnerable, tackling inequalities
- Tackling smoking, drugs and alcohol misuse
- Early identification of people at end of life
- Promote accessibility of end of life care for all
- Out of hospital end of life care coordination

5.48 These local priorities will be delivered by the following key enablers:

- Addressing workforce challenges
- Use of digital technology and date
- Replace outdated estate in Hampshire
- Improve collaboration across the system through development of the ICP

5.49 The following figure shows how the clinical strategy will support delivery of the JFP.

Figure 26: The principles of the clinical strategy support delivery of the JFP

Key themes of the JFP	Principles of the clinical strategy for the new Trust
Tackling health inequalities	Collaborative working with people with lived experience of using services, their families and carers, our communities and with system partners
Ensuring the voices of local people and communities are heard	
Transformation programmes to improve models of care	Sustained high quality care for the people of Hampshire and the Isle of Wight
Improving end of life care, maternity care and cancer care.	
ICP priorities to improve population health	Life course approach, including prevention and early intervention
	Clinical and professional leadership and workforce equipped to deliver high quality care
Working together as a system to improve productivity and efficiency, grip and control and system working.	Continuous improvement, innovation and research

6 Operating model

Chapter summary

- This chapter describes the current operating models (governance, systems and processes, organisation structures, roles and capabilities, culture and behaviours) of the three Trusts and the operating model of the new Trust.
- A key difference in Southern's operating model is that it has a Council of Governors, which is a required mechanism for foundation trusts to be held accountable by their members.
- An assessment of existing cultures and behaviours was undertaken as part of the work to inform the development of the operating model for the new Trust.
- The operating model for the new Trust includes:
    - Amending the Southern constitution to ensure the membership for the new Trust reflects its broader geography, focus on lived experience and greater representation from local authorities.
    - Changes in governor constituencies and posts, increasing the number of public and staff constituencies to reflect the wider geography and including an additional service user and carer constituency.
    - Development of a membership strategy to ensure that the public membership is diverse and inclusive and represents local communities.
    - Development of a Board structure and appointment of designate Board members who will take up their posts on Day 1.
    - The committee structure for the new Trust and a plan to determine the membership of each committee based on the skills matrix for Board members.
    - The approach to risk management and the Board Assurance Framework, which brings together similar processes that are already in place across the three Trusts.
    - Performance processes for the new Trust, along with the performance governance structure and metrics to be reported within the new Trust's Integrated Performance Report.
    - The operational management structure for the new Trust which will build on a set of agreed principles.

Current operating model

Governance, systems and processes

6.1 This section provides a brief overview of the existing governance systems and processes of Solent, Southern and IoW.

Council of Governors

6.2 Southern has a Council of Governors (CoG), as a required mechanism for foundation trusts to be held accountable to their members. The CoG at Southern meets quarterly

and on an ad hoc basis where required. Four governor development sessions are also held each year, along with ad hoc webinars as required. The Appointment Committee (for the appointment of NEDs and the Chief Executive) is a Committee of the CoG.

6.3 Solent and IoW are not foundation trusts and therefore do not have CoGs.

Trust Boards

6.4 Solent's Trust Board meets every two months. Southern's Trust Board meets six times each year in public and holds four public Focus meetings with confidential sessions held (following resolution to exclude public) for matters as required. Board Focus meetings are dedicated to discussing and exploring one or two important strategic items in detail. Ten Board seminars are held each year (with one or two held jointly with governors) and three Board development sessions. IoW's Trust Boards meets every two months.

6.5 The Board roles at each of the three Trust are listed in the figure below.

Figure 27: Trust Board roles at Solent, Southern and IoW

Solent	Southern	IoW
Executive board roles		
• Chief Executive Officer • Deputy Chief Executive Officer and Chief Medical Officer • Chief Financial Officer • Chief of Nursing and Allied Health Professionals • Chief Operating Officer • Acting Chief People Officer (non-voting) • Chief Strategy and Transformation Officer (non-voting)	• Chief Executive • Deputy Chief Executive and Finance Director • Acting Chief Medical Officer • Director of Nursing and Allied Health Professionals • Chief Operating Officer • Chief People Officer • Director of Strategy and Infrastructure Transformation	• Chief Executive • Chief Medical Officer • Finance Officer • Chief Nurse • Chief Officer Isle of Wight • Chief Officer PHU (non-voting) • Chief Transformation Officer (non-voting) • Chief Research Officer (non-voting) • Group Director CMHLD (non-voting) • Chief People Officer (non-voting) • Chief Strategy Officer (non-voting)
Non-executive roles		
• Acting Chair and four further NEDs	• Chair and eight further NEDs and an associate NED	• Chair (joint with Portsmouth Hospitals NHS Trust), five further NEDs and one associate NED

Committee structures

6.6 The figure below lists the committees that report into the Trust Boards of Solent, Southern and IoW.

Figure 28: Committee structures at Solent, Southern and IoW

Solent	Southern	IoW
Statutory committees		
• Audit and Risk Committee – quarterly and a private meeting • Remuneration and Nominations Committee – at least twice per year and as required • Charitable Funds Committee – three times per year	• Audit, Risk and Assurance Committee – five times a year • Nominations and Remuneration Committee (for Executive appointments) – annually and ad hoc • Charitable Funds – three times per year	• Audit Committee – up to six per year • Remuneration and Nominations Committee – as required • Charity Committee (separate legal entity) – quarterly
Other committees		
Designated committees: • Mental Health Act Scrutiny Committee – quarterly • Quality Assurance Committee – every two months • Finance and Infrastructure Committee – every two months • People Committee – every two months • Strategy and Partnership Committee – every two months	Committees required by the foundation trust constitution: • Quality and Safety – eight times per year • People – six times per year • Health, Ethics and Law – quarterly • Finance and Performance – six times per year	Designated committees: • Quality and Performance Committee – monthly • People and Organisational Development Committee – monthly • Finance and Infrastructure Committee – monthly The Trust also has a combined Community and Mental Health and Learning Disabilities Divisional Board.

Risk management and Board Assurance Frameworks

6.7 Solent has a Board Assurance Framework (BAF) and a corporate risk register that is managed by the Head of Risk and Litigation. The Audit and Risk Committee is responsible for testing the effectiveness of the BAF. The corporate risk register is managed through an online risk system that enables real time reporting and escalation. The system also aligns with existing systems used for incident, complaints and claims reporting. The use of this system supports the triangulation of data from incidents, claims and complaints for further analysis and assurance.

6.8 In Southern the executive lead for the BAF is the Director of Strategy and Infrastructure Transformation who is supported by the Associate Director of Corporate Governance and Risk. Southern's BAF underwent a comprehensive review in 2022/23, with strategic risks now aligned to the Trust's strategic objectives. The executive lead for operational risk management is the Director of Nursing and AHPs, supported by the Associate Director of Corporate Governance and Risk.

6.9 The IoW has a Trust-wide BAF and corporate risk register (i.e. includes some risks that do not apply to the CMHLD division). The risk management policy for the IoW is being refreshed to improve referencing to the BAF, training and to explain the need for risk appetite.

Performance management

6.10 In Solent bi-monthly Performance Review Meetings (PRM) are held with each clinical service line and corporate team. The PRMs are led by the service line triumvirates, focussing on key performance metrics across finance, quality, people and operational performance. Performance escalations are backed up with evidence from the Trust's reporting tool (Power BI) or alternative sources of data. Corporate partners attend the clinical service line meetings to support discussions along with the recent inclusion of commissioning managers.

6.11 Significant performance escalations discussed at PRM are included within the Integrated Performance Report (IPR) which also includes a summary of the Trust's performance against the System Oversight Framework, quality standards, people metrics and financial information using the NHS Improvement 'Making Data Count' statistical analysis to focus attention to metrics which have significant variation or trends emerging. The IPR is presented to the Executive PRM, where performance issues are discussed in-depth, necessary mitigations identified, and assurance sought where appropriate. The IPR is also presented to the Trust Board.

6.12 In Southern the Trust has systems in place to assure the quality of performance information through its Business Intelligence System (Insights) as well as through the internal audit function, annual programme of data quality audits and external validation of performance reporting by NHSE. Performance data is scrutinised through the governance structure at divisional level via the Executive Performance Groups, prior to reporting collectively via the IPR that is reviewed by the Finance and Performance Committee before being submitted to the Trust Board.

6.13 Southern's Quality and Performance Governance Framework describes how the Trust oversees the quality and performance of services and relevant information feeds into ongoing quality improvement initiatives. This framework also provide assurance to the Trust Board, stakeholders and regulators on the Trust's performance and on mechanisms in place to mitigate risks and make changes where improvements are required.

6.14 Oversight of performance is provided at individual, team, division and Trust-wide level through regular reports and performance meetings, with a clear mechanism for escalation. At Trust Board and Committee level the IPR, Priority Programme reports and subject-specific dashboards support decision-making. Divisions and teams use Insights reports to review performance daily and weekly, with findings and actions being presented monthly to the Executive Performance Group which provides executive director oversight of performance.

6.15 In the IoW performance reporting flows upwards from divisions to corporate sub-committees and committees to Board committees and then Trust Board. All performance data is reviewed at division and then at corporate sub-committees prior to review by the Trust Board.

Organisational structures

6.16 Solent is structured around the following service lines, which sit under the chief operating officer:

- Child and family services
- Adult services Portsmouth
- Mental health services
- Sexual health services
- Specialist dental services
- MSK, podiatry and pain services
- Primary care services
- Adult services Southampton
- Emergency planning and business continuity

6.17 Each of these service lines has a clinical director, operations director and head of quality and professions, which report through the Trust's Deputy Chief Operating Officer to the Chief Operating Officer (COO).

6.18 Southern's services are organised into four geographic divisions, along with a separate specialist services division:

- South-West Hampshire
- Southampton
- Mid and North Hampshire
- Portsmouth and South-East Hampshire

- Specialist services

6.19 Each division has its own management structure comprising: divisional director of operations, clinical director, medical director, director of nursing and AHPs and a director of psychology. Each division has associate directors for the relevant services within that division (including mental health, community health, planned care, CAMHS, adults forensic and secure). These associate directors report to the divisional director of operations, who reports to the Trust's COO.

6.20 The IoW is currently structured around the following divisions:

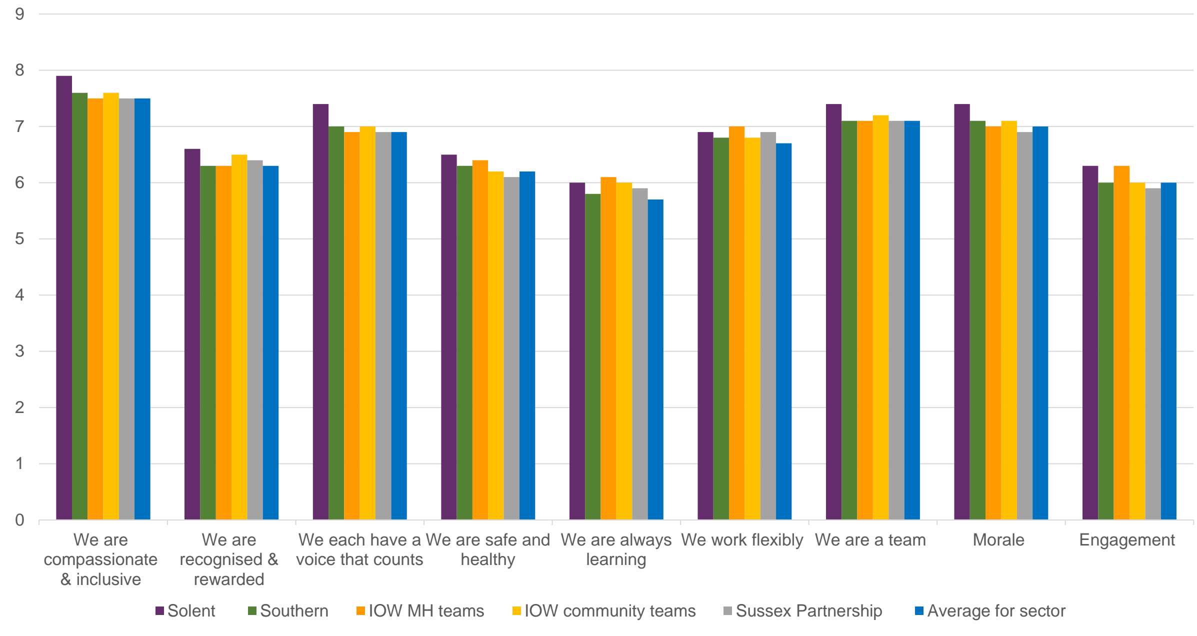
- Acute
- Ambulance
- Community
- Mental health and learning disabilities

6.21 Each division has a director of operations who reports into the relevant Executive Director.

Culture and behaviours

6.22 The cultural analysis undertaken by the Organisational Development Steering Group included a comparison of the themes of the NHS People Promise. The relevant data is summarised in the figure below, followed by key recommendations arising from the analysis.

Figure 29: Analysis of staff survey scores across the Trusts on themes of the NHS People Promise



6.23 Key recommendations from the cultural analysis were:

- There should be an approach in place for Day 1 with a clear strategic approach, budget, opportunities for staff input and engagement plan for sharing;
- Encouraging staff to share their ideas and concerns is central to engagement and a culture of belonging. There is an opportunity to link a new Trust value explicitly to this;
- There is an opportunity to maximise the joint resources available through health and wellbeing teams and other stakeholders such as patient safety to create a shared vision for improving the workplace in the new Trust and embedding a just culture;
- Enabling staff to fulfil their potential, when it is right for them to do so, will support the ambition to be an organisation at the heart of the community;
- The Trusts' performance in the "We Work Flexibly" theme is strong and this should be capitalised on through the strategic approach to how flexible and agile the new, larger Trust can be; and
- The creation of a 'healthy team checklist' should be considered to enable teams to reflect on their needs and be supported to make any changes. This could be underpinned by an organisational commitment to away days, and a reminder of charity days and other opportunities to enhance teamwork.

Governance, systems and processes of the new Trust

Council of Governors

6.24 In May 2023 a Constitution Review Group was established, with all governors on the Southern CoG invited to participate as members. The membership of the Group also included senior corporate governance leads and engagement colleagues from Solent and Southern, along with representation from IoW. A representative from the lived experience workstream was also a member of the group.

6.25 The Constitution Review Group used the Southern constitution as the basis for the work and undertook the following:

- Reviewed and developed proposals to amend the public constituencies, the staff constituency and appointed governors;
- Made recommendations on the overall composition of the CoG, including the number of governors required in each constituency; and
- Engaged on proposals for amendments to the remaining (non-model) sections of the Constitution, including annexes (proposed by the Corporate Governance Steering Group).

6.26 The Group met three times, to agree key principles, explore options and determine the preferred way forward before seeking legal advice prior to selecting a final option.

6.27 The key changes to be made to the Southern constitution, to take effect from Day 1, are:

- In line with the guiding principle for the new Trust of having the voice of lived experience at its heart, the introduction of a service user and carer constituency, with effect from Day 1;
- Changes to the public constituencies, to develop two new geographically based constituencies for Portsmouth and Isle of Wight, with effect from Day 1;
- Extending the classes of the staff constituency to include two new geographically based classes, with effect from Day 1;
- Transitional provisions to alter the number of governors within the current geographic-based public constituencies upon termination of current governor terms;
- Amendments to the appointed governors to increase representation from local authorities across the broader geographic footprint and to vary the designated partner organisations; and
- Other amendments required as a result of the transaction, such as reflecting the name of the new Trust.

6.28 The revised constitution is provided as a supporting submission to this FBC. The changes to the constitution described in the paragraph above will come into effect from Day 1, with existing Southern CoG members appraised of the amendments and invited to self-allocate to the new service user and carer constituency if eligible, and for those CoG members currently in the Rest of England constituency to be allocated to Portsmouth or Isle of Wight public constituencies if eligible. Staff expected to transfer into the Trust, along with existing staff members, will be informed of the staff governor election schedule, with elections expected to take place shortly after Day 1.

6.29 The standing orders for the Board of Directors and CoG, along with the scheme of delegation and schedule of Board reserved powers and the standing financial instructions will be reviewed by the Corporate Governance Steering Group and will be approved by the Southern Board of Directors in early 2024 in readiness for implementation from Day 1.

Governors

6.30 The current Southern constitution has 23 governor posts comprising 13 public governors (across five geographic constituencies), four staff governors (across four separate geographic-based classes) and six appointed governors (two local authority governors and four partnership governors).

6.31 Changes to the constitution relating to the composition of the CoG will come into effect from Day 1, with transitional provisions in place relating to some of the amendments to the public constituencies and the appointed governors.

6.32 The public constituencies will be increased from five to seven, with two governors per public constituency area (except for 'rest of England', where there will be one governor). Transitional provisions will apply to allow a reduction from three to two governors in the existing Southern public constituencies at the natural end of term where there are three governors in post as at Day 1.

6.33 The creation of a service user and carer constituency is proposed, with six governor posts proposed for this constituency, and no classes thereof. Eligibility criteria for membership of this constituency will be defined in the constitution and will require an individual to have used any of the Trust's services as a patient or have been a carer of anyone using the Trust's services within the three years immediately preceding the date of an application.

6.34 The classes of the staff constituency will be increased from four to six and the number of staff governor posts will increase from Day 1 from four to six. Staff membership will be expanded on Day 1 as a result of the automatic opt-in provision for staff members.

6.35 The new Trust is not yet in a position to confirm key strategic partners, and as such, no changes are proposed to the stated partner organisations of Age Concern, Carers Together and Unloc. However, the new Trust may review and reconfirm the designated partner organisations at the expiry of existing governor terms. Provisions relating to the appointment of the additional local authority governors will be scheduled to allow for completion of elections, so as to ensure the aggregate number of public and service user and carer governors remain the majority.

6.36 Elections for vacancies on the CoG are planned shortly after Day 1, with work undertaken in advance to ensure that there is an adequate membership of each of the revised constituencies to enable elections to be held.

6.37 The CoG will continue to meet four times per year, with additional quarterly sessions dedicated to governor development, and supplemented by a programme of governor webinars, as has been in place within Southern.

6.38 Southern currently has a Governor Agenda Planning Group, and it is proposed that this will continue into the new Trust. This group will be involved in designing the programme of governor development support.

Membership

6.39 As at August 2023, Southern had 6,632 public members across the five public constituencies and 6,992 staff members across the staff constituency. Members have the opportunity to contribute to the strategic direction of the new Trust, stand for election as a governor or participate in election for governors. A membership strategy for the new Trust is under development and one of the key areas of focus is to ensure

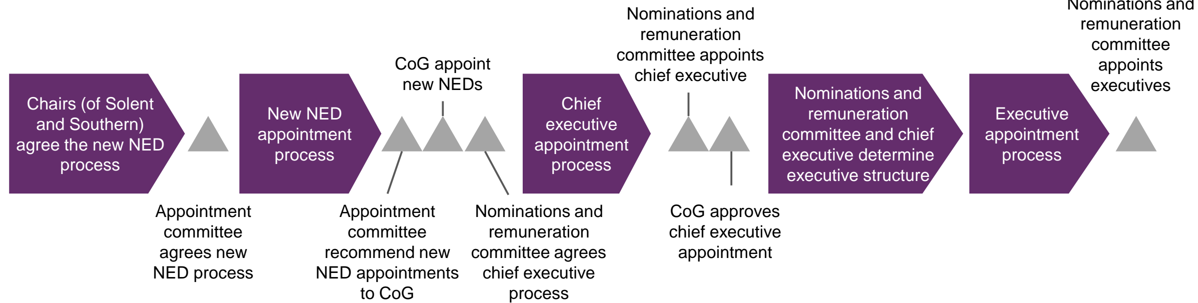
that the public membership is diverse and inclusive and represents local communities. The membership strategy will describe how membership of the new 'service user and carer' constituency will be grown, potentially utilising the skills of the Lived Experience Network[31] and of the new Trust's communications and engagement function.

6.40 Neither Solent or IoW are existing Foundation Trusts and neither therefore has a current membership. However, both hold contact details for networks of individuals with whom they regularly communicate and engage. Communications have been sent to the existing networks to inform them of Fusion and the potential to sign up for membership. Follow up communications are planned which will include information on how to sign up as members, with reminders to follow.

Trust Board

6.41 The process to appoint designate members of the new Trust's Board was developed based on the Partnership Agreement[32] and to comply with Southern's constitution and the Code of Governance. This process is summarised in the figure below.

Figure 30: Overview of the Trust Board appointment process



6.42 Through this appointment process, the designate Chair for the new Trust (Lynne Hunt, the current Chair of Southern) was appointed by the CoG in May 2023.

6.43 Southern's appointments committee then determined the process to appoint new NEDs to the Board of the new Trust. Following that process, the CoG appointed three designate NEDs in June 2023: two current NEDs of Solent (Mike Watts and Gaurav Kumar) and one current NED of IoW (Sara Weech).

6.44 Southern's Nominations and Remuneration Committee, including the three designate NEDs, agreed the process to appoint the designate chief executive. Following that process, the nominations and remuneration committee appointed Ron Shields (the

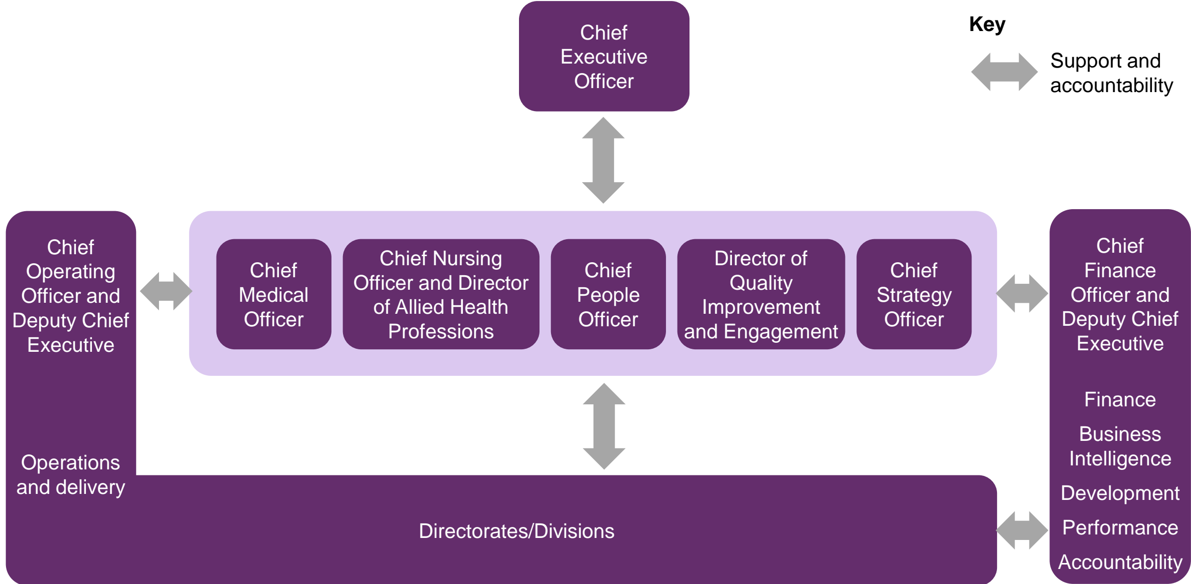
[31] The Lived Experience Network is a lived experience-led organisation made up of staff and individuals with lived experience from across health and social care, who are committed to enhancing co-production and providing independent feedback and observations.

[32] A Partnership Agreement (based on NHSE's Heads of Terms template) was signed by Solent, Southern and IoW in April 2023 setting out how the Trusts would work together in the development of the FBC.

current chief executive of Southern) as the designate chief executive. This appointment was approved by the CoG.

6.45 The Nominations and Remuneration Committee has determined the structure of the new Trust's executive team, shown in the figure below, and will appoint the designate executive directors by the end of December 2023.

Figure 31: Executive Board structure for the new Trust



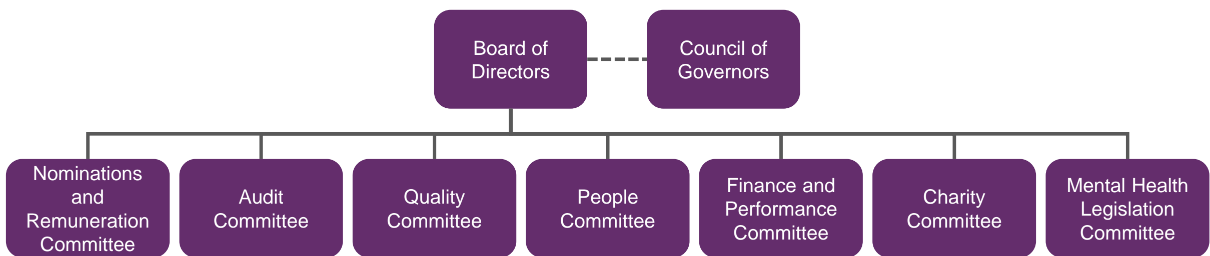
6.46 Summary biographies for designate Board members appointed to date are included in appendix 6. All designate Board members will take up their new roles on Day 1 of the new Trust.

Committee structure

6.47 The Corporate Governance Steering Group has reviewed the committee structures within Solent, Southern and the IoW to support the development of the committee structure for the new Trust. The existing Committee structures of the organisations and purview of the Committees are largely consistent, with the principal difference being the approach to performance oversight.

6.48 The outline of the proposed Committee structure for the new Trust is set out below. This will be refined, including agreeing the names and memberships of the Committees, to allow Terms of Reference to be in place for Day 1 of the new Trust.

Figure 32: The proposed committee structure for the new Trust



6.49 Approval of the establishment of the Board committee and appointments to these committees will be in line with the provisions of the constitution and standing orders; this includes the discretion for the Board to be able to establish any other committees of the Board required.

6.50 Once the Board composition has been finalised, including the executive portfolios, a process will be agreed with the Chair designate to review the skills matrix for Board members to inform the membership of committees and appointment of committee chairs. Appointments to committees will, where possible, take account of tenures of NEDs to ensure stability is maintained within committees through the transitional period and into the first year of the new Trust.

6.51 The Corporate Governance Steering Group will design, through detailed integration planning, the approach and templates for Board and Committee administration. This will include, but is not limited to, agendas, minutes (including house style), action logs, reports, escalation reports from committees to the Board of Directors and the process for the annual committee effectiveness review process. The approach will be to adopt areas of good practice from existing Trusts and beyond. The Corporate Governance Steering Group will ensure that all actions attributed to the Board and committees from the Trusts are transferred into the new governance framework and allocated accordingly for committee oversight to ensure that these are seen through to completion.

6.52 Quality and performance reports to the Trust Board and committees will enable clear visibility of operational performance throughout the organisation and will be presented in a format that supports identification of trends and highlights areas for improvement. Trust level reporting will encompass operational performance across all sites and cover all statutory national performance standards, alongside other indicators of patient quality, safety and patient experience.

Risk management and Board Assurance Framework

6.53 During quarter 4 2023/24, the designate Board will develop a clear and aligned risk management vision statement, strategic aims, risk appetite and tolerance to inform the development of the risk management strategy and BAF for the new Trust.

6.54 Following agreement of the Trust's strategic objectives, the Corporate Governance Steering Group will support the designate Board in identifying the principal risks to delivery of the strategic objectives and developing the BAF.

6.55 The BAF models in use within the Trusts are broadly similar in their style in that they follow the recognised good practice model which sets out the principal risks to delivery of the strategic objectives, the controls in place to mitigate these risks, the assurance as to the effectiveness of the roles and any required actions to address any gaps in controls or assurance.

6.56 The BAF, and highest scoring risks from the corporate risk register, will be reviewed by the relevant Board Committees on a quarterly basis, and in consolidated form quarterly by the Audit Committee and Board of Directors.

6.57 The ongoing management of the BAF will be led by the corporate governance function in the new Trust.

6.58 All Trusts have effective processes in place for the identification, reporting and management of clinical and non-clinical risks via the corporate risk register. The risk management processes for the new Trust will be supported by the quality governance teams and the transitional processes will be overseen via the Clinical Steering Group.

6.59 The risk management processes in each Trust are based on the National Patient Safety Agency risk matrix developed in 2008. Both Solent and Southern utilise the same electronic system to record and monitor risks. As part of the transition arrangements, risks relating to mental health and community services within the Isle of Wight will be transferred into the Ulysses system prior to Day 1. Additionally, any risks identified by workstreams that relate to post-transaction implementation beyond Day 1 will be included within the risk register for the new Trust.

6.60 The Trusts plan to develop a risk management strategy and policy framework for the new Trust by the end of January 2024 to ensure that patients, visitors, employees, contractors and other members of the public are not exposed to unnecessary risks. This will be supported by a single risk matrix and risk register template.

6.61 The proposed structure for the quality governance function includes a risk manager post to work across the new Trust and support effective risk management.

Performance management

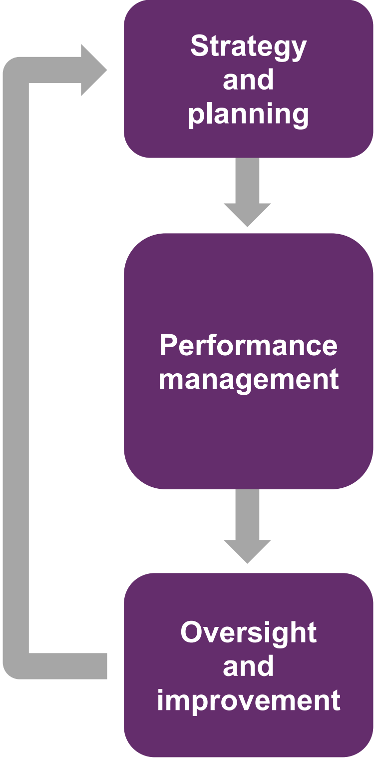
6.62 The performance framework for the new Trust has been designed to improve decision-making and the execution of the new Trust's strategy through measurement, reporting, analysis and oversight. This framework requires individuals, services, localities, specialisms and the Trust to report, explain and improve performance against agreed standards and targets. These standards and targets reflect best practice and focus on delivering high quality outcomes. Oversight of performance enables identification of areas where further support for improvement is required. The new Trust plans to develop the framework to support population health management,

including consideration of the local Joint Strategic Needs Assessment and health inequality information to help inform service development, to meet the needs of the population equitably.

6.63 The new Trust will use performance information to improve services, ensuring that:

- Staff can assess performance against targets and predict future performance, enabling decisions to be made around performance improvement. Relevant information will be made available to all staff in a number of ways, but predominantly through the new Trust's automated business intelligence (BI) platforms;
- Strategic decisions support continuous improvement and are informed by evidence;
- Internal benchmarking of services and localities/specialisms against core standards is undertaken and reported to Board;
- External benchmarking is used to assess and improve services; and
- Sharing good practice across services and localities/specialisms is embedded within business-as-usual processes.

Figure 33: The performance process for the new Trust



- Define strategic priorities and set performance deliverables and KPIs
- Set targets and thresholds at individual, service, locality/specialism and Trust level
- Agree monitoring and reporting mechanisms

- Collate and report through the Trust's automated BI platforms and other required mechanisms
- Undertake formal performance reviews at individual, service and locality/specialism levels
- Provide internal reports for oversight and assurance through Board and committees
- Provide external performance reports as required to commissioners and regulators

- Identify and implement corrective action for services requiring additional support
- Review and challenge at Executive/Trust Board level as well as externally with commissioners and NHSE
- Implement individual support and review through appraisal and supervision processes

6.64 The performance governance structure for the new Trust is summarised in the figure below, and the performance management responsibilities for individuals and teams are set out in appendix 7.

Figure 34: Governance structure for performance management in the new Trust

Meeting	Content	Benefit	Frequency
Trust Board	• Presentation of the IPR containing performance exceptions in metric and narrative format	Oversight by Board Directors, assurance and approval	Bi-monthly
Executive Performance Oversight Group	Escalations of performance exceptions in metric and narrative format from the following: • Locality/specialism performance reports • Corporate teams performance reports • Trust-wide financial Reports • Trust-wide quality Reports • Trust-wide workforce Reports	Triangulation, review and challenge by Executive Directors Action planning and delivery	Bi-monthly

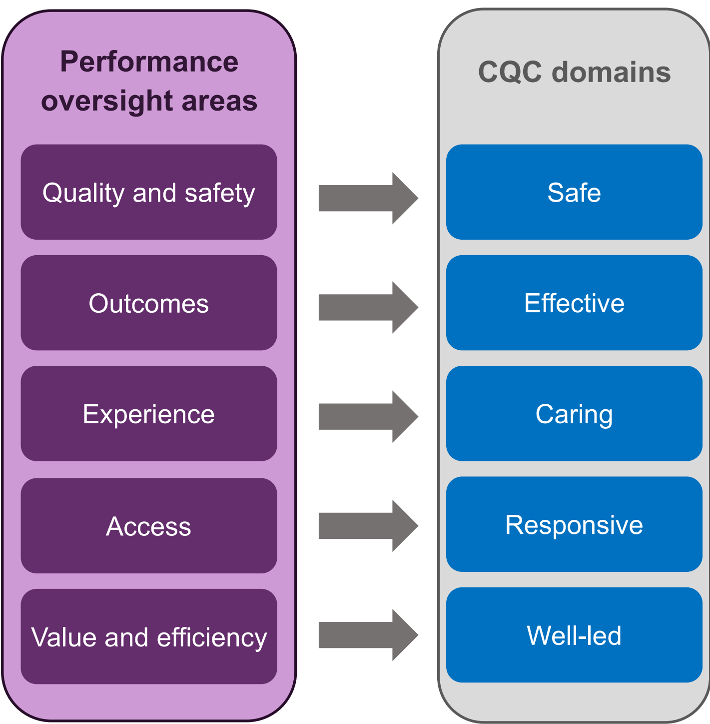
Meeting	Content	Benefit	Frequency
Locality/Specialism Performance Oversight Group	Review of services and overall locality/ specialism to include: • Review of performance against the five oversight areas • Evidence-based performance hotspots • Snapshot report of key metrics • Performance actions plans (as appropriate) • Escalations from locality/specialism operational boards • Commissioner attendance for oversight and constructive challenge	Internal assessment of performance, analytics, decision-making, benchmarking, sharing good practice	Bi-monthly
Locality/Specialism Operational Boards	• Review of operational performance at service level within each locality/specialism • Review of performance against the five oversight areas, with specific content defined by each locality/specialism	Internal assessment of performance, decision-making, benchmarking, sharing good practice	Monthly
Service specific meetings	• Review of service level performance data • Specific content defined by each locality/specialism or individual service	Operational management and action planning	Individually defined
Individual performance reviews (1:1s)	• Review of individual performance • Personal Development Plans • Individual activity/assurance reports from the Trust's automated BI platforms	Accountability for performance throughout the Trust	Monthly/ annually

6.65 Measurement of performance is largely influenced by national and local priorities and the NHS Oversight Framework[33]. These metrics, paired with a range of internally identified measures that can be reviewed at various levels of the Trust, from individual service to Board, inform decision-making, highlight best practice, provide oversight

[33] https://www.england.nhs.uk/nhs-oversight-framework

and support risk management. The identified metrics are set out under five key oversight areas, which are broadly aligned to the CQC domains:

Figure 35: The five performance oversight areas for the new Trust



6.66 Metrics will be monitored at service and locality/specialism levels and reported by exception through the performance framework governance structure, however a standard set of metrics (outlined below) will be reported routinely within the IPR to provide an overview of performance across the oversight areas, utilising NHSE's Making Data Count[34] methodology to identify significant trends and variation which require further scrutiny. This represents the starting point that will ensure safe and effective delivery of care from Day 1 and the new Trust collaborate with the ICB to review the metrics used for CMHLD over the following two years, linked to the work arising from the transformation programmes.

[34] https://www.england.nhs.uk/publication/making-data-count

Figure 36: Metrics to be reported within the IPR for the new Trust

Quality and safety

- Incidents
- MH risk assessments
- MH physical health monitoring
- Patients on caseload receiving active treatment
- Readmission/re-referral rates
- MH 72 hour follow-up
- MH crisis planning
- Never events
- Patient safety events
- VTE risk assessment
- Clostridium difficile rates
- MSSA rates
- Escherichia coli rates
- MRSA rates
- MH detentions in acute hospital

Experience

- Patient and carer experience
  - FFT
  - Coproduction of care plans
  - Complaints
  - Compliments
  - PLACE audits
- Staff FFT/cultural insights
- Out of area bed use
- Mixed sex breaches

Outcomes

- PROMS/CROMS
- WRES/WDES
- Inpatient outcomes
  - Bed occupancy
  - Length of Stary
  - Criteria to reside
- Virtual ward occupancy
- Mix accommodation status
- Talking therapies recovery rates
- Population health
- Public health outcomes
  - SAI vaccination rates
  - Sexual health outcomes
  - Healthy child programme

Access

- Waiting times
  - RTT incomplete pathways
  - 52/65 week+ waiters
- Community waiting times
  - Community waiting list
  - Time from referral to 1st and 1st to 2nd appointment
  - 18 week+ waiters
  - 6 week diagnostic standard
  - 2 hour UCR standard
- Mental health waiting times
  - 2 week EIP standard
  - Talking therapies waiting times
- Activity
  - No. of referrals
  - First:follow-up contacts
  - Elective recovery
  - Inpatient admissions/discharges
  - No. patients declined at referral/assessed by NFA
  - UDA delivery
- Transition between services
- MHSDS DQMI scores
- Access to CYP MH services
- Access to core community MH services for people with SMI

Value and efficiency

- Activity
  - Length of time on caseload
  - DNA/cancellations
- Temporary staffing
  - Agency locum costs
  - Proportion of temporary staff
  - Agency spend % of pay
- People
  - Sickness
  - Turnover
  - New starters
  - Proportion
- Finance
  - Finance actual vs budget
  - Cash balance
  - Aged debt
  - NHSE use of resources score

Operational management structure

6.67 In July and August 2023, an options appraisal was undertaken to inform the design of the operational management structure and to establish principles for its development. This options appraisal involved staff from across the Trusts and took into account what already works well in each Trust. The conclusions of the options appraisal include:

- The final operational management structure needs to be flexible, recognising that some services are better delivered at HIOW scale and others organised around local geographies;
- Rigid operational management structures, for example all HIOW community and mental health services organised in local geographical directorates, or all services managed at scale across HIOW, should be discounted;
- Many services suit delivery in local geographical divisions, with some best organised around acute hospital footprints (Local Delivery System (LDS) level) and others organised around local authority boundaries (Place);
- Other services, particularly specialist services, are better organised at HIOW scale;
- A flexible matrix, or hybrid operational management structure is preferable, which will enable services to be delivered at the optimum scale for the best patient outcomes; and
- To support the case for change, whether services are organised in local geographical directorates or at HIOW scale, clear mechanisms are needed to ensure learning across HIOW and reduce unwarranted variation.

6.68 Following the options appraisal, a workshop was held with attendees from all four Trusts. The following was agreed at the workshop:

- The definition of service groupings for HIOW community and mental health services;
- The proposed delivery scale for each service: PCN, local authority boundary (Place), acute boundary (LDS) or HIOW boundary;
- It was also noted that many IoW services are small scale and currently managed together to provide resilience (e.g. liaison services for adults, children and LD). This may change the recommendations for grouping/scale of some IoW services during the implementation planning stage; and
- Further work is needed to list and map all Trust services to a greater level of detail. Clinical and operational leads from across the Trusts should be involved in this and work being undertaken by clinical transformation workstreams needs to be taken into account, once available.

6.69 The principles for the organisational management structure for the new Trust are set out in the figure below. The structure will be designed to enable the delivery of the clinical strategy, recognising the importance of a matrix approach to leadership that enables the organisation to maximise the benefits of working at place, while at the same time driving out unwarranted variation.

Figure 37: Principles for the organisational management structure of the new Trust

Principle	Description
1. Consistency and safety	• At Day 1 of the new Trust, the priority is to ensure clarity, consistency, effectiveness and safety of service delivery. Decisions that are not critical for Day 1 will not be rushed. • The new Board structure, and next-in-line structure, will be in place by this time, which may mean a change in reporting for some services. This is the main change services will see and, in practice, current operating models will continue from 1 April 2024, until a specific new structure has been designed for each area.
2. Leadership and governance	• Operating models and structures will be designed to enable consistent, autonomous clinical and professional leadership and governance. • Structures and supporting processes will ensure clear lines of accountability and consistent clinical governance can operate well across the Trust.
3. Population and system needs	• Structures will allow services and pathways to be designed around local populations, build on local community assets, reduce health inequalities and address the wider determinants of health. • Structures will be designed so that services work collaboratively to maximise care closer to home. Operating models will allow budgets to be used flexibly to best meet population needs and respond to system pressures.
4. Integration and partnership working	• Structures will be designed to enable effective collaboration and coproduction with health and care providers and local communities, including VCSE organisations. • The new Trust will build and maintain partnership working and maximise integrated working and patient flow between health organisations and between health and care.
5. New ways of working	• Structures, terminology and operating models will take into account a range of views and best practice, recognising that the Trust should look and feel new. • Structures will be designed to maximise sharing of learning and deliver innovation. New ways of working will be embraced and unwarranted variation will be reduced in professional practice, clinical pathways, patient experience and patient outcomes.

6. **Sustainability**	• Structures will be as flat as possible and minimise duplication of leadership. • The new Trust will adopt flexible workforce, financial and clinical models which are sustainable for the long term.

6.70 The three Trusts have different operational management structures (see paragraphs 6.16 to 6.21). Solent has eight Operations Directors each of which is linked with the Deputy Chief Operating Officer (who reports to the COO). Southern has five Operations Directors and two Clinical Directors currently, all of whom report to the Chief Operating Officer. The IoW CMHLD division has two Directors of Operations – one for community services and one for mental health services.

6.71 On Day 1 it would not be practicable for the COO of the new Trust to have eighteen direct reports (two from the IoW, eight Clinical Directors and a Deputy COO from Solent and five Operations Directors and two Clinical Directors from Southern). It is therefore expected that the COO of the new Trust will need to be supported by deputy COOs in the interim period before the Trust adopts its new operational management structure. Following appointment of the designate COO in late October / early November, the designate COO will work with the existing operational leads to agree the interim structure including the number and responsibilities of deputy COOs. The interim operational management structure will ensure services are managed safely from Day 1 with very limited change in terms of reporting arrangements.

6.72 The next steps to develop the operational management structure are detailed service mapping work and engagement with clinical teams where there are different options to consider. In October 2023 the designate CEO wrote to leaders and managers across all three Trusts seeking feedback on how services should be grouped in the new Trust by 1 December 2023. The intention is to agree the operational management structure by the end of December 2023.

6.73 The principles set out in figure 37 above are clear that ‘place’ will be an important building block of the operational management structure with the majority of the new Trust’s services delivered in local communities.

6.74 For the operational management structure to be effective the new Trust will need strong, multi-disciplinary clinical leadership (both formal and informal) at its heart. Following agreement of the operational management structure, there will be engagement with clinical staff in early 2024 on how clinical leadership could and should work in practice to maximise the breadth and depth of skills and experience in the new Trust and ensure the clinical voice is heard. This will include exploring how to involve the wider clinical body through broader fora.

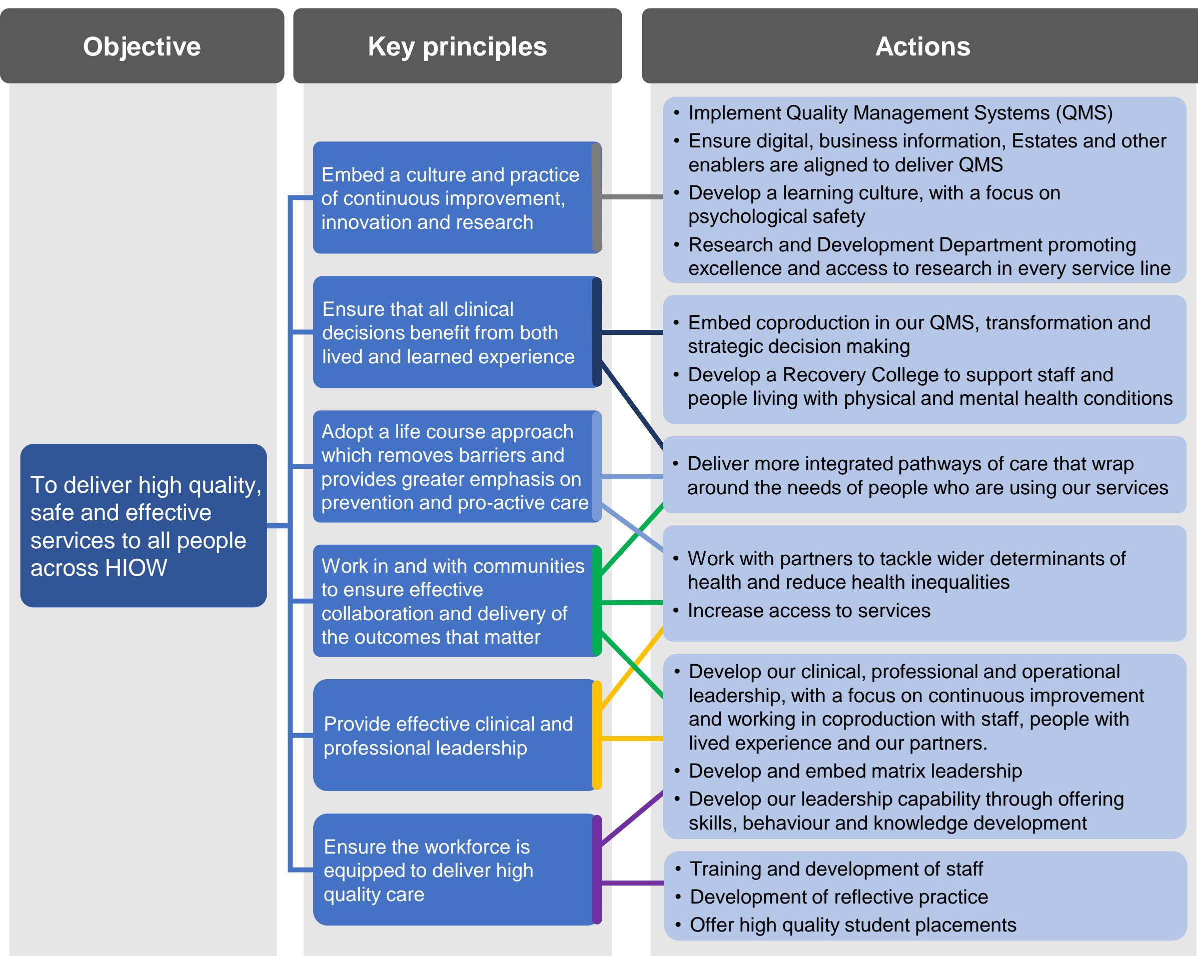
7 Quality governance

Chapter summary

- This chapter sets out the proposed approach to quality governance in the new Trust.
- The quality governance strategy has been developed to support the principles of the clinical strategy for the new Trust.
- Each of the Trusts currently has robust governance and risk management strategies and processes in place. The new Trust will build upon best practice from each Trust to embed a ‘just culture’ that learns from incidents and concerns.
- The new Trust’s reporting mechanisms from floor to Board will support assurance and good governance. A Quality Oversight Group will report into the Quality Committee which will report directly to the Trust Board where matters require escalation.
- The new Trust will adopt a quality management system based on the ‘learning health system’ approach, comprised of:
  - Quality planning: understanding of the needs of the population and co-designing an approach that meets these needs with measurable outcomes;
  - Quality control: measuring quality outcomes and using this information to identify and address emerging problems. Standardisation is an important quality control measure; and
  - Quality improvement: using evidence-based methodologies to address improvement priorities.
- The new Trust will embrace patient experience and coproduction and a Lived Experience Steering Group is leading the development of the approach the new Trust will take in order to ensure it is representative of the people who use its services.
- Quality improvement and innovation are fundamental to the successful delivery of the clinical strategy. The new Trust will combine the knowledge, experience and resources of the existing Trusts and will refer to the NHSE Delivery and Continuous Improvement Review to guide the further development of the quality improvement approach. Research will play a pivotal role in developing best practice across the new Trust to improve patient outcomes.
- The new Trust will ensure any proposed changes to service design or delivery are assessed for any potential risk to patient safety by adopting a Quality Impact Assessment process that includes a panel to scrutinise these assessments. Best practice from existing Trusts will be utilised to develop the risk management and quality management systems for the new Trust.

7.1 Quality governance is the overarching framework that provides assurance of compliance with regulatory standards, best practice standards and evidence and is underpinned by a culture of continuous improvement. Quality governance is embedded in the clinical strategy for the new Trust which places outstanding quality of care as the core ambition.

Figure 38: Quality governance strategy overview



Current structures and processes

7.2 Each of the Trusts currently has robust governance and risk management strategies and processes in place. Best practice from each Trust will be amalgamated to ensure the delivery of high quality, safe, patient care. Where there are positive learning cultures present within the existing Trusts, this will be harnessed and built upon in the new Trust. In particular, the new Trust will embed a 'just culture' that considers and learns from systemic issues when failings occur, as research clearly demonstrates that a no blame approach within patient safety is intrinsic to safe health care environments and the ability to learn from incidents and concerns.

Staff story – Quality governance improvement at Solent

Solent has a range of meetings and processes designed to ensure the right information about patient safety and risk is reviewed and actioned by the right people at the right time. There are clear escalation procedures and processes and a robust meeting and governance structure in place to support this.

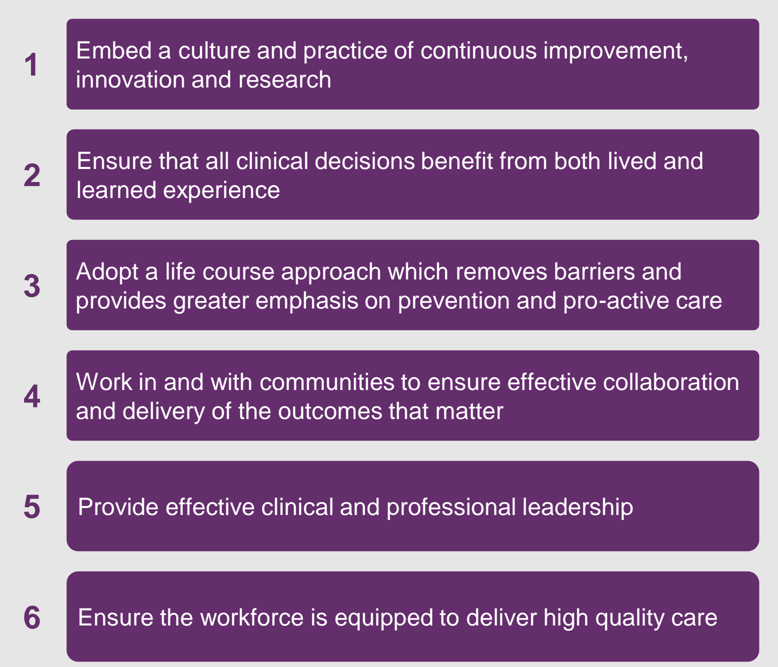
However, the Heads of Quality and Professions (HQPs) identified that the Quality Improvement and Risk Group (QIR) was not able fulfil all of its governance requirements due to the volume of information it was being sent. The HQPs also identified the potential for multiple reporting streams for some information, leading to duplication of energy and over-populating agendas, bringing the risk of important information not receiving the scrutiny it merited. Whilst there was no evidence to suggest that this had led to patient or staff harm, it was decided that a review was required.

The Deputy Chief Nurse and Head of Quality and Safety led a consultation of the wider staff teams to identify a solution. As a result, it was determined that meeting structures would be adapted to eradicate duplicate reporting and reduce the number of items on meeting agendas. This approach has enabled enhanced scrutiny of escalated items and has therefore provided greater assurance that the right information is going to the right people at the right time. This approach of reviewing the efficacy of meetings using the skills and knowledge of our team will be replicated in the governance structure of the new Trust.

Quality governance of the new Trust

7.3 Quality governance arrangements for the new Trust will include a clear framework for measuring and monitoring safety to enable robust methodologies for ensuring patient safety. This will include forums for patients, carers and staff to share their experiences of services. Any changes to services arising from consultation will be subject to review under quality impact assessment processes and the findings will be reviewed by the senior clinical leadership team to ensure any risks or potential negative impacts are appropriately mitigated. Six core principles have been articulated that will underpin quality governance for the new Trust.

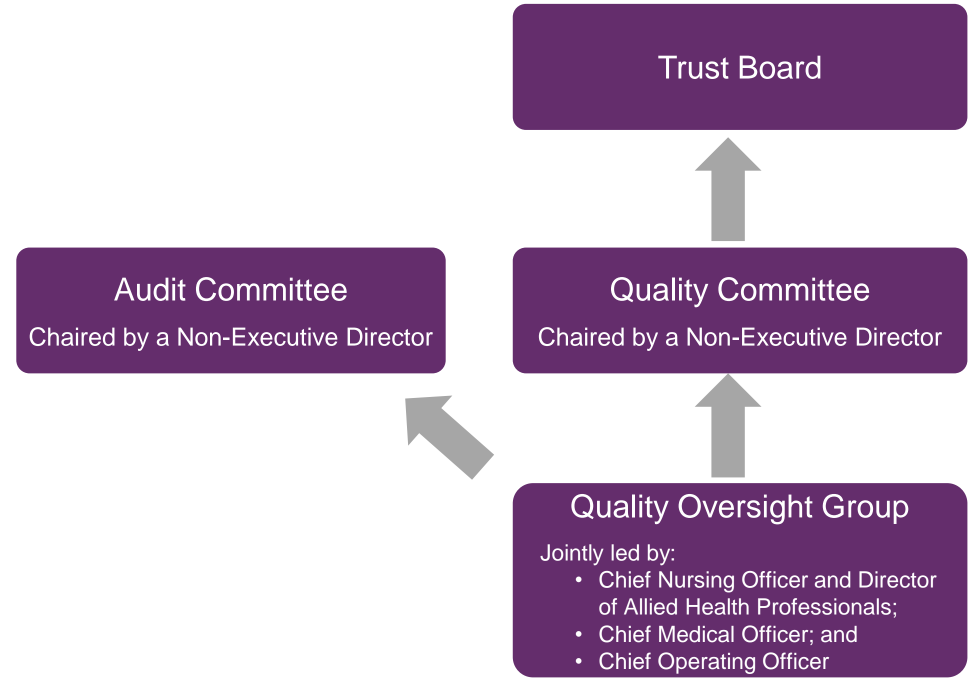
Figure 39: Quality governance principles



Quality governance structure

7.4 The new Trust's reporting mechanisms will support assurance and good governance from floor to Board. A Quality Oversight Group will report into the Quality Committee which will report directly to the Trust Board where matters require escalation.

Figure 40: Quality governance structure for the new Trust



7.5 The Quality Oversight Group will be jointly led by the Chief Nursing Officer and Director of Allied Health Professionals, the Chief Medical Officer and the COO. The group's principal responsibilities are listed in the figure below.

Figure 41: Principal responsibilities of the Quality Oversight Group

1	To ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports e.g. CQC
2	To ensure that care is based on evidence of best practice/national guidance
3	To monitor and approve the **development of quality indicators** throughout the Trust
4	To ensure that where practice is of high quality, that practice is recognised and propagated across the Trust
5	To receive and **act upon reports from key organisational functions** including: Safeguarding, Infection Prevention and Control, Health and Safety, Medicines Management amongst others
6	To **undertake a structured programme of on-site audit** activity and where required develop measured and achievable action plans
7	To develop reporting functions that enable the monitoring of the effectiveness of activity implemented following investigation or structured judgement review. Adopt a QI methodology approach such as a PDSA cycle for any remedial actions arising from incidents and patient experience feedback and complaints.
8	To build upon existing staff feedback mechanisms to **ensure staff are able to share concerns or plaudits to drive improvement** in care and delivery across the Trust.

7.6 The Quality Committee will be chaired by a NED and will receive reports from the Quality Oversight Group. The Committee will be responsible for the areas described in the figure below, which are based on NHS Providers and DAC Beachcroft "The Foundations of Good Governance"[35].

Figure 42: Principal responsibilities of the Quality Assurance Committee

1	To ensure that **robust arrangements are in place for the review of patient safety incidents** from within the Trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning (including near-misses, complaints, claims reports from HM Coroner, learning from deaths and high-profile cases).
2	To **identify areas for improvement** in respect of incident themes and complaint themes from the results of national patient survey/PALS and ensure appropriate action is taken.
3	To monitor and ensure the Trust's compliance with the national standards of quality and safety.

[35] https://nhsproviders.org/media/1738/foundations-of-good-governance-web-file.pdf

4	To **ensure that risks to patients and carers are minimised** through the application of a comprehensive risk management system including identifying areas of significant risk, set priorities and place actions using the assurance framework.
5	To ensure that processes are in place to **ensure the escalation** of risks from local and clinical service risk registers to the corporate risk register and receive reports from the Trust's risk manager.
6	To **assure that procedures stipulated by professional regulators of chartered practice are in place and performed** to a satisfactory standard (i.e. General Medical Council; Nursing & Midwifery Council; Healthcare Professionals Council).
7	To ensure that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines including but not limited to NICE guidance and guidelines and radiation use and protection regulations.
8	To assure that there are processes in place that safeguard children and adults within the Trust.
9	To **escalate** to the executive board and/or audit committee and/or board any identified **unresolved risks arising that require executive action** or that pose significant threats to the operation, resources or reputation of the Trust.
10	To **monitor the Trust's compliance with the national standards of quality and safety of the CQC**. To respond to findings of any regulatory inspection activity and ensure that remedial action is undertaken in a timely manner as required. This includes a robust mechanism for undertaking and measuring Quality Impact Assessments pending service changes or re-design.

Patient experience and coproduction

7.7 There is increasing evidence that decisions and interventions that are coproduced are more likely to be implemented, understood, accessed and utilised by those for whom they are intended. In addition, it leads to greater ownership of decisions, increased self-responsibility, improved priority setting and decision making, reduced power imbalances, reduced inequalities, reduced and transformed complaints that more effectively support learning and increased patient and staff morale. The four Trusts have been working collaboratively to ensure that at the core of the new Trust will be full collaboration with people who have personal experience of living with health conditions and/or using services and their family members/informal carers and staff. This is embedded explicitly in the desired culture (see figure 13) and clinical strategy (see paragraph 5.11) of the new Trust.

7.8 Currently there are a variety of lived experience positions within the Trusts including Peer Support Workers, peer trainers and engagement and involvement roles. A Lived Experience Steering Group is leading the development of the approach the new Trust will take in order to be more representative of the people who use its services. The new Trust's ambition is to ensure people using mental and physical health services across the life course benefit from this approach. The approach and measurable benefits of this work is described in detail in the PBC.

Quality management system

7.9 The new Trust will adopt a quality management system that is based on the 'learning health system' approach. This system is summarised in the following figure and is comprised of three principal components:

- **Quality planning:** understanding of the needs of the population and co-designing an approach that meets these needs with measurable outcomes;
- **Quality control:** measuring quality outcomes and using this information to identify and address emerging problems. Standardisation is an important quality control measure; and
- **Quality improvement:** using evidence-based methodologies to address improvement priorities.

Figure 43: The quality management system for the new Trust

We understand the needs of our population and we plan together to meet those needs
Quality planning

Identify strategic improvement priorities

Insights and feedback

Service standards and expectations of quality

Feedback on delivery and outcomes

Learning Health System

We are able to improve together as partners
Quality improvement

Standardise and move to daily operations

Solve problems using improvement science

We know how well we are doing and work together to meet our challenges
Quality control

Quality assurance framework

7.10 A Quality Assurance Framework for the new Trust has been developed that aligns with the current structures and processes within the existing Trusts, maximising the strengths of current structures and improving on perceived areas for improvement. This framework will provide a clear pathway for board to floor governance of quality:

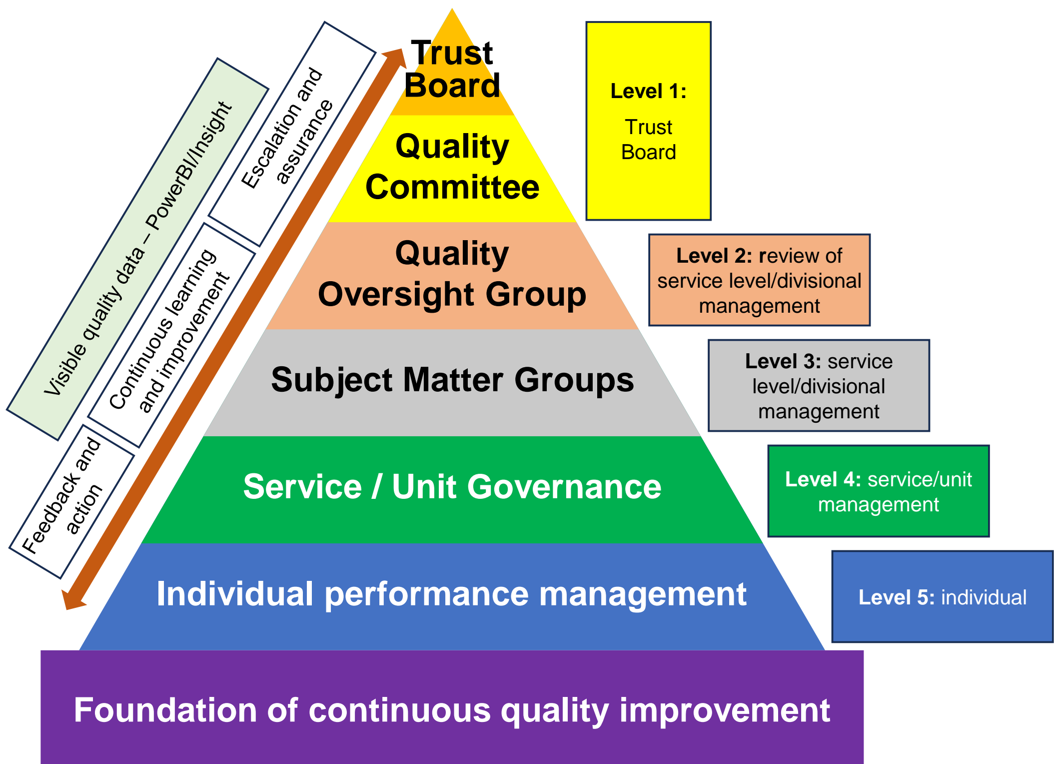
- Ensuring required standards of quality are achieved;
- Providing opportunities for ensuring substandard quality performance are investigated and appropriate remedial action taken;
- Planning and driving continuous improvement;
- Identifying, sharing and ensuring delivery of best practice;
- Identifying and managing risks to quality of care; and
- Hears and involves patient and staff voices and other key stakeholders.

7.11 The proposed approach is built on a foundation of continuous learning and improvement which will be a constant thread through the hierarchy of quality management across the new Trust. The framework provides a starting point for a comprehensive quality management system for the new Trust to evolve.

7.12 The approach involves two paths for quality assurance from floor to Board and vice versa. These are designed to assess, monitor and improve the quality and safety of the services provided. Careful monitoring of the outcomes from governance processes will enable the new Trust to take action where there is room for improvement or a need to take corrective action. The range of permanent processes and systems are in place designed to monitor quality that currently exists in the Trusts will continue to be monitored and reviewed through this framework.

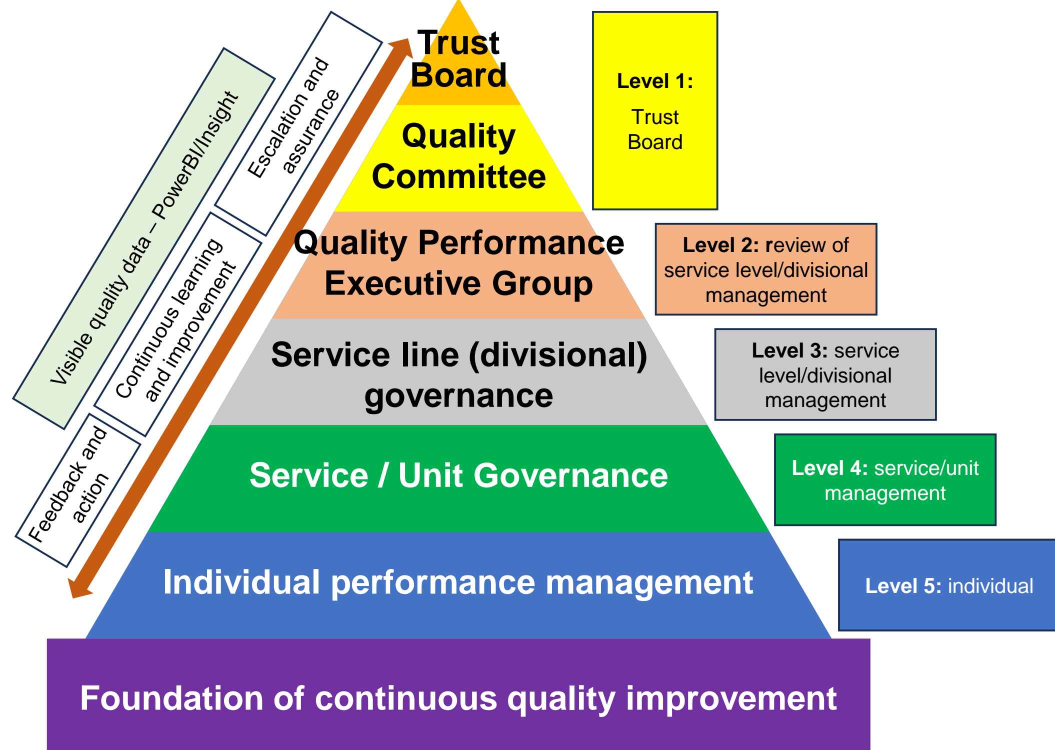
7.13 The figure below shows the first path which proposes quality assurance through the subject matter groups to the Quality Oversight Group and Trust Board, and back. The subject matter groups in this case will include groups such as Medicines Safety Group, Research, Clinical Effectiveness and Quality Improvement Group, Learning from Events Group, Infection Prevention and Control and Decontamination Group, Risk Management Group, Engagement and Experience Group, Mortality Review Group and Safeguarding Group.

Figure 44: Quality assurance through subject matter groups (path 1)



7.14 The second path to board for quality assurance will be through service line/divisional governance groups as shown in the figure below. These groups will provide operational quality governance performance oversight through the quality performance executive group to Board.

Figure 45: Quality assurance through service line/divisional governance groups (path 2)



7.15 The smooth running of the proposed framework will be based on visibility of quality data at all levels through the quality assurance framework hierarchy.

7.16 The two paths join to provide a clear hierarchy of Board to floor (and back) quality assurance, with effective, efficient, and continually improving, overall, high quality related performance being the intended result.

Quality improvement and innovation

7.17 The new Trust will combine the knowledge, experience and resources of the existing Trusts to drive quality and innovation benefits for staff, patients and communities. Training and development programmes for staff are already in place as well as dedicated resources to support the delivery of collaborative quality improvement projects. The new Trust will refer to the NHSE Delivery and Continuous Improvement Review to guide the further development of the quality improvement approach. The new Trust executive structure includes a Board level role to lead on quality improvement and engagement (see figure 31 at paragraph 6.45).

Research and ethics

7.18 Research will play a pivotal role in the development of best practice to deliver positive outcomes for patients. All research activity will be undertaken with patient benefit at the forefront and will be aligned to the expectations of the UK Policy Framework for Health and Social Care Research. The new Trust will implement a rigorous approach to research management.

Quality impact assessments

7.19 All four Trusts have processes to ensure that any changes made to service design or delivery are appropriately assessed for any potential negative impacts on patient safety. The new Trust will continue with these processes including a panel to scrutinise Quality Impact Assessments.

Incidents and complaints

7.20 Options appraisals to determine the approach for management of incidents and complaints have been developed and will be reviewed and concluded by the Clinical Steering Group by the end of October 2023.

Quality risk management

7.21 Quality risk management is embedded into the reporting process across all four Trusts, and best practice from each Trust will be utilised to develop the risk management and quality management systems for the new Trust. Risk will be monitored by the Quality Oversight Group and the Quality Assurance Committee as described in the respective responsibilities of each, set out in figures 41 and 42.

8 Enabling strategies and support functions

Chapter summary

- This chapter describes how people, digital and estates strategies will enable successful delivery of the clinical strategy of the new Trust.

People

- A four phase approach to organisational development has been adopted to understand the cultures of the Trusts and develop plans for the new Trust: scoping, discovery, design and delivery. Staff and senior leadership are being engaged throughout.
- The approach to embedding cultural change in the new Trust includes building the culture into everyday ways of working, leadership commitment, visible changes and combining interventions to deliver the desired culture.
- An initial set of priorities of the emerging people strategy has been articulated, along with associated measures and metrics to monitor. The people strategy is in development, with further engagement activities planned before it is finalised.
- The proposed components of the people function for the new Trust have been identified, which includes a single Occupational Health and Wellbeing service for all staff groups, based on the recently implemented Solent model.
- The key actions required in respect of workforce change management have been identified, including those to be completed ahead of Day 1.

Digital

- The HIOW ICB has recently developed a Digital, Data and Technology Transformation Plan for the system. This plan includes a series of objectives designed to deliver the vision, which have been considered in the development of the emerging digital strategy for the new Trust.
- The Trusts are in different stages in respect of their digital strategies. Solent approved its current three year strategy in 2022, Southern's digital strategy is currently being refreshed, the IoW's digital strategy spans 2020-2025 and Sussex Partnership's digital strategy was launched in 2020.
- Each of the four Trusts operate a number of different Electronic Patient Record systems. £1.3m of national EPR funding has been secured to transfer Hampshire CAMHS from Carenotes to Rio by 1 March 2024. An options assessment to develop plan for the convergence or rationalisation of EPR systems will be undertaken as part of the ongoing development of the digital strategy. Any significant investment will be subject to a separate business case.
- Safe digital transition involves a number of changes to be made ahead of Day 1 to ensure access to appropriate software and systems, alignment of networks and infrastructure and consolidation of corporate systems where essential.
- For digital services relating to IoW, a service level agreement is planned for an initial period of two years.

Estates

- The existing estates strategy for the HIOW ICS was developed by the HIOW STP in 2018. A new Estates Infrastructure Strategy for the ICS will be developed by the end of 2023/24, with the new Trust expected to play a significant role in its development.

- The existing estates strategies of each of the four Trusts identify specific areas of focus. These strategies will be aggregated, reviewed and consolidated in developing the estates strategy for the new Trust. The emerging estates strategy articulates a vision for estates and facilities and outlines the ways in which it will support the NHS LTP, JFP and ICS partnership strategy to deliver place-based care by integrating technologies that support the elimination of geographic boundaries.
- The estates function for the new Trust will be designed to support the emerging estates strategy, including specialised functions such as computer aided facilities management that will support innovation.

8.1 The new Trust will rely on efficient and effective support functions to ensure that the new Trust is properly integrated and that the clinical strategy is implemented fully.

People and organisational development

8.2 This section sets out the emerging people strategy and organisational development strategy, and how this will support delivery of our vision. The approach set out in this chapter has been undertaken in line with the **NHS transactions: Culture and staff engagement Guidance for Trusts** (April 2022).

Culture

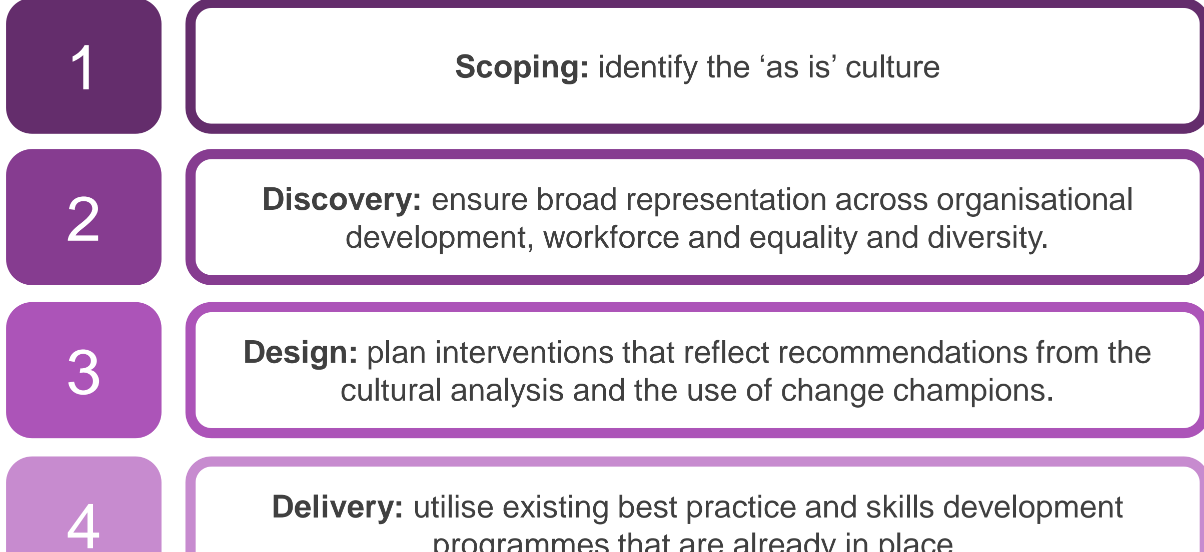
8.3 The Organisational Development Steering Group led the following process to understand the cultures of the Trusts to inform the plans for the new Trust:

- Two in-person joint senior leadership events were held (one in October 2022 and the second in February 2023) to commence discussions about existing cultures and the desired culture of the new Trust. Each event involved around 120 senior leaders from across the four Trusts. The event in February was followed by a session with system partners, which invited local authorities and members of the ICB.
- Staff check-in sessions were run in February and March 2023 to allow staff to feed into the process. These sessions were virtual meetings led by senior people from each Trust to share the latest information and to provide an opportunity for staff to ask questions. Approximately 600 staff participated in these sessions. A key theme arising from these sessions was concerns about job security, despite assurances already provided by senior leaders. These concerns have informed the planning of the organisational development support around the Transfer of Undertakings (Protection of Employment) (TUPE) consultation and subsequent change processes.
- The Shape Our New Trust engagement programme was run for six weeks in May and June 2023 (see chapter 12 for more detail). One of the four pillars of this programme was the desired culture of the new Trust. The programme was led by the Operating Model Advisory Group (OMAG) and included a survey and virtual events with Trust executives.

- A third joint senior leadership team event was held in June 2023. The purpose of this meeting was to assess findings from the key themes arising from the Shape Our New Trust engagement programme and to develop these into recommendations for the new Trust. The outputs from this event were presented to OMAG at the end of June 2023 and incorporated into the FBC.

8.4 The Organisational Development Steering Group has followed the approach set out in NHSE's Culture and Leadership Programme. This programme sets out a four phase approach to organisational development that will ensure the desired culture emerges in the new Trust:

Figure 46: The four phase approach to organisational development for the new Trust



8.5 The Organisational Development Steering Group undertook a cultural analysis for the scoping phase of the approach. This analysis involved a comparison of staff survey results for the People Promise theme, based on IQVIA provider statistics (Sussex Partnership data was not available). The scores across the three Trusts were compared to identify insights, reflections and recommendations for improvements.

8.6 The discovery phase involved developing the desired culture, values and behaviours for the new Trust. An overview of the outputs of this phase is set out in chapter 4.

8.7 The design phase involves planning the approach and interventions that will embed the desired culture. The figure below summarises the approach to embedding cultural change in the new Trust.

Figure 47: The approach to embedding cultural change in the new Trust

8.8 The establishment of the new Trust will have a significant impact on staff and it is imperative that all staff are supported at all times. A series of organisational development interventions has therefore been developed that will support staff through this period of change, whilst helping deliver the desired culture of the new Trust. These interventions include:

Embedding the desired culture in the new Trust

- An appropriate warm welcome for all staff transferring into the new Trust. Activities are likely to include opportunities for staff to meet support service colleagues, as well as support for team away days to help create new relationships and define new shared team purpose statements;
- A cultural influencer programme to be designed and delivered to embed the new culture. Supporting change sessions have been added to the organisational development offer to better equip managers and leaders to support teams through the change process. The programme will be planned in October 2023 and launched in November 2023;

Creating leadership commitment to the culture

- Coaching support for individuals or teams, including leadership training, which will be designed around existing challenges;
- A range of directed learning tools, tools to help leaders run team away days, access to a facilitated team day, leadership programmes and a 'bitesize skills' offering;

Driving visible and sustainable change

- A talent management approach to be developed and implemented in the new Trust; and
- Networking opportunities for leaders to provide opportunities to share and challenge ideas, supported by organisational development professionals.

8.9 An overview of the key activities that will help create and embed the culture of the new Trust is provided in the following figure.

Figure 48: Overview of activities to create and embed the culture of the new Trust

	Start	End
Embedding the desired culture in the new Trust		
• Work with executive colleagues to ensure **culture and values are clearly defined** and included in new Trust's mission and vision.	Oct-23	Mar-24
• Create a **behavioural framework** for the new Trust which translates the values into a set of core behaviours.	Dec-23	Mar-24
• **Warm welcome 1.0**: Day 1 welcome communication from the new Board, including reference to staff having equal access to learning and development opportunities to support their skills, knowledge and behaviours. Also included will be an FAQ to help staff know how things will be working if they have changed.	Nov-23	Mar-24
• **Warm welcome 2.0**: Plan welcome activities to ensure staff can access to support for team events including meet and greets and away days, to help create new relationships and define new shared team purpose statements.	Nov-23	Mar-24
• **Warm welcome 3.0**: Design a warm welcome for Sussex Partnership CAMHS staff. Activities to include monthly Senior Leadership Team events, TUPE support for staff, welcome sessions, marketplace events to showcase support offer available, adapted version of change support offer, welcome pack for Day 1.	Aug-23	Feb-24
• **Cultural influencer programme:** recruit people who demonstrate the values be role models in everyday behaviours, promote the OD change management offer, signpost staff to support, and encourage staff to engage with comms and surveys.	Nov-23	Mar-24

	Start	End
• **Preparing for Change insight sessions:** to enable members of the People Directorate teams to engage across the Fusion organisations, sharing updates around: key messages and decisions made to date about the OD and workforce workstreams, opportunities to get involved and support available. They will also listen to what staff are experiencing and answer questions.	Nov-23	Mar-24
Creating leadership commitment to the culture		
• **Coaching support:** as well as BAU coaching offerings, scope, design and deliver a collaborative Chartered Management Institute Level 5 qualification in Professional Coaching for leaders who wish to gain this qualification.	Sep-23	Mar-24
• **Create and combine existing content** made up of self-directed learning tools, tools to enable away day running by leaders, access to a facilitated away day, leadership programmes and bitesize skills.	Jun-23	Mar-24
• **Design and deliver a change support package** offering for managers, including signposting to resources, facilitated support for groups and leadership development.	Aug-23	Mar-24
• **Harmonising leadership competencies** and aligning with clinical strategy lived experience, continuous improvement, new Trust values, reflective practise, trauma informed approach.	Nov-23	May-24
• **Leadership development programme** to upskill senior managers in managing during change.	Nov-23	Mar-24
Driving visible and sustainable change		
• **Talent Management**: design a strategy that incorporates appraisal framework, talent definition, skills, knowledge, continuous improvement competencies, diversity and talent, succession planning, talent development offering, executive development, insight tools. All linked to the values of the new Trust.	Nov-23	Jul-24
• **Develop a programme of networking opportunities** for leaders to provide opportunities to share and challenge ideas, supported by organisational development professionals.	Oct-23	Mar-24
• The **internal cultural measurement tool** created by Southern to measure staff engagement, and structure support around behaviours and cultural domains, will be adapted to be fit for the new Trust.	Oct-23	Mar-24
• Work with **reward and recognition** colleagues to develop a recognition scheme linked to how well staff display the value.	Dec-23	Mar-24
• Work with workforce colleagues to embed values and culture into employee lifecycle and employee relations **processes and policies**.	Dec-23	Mar-24
• Use **of staff survey and Pulse surveys** to measure engagement and receive feedback.	Sep-23	Mar-24

Staff story: Sam's story

Culture, values and behaviours can often feel like the buzzwords of the day, but without them our workplace would not be the place that it is. The values that we hold are reflected in everyday behaviour which then create our culture. It matters when we are heard by our colleagues and supported when necessary and anyone joining our teams will quickly see that our culture is one of inclusivity and empathy.

Developing an organisational culture is difficult to achieve in any organisation, however I feel that each person that I have met has joined the Trust to improve the lives of staff and patients. The trainee coaches that I meet have a deep desire to connect with their colleagues and to help them tackle parts of their lives they need help with; the staff networks that I either co-chair or attend show a strong drive to improve the working lives of those with protected characteristics; and the quality improvement leaders strive to improve the culture, values, and behaviour of the organisation by giving staff the space and time to focus on improving services for patients and staff.

As a service manager, I reflect that while I haven't always got it right, I strongly believe in supporting staff in areas such as reasonable adjustments, working flexibility and offering support through any personal issues. This means that my colleagues feel they have a supportive team around them and feel encouraged to be open about the support they need. They see that the values of the team are those of support and a willingness to help. This is then reflected in the general culture where people feel safe and secure in the knowledge that, no matter the issue, they will be supported.

On a more personal level, as someone with a hearing loss, I see that the culture, values, and behaviours of my immediate colleagues, wider team and the Trust give me the time and space to manage my disability. Colleagues wait for me to turn on captions on MS Teams or save me a space at the front of training sessions, or simply recognise the fact that I do not use the telephone. These behaviours reflect the value and the culture of the organisation. In many ways, I have seen that my views matter and are taken into account, I have a voice and this is a thread that I see through many parts of the Trust – staff have a voice to share in and to develop the culture of the Trust and I look forward to seeing how this continues with Project Fusion.

People strategy

8.10 The workforce challenges faced by each of the four Trusts and mirrored nationally, highlight the need to put the new Trust's people first. Attracting, recruiting, and retaining high quality, engaged staff is key to the successful delivery of the clinical strategy and improved outcomes for patients and families.

8.11 The new Trust will aspire to be the employer of choice for those with a desire to work in mental health, learning disabilities and community services. Delivery of the people strategy will create a compelling offer for new staff and a colleague experience that recognises and values the contribution all staff make in providing services to patients.

8.12 Each existing Trust has its own people strategy and there are many areas of commonality given the Trusts' similar workforce challenges. Southern has recently refreshed its People Plan to align it with the NHS People Plan[36], NHS People Promise[37] themes and the recently published NHS Long Term Workforce Plan[38].

8.13 The people strategy for the new Trust will incorporate the best elements of each Trust's existing people strategy. The people strategy will describe how the new Trust will attract, recruit, develop and retain staff in order to deliver services across a broader footprint. The people strategy and priorities will be aligned to national and ICS strategies and will also be developed and informed by:

- staff survey results and actions to date;
- cultural insights and pulse surveys;
- stay and exit interviews;
- staff networks, staff action groups and a range of Trust-wide engagement sessions;
- results of the cultural analysis work;
- Guidance around Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Medical Workforce Race Equality Standard (MWRES), Bank WRES and Equality Delivery system (EDS); and
- feedback following engagement with staff on what matters to them most.

8.14 These include career development opportunities for ethnic minority staff and staff with disability, who are neuro divergent and/or have long term health conditions, flexible working, managing violence and aggression towards staff from patients, resourcing and pay and further tools to help staff in their roles. These will feature in the people priorities which are likely to include:

- Attraction, inclusion, recruitment and retention
- Equality, diversity, inclusion and belonging
- Reward and recognition
- Values and behaviours
- Health, wellbeing and security
- Sustainable workforce and transformation

[36] https://www.england.nhs.uk/ournhspeople
[37] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise
[38] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan

- People development

8.15 Self-reflection and 360 tools will support individuals to reflect and enhance their style and skills. Leadership actions and behaviours consistent with desired culture will reinforce its importance.

8.16 A staff survey for senior leaders has been developed to help identify areas of best practice and areas for improvement. Senior leaders across Solent, Southern and IoW will be surveyed in October 2023, again in January 2024 and then following the creation of the new Trust in summer 2024. A subset of these questions will be used to survey the wider organisations through the addition of questions to the annual NHS Staff Survey and the People Pulse to provide a baseline initially, and then to measure change ahead of completion of the transaction. The results of these surveys will inform the development of organisational development plans.

8.17 It is important that the people strategy is co-delivered with a range of key stakeholders to ensure that it is targeted and delivers the desired impact. A vital part of its success is to ensure broad understanding, engagement and accountability. This will include ensuring the voice of the staff networks is heard so that marginalised groups are heard. The people strategy will place staff involvement and continuous engagement at its core and will ensure the voice of a broad range of staff and stakeholders is heard and reflected. A communications and engagement plan will support the launch of the new Trust's people strategy, describing how staff can get involved in helping to shape and deliver the strategy.

8.18 The priorities set out within the people strategy will be underpinned by measures which will be reported to the People Committee. These measures are likely to include some of the following:

- Staff survey results are within the upper quartile of best performing Trusts (for "recommend as a place to work", "recommend as a place to be cared" or all results)
- Increase in the number of flexible working requests approved
- The experience and career progression of our minority ethnic colleagues and colleagues with a disability or long term health condition, measured through WRES and WDES indicators, is as good as for the rest of the workforce
- Reduction in incidents relating to violence and aggression towards staff
- Staff report having the tools and materials to do their job well
- Reverse mentoring scheme evaluated, future model developed and rolled out across the new Trust
- Reduce number of staff reporting personal experience of harassment, bullying or abuse at work, with a specific focus on improving WRES and WDES indicators

- Reduction in the use of agency staff by converting to substantive contracts
- Elimination of Band 2 Health Care Support Workers agency usage
- Improved staff survey outcomes for the percentage of staff feeling their appraisal experience was positive
- Staff reporting feeling valued by colleagues within their immediate team
- Staff turnover with a focus on staff leaving within the first year
- Percentage uptake of exit interviews
- Number of staff and teams being recognised at Trust and local level and nominations for external awards.

8.19 The new Trust's retention strategy will focus on four key pillars:

- Pillar 1 – Supporting new starters e.g. rotational posts / mentoring from experienced professionals / insight days / induction and preceptorship support;
- Pillar 2 – Staff in mid careers e.g. flexible working / staff ambassadors / role transfers;
- Pillar 3 – Legacy mentorship / retire and return / campaign to celebrate careers of staff; and
- Pillar 4 – Stay interviews / itchy feet conversations.

8.20 The next steps in developing the people strategy are:

- Detailed review of existing people strategies from each of the four Trusts to identify the best of each to shape the people strategy for the new Trust, aligned with the clinical strategy, emerging vision and strategic objectives and values and behaviours of the new Trust;
- Develop the communications and engagement plan to drive interest, awareness and involvement with all stakeholders in helping to shape the people strategy;
- Further workshops to assess existing workforce plans and analyse data across the four Trusts to identify and understand gaps and areas of strength; and
- Establish focus groups to develop and implement detailed action plans to deliver the people strategy.

People function

8.21 The vision for the people function is to provide outstanding, dynamic and inclusive people practices to support service transformation and cultural change, to meet the

needs of the people across the new Trust, and to support the delivery of high-quality patient care.

8.22 The people function will include:

- HR operational services
- HR strategic services
- Organisation development
- Employee relations
- Training and education
- Occupational health and wellbeing
- Diversity and inclusion
- Freedom to speak up

8.23 Solent has recently implemented the national NHS health and wellbeing framework[39], whilst Southern currently outsources its occupational health service provision. The new Trust will implement a single Occupational Health and Wellbeing service for all staff groups, based on the Solent model. This service will influence decisions that impact the health and wellbeing of the workforce of the new Trust, helping to prevent ill health and improve personal health and wellbeing across the new Trust.

Change management

8.24 The following workforce change management measures are being planned for the new Trust. Details of milestones and timelines for each of these are included in the Post Transaction Integration Plan (PTIP):

- **Integrate HR systems** over time including Allocate, Electronic Staff Record, Oleeo ATS recruitment system, and the Learning Management System (LMS).
- **Align workforce intelligence and workforce planning** to develop a strategic workforce planning framework which will help understand gaps between current and future workforce needs, and to develop and implement strategies to address these gaps.
- **Training and education programmes** will be integrated. The apprenticeship teams are already exploring how to working together collaboratively.
- **Pay, reward and pension** processes will be aligned.
- **Recruitment** attraction, interviewing, selection and onboarding processes will be aligned. This includes domestic and international recruitment. A temporary staffing model options appraisal will be conducted to select the best solution for the new Trust. Informal arrangements have already been put in place between Solent and Southern for both recruitment teams to work together collaboratively at scale.

[39] https://www.england.nhs.uk/publication/nhs-health-and-wellbeing-framework

- **Employee relations**, case management and performance management processes and procedures will be integrated.

- **Occupational health and wellbeing service** provision processes, policies, and systems will be aligned. Southern will cease use of their external occupational health provider and will transfer to Solent's internal occupational health operating model from 4 January 2024. The arrangements for the IoW will be considered once the segmentation exercise has been completed.

- All **changes to policies required for Day 1** have been identified, with clear authors/owners and dates to implement. The approach for policy review will ensure that best practice is taken from each Trust that staff networks and trade unions are engaged, with equality impact assessments where required. In time, all policies and procedures will be updated to reflect the vision and culture of the new Trust.

- An **equality, diversity, inclusion and belonging (EDIB)** action plan that develops an inclusive culture and is aligned to the WRES and WDES. These are integral to the culture change for the new Trust and to embed psychological safety, inclusion and belonging for staff who have gone through change as well as for new starters.

- **Freedom to speak up** policies will be aligned to reflect the national NHS policy which outlines the minimum standard across the NHS so that workers know how to speak up and what will happen if they do. It is designed to be inclusive and support resolution by managers wherever possible.

- **Organisational learning and development** will be aligned. An options assessment will be conducted to determine whether an internal model or a hybrid model with external providers should be used to support leadership development programmes.

8.25 The key activities to be completed prior to Day 1 are:

- Agree measures for TUPE and create documents needed for TUPE consultations;

- Develop and agree standard contract of employment for the new Trust;

- Deliver staff consultations for TUPE out staff;

- Harmonise and complete Equality Impact Assessment for the new Trust's people policies on a prioritised basis;

- Develop and implement integrated freedom to speak up (FTSU) processes and policies;

- Plans to establish a single payroll system will have been approved, although existing payroll processes will remain in place for the first 100 days; and

- Provide amended certificates of sponsorship in line with UK Visas and Immigration guidelines.

8.26 An integrated people function will enable it to support the increased scale of the new Trust. The function will remove duplication in processes and improve automation digitally once systems are integrated to improve efficiency. The new Trust will be able to attract a larger pool of candidates and fill more vacancies and hard to fill posts through the increased mobility and career opportunities it will be able to offer. As a result the new Trust will be able to respond to ever changing organisational needs with agility, as well as developing and implementing more strategic and innovative initiatives to enable the new Trust to be fit for the future.

8.27 There is significant broad and deep experience within the organisational development and EDIB teams of the three Trusts from different industry sectors and with relevant academic and vocational qualifications. This includes colleagues with skills in either organisational development, organisation design and transformation and change management. These staff hold qualifications such as level 5 or level 7 coaching qualifications, Chartered Institute of Personnel and Development qualifications such as Myers Briggs, FIRO-B and Belbin's Team Roles. These professionals have been identified and are members of the Organisational Development Steering Group and are contributing to the development of the plans for the new Trust.

8.28 These existing skilled and experienced staff will be used to support activities such as:

- helping staff understand the change process and lead their team through the stages of change;
- helping design, facilitate and deliver team away days to support teams integrating into the new Trust;
- support for designing changes to team operating models and developing associated restructuring plans;
- creating a high performing, diverse and inclusive culture that is free from bias and discrimination; and
- support for designing the leadership framework, appraisal framework, values, and behaviours framework for the new Trust.

Digital

8.29 Each Trust has its own digital strategy, IT function and systems. This section sets out the existing arrangements for each Trust and describes how these will be brought together in the new Trust.

HIOW ICB digital strategy

8.30 The HIOW ICB has developed a Digital, Data and Technology Transformation Plan for the system which was completed in April 2023. Solent has developed its own digital strategy to align with this and Southern is currently refreshing its digital strategy, whereas IoW developed its current digital strategy prior to the creation of the ICB.

8.31 The vision of the HIOW ICB digital strategy is "for our citizens, carers, health and care staff to feel empowered to improve the health and wellbeing of people living in Hampshire and the Isle of Wight through use of digital solutions and services.". This vision is underpinned with the following objectives:

- To empower citizens to use digital solutions
- To support the workforce to be confident and competent in using digital solutions to provide high quality care
- To develop interoperability solutions
- To continue the digitisation journey
- To continue to implement the Population Health Management solution
- To develop the business intelligence function
- To support digital innovation

8.32 The objective of empowering citizens to use digital solutions is particularly relevant to the services provided by the new Trust as the associated benefits will particularly support patients and carers that are based in the community. Similarly, supporting the workforce to be confident and competent in using digital solutions will benefit staff at the new Trust, many of which will work across different Trust sites and in communities.

Existing digital strategy: Solent

8.33 Solent approved its three year digital strategy in April 2022. The strategy was initially focussed on the implementation of a new IT service to create a solid foundation on which to deliver further digital transformation. This new service comprises of replaced network infrastructure, End User Devices and a new Service Desk.

8.34 The strategy describes five digital transformation journeys which set out how the experience of staff and service users will be improved by optimising existing practice, innovating new practice and enabling effective decision-making through excellent data and business intelligence:

- Information – We will improve upon our understanding, management, exploitation and governance of our information.
- Efficiency – Infrastructure, applications, systems & processes are increasingly simplified, well designed, efficient and productive.

- Service User focus – Co-design increasingly delivers a consumer-focused approach to improved safety, effectiveness and user experience.
- Workforce – Staff, from board to floor, become increasingly trusting, competent and innovative with digital solutions to optimise and innovate.
- System Integration – Solent's digital activities increasingly align and blend with the wider health and social care information.

8.35 Solent has adopted the following key principles for the delivery of Digital services to rationalise and simplify its systems: Microsoft first; Cloud first and SystmOne first.

8.36 In terms of electronic patient records (EPR) systems, Solent has implemented SystmOne for community and mental health services, R4 for dental services, INFORM for sexual health services and Iaptus for talking therapies.

Existing digital strategy: Southern

8.37 Southern's digital strategy is currently being refreshed and is due to be finalised in December 2023. The mission has been articulated as: "Harness the power of information and technology to deliver outstanding treatment and care that improves lives" and the vision as: "Clinically led, intuitive, easy to use and connected technology and data that supports and informs outstanding treatment and care".

8.38 The emerging strategy is designed around four key themes:

- Digitally enabled – provide the right hardware and systems to support clinically-led, digitally enabled treatment and care that exceed expectations and improves lives
- Supported – empower and enable service users and staff to harness the power of information and technology
- Connected – connect service users, staff and partners through reliable and interconnected networks, devices, and systems
- Informed – use the power of data safely, securely and consistently to inform outstanding care delivery, decision-making and planning

8.39 Southern uses four EPR systems: RiO, Iaptus, SystmOne and eCaMIS.

Existing digital strategy: Isle of Wight

8.40 The IoW's digital strategy spans 2020-2025 and covers the entire Trust (not just community, mental health and learning disability services). Its mission is "to ensure that information is collected digitally and made available in the right place, in the right hands, securely, accurately and timely, to enable the best possible care to be delivered".

8.41 The strategy aims to deliver digital transformation that is underpinned by three themes:

- Information led
- Clinically driven
- Digitally accessible

8.42 The IoW digital strategy is designed to support a place-based care model and interoperability/integration with primary care and social care on the island.

8.43 The IoW is currently undertaking a programme to migrate community and mental health services to SystmOne which is due to be completed by March 2024.

Existing digital strategy: Sussex Partnership

8.44 The Sussex Partnership digital strategy was launched in 2020 and sets out a delivery plan that encompasses the following digital projects:

- Patient Interactions and Innovation
- User Experience
- Digital transformation and EPR optimisation work
- Sharing Data
- Population Health Management
- Infrastructure and Cyber Resilience
- Interoperability and Systems

8.45 CAMHS at Sussex Partnership is currently operated under the Advanced Carenotes EPR. An options appraisal has been undertaken to determine the most appropriate EPR to adopt as the service transfers to Southern. The options appraisal concluded that:

- the service should transfer to Rio by 1 March 2024, as a joint project that involves CAMHS across Southampton and Portsmouth[40]; and
- a review should be conducted on the option to move CAMHS across Southampton and Portsmouth to Rio to create a single EPR for the service and to move the Closer to Home teams from the Dorset version of Rio to the Southern version.

[40] £1.3m has been secured from national EPR funding to implement the transfer.

Digital function for the new Trust

8.46 The digital function of the new Trust has been designed to deliver the emerging digital strategy whilst providing direct support to clinical and corporate services. The digital function builds on the best of each Trust's existing arrangements and will include the following services:

- Technical Design;
- Information Technology Infrastructure Library (ITIL) Service Management;
- Clinical Systems and Applications Support;
- Programme and Project management;
- Information and Communication Technology and Clinical Systems training;
- Business Intelligence, Data and Insights;
- Digital Security; and
- Digital Clinical Leadership: Chief Nursing Information Officer (CNIO) and Chief Clinical Information Officer (CCIO)

8.47 The new Trust will retain the three Trusts' existing digital teams and processes for Day 1, which will minimise the risk to service delivery. A summary of the Day 1 plan for infrastructure is provided in appendix 8.

8.48 The role of clinical leadership within digital functions is particularly important to ensure that the digital strategy remains relevant and aligned to service needs. Each digital team will therefore include representation for clinical leadership wherever relevant.

8.49 Where specialist subject matter expertise is required, the team will utilise temporary support from external partners. This may be necessary for specialist projects or where additional capacity is required for short periods of high activity.

8.50 A single governance model will be implemented across the new Trust that will provide a robust framework to manage activity. This framework will map governance, rather than an organisational structure, to functional outputs, allowing flexibility during the integration of the new Trust. Programmes and projects will be delivered aligned to a standard methodology and business as usual (BAU) services managed according to ITIL best practice. The new Trust will adopt a collaborative approach to digital transformation with its workforce, with service users being represented at all stages to enable co-design, transparency and challenge where appropriate.

8.51 The digital teams will embrace an approach of continual service improvement. The service engagement and communications functions will gather feedback as the new Trust matures and this will help update and iterate our digital strategy as user requirements change over time.

Digital transition

8.52 The current objective for Day 1 is to allow colleagues to work seamlessly side by side from all legacy organisations and sites, wherever possible, allowing the right access for the right staff from any place. This will result in very little changing for Day 1. The current intention is that a digital roadmap will be developed that describes two main phases:

- **Phase 1:** Introduce greater interoperability and collaborative working between legacy organisations for Day 1 by:
    - Providing access to appropriate software and systems across legacy organisations. These include Microsoft Tenancies, EPRs (Rio and SystmOne), shared data and corporate systems;
    - Ensuring networks and infrastructure are aligned to allow legacy staff to connect from any site; and
    - Consolidating corporate systems where essential (e.g. rostering systems and Shared Business Services) in preparation for Day 1.
- **Phase 2:** Develop a series of options around consolidation of remaining software and systems for consideration by the new Trust, resulting in development of a plan for convergence/rationalisation of systems (where required). The considerations for options will need to be a blend of patient and user impact, capability and cost. Indicative costs, for example, for EPR migration and convergence of Microsoft tenancies are in the £5m-£10m range for each system, meaning that convergence of systems may not result in a cost effective solution and interoperability is a more viable solution.

8.53 Wherever possible, the plan is to avoid dual run licences to minimise costs. Where migration of systems is required, this would be phased to eliminate or minimise dual running of licences. Current Microsoft configurations enable access to staff from legacy organisations in a way that feels 'joined up' without the need to have multiple licences per individual. The principal exception to this would be the clinical requirement for access to both EPRs and this use case is being coordinated by the CCIOs to inform likely licence costs.

8.54 For digital services relating to IoW, a service level agreement (SLA) is planned. This will involve IoW continuing to provide a full digital service for all IoW-based staff in the new Trust, ensuring continuity of access to clinical information in support of the IoW place-based care approach. Community and mental health staff will retain easy access to systems, thereby mitigating the potential risk to patient safety. The SLA will operate for an initial period of two years, with a review at the end of year one. This avoids the need for immediate capital funding for changes to infrastructure or digital services and retains the existing specialist digital capability and capacity working across all services. Digital services will transfer over to the new Trust prior to the end of the SLA wherever this is possible and safe.

The emerging digital strategy for the new Trust

8.55 The Digital Steering Group is developing the digital strategy for the new Trust. This is being done through combining elements of the existing digital strategies of each Trust, particularly areas of commonality (e.g. improving digital literacy), in a way that best supports delivery of the clinical strategy for the new Trust. This work is being undertaken in line with the **NHS transactions: Digital integration Guidance for trusts** (March 2022), which sets out good practice across the key areas of digital integration. The resulting strategy will be aligned with local and national digital strategies. The emerging digital strategy outlined in this chapter will be developed into a draft strategy ahead of Day 1 and will be refined throughout the first year of integration.

Figure 49: The new Trust's digital strategy is being developed to support the new Trust's clinical strategy

8.56 Delivery of the digital strategy will empower patients and clinicians to improve services through:

- the use of telehealth to support out-of-hospital care and remote monitoring. For example, Solent are currently undertaking a frailty pathway trial that uses remote patient monitoring as part of a pilot for the ICB;
- The adoption of Patient Portal to improve patient access to services relevant information. Patient Portal is currently implemented across some, but not all services;
- Integration through the NHS App wherever possible. This will simplify access to services for patients; and
- Standardisation across HIOW footprint meaning more consistent experience for patients. For example, joint procurement of a video appointment solution across the ICB to simplify access for patients.

8.57 Solent and Southern have existing mature EPRs in operation and IoW is due to complete the migration to a new EPR ahead of the creation of the new Trust. The decision on the best long term solution for the new Trust will be largely driven by the emerging clinical strategy and transformation plans. An EPR options appraisal will be undertaken as part of the development of the digital strategy for the new Trust. This will be informed by the requirements of the clinical services and will consider the costs, benefits and risks of the various options. This options appraisal will be completed by the end of March 2025. In the shorter term, an interoperability solution will be implemented and the current plan is that this will be based on Southern's integration engine.

Estates strategy

8.58 The four Trusts have worked together through the monthly Estate Director Forum to develop the estates strategy for the new Trust. This Forum includes representation from providers across the HIOW system as well as Hampshire County Council, Community Health Partnerships and NHS Property Services. The following process was followed:

- Identify common themes and variations across existing Trust strategies
- Assess estate performance across existing Trusts, based on factors such as physical condition, functional suitability, space utilisation, quality, statutory compliance and environmental management.
- Identify particular areas of focus for each Trust
- Agree the scope of the Estates function for the new Trust

- Consolidate the above information into a coherent strategy that also supports delivery of the NHS LTP

Eastleigh Health Hub – bringing healthcare to the high street

Staff in Solent's child therapy service were working out of cramped and outdated accommodation scattered across the patch, much of which was no longer fit for purpose. Meanwhile the sexual health team worked without a suitable central base in Eastleigh, forcing patients and staff to travel out of the area for certain appointments and procedures.

By bringing both services together into a new multi-purpose health facility in the middle of a thriving shopping area at The Swan Centre, they became instantly easier for the local community to access. This new purpose-built Eastleigh health hub brought the following benefits for patients and staff:

- Improved and more flexible accommodation for the child therapies team meant more counselling rooms and an area suitable for group work, all boasting a colourful and child-friendly décor to help put young patients at ease.
- A better clinical environment for the sexual health team, including the introduction of four consulting rooms, an interview room and a small on-site laboratory to speed up test results for anxious patients.
- Although entirely separate clinical areas, each with their own entrance, the two services share backroom functions such as IT, staff changing rooms, storage and housekeeping.

The increased scale of the new Trust will create many more opportunities to do the similar projects, bringing together teams and making better use of the estate.

8.59 The existing estates strategy for the HIOW ICS was developed by the HIOW STP in 2018. A new Estates Infrastructure Strategy for the ICS will be developed by the end of the 2023/24 financial year, in line with NHSE guidance. The new Trust is expected to play a significant role in developing the Estates Infrastructure Strategy for the ICS.

8.60 The existing areas of focus of the estates strategies for each Trust are summarised in the figure below.

Figure 50: Summary of the existing estates strategies of the four Trusts

Solent	
Ways of working	• Space occupancy, management and culture change to promote high utilisation and flexibility.
Incumbency review	• Existing occupation reviewed against criteria, with services and working models challenged to enable best use of built assets.
Ownership	• Key strategic estate should be owned and operated to deliver best overall value, taking into account aspects including workforce modelling and not just estate priorities.
Southern	
Internal redesign	• Do everything we can internally to redesign our services to provide better quality and better value for money.
Integration	• Work with our partners to develop an integrated health and social care system.
Growth	• Grow our business where this means we can deliver better outcomes, better patient experience or greater efficiency.
IoW	
Segregation of acute	• Develop a 'hot' (acute or non-elective) zone of the St Mary's hospital site and a 'cold' (planned care or elective) zone of the site, with services that support both areas being sited in the confluence of these zones.
Emergency acute	• Develop effective emergency acute services that manage the level of admissions into the non-elective and speciality bed stock to ensure capacity is available as required for emergency and elective services.
	• Start the journey of redevelopment of the community offering across primary and social care, and physical and mental health services creating an available and accessible community hub and spoke model.
Sussex Partnership	
Staff co-location	• Support new models of integrated care through physical co-location of staff groups.
Fewer sites	• Reduce the overall occupied footprint, whilst improving the quality of the retained estate.
Sustainability	• Continue making progress on environmental sustainability, particularly in the areas of travel and building improvement to reduce carbon emissions.

8.61 The estates teams of the four Trusts currently collaborate in several ways, through engagement in monthly ICS Estate Director meetings, One Public Estate (OPE)

meetings and Local Estate forums. Recent examples of what has been achieved include:

- engagement with local authorities and OPE colleagues to deliver shared space schemes and other projects;
- NHS occupation of local authority assets, jointly managed NHS and local authority teams in shared NHS space;
- sustainable bike and scooter networks;
- shared keyworker housing project; and
- strategic disposals and reciprocal office use agreements.

8.62 The new Trust's vision for estates and facilities is: "To provide, service and maintain highly effective, high quality, best value and fit for future physical assets in which to support and deliver world class community, mental health and learning disability services."

8.63 The new Trust's emerging estates strategy focuses on creating a highly efficient and interoperable networks of locations. It will support the NHS LTP, JFP and ICS partnership strategy to deliver place-based care by integrating technologies that support the elimination of geographic boundaries. More specifically it will:

- support community-based outpatient, acute and diagnostic treatment, reducing the pressure on the acute hospital estate;
- deliver best value, efficient and fit for future accommodation, integrating with and supporting primary care to reducing the need for acute admission;
- establish the community estate as the 'nurses station' for community-based care, providing effective 24/7 support for staff and patients, and developing supportive environments in place of outdated inflexible and expensive primary and community built environments; and
- support the next generation of healthcare provider, in carbon neutral, socially conscious and environmentally positive surroundings.

8.64 Capital funding for estates will focus first on reducing the dependence on the physical estate. For example, technology will be implemented to support effective home-based care (such as increased use of virtual wards and telehealth). Secondly, the new Trust will invest in effective, sustainable and healing environments in the community for staff and patients. Finally, the new Trust's capital plan will ensure that where admission is necessary, the estate is flexible, high quality and patient-centred.

Estates function

8.65 The estates and facilities management function has been designed to support delivery of the new Trust's estates strategy by enabling the development of new technical roles

and specialisation of functions that will deliver rapid development and adoption of innovation at scale. The estates function will comprise the following aspects:

- Buildings (excl. IoW St Marys)
- IoW St Marys
- Projects
- Green plan/sustainability
- Waste management
- Hard facilities management
- Medical engineering
- Premises and space management
- Property management
- Utilities
- Catering
- Health and safety
- Security
- Fire
- Ligature management
- Computer aided facilities management
- Soft facilities management
- Travel and transport
- Estates contracts
- Estates IT systems

9 Benefits

Chapter summary

- This chapter sets out the expected benefits for patients and carers, staff and the wider health and care system. The financial benefits of creating the new Trust are set out in chapter 10.
- Working with stakeholders including staff, patient groups and the ICB, the principal benefits that will be achieved through the creation of a new Trust have been identified. This has been embedded in the integration planning process to ensure that the activities to realise potential opportunities are reflected in the PTIP and supported by a robust approach to benefits realisation.
- The new Trust will deliver benefits for patients and carers by:
    - Improving accessibility of services;
    - Improving continuity of care;
    - Simplifying pathways;
    - Providing the right care first time;
    - Providing integrated care and supporting people more effectively at home and in the community;
    - Strengthening the alignment of capacity and need;
    - Improving the quality of patient care by maintaining safe staffing levels;
    - Developing a culture that values the voice of lived experience; and
    - Expanding opportunities for research activities.
- The new Trust will deliver benefits for staff by:
    - Tackling recruitment and retention challenges;
    - Improving career progression and development;
    - Improving job satisfaction;
    - Development of an inclusive, open culture; and
    - Improving service resilience.
- The new Trust will deliver benefits for the wider health and care system by:
    - Tackling health inequalities;
    - Responding better to local communities;
    - Supporting the delivery of health and wellbeing strategies;
    - Aligned operational planning;
    - Enabling the streamlining of system assurance processes;
    - Supporting large-scale transformation of models of care;
    - Enhancing the focus on population health; and
    - Being a strong and consistent voice for community and mental health and learning disability services across the ICS.
- There are additional benefits specific to the population of the Isle of Wight, including strengthening the resilience of sub-scale services, helping to address the highest risks in service delivery, enabling opportunities for training and development for IoW staff and reducing the professional isolation associated with delivering sub-scale services in a geographically isolated location.

9.1 This chapter sets out the approach to identifying, developing and realising the benefits from the creation of the new Trust. It also sets out the key details of the main non-financial benefits (financial benefits are described in more detail in chapter 10).

Approach to benefits identification and development

9.2 Identification of benefits has combined both a top-down and bottom-up approach. Benefits were identified at a high-level through development of the Strategic Case, including consideration of how the new Trust would seek to address the case for change.

9.3 Development of the case studies in the PBC identified specific benefits which illustrate the overall patient benefits which will be realised through creation of the new Trust. The approach to benefits identification and development was designed with reference to the **NHS transactions: Patient benefits Guidance for Trusts** (May 2022) document. The approach is described in the PBC.

9.4 In addition, the Steering Groups were tasked with identifying benefits and potential disbenefits as part of the development of detailed integration plans. These benefits were collated by the Programme Team and are reflected in the PTIP.

9.5 In relation to financial benefits, the Finance Steering Group undertook some high-level benchmarking to identify potential synergies. This informed discussions with the other Steering Groups to identify and quantify benefits, supported by the Finance Steering Group, and reflect them in the financial model.

9.6 Where a change to a service is been planned, the impact will be evaluated through the use of use of quality and equality impact assessments. These assessments will be undertaken by the relevant service team, with support from operational leads.

Approach to benefits realisation

9.7 The approach to benefits realisation has been developed to enable the identification, delivery and measurement of benefits for the new Trust. This approach is described in the figure below.

Figure 51: Benefits realisation approach

Activity
Define benefits • Identify and articulate the specific benefits that are expected to be achieved as a result of the creation of the new Trust
Establish metrics • Select measurable KPIs that will be used to track progress and outcomes. • Ensure that KPIs are aligned with the defined benefits.

Activity
Baseline measurement • Capture the baseline performance of the relevant metrics
Set targets • Define the target values for each metric and timescales for delivery (trajectories) based on the planned timescales of integration activities
Implementation and monitoring • Implement the integration plan and monitor progress • Regularly track and report the actual performance of against the defined metrics and targets
Performance management • Analyse the reasons for shortfalls against delivery of benefits • Take corrective actions as needed
Identify lessons learned • Capture lessons learned and best practice for future projects

9.8 To ensure that the realisation of benefits is embedded within delivery of the overall programme, plans to realise the identified benefits are an integral part of each Steering Group's integration plans. These integration plans are set out in detail in the PTIP.

9.9 Benefits realisation will be an ongoing process and, as additional benefits are identified, Steering Groups will continue to define and refine the relevant metrics. This will include the development of metrics down to a service delivery level, in conjunction with the staff responsible for delivering affected services, and responding to improvement opportunities identified during implementation.

9.10 The programme is currently developing a suite of metrics to track overall progress and delivery of key benefits as a result of creating the new Trust.

Patient and carer benefits

9.11 This section sets out the benefits for patients and carers and describes how the new Trust will deliver them.

Improvements to patient experience

9.12 **Improved accessibility of 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.

9.13 For example, OPMH and dementia services plans include joining up mental health and primary care services to provide support and treatment to patients in a place that

is familiar and easy to access. The new Trust will also develop new blended roles to increase the offer of primary care mental health teams.

Patient story – person with dementia

John is a retired engineer living in Hampshire. He noticed after Christmas that he felt much more disorientated when staying with his daughter and struggled to use the unfamiliar TV controller, microwave and felt unsure where he was on waking at her house. When he returned home, he saw his GP who arranged some blood tests and found no abnormalities and completed a screening test for his memory. John didn't do as well as he expected, and he agreed to a memory clinic referral.

How it can be

He went to the clinic and saw a nurse, who then said she'd need to speak to a doctor about a scan. A few weeks later, John got a phone call a scan would be arranged. About 3 months later he got a scan appointment which is daughter took him to. After another few months, he got a letter about a memory clinic appointment.

It had now been over six months since Christmas, and he attended anxious to hear the result. He was told it looked like Alzheimer's dementia. He was started on a tablet and discharged with some leaflets, after care phone numbers and discharged back to GP care. Over the pandemic, he didn't receive any annual reviews of his dementia and he became increasingly isolated, forgetful and at times, left the gas on, forgot to feed the dog, was struggling to heat the microwave meals his daughter arranged for him, who lives two hours away so sees him once a month.

On an August morning, he woke up at 6am and thought it must be bin day, he got up in his pyjamas and slippers and put the bin out. He then took a walk and got lost. He was found that night about eight miles from his house near a busy dual carriage way by the Police, who couldn't decide if best to take him to the hospital or a S136 as he became aggressive and agitated when approached and seemed hugely confused as to why they were concerned. He was taken to the general hospital.

No medical cause is found, and he is admitted for discharge planning, whilst a safeguarding alert was made. He spends four weeks on the wards, getting a hospital acquired infection mid-way through which delays his discharge, and is discharged to a Discharge to Assess pathway in a different part of the county away from his networks of friends and not near his family. He loses contact with his GP surgery of 40 years.

How we want it to be

The GP in the first instance arranged a brain scan, which he had at his local community hospital within four weeks and then receives a letter for a memory clinic specialist. He is seen at specialist memory clinic and has a one stop shop appointment, having assessment, treatment, being introduced to information about advanced care planning (wills, lasting power of attorney) and is started on evidence-based memory medication. He receives a menu of options for post diagnostic support and chooses to attend singing for the brain as he would prefer an activity rather than a talking group. He also accepts a referral to the memory research centre and joins a trial over the next two years which helps him to be feel supported.

Over the coming years, he becomes well connected to dementia support networks, receives annual review of his dementia and when things start to progress his daughter knows to ring the services and they re-assess for the next step of his memory medication. He also accepts a referral for some assessment for aids and decides after to speaking to the occupational therapist and reflecting with his daughter that his large house and garden are becoming too difficult. He makes a choice to move within his market town to a flat with a warden and on-site activity, stimulation, and support. He thrives, meeting people there he has known for many years in the town and finding new joy in life. He lives there for a further five years and passes away in his own home, surrounded by his dog and family.

9.14 **Improved continuity of care** by aligning the geographic coverage of service teams and reducing the number of interfaces across care pathways.

9.15 For example, the new Trust will provide CAMHS under the iTHRIVE framework. Existing services will be mapped to this framework, enabling any gaps to be identified and addressed. The framework will help with clearer identification of the right service at the right time as well as more timely and joined up transitions for children and young people.

Patient story – Frances

How it can be

Late Friday afternoon, Senior Tier 4 CAMHS staff were made aware that 17-year-old Frances had been detained under Section 136 Mental Health Act (MHA) and taken to a designated Place of Safety (PoS) in a local adult mental health hospital (EPR – Southern RiO). Frances had been there for approximately 65 hours – she was admitted to the PoS Suite in the early hours of Wednesday morning.

Frances had attended the local emergency department on Monday evening following a self-inflicted laceration to her wrist and an overdose of ketamine. She had been assessed and then discharged home to the care of her parents on Tuesday morning (EPR – Solent System One). Southern and Sussex Partnership colleagues are unable to access these notes. On Tuesday evening, Frances took advantage of her mum leaving her alone for a few moments, left the home address via a window and made her way to a railway bridge with the expressed intent to end her life by jumping in front of a train. Police attended and, in liaison with NHS 111, decided to detain Frances on Section 136 of the MHA as she was unable to engage in a plan to keep herself safe.

Whilst in the PoS, Frances engaged in self-harming behaviours (cutting, headbanging), damaged fixtures and fittings, attempted to abscond, was verbally abusive to staff and physically assaulted them by throwing mouth wash at their eyes. Nursing staff administered lorazepam intramuscular (IM) under restraint to reduce agitation. She also began restricting food intake although continued to accept drinks of tea and water.

Community Mental Health Team (EPR – Sussex Partnership Care Notes) launched an unsuccessful local and national search for a hospital bed. Frances began to decline drinks as well as food, her forehead began to swell and formed an abrasion from the intensity of her headbanging and she complained of a headache and stomach-ache. Frances' parents were able to visit her on Thursday afternoon.

Frances' parents contacted their MP who asked the Trust's Executive team to expedite the search for a hospital bed for Frances due to her prolonged detention in the PoS. No appropriate bed was available, however there was considerable pressure from all parties to find a compassionate solution for the young person. Late Friday afternoon, the reluctant decision was taken to admit Frances to the least worst option of the local Low Secure Unit (LSU) for the containment of risk and all necessary arrangements and preparations made.

Frances received compassionate care during her emergency admission to the low secure unit – the staff team adapted positively in the unusual circumstances and made sure she was well cared for, however, the situation was unsatisfactory. Once Frances was in a hospital, there was a retreat from all parties who had applied pressure to make that happen – the LSU had been agreed as a brief admission for the containment of immediate risk, but it was not the right clinical environment for her assessment, treatment, or recovery, yet there was no longer any interest or urgency to appropriately place the young person.

How it could be

Frances attended the local emergency department (ED) on Monday evening following a self-inflicted laceration to her wrist and an overdose of ketamine. She was assessed and then discharged home to the care of her parents on Tuesday morning. The assessment and outcome are available for all CAMHS staff to view on one EPR system to inform decision making and improve the young person's experience.

Frances' Community Mental Health Team (CMHT) were alerted to her visit to the ED and were able to arrange to meet with her as urgent follow up. The visiting practitioners find Frances unwilling to engage with them or a plan to keep herself safe at home so they make an immediate urgent referral to the CAMHS Crisis service for more intensive support.

The CAMHS Crisis service, which acts as a gatekeeper to inpatient beds, can review all the clinical documentation on the shared EPR and contact Frances and her family the same day. Frances continued to express a wish to end her life and was again unwilling to engage with the Crisis service, so they arranged for her to access a community crisis bed for the night to provide her parents with some respite and to enable Frances some time and space to rest and reflect whilst ensuring her safety.

Frances spent two nights in the community crisis bed with the support of the CAMHS Crisis service. Her mental health and schooling had been significantly affected by the COVID-19 pandemic restrictions and she was struggling with her role and identity within her family unit. Her younger sister was autistic and their parents were exhausted trying to ensure that both of their children are well-supported.

After leaving the community crisis bed, as well as having ongoing support from the Crisis service, Frances and her family were offered the input of a Family Therapist to support and address their complex needs. Frances' parents were also offered a carer support assessment to ensure that they had everything they were entitled to. The CMHT remained involved throughout to ensure that once Frances required less intensive support, her care could be seamlessly handed over.

9.16 **Simplifying pathways** and reducing hand-offs so that a single Trust will be the single point-of-contact across the ICS for a patient to contact. Reducing the inter-organisational boundaries along patient pathways will also improve communication

with patients, their carers, and across clinical teams, as these boundaries can act as barriers to the provision of consistent and complete information.

9.17 For example, planned changes for frailty and urgent response services include implementing patient-defined outcomes and care based on individual need. This will help ensure that longer-term needs are met as well as urgent needs, supporting long term care planning for patients. This will help to ensure that care is less medicalised/interventional, reducing avoidable admissions and support better management of conditions. Patients will be supported as close to home as possible, improving patient and carer experience.

Improvements to patient safety and outcomes

9.18 **Providing the right care first time**: the new Trust will adopt a tiered approach to service improvement, innovation and transformation that utilises existing transformation expertise and recognises the importance of standardisation to reduce unwarranted variation and adaptation to meet the needs of place, as set out in the figure below.

Figure 52: Tiered approach to service improvement, innovation and transformation

Scale	Approach
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

9.19 The new Trust will have a view of performance and outcomes across HIOW, collating datasets to allow benchmarking between different geographies both within and beyond the ICS and inform transformation programmes to reduce unwarranted variation.

9.20 **Providing integrated care and supporting people more effectively at home and in the community:** the new Trust will be better able to give meaning to integrated care by bringing physical and mental health services together within the Trust as well as strengthening links with system partners, including the VCSE sector and local authorities, in delivering care in local communities and ensuring that services are tailored to specific local needs.

9.21 For example, the new Trust's frailty and urgent response services will bring together existing virtual wards into a single model that allows for appropriate oversight of

patients experiencing a crisis at home, with medical support, meaning that clinical progress can be monitored and treatment decisions reviewed regularly. Such a system reduces the pressure on initial assessments and enable patients to be safely supported at home.

9.22 **Strengthening the alignment of capacity and need:** the new Trust will be able to better match capacity of services to the level of need in different geographies and patient cohorts within HIOW. This requires a framework for assessing the level of patient need and flexibility in service provision to match that need. It will be easier for to deploy staff flexibly through adoption of common service models.

9.23 For example, the iTHRIVE framework that will be implemented across CAMHS will enable capacity to be optimised through adopting a stepped care approach that respond to individual needs. Where additional, higher intensity support is required, the young person will be offered higher intensity intervention through locality-based treatment teams.

9.24 In partnership with the ICB, acute trusts, GPs and people who use services, the new Trust will be committed to addressing the capacity issues in acute adult mental health services. The first stage will be to review capacity across all parts of the acute mental health pathway and then to agree a plan, developed with people who use services, to ensure access to the right sort of crisis services, beds and alternatives to beds, where and when they are needed. The intention is to scope this work in early 2024.

9.25 The new Trust will **improve 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.

9.26 The new Trust will **develop a culture that values the voice of lived experience,** from every clinical interaction to the design and delivery of services. The culture will support recovery and coproduction resulting in improved safety, outcomes and experience for patients.

9.27 For example, one of the ways that the new Trust will embed lived experience is through greater use of Peer Support Workers (PSW) in integrated Multi Disciplinary Teams (MDTs). PSWs will work across all teams and will help improve patient outcomes by improving self-efficacy, reducing admissions and length of stay, improving community engagement and driving forward patient centred changes in culture and practice. PSWs will help ensure that the voices of patients and carers are heard by someone with relevant lived experience, improving communication between the patient and all relevant services.

Stakeholder story – Peer Support Worker (PSW) story

Ben is 45 and has depression and anxiety as well as multiple physical health conditions. He is prescribed various medications but struggles to take these and is unable to work. He finds it difficult to leave the house due to the impact of his physical health conditions, which in turn has a negative impact on his mental health.

How it can be now

Ben had been hospitalised due to physical health issues after he stopped taking medications due to concerns around side effects. Although he was supported by the psychiatric liaison team whilst an inpatient and referred to the local community mental health team, his anxiety and challenges with his physical health prevented him from attending scheduled appointments which led to him being discharged from the service back to his GP. He continued to have challenges taking his medications and was readmitted to hospital for one of his physical health conditions and his mental wellbeing had also deteriorated substantially.

How we want it to be

Whilst an inpatient in the hospital, the psychiatric liaison team contacted the community mental health team who assigned a community peer support worker to support Ben to access services and reduce any barriers to this. The peer support worker visited Ben in hospital to start to build a relationship so he felt supported on discharge and Ben felt it was easier to talk to someone who had used services and could understand what he was experiencing.

The peer support worker supported Ben to plan how to manage his own health and access the support he needs from services, and Ben is currently taking his medication and attending his appointments. Developing an empathetic, non-judgemental relationship with his PSW instilled a sense of hope in Ben, and empowered him to believe he could recover. His physical health has stabilised, in turn leading to an improvement in his mental health. He has accessed the local Wellbeing service to support him in his local community and has also become a student at the Recovery College.

Ben has now been discharged by the peer support worker and feels empowered to manage his own recovery journey going forward.

Research

9.28 The new Trust will also provide benefits for research teams, which will ultimately support improvements in patient care:

- 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 Solent and Southern 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.

Staff benefits

Tackling recruitment and retention challenges

9.29 The new Trust will adopt a single approach to tackle recruitment and retention challenges and fill 'hard to fill' posts, including developing new innovative roles where traditional recruitment has been challenging. This will build on existing collaboration, including in international recruitment where Solent, Southern and IoW have been working together since 2022. This will reduce vacancies, which will also help reduce operational pressures on staff and improve staff satisfaction.

9.30 Increasing the scale of the recruitment team will provide capacity to spend more time partnering with services to understand their workforce plan needs, design recruitment strategies, develop more targeted and tailored recruitment campaigns and host more recruitment roadshows to attract new candidates.

9.31 The new Trust will also explore innovative employment models. For example, as a provider of primary care services, the new Trust will look at the potential for alternative GP employment models which could improve recruitment and retention, as well as having a positive impact on job satisfaction.

9.32 Recruitment and retention benefits will be measured by monitoring vacancy rates and temporary staffing, agency, and locum costs, which will be reported to the Board of the new Trust through the IPR, as described in chapter 6.

Staff story – recruitment

Whilst there is some co-ordination of recruitment initiatives at an ICS level, this doesn't focus on community and mental health services. The new Trust will have a single recruitment strategy that will help attract new staff to work in services in particular those areas with high vacancy rates and turnover where safer staffing is most challenged. This will help to distinguish, particularly for those new to healthcare, the new Trust's services, career opportunities and benefits whilst addressing preconceptions of a career in the NHS.

Lesley had been made redundant from their retail post and was looking for a career change. She was interested in working in health care but didn't have any previous experience or qualifications in health and social care and didn't know where to start.

Lesley saw an online campaign on her social media account promoting an open day for candidates new to care with opportunities in a variety of community settings. Lesley has a family member that access community mental health services, and this sparks interest, so she goes along.

On the day, she has the opportunity to speak to a number of different services, Lesley feels a connection to the CAMHS team and makes an application. She is successful and is offered a post with a comprehensive induction and opportunity to gain The Care Certificate. After a year in post things are going well and Lesley is loving the work, but her personal circumstances change and she has to relocate from Basingstoke to Southampton. It's too far to commute, but Lesley speaks to her manager, who identifies a role available in Southampton that Lesley can transfer into. She embraces the change, moves to the Southampton team and performs well in her role demonstrating potential. When nurse apprentice secondment opportunities are advertised, Lesley is encouraged by her manager to apply; she is successful and will become a registered nurse within four years.

Enabling people to remain within the Trust wherever possible to progress their careers delivers improved return on investment from training and development, retains talent and delivers improved patient safety through better resourced teams.

Career progression and development

9.33 The greater scale of the new Trust will reduce the need for staff to move between organisations to progress their careers and thereby will improve talent retention, career progression and development opportunities. The creation of a shared training function will offer improved professional development and training opportunities,

including strengthened access to support, advice, and supervision, providing high quality and consistent training that is accessible and equitable.

9.34 The new Trust will develop a talent management strategy to enable effective career progression pathways, succession planning to retain talent and strong leadership. This will help to increase staff retention rates.

9.35 Apprenticeship teams will be aligned in order to improve the new Trust's ability to 'grow our own' at scale. This brings the opportunity to look at innovative ways of working and building on T-levels education through to employment with community colleges, to strengthen the attraction and pipeline of resource into the new Trust and wider health and care system.

9.36 Career progression and development benefits will be measured by monitoring the NHS staff survey, particularly focusing on appraisal sub-scores, we are always learning and the meaningful appraisal rating. Other measures include the uptake on LMS courses, training course feedback evaluation forms, apprenticeship retention rates, 'T-level' (a technical alternative to A-levels) programme retention rates, preceptorship data, staff turnover rates and exit interview data.

Improving job satisfaction

9.37 Staff will be supported by the people function that builds on the best of the existing ways of working across people directorates of existing Trusts and the existing wellbeing offers for staff. For example, the new Trust will implement the national NHS health and wellbeing framework that has recently been adopted by Solent. Health and wellbeing is closely linked to job satisfaction and this framework provides a model for creating a health and wellbeing culture through addressing the key factors that drive the design and delivery of interventions that improve staff wellbeing.

9.38 Job satisfaction benefits will be measured by looking at the NHS staff survey, in particular: staff engagement, staff morale, staff advocacy sub score, satisfied with recognition for good work, we are safe and healthy, I always know what my work responsibilities are, I am trusted to do my job, thinking about leaving sub score, my immediate manager cares about my concerns, my immediate manager listens to challenges I face, my immediate manager works with me to understand problems. Other measures will include staff turnover rates and exit interview data.

Continued development of an inclusive, open culture

9.39 The new Trust will develop an open, inclusive culture, that promotes learning and continuous improvement by strengthening professional, clinical, and operational peer networks and creating opportunities for shared learning wherever possible. The new Trust will use accessible and inclusive language in all people policy processes and frameworks, values and behaviours. Working with FTSU, health and wellbeing colleagues, and assessing culture on an ongoing basis will be integral to measure this benefit and a cultural assessment tool has been identified to enable this.

9.40 A human-centred approach in the management of all people practices will ensure staff are treated with compassion. A restorative and Just culture will be embedded in all people policies and processes and this will benefit a reduction in employee relation cases such as formal resolution cases (grievances), with managers feeling supported to navigate employee relation matters compassionately, improving staff job satisfaction and health and wellbeing.

9.41 These benefits will be measured by looking at the NHS staff survey, specifically: we are compassionate and inclusive, we each have a voice that counts, we are always learning, as well as the results from the MWRES and Bank WRES staff survey. Other measures will be the national WRES and WDES 18 indicator scores, the EDS three domains, workforce EDIB profiling data, and FTSU concerns raised, employee relation number of formal cases.

9.42 An example of how the continued development of an inclusive, open culture will impact staff is provided in paragraph 8.8.

Improve service resilience

9.43 The creation of the new Trust will improve service resilience and reduce professional isolation, particularly of smaller services.

Benefits for the wider health and care system

9.44 The creation of the new Trust will deliver benefits for the health and wider care system:

- **Tackling health inequalities:** the new Trust will be better placed to work with system partners to address health inequalities, for example by strengthening leadership and accountability and accelerating prevention. Through a more strategic approach to commissioning, the ICB intends to work with the new Trust to develop outcome metrics, in order to gain a better understanding of health inequalities and to accelerate work to achieve equity of outcomes.
- **Responding to local communities:** The new Trust will respond to the system priorities identified through engagement with local communities, in particular:
    - People want more joined up services, from GPs to hospitals to social care, education and housing;
    - People want to be more involved in how their care is delivered, to have better communication with health and care services, and be clearer about what is available to them; and
    - Access is an issue, with people identifying the need for more specialist access and shorter waiting times, and more consistent support services across our geography.

- The design of the new Trust will promote ongoing engagement and co-design with local communities, system partners (including local authorities and VCSE partners) and people with lived experience.
- **Delivery of health and wellbeing strategies:** each of the places (Hampshire, Isle of Wight, Portsmouth and Southampton) has a Health and Wellbeing Board which sets the strategy for its population. The new Trust will be an active partner in each of the place-based partnerships, facilitating delivery of these strategies and enabling realisation of the associated benefits for the population in each place. The new Trust's strategy will be aligned with system strategies, as described in chapter 5 and the new Trust will play an important role in setting the strategic direction for mental health, community and LD services across HIOW, including as a member of provider collaboratives (see paragraph 2.66).
- **Aligned planning**: the new Trust will develop a single operational plan, working closely with commissioners to ensure it is aligned to system priorities. Work has already started on the development of a single plan for 2024/25, using a standardised process across the three Trusts.
- **Effective system assurance**: the ICB and new Trust geographies will be coterminous allowing streamlining of system assurance processes. There will be an opportunity for the ICB and the new Trust to work collaboratively to design system governance that supports line of sight from a neighbourhood team to a system level as well as increasing opportunities to share learnings and spread innovation.
- **Transformed models of care**: large-scale transformation is needed across the ICS, including new models of care and rebalanced health investment. The new Trust will help to transform services and realise system benefits particularly around the Clinical Transformation Group workstreams (see figure 16) with potential benefits across the system.
- **Renewed focus on population health**: the new Trust will work with system partners on population health management, thereby helping to improve the health and care for the population across HIOW.
- **Being a strong and consistent voice** for community and mental health and learning disability services across the ICS, working with partners at neighbourhood, place and system levels to achieve the system's aims.

Benefits for the population of the Isle of Wight

9.45 In addition to the wider benefits articulated above, there are benefits specific to the population of the Isle of Wight which include:

- Strengthening the resilience of sub-scale community, mental health and learning disabilities services on the Island;
- Addressing the highest risks in community, mental health and learning disabilities services in HIOW through a collaborative programme of clinical transformation. The transformation programme aligns well with the highest clinical priorities and risks from an Isle of Wight perspective, including the provision of frailty services and development of a HIOW neurodiversity pathway;
- Enabling community, mental health and learning disabilities-specific opportunities for training, development and career progression that are not currently available for IoW staff; and
- Reducing the professional isolation that arises from delivery of sub-scale services in a geographically isolated location by ensuring IoW staff have access to resilient peer networks.

10 Financial case

Chapter summary

- This chapter describes the financial impact of creating the new Trust.
- To describe the context, the financial positions of the following are set out:
    - HIOW ICS;
    - Solent;
    - Southern;
    - the community, mental health and learning disabilities segment of IoW; and
    - the Hampshire CAMHS element of Sussex Partnership.
- The HIOW system plan for 2023/24 is a deficit of £105.4m and the ICS has developed a system Financial Recovery Plan as well as five longer term transformation programmes to improve the overall system position.
- Solent's plan for 2023/24 is a deficit of £2.2m, which requires the delivery of £23.8m of net savings.
- Southern submitted a breakeven plan for 2023/24, which requires the delivery of £25.3m savings.
- 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 submitted a plan for a deficit of £24.8m in 2023/24, with the community and mental health segment having an identified deficit of £5.2m. The unique nature of delivering services on the Isle of Wight creates additional costs, referred to as the structural deficit. The proportion of the structural deficit attributable to community, mental health and learning disabilities in 2019/20 was £1.7m, related to staff pay premium costs.
- Hampshire CAMHS has operated within its budget in each of the last five years and the forecast position for 2023/24 is breakeven against funding, which includes a £3.2m contribution to Sussex Partnership overheads and a £0.4m write off of capital costs.
- In the event there is no change (the counterfactual position), the aggregate deficit is forecast at £1.7m in 2026/27. This forecast assumes significant efficiency requirements.
- Partners are working to minimise the impact of stranded costs which might arise from the creation of the new Trust, which have been estimated at £4.5m in the worst case. The options to address this issue are being assessed by all partners, with recommendations being made by the end of December 2023.
- Although the primary driver for the transaction is the significant benefits that can be realised for patients, the Trusts have identified recurrent savings of £4.1m by 2026/27. The new Trust will re-invest net savings in clinical services, providing benefits to patients and staff. There are also further indirect financial benefits to system partners that are described in this chapter.
- Transaction and integration costs have been quantified and total £3.5m in 2024/25. These costs are principally non-recurrent costs of integration and implementing the clinical strategy. Recurrent annual costs relating to staff pay are estimated at £0.5m.
- Existing sources of capital funding and capital expenditure will be retained in the new Trust. Any significant investments (e.g. arising from the options assessment for EPR

systems) will be subject to business case which will set out the funding source. £1.3m of national funding has already been secured to transition the EPR for Hampshire CAMHS prior to Day 1.

- Financial risk has been quantified through a sensitivity analysis which considers a range of potential downside risks, mitigations and upside opportunities. This analysis highlights the level of risk that exists within the counterfactual case, as well as the potential impact of the creation of the new Trust on risks of increased activity growth, CIP delivery and integration costs.

10.1 This chapter sets out the historic and forecast financial performance of each of the Trusts (for in-scope services for IoW and Sussex Partnership), the expected costs and savings arising from the creation of the new Trust and the resulting forecast performance of the new Trust compared to the counterfactual case.

ICS context and historical Trust performance

HIOW ICS position

10.2 The HIOW system reported a £83.2m deficit in 2022/23 which comprised of £12.6m for the ICB and £70.6m for providers. For the 2023/24 plan the ICB initially submitted a £7.1m deficit and the providers a £111.3m deficit. Clearly this was not a position that was compliant with the organisations' statutory responsibilities and as a result the system moved into the Recovery Support Programme and moved to segment 4 of the NHS Oversight Framework. In month 2, NHSE notified a change in allocations for the ICB on the condition it was reflected in a change to the financial position. As a result, the ICB plan moved to a surplus of £5.9m and the system overall moved to a plan of £105.4m deficit. The drivers of this deficit position include:

- **Productivity has declined**. Despite a rise in income there has been a decline in financial positions since 2019/20;
- **Occupied Bed Days have increased**. People are spending more time in a hospital bed after treatment has ended due to challenges in getting them back to their usual place of residence;
- **Workforce costs have risen** with increased use of temporary staffing despite core workforce numbers increasing;
- **Non-pay costs are higher than envisaged**. The cost of drugs and services are higher than planned;
- **Emergency activity has risen** above 2019/20 levels and 8% higher than nationally;
- **Rising emergency lengths of stay**, partly due to delays in discharge linked to the availability of physical and mental health and care services in the community;

- **Short-term operational pressures** have led to inefficiencies and under-delivery of Cost Improvement Programmes (CIPs); many focused on closing escalation beds, improving discharges, reducing agency spend and improving procurement, which were not delivered due to a mix of activity levels and inflation;

- **Operational pressures on mental health, learning disability and autism services** are leading to high mental health inpatient occupancy and long waits, which are having an increasing impacting on quality of delivery and patient experience;

- **Significant areas of population growth in some areas of the system**: Test Valley and Basingstoke and Dean – 12% and 10% respectively compared to 6% England average (2011 – 2021);

- **Models of proactive, preventative physical and mental health care not yet scaled** to impact across the system footprint. Outcomes and activity indicate that focusing on cardiovascular disease prevention and proactive care for older people are priorities for the whole health system, as well as mental health, learning disability and autism support and services e.g. personality disorder, eating disorder, children and young peoples' mental health care and support and autism assessments;

- **High levels of independent sector choice** within the HIOW ICS;

- **Some estates are no longer fit-for-purpose** leading to inefficient use of buildings and impacts on care delivery;

- Delivering 24/7 services on the Isle of Wight requires **additional cost to ensure sustainable and resilient service deliver**y; and

- The Hampshire and Isle of Wight system is **over target for its population allocation**, and as at 2023/24 a significant reduction is required.

10.3 The current trajectories for the HIOW ICS forecast a £33.5m deficit in 2024/25, with Solent and Southern at breakeven and IoW at an £18.2m deficit for the year. All but one organisation in the ICS is planning to deliver a breakeven run rate from month 7 onwards which would result in a further improvement in the overall system position for 2025/26. This will require the successful delivery of the aims set out in the JFP, in particular the following five transformation programmes:

- Primary and local care;

- Urgent and emergency care;

- Discharge;

- Planned care; and

- Workforce productivity and staffing costs.

10.4 The HIOW system partners have identified several key strategic changes that constitute the system's Financial Recovery Plan (FRP). Bringing together community, mental health, learning disability and autism services into a single entity is a fundamental element of the system's FRP. The new Trust will enable a reduction in unwarranted variation in service provision as well as improvements in quality, productivity, performance and financial outcomes through working at scale whilst delivering for local need. In the longer term, improvements in services will enable the system to release and repurpose cost through providing proactive care in the most appropriate setting.

10.5 The HIOW system plans to review and reshape investment in health and care to increase the proportion of spending in primary, community and mental health care, to better prevent and manage healthcare needs so that people receive the right care in the right place and reduce growth in demand for the most expensive hospital and specialist services. The creation of the new Trust is a key enabler of this plan.

Solent historical performance

10.6 Over the past six 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).

10.7 In 2022/23 Solent planned to achieve a breakeven position and in Q4 reforecast to deliver a surplus of £437k. This surplus was achieved despite significant financial pressure particularly due 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. The surplus was achieved primarily through non-recurrent benefits and the underlying deficit for 2022/23 was £13.4m.

10.8 Solent's plan for 2023/24 is a deficit of £2.2m, linked to additional activity in the termination of pregnancies contract that moved from an activity-based contract to block in 2020/21. Achievement of the deficit plan requires the delivery of an ambitious financial recovery plan to make net savings of £23.8m, of which £7.3m is planned to be non-recurrent.

10.9 There are some emerging pressures that the Solent Trust Board considers will be mitigated and have therefore not been included in the plan, principally a pay inflation

pressure following the recent pay award of £1.2m. Including these pressures, the underlying forecast position for 2023/24 is a £10.5m deficit (taking into account non-recurrent cost improvement plan (CIP) delivery).

10.10 Solent's historical income and expenditure (I&E) performance and current year plan is summarised in the figure below.

Figure 53: Solent's financial performance

Solent Income and expenditure (£000)	2020/21	2021/22	2022/23	Plan 2023/24	
Clinical income	202,946	227,989	248,417	233,536	*
Other income	35,631	30,108	26,385	17,698	*
Pay	(156,064)	(178,619)	(197,257)	(184,222)	*
Non-pay	(79,485)	(76,713)	(72,390)	(65,852)	
Operating surplus/(deficit)	**3,028**	**2,765**	**5,155**	**1,160**	
Gain/(loss) on disposal of fixed assets	6	(12)	-	-	
Net finance costs	3	20	248	161	
PDC dividend	(2,080)	(2,437)	(2,993)	(3,348)	
Retained surplus/(deficit)	**957**	**336**	**2,410**	**(2,027)**	
Revaluation (exceptional)	(364)	(136)	(1,486)	-	
Donated assets and other impacts	(505)	(133)	(487)	(204)	
Surplus/(deficit) pre-exceptional items	**88**	**67**	**437**	**(2,231)**	

Plan	**(2,955)**	**(1,544)**	**-**
Variance from plan	**3,043**	**1,611**	**437**

*2022/23 Income includes £7.7m for the additional pay award (non-consolidated); £2.5m for the vaccine centre and £1.6m for Research and Development.
*2023/24 plan for Income and Pay doesn't include the annual accounts adjustment for 6.3% centrally funded pensions, which was £7.7m in 2022/23.

10.11 Solent's historical balance sheet and the current year plan are set out in the figure below. Cash balances remain high within the Trust due to the system controls in place for the use of capital.

Figure 54: Solent's balance sheet

Solent Balance sheet (£000)	As at 31/3/21	As at 31/3/22	As at 31/3/23	Plan As at 31/3/24
Non-current assets	102,827	111,268	178,330	191,742
Cash	36,356	36,832	26,304	10,870
Current assets	13,500	14,137	23,562	24,765
Current liabilities	(47,475)	(49,337)	(59,711)	(50,390)
Assets less current liabilities	**105,208**	**112,900**	**168,485**	**176,987**
Non-current liabilities	(128)	(147)	(37,129)	(35,280)
Total assets employed	**105,080**	**112,753**	**131,356**	**141,707**
Financed by:				
PDC	32,875	35,545	41,946	54,610
Revaluation reserve	5,080	9,601	17,032	17,032
Income & expenditure reserve	67,125	67,607	72,378	70,065
Total taxpayer's equity	**105,080**	**112,753**	**131,356**	**141,707**

10.12 CIP targets are set based on a set of principles which state that the CIP target will include:

- Unmet carry forward from prior years including the previous year's non-recurrent CIP;
- Tariff deflator and convergence adjustments towards fair share allocations where levied; and
- Additional requirement to achieve control total and fund internal investments.

10.13 Solent has set consistent CIP targets over the past five years of 4% with the exception of 2020/21 and 2021/22 when the focus was responding to the COVID-19 pandemic. CIP delivery has become more challenging through the years as there are fewer opportunities for cost reduction and CIPs have needed to be delivered through transformation.

Figure 55: Solent's historical CIP delivery

Solent CIP (£000)	2018/19	2019/20	2020/21	2021/22	2022/23
Plan	**7,674**	**8,121**	**1,314**	**198**	**8,874**
Delivery recurrent	5,077	3,102	-	115	4,390
Delivery non-recurrent	980	1,145	-	372	1,466
Total	**6,057**	**4,247**	**-**	**487**	**5,856**
% against plan	78.9%	52.3%	-	246.0%	66.0%
% of income	3.1%	2.1%	-	0.2%	2.1%
% recurrent	83.8%	73.0%	-	23.6%	75.0%

Southern historical performance

10.14 Southern was able to deliver a breakeven position in both 2020/21 and 2021/22 due to the revised financial regime that was implemented during COVID-19, 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 inpatient accommodation and increase ensuite facilities in mental health wards as well as investing in digital development.

10.15 In 2022/23 Southern planned to achieve breakeven and in Q4 reforecast to deliver an improved position of £1.5m surplus. This surplus was achieved despite significant financial pressure particularly due to high temporary staffing costs and cost increases in non-pay linked to inflationary pressures. The surplus was achieved primarily through increased non-recurrent CIP delivery and other non-recurrent benefits, when these are excluded the Trust's underlying deficit was £15m.

10.16 Southern's plan for 2023/24 is a breakeven position, although this requires delivery of an ambitious £25.3m financial recovery plan which includes £6m of non-recurrent savings. There are some emerging pressures which have not yet materialised, including a potential reduction in Hospital Discharge Programme (HDP) funding of £3.4m and a pay inflation pressure following the recent pay award of £1.2m. Excluding the impact of HDP but including the pay inflation impact, the underlying position for 2023/24 is a deficit of £9.2m.

10.17 Southern's historical I&E performance and current year plan is summarised in the figure below.

Figure 56: Southern's financial performance

Southern Income and expenditure (£000)	2020/21	2021/22	2022/23	Plan 2023/24	
Clinical income	340,078	378,521	430,473	422,039	*
Other income	43,180	23,224	24,531	21,803	*
Pay	(277,414)	(291,421)	(347,046)	(336,061)	*
Non-pay	(103,303)	(111,675)	(109,737)	(100,296)	
Operating surplus/(deficit)	**2,541**	**(1,351)**	**(1,779)**	**7,485**	
Gain/(loss) on disposal of fixed assets	609	(496)	(12)	-	
Net finance costs	(1,231)	(1,175)	(930)	(1,332)	
PDC dividend	(4,491)	(4,786)	(5,397)	(6,336)	
Retained surplus/(deficit)	**(2,572)**	**(7,808)**	**(8,118)**	**(183)**	
Revaluation (exceptional)	2,702	7,781	9,904	-	
Donated assets and other impacts	3	109	(261)	183	
Surplus/(deficit) pre-exceptional items	**133**	**82**	**1,525**	**-**	

Plan	**-**	**-**	**-**
Variance from plan	**133**	**82**	**1,525**

*2022/23 Income includes £13.1m for the additional pay award (non-consolidated).
*2023/24 plan for Income and Pay doesn't include the annual accounts adjustment for 6.3% centrally funded pensions, which was £12.1m in 2022/23.

10.18 Southern's historical balance sheet and the current year plan are set out in the figure below. Cash balances have remained high due to the system controls in place that have limited the use of capital.

Figure 57: Southern's balance sheet

Southern Balance sheet (£000)	As at 31/3/21	As at 31/3/22	As at 31/3/23	Plan As at 31/3/24
Non-current assets	207,364	223,885	331,053	321,501
Cash	46,752	58,654	47,360	44,514
Current assets	8,758	11,005	28,802	16,822
Current liabilities	(60,111)	(75,645)	(90,921)	(77,985)
Assets less current liabilities	**202,763**	**217,899**	**316,294**	**304,852**
Non-current liabilities	(16,203)	(15,874)	(93,447)	(78,318)
Total assets employed	**186,560**	**202,025**	**222,847**	**226,534**
Financed by:				
PDC	103,870	114,213	118,788	119,626
Revaluation reserve	54,177	67,107	91,470	85,106
Other reserves	(755)	(755)	(755)	(755)
Income & expenditure reserve	29,268	21,460	13,344	22,557
Total taxpayer's equity	**186,560**	**202,025**	**222,847**	**226,534**

10.19 CIP targets are set based on the same set of principles described for Solent in paragraph 10.12. During 2020/21 and 2021/22 the financial regime and focus was predominately managing the COVID-19 pandemic and returning services to normal. 2022/23 was therefore the first year where CIP returned as a priority for Southern.

Figure 58: Southern's historical CIP delivery

Southern CIP (£000)	2018/19	2019/20	2020/21	2021/22	2022/23
Plan	**13,150**	**18,699**	**19,800**	**7,864**	**14,500**
Delivery recurrent	7,589	5,764	9,865	2,140	9,753
Delivery non-recurrent	4,923	7,400	8,147	4,651	8,783
Total	**12,512**	**13,164**	**18,012**	**6,791**	**18,536**
% against plan	95.1%	70.4%	91.0%	86.4%	127.8%
% of income	4.0%	3.9%	4.7%	1.7%	4.1%
% recurrent	60.7%	43.8%	54.8%	31.5%	52.6%

IoW historical performance

10.20 On the IoW, community, mental health and learning disabilities services are delivered alongside acute and ambulance services in an integrated Trust. 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).

10.21 IoW 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 financial performance deteriorated resulting in an outturn position of £24.8m deficit for the Trust as a whole and a segment deficit of £2.9m. This was mainly due to unfunded pay award pressures, unfunded non-pay inflation, increased acute escalation capacity as a result of continued operational pressures in relation to increased urgent and emergency demand and patients no longer meeting the criteria to reside. The Trust submitted a £24.8m deficit financial plan for 2023/24, of which a £5.2m deficit has been identified as relating to the transferring segment. There is an income risk of £0.6m for commissioned community services where funding is now unlikely, which would adversely impact the position for CMHLD services. Other than this, CMHLD are managing within the planned expenditure budget for this year.

Figure 59: IoW's financial performance for the community, mental health and learning disabilities segment

IoW Income and expenditure (£000)	2020/21	2021/22	2022/23	Plan 2023/24
Clinical income	44,564	51,068	54,435	58,485
Other income	10,169	4,372	2,442	1,281
Pay	(37,485)	(41,679)	(44,365)	(50,073)
Non-pay	(17,248)	(13,761)	(15,423)	(14,902)
Operating surplus/(deficit)	**-**	**-**	**(2,911)**	**(5,208)**

Plan	**-**	**-**	**(2,271)**
Variance from plan	**-**	**-**	**(640)**

Figure 60: IoW community and mental health segment summary balance sheet

£m	IoW: community and mental health segment
Non-current assets	22
Current assets	2
Current liabilities	(9)
Total equity	**16**

10.22 Non-current assets mainly consists of buildings (£15m), assets under construction (£6m) and land (£2m). The land associated with the mental health inpatient unit (Sevenacres) is not included as the Valuation Office Agency is determining the associated value; the land is part of the full St. Mary's Hospital land asset and requires segregating. All assets under construction are expected to complete prior to 31 March 2024.

10.23 Final agreement on the transfer of current assets and liabilities is still to be reached, for example, historical current assets and liabilities could remain with the IoW. It is expected that all non-current assets will transfer. Changes to transferring assets and liabilities will not materially impact the financial assessment of this case.

Figure 61: IoW's historical CIP delivery

IoW CIP (£000)	2018/19	2019/20	2020/21	2021/22	2022/23
Plan	**-**	**-**	**-**	**-**	**2,060**
Delivery recurrent	395	865	-	-	12
Delivery non-recurrent	1,176	584	-	-	2,048
Total	**1,571**	**1,449**	**-**	**-**	**2,060**
% against plan	-	-	-	-	100.0%
% of income	-	-	-	-	3.6%
% recurrent	25.1%	59.7%	-	-	0.6%

10.24 The contracting and payment regime differed during financial years 2020/21 and 2021/22, which included a different approach for the delivery of efficiency programmes. The reporting of efficiency in line with previous years wasn't required.

Sussex Partnership historical performance

10.25 Hampshire CAMHS[41] has operated within its budget over the past five years, delivering a £0.7m deficit in 2020/21, a £0.5m surplus in 2021/22 and a breakeven position in 2022/23. This includes around £3m (10%) of contribution to overheads in Sussex Partnership each year. The historical position reflects increased investment

[41] The figures in this section relate to the entire Hampshire CAMHS including services provided to the population of Frimley ICS in North-east Hampshire which are expected to transfer to Surrey and Borders Partnership NHS Foundation Trust.

into Hampshire CAMHS over recent years, with a historical deficit position turning to surplus as the recruitment to staff has not kept up with the investment levels, due to the impact of national workforce shortages. The plan for 2023/24 includes a recurrent CIP target of £0.6m to address unfunded pay award pressures arising from national pay deals and inflation non-pay costs. The forecast position for 2023/24 is breakeven against funding, which includes a £3.2m contribution to Sussex Partnership overheads and a £0.4m write off of capital costs.

10.26 The figure below summarises the financial performance of the Hampshire CAMHS. This includes £3.6m of income that relates to Frimley ICS and will therefore transfer to Surrey and Borders Partnership NHS Foundation Trust.

Figure 62: Sussex Partnership's financial performance for Hampshire CAMHS

Sussex Partnership Income and expenditure (£000)	2020/21	2021/22	2022/23	Plan 2023/24
Clinical income	15,825	23,198	27,078	30,935
Other income	1,225	517	1,549	1,582
Pay	(13,387)	(16,438)	(21,398)	(24,910)
Non-pay	(4,307)	(6,817)	(7,219)	(7,597)
Operating surplus/(deficit)	**(644)**	**460**	**10**	**10**
PDC dividend	(10)	(10)	(10)	(10)
Retained surplus/(deficit)	**(654)**	**450**	**-**	**-**

Plan	-	-	-
Variance from plan	**(654)**	**450**	-

Modelling approach and assumptions

10.27 This section sets out how the financial information from each of the Trusts has been input into the model template to inform a historical consolidated position forming the basis for the new Trust's forecast position. This section also sets out the key assumptions agreed between the Trusts and ICS stakeholders to underpin the forecast position.

10.28 The detailed template is provided as a supporting submission to this FBC.

10.29 Historical data for each of the Trusts has been taken from each Trust's audited financial statements. While 2023/24 figures are based on each Trust's operating plans there are some emerging pressures which have not yet materialised, these include potential reductions in block contracts and pay inflation pressures. 2024/25 figures are based on the year two projections submitted to the ICB in May 2023. These pressures are reflected in the sensitivities as part of the risks around higher inflation costs and reduction in CIP delivery.

IoW segmentation

10.30 The IoW financial segmentation has been undertaken through the following approach:

- Direct costs transfer in full to the new Trust, including vacant posts within the agreed establishment;
- Statutory costs relating to the continued operation of IoW do not transfer;
- Shared corporate staff have been provisionally segmented based on estimated share of business split, which will be refined based on TUPE and shared service arrangements; and
- Income has been allocated according to the split of income by service segment within the ICB contract. The Trust also received income from NHSE and the allocation will require review before the segmentation plan is finalised.

IoW structural deficit

10.31 The unique nature of delivering essential local NHS hospital services, 24/7, to a geographically isolated and sub-scale population of 143,000 island residents, without any boundary neighbours to provide mutual aid or support creates additional financial challenges referred to as the 'structural deficit'. The IoW structural deficit was independently verified in 2017/18 and 2019/20, each time confirming it represents 10% of the Trust's cost base. This was formally recognised by NHS Improvement, the regulatory body at that time.

10.32 The proportion of the structural deficit attributable to community, mental health and learning disabilities in 2019/20 was £1.7m, related to staff pay premium costs. The new Trust will continue to work with partners to understand these costs and to assess whether there is a resolution for solving them in the medium term. Currently they are assumed to continue as a structural deficit within the new Trust.

IoW corporate overheads and stranded costs

10.33 Bringing together CMHLD services into one organisation will contribute to future clinical and financial sustainability for Isle of Wight services. There is a risk however that the transfer of these services from IoW to the new Trust could result in a deterioration in IoW's run rate after 1 April 2024 due to the cost and income position of those services as compared to acute and ambulance services (which IoW will continue to provide into the future), as well as the risk of stranded costs associated with decisions about transfers of staff, assets and liabilities.

10.34 In the TUPE exercise, a proportion of staff were identified who spend a small proportion of their time on CMHLD related activities, but do not meet TUPE criteria. Partners are working to minimise the impact of stranded costs which might arise

consequently, which at worst case have been estimated at £4.5m. Options being considered include:

- IoW continues to offer a limited number of corporate functions under a 'provider-to-provider' service level agreement. This has the advantage of continuity, resilience, and local knowledge of service delivery, whilst also reducing the impact of any potential stranded costs;
- Partners agree a principle that 'income follows cost' for those posts that cannot be segmented, such as unavoidable statutory costs remaining with IoW (Board, statutory responsibilities related to running the Trust); and
- Remaining corporate functions are redesigned to meet the needs of the new Trust and the re-configured IoW. There is opportunity through both the creation of the new Trust and the group partnership between IoW and PHU to maximise efficiencies in operating costs to mitigate risk arising from these changes.

10.35 An IoW executive-led process has been established to review and make recommendations by the end of December 2023. The current assumptions around the current year deficit attributed to mental health and community services and the stranded costs estimate of £4.5m are the worst case scenario. Ongoing work is being led by the Island with support from all partners and seeks to understand, then appropriately minimise these risks.

10.36 The aim is to achieve the best outcome for the system overall and take decisions together on the impact on individual organisations. Partners are committed to ensuring the associated service transfer transaction releases efficiencies for the HIOW system and have an established working group (Partnerships Interdependencies Working Group) and Chief Finance Officer-led discussions have set agreed principles to underpin detailed agreement of income and expenditure transfers. This will be substantially concluded by the time of the service transfer and financial close.

Hampshire CAMHS disaggregation

10.37 Financial information for Hampshire CAMHS has been disaggregated from Trust level information as follows:

- **Direct costs** have been captured through the direct coding of Hampshire spend to Hampshire cost centres within the ledger;
- **IT costs** – the Hampshire usage of IT systems was identified and costs were allocated on this basis;
- **Estates** – the estates and any facilities costs linked to buildings that are geographically located in Hampshire and form the basis of the estates transfer; and

- **Overheads** have been calculated as a "contribution" after the above costs have been deducted from the total contract value**.**

Modelling assumptions

10.38 This section sets out the key assumptions input into the Financial Plan and the processes by which these have been tested and agreed with ICS stakeholders.

Figure 63: Assumptions

<table>
<tr><th>Area</th><th>Assumption and rationale</th></tr>
<tr><td>Inflation</td><td>The 2024/25 rates from the ICB guidance for the year two projections have been used as the basis for future years, due to the lack of national guidance on future years' pay and price inflation.
<table>
<tr><th>Inflator assumptions</th><th>2023/24</th><th>2024/25</th><th>2025/26</th><th>2026/27</th></tr>
<tr><td>Pay</td><td>2.1%</td><td>2.1%</td><td>2.1%</td><td>2.1%</td></tr>
<tr><td>Drugs</td><td>1.3%</td><td>0.5%</td><td>0.5%</td><td>0.5%</td></tr>
<tr><td>Capital</td><td>4.0%</td><td>1.3%</td><td>1.3%</td><td>1.3%</td></tr>
<tr><td>Other</td><td>5.5%</td><td>1.3%</td><td>1.3%</td><td>1.3%</td></tr>
<tr><td>Income</td><td>2.9%</td><td>1.8%</td><td>1.8%</td><td>1.8%</td></tr>
</table>
</td></tr>
<tr><td>Tariff income deflator</td><td>The tariff income deflator assumptions include the impact of convergence, which applies a reduction to income for physical health services in order to rebalance funding towards mental health services.
<table>
<tr><th>Deflator assumptions</th><th>2023/24</th><th>2024/25</th><th>2025/26</th><th>2026/27</th></tr>
<tr><td>Tariff income</td><td>1.1%</td><td>1.1%</td><td>1.1%</td><td>1.1%</td></tr>
<tr><td>Convergence
(physical health income only)</td><td>0.6%</td><td>1.1%</td><td>1.1%</td><td>-</td></tr>
</table>
</td></tr>
<tr><td>Demand growth</td><td>• The two year projections submitted to the ICB in May 2023 included nil growth and this assumption has been continued for the future years. There is no new funding for demand growth across the HIOW system due to the system deficit.</td></tr>
</table>

<table>
<tr><th>Area</th><th>Assumption and rationale</th></tr>
<tr><td>CIP</td><td>Solent and Southern

In the counterfactual financial model, CIP is assumed at the level of tariff efficiency (1.1% plus 1.1% convergence applied to physical health contracts) plus the additional requirement to achieve break-even for each Trust (summarised in the table below).
It is assumed that creation of the new Trust will enable an increase in recurrent CIP delivery to 67% of total (recurrent and non-recurrent) CIP delivery from 2026/27.

<table>
<tr><th rowspan="2">CIP delivery £000</th><th colspan="2">2023/24</th><th colspan="2">2024/25</th><th colspan="2">2025/26</th><th colspan="2">2026/27</th></tr>
<tr><th>Recurrent</th><th>Non-recurrent</th><th>Recurrent</th><th>Non-recurrent</th><th>Recurrent</th><th>Non-recurrent</th><th>Recurrent</th><th>Non-recurrent</th></tr>
<tr><td>Solent</td><td>15,866</td><td>7,987</td><td>10,482</td><td>6,164</td><td>6,793</td><td>2,911</td><td>4,262</td><td>1,827</td></tr>
<tr><td>Southern</td><td>18,933</td><td>6,367</td><td>9,494</td><td>4,069</td><td>7,914</td><td>3,392</td><td>6,221</td><td>2,666</td></tr>
<tr><td>IoW</td><td>5,052</td><td>-</td><td>988</td><td>2,049</td><td>1,469</td><td>1,792</td><td>736</td><td>1,057</td></tr>
<tr><td>New Trust</td><td>-</td><td>-</td><td>2,409</td><td>-</td><td>3,170</td><td>-</td><td>4,130</td><td>-</td></tr>
<tr><td>Total</td><td>39,851</td><td>14,354</td><td>23,373</td><td>12,282</td><td>19,345</td><td>8,095</td><td>15,349</td><td>5,550</td></tr>
</table>
</td></tr>
<tr><td>IoW structural deficit</td><td>The estimated proportion of the current structural deficit related to CMHLD services (£1.7m) is assumed to transfer to the new Trust.</td></tr>
<tr><td>IoW stranded costs</td><td>The projections do not include any stranded costs that arise in IoW following the transaction.</td></tr>
<tr><td>Capital</td><td>Existing sources of capital funding and capital expenditure will be retained in the new Trust. Any significant investments (e.g. arising from the options assessment for EPR systems) will be subject to business case which will set out the funding source.</td></tr>
</table>

Counterfactual forecast position

10.39 Financial templates have been populated for each Trust on a standalone basis (i.e. applying the assumptions above and assuming no organisational changes). For IoW and Sussex this only includes the transferring services and not the entire Trust.

Solent standalone position

10.40 Figure 64 below shows the standalone plan for Solent for the current and following three years. The plan assumes that the full year effect of current year investments are funded by commissioners and removes non-recurrent income and expenditure in 2023/24 from future years' plans.

10.41 The achievement of the planned £2.2m deficit position in the current year assumes delivery of an ambitious CIP and recovery plan. Future years assume CIP starting at 5.8% in 2024/25 reducing to 2.4% in 2026/27. 30% to 40% of the combined CIP and recovery programme is considered to be non-recurrent which is driving the continued underlying deficit, albeit on a reducing basis.

Figure 64: Solent's standalone counterfactual forecast

Solent Income and expenditure (£000)	2023/24	2024/25	2025/26	2026/27
Clinical income	238,338	239,266	239,415	241,373
Other income	17,698	17,788	18,030	18,277
Pay	(189,024)	(183,801)	(184,551)	(186,784)
Non-pay	(65,852)	(70,065)	(69,707)	(69,677)
Operating surplus	**1,160**	**3,188**	**3,187**	**3,189**
Finance costs	(3,187)	(3,188)	(3,187)	(3,189)
Net surplus/(deficit)	**(2,027)**	**-**	**-**	**-**
Adjustments	(204)	-	-	-
Adjusted surplus/(deficit)	**(2,231)**	**-**	**-**	**-**
Underlying deficit	**(10,482)**	**(6,164)**	**(3,141)**	**(1,895)**

Southern standalone position

10.42 Figure 65 below shows the standalone plan for Southern for the current and following three years. The plan assumes that the full year effect of current year investments are funded by commissioners and removes non-recurrent income and expenditure from future years' plans.

10.43 In order to achieve a breakeven position in the current year Southern has a significant CIP and recovery plan. Future years assume CIP at 3.0% in 2024/25 reducing to 1.9% in 2026/27. 30% of the combined CIP and recovery programme is considered to be non-recurrent which is driving the continued underlying deficit, albeit on a reducing basis.

Figure 65: Southern's standalone counterfactual forecast

Southern Income and expenditure (£000)	2023/24	2024/25	2025/26	2026/27
Clinical income	428,285	431,032	432,220	435,114
Other income	22,146	22,301	22,457	22,614
Pay	(343,014)	(344,300)	(346,001)	(349,010)
Non-pay	(99,932)	(101,547)	(101,190)	(101,233)
Operating surplus	**7,485**	**7,485**	**7,485**	**7,485**
Finance costs	(7,668)	(7,668)	(7,668)	(7,668)
Net deficit	**(183)**	**(183)**	**(183)**	**(183)**
Adjustments	183	183	183	183
Adjusted surplus/(deficit)	**-**	**-**	**-**	**-**
Underlying deficit	**(9,609)**	**(4,069)**	**(3,392)**	**(2,666)**

IoW transferring services standalone position

10.44 The financial figures for IoW in this FBC reflect the latest position based on detailed segmentation work undertaken to date but it is recognised work is ongoing to identify

TUPE obligations and finalise transfer values. Therefore, the figures included herein are not the final transfer values.

Figure 66: IoW's standalone counterfactual forecast for transferring services

IoW Income and expenditure (£000)	2023/24	2024/25	2025/26	2026/27
Clinical income	58,485	58,101	59,670	61,573
Other income	1,281	1,197	1,222	1,248
Pay	(50,073)	(46,972)	(47,327)	(47,740)
Non-pay	(14,902)	(15,425)	(15,265)	(16,781)
Operating deficit	**(5,208)**	**(3,099)**	**(1,700)**	**(1,700)**
Underlying deficit	**(5,739)**	**(4,637)**	**(3,493)**	**(2,757)**

Sussex Partnership transferring service standalone position

10.45 The table below shows a planned breakeven position for the four years to 2026/27. This includes the delivery of efficiency measures required to offset unfunded pay awards and inflation in the absence of any new funding. From 2024/25, the forecast includes additional income from Mental Health Investment Standard (MHIS) investment of £0.9m and an inflation uplift of £0.9m (1.8%), each of which are offset by the associated expenditure.

Figure 67: Sussex Partnership counterfactual forecast for transferring services

Sussex Partnership Income and expenditure (£000)	2023/24	2024/25	2025/26	2026/27
Clinical income	30,935	33,472	34,983	36,534
Other income	1,582	1,615	1,649	1,684
Pay	(24,910)	(27,118)	(28,284)	(29,475)
Non-pay	(7,597)	(7,959)	(8,338)	(8,733)
Operating surplus	**10**	**10**	**10**	**10**
Finance costs	(10)	(10)	(10)	(10)
Net surplus/(deficit)	**-**	**-**	**-**	**-**
Underlying surplus/(deficit)	**-**	**-**	**-**	**-**

Aggregate counterfactual position

10.46 The following figure shows the aggregate counterfactual forecast position of relevant services from the four Trusts. This presents an improving underlying performance that reflects significant efficiency requirements. The forecast in 2026/27 shows a deficit position of £1.7m and an underling deficit position of £7.3m.

Figure 68: Aggregate counterfactual forecast position

Aggregate standalone Income and expenditure (£000)	2023/24	2024/25	2025/26	2026/27
Clinical income	756,043	761,871	766,288	774,594
Other income	42,707	42,901	43,358	43,823
Pay	(607,021)	(602,191)	(606,163)	(613,009)
Non-pay	(188,283)	(194,996)	(194,500)	(196,424)
Operating surplus	**3,447**	**7,584**	**8,982**	**8,984**
Finance costs	(10,865)	(10,866)	(10,865)	(10,867)
Net deficit	**(7,418)**	**(3,282)**	**(1,883)**	**(1,883)**
Adjustments	(21)	183	183	183
Adjusted deficit	**(7,439)**	**(3,099)**	**(1,700)**	**(1,700)**
Underlying deficit	**(25,830)**	**(14,869)**	**(10,026)**	**(7,318)**

New Trust financial forecast

10.47 The proposed creation of the new Trust will bring together services from Solent and Southern, mental health, community and learning disabilities services from IoW and Hampshire CAMHS from Sussex Partnership into a single provider across HIOW. The creation of the new Trust will have a number of financial impacts, both costs and benefits.

10.48 Financial benefits and integration costs have been developed using a bottom-up approach as part of the integration planning process. Finance provided guidance and support to Steering Groups throughout this process to ensure a consistent and comprehensive approach to identifying and quantifying financial impacts.

Financial benefits

10.49 Each of the Trusts already have significant savings plans to deliver in both 2023/24 and 2024/25. In addition, the overall ICS is not in financial balance and is undertaking a system recovery plan as part of the oversight requirements of being in segment 4 of the NHS Oversight Framework. Existing plans for 2023/24 already assume a level of corporate reduction and productivity improvements as well as an estimate of the minimum savings that will be required in 2024/25. This context has been taken into account when identifying financial benefits to avoid any double-counting of cost reductions.

Corporate savings

10.50 A review of the corporate benchmarking for 2022/23 showed that when comparing to sector medians Southern was below the median for mental health Trusts (£6m per £100m versus £6.56m per £100m for national median) and Solent was above the median for community trusts (£9.99m per £100m versus £7.16m per £100m for the

national median). There are a number of factors to consider regarding corporate overheads:

- Taking account of the sector medians based on estimated share of business: based on this overheads would be £6.89m per £100m (55% community services, 45% mental health services). Based on total income of £801m this implies median corporate overheads of £55.2m.
- Taking account of the fact that Southern is currently below the national median for mental health services, this would reduce the overall overhead to £6.64m per £100m. For total income of £801m, this implies median corporate overheads of £53.2m.
- The current assessment of overheads across the four Trusts is a total of c£60m, although this could be understated for IoW in relation to future costs of their improved digital offer.

10.51 Understanding the potential achievable costs of corporate overheads between £60m and £53.2m will be a key area of work as the new Trust forms. Reduced corporate overheads of £2.2m by 2026/27 have been assumed (which includes £0.9m from the Sussex Partnership overheads) and there is a further £1m-£2m potential upside opportunity reflected in the sensitivity analysis. It is worth noting that £7.2m of the difference between median cost calculations relates to the relative difference between costs of digital between Southern and Solent. There are significant differences between the delivery models for digital including contracted in or out, the exclusive use of cloud technology and whether key equipment is effectively paid for through revenue or capital. It is currently assumed within the FBC that not all the Sussex Partnership overheads would need to be reinvested but it is assumed the IoW overhead will be. All the Steering Groups covering corporate services have been asked to consider the benchmarking quality and financial aspects in designing their corporate structures.

10.52 Further potential savings linked to key leadership posts that will be duplicated within the corporate structure of the new Trust have not yet been assessed. As the organisational structure is implemented for the new Trust and the clinical strategy is launched, corporate structures will be established to support services and clinical teams. In some areas, implementing these structures will release further savings over time, with additional potential savings anticipated to be in the region of £1m-£2m. Potential savings from key leadership posts and corporate structures have not been included in the financial projections of this FBC. These areas may include:

- Existing separate divisional structures within the legacy organisations that are unlikely to be replicated;
- Where multiple teams exist in footprints whose role is duplicative then the leadership posts could be redeployed;

- Considering current services that do not operate at scale and how the new Trust should respond to this without losing the strength of services at locality level;
- Multiple help desks or single points of access which can be appropriately reduced; and
- Multiple on call arrangements which are not resilient but operate across HIOW.

Clinical transformation

10.53 Clinical transformation will be a key part of delivery of the new Trust's strategy and this is reflected in the integration principles agreed by the Programme Board which recognise that the new Trust will need to transform services to ensure they are clinically and operationally sustainable and deliver equitable outcomes informed by population need. However, the financial model does not assume savings from clinical transformation. The potential financial benefits have not yet been quantified and this will be a focus for the new Trust. As described in paragraph 10.61 below, savings from clinical transformation will be reinvested in services.

Figure 69: Financial benefits of the transaction

Financial benefits (£000)	2024/25	2025/26	2026/27
Corporate services and organisational overheads	2,409	3,170	3,780
Agency premium savings	-	-	350
Total recurrent benefits	**2,409**	**3,170**	**4,130**

Indirect financial benefits to system partners

10.54 The creation of the new Trust will create a range of indirect financial benefits to system partners, as it begins to act and plan as a single entity.

10.55 Through the harmonisation of eligibility criteria and processes to access services, system partners will experience improvements within their operational processes, helping to free up resources. A reduction in delayed transfers of care from acute settings will result from the improved consistency across services provided by the new Trust, improving patient flow and reducing expenditure on surge capacity. For example, the PBC identifies specific opportunities for OPMH services (described in chapter 5 of the PBC), where there is wide variation in access to discharge support across the region that significantly affects length of stay.

10.56 Reducing the number of organisations in the system will reduce the administrative burden for commissioners and other system partners associated with contracting and partnering. Decision making and implementing initiatives will become faster, reducing variability in adaptation and creating an environment that is able to be more agile to the shifting economic environment.

Transaction and integration costs

10.57 The recurrent and non-recurrent costs identified through detailed integration plans by the Steering Groups have been included into the financial case and comprise:

Recurrent integration costs:

- Pay **alignment, pay drift and pay protection** recognising that there are likely to be some additional costs from these elements as different teams and services are integrated.

Non-recurrent integration costs:

- **implementation of the clinical strategy**; and
- **other integration costs**, including the integration of systems, data migration, digital mobilisation, harmonisation of reporting processes and functions, new organisational development, TUPE transfers, legal services, branding including signage and uniforms, communications, mobilisation of facilities management services being transferred from IoW and outsourcing to create a single finance ledger.

Capital costs:

- The **transfer of Hampshire CAMHS to the Rio EPR**. This is estimated at £1.4m, comprising of £780k for creating the network infrastructure, supplying and building laptop devices, supplying and configuring mobile and Cisco phones, licences and support. A further £656k is required for creating the Rio environment along with licences, training and creating a reporting function. This capital cost will be incurred in 2023/24, and **£1.3m has been secured from national EPR funding** to implement the transfer, with the remaining £0.1m to be funded from existing Trust budgets.

10.58 Transaction costs incurred in 2023/24 have been absorbed into existing budgets.

10.59 The current forecast outturns for 2023/24 for existing Trusts assume that in-year pressures can be managed within this position. There is a risk that the Board appointments will lead to redundancies which are not yet known or quantified, but would be in advance of the end of the year. These costs will need to be provided in the 2023/24 accounts and will therefore be another financial risk that is being managed by existing Trusts in the current year.

Figure 70: Integration costs

Integration costs (£000)	2024/25	2025/26	2026/27
Pay alignment, pay drift and pay protection	(250)	(500)	(500)
Recurrent integration costs	**(250)**	**(500)**	**(500)**
Implementation of the new clinical strategy	(300)	(300)	(150)
Revenue integration costs	(2,928)	(702)	(347)
Non-recurrent integration costs	**(3,228)**	**(1,002)**	**(497)**
Total integration costs	**(3,478)**	**(1,502)**	**(997)**

Summary of the impact of creating the new Trust

10.60 The transaction has a positive recurrent impact on the income and expenditure from 2025/26, following a net cost of £1.1m projected for 2024/25 as a result of the integration. The net benefit of the transaction will be re-invested in clinical services, as described in the following section. By 2026/27 the underlying deficit is expected to improve from £7.3m in the standalone organisations to £3.7m in the new Trust.

Figure 71: Forecast financial impact of the transaction

	In year		
New Trust costs and benefits (£000)	**2024/25**	**2025/26**	**2026/27**
Financial benefits	2,409	3,170	4,130
Integration costs	(3,478)	(1,502)	(997)
Re-investment in clinical services	-	(1,668)	(3,133)
Net impact of creating the new Trust	**(1,069)**	**-**	**-**

Re-investment of net savings into clinical services

10.61 The new Trust intends to reinvest any net savings into clinical services, providing benefits to patients and staff. Areas that could be considered include:

- Investment in public health and population health expertise to support decision making, investment prioritisation and system influence;
- Address the inconsistency in mental health investment levels between places. For example there is a £79 per head difference between the top and bottom investment levels for places within the population of around 800,000 in HIOW (£149 per head and £228 per head respectively);
- Provision of additional bed capacity if required. The HIOW system has a relatively low number of acute mental health beds which operate across multiple sites. Additional bed capacity may be required to ensure patients are supported appropriately and do not face delays in accessing beds; and

- Improve access for young people accessing CAMHS – the NHS LTP, published in 2019, described a goal that 100% of children and young people who need specialist care can access it "over the coming decade". The new Trust would seek to reinvest net savings to accelerate delivery of this from the current timeline of 2029.

New Trust financial forecast

10.62 The financial forecast for the new Trust is shown in figure 72 below. This represents the projected counterfactual standalone financial plans, combined with the integration costs and expected savings from the transaction to produce the new Trust financial plan.

10.63 The new Trust projects a £1.7m deficit in 2026/27 reflecting the transferring segment of the IoW's share of the structural deficit.

Figure 72: Forecast financial performance for the new Trust

New Trust Income and expenditure (£000)	2024/25	2025/26	2026/27
Clinical income	761,871	766,288	774,594
Other income	39,414	39,798	40,188
Pay	(601,642)	(605,781)	(612,619)
Non-pay	(193,128)	(191,322)	(193,180)
Operating surplus	**6,514**	**8,982**	**8,983**
Finance costs	(10,866)	(10,865)	(10,867)
Net deficit	**(4,352)**	**(1,883)**	**(1,884)**
Adjustments	183	183	183
Adjusted surplus/(deficit)	**(4,169)**	**(1,700)**	**(1,701)**
Underlying surplus/(deficit)	**(12,710)**	**(7,356)**	**(3,688)**

10.64 As part of developing the 2024/25 operating plan, the Trusts will develop the capital plan for the new Trust. Capital allocations to existing organisations for 2024/25 have already been confirmed with a total of £14.4m for Southern and Solent. HIOW ICB has estimated a capital allocation of £0.4m will transfer from IoW for CMHLD services for 2024/25. This will be confirmed once final capital allocations and existing asset transfers are known.

10.65 The emerging digital strategy requires decisions to make made around key digital systems and infrastructure as described in chapter 8, which require detailed options assessments. The potential costs of some options vary significantly and this will be taken into account when assessing the options, along with potential funding routes. The projections for the new Trust reflect a level of capital spending in line with the standalone Trusts and the new Trust will evaluate any significant further capital investment based on separate business cases. As noted in paragraph 10.57 above,

national funding has been secured for the transfer of Hampshire CAMHS to the Rio EPR.

Scenario analyses and sensitivities

10.66 There are a number of risks associated with financial forecasts presented above. These include risks to the counterfactual position as well as risks relating to the creation of the new Trust. These risks are described and quantified in the figures below, along with potential upside opportunities.

Figure 73: Summary of financial risks and mitigations

Downside risk	Risk modelled	Potential mitigations: counterfactual	Potential mitigations: new Trust
Increased costs associated with growth – MH out of area beds Due to the system deficit position, no new growth funding has been assumed however some costs may be incurred as a result of responding to increased demand	An increase in the requirement of 20 out of area mental health beds has been assumed due to the lack of any in-house capacity. The risk is anticipated to be lower in the new Trust with the ability to flex across localities.	Working with system partners to manage increased demand, drive productivity improvements to increase activity within existing resources, extend waiting times.	Working with system partners to manage increased demand and establishing a joint Financial Recovery Working Group in September 2023, as part of the Fusion Finance Integration Plan. Economies of scale from larger teams to support the productivity improvements to increase activity within existing resources, reduce lengths of stay. Fund from the net financial benefits
Increased costs associated with growth – community services Due to the system deficit position, no new growth funding has been assumed however some costs may be incurred as a result of responding to increased demand	An increase of 50 FTE or virtual ward capacity of 70 beds. The risk is anticipated to be lower in the new Trust with the ability to flex across localities	Working with system partners to manage increased demand, drive productivity improvements to increase activity within existing resources, extend waiting times.	Working with system partners to manage increased demand and establishing a joint Financial Recovery Working Group in September 2023, as part of the Fusion Finance Integration Plan. Economies of scale from larger teams to support the productivity improvements to increase activity within existing resources, extend waiting times for elective activity and routine appointments, reduce lengths of stay. Fund from the net financial benefits
Reduction in BAU CIP delivery Significant CIPs are required to achieve break-even in the standalone organisations which is a stepped increase from past performance	Maximum savings of 3.2% as per the average combined rate of delivery over the last 3 years excluding the COVID-19 years. The risk is expected to be less for the new Trust with higher efficiency opportunities.	Early engagement with services to provide support with the identification and development of both Trust wide and local workstreams.	An early focus on bringing together the current CIPs, rolling out schemes at scale, sharing best practice and investing in resources to support services to maintain the momentum of delivery

Downside risk	Risk modelled	Potential mitigations: counterfactual	Potential mitigations: new Trust
Slippage of BAU CIP delivery in year 1 The focus for the lead up to Day 1 and year 1 post integration will be bringing teams and service together which may be a distraction to CIP delivery	1% CIP delivery slippage in year 1 which is recovered in years 2 and 3.	Early engagement with services to provide support with the identification and development of both Trust wide and local workstreams. Use of short-term non recurrent measures to offset the slippage	An early focus on bringing together the current CIPs, rolling out schemes at scale, sharing best practice and investing in resources to support services to maintain the momentum of delivery. Use of short-term non recurrent measures to offset the slippage
Agency premium savings not realised Benefits are reliant on making additional reductions to the existing ambitious agency reduction plans and they rely on improving substantive recruitment and retention which is difficult to predict.	50% of the agency premium savings	N/A	Early engagement with the workforce, both substantive and temporary, about the new Trust's aspirations of being the employer of choice and the creation of a compelling offer that recognises and values the contribution all staff make in providing services to patients
Higher inflation costs Inflation is projected to remain high in 2024/25 and it is unlikely that this will be fully funded	An additional 0.5% inflation on operating costs	Strong negotiation of contracts to cap non-pay inflation, generation of new CIPs and / or securing new income	Strong negotiation of contracts to cap non pay inflation, generation of new CIPs and / or securing new income
Higher integration costs Additional integration costs from future business decisions mainly linked to the digital priorities such as the requirement of a single EPR and the harmonisation of other systems and processes.	20% increase on the years 2 and 3 integration costs	N/A	Stretch and / or accelerate CIP delivery and less re-investment in clinical services

Figure 74: Summary of potential upside opportunities

Upside opportunity	Opportunity modelled
Leadership posts As the organisational structure is implemented for the new Trust and the clinical strategy is launched, corporate structures will be established to support services and clinical teams. Further potential savings linked to key leadership posts that will be duplicated within the corporate structure of the new Trust have not yet been assessed.	Potential savings are anticipated to be in the region of £1m-£2m.

Figure 75: Summary of downside risks

	Counterfactual			New Trust			Net Impact of new Trust		
Estimated impact of downside risks – cumulative (£m)	**2024/25**	**2025/26**	**2026/27**	**2024/25**	**2025/26**	**2026/27**	**2024/25**	**2025/26**	**2026/27**
Increased costs associated with growth – MH inpatients	(5.0)	(10.0)	(15.0)	(4.0)	(8.0)	(12.0)	1.0	2.0	3.0
Increased costs associated with growth – community services	(3.0)	(6.0)	(9.0)	(2.0)	(4.0)	(6.0)	1.0	2.0	3.0
Reduction in business as usual CIP delivery	(5.8)	(5.8)	(5.8)	-	-	-	5.8	5.8	5.8
Slippage of business as usual CIP delivery in year 1	-	-	-	(8.0)	(4.0)	-	(8.0)	(4.0)	-
Agency premium savings not realised	-	-	-	-	-	(0.2)	-	-	(0.2)
Higher inflation costs	(4.0)	(8.0)	(12.0)	(4.0)	(8.0)	(12.0)	-	-	-
Higher integration costs	-	-	-	-	(0.3)	(0.5)	-	(0.3)	(0.5)

Note: downside risks are presented on a cumulative basis, with each year including the recurrent impact of previous years as well as the in-year impact.

10.67 The summary of downside risks shows that:

- The creation of the new Trust should reduce the impact of the risk of increased costs associated with growth by implementing services that are more adaptable to the differing needs of the places in the system. The new Trust should provide further opportunities to support the delivery of BAU CIP that is already included in the plans of existing Trusts. As a larger organisation, the new Trust will have a view of performance across HIOW, collating datasets to allow benchmarking between different geographies both within and beyond the ICS and inform transformation of corporate and clinical services;
- This reduces the impact of the risk of under-delivery of CIP;
- Slippage of 1% of BAU CIP delivery in year 1 would create a deficit of £8.0m in that year, which the new Trust would plan to recover in the following two years;
- Non-delivery of agency premium savings would create a deficit of £0.2m in 2026/27;
- The impact of unfunded inflation pressures would not be significantly different under the new Trust compared to the counterfactual; and
- Higher than expected integration costs could create additional costs of £0.3m and £0.2m in years 2 and 3 respectively.

Figure 76: Summary of upside opportunities

	Counterfactual			New Trust			Net Impact of new Trust		
Estimated impact of upside opportunities – cumulative (£m)	**2024/25**	**2025/26**	**2026/27**	**2024/25**	**2025/26**	**2026/27**	**2024/25**	**2025/26**	**2026/27**
Key leadership posts £1m - £2m	-	-	-	1.5	1.5	1.5	1.5	1.5	1.5

11 Transaction execution

Chapter summary

- This chapter describes the plan to deliver the transactions to create the new Trust. Further details are set out in the PTIP, which also describes the plan for integrating the organisations and transferring services.
- A timeline has been developed, showing the key activities and milestones required to create the new Trust on 1 April 2024. This includes Trust Board approvals, regulatory review and approval by NHSE, TUPE consultation and ongoing communications and engagement activities. Creation of the new Trust on 1 April 2024 does not include any service changes requiring formal public consultation.
- In developing the programme for creation of the new Trust, the Trusts have considered and reflected lessons learned from previous transactions in the NHS.
- Robust programme governance arrangements were put in place to develop this FBC, including a Programme Board, Programme Team and Steering Groups. The Segmentation and Service Transfer Executive Advisory Group (SSTEAG) was established to advise the IoW Board and Fusion Programme Board on the approach to segmentation and the transfer of community and mental health services from IoW. These programme governance arrangements will remain in place following the creation of the new Trust to oversee the integration process.
- The transaction programme has been led by an independent Programme Director, supported by a Programme Manager. Steering Groups have been resourced in-house wherever possible, with roles back-filled to release existing staff to support due diligence and integration planning. The three Trusts procured expert legal advice and specialist consultancy support to prepare the FBC, PTIP and PBC.
- Robust risk assessment and management processes have been put in place, including a comprehensive due diligence process. Risks have been identified from a range of sources including the due diligence process, Steering Groups and external sources. Risks are monitored through the programme governance structure.
- The process for determining the name for the new Trust involved extensive engagement with stakeholders including staff, system partners and communities. Based on this engagement and following NHS guidance, options for potential names were agreed at Programme Board and shared with NHSE. The geographical descriptor was agreed as "Hampshire and Isle of Wight" and a poll was conducted to assess options for the additional descriptor required to differentiate the new Trust from other providers in the system. The resulting proposed name of the new Trust is **Hampshire and Isle of Wight Healthcare NHS Foundation Trust**.
- The new Trust will be created through two legal transactions to bring services together into Southern, as the existing NHS Foundation Trust:
    - a merger of Solent and Southern, executed as an acquisition of Solent by Southern under section 56 of the NHS Act 2006; and
    - a statutory transfer under section 69A of the NHS Act 2006 of the Isle of Wight community, mental health and learning disabilities services from IoW to this enlarged organisation.

- The transfer of Hampshire CAMHS from Sussex Partnership to Southern is planned for 1 February 2024.
- For staff transferring from IoW to Southern, the TUPE consultation commenced on 30 October 2024 for a period of seven weeks, concluding on 17 December 2023. Solent is expected to commence its TUPE consultation following Board approval of the FBC.
- The new Trust will undertake post transaction evaluations to learn from successes and challenges of the integration as it progresses. These will be conducted one month after Day 1 and annually thereafter for three years.

11.1 This chapter sets out the plan to deliver the transaction on 1 April 2024. Further detail of the plans to integrate the transferring services and functions from the four Trusts is provided in the **Post Transaction Integration Plan (PTIP)**, which is a comprehensive overall plan that sets out the required actions to complete the transaction, integrate the organisations and transform services.

11.2 The PTIP has been developed through a bottom-up process based on detailed planning activities undertaken by the programme's Steering Groups. The detailed planning activities have been framed by the emerging clinical strategy which was outlined in the Strategic Case and is set out in chapter 5 and the following overarching integration principles:

- Integration plans will seek to address the challenges identified in the case for change in the Strategic Case and deliver improved outcomes for patients and carers.
- The Trusts will aim for all staff to feel part of a single organisation with a single vision from Day 1.
- The focus for Day 1 will be for the new Trust to be safe and legal and for there to be no adverse impact on operations.
- In developing plans for the services and functions of the new Trust, the scale and geographical spread of the new Trust must be considered, including provision of services to an island population.
- The new Trust will retain expertise and leadership talent and there will not be any compulsory redundancies arising from the creation of the new Trust.
- There will be opportunities to streamline corporate services (for example through vacancy management and natural turnover) to deliver value for money.
- The Trusts recognise that services will need to be transformed to ensure they are clinically and operationally sustainable and deliver equitable outcomes informed by population need.

11.3 Steering Groups were provided with a planning workbook that established a standardised framework to ensure that a consistent and comprehensive approach was taken to planning integration activities. The programme's Integration Planning

Group (IPG) undertook a cycle of “deep dives” into each of the Steering Groups’ integration plans in July and August 2023 in order to obtain more granular assurance over the development of detailed integration plans.

Transaction timeline

11.4 Assuming that the required support and approvals from the Trust Boards, Council of Governors, key ICS stakeholders, and NHSE are secured, Day 1 of the new Trust will be 1 April 2024.

11.5 A timetable has been developed for creation of the new Trust at pace without diverting senior management from supporting delivery of high quality and safe care for patients.

Figure 77: Transaction timeline as at November 2023

Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24

13/11: Approval by Trust Boards of FBC, PBC, PTIP & Board certification for submission to NHSE

Trust Boards approve management letter of representation

Trust Boards approve transactions

Go live 1 April 2024

NHSE FBC review
(Financial and quality governance reviews commenced Oct 2023)

Statutory approval process

NHSE SPI meeting to agree FBC risk rating

Southern CoG approve application to NHSE and Constitution

Integration planning and delivery
(Note: delivery will continue beyond 1 April 2024)

Appointment of designate executives

Formal TUPE consultation and transaction work
(IoW formal consultation currently planned for 31 October – 17 December 2023, Solent to consultation to commence following FBC approval and duration TBC)

Confirmation of staff transfer list

Approval of Heads of Terms

Launch of clinical strategy

Communications and engagement

Notes:

1. ‘Trust Boards’ refers to the three Trusts (Solent, Southern and IoW)
2. Timing for transfer of Hampshire CAMHS (excluding NE Hampshire which will transfer to Surrey and Borders NHS Foundation Trust) from Sussex Partnership to Southern expected to take place on 1 February 2024
3. A detailed programme plan is maintained by the Programme Team

Lessons learned from previous transactions

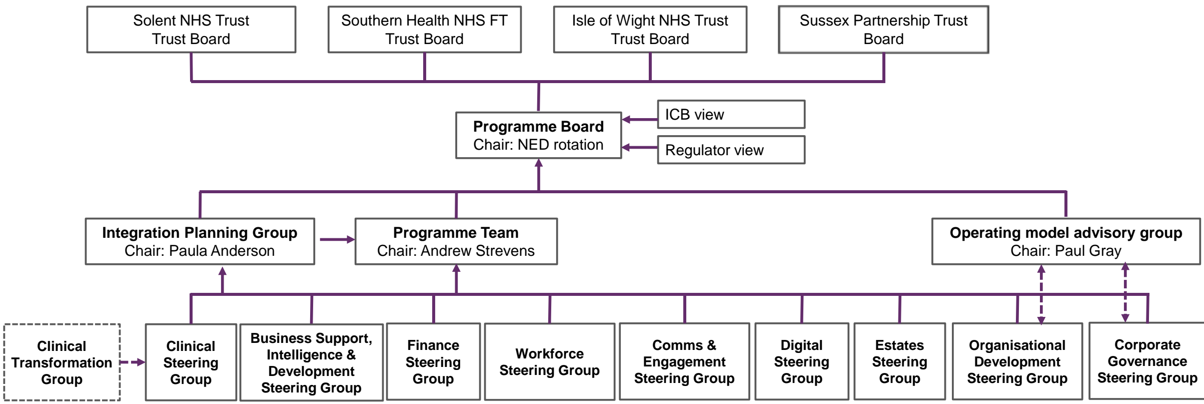
11.6 In February 2023 the Programme Board considered a paper setting out the key themes from NHS transactions over the last five to ten years and recommendations for Project Fusion. In August 2023 this paper was updated to demonstrate how the lessons learned have been incorporated in the plans for the new Trust, including in this FBC and the PTIP. The paper approved by the Programme Board is included in appendix 9.

11.7 The Northern Care Alliance was formed through a complex transaction that included the segmentation of an organisation, and learning from their experience has been incorporated into the IoW segmentation planning and process.

Transaction governance

11.8 The figure below sets out the governance structure for the programme which will remain in place until approval of the FBC, PTIP and PBC by the Trust Boards.

Figure 78: Programme governance structure



11.9 The roles and responsibilities of the key groups of the programme are:

- **Council of Governors** of the Trusts have been kept informed of progress on the proposed creation of the new Trust at their individual meetings since April 2022. All governors were invited to observe the confidential Board meetings, as well as meetings held in public, where there have been regular updates on Fusion. Bespoke development sessions were held for governors on their role in relation to the transactions, which included inviting NHSE to attend and advise the CoG on its role. A framework of assurance for governors in relation to discharge of statutory duties was developed in workshop and governors have been kept up to date on this as work progresses. Governors were invited to observe at Board Committee meetings, including those where the due diligence reports and FBC content were reviewed.

- Governors have been involved in the transaction by delivering their statutory duties, including the appointment of designate Chair; designate NEDs and approval of the appointment of the designate Chief Executive. The governors also led the Constitution Review Group, including three meetings to engage on and agree the composition of the CoG for the new Trust, as described in the new constitution.

- **Trust Boards** have been provided with periodic progress updates since autumn 2022. These updates have covered programme status, risks and timeline including major milestones.

- **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 NED from each of the Trusts and the Programme Director. The Chief Strategy and Transformation of Officer of the ICB is in attendance.

- 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 Trust Boards, the ICB and NHSE.

- **Programme Team:** meets on a fortnightly basis and is chaired by the Chief Executive Officer of Solent. The membership of the Programme Team comprises the Chair, 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.

- **Integration Planning Group (IPG):** meets on at least a fortnightly basis and is chaired by the Deputy Chief Executive and Finance Director of Southern. Membership comprises the Chair, nominated representatives from each of the Steering Groups, the Programme Director and Programme Manager.

- The IPG provides assurance around the integration plans and activities required to deliver the new Trust on 1 April 2024. The IPG reports progress and escalate issues to the Programme Team.

- **Operating Model Advisory Group (OMAG):** meets as required to fulfil its advisory role, typically on a monthly basis, and has an independent chair. Membership comprises the Executive Director members of the Fusion Programme Board from Solent, Southern and IoW, the Southern Chief People Officer and the Programme Director.

- OMAG leads the process to develop the operating model for the new Trust on behalf of the Programme Board. OMAG fulfils an advisory role, making recommendations about the future operating model to the Programme Board and to the leadership team of the new Trust (once appointed). OMAG works closely with the Clinical Steering Group (of which two members are also members of the OMAG) to ensure that the recommended new operating model supports the delivery of the emerging clinical strategy.
- **Steering Groups:** nine Steering Groups report into the Programme Team, as set out in figure 78. Each Steering Group has an executive sponsor and an agreed scope setting out the deliverables and milestones. Each Steering Group meets regularly (at least monthly).
- Each Steering Group has determined the governance and supporting resources needed for the scope of work. In some cases, Steering Groups have established sub-groups to oversee progress on the development of integration plans at a more granular level.

11.10 In addition, IoW has established a Segmentation and Service Transfer Executive Advisory Group (SSTEAG) to inform executive advice to the IoW Trust Board and Fusion Programme Board on the preferred approach to segmentation and transfer of community, mental health and learning disabilities services to the new organisation for the benefit of the Isle of Wight population.

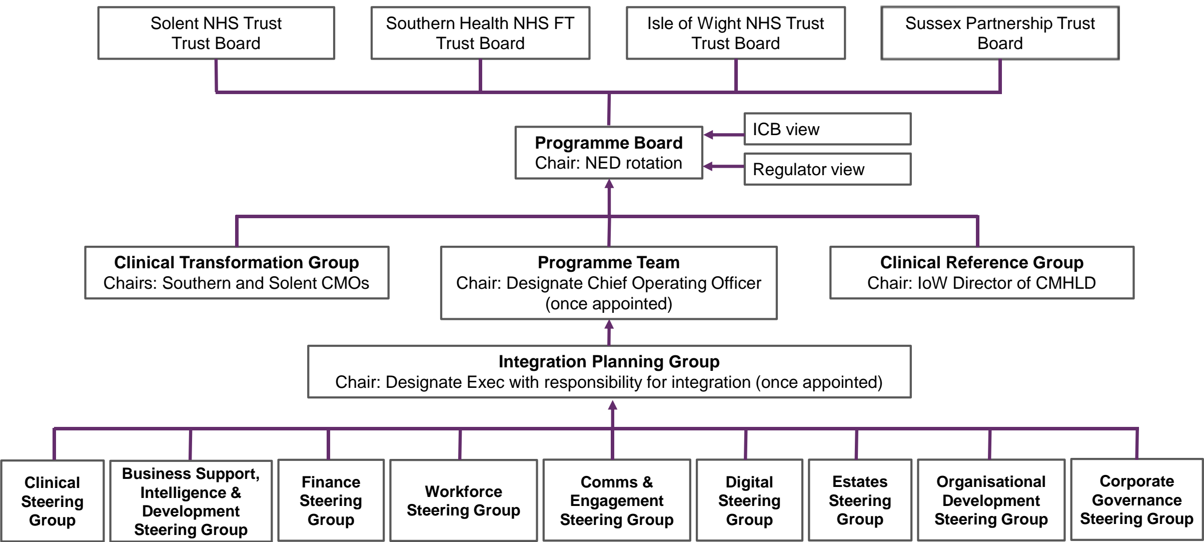
11.11 Following approval of the FBC for submission to NHSE, the programme governance arrangements will be updated to reflect the progress that has been made towards delivery of the Day 1 integration plans. In particular:

- **Designate Board:** The designate Board will hold development sessions/ workshops to develop the following aspects of the new Trust: strategic objectives, financial plan, Board development programme, evolving quality management system approach and Board and Committee governance (including terms of reference for committees and membership);
- **Programme Board:** the Clinical Transformation Group and a newly established Clinical Reference Group will report to Programme Board. In addition to nominated NED representatives, NEDs who will be NEDs in the new Trust on 1 April 2024 will be invited to attend the Programme Board in order to help build their knowledge of the new Trust;
- **Programme Team:** The Programme Team's chair will be the designate Chief Operating Officer once appointed. Membership of the Programme Team will comprise the chairs of the programme's Steering Groups;
- **IPG:** the chair of the IPG will be the designate executive with responsibility for integration, once appointed. A representative from the Clinical Transformation Group will sit on the IPG. The IPG will meet on a weekly basis from January

2024, with the Steering Group highlight reporting refreshed to reflect the increasing focus on delivery of integration plans;

- **OMAG** will be stood down by the end of October 2023, with responsibility for operationalising the agreed operating model to sit with the Programme Team; and
- **Steering Group** chairs will transition to the designate executives with responsibility for the services within scope of each Steering Group. Membership of the Steering Groups is otherwise expected to remain the same.

Figure 79: Programme governance structure from November 2023



11.12 The three Trusts have agreed to think as a single organisation wherever possible in the period leading up to Day 1. The Trusts have established a fortnightly Chairs and CEOs forum and are also undertaking further work with the Good Governance Institute to refine the governance arrangements in the following months and beyond.

Resources and programme management

11.13 The programme is being led by an independent 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 leads on the drafting of the FBC, PTIP and PBC, 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.

11.14 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.

11.15 The Trusts have used a workstream approach (with each workstream led by a Steering Group) to develop the PTIP. The Trusts have used in-house resources as far as possible, to maintain ownership, retain skills, and keep costs down. Each Steering Group identified the resources it needs to prepare its integration plans, which primarily comprises back-fill to release existing staff to support due diligence and integration planning, including:

- More than 20 FTEs in Solent and Southern to support the programme across the Steering Groups; and
- 17.5 FTEs in IoW to support its strategic change programmes.

11.16 The three Trusts have additionally procured expert legal advice and specialist consultancy support to help prepare the FBC, PTIP and PBC.

Risk assessment and management

11.17 The Trusts' risk management strategies set out the key responsibilities for managing risk within the organisations, including the ways in which risks are identified, evaluated and mitigated. BAU risks arising from the Trusts' ongoing activities are captured on the Trusts' individual risk registers.

11.18 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. A risk assessment matrix is used to ensure a consistent approach is taken to assessing and responding to identified risks.

11.19 Risks have been categorised as either transaction risks (risks to creation of the new Trust on 1 April 2024), integration risks (risks arising from bringing the Trusts and services together) or BAU risks (relevant risks arising from the Trusts' ongoing activities which may impact on the programme).

11.20 As set out in the risk management section below, Steering Groups report key risks to the Programme Team and the most significant risks are reviewed at the monthly Programme Board meetings.

Risk identification

11.21 Risk have been identified from a number of sources including:

- Due diligence reports which were prepared between May and July 2023 and reviewed by Trust Boards in September 2023;
- Individual Steering Groups;
- External sources, such as in relation to policy changes; and
- The development of the Strategic Case and FBC.

11.22 The Steering Groups identify risks to the delivery of integration plans. These are captured in a programme-wide risk register by the programme manager, and are escalated on the basis of the scoring assigned and mitigating action required.

Risk categorisation

11.23 Transaction risks are those which may impact on the creation of the new Trust on 1 April 2024. If transaction risks are not effectively mitigated then the proposed creation of the new Trust may be delayed or cancelled – or potentially significant issues may require retrospective remedy after the Day 1. **Transaction risks** include:

- Legal risks, such as maintaining compliance with statutory guidance and transaction requirements;
- Financial risks, such as in relation to the costs and benefits of the programme and the valuation of contingent liabilities; and
- Cultural and Human Resources risks, such as the resources required for the programme and increased vacancy rates.

11.24 **Integration risks** are those which may impact on the delivery of the PTIP. If integration risks are not effectively mitigated then the benefits of creating the new Trust may not be achieved. Integration risks include:

- Operational, including patient safety, risks such as in relation to harmonising policies and procedures;
- Financial risks, such as in relation to the robustness of benefit calculations and the forecast costs of integrated services;
- Cultural and Human Resources risks, such as in relation to aligning different ways of working and managing vacancy rates; and
- IT and Technology risks, such as in relation to running multiple reporting systems.

11.25 **BAU risks** are those arising from the Trusts' ongoing activities which may impact on the programme. BAU risks are included in the programme risk register for information but are not owned or managed by the programme.

Risk management and mitigation

11.26 The programme risk register includes the following information:

- Source of the risk
- Risk category
- Risk subject and description, including the including the potential unmitigated outcome

- Impact description and score (in accordance with the matrices above)
- Probability description and score (in accordance with the matrices above)
- Residual risk score (in accordance with the matrices above)
- Trend (in risk score)
- Description of controls in place and planned mitigating actions
- Date identified and last reviewed

11.27 Steering Groups consider their own risk registers and escalate risks if they are scored (in accordance with the matrices above) as follows:

- Above 8 (medium-high), to the Programme Team; and
- Above 10 (high) to the Programme Board.

11.28 Board oversight of risks is carried out through:

- The NED chair and members of the Programme Board;
- The periodic progress updates submitted by the Programme Director
- The Trusts Boards' reviews of the Strategic Case, FBC and PTIP, which contain highlighted key risks and include the full risk registers as appendices.

11.29 The IPG provides a forum to discuss and resolve any risk management issues arising from interdependencies between Steering Groups.

Key programme risks

11.30 Programme risks with a post-mitigation score of 12 or higher as at 30 October 2023 (excluding BAU risks) are summarised in the figure below. This figure shows the revised presentation of risks that has been adopted from November 2023 and categorises risks by theme.

Figure 80: Programme risks scoring 12 or higher (transaction and integration risks only)

	ID	Risk	Impact	Probability	Score (mitigated)
Transaction	R02	IoW does not have resource to support the programme alongside demands from ither strategic programmes.	3	4	12
	R29	If there is insufficient time, capacity or capability to undertake thorough integration planning there is a risk that critical path activities are not completed and the planned Day 1 is not achieved.	4	3	12
	R07	Risk that identified benefits do not outweigh risks and costs and FBC does not contain sufficient detail to assure Boards (for example in respect of patient benefits) and the FBC is not approved by Trust Boards	5	3	15
People	R01	Reduced staff morale leads to loss of staff during the period of transition, impacting productivity and potentially destabilising services leading to incidents and reputational damage.	4	4	16
	R95	Potential disparity in remuneration approaches for staff across the different Trusts could result in inequities that could negatively impact on staff morale if not dealt with in a timely and agreed way.	4	4	16
	R91	Risk that a temporary staffing model is not put in place and operational teams cannot access temporary staffing from Day 1.	4	3	12
	R88	If the creation of the new Trust's culture, behaviours and values does not address concerns raised and is not co-designed and embedded with staff and supported by managers, there is a risk that acceptance of the transition will be poor, we will not create the positive conditions for a healthy culture and staff turnover rates will increase.	4	4	16
	R89	Risk that compliance with statutory and mandatory training reduces.	4	3	12
Quality, safety & performance	R05	Risk that ICS financial position puts pressure on programme budget, resulting in sub-standard delivery or delay, ultimately leading to benefits not being realised.	4	4	16
	R04	Risk that 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
	R55	Risk that staff are not aware of or trained in the policies in place on Day 1, potentially leading to adverse outcomes.	4	3	12
	R97	Risk that quality governance, quality assurance and quality improvement arrangements may be ineffective if the new organisational structure, governance arrangements, design and clinical service models do not take account of the size and scale of the new Trust, resulting in adverse impact on board oversight and assurance, patient safety and risk management, as well as compliance and regulatory requirements.	4	3	12
	R98	Potential risk of harm to patients if the integration planning and wider full business case process misses any critical components or fails to recognise the significance or unintended consequences of any actions taken.	4	3	12
	R11	Risk that creating the new Trust leads to "levelling down" of services in some areas and/or loss of local focus and existing strengths resulting in loss of Board to ward connection and negative impact on patient experience and outcomes.	4	3	12
Governance	R51	Risk that uncertainty over organisational form and SLT including future executive structure and portfolios will delay efficiency improvements and team cohesion.	4	4	16
	R45	Risk that community services resource may be lost following the disaggregation of IoW, due to the acute integration with PHU.	4	3	12
	R99	Risk that if safeguarding processes, supervision models, learning from incidents, governance and systems are not aligned effectively to the structure of the new Trust and preserve the place-based requirements, there could be a negative impact on staff wellbeing, morale, recruitment and retention which could impact on safeguarding activities.	4	3	12
Infrastructure	R60	There is a risk that staff are not supported by resilient digital services and progress to new infrastructure solutions is not maintained.	4	3	12
	R94	Risk that if impact assessments and requirements for Day 1 access to digital systems are not completed and in place in time, clinical care and patient safety could be impacted as staff may not be able to access key systems and historical data or be able to document essential information.	4	3	12

Due diligence

11.31 The Trusts undertook a due diligence exercise to identify and evaluate the risks inherent in each Trust, identify mitigating actions, and support effective integration planning. The due diligence exercise covered all key lines of enquiry set out in NHSE's transaction guidance for trusts undertaking transactions, including mergers and acquisitions.

11.32 The due diligence was carried out by internal teams, with independent 'critical friend' support.

11.33 The due diligence was undertaken between May and July 2023, with final reports reviewed by Trust Boards in September 2023.

11.34 The risk assessment matrix is provided in appendix 10 and a list of all integration risks identified through due diligence scoring 8 or higher is provided in appendix 12.

Name of the new Trust

11.35 The process for determining the name for the new Trust involved extensive engagement with stakeholders including staff, system partners and communities. Based on this engagement and following NHS guidance, options for potential names were agreed at Programme Board and shared with NHSE. This resulted in agreement on 'Hampshire and Isle of Wight' as the geographical descriptor, with an additional descriptor required to differentiate the new Trust from other providers in the system. Programme Board agreed to test two options for this additional descriptor – 'Community Partnerships' and 'Healthcare' – with staff and community partners.

11.36 The Communications and Engagement Steering Group conducted a poll which was shared in numerous channels and forums, including:

- Staff networks;
- Staff internal Facebook groups in Solent and Southern, which were added to the overall poll:
    - The Solent poll had 360 votes to 70 in favour of 'Healthcare'
    - The Southern poll had 534 to 44 in favour of 'Healthcare'
- Staff bulletins;
- Governors;
- Southern Foundation Trust members;
- Community partner networks; and
- Service user networks.

11.37 The testing period lasted approximately one week, during which time 5,914 responses were received:

- 85% of responders preferred ‘Hampshire and Isle of Wight Healthcare NHS Foundation Trust’; and
- 15% of responders preferred ‘Hampshire and Isle of Wight Community Partnerships NHS Foundation Trust’

11.38 Ultimately the name of the new trust should be one which is most meaningful and appealing to staff, communities and people using services. Based on the engagement to date, the NHSE guidance, and the most recent poll, **Hampshire and Isle of Wight Healthcare NHS Foundation Trust** has been selected as the preferred option for the name of the new Trust.

Legal form of the transaction

11.39 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 the existing NHS Foundation Trust (Southern). The Trusts have obtained legal advice on the most appropriate mechanisms to achieve this and have decided 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
- a statutory transfer under section 69A of the NHS Act 2006 of the Isle of Wight community, mental health and learning disabilities services from IoW to this enlarged organisation.

11.40 The transfer of CAMHS from Sussex Partnership to Southern is planned for 1 February 2024, subject to commissioner decision. These services will also form part of the new Trust.

11.41 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 FBC).

11.42 The constitution of Southern will be updated to reflect the revised population served, service portfolio and shared future ambitions as described in paragraphs 6.24 to 6.28.

Formal consultations

11.43 The programme plan includes no service changes requiring formal public consultation as part of the creation of the new Trust.

TUPE process

11.44 Transfer of Undertakings (Protection of Employment) (TUPE) regulations protect individuals' rights as employees when they transfer to a new employer. The creation of the new Trust requires staff to transfer under TUPE from Solent and IoW to Southern at midnight on 31 March 2024. Prior to this, staff from the Hampshire CAMHS of Sussex Partnership will transfer into Southern (planned for 31 January 2024).

11.45 Prior to the TUPE transfer, the following must be completed:

- The list of staff that will transfer must be finalised 28 days before the transfer; and
- A TUPE consultation.

11.46 For staff transferring from IoW to Southern, the TUPE consultation commenced on 30 October 2024 for a period of seven weeks, concluding on 17 December 2023. This timeline is subject to the ongoing segmentation process for the IoW. Solent is expected to commence its TUPE consultation following Board approval of the FBC.

Public sector equality

11.47 As a public sector entity, Trust Boards must ensure that the proposed transaction is compliant with Public Sector Equality Duty, which requires organisations to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people.

11.48 The new Trust will be committed to building inclusion into all services and ways of working, as described in chapter 8. Plans developed prior to Day 1 will be subject to Trusts' existing equality impact assessments (EIA) and subsequent plans will be subject to the EIA process for the new Trust, which involves:

- Collating and analysing information to highlight the actual or potential impact on people and current levels of public satisfaction and/or confidence in the way the service is provided;
- Investigating the underlying causes of any adverse impact or inequality; and
- Making improvements in the way services are delivered with the aim of improving public satisfaction and/or confidence and removing or reducing adverse impact or unfairness.

Post transaction evaluation

11.49 The new Trust will undertake post transaction evaluations to assess the actual benefits realised compared to expected benefits during the implementation of the integration plans. These evaluations will be used to identify lessons learned and, where appropriate, inform updates to integration plans.

11.50 The new Trust will undertake evaluations:

- Approximately one month after Day 1 to identify any learning arising from the first month, including in relation to the process of creating the new Trust; and
- On an annual basis for three years to identify any learning arising from the continued implementation of the integration plans, including understand the sustainability of reported benefits.

11.51 Ongoing evaluations of the actual benefits realised compared to expected benefits will also take place in line with performance management processes set out in chapter 6.

12 Communication and stakeholder engagement

Chapter summary

- This chapter describes engagement with key stakeholders to date, as well as the planned approach for communications and engagement up to and following the creation of the new Trust. This plan includes a programme of engagement with people who use Trust services, their families and carers and with 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.
- The Communications and Engagement Steering Group has developed a strategy that aims to:
  - deliver coordinated communications and engagement activity;
  - support the delivery of timely and meaningful community and employee engagement programmes;
  - shape key messages and ensure these are communicated and understood by all audience; and
  - as far as possible, ensure that media reporting is factual and accurate.
- Communications and engagement activities are guided by the following principles: patient centred, clinically led, honest and transparent and two-way local engagement.
- The approach followed considers 'Communications and engagement' as a set of activities ranging from providing information to full participation and coproduction, with 'Community engagement' being a separate but complementary activity that involves engaging with local people to understand what matters most to them, to build relationships and to work as equal partners.
- The Shape Our New Trust engagement programme was developed in order to engage with patients, communities, staff and partners on key matters relating to the development of the new Trust. The engagement programme ran for six weeks in May and June 2023 and involved a series of surveys, meetings and events. Feedback from the programme was shared with the senior leaders from across all four Trusts at the end of June at a joint senior leaders event. Key themes have also been shared with staff through the monthly e-newsletter.
- Key themes arising from engagement to date are:
  - Concerns regarding the potential impact of the new Trust on accessibility of services, particularly regarding the Isle of Wight;
  - Ensuring equitable access to all services across the region along with clear information about how to access services;
  - The need to see the new Trust address inequalities between different groups so that diverse communities have equal access;
  - A desire to see improvements in identifying clear pathways for diagnosis, treatment and support of mental health for people of all ages and for those with dementia;
  - Services should work more effectively to address waiting lists;
  - Concerns about communities across the area having an equal voice in developing services and a desire to see services improved in line with the best available provision; and

- A desire to ensure that voluntary sector providers were recognised as an important and equal part of overall service provision.

- Feedback from engagements was provided to the Communications and Engagement Steering Group and where responses are required these are being actioned by the group or through local contact. Specific feedback relating to clinical priority workstreams is fed back to the Clinical Transformation Group.
- The frequency and reach of engagement with staff and external stakeholders, including people in local communities, will increase in the approach to Day 1.
- A communications and engagement strategy for the new Trust will be developed to deliver an enhanced programme of activity in the first year of the new Trust. The emerging strategy sets out the planned aims, approach, audiences and channels of communication.

Communication and engagement to date

12.1 A comprehensive communications and engagement plan has been developed to inform and support communications and engagement for the creation of the new Trust. The plan sets out the aims, principles, key messages, audiences and approach to communications and engagement. The strategy is delivered through a phased action plan.

Figure 81: The phased action plan to deliver the communications and engagement strategy

Phase 1

Development of strategic case – sharing case for change and developing plans for engagement in the development of the 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 the outcome and next steps

Phase 5

Mobilisation – preparation for the launch of the new Trust

Phase 6

Go live – launch the new organisation and describe next steps for ongoing communications and engagement, covering the first year of the new Trust

Strategic communications and engagement aims

12.2 The aims of the communications and engagement strategy are to:

- deliver coordinated communications and engagement activity;
- support the delivery of timely and meaningful community and employee engagement programmes, led by each Trust's 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.

Communications and engagement principles

12.3 Communications and engagement activities are guided by the following principles:

Figure 82: Communications and engagement principles

Principle	Description
Patient centred	A focus on the patient and their carers is front and centre of the approach. This is critical to the successful delivery of joined-up, high quality and equitable services. The approach focuses the narrative on the benefit to the people who use services and their carers and ensures meaningful opportunities to engage and coproduce plans.
Clinically led	Clinical leadership, and peer to peer engagement is central to the approach to communications and engagement. Clinical input is fundamental to articulating the positive impact of any changes on patients and service users and clinical leaders should be highly visible through communications and engagement activities.
Honest and transparent	Communication must be open, honest, and transparent. Where plans may impact staff or access to services, this should be made clear for all to understand. It has also been made clear which aspects of the proposals can be influenced and the corresponding areas where views were being sought.
Two-way local engagement	Engagement with stakeholders, staff and partners should be timely to allow adequate opportunity for queries and clarification. Planned changes are being coproduced, supported and endorsed by stakeholders, staff and communities, building upon existing relationships around place.

Approach to 'communications and engagement' and 'community engagement'

12.4 'Communications and engagement' and 'community engagement' are two different and complementary types of activity:

- **Communications and engagement** is a set of activities ranging from providing information to full participation and coproduction; and
- **Community engagement** is engaging with local people to understand what matters most to them, to build long term, trusting relationships and to work as equal partners.

12.5 The approach to communications and engagement is aligned to NHSE's statutory guidance on working in partnership with people and communities[42] and is summarised in the figure below.

[42] https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance

Figure 83: Approach to communications and engagement

Inform

Sharing information about proposed changes so people understand what they mean

Co-production

An equal partnership where people with lived and learnt experience work together from start to finish.

Start with People

Consult

Asking for people's opinions on one of more ideas or options

Co-design

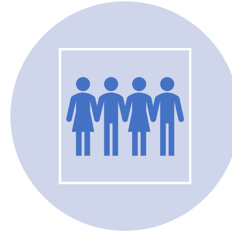
Designing with people and incorporating their ideas into the final approach.

Engage

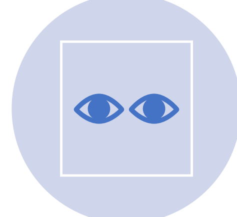
Listening to people to understand issues and discuss ideas for change.

12.6 The agreed approach to community engagement is designed to ensure that the voice of local communities actively informs the development of the new Trust. The approach recognises local communities as an asset, with strengths, knowledge, experience and skills that should be used to support programmes of change. This approach enables the active involvement of communities in the cocreation of solutions to local issues with care and treatment, and in the design, development and delivery of those services.

Figure 84: Approach to community engagement



Inclusive
Hear every voice, holding conversations with different parts of our communities. Invite us to any of your groups.



Discovery
We don't have the answers and are genuinely looking for feedback.

Recognise and harness communities' strengths
Build on strengths, knowledge, experience and skills of communities.

Services created by communities
Ensure communities help create their health services.

12.7 The community engagement programme comprises the following components:

- **Development of an understanding of the key characteristics of a great Trust** from a community's perspective by reviewing available evidence, insights and feedback from routine engagement and experience from existing services. The "What makes a great community, mental health and learning disability Trust" document was published in March 2023 and identified the gaps which provide the foundation for the second phase of the programme. Using this approach, feedback and insights were drawn from over 50,000 people from across Hampshire, Isle of Wight, Portsmouth and Southampton.

- The second phase comprised **focussed work with communities whose voice was not yet present or seldom heard**. This included carrying out engagement sessions with groups with protected characteristics and specifically organisations and representatives of people from Chinese, black and south-east Asian communities, people living in residential and nursing homes, young people (including those in care), carers, people living with mental ill health and other long term conditions, the LGBTQ+ community and people living with learning disabilities and those with sensory impairments. Sessions were also held with services users and the wider public to ensure feedback was gathered from a wide spectrum of our communities across the whole region. Across Hampshire, Southampton, Isle of Wight and Portsmouth conversations have been held with over 2,500 people and these conversations are still ongoing.

- The third phase is underway and focuses on supporting the Clinical Transformation Group workstreams in their **development and design of clinical pathways,** carrying out community engagement to ensure access to the voices and priorities of service users and communities. Work with the workstreams of the Clinical Transformation Group has gathered feedback from communities as well as over 350 people directly.

- Community engagement has also been carried out as part of the **Shape Our New Trust engagement programme** as described in paragraphs 12.9 to 12.11 below.

- **A Community Engagement working group** (reporting into the Communications and Engagement Steering Group) has been set up to ensure the voice of local communities continue to be represented and that engagement continues to meet their priorities. The group is made up of a diverse number of community members from over 20 organisations, including Healthwatch, representatives of currently unrepresented communities and partner community engagement leads.

- **A survey** has been publicised through posters, leaflets and patient letters to capture the hopes and concerns of any member of the public who wishes to engage. As at the end of July, 233 responses had been received and the survey remains open with monthly snapshots of key feedback themes being used to inform the development of the new Trust.

12.8 Engagement activities with communities across Hampshire, Southampton, Portsmouth and Isle of Wight have involved direct conversations with over 2,000 people from diverse backgrounds. The full engagement plan, including the detailed activity plan, is included in the supporting information that accompanies this FBC.

Stakeholder story: Healthwatch

In the early stages of the transaction, the Trusts received feedback that some stakeholders did not feel as involved in the development of plans as they would have liked. Key amongst these were the local Healthwatch organisations.

In response, the Community Engagement working group was established including Healthwatch representatives and other community partners. The Trusts co-developed the engagement approach with this working group and collaborated on activity such as public communications materials to ensure that the programme was being described in a straightforward way. The group also facilitated conversations between Healthwatch leaders and executives from the Trusts and the ICB.

Healthwatch colleagues are now a key stakeholder working alongside the Trusts to develop and implement their plans.

Shape Our New Trust

12.9 An engagement programme was developed in order to engage with patients, communities, staff and partners on key matters relating to the development of the new Trust. The Shape Our New Trust programme was run for six weeks in May and June 2023, involving a series of surveys, meetings and events for staff, patients and carers, communities and partners. The programme included opportunities to engage online

through interactive engagement sessions, as well as a face-to-face workshop. This programme helped in the development of the following aspects of the new Trust:

- the emerging vision and strategic objectives;
- the development of the clinical strategy;
- the desired culture, values and behaviours;
- the design of the structure and governance; and
- the name of the new Trust.

12.10 The key themes that arose from this programme were:

- The need for services to be organised around communities and based on communities' needs, but recognising the need for consistent care across the Trust, reducing any 'postcode lottery'.
- Better access, with reduced waiting times and a better response when in crisis, have all been emphasised as important.
- A further theme to emerge was ensuring people receive clearer information about support and the services that are available and how they can access these.
- Generally, people felt the clinical priorities discussed were the right ones, but that these needed to be communicated using simpler and more everyday language.
- When it comes to the values of the new Trust, the most prominent words that have recently emerged are those of 'compassion', 'respect' 'accountability' and 'trust'.

12.11 Feedback from the programme was shared with the senior leaders from across all four Trusts at the end of June at a joint senior leaders event which was focused on generating outputs and recommendations to be considered by OMAG and Programme Board. Key themes from the Shape Our New Trust exercise have also been shared with staff through the monthly e-newsletter and plans are underway to share the outcome of the operating model, visions and values work that the feedback has influenced.

Key themes arising from internal and external engagement

12.12 There are some prominent themes from the engagement sessions undertaken to date:

- Many people have expressed their concerns regarding the potential impact of the new Trust on accessibility of services. A priority of local communities is the need to have services close to home or place-based, particularly for

communities on the Isle of Wight. Communities are concerned about travel costs should people be required to travel further to access services.

- A desire from communities to see better communication and coordination between teams and service, for example better transition to adult mental health services.
- Ensuring equitable access to all services across the region, with no geographical boundaries, and the provision of better information about how to access services.
- The need to see the new Trust address inequalities between different groups so that diverse communities can have equal access to support and are not disadvantaged, for example because of their ethnicity or disability.
- A desire to see improvements in identifying clear pathways for diagnosis, treatment and support of mental health for people of all ages and for those with dementia.
- Services should work more effectively to address waiting lists.
- People also expressed concerns about communities across the area having an equal voice in developing services and a desire to see services improved in line with the best available provision.
- There was also a desire to ensure that voluntary sector providers were recognised as an important and equal part of overall service provision.

12.13 Feedback is being provided to the Communications and Engagement Steering Group and where responses are required these are being actioned by the group or through local contact. Feedback is regularly reported to the Programme Team through highlight reports. Specific feedback relating to clinical priority workstreams is fed back through the Clinical Transformation Group.

Communication and engagement to Day 1

12.14 The frequency and reach of engagement with staff and external stakeholders, including people in local communities, will increase in the approach to Day 1 focusing on:

- Specific communication activities for those staff who will transfer under TUPE into the new Trust;
- Progress around the integration programme to merge systems, processes, policies and operations and the process around the formal establishment of the new Trust;
- Building a sense of team for the new Trust, aligned to the emerging Trust strategy, clinical strategy, vision, values and key cultural elements and the

name of the Trust. This will take the form of a communications campaign and events/meetings, aligned to the work of the Organisational Development Steering Group;

- Launch communications for Day 1, ensuring staff are informed, empowered and supported to do their jobs. This will include a 'Day 1 survival guide' as well as welcome letter, lanyard and ID badge. A launch video will be produced to thank staff, reinforce the benefits of the new Trust and capture the hopes of staff at every level about what the future holds. Launch events will also be delivered; and

- Raising awareness of the new Trust and its purpose with external stakeholders, people in local communities and people using Trust services. This will include a new strategic approach to stakeholder management that will link to the community engagement work. Activities will focus on external communication channels and messaging around people being provided with continued great care, as well as the benefits that the new Trust will bring. Messages to reinforce the engagement and involvement opportunities will also be shared.

12.15 Leaders and managers will be crucial to this part of the journey. They will be equipped with toolkits and guidance to support their conversations with staff.

Communication and engagement strategy for the new Trust

12.16 The communications and engagement strategy for the new Trust will ensure that the Trust will operate essential communications activity and also an enhanced programme of 'new Trust' activity, recognising that things will not be 'business as usual' from Day 1. This will require enhanced communications and engagement in the first year of the new Trust, with detailed plans to deliver activities such as:

- Launch activities to raise awareness internally and externally about the new Trust and firmly establish the new brand identity, vision, clinical strategy and the difference it will make to people's lives across local communities;

- Highly visible and far-reaching communications materials to raise awareness and engage audiences in the new Trust vision, values and other key elements of the strategy;

- A programme of regular roadshows and events to provide opportunities for colleagues to come together;

- A unified reward and recognition programme including a single Trust award ceremony in year one;

- Regular communications via Trust channels to ensure staff and volunteers feel supported to navigate any changes as they arise and can be confident in articulating information about the new Trust to external stakeholders;

- Ongoing communications and engagement programme to support the development of the new Trust, clinical services transformation and integration activities;
- Development of channels and communication materials to help people in local communities access the information and support they need; and
- A programme of engagement with local communities and key stakeholders and ensuring an ongoing dialogue so that their feedback is actively encouraged and used to inform the development of services.

12.17 A comprehensive two year communications and engagement strategy will be developed in the first year of operation, with objectives delivered through an annual plan. The high level aims, strategy and audiences are expected to be as follows:

Aims

- To help position the new Trust regionally and nationally as a leading provider of community, mental health and learning disability services.
- To demonstrate through compelling stories and other communications activity the difference that care makes to the lives of service users and local communities.
- To lead the narrative of out of hospital care, raising the profile of community services.
- To develop an organisation with a strong sense of team and a positive culture where people thrive and are at their best whilst at work.
- To ensure the new Trust is seen as an attractive NHS employee within the region.
- To communicate in a way which is timely, accurate, culturally positive and accessible to a wide audience.
- To engage with a range of diverse audiences, using a multichannel approach.

Approach

- The communications and engagement strategy will establish a four-pronged approach:
    - Raising awareness of the brand and our services, proactively managing the reputation of the organisation – this will require enhanced level of activity recognising that this is a new Trust;
    - Engaging our people through effective use of communications channels and messaging, mobilising our leadership and influencers across the organisation;

- Building strong relationships with our stakeholders and partners across the system through effective community engagement, patient involvement and a coordinated approach to informing and collaborating with key system partners; and
- Working closely with those with lived experience to develop and coproduce our communications and engagement activity.

Audiences

- **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. Regular updates will be provided to the scrutiny committees across the geography of the new Trust. This will take the form of written updates, informal meetings and briefings through existing statutory meetings.
- **People who use services, their carers and the public**: there are a range of ways of communicating and engaging with patient and carer groups and the wider public. Existing patient and public involvement networks will be used to share information and gather feedback. Those that would like to be more involved will be used to develop, inform and increase the reach of our messages through local communities. Corporate channels, particularly websites and social media, will be used to keep those who are interested informed and up to date.
- **Voluntary, community and patient groups (including PPGs, governors and patient and community partners) and Healthwatch:** as representatives of their members and key partners, these groups will also have a keen interest in their local health services and any proposals that may impact on them. These groups will receive regular communications and will have opportunities to engage. Any communications and engagement will reflect the statutory role of governors.
- **Health and care system partners:** including colleagues from partner NHS Trusts, local authorities, other statutory organisations and others who support the delivery of services. These stakeholders will have a keen interest in how the new Trust 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 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. The new Trust will take a proactive approach, ensuring local press are aware of our plans, including providing background briefings as plans develop.

12.18 Stakeholder mapping will be used to determine the approach taken to stakeholder engagement, as summarised in the figure below.

Figure 85: Stakeholder mapping to inform the approach to engagement

Engage closely	Keep satisfied	Involve and activate	Monitor and inform
• Consult and keep informed • Communicate closely at individual level • Actively seek opinions and suggestions • Enable opportunities for inclusion in the work	• Inform and regularly review the need for more active involvement • Provide key messages without too much detail • Be prepared to provide extra detail if requested	• This group often involves patients • Communicate via existing channels e.g. existing groups, forums, newsletters, etc.	• Provide optional access to information to maintain engagement • Use existing communications methods e.g. existing forums, newsletters, etc.

Channels of communication

- To support our communications and engagement activity a range of channels will be used, and materials developed. These will be flexible enough to adapt and change to the needs of the audience and will include:
  - Core narrative and key messages documents
  - 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 and audio content for internal and external communications
  - Social media as needed, for example 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

- Building networks of staff and service user representatives who can advocate for and inform the new Trust and its services and help develop, coproduce and support the implementation of communications and engagement activities

Appendices

1 Key performance and activity metrics 222

2 ICB letter of support 225

3 Independent review of community and mental health services across HIOW ICS 227

4 ICB briefing on independent review recommendations 264

5 ‘To be’ culture 270

6 Designate Board members 276

7 Performance management responsibilities for individuals and teams 281

8 Summary of digital infrastructure plans for Day 1 283

9 Learning from previous transactions 285

10 Risk assessment matrix 306

11 Programme risk register 307

12 Due diligence risks 331

Appendix 1: Key performance and activity metrics

Key performance metrics – year to date as at 31 August 2023

Source	Area	Measure	Year to date (31 August 2023)		
			Solent	Southern	IoW
NHS Oversight Framework metrics for 2022/23	Primary care and community services	Proportion of Urgent Community Response referrals reached within two hours	63.3%	91.8%	84.7%
NHS Oversight Framework metrics for 2022/23	Primary care and community services	Available virtual ward capacity per 100k head of population and occupancy	Portsmouth: 7.0 beds per 100k 113% occupancy Southampton: 4.7 beds per 100k 154% occupancy	9 beds per 100k population 108.3% occupancy	18.5 beds per 100k population YTD occupancy 66.9% August occupancy 83.6%
NHS Oversight Framework metrics for 2022/23	Mental health services	Number of people accessing IAPT services as a % of trajectory	87%	98.2%	19%
NHS Oversight Framework metrics for 2022/23	Mental health services	Inappropriate adult acute mental health placement out-of-area placement bed days	6	104 Acute 47 PICU All bed days spot purchase	32
Targets	Elective care	RTT, 52 week waits	76.6% 5 patients waiting over 52 weeks	96.5% 0 patients waiting over 52 weeks	OPMH – 42.03% 48 patients waiting over 52 weeks
Targets	Elective care	6-week waiting time diagnostics	97%	95.3%	90.9%

Source	Area	Measure	Year to date (31 August 2023)		
			Solent	Southern	IoW
Targets	Mental Health	EIP 2-week access	99.6%	99%	99.6%
Targets	Mental Health	NHS Talking Therapies 6 weeks	11.7%	29.2%	6 weeks or less to 1st appt: 99.3% 18 weeks or less to 1st appt: 100%
Targets	Mental Health	NHS Talking Therapies 18 weeks	51.7%	52.1%	55.5%
Targets	Mental Health	NHS Talking Therapies 1st/2nd appt	4.7%	16%	16.2%
Targets	Mental Health	NHS Talking Therapies Recovery	100%	98%	93.9%
Targets	Mental Health	Readmissions in 30 days	90.4%	91.8%	86.2%
Targets	Mental Health	Gatekeeping	N/A	99.%	N/A
Targets	Mental Health	72 hour follow up	97%	95.3%	90.9%
Targets	Urgent Care	UTC attendances completed in 4 hours	99.6%	99%	99.6%

Activity data – 2022/23

	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	479,099		896,049	74,406	151,739	4,911
Adults Outpatient	91,789	N/A	143,381		46,459	N/A
Forensic - CAMHS	N/A	N/A	15	9,292	n/a	N/A
Learning Disabilities	6,704	N/A	23,064	N/A	2,223	N/A
Older Persons Mental Health	10,477	4,369	85,312	30,624	5,114	2094
Forensic - Adult	N/A	N/A	5,339	35,193	n/a	N/A
Adults Mental Health	32,089	7,297	285,573	75,981	30,863	7,956
IAPT	39,004	N/A	99,679	N/A	13,462	N/A
Children and Families - Community	195,522	N/A	136,112	N/A	13,476	N/A
Children and Families - Outpatient	6,436	N/A	N/A	N/A	N/A	N/A
Children and Families - CAMHS	26,875	N/A	N/A	N/A	8,278	N/A
Diagnostics	6,787	N/A	66,711	N/A	N/A	N/A

Appendix 2: ICB letter of support

[To be inserted once received]

Appendix 3: Independent review of Community and Mental Health Services across the HIOW ICS

Independent Review of Community and Mental Health Services across the HIOW ICS

Report of findings

April 2022

Contents page

1. Executive summary **3**
1.1 Introduction 3
1.2 Case for change 3
1.3 Strategic priorities for community and mental health services 5
1.4 Future arrangements of community and mental health services 5
1.5 Recommendations and next steps 6

2. Introduction **8**
2.1 Methodology 8
2.2 Governance 10

3. Context **11**
3.1 About the HIOW ICS 11
3.2 National context 11
3.3 Current mental health service arrangements in HIOW 12
3.4 Current community health service arrangements in HIOW 13
3.5 Current collaboration in mental health and community services 13
3.6 HIOW population needs 14

4. The Case for Change **15**
4.1 Rising demand for community and mental health services 15
4.2 Capacity-need mismatch and staff shortages in mental health 16
4.3 Fragmentation of care delivery and inconsistencies in care models 19
4.4 Lack of clarity around ownership and imbalance of clinical risk 21

5. Strategic priorities for community and mental health services **21**
5.1 Clinical priorities for future services 21
5.2 Future arrangements of community and mental health services 22

6. Recommendations and next steps **25**
6.1 Recommendations 25
6.2 Next steps to developing a new Trust 27

Annex 1: List of interviewees and workshop attendees **28**
A1.1 Governance 28
A1.2 List of interviewees 28
A1.3 Attendees at First System Workshop – Wednesday 16 March 30
A1.4 Attendees at Second System Workshop – Monday 28 March 30
A1.5 Attendees at First Clinical Summit – Wednesday 2 March 31
A1.6 Attendees at Second Clinical Summit – Thursday 24 March 32

Annex 2: Options appraisal process **33**
A2.1 Options appraisal process 33
A2.2 Options appraisal: hurdle criteria 33
A2.3 Shortlisted options 34
A2.4 Options appraisal – detailed evaluation criteria 34
A2.5 Outcomes of the options evaluation 35

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

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.

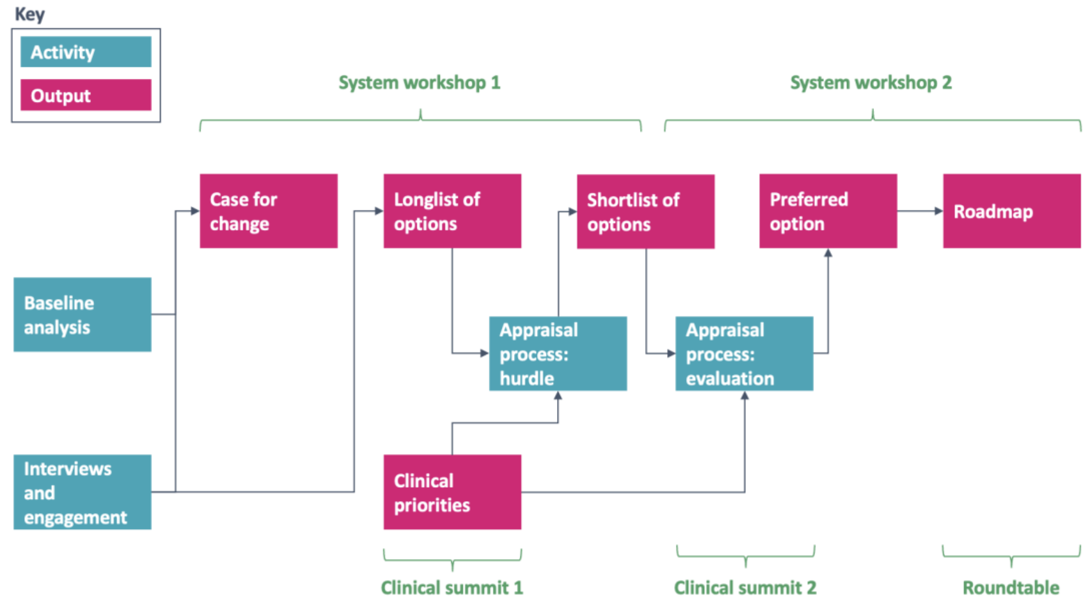


Exhibit 1: Infographic of the overall process for the Review

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 • Consider future options for how community and mental health services are organised in HIOW	7 March 22	Solent Board members
	Context session for Southern (90 min)		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

Provider Collaboratives

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 (*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			

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:

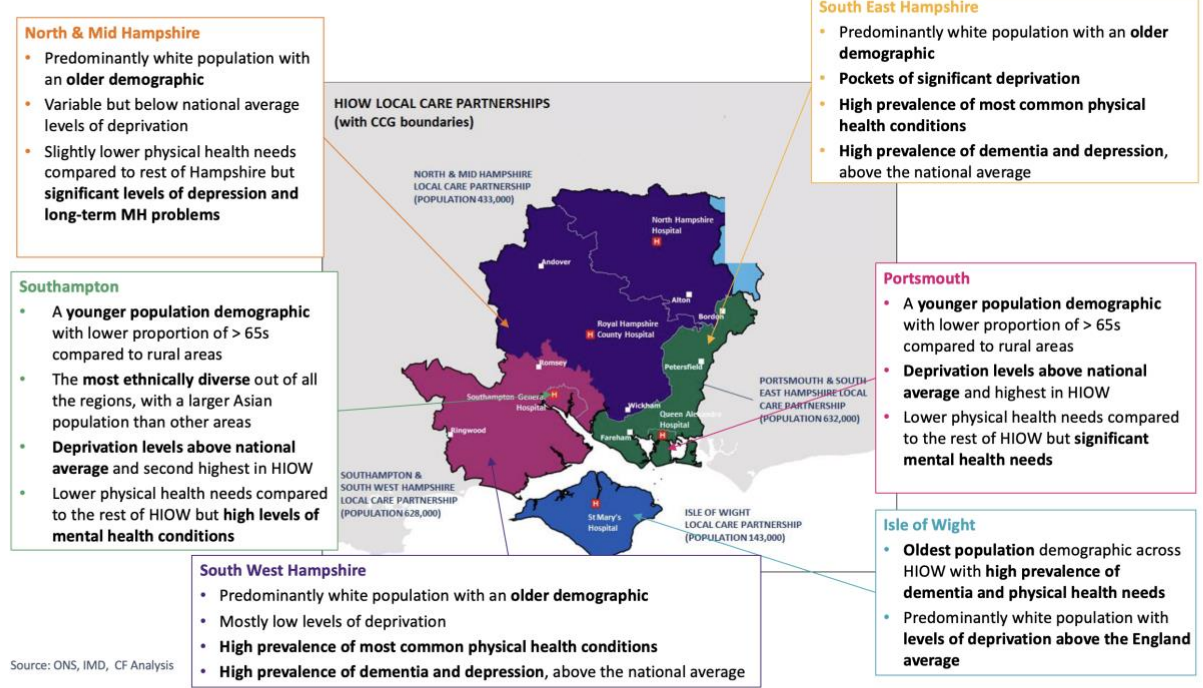


Exhibit 6: Summary of physical and mental health needs across HIOW ICS

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.

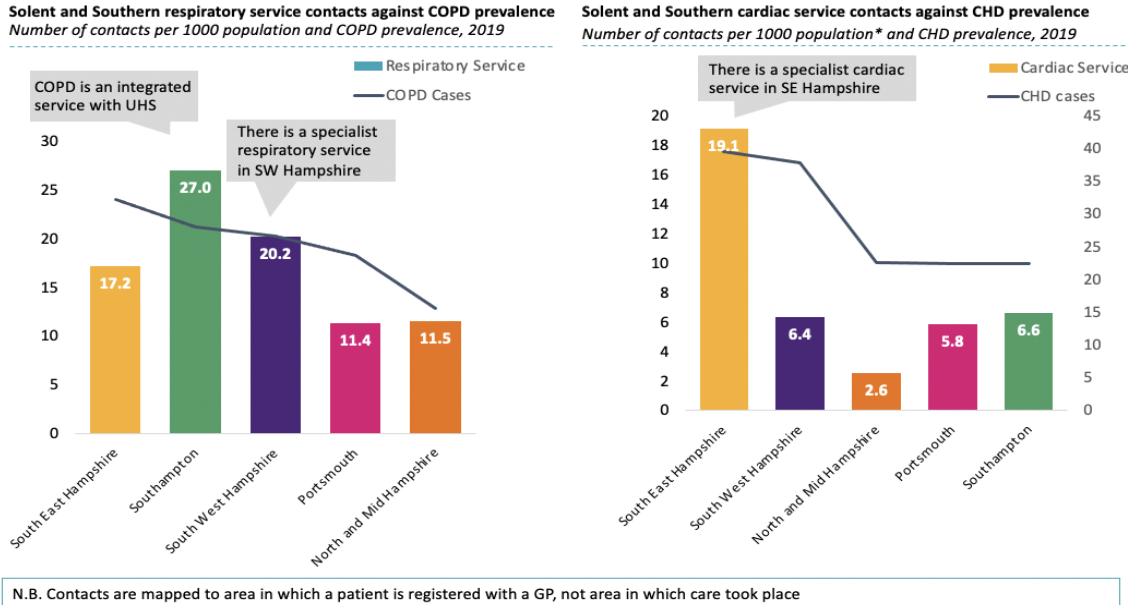
The HIOW population is older than the England average and ageing faster than most of the country. This will be the primary driver for an increase in demand for community services over the next few years. As a result, demand for community health services could grow by ~11% by 2025 (see Exhibit 7) and 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.



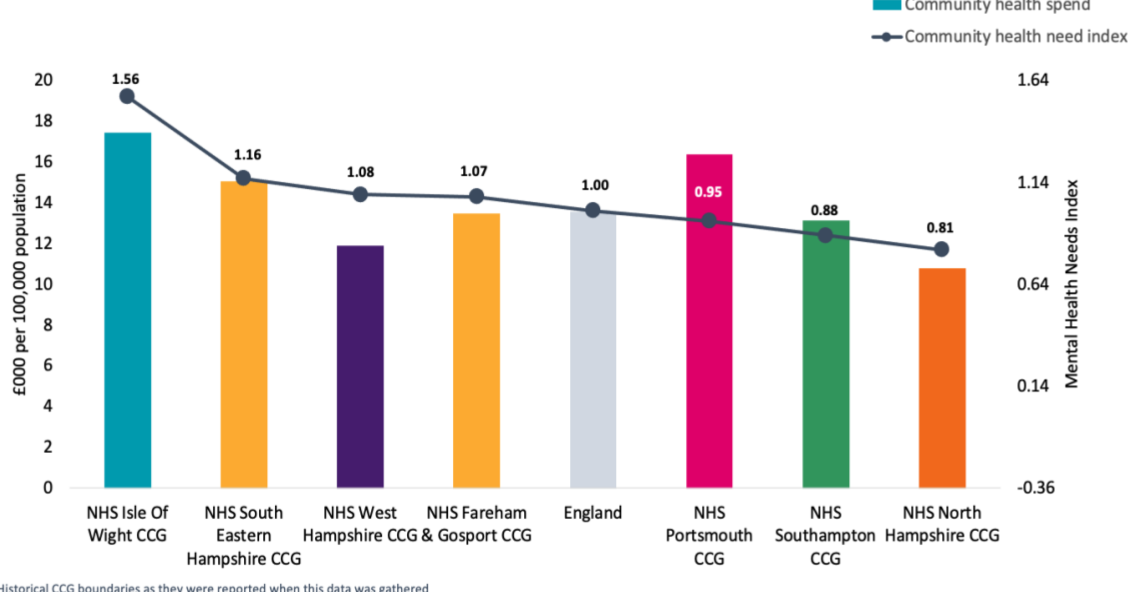
N.B. Contacts are mapped to area in which a patient is registered with a GP, not area in which care took place

Source: Southern and Solent activity data, Fingertips, CF analysis

Exhibit 8: Number of contacts compared to prevalence of relevant condition across HIOW

Community Health Spend compared to community needs index by CCG*

£k per 100,000 population / CH need index score, 2019/20

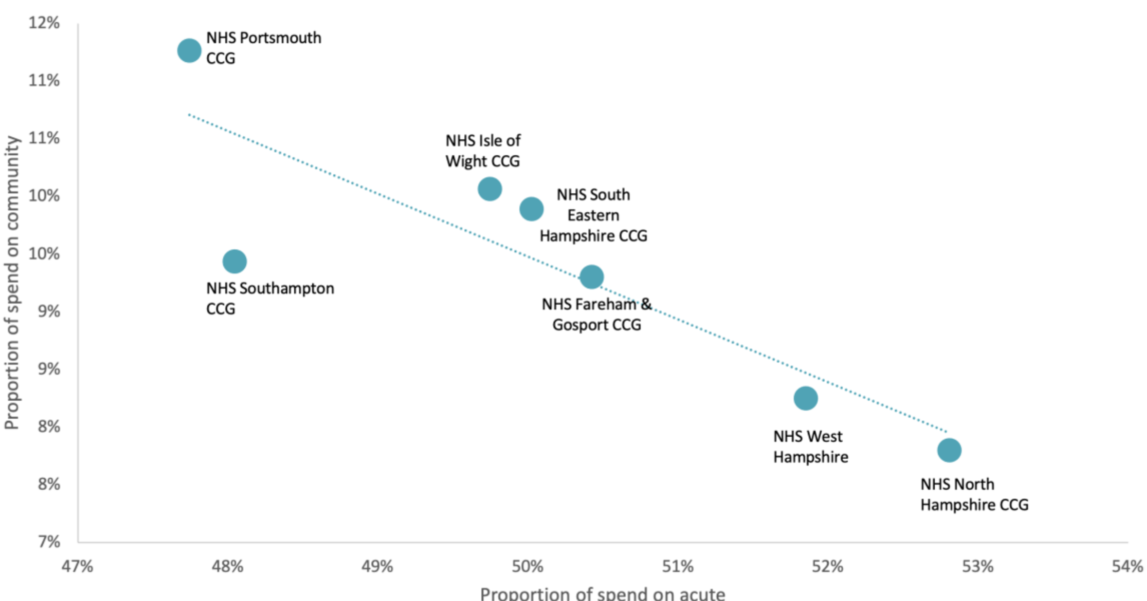


*Historical CCG boundaries as they were reported when this data was gathered

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.

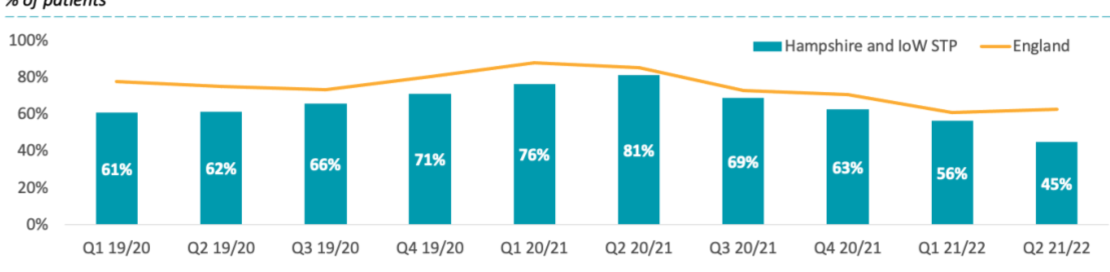


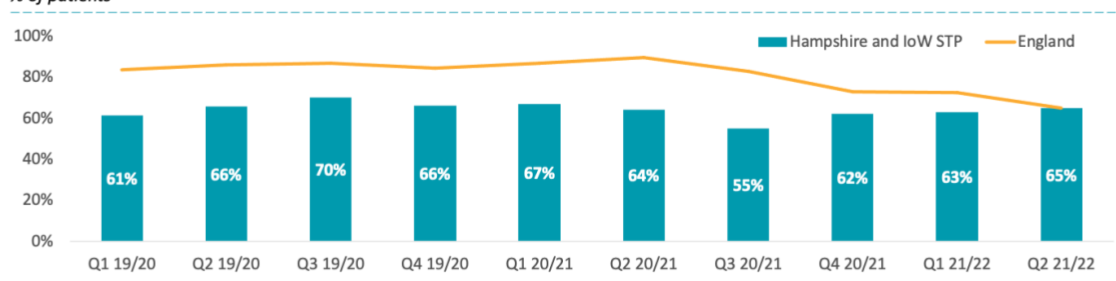
*Historical CCG boundaries as they were reported when this data was gathered
Source: Solent/Southern Finance data returns, Mental health need index, NHS Digital, CF Analysis:

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.

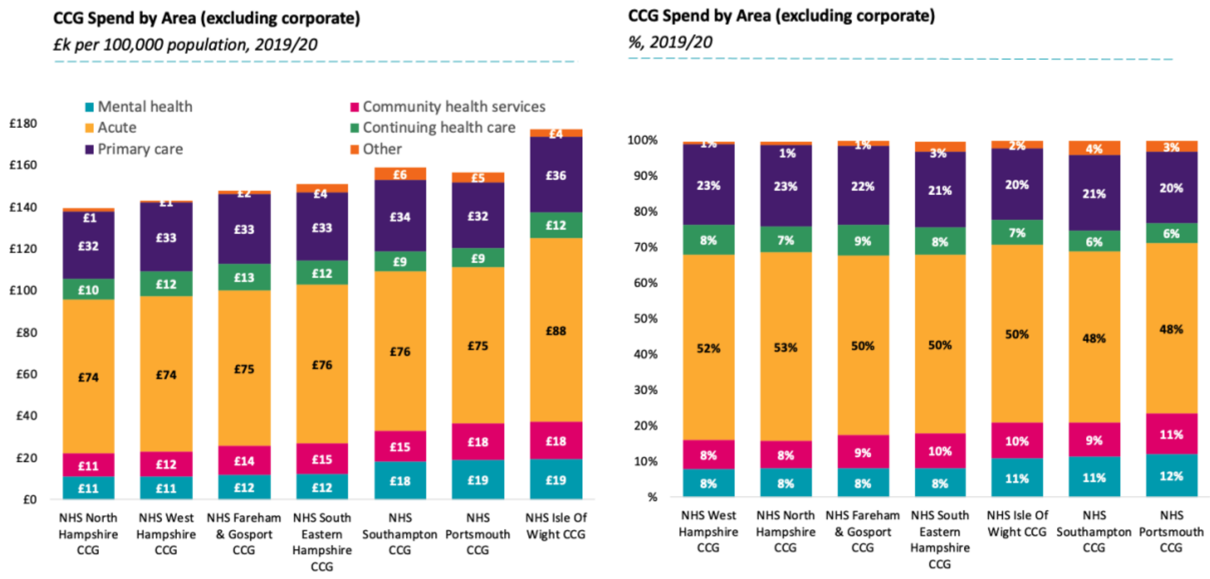


Exhibit 12: Historical CCG spend across service groups in 19/20

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

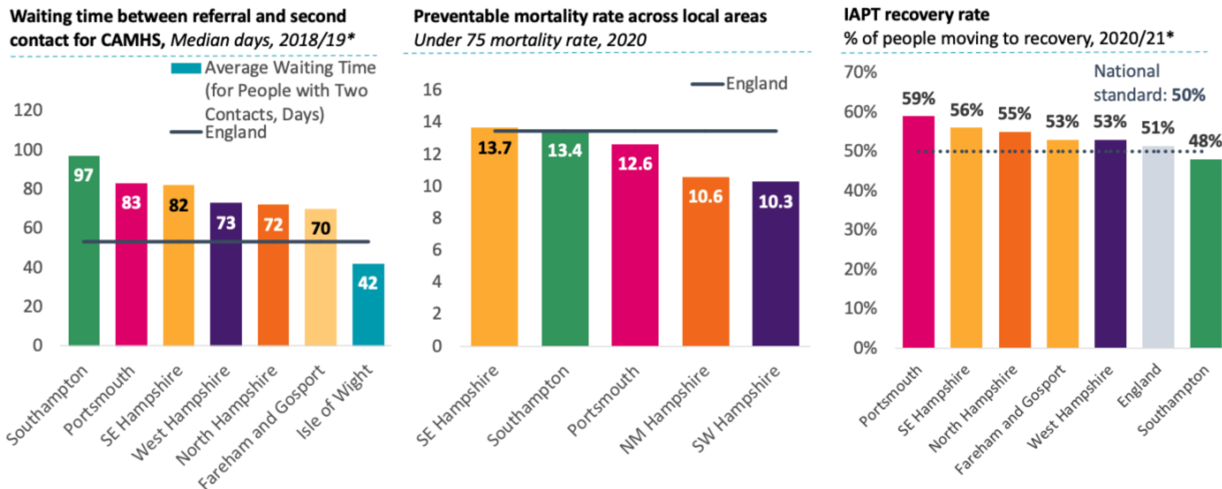


Exhibit 13: Variation in patient access and outcomes across HIOW

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.

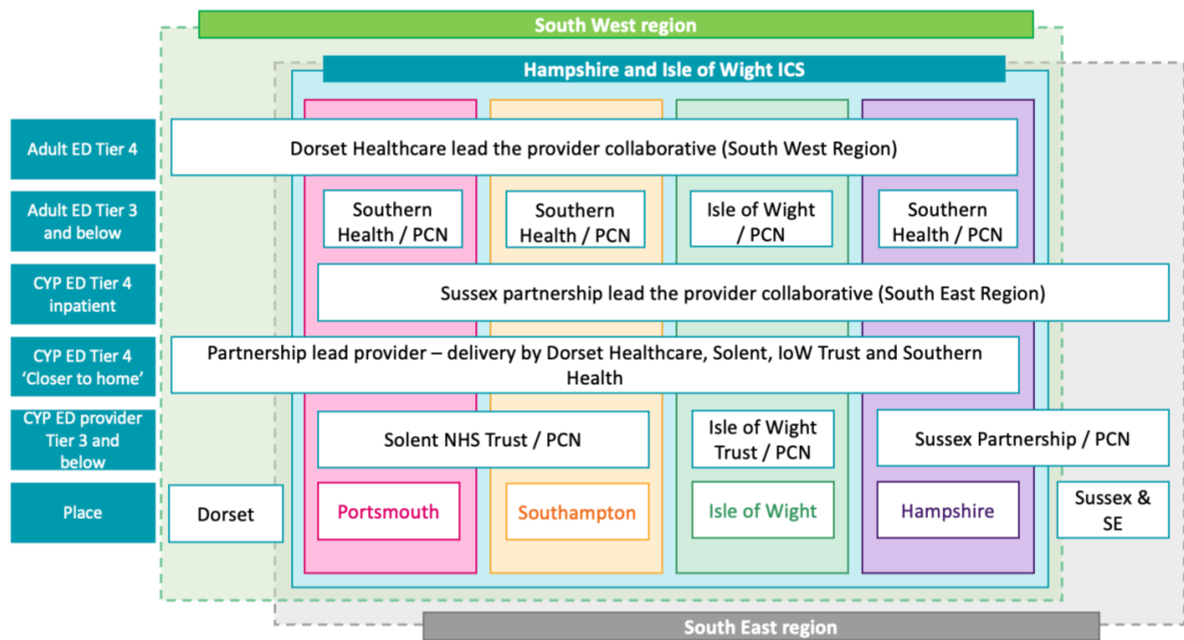


Exhibit 14: Pathway showing the complexity of all-age Eating Disorder pathways across different providers in HIOW

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.

1. Optimising patient safety, quality and experience

- Developing an agreed and consistent set of quality and safety standards across the system for services to strive towards
- An open and honest culture with learnings and best practice shared across organisations within the ICS
- Empower patients to self-manage and define their care plans, and treating patients in the most appropriate care setting for their needs, as close to home as possible

2. A more holistic and preventative approach to care, joining up services across the life-course

- Preventative approach to care so people gain maximum potential in early adulthood, maintain independence and 'live well' in the community with long-term conditions
- Early intervention and a more holistic approach by integrating across multiple community teams to support all needs at once
- Reducing fragmentation in service provision across the system to reduce the number of hand-offs and smooth transition of care to improve patient outcomes – particularly CAMHS and Eating Disorders and at the transition from child to adult services

3. Alignment of care models to optimise patient access and ensuring clearer ownership of care

- Addressing overlap of services and standardising criteria for referral and treatment to provide clarity in a complex landscape
- Reducing the complexities of the provider landscape to help reduce unnecessary referrals and uncertainties around risk sharing

4. Establishing a flexible, sustainable and engaged workforce

- Sustainable approach to workforce using existing skills across the system, flexible sharing and optimising use of existing resource
- A unified and/or aligned leadership and shared vision for C&MH services across the system to provide direction and assurance

5. Services resourced according to local need and required scale of delivery

- A service landscape designed and resourced according to local population needs and wants
- Effective delivery of more generalist services locally and specialist services at scale (what is local vs. regional)

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

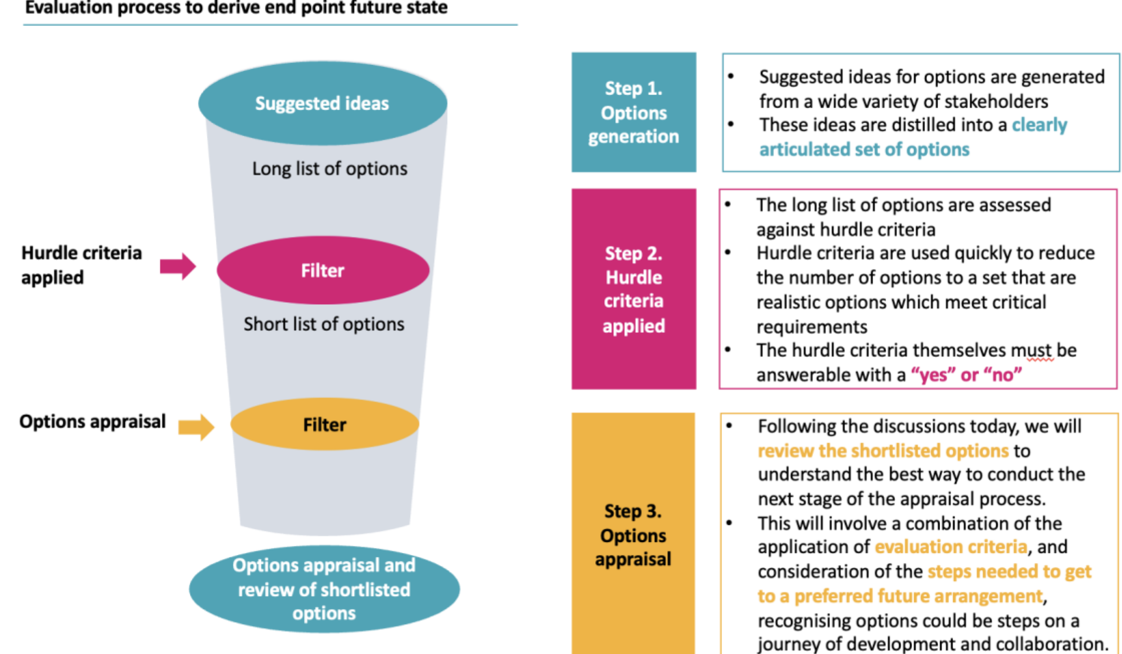


Exhibit 17: The clear, two-part options appraisal process that was used to shortlist and evaluate options

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

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.

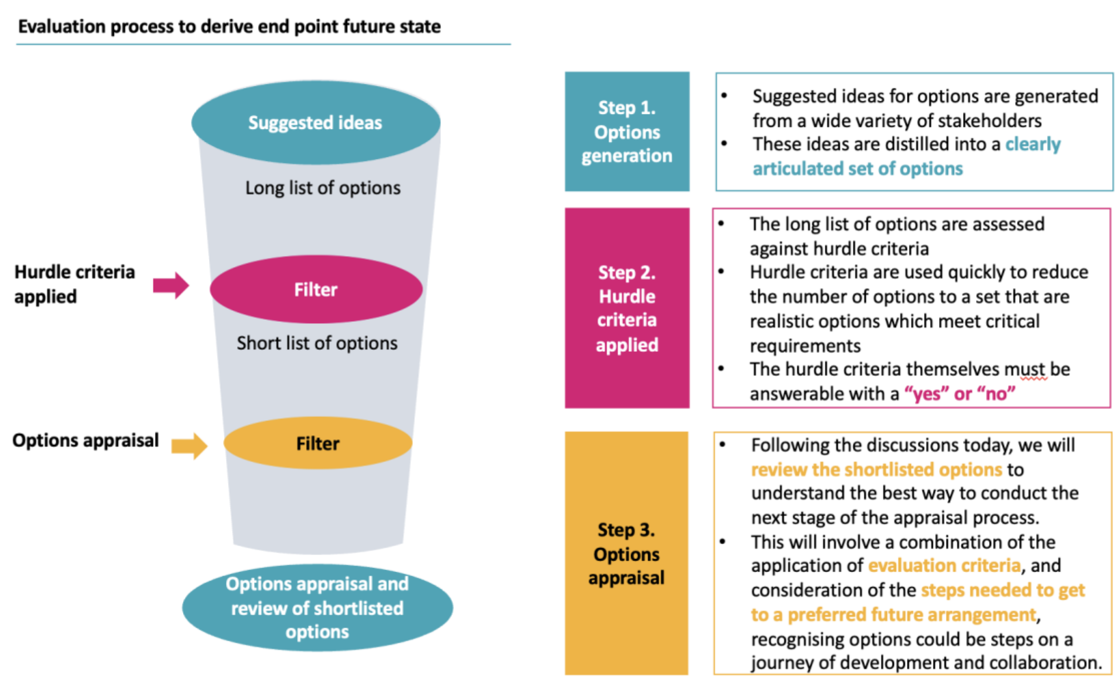


Exhibit 19: Clear and transparent options appraisal process to shortlist and evaluate options

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.

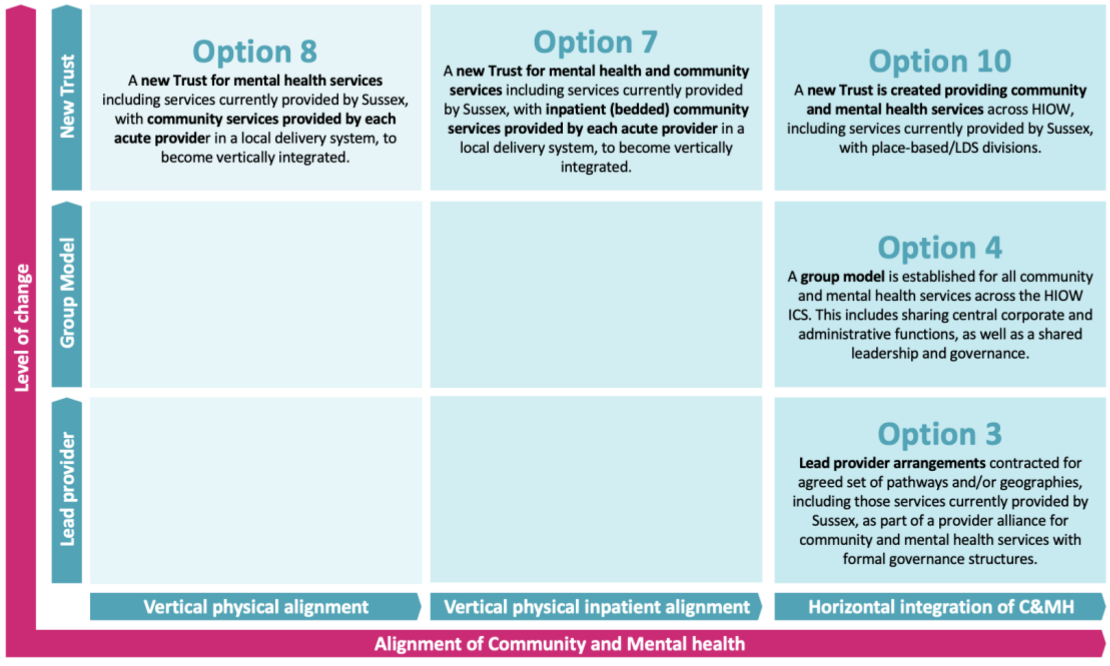


Exhibit 20: Shortlisted options shown on a matrix of alignment and level of change

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 coterminosity 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.

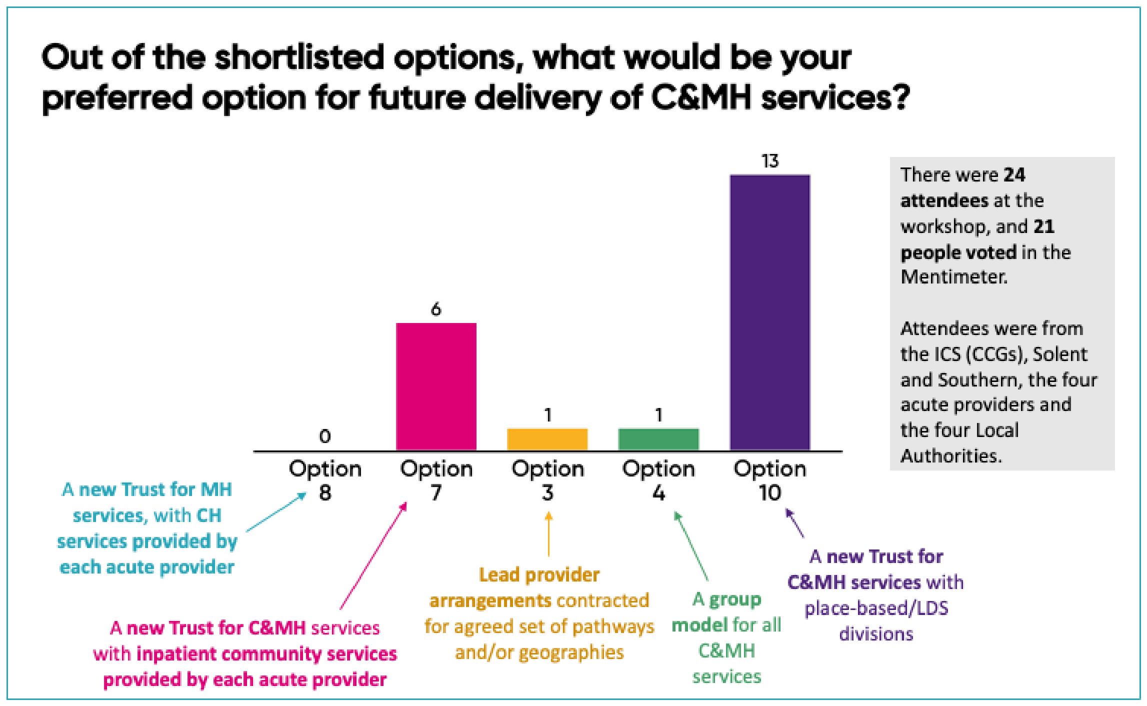


Exhibit 23: Results of a vote at the second system workshop on the preferred option for future services

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 4: ICB response to recommendations from the independent review

Hampshire and Isle of Wight

Briefing on our response to the recommendations from an independent review of community, mental health and learning disability services

1 Introduction

This paper summarises our joint system response to the recommendations made following an independent review in 2022, which was commissioned by the Hampshire and Isle of Wight integrated care system to understand how to best meet the current and future demands of our local populations and how organisations might work together.

2 Independent review and recommendations

2.1 Case for change

The review found a compelling case for changing the way that community, mental health and learning disability services are organised in Hampshire and Isle of Wight.

The current arrangements are fragmented and complicated, after many years of piecemeal commissioning across multiple providers and inequal funding in different areas.

As a result, it is difficult for some people to access care when they need it, and there are unwarranted variations in the services provided, experience and outcomes for people living in different parts of Hampshire and Isle of Wight.

2.2 Recommendations

The review concluded with five recommendations, which are summarised below:

a) Develop a shared system-wide clinical strategy for these services, focussing on prevention, early intervention and user-centred care

b) Develop a clear, system-wide strategy for place and place-based leadership

c) Undertake a review of the use of community physical health beds

d) Establish a more strategic approach to funding these services

e) Create a new Trust, bringing services together across Hampshire and Isle of Wight.

The remainder of this paper describes our response to each of these recommendations.

3 System-wide clinical strategy

3.1 Recommendation from the independent review in 2022

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 Approach in response to this recommendation

The strategic priorities for community, mental health and learning disability services are closely aligned with the goals of the integrated care system: to keep people as healthy and independent as possible, and to provide swift access to efficient, high quality care for those who need it.

Therefore, we have linked our response to this recommendation with our wider Partnership Strategy and the Joint Forward Plan for NHS partners, rather than considering community, mental health and learning disability services in isolation.

3.3 System wide strategy

Our vision is for people living in Hampshire and Isle of Wight to be Happier, Safer, Healthier. Together. To achieve this, we need to adopt a more proactive and preventative approach, to promote mental and physical wellbeing, to offer integrated holistic care, and to support more people to live independently in their own homes.

Across the integrated care system, we need to rebalance the total health investment and focus on the population's long-term health. This includes resetting the system of care and introducing new care models to ensure consistently high standards and outcomes.

Community, mental health and learning disability services are pivotal in the transformation required across Hampshire and Isle of Wight. The Fusion programme will create a new Trust for these services and it will be a crucial partner in the integrated care system, with important interfaces with other services and key relationships with other system partners, especially the four local authorities, primary care services and the voluntary sector.

Workforce and digital are two of the five areas prioritised by all system partners for a more strategic focus across Hampshire and Isle of Wight, and they are also key enablers in our work to improve community, mental health and learning disability services.

3.4 Clinical strategy for the new Trust

A clinical strategy has been developed in preparation for the launch of the new Trust.

The strategy was co-produced by staff, people who use services and system partners, and it sets out six principles to enable all parts of the diverse new organisation to deliver high quality, safe and effective services to all people in Hampshire and Isle of Wight.

a) Embed a culture and practice of continuous improvement, innovation, training and research

b) Ensure that all clinical decisions benefit from both lived and learned experience

c) Adopt a life course approach which removes barriers and provides greater emphasis on prevention and a pro-active care

d) Work in and with our communities ensuring that we collaborate effectively and deliver outcomes that matter

e) Provide effective clinical and professional leadership

f) Ensure our workforce is equipped to deliver high quality care.

Clinical, professional, operational and corporate staff will need to work together and in collaboration with system partners, the people who use services and their families to deliver this strategy.

4 Place-based strategy and place leadership

4.1 Recommendation from the independent review in 2022

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 Approach in response to this recommendation

The four Local Authority places are the cornerstones of the integrated care system: Hampshire, Isle of Wight, Portsmouth and Southampton.

The system strategy was developed by the Integrated Care Partnership, which is a statutory joint committee between the four Local Authorities and the Integrated Care Board. The partnership also brings together a broad range of partners from different sectors.

This recommendation applies both to the strategic leadership across the integrated care system and within the new Trust.

4.3 Integrated care system

Each of the places has a Health and Wellbeing Board, with a statutory role to assess people's needs and to set the strategy for the local population. The Health and Well-being Strategies for Hampshire, Isle of Wight, Portsmouth and Southampton were used to inform the overarching Partnership Strategy for Hampshire and Isle of Wight.

There is a Health and Care Partnership Board in each place, which brings together the local authority, health services and voluntary sector partners to work together in response to the Health and Well-being Strategy and to provide joined up solutions for local people.

The NHS Joint Forward Plan includes a focus on 'Local Care', with the development of services for local communities and multi-disciplinary teams within local neighbourhoods.

4.4 New Trust

One of the six principles in the Trust's clinical strategy is to work in and with communities to ensure effective collaboration and deliver outcomes that matter.

The new Trust will have a key role in collaborating with partners across the health and care system, including the integrated care board, local authorities, primary care, acute providers, ambulance providers and the voluntary and charitable sector. This collaboration is essential to the delivery of high quality person-centred care that is able to wrap seamlessly around the holistic needs of individuals.

The new Trust will be large, bringing potential benefits by reducing unwarranted variation. It is also important to realise the benefits of delivering services locally in response to local needs. A service should be delivered at the scale that most effectively meets the needs of individuals using the service, delivering the outcomes that matter to them.

5 Strategic approach to funding these services

5.1 Recommendation from the independent review in 2022

> **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 Approach in response to this recommendation

The Integrated Care Board has established a working group to develop a more strategic approach to commissioning community, mental health and learning disability services.

Services will be commissioned to support achievement of the Partnership Strategy (see 3.3) and delivery of the Joint Forward Plan, addressing health inequalities and responding to place-based priorities (see 4.3). It will also support the system's financial recovery.

The intention is to build on the public and stakeholder engagement for the Partnership Strategy and Joint Forward Plan, rather than to do this separately for these services.

5.3 Financial context

A major priority for our system is to address our system-wide deficit, bringing our system back into balance and ensuring that collectively we live within our means. Hampshire and Isle of Wight faces very significant financial challenges, which need to be addressed by rebalancing the total health investment, resetting the system of care, and focussing on the population's long-term health needs.

The commissioning of community, mental health and learning disability services will reflect the need to rebalance the system as part of system-wide financial recovery.

5.4 Transitioning contracts for the new Trust

Initially, existing contracts will transfer with the current providers into the new Trust.

Over time, the Integrated Care Board will review each contract, what we commission and how we commission services. This will include consideration of how we work alongside commissioning partners, including the Local Authorities and Specialised Commissioning, and provider colleagues with the aim of developing a joint approach that recognises the breadth and complexity for the full range of contracts being novated to the new Trust.

5.5 Addressing inequalities and ensuring equity of outcomes

The commissioning approach will support the new Trust to align services and address health inequalities across Hampshire and Isle of Wight. This includes working through historic inequities in funding, identifying key performance indicators, and addressing the contracts differences leading to unwarranted variations in the access and outcomes.

The Integrated Care Board's intention is to move to contractual arrangements that support equitable outcomes for people across Hampshire and Isle of Wight, recognising that the approach may need to adapt in response to the health inequalities and differing needs across the population. To support this, the plan is to focus on outcomes metrics and to develop a potential set of metrics through co-design with both providers and commissioning partners for this health sector.

6 Review the use of community physical health beds

6.1 Recommendation from the independent review in 2022

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 Approach in response to this recommendation

The Clinical Transformation Group is taking forward this recommendation as part of the 'community hospitals and community inpatient rehabilitation' workstream (see 3.4).

The initial focus has been to understand the current service provision across the different parts of Hampshire and Isle of Wight and to link with system transformation programme to ensure that people are discharged home as soon as they no longer need hospital care.

In line with the original recommendation, the next phase of work needs to broaden the engagement and to ensure a wider review of community physical health beds, including consideration of the interface with social care provision in the four local authority areas.

The next phase also needs to align with the integrated care system's 'recovery and transformation programmes' to develop new care models (for local care, planned care, urgent and emergency care, and hospital discharge) particularly where there are inter-dependencies linked to intermediate care, virtual health and care, and frailty.

7 Bring services together into single Trust for Hampshire and Isle of Wight system

7.1 Recommendation from the independent review in 2022

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 Approach in response to this recommendation

In response to this recommendation, the four Trusts that provide the majority of these services in Hampshire and Isle of Wight have jointly established the 'Fusion programme', to create a new Trust in accordance with NHS England's Transaction Guidance.

Isle of Wight NHS Trust
Solent NHS Trust
Southern Health NHS Foundation Trust
Sussex Partnership NHS Foundation Trust.

It is important to note that bringing existing services together into one organisation does not in itself change the services. Bringing services from four organisations into one Trust 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.

7.3 'Fusion programme' to create the new Trust in April 2024

The programme is currently on track to create the new Trust in April 2024, with appointments already made to the Chair and Chief Executive posts for the new Trust.

The Strategic Case for the new Trust was developed and approved by the four Trusts, and it was supported by the ICB. NHS England reviewed the Strategic Case and confirmed support for proceeding to the Full Business Case stage.

Significant engagement was undertaken in 2022, including events with staff, local communities, senior leaders and stakeholders. More recently, there have been a series of discussions with staff, local communities and stakeholders to 'shape the new Trust'.

The proposals include transferring responsibility for the delivery of community, mental health and learning disability services into the new Trust for Hampshire and Isle of Wight. Plans are progressing well to segment the Isle of Wight NHS Trust into service sectors, ready for the proposed transfer of these services in April 2024.

7.4 Full business case for the new Trust

The business case to create the new Trust has been drafted and will be updated based on feedback. The final draft of the Full Business Case is expected in September.

Over the next few weeks, the Trusts Boards and the Integrated Care Board will each consider the draft business case and confirm support in private meetings. In October, the Trust Boards will meet in common and in public to agree to submit the Full Business Case to NHS England for approval.

If approved, the new Trust will be created in April 2024, bringing together the provision of community, mental health and learning disability services for Hampshire and Isle of Wight.

8 Next steps and further information

8.1 Next steps

The creation of the new Trust in April 2024 will be a very important milestone, but it marks the conclusion of the enabling period rather than the end of our work to improve services.

From next year, the commissioning and provision of community, mental health and learning disability services will be aligned across Hampshire and Isle of Wight.

The new Trust, the Integrated Care Board, the four Local Authorities and other partners will embark upon an important period of work together, to understand and address the health inequalities faced in Hampshire and Isle of Wight, to eliminate the unwarranted variations and historical inequities in funding, to ensure high quality care with good outcomes, and to support more people to live independently in their own homes.

8.2 Further information

This briefing only outlines the various strands of work to improve community, mental health and learning disability services for people living in Hampshire and Isle of Wight.

Please contact me if you would like more information.

Isobel Wroe
Transformation Director
Integrated Care System

On behalf of system partners
18 September 2023

Appendix 5: 'To be' culture

"To be" culture

Creating our ' To Be ' Culture

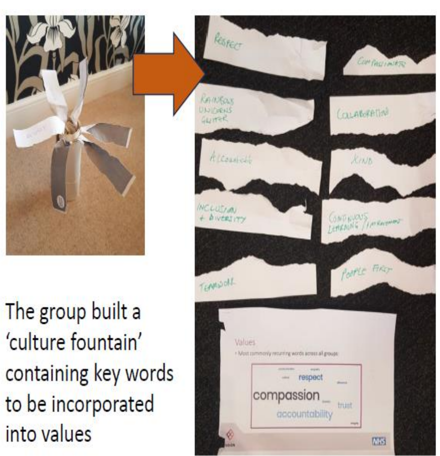
- Staff engagement sessions
- 'As is' cultural review
- Engagement events with staff, stakeholders, service users, carers and partners
- 'Shape Our New Trust'
- Senior Leadership Team Events
- OD Steering group

To follow:

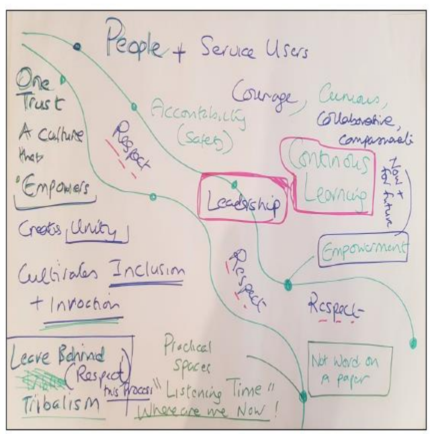
- Network involvement
- Wider organisational "Have your say" communication

Our Trust will have a Culture that is Compassionate and Empowering

Culture, values and behaviours



The group built a 'culture fountain' containing key words to be incorporated into values

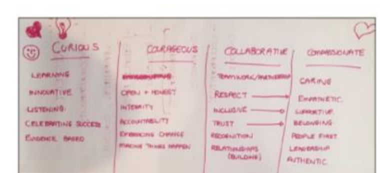


The group also described a culture anchored in having respect, and in which values were lived, not just words on a piece of paper

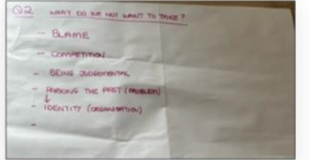
PROJECT FUSION

Room 2 - Culture and values

A strong desire emerged for a culture which empowers, creates unity and cultivates innovation



Four 'C's were presented as one way of capturing the essence of the desired culture



As well as some specific that we don't want to take with us into the new Trust

What will our culture feel like

Values that are actively embedded, socialised and role modelled by leaders and staff

Needs of the people we serve are at the heart of everyday working; decision-making, processes, communication, roles & responsibilities

Participative decision-making process, where staff feel their voice is heard and where they are actively invited to contribute to finding solutions

Leaders and teams recognise success is achieved through collaboration and partnerships across and beyond organisational boundaries

Psychologically safe environments for our staff and all those who engage with our services

Environment of open communication where agendas are transparent and new information is communicated in advance of major decisions across the organisation

Our people feel and see that action is taken in response to their feedback and issues about culture

Leaders committed to incremental innovation, seeking out different perspectives and testing new ideas to improve performance and delivery

Leaders who understand their respective roles in achieving organisational outcomes and who hold each other accountable

Lower turnover driven by enhanced staff satisfaction and engagement and a collective sense of impact

People are energised, compelled and empowered to bring their voice to the table.

Every individual feels they ‘belong’ and valued for their unique background and lived experience

Approach to embedding cultural change

Successful culture change will build on current strengths, create and embed reinforcing interventions in formal policies and processes and informal ways of working to achieve desired culture outcomes.

Embedding into everyday policies, processes and ways of working will bring the desired culture alive for all

Build into the fabric of the organisation

Leadership actions and behaviours consistent with desired culture will reinforce its importance

Leadership Commitment

Visible changes and signals will set expectations and highlight change

Visible change

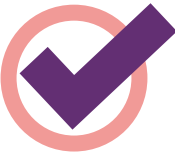
Create the people experience

The combination of interventions will reinforce and deliver the desired cultural outcomes

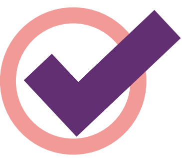
We always put our people first

We are **Accountable** -We accept responsibility for our work, and do what we say we will

We are **Respectful** – We treat people as we would want them to treat us



We are **Collaborative** – we work alongside our patients, staff and community partners to improve health outcomes



We are **Innovative** – we adapt to the every changing needs of the future

Initial set of values

People first

We are kind, caring and compassionate.

Creative

We empower and innovate to constantly improve.

Accountable

We are open, we act with integrity and take responsibility.

Respectful

We are inclusive and treat people as they want to be treated.

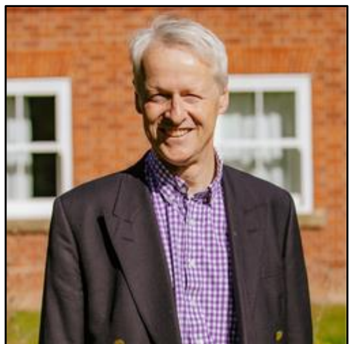
Working together

We work in partnership with our patients, staff and communities.

Appendix 6: Designate Board members

The designate Board members for the new Trust are listed below. The remaining designate executive directors will be appointed by the end of December 2023.

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: 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: 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 (subject to reappointment)

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 the Wellbeing Guardian for Southern. 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 (subject to reappointment)

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.

Non-Executive Director: Mike Watts

Mike grew up and went to school in Southampton. He is a Hampshire resident 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 to the Solent Board in October 2016.

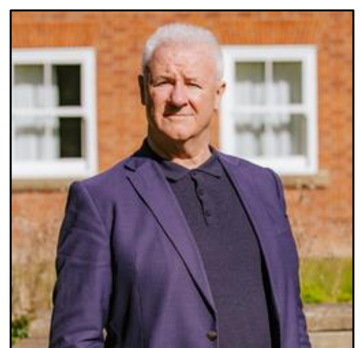
Non-Executive Director: Gaurav Kumar

Gaurav is a Hampshire resident with extensive Global experience. During his career he has worked and lived in India, New Zealand, Australia, U.A.E and the UK. He is presently employed as the Global Chief Information Officer 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.

Non-Executive Director: Sara Weech

Sara joined the Isle of Wight NHS Trust as an Associate Non-Executive Director in January 2018 and was made a Non-Executive Director in January 2023. 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: 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.

Appendix 7: Performance management responsibilities for individuals and teams

Team/ individual	Responsibilities
Individuals	• Deliver excellent service performance to patients and service users • Share good practice within the team • Record all information required in an accurate and timely way using Trust systems and standard operating procedures • Make use of the Trust's automated BI platform/s visualisations and reports to monitor and manage their own performance, and identify and escalate risks as appropriate • Raise any significant trends, gaps, risks and issues to managers • Work with team leaders to develop and implement plans to mitigate any areas of poor performance
Service/team managers	• Ensure services perform to the required standards • Acknowledge and reward excellence in teams • Analyse service performance weekly as a minimum, establish variation, trends, and gaps. Triangulate data, identify root causes and take corrective action • Scrutinise service performance at weekly/monthly operational meetings • Identify underperformance, agree and monitor improvement plans and escalate where required • Provide clear narrative for team performance, review highlight reports including performance risks, actions and improvement trajectories
Locality/ specialism leadership teams	• Comply with the requirements set out in the performance framework • Ensure the services/teams under their management perform to required standards and hold to account for delivery • Develop local priorities, outcomes and measures as part of the planning process • Work with corporate partners to agree contractual KPIs and outcome measures • Analyse performance within the locality/specialism weekly as a minimum, triangulate data, identify root causes and take corrective action • Identify underperformance in services/teams, agree and monitor improvement plans and escalate where required • Acknowledge and reward excellence, ensure roll out of good practice across the locality/specialism and beyond • Attend bi-monthly Locality/Specialism Performance Oversight Group, providing clear narrative on areas of good practice and concern, plans and actions taken, levels of assurance and timescales for improvement • Escalate areas of significant risk or opportunity through the performance framework process and to the Executive team as appropriate • Provide clear detail on escalations to feed into the Trust IPR including performance risks, actions and improvement trajectories

Team/ individual	Responsibilities
Corporate teams	• Deliver excellent performance in their area • Make use of the Trust's automated BI platforms' visualisations and reports to monitor and manage their own performance • Escalate any significant trends, gaps or issues to managers • Provide information to support the accurate and timely delivery, analysis and interpretation of performance data • Develop and deliver robust and effective performance management processes and governance • Scrutinise locality/specialism/service performance at operational meetings • Work with locality/specialisms to identify underperformance and develop, agree and monitor improvement plans, escalating where required • Provide clear detail on escalations from within the team to feed into the Trust IPR including performance risks, actions and improvement trajectories as appropriate
Executive team	• Develop strategic objectives for the Trust, including metrics and thresholds • Attend and actively participate in Executive Performance Oversight Group meetings • Support and enable locality/specialisms where significant or long-lasting performance issues arise • Ensure a culture of continuous improvement is embedded; that success and achievement are recognised and that good practice is replicated across the Trust • Review and evaluate the effectiveness of the Performance Framework • Provide assurance to the Board of the Trust's overall performance and be held to account for delivery of performance improvement action plans • The Chief Operating Officer will ensure the Trust remains cognisant about performance related regulatory targets and will act as the co-ordinating link between the Trust, the ICB and NHSE on performance related matters
Trust Board	• Develop Trust strategy and approve strategic and business objectives to ensure resources are translated into the best outcomes for the population • Approve Performance Framework and ensure it is implemented and maintained • Receive, consider, and challenge Executive Officers and Trust Managers on the Trust's performance as reported within the bi-monthly Integrated Performance Report and other oversight and assurance reports

Appendix 8: Summary of digital infrastructure plans for Day 1

Area	Description	Day 1 objectives	Day 1 staff experience
Deskside management	Service desk, online portal requests	Implement single portal covering the whole new Trust	Single portal for staff to go through for access to service desk functions
End User Device (EUD) management	Device supply and issue (laptops, desktops, tablets)	Supply staff with new/replacement devices	Devices will be supplied by legacy Trusts dependant on geographic locations and requirements for access to existing EPR – ie Rio or SystmOne
Networks	Allow connectivity of all staff in new Trust from any site	Align networks to allow greatest connectivity, via WiFi or docking stations.	Staff will be able to move freely through the new Trust and connect.
Microsoft tenancy	Licencing, calendar sharing, Teams presence, shared drives, SharePoint online, Teams, shared mailboxes	Create an environment with the greatest collaborative working and sharing given legacy Trusts will be on separate tenants	Implement changes to allow collaborative working across tenancies.
Single email solution	Provide a single email address for all staff	Create a new email address to allow staff to feel like they are part of a new Trust	Ideally a new email address pulling together corporate identity.
Service desk	Create a single point of contact (SPOC) for the new Trust and service desk requests	Have staff request IT services from one place	All staff go to one place for service desk requests
IT training	IT training on all systems	Provide a single mechanism for staff to be trained on systems	Staff request training and are provided it through the new Trust. New starters have a defined training package based on requirements.
Telephony	Soft telephony (Teams and Jabber)	Create shared directory via csv dump or equivalent to provide numbers	Continue to operate as now
Mobile telephony	Mobile phones	Seek to rationalise prior to Day 1	Similar to EUD supply, may be cost effective to bring this in-house

Area	Description	Day 1 objectives	Day 1 staff experience
Screen savers, desktop, corporate branding	Corporate branding of desktops, screen savers etc for a one organisation feel	Single ‘feel’ of desktop experience for the new Trust	Single ‘feel’ of desktop experience for the new Trust
Policies	Rationalisation of policies for the new Trust	Seek to rationalise prior to Day 1	Single set of rationalised policies for the new Trust

Appendix 9: Learning from previous transactions

1. Introduction

In February 2023 the Programme Board considered a paper setting out the key themes from NHS transactions over the last 5-10 years and recommendations for Project Fusion.

This paper has now been updated to demonstrate how the lessons learned have been incorporated in the plans for the new Trust, including the Full Business Case and the Post Transaction Integration Plan.

The paper takes into account the following sources of information:

- *"One Year Post-Merger report"*, Manchester University NHS Foundation Trust (November 2018)

  https://democracy.manchester.gov.uk/documents/s3976/MFT%20One%20Year%20Post%20Merger%20Report.pdf
- *"Foundation trust and NHS trust mergers 2010 - 2015"*, The King's Fund (September 2015) https://www.kingsfund.org.uk/publications/foundation-trust-and-nhs-trust-mergers
- "*Revising the NHS transactions guidance for trusts undertaking transactions, including mergers and acquisitions: Consultation response*", NHS England (October 2022) https://www.england.nhs.uk/wp-content/uploads/2022/10/B1464_i_revising-NHS-transactions-guidance-for-trusts-consultation-response-1.pdf
- *Programme Director's experience of reviewing transactions as a senior manager at Monitor and subsequently supporting a number of transaction programmes*

This paper also sets out more specific recommendations from and observations made in the following reviews into Southern Health NHS Foundation Trust's ("Southern's") acquisition of the Oxford Learning Disabilities NHS Trust ("Ridgeway") that may be relevant to Project Fusion:

- *"Review of due diligence undertaken on acquisition of the Ridgeway Partnership Trust (Oxford Learning Disabilities Trust)"*, PricewaterhouseCoopers – commissioned by Southern Health (March 2014)
- *"Independent review into issues that may have contributed to the preventable death of Connor Sparrowhawk"*, Verita – commissioned by NHS England and Oxfordshire Safeguarding Adults Board (October 2015); https://www.england.nhs.uk/wp-content/uploads/2015/10/indpndnt-rev-connor-sparrowhawk.pdf

2. Analysis

The table at Annex A sets out lessons learnt based on the reports referenced above, grouped into key themes. The table sets out how these lessons have informed the Project Fusion approach.

The table at Annex B sets out findings, recommendations and (where considered relevant) comments made within the two reports specifically relating to Southern Health. It identifies if,

and how, these may be relevant to Project Fusion and sets out what we are doing, or intend to do, to mitigate risk or take account of the learning from the Ridgeway acquisition. The table sets out where the responsibility and oversight for ensuring that this action is addressed is made, along with any anticipated timings.

Annex A – Thematic lessons learnt from previous NHS transactions

Lessons learnt	Fusion response
Based on lessons learnt from the Manchester University NHS Foundation Trust transaction and the experience of the Programme Director, it is critical to the success of the transaction that the new organisational structure, including the operating model and governance arrangements, is well planned pre-merger and established quickly. This allowed certainty to be provided to staff at an earlier stage, which helped minimise the negative impact of a process that executives commonly described as difficult and painful. This is particularly important to the successful delivery of improvements for those transactions which were a ‘merger of equals’ where the new leadership teams should include experienced individuals from the predecessor organisations. The relationship between the group management and the hospital leadership teams should be given careful consideration prior to the transaction date and it is likely to continue to be a subject for active consideration throughout the first year of operation. Southern’s Associate Director of Corporate Governance and Risk noted that this was a theme from discussions with peers at Somerset, Liverpool and Merseycare.	The Board appointment process has been developed. The designate Chair was appointed in June 2023 and Non-Executive Director designates appointed. The designate Chief Executive was appointed in July 2023. The Nominations and Remuneration Committee (with Non-Executive Director designates in attendance) will work with the designate Chief Executive to agree the executive structure which will be reflected in the Full Business Case. Activities to support succession planning for key Board roles where terms come to an end in 2024 is included within the corporate governance post-transaction implementation plan (Audit Chair, Chair). The Operating Model Advisory Group is leading on developing the operating model for the new Trust and will make initial recommendations to the Programme Board in August 2023 to allow the operating model to be articulated in the Full Business Case. The Full Business Case will also set out the post integration evaluation approach, including an assessment of the effectiveness of the operating model.

Lessons learnt	Fusion response
Communicating and engaging with staff is crucial throughout the merger and post-merger. Staff are central to the planning and delivery of the merger work and the development of the vision and values of the new Trust. This helps to ensure that despite the significant level of change taking place, staff engagement remains strong. In the case of Manchester University NHS Foundation Trust, a significant amount of time and effort was expended on involving and engaging key stakeholders in the process, most importantly senior clinical staff throughout the Trusts. In particular, clinicians with dedicated Clinical Lead roles were identified and a Clinical Advisory Group was put in place. These arrangements proved to be invaluable in the run up to the merger and the early period post-merger, and were a strong influence on how the “business as usual” operation of the new organisation was developed. In the case of transactions reviewed by the Programme Director, clinicians working together as a single team from across the merged trust was recognised as a key ingredient in achieving success and improved patient outcomes. Where teams remained separate, this generally reduced the likelihood that productive working relationships would develop and lead to new ideas and an internal clinical consensus about the best way to deliver services across the merged trust.	A communications and engagement plan has been developed and continues to evolve. This includes the approach for engaging with staff. The latest version of the communications and engagement plan will be appended to the Full Business Case. The Clinical Steering Group has led on the development of the clinical strategy (which will be appended to the Full Business Case) and engagement with clinical staff (including through the Clinical and Professional Leadership Network Forum), building on the work of the Clinical Transformation Group which has brought together clinicians and operational leads across ten priority areas.
NHS England’s new Transactions Guidance (published October 2022) placed a greater emphasis on the theme of culture. NHS England’s consultation response describes how cultural considerations have been developed further in the updated guidance, particularly for the FBC and PTIP stages. NHS England has developed a separate good practice guide in relation to culture and staff engagement. The following areas are required to form part of the SC, FBC and PTIP content: Are there clear plans to engage with staff in the period leading up to the proposed transaction date, and think about culture development? The SC clearly explains what engagement there has been to date, the major issues highlighted from that engagement and the detailed programme for future staff engagement and cultural due diligence. For the FBC: Is a well-planned culture development and staff engagement programme in place? Is there an adequate understanding of the cultures of all organisations, resulting from thorough cultural due diligence?	The proposed approach to cultural alignment and organisational development will be articulated in the Full Business Case (with reference to the NHS England guidance). There has been significant staff engagement including through joint leaders events in October 2022, February 2023 and June 2023, and a six week engagement period led by the Operating Model Advisory Group in May/June 2023.

Lessons learnt	Fusion response
Is there a robust and detailed plan to develop the desired culture for the enlarged organisation? Has communication and staff engagement been effective and are there robust plans for future engagement? For the PTIP, organisations should demonstrate the following: • Cultural change management strategy providing detailed and robust plans for developing the desired culture for the enlarged organisation, including details of: – plans for embedding a single vision, set of core values and behaviours, and gathering feedback and responding to concerns – ongoing actions to address any identified cultural concerns. How success of cultural development will be measured and assessed. • Resourcing plans ensuring availability of experienced staff representative of various grades and services. Further lessons regarding cultural integration have been learnt from the Manchester University NHS FT merger: There has been a clear and sustained emphasis on cultural work and organisational development. This commenced from the audits of organisational culture that were undertaken prior to the merger and has been maintained through the organisational change processes, the development of the new statement of behaviours and values, and other key OD activities. Cultural differences are known to be a key risk issue in organisational mergers, and the time and effort put into developing a positive approach has been beneficial. In addition, Southern's Associate Director of Corporate Governance and Risk noted that this was a theme from discussions with peers at Somerset, Liverpool and Merseycare.	
The value of having a robust Post-Transaction Integration Plan (PTIP) cannot be overstated. In the case of Manchester University NHS FT, the PTIP provided the Group Board of Directors with a framework to assess progress and gain assurance about the merger. More importantly, it afforded staff, clinical	Following approval of the Strategic Case in March 2023 the Integration Planning Group was established which meets at least fortnightly and brings together

Lessons learnt	Fusion response
leaders, managers and transformation teams a framework against which to operate from day one of the merger. In this example, the merging Trusts recognised that, as well as being a requirement of external assurance processes, the PTIP was of primary importance in managing the organisational merger. The Trusts took the development of the PTIP very seriously, and invested a lot of time and effort in developing multiple iterations, so that the document remained relevant and up to date. Three iterations were developed in the run up to the merger, and a fourth version following the first 100 days. The fifth iteration was developed following completion of the first year of operation. Board members were closely involved in the development of PTIP, and there have been regular progress reports at Board level throughout the merger process. This has meant that the PTIP has continued to be the central function in guiding the Trust's management of its integration agenda. The merger process has been subject to a number of external audit processes, from the original Reporting Accountant Reports, through to follow-ups on PTIP and on how the new organisation performs against the Well Led framework. These processes have helped to maintain the standard of the integration work in the merger, from planning through to implementation, and although the audit outcomes have always been positive there has also been something to learn from each exercise.	representatives from each Steering Group leading on integration planning. The proposed structure of the PTIP was shared with the Programme Board (which includes NED representation from the three Trusts) in April 2023 for comment. The draft PTIP narrative will be shared with the Programme Board on 21 August and with Trust Boards in early September. The first draft of the PTIP (including integration plans) will be shared with Programme Board on 18 September and with Trust Boards in early October. The final draft PTIP will be reviewed by Programme Board on 16 October before approval at a Boards-in-common meeting on 23 October.
The King's Fund paper reflecting on a number of transactions in the NHS noted that the strategic rationale had been too generic and did not explain in detail how the benefits and efficiencies outlined would be secured, nor why they were thought to be substantial. In particular, very few of the merging parties could claim to have set out a 'distinctive strategic rationale' for the merger (as opposed to tactical plans to exploit improvement opportunities as a combined organisation), such as the opportunity to develop a specific business model or a fundamentally different system of care. On the contrary, experience from Manchester University Foundation Trust notes this as one of its key areas of strength during the process. In January 2016, the Manchester Health and Wellbeing Board commissioned Sir Jonathan Michael to lead an independent review of the potential benefits and mechanisms for improved cooperation between hospital services across the City of Manchester. The Manchester Single Hospital Service review took place in two stages: the first stage assessed the potential benefits arising from adopting single hospital service models in	The strategic rationale was articulated in the Strategic Case. The strategic rationale builds on the independent review of community and mental health services and was further developed at a strategic case development workshop in December 2022 which was attended by a range of Executive and Non-Executive Directors from across the Trusts. The strategic rationale received positive feedback from NHS England who stated in their letter dated 15 June 2023: "Our review [of the Strategic Case] has found the transaction has a clear strategic

Lessons learnt	Fusion response
selected specialties (as case studies), and the second stage gave an appraisal of the most appropriate organisational and governance arrangements to deliver these benefits. The review consequently provided a firm strategic basis for the merger programme, with a clear vision that was widely understood and accepted. The key messages from the original review have been sustained throughout the process and are still relevant post-merger. The clarity of the strategic approach also facilitated effective stakeholder engagement, and the new organisation has been fortunate to benefit from positive relationships with its main Commissioners and other partners throughout Greater Manchester. Detailed stakeholder mapping from the early stages of the programme was an essential part of optimising relationships, understanding, and support for the merger.	rationale recognised by the trusts and supported by the Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) and other stakeholders." The communications and engagement plan includes stakeholder mapping. The latest version of the plan was reviewed by Trust Boards in April 2023.
In the process of preparing for the merger, establishing an Integration Programme Team with a semi-independent role and working across the merging parties can help to avoid the deployment of external consultancy and to enable delivery of the PTIP as a local product recognised and owned by staff. It also provides a resource to coordinate post-merger work, including the transition from merger change processes to business as usual, linked to portfolios of individual directors. In the case of Manchester University NHS FT, the Integration Programme Director was clearly understood to be independent, and had sufficient seniority to join the Executive Team and Board meetings at merging Trusts. This was of great benefit in fostering confidence in the Trusts as to the fairness of the process and allowed more rapid progress to be made. The use of external support, for example from the major consultancies, was deliberately kept to a minimum, and was focused on areas where specialist skills were required, rather than just additional capacity. This approach meant that there was far better ownership, and buy-in to the integration process, and that continuity and organisational memory were maintained. In essence, the people involved in diagnosing the challenges and developing the integration plans are the same people who then take responsibility for implementation. This was balanced with sufficient external due diligence and audit work to provide adequate assurance on the information being reported at Group Board-level. There were however some areas for improvement identified during the transaction:	Programme Director (external) and Programme Manager (internal secondment) have been in place since October 2022. The Programme Director is a member of the Programme Board and Operating Model Advisory Group, as well as the Programme Team and Integration Planning Group. Steering Groups have put in place project management resource as required. Excel has been used as the programme management tool to support integration planning as each Trust uses different programme management software. The Full Business Case will articulate the integration resources and tools required up to and beyond 1 April 2024.

Lessons learnt	Fusion response
The scale and complexity of the programme made it inherently difficult to manage, and this was particularly true of the PTIP, where there were a very significant number of different activities that had to be monitored and managed, and a changing programme of work that was updated with each iteration of PTIP. To support the management of this process, the Trusts agreed to deploy a programme management tool. The functionality of the tool proved to be very useful and is now used to support all of the new Trust's integration and transformation activities. There was a problem, however, with the initial implementation process. The need for a structured programme management tool was not recognised until the PTIP was quite well developed, and many of the Day One plans were being implemented. As such, the Single Hospital Service Programme Team and IM&T had to support the implementation of the package at a time when the planning and implementation agenda was already very busy, and sometimes plans that had already been recorded in other formats had to be re-keyed. The tool has been used extensively and actively in managing the integration process, and over the long term, there is no doubt that it has been beneficial to have a structured programme management tool in place. However, it is likely that the benefits would have been greater, and the disadvantages reduced, if there had been an earlier realisation that a system of this sort would be required.	
NHS England's new Transaction Guidance (published October 2022) placed a greater emphasis on the theme of digital transformation. Digital transformation considerations have been developed further in the updated guidance, particularly for the FBC and PTIP stages. NHS England has developed a separate good practice guide in relation to digital integration. For the FBC: Is a well-planned digital integration programme in place? Is there an adequate understanding of the risks and opportunities of digital integration from robust IT due diligence? Has there been robust planning in relation to the digital requirements of the new clinical and operating model? Are there safe and deliverable plans in place for the transition of key systems? Are the costs of transition (including capital) and funding sources clear?	Following development of the Strategic Case, the Infrastructure Steering Group (which covered Estates and Digital) was split into two separate Steering Groups to allow sufficient focus and executive leadership. The Full Business Case will set out the digital strategy for the new Trust and proposed approach to digital transformation to support delivery of the clinical strategy (with reference to the NHS England guidance).

Lessons learnt	**Fusion response**
For the PTIP, organisations should demonstrate the following: Details of work carried out to understand current systems across transacting organisations. The opportunities that the transaction creates for improving digital infrastructure and/or reducing cost. Proposals for integrating (or not) key systems, including performance reporting, health records, risk management, staff records and financial ledger. To include clarity on what must be implemented for day 1. IT integration prioritisation with phased implementation plan; considering the urgency of integration and resources available. Resourcing plans for integration delivery alongside BAU, including delivery of staff training needs in a timely manner. Key digital policies and processes to be harmonised.	

Annex B – Lessons learnt from Southern acquisition of Ridgeway

<table>
<tr><th>Recommendation</th><th>Action / assurance required</th><th>By whom / when</th></tr>
<tr><td colspan="3">PricewaterhouseCoopers - Review of due diligence undertaken on acquisition of the Ridgeway Partnership Trust (Oxford Learning Disabilities Trust) [March 2014]</td></tr>
<tr><td>Recommendation 1
When considering future transactions, the Board should determine, and clearly set out in a written record, what information and assurances it requires in order to:
a) Make a decision to approve the transaction
b) To sign the declarations required by Monitor
c) Discharge any other related duties that arise for the specific transaction.
Once the Board has determined its requirements, these should be formulated into a project plan setting out responsibilities for providing the required information and assurances and the timeframes. The project plan should be clearly mapped to the requirements of regulators, legislation and any other applicable guidance.</td><td>Legal advice has been sought on the precise decisions each Trust Board will be required to make and this will be shared with Trust Boards in early September.
In early September Trust Boards will consider a paper setting out the Board certification and the information and assurances to be provided to support the certification.</td><td>Trust Boards</td></tr>
<tr><td>Recommendation 2
The Board (and relevant sub-committees) should consider how information is evaluated in the future. Consideration of what may be seemingly low risk or insignificant observations could, when taken in conjunction with other observations, be a signal of something more serious.
In future due diligence exercises, the read-across between different elements of work by appropriately skilled individuals should be built into the project plan to ensure that appropriate triangulation takes place on a timely basis allowing a fuller identification and mitigation of risks.</td><td>Initial due diligence included an indicative risk assessment and development of scope and approach for due diligence at Full Business Case stage. Due diligence reports will be considered by relevant Board Committees and by Boards in advance of the Full Business Case being finalised.</td><td>Trust Boards</td></tr>
<tr><td>Recommendation 3
The Trust should ensure that key decisions, processes and considerations are effectively documented to ensure that knowledge is retained within the organisation.</td><td>Decision logs are maintained for the Programme Board, Programme Team and Integration Planning Group.</td><td>Trust Boards</td></tr>
</table>

Recommendation	Action / assurance required	By whom / when
Where action plans are developed, an Executive Lead should be assigned and for a transaction of this nature and size, consideration should also be given to whether a Non-Executive Lead also should be assigned. Action plans should be prepared on a timely basis and should cover all relevant internal and external risks.	Each Trust has identified an Executive Lead for Project Fusion. From February 2023 the Programme Board membership has included NEDs from Southern, Solent and IoW. In addition, each Steering Group has an Executive Lead. Integration planning has been lead by Steering Groups, reporting into the Integration Planning Group which focuses on reviewing integration plans and inter-dependencies between Steering Groups. Integration plans include actions to respond to risks identified in due diligence. The Full Business Case will set out the approach for monitoring the post-transaction integration plan post 1 April 2024.	
Recommendation 4 There is a disconnect between the minuted discussions at Board and the recollection of Board members of the debate and challenge surrounding the transaction decision-making. This may be reflective of some gaps in the minutes of meetings and/ or the fact that some information and discussion occurred outside the Board room, for example in the Investment Committee. In the future the Trust should endeavour to ensure that good governance can be demonstrated by retaining complete and accurate evidence of Board information and debate.	Trust Boards to ensure that there is an adequate record of all discussion – whether this is undertaken in public Board meeting or in a private meeting / seminar / Committee.	Trust Boards
Verita – ***Independent review into issues that may have contributed to the preventable death of Connor Sparrowhawk*** **- Findings, Conclusions and Recommendations [June 2014]**		

Recommendation	Action / assurance required	By whom / when
(p31) **Finding 1** (Chapter 6 – Executive summary) Legislation and guidance was in place during the period of Connor's care in relation to: • admission and discharge; • transition from children's services to adult services; • care planning; including, risk assessment and involvement of families; • multi-professional and multi-agency working; • adult safeguarding; and • commissioning, including contracting and commissioner quality reviews.	*Not considered applicable to transaction*	
(p31) **Finding 2** (Chapter 6 – Executive summary) NHS England and learning disability service providers do not have any learning disability national service level agreements, unlike those for mental health services. This means that service models for learning disability provision are open to wide variation throughout the country and consequently there are limited national standards against which learning disability services can be assessed.	The clinical strategy (which will be appended to the Full Business Case) will set out the approach to identify variation in service models, determine best practice and reduce unwarranted variation. The Full Business Case will articulate the approach to performance management for the new Trust.	Programme Board (and ultimately new Trust Board)
(p31) **Finding 3** (Chapter 6 – Executive summary) We found only a small amount of best practice guidance specific to short-term assessment and treatment units. The main exceptions were the guidance issued by the Royal College of Psychiatrists in 2010 and that produced in 2013 in relation to commissioning services - which the college part-authored.	*Not considered applicable to transaction*	
(p32) **Finding 4** (Chapter 6 – Executive summary) We endorse the work of Sir Stephen Bubb (appointed by NHS England to report on learning disability services in the light of the Winterbourne scandal) in seeking to ensure that the commitments made by NHS England to people with learning disabilities and their families and carers are met. NHS England must give the priority required to ensure the targets set out in *Time*	The performance management and quality improvement approach for the new Trust will ensure relevant guidance and national learning is adopted and will be articulated in the Full Business Case.	Programme Board (and ultimately new Trust Board)

Recommendation	Action / assurance required	By whom / when
for change are delivered and real and substantial change in learning disabilities services takes place.		
(p32) **Finding 5** (Chapter 6 – Executive summary) The trust undertook appropriate, adequate and reasonable due diligence into the quality and safety of the services prior to acquisition. The due diligence reviews did not identify any acute concerns about the safety of services in STATT. The more acute concerns were focused on the non-Oxfordshire services.	Initial due diligence included an indicative risk assessment and development of scope and approach for due diligence at Full Business Case stage. Due diligence reports will be considered by relevant Board Committees and by Boards and the findings reflected in the Full Business Case.	Programme Board
(p32) **Finding 6** (Chapter 6 – Executive summary) The County Council quality and contracts review carried out in November and December 2012 was thorough. It was conducted over a number of days and the range of interviews was comprehensive and appropriate. As matter of good practice, it would have been beneficial to include NHS professionals in the team.	*Not considered applicable to transaction*	
(p32) **Finding 7** (Chapter 6 – Executive summary) The communication and engagement strategies Southern Health put in place for the period up to the acquisition were of a high quality and comprehensive. The approach taken to communication and engagement with Ridgeway staff after acquisition was inadequate and failed to ensure that the natural concerns of a staff group taken over by a large and distant trust were properly addressed.	The communications and engagement approach (as set out in the Strategic Case and will be further developed in the Full Business Case) ensures that themes from engagement shape the plans for the new Trust including the operating model.	Communications & Engagement Steering Group
(p32) **Finding 8** (Chapter 6 – Executive summary) The post-acquisition model of 'business as usual' was flawed because concerns had been raised about the quality of management in Ridgeway. Southern Health divisional managers needed to	The Full Business Case will set out the approach the new organisation will take to ongoing implementation and monitoring of the post-transaction integration plan.	Programme Board

Recommendation	Action / assurance required	By whom / when
fully engage with managers and clinicians in Ridgeway to ensure that the board level executives could rely on the reports they were receiving.		
(p32) **Finding 9** (Chapter 6 – Executive summary) Southern Health was taking over a long-standing service and the approach to the post-acquisition period lacked a viable strategy to mitigate the negative effects of significant organisational change. In particular they lacked: • a communication strategy that was as effective after the acquisition as before it, so that as far as possible staff concerns during the immediate months after the acquisition were listened to and acted on; and • an enhanced presence of Southern Health senior executive leaders meeting with staff, families and commissioners in the former Ridgeway area in the year after acquisition.	The communications and engagement plans for the new organisation will be articulated in the Full Business Case and will reflect the need for continued engagement with staff post Day 1. The Full Business Case will also articulate the leadership and operating model for the new Trust to ensure visibility of senior leadership across entirety of Trust footprint and services.	Communications & Engagement Steering Group Programme Board
(p33) **Finding 10** (Chapter 6 – Executive summary) The decision of the best-interest assessor that Connor was not deprived of liberty was consistent with the law and the practice of best-interest assessors at the time	*Not considered applicable to transaction*	
(p33) **Finding 11** (Chapter 6 – Executive summary) The approach to the MHA by the staff of STATT appears to have been consistent with law and practice at the time.	*Not considered applicable to transaction*	
(p33) **Finding 12** (Chapter 6 – Executive summary) The use of both DoLS and the MHA were consistent with professional practice at the time.	*Not considered applicable to transaction*	
(p33) **Finding 13** (Chapter 6 – Executive summary) Southern Health's strategy for introducing a number of clinical pathways and maps was appropriate.	*Not considered applicable to transaction*	

Recommendation	Action / assurance required	By whom / when
(p33) **Finding 14** (Chapter 6 – Executive summary) The clinical decisions of the qualified and registered health professionals at STATT around the care of Connor's epilepsy and risk management as set out in our first report were inappropriate and unsafe. They were not caused by a failure to have in place appropriate epilepsy policies or trust guidance.	*Not considered applicable to transaction*	
(p33) **Finding 15** (Chapter 6 – Executive summary) The learning disability divisional action plans developed in 2014 are of a good quality, comprehensive in their scope and linked directly to the issues CQC and Verita identified, post-Connor's death. Southern Health recognised a potential shortfall in capacity for the oversight of the plans and responded by commissioning external experts (MBI Health Group). They combined this with the commissioning of an external review of quality. This demonstrates that they recognised the problems and acted to address them.	*Not considered applicable to transaction*	
(p33) **Conclusion 1** (Chapter 6 - Executive Summary) / (Chapter 14 – Conclusions) 6.70 The County Council, commissioners of the STATT, carried out a quality monitoring review of STATT in November/December 2012. An action plan was produced by Southern Health and this was reviewed by the commissioners in July 2013. The commissioners also reviewed the update of the Southern Health quality and safety review in May 2013. The commissioners chased up Southern Health senior managers in the first few months of the contract to get them to be more engaged with the regular contract review meetings. 6.71 There is no evidence that acts or omissions of commissioners contributed to the inadequate care received by Connor that led to his preventable death. We set out our rationale for this in our overall conclusion.	*Not considered applicable to transaction*	
(p34 / 192) **Conclusion 2** (Chapter 6 - Executive Summary) / (Chapter 14 – Conclusions) 6.72 Quality reviews carried out before the acquisition or at the point of acquisition did not find that STATT had acute clinical, managerial or systems failures. In contrast, concerns were	Clinical due diligence scope is in line with NHSE indicative scope and includes a number of quality domains in addition to patient safety (including patient experience and workforce). The	Clinical Steering Group

Recommendation	Action / assurance required	By whom / when
focused on the non-Oxfordshire part of the former Ridgeway services where patient safety risks had been identified.	Post-transaction integration plan will articulate plans to ensure robust performance monitoring, escalation and oversight processes are in place from Day 1.	
(p34 / 192) **Conclusion 3** (Chapter 6 - Executive Summary) / (Chapter 14 – Conclusions) 6.73 An over reliance on a 'business as usual' approach to this acquisition was not appropriate. Southern Health should have ensured that any deterioration in the quality of services could be identified quickly and by processes that Southern Health had confidence in.	The Full Business Case will set out the approach the new organisation will take to ongoing implementation and monitoring of the post-transaction integration plan.	Programme Board
(p34 / 192) **Conclusion 4** (Chapter 6 - Executive Summary) / (Chapter 14 – Conclusions) 6.74 The post-acquisition process by Southern Health was not effective because: • the two key managers with an experienced learning disability background, prior to or close to the date of the acquisition, made it known that they did not want to be part of managing the new services; • the trust had not put in place sufficient and timely actions needed to begin to address the cultural change required of an established learning disability service joining a large mental health and community trust with a small learning disability service; • the trust did not evaluate or address the known concerns about the quality of local leadership; and • local managers were also dealing with a number of significant issues existing in the non-Oxford part of the former Ridgeway services.	The Strategic Case sets out the proposed approach to cultural alignment and organisational development and this will be developed further in the Full Business Case stage.	Programme Board
(p35 / 193) **Overall conclusion** (Chapter 6 - Executive Summary) / (Chapter 14 – Conclusions) 6.75 In our first report we took the view that the key issue in Connor's care was poor practice by clinical staff. We have not seen anything during our work on this second investigation to change that. While we have identified deficiencies in the way Southern Health carried out its post-acquisition actions and that these had an impact on staff (as the independent reports commissioned by Southern Health in late 2013 show in relation to the Oxford services) there is no	The post-transaction integration plan will incorporate all relevant actions to ensure that services in the new organisation are safe, including developing policies and procedures for	Programme Board

Recommendation	Action / assurance required	By whom / when
evidence that these affected the clinical decisions or team working in STATT, as they related to the care of Connor. 6.76 If Southern Health had carried out their post-acquisition actions more effectively this may have identified weaknesses in the way staff in STATT were working. We have not seen evidence which would allow us to conclude that this would have prevented the poor decisions around Connor's care. 6.77 The failures in care during Connor's inpatient admission were not caused by Southern Health managers or commissioners. The clinical staff failed to carry out procedures and processes that were their responsibility and within the competence and knowledge expected of registered health professionals. Principally clinical staff did not effectively work together and follow NICE guidelines regarding the care of individuals with epilepsy.	the new organisation and ensuring that all staff are aware of these. Steering Groups have reviewed existing policies and developed plans to harmonise these.	
(p36) **Recommendation 1** (Chapter 6 – Executive Summary) Commissioners should continue to ensure that service user views are (and are seen to be) taken into account in commissioning decisions.	*Not considered applicable to transaction*	
(p36) **Recommendation 2** (Chapter 6 – Executive Summary) In light of the comments from Professor Bartlett and the new Code of Practice, Southern Health should update their Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policies to provide clearer guidance about: • overall responsibility for implementation; • MCA provisions concerning best interests in the context of restraint; • the determination of deprivation of liberty; • the eligibility requirement; and • the provision of independent mental capacity advocates.	*Not considered applicable to transaction*	

Recommendation	Action / assurance required	By whom / when
Verita – ***Independent review into issues that may have contributed to the preventable death of Connor Sparrowhawk*** **- Relevant Comments**		
(p27) (Chapter 7 – Background) It was appropriate for Southern Health to put in place, post-acquisition, its quality assurance and governance processes. These relied on sound information feeding into the processes. But for Southern Health to only rely on its normal reporting mechanisms without addressing the Contact Consulting warning and ensuring that information from local managers was accurate was a serious failure.	The Full Business Case will set out the approach the new Trust will take to quality assurance and governance including triangulation with local intelligence.	Programme Board
(p28) (Chapter 7 – Background) We are not saying that no communication occurred after acquisition. Our concern is that over-reliance on systems that were well-known to Southern Health staff was unwise. There should have been as much effort put into the post-acquisition communication and engagement as prior to it, in particular for new divisional managers and executives to get to understand the service that had just been acquired.	The communications and engagement plans for the new organisation will be articulated in the Full Business Case and will reflect the need for continued engagement with staff post Day 1.	Communications & Engagement Steering Group
(p44) (Chapter 7 – Background) The scale of the NHS reorganisation and the impact it had on staff and services should not be underestimated. These changes directed focus on implementing changes and operating under the new working model.	The Strategic Case sets out the proposed approach to cultural alignment and organisational development and this will be developed more fully in the Full Business Case.	Programme Board
(p94) (Chapter 10 – The Ridgeway Trust era) Most people we spoke to did not think the services Ridgeway provided were outstanding; neither did they see them as particularly bad at that time. A perception that the services had once been ground-breaking but were now declining in quality was expressed by a number of interviewees. In general, concerns about the quality of services related to those outside Oxfordshire, although some people raised quality concerns across Ridgeway's activities. If the Oxfordshire services were flattered by comparison with the Ridgeway services outside Oxfordshire, they were even more flattered by comparisons with Winterbourne View. Restraint	Clinical due diligence scope is in line with NHSE indicative scope and includes a number of quality domains in addition to patient safety (including patient experience and workforce). The Post-transaction integration plan will articulate plans to ensure robust performance monitoring, escalation	Clinical Steering Group

Recommendation	Action / assurance required	By whom / when
practice had been a problem in other Ridgeway locations but it had not been an issue in Oxfordshire. Judged by the Winterbourne View standard, and in the context of the rest of the Ridgeway services, STATT and John Sharich house were considered adequate and therefore were not singled out for particular attention.	and oversight processes are in place from Day 1.	
(p97) (Chapter 11 – Southern Health's acquisition of Ridgeway) One aspect of the acquisition process of Ridgway by Southern Health was driven by concerns that Ridgeway was too small to achieve foundation trust status. However, many people saw the acquisition of Ridgeway by a larger provider as the best way of improving services at the time. In the aftermath of Winterbourne View, a small, isolated service different from most comparable services suddenly made many feel vulnerable. Commissioners and staff at the strategic health authority (SHA) were relieved when Southern Health was appointed. They saw it as having solved a difficult problem.	The Strategic Case sets out the key principles to enable sustainable change and address the challenges set out in the case for change and these will inform the operating model for the new Trust which will be articulated in the Full Business Case.	Programme Board
(114) (Chapter 11 – Southern Health's acquisition of Ridgeway) …The various reviews of the Ridgeway services did not give them a clean bill of health. The reviews raised concerns about governance at Ridgeway and whether local managers were fully aware of the quality of local services. Managers needed to improve MDT working and risk assessments and care planning. Even so no acute concerns about the safety of services in STATT were raised by the reviews. The more acute concerns were focused on the non-Oxfordshire services. Commissioners and other external partners expected that Southern Health would have a strategy to address the issues raised in the County Council, Contact Consulting and the Southern Health quality reviews, if not in late 2012 but as soon as possible in 2013. The next section looks at how Southern Health responded to the issues raised in the reports.	Risks identified through due diligence will be reflected in the Full Business Case.	Programme Board
(p122) (Chapter 12 – Post-acquisition – November 2012 to July 2013) The contract of the interim transaction director was a fixed term contract and lapsed at the point of the acquisition	The Full Business Case will set out the approach to ongoing integration beyond 1 April 2024, including considering the resources required and executive responsibilities.	Programme Board

Recommendation	Action / assurance required	By whom / when
(p125) (Chapter 12 – Post-acquisition – November 2012 to July 2013) Both the operational director and the clinical director, having been key to the acquisition, had said they did not want to continue in their operational roles. The operational director had difficulty because she did not drive and wanted to be at home with her children at night. The clinical director was clear he could not carry out the extra responsibilities he had been given on top of his full-time consultant job. The clinical director made some interim medical arrangements but they were no substitute for having an engaged clinical director committed to making the improvements promised as part of the acquisition. They could only be described as stop-gap arrangements	The Full Business Case will set out the approach to ongoing integration beyond 1 April 2024, including considering the resources required, continuity of leadership and retention of corporate memory.	Programme Board
(p131) (Chapter 12 – Post-acquisition – November 2012 to July 2013) Commissioners identified a lack of practical engagement by Southern Health divisional managers on day-to-day matters and by February 2013 they were complaining about insufficient contact from the divisional directors not board level directors. Soon after the acquisition, significant difficulties arose in Southern Health as there were insufficient senior and experienced staff to take forward vital post acquisition actions. All services face changes in key leadership positions. In this case, the changes came when Southern Health needed to deal with the mechanics of the acquisition. Concerns about leadership and culture in Ridgeway had been raised in various reviews prior to acquisition and these also needed addressing. The 100 days after an acquisition or a merger are considered as a key time to set down the foundations necessary for change and improvement. In this critical time senior trust board executives should have considered how they might reinforce the learning disabilities divisional leadership as a result of the impending changes to key leaders. Driving forward the changes set out in the acquisition bid document required senior experienced learning disability professionals. The failure to replace the operational director and the clinical director in a timely fashion hampered Southern Health's ability to make the changes needed.	The Full Business Case will set out the approach to ongoing integration beyond 1 April 2024, including considering the resources required (internal and external). The Strategic Case sets out the proposed approach to organisational development and this will be developed more fully in the Full Business Case. This will include considering the cultures of the Trusts and plans for cultural alignment, with reference to NHSE's guidance in this area.	Programme Board

Recommendation	Action / assurance required	By whom / when
(p145) (Chapter 12 – Post-acquisition – November 2012 to July 2013) At first glance, a 'business as usual' methodology for a small newly acquired service may appear appropriate if that service is mature and relatively problem-free. The due diligence and quality assessments before acquisition did not identify significant concerns about clinical practice. Though significant signs of a lack of confidence in local leadership, the effective governance of serious incidents and particular difficulties about care issues at Postern House were identified. With hindsight, the 'business as usual' approach was not successful. The CQC inspection in September 2013 bears this out as does an independent management consultant review commissioned by Southern Health into managerial performance. We provide details of these reviews later in this section.	The Full Business Case will set out the approach the new Trust will take to ongoing implementation and monitoring of the post-transaction integration plan.	Programme Board
(p154) (Chapter 12 – Post-acquisition – November 2012 to July 2013) This report reveals clinical and managerial issues that should have been addressed after acquisition that were not identified with the speed and urgency necessary.	The Full Business Case will set out the proposed approach to quality governance for the new organisation.	Programme Board
(p155) (Chapter 12 – Post-acquisition – November 2012 to July 2013) The combination of the assessment and treatment manager being based at a unit remote from Oxford and the continuing uncertainty around future changes to roles had an impact on the level of support available to the unit manager for JSH and STATT, who was in his first managerial post.	The Full Business Case will set out the approach to ongoing integration beyond 1 April 2024, including considering the resources required, leadership and individual and / development requirements.	Programme Board
(p158) (Chapter 12 – Post-acquisition – November 2012 to July 2013) Some of the problems this independent investigation found can be attributed to how the service was managed locally. The pre-acquisition quality reviews had provided warnings.	Risks identified through due diligence will be reflected in the Full Business Case.	Programme Board

Appendix 10: Risk assessment matrix

Descriptions for the risk probabilities are outlined in the table below:

Probability score	1	2	3	4	5
Descriptor	Unlikely	Possible	Likely	Very Likely	Extremely Likely
% Probability	< 20%	20% - 39%	40% - 59%	60% - 79%	> 80%
Frequency/how likely to happen	This probably will never happen/recur	Do not expect it to happen/recur, but it is possible it may do so	Will probably happen/recur, but is not a persisting issue or circumstance	Very likely to happen/recur; possibly frequently	Extremely likely to happen/recur on a very regular basis

Descriptions for the transaction risk impacts are outlined in the table below:

Impact score	1	2	3	4	5
Descriptor		Minor	Moderate	Major	Critical
Impact on the safety of the patient, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention	Incident resulting serious injury or permanent disability/incapacity	Incident resulting in fatality or multiple fatalities
	No time off work	Increase in length of hospital stay by 1–3 days	Increase in length of hospital stay by 4–15 days	Increase in length of hospital stay by >15 days	An event which impacts on a large number of patients
			RIDDOR/agency reportable incident	Mismanagement of patient care with long-term effects	
			An event which impacts on a small number of patients		
Quality	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service

Risks should be rated in the template as per the scoring matrix below:

			Probability				
			Unlikely	Possible	Likely	Very likely	Extremely likely
			1	2	3	4	5
Impact	Critical	5	5	10	15	20	25
	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Minor	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5

Appendix 11: Programme risk register

Risks scoring 8 or above from the programme risk register as at 31/10/23:

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R21	1/8/22	Programme Board	BAU	External factors impact funding	External factors including economic situation and progress in implementing the other Carnall Farrar recommendations impacts on funding of new Trust and its ability to realise benefits.	Critical	5	Very Likely	4	20	⟷	New Trust will provide a strong collective voice for community and mental health services. The partners are supporting implementation of the other CF recommendations.	06/10/23	This risk is reported to Programme Board for information as it is a BAU risk.
R01	1/8/22	Programme Board	Integration	Reduced staff morale	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.	Major	4	Very Likely	4	16	⟷	Comms and eng plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.	06/10/23	28/07: Controls updated

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R05	1/8/22	Programme Board	Transaction	ICS financial position	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.	Major	4	Extremely Likely	4	16		Continued engagement with the ICB regarding the strategic importance of the programme.	06/10/23	March 23: Risk description updated to change from ICB financial position to ICS financial position. Probability score reduced from 4 to 3. 18/04: Andrew and Paula to review this risk in light of SOF4 28/07: Probability increased from 3 to 4 to reflect the system in SOF4
R20	1/8/22	Programme Board	BAU	Quality impacted by leaders distracted by transaction	There is a risk that there is a detrimental impact on performance/quality/compliance because staff are distracted/uncertain and have additional work pressures from transaction activities.	Major	4	Very Likely	4	16		Programme Director and programme management resource are in place. Process is in place for Steering Groups to request resources to support with development of FBC and integration planning. Trusts continue to operate as sovereign organisations until the agreed transaction ensuring focused governance and oversight is maintained in each Trust.	06/10/23	This risk is reported to Programme Board for information as it is a BAU risk. 28/07: Controls updated 12/10: risk description updated

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R51	15/8/23	All Steering Groups	Integration	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	Major	4	Very Likely	4	16	↔	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned	06/10/23	9/10/23 - have changed to all SGs as this risk applies to all SGs 12/10/23 - risk description and mitigations updated
R95	30/8/23	Workforce Steering Group	Integration	Disparity in remuneration	There is a risk that disparity in remuneration approaches for staff across the different Trust could result in inequities and variations that could negatively impact on staff morale if not dealt with in a timely and agreed way.	Major	4	Very Likely	4	16	New	TUPE measures and evaluation of the salaries must be assessed, and any risks worked through, and options appraisals presented to the new Board to decide on a fair and equitable decision.	19/10/23	
R07	5/12/22	Programme Board	Transaction	FBC not approved by Trust Boards	Risk that identified benefits do not outweigh risks and costs and FBC does not contain sufficient detail to assure Boards (for example in respect of patient benefits) and the FBC is not approved by Trust Boards	Critical	5	Likely	3	15	↔	Robust approach to benefit identification and risk identification and mitigation. Draft FBC to be shared with Boards in early Sept and finance workshop on 10/08 will provide opportunity for NEDs to give an early steer (as well as NED representation on Prog Board).	06/10/23	13/07: Risk description changed to re-focus risk from SC to FBC not approved by Trust Boards. 28/07: Risk description and controls updated and probability score increased from 2 to 3.
R41	10/05/23	Programme Team	BAU	BAU Financial Risk	There is a risk that the BAU cost of delivery for Day 1 is larger than the sum of the existing budgets as we will not have realised efficiency benefits.	Moderate	3	Extremely Likely	5	15	↔	All SG to quantify impact as part of integration planning. Finance Steering Group is working with other Steering Groups to identify synergies.	06/10/23	28/07: Risk description and controls updated

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R88	1/8/23	OD Steering Group	Integration - DD	Embedding the new culture and values	If the creation of the new Trust values is not co-designed and embedded with staff and supported by managers, there is a risk that acceptance of the transition will be poor and will have a negative impact on the cultural alignment and identity of the new Trust.	Major	4	Likely	3	16	New	Shape Our New Trust staff engagement programme and Manager's Change Support pack and training offer. Further engagement planned on values, new Trust strategy and operational management structure. Series of pulse check surveys to measure how staff are feeling specifically relating to the Fusion change programme.	06/10/23	12/10: mitigations updated
R02	1/8/22	Programme Board	Transaction	IOW capacity	IoW does not have resource to support the programme given other demands on time from strategic programmes.	Moderate	3	Very Likely	4	12	⬌	IoW segmentation has been prioritised with governance in place and progress reported to Fusion Programme Board.	12/09/23	08/06: PF Operational Lead for IoW starts on 12 June and will support DD and PTIP work. Three project managers have also been recruited to support steering groups. 28/07: Controls updated 18/10: mitigations updated

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R60	1/8/23	Digital Steering Group	Integration - DD	IoW SystmOne continuity	There is a risk that staff are not supported by resilient digital services and progress to new infrastructure solutions is not maintained.	Critical	4	Likely	3	12	New	Joint working underway to define SLA requirements, agreement SLA requirement will be minimal and required staff will TUPE transfer	06/10/23	12/10: updates to risk description and mitigation 30/10: risk description updated
R17	18/1/23	Workforce Steering Group	Transaction	Vacancy rates increase impacting Bank/Agency costs	There is a risk that vacancy rates increase as posts become difficult to fill and retain if candidates feel unsure about the future organisation and this will impact patient safety and increase Bank and Agency costs	Moderate	3	Very Likely	4	12	↔	Workforce pipelines, bank and agency usage, recruitment campaigns, innovative recruitment plans	12/09/23	This risk is not reported to Programme Board as it is reflected in R01
R04	1/8/22	Programme Board	Integration	Leadership burn out / distraction	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).	Major	4	Likely	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 will be articulated in the PTIP and will inform plans for the new Trust, including resource requirements.	12/09/23	28/07: Controls updated
R18	18/1/23	Workforce Steering Group	Transaction	Sickness absence levels increase	If staff feel unsure and unsettled about the changes ahead, there is a risk that sickness absence levels increase which could destabilise services and increase costs.	Moderate	3	Very Likely	4	12	↔	Wellbeing interventions, Health and wellbeing plan, line manager education, comms to staff.	12/09/23	This risk is not reported to Programme Board as it is reflected in R01

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R45	5/4/23	Clinical Steering Group	Integration	Resourc es	With the disaggregation of the IOW Trust there is a risk the community services resource may be lost due to the acute integration with PHU	Major	4	Likely	3	12	⬌	IoW segmentation (reported to through IoW segmentation governance and to Fusion Programme Board) will ensure clarity on clinical resources that are/aren't transferring to the new Trust. Integration planning to mitigate any risks arising from agreed position.	12/09/23	28/07: Controls updated 18/10: mitigations updated

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R29	1/2/23	All Steering Group	Transaction	Capacity and capability	If there is insufficient capacity or capability to undertake thorough integration planning there is a risk that critical path activities are not completed and the planned Day 1 is not achieved.	Moderate	3	Very Likely	4	12	⬌	Where possible backfill arrangements have been put in place to cover the needs of the programme. 'Snapshots' of the Steering Group integration plans will be taken on 24/08, 15/09 and 03/10 to populate the PTIP and provide the opportunity to QA integration planning. Suggested Day 1 activities have been provided to Steering Groups to inform their integration plans.	12/09/23	8/6: Solent CoS is leaving 26 July and there is concern regarding delivery of CG day 1 readiness - ICS resource being sourced but any delay will result in less handover time regarding this key role. 12/7: fixed term replacement for Solent CoS has been secured from SPFT and has been involved in the Fusion programme previously 28/7: risk description and controls updated to reflect the fact that due diligence is now complete 30/10: likelihood increased from 3 to 4

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R55	1/8/23	Corporate Governance Steering Group	Integration - DD	Day 1 policies	There is a risk that staff are not aware of or trained in the policies in place on Day 1 and do not follow and this leads to an adverse outcome.	Major	4	Likely	3	12	New	Steering Groups have been allocated policies and agreed those for harmonisation on Day 1 and process for approval has been developed. Communication and training for staff.	06/10/23	12/10: risk description and mitigation updated
R80	1/8/23	Estates Steering Group	BAU	Continuity of service re estates PPM (IoW)	There is risk of possible non-compliance associated with PPM schedules on the IOW that results in patient safety or regulatory issue.	Major	4	Likely	3	12	New	Commissioning a full H&S Management Audit for buildings transferring with an aim to complete in Sept 23.	06/10/23	12/10: risk category updated from integration DD to BAU
R91	1/8/23	Workforce Steering Group	Integration - DD	Temporary staffing model	There is a risk that a temporary staffing model is not put in place and operational teams cannot access temporary staffing from Day 1.	Major	4	Likely	3	12	New	Options appraisal regarding temporary staffing model to guide decision is being worked on for consideration at November programme team meeting. IoW & CAMHS staff from Sussex will need to join a roster by April 2024	06/10/23	12/10: Risk description updated
R89	1/8/23	Workforce Steering Group	Integration - DD	Statutory and mandatory training	There is a risk that compliance with stat/mand training reduces.	Major	4	Likely	3	12	New	Exec review of LMS options (October)	06/10/23	12/10: Risk description updated

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R11	30/11/22	Programme Board	Integration	Levelling down of services	If quality governance arrangements in the new Trust are not designed and implemented effectively there is a risk of a loss of Board to ward connection and negative impact on patient experience and outcomes.	Major	4	Likely	3	12	⬌	Partners are supporting implementation of other CF recommendations. Maintaining local focus will be key consideration in development of operating model. 'Best in class' approach to developing integration plan. Provider involvement in emerging commissioning and funding plans	06/10/23	12/10: Risk description updated and probability increased from 2 to 3 30/10: risk description updated (risk of levelling down is a separate risk - R22)
R94	30/8/23	Clinical Steering Group	Integration	Digital systems readiness	There is a risk that if impact assessments and requirements for Day 1 access to digital systems are not completed and in place by 1 April 2024 there is a risk that clinical care and patient safety will be impacted as staff may not be able to access key systems, historical data and be able to document essential information to support patient care.	Major	4	Likely	3	12	New	Digital Steering Group has collated a list of systems which has been issued to all steering groups to ensure clarity on digital support for systems transitions for Day 1 and beyond.	19/10/23	

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R97	30/8/23	Clinical Steering Group	Integration	Quality governance	If the new organisational structure, governance arrangements, design and clinical service models do not take account of the size and scale of the Trust, then there is a risk that quality governance, quality assurance and quality improvement arrangements may be ineffective resulting in adverse impact on board oversight and assurance, patient safety and risk management, as well as compliance and regulatory requirements.	Major	4	Likely	3	12	New	A core outcome of project fusion will be the developing and designing of the governance framework for the new Trust.	19/10/23	
R98	30/8/23	Clinical Steering Group	Integration	Integration planning	There is a potential risk of harm to patients if the integration planning and wider full business case process misses any critical components or fails to recognise the significance, or unintended consequences of any actions taken.	Major	4	Likely	3	12	New	Robust programme governance is in place and being followed to ensure the production and management of detailed workstream based integration plans that consider all interdependencies.	19/10/23	

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R99	30/8/23	Clinical Steering Group	Integration	Safeguarding	There is a risk that if safeguarding processes, supervision models, learning from incidents, governance and systems are not aligned effectively to the structure of the new Trust and preserve the place-based requirements there could be a negative impact on staff wellbeing/morale/ workforce recruitment and retention which could impact on safeguarding activities.	Major	4	Likely	3	12	New	Safeguarding leads meeting regularly to map current processes and understand any differences to ensure service is aligned to requirements for 1 April 2024.	19/10/23	
R08	5/12/22	Programme Board	Transaction	ICB/NHSE do not support proposal	Proposals are not supported by ICB and/or NHSE (potentially as a result of Project Fusion not delivering significant system financial benefits)	Critical	5	Possible	2	10		Regular engagement with ICB and NHSE to agree approach and ensure requirements are met. NHSE feedback on strategic case set out areas of focus and checkpoint meeting on 05/09 provides opportunity for the Trusts to present progress against these. ICB in attendance at Programme Board to ensure alignment.	06/10/23	
R57	1/8/23	Corporate Governance Steering Group	Integration - DD	Management of coroners' cases	There is a risk that any changes to processes for managing coroners' cases as a result of integration may impact the outcome for the new Trust and the ability for learnings to be shared and addressed.	Moderate	3	Likely	3	9	New	Integration planning for coroners processes and quality governance to disseminate learnings. Maintaining links with IoW corporate team.	06/10/23	12/10: risk description and mitigation updated

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R16	1/11/23	BSID Steering Group	Transaction	IOW Contracts Due Diligence	Concern around the coordination of IOW DD as there is no specific Commercial Team in place at IOW NHS Trust. One person in the Trust contracts team holds the list of healthcare contracts for the CMH divisions. There is no specific commercial or corporate resource available to support.	Moderate	3	Likely	3	9		Early estimation of resources required, options (e.g. backfill, outsourcing etc.) and preferred solutions. Potential to consider outsourcing of IOW contracts and commercial DD?	12/09/23	This risk is not reported to Programme Board as it is reflected in R03 9/10/23 - Prob score reduced from 4 to 3 to reflect that IoW now have additional resource gathering this data
R09	5/12/22	Programme Board	Transaction	External stakeholders do not support proposal	Broader external stakeholders (local authorities, GPs, other NHS organisations) are not supportive of proposals which could impact income (e.g. from local authorities)	Moderate	3	Likely	3	9		Comms and engagement plan in place.	06/10/23	28/07: Controls updated
R23	18/1/23	Workforce Steering Group	Transaction	Combined payroll provider	Solent SBS payroll contract expires 31.3.24 and plan is to change provider to Salisbury (SHFT payroll provider). If new combined payroll service is not achieved by 1.4.24 (there are dependencies on IBM for data migration) Solent will have to extend the SBS contract which will bring additional cost and risk as the service is poor.	Moderate	3	Likely	3	9		Plan to procure Salisbury as new provider, collaboration with Southern who also have Salisbury as existing provider, SBS get out clauses available, bring payroll provider re-procurement process forward.	06/10/23	

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R10	5/12/22	Programme Board	Integration	Segmentation - IOW deficit and stranded costs	Given underlying deficit at IoW there is a risk that apportionment of costs makes new Trust unsustainable and there is a risk of stranded costs as well inadequate level of resources for the IOW to operate as a single legal identity. Specifically, we do not have details of the income, corporate non-pays costs and expenditure linked to the P2P contract.	Moderate	3	Likely	3	9	⟷	Monthly Partnership Interdependencies Group with representatives of Southern, Solent, IoW and PUH and Programme Director in place to ensure alignment of IoW/PUH group and Fusion programmes. Detailed segmentation exercise with full engagement from all parties.	06/10/23	28/07: Controls updated 17/10/23 - have update risk description to include risk that there may be inadequate level of resources for the IoW to operate as a single legal identity
R24	18/1/23	Workforce Steering Group	Transaction	Payment errors due to bringing payrolls together	There is an overall risk that there may be payment errors arising from the TUPE transfer due to the complexity of bringing payrolls together and the quality of the current SBS provider.	Moderate	3	Likely	3	9		Robust due diligence exercise and controls in place, ESR running the merge behind the scenes. Dedicated resource to this key element of the transaction	06/10/23	
R31	1/2/23	BSID Steering Group	Transaction	Consolidated national reporting	The new organisation will require national datasets to be submitted jointly under one provider code from 1/4/24. The integration process is complex and there is a risk the necessary resource and expertise will be unavailable to complete in the timeframe whilst meeting existing reporting requirements until the integration date.	Moderate	3	Possible	3	9	⟷	BI/Data Insights teams are meeting to establish data sets required, source data and formats for production.	06/10/23	Additional resource is being sought from CSU but due to delays this will not be in place to support due diligence work which may have an increased impact on the team.

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R33	1/2/23	Digital Steering Group	Transaction	Shadow IT	There is a risk that a number of systems/applications are not considered and transitioned/transformed appropriately as they are not managed by/known to Digital Services (Shadow IT)	Moderate	3	Likely	3	9	↔	Digital Steering Group has collated a list of systems which has been issued to all steering groups to ensure clarity on digital support for systems transitions.	06/10/23	18/4: impact increased from 2 to 3, though expect that due diligence work once completed will mean this risk can be reduced back down as complete picture of digital systems is better understood and planned for. 28/7: risk description and controls updated. Probability score reduced from 4 to 3 to reflect controls now in place.
R42	10/05/23	Estates Steering Group	Integration	Building compliance	Until we know the condition of all properties, there is a risk that environments do not meet statutory minimum.	Moderate	3	Likely	3	9	↔	Commission aligned 6 facet surveys for buildings where they currently don't existing or are out of date	06/10/23	
R43	10/05/23	Estates Steering Group	Integration	Estates backlog	Completion of 6 Facet Surveys on properties could output a larger envelope than the sum of parts depending on application of Survey Guidance and approach to risk assessed evaluation	Moderate	3	Likely	3	9	↔	Make appropriate allowances against latent backlog issues - say 20% - until surveys are complete. Surveys due to take place by end June (will use same company as have done surveys for IoW and SHFT)	06/10/23	Await outcome of updated 6 facet surveys

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R49	16/5/23	Programme Team	BAU	2023/24 Financials	There is a risk that the financial plan for the new organisation in 2024/25 will be impacted by failure to achieve the ambitious recovery plans in all component organisations in 2023/24.	Moderate	3	Likely	3	9	↔	Oversight of in year financials will be reflected in the FBC including non recurrent aspect Via the ICS CFOs, organisations will be aware of financial positions and risks as the year progresses The 24/25 Operating Plan including the financial plan will be carried out jointly.	06/10/23	
R67	1/8/23	Digital Steering Group	Integration - DD	Community & MH EPR migration	There is a risk that there are not enough resources to meet the Clinical Safety compliance requirements of the EPR/Fusion requirements	Moderate	3	Likely	3	9	New	Ensure reflected in the Operating Model for how Digital services are delivered moving forward. Clinical Safety Officer function can be procured from a third party company if required	06/10/23	
R68	1/8/23	Digital Steering Group	Integration - DD	Email admin accounts	There is a risk that if email admin accounts are not upgraded in a timely way this will adversely affect EPR functionality	Moderate	3	Likely	3	9	New	An assessment of impact and plan for remedial actions before 1st April 2024 is required.	06/10/23	
R69	1/8/23	Digital Steering Group	Integration - DD	New Trust details configured on templates	There is a risk that there is insufficient time to complete the necessary configuration changes in systems to reflect new organisation details e.g. EPR letter templates	Moderate	3	Likely	3	9	New	An assessment of impact and plan for remedial actions before 1 April 2024 is required	06/10/23	
R70	1/8/23	Digital Steering Group	Integration - DD	Smartcard management	There is a risk that smartcard management will be disrupted over the transition period due to required reconfiguration	Moderate	3	Likely	3	9	New	TBC	06/10/23	

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R81	1/8/23	Estates Steering Group	Integration - DD	Sufficient IOW EFM staff for Day 1	Insufficient IOW EFM staff available on Day 1 to ensure continued safe operations & inability to recruit and retain	Moderate	3	Likely	3	9	New	Working groups created to identify all functions, compare options for Day One delivery and implementation. Important to consider the 'Island Factor' when discussing and agreeing the future operating model.	06/10/23	
R82	1/8/23	Estates Steering Group	Integration - DD	Safety Committee	There is a risk that any delays to establishing the new Trust's Safety Committee could lead to delay for any urgent action required	Moderate	3	Likely	3	9	New	Ensure future org structure is fully compliant and change terms of reference for the H&S committee to ensure they have powers to act.	06/10/23	
R83	1/8/23	Estates Steering Group	Integration - DD	Hazardous substances	Hazardous substances - there is a risk of non-compliances due to fragmented approach within SHFT.	Moderate	3	Likely	3	9	New	COSHH awareness and training is being developed in estates. There is work being undertaken for training and management of COSHH. There is also collaboration with the H&S teams from Solent and the IoW who use a system called SYPOL. Extra licenses can be purchased and many of the substances will be the same.	06/10/23	
R84	1/8/23	Estates Steering Group	Integration - DD	Fire Warden Training (IOW)	Existing levels of fire warden training on IoW are low which could result in risk in relation to fire safety matters	Moderate	3	Likely	3	9	New	Include in scope for Compliance Working Group	06/10/23	

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R12	30/11/22	Programme Board	Integration	Loss of corporate memory on IOW	Disaggregation (of IoW) results in loss of corporate memory in relation to transferring services (clinical and support.)	Moderate	3	Likely	3	9		Due diligence exercise completed to identify risks and inform integration planning. These will be further refined once there is clarity on transferring services/individuals.	06/10/23	As well as risk/cost around delivery services on the island whilst being reliant upon SLAs e.g. Estates and Digital - review impact and increase to a 3? 28/07: Controls updated
R96	30/8/23	Clinical Steering Group	Integration	Complaints processes	There is a risk that transition to the new Trust's complaints policies and procedures results in a failure to respond in a proactive, timely and comprehensive way to concerns and complaints that are in the process of being responded to on Day 1.	Moderate	3	Likely	3	9	New	Complaints teams meeting regularly to map current processes and understand complaints and their statuses in preparation for 1 April 2024.	19/10/23	
R93	17/10/23	Estates Steering Group	Integration	IOW Building Access Control	There is a risk that staff and patients are not able to access IoW buildings on Day 1 due to loss of functionality of the SALTO Access Control System, which currently sits across the IOW Trust Network and may no longer be available since the option for a digital SLA has been removed.	Major	4	Possible	2	8	New	Maintain existing SALTO networking and functionality intact until such time as appropriate alternative arrangements have been implemented and fully tested. Develop BCP plans to operate without electronic access control.	17/10/23	30/10: probability updated to 2

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R25	18/1/23	Workforce Steering Group	Transaction	ESR data migration	There is a risk that if the ESR data is not available in the correct format or at the required point then this affect the extract of data from Solent payroll to the new payroll provider.	Major	4	Possible	2	8	⇔	ESR nationally being informed, project and plan and team in place to deliver	06/10/23	
R65	1/8/23	Digital Steering Group	Integration - DD	Tenancy consolidation	There is a risk that, due to time constraints and resources, there will not be enough time to amalgamate/rationalise or consolidate tenancies prior to 1 Apr 24.	Minor	2	Very Likely	4	8	New	We will implement collaborative working features across tenancies as an interim solution. Decision on appropriate configuration of tenancies will be taken as part of Fusion governance process.	06/10/23	19/10 - Impact reduced from 3 to 2
R61	1/8/23	Digital Steering Group	Integration - DD	ODS Code	Changes to the ODS code will disrupt patient system operations e.g. eRS, electronic prescribing, RBAC management	Major	4	Possible	2	8	New	Engagement with NHSE to understand process and seek advice on how to manage this change. BCPs to be updated to reflect this.	06/10/23	12/10: likelihood reduced from 3 to 2
R63	1/8/23	Digital Steering Group	Integration - DD	Digital team capacity	There is a risk that the Digital team will be unable to complete the tasks required to support the transition due to the current level of vacancies	Major	4	Possible	2	8	New	Process in place for Steering Groups to request additional resource	06/10/23	12/10: mitigations updated and likelihood reduced from 3 to 2

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R13	5/12/22	Programme Board	Integration	Clinical and enabling strategies not aligned	Clinical strategy development is not aligned with key enabling schemes for digital, estates, workforce, etc and as a result the strategy for the new organisation will not be delivered.	Major	4	Possible	2	8		Monthly Programme Team meetings bring Steering Group chairs together and interdependencies are managed via Integration Planning Group (which meets at least fortnightly). High level clinical strategy to be shared at IPG meeting on 02/08. Full clinical strategy to be developed and appended to FBC and can then inform detailed digital, estates, workforce strategies.	06/10/23	28/07: Controls updated
R22	18/1/23	Workforce Steering Group	BAU	Combined OH & WB service	There is a £1.7m financial risk relating to the combined OH&WB service for the new organisation. Budget funding needs to be agreed and resource needed for the change programme and staffing. There is a risk to levelling down of service standards.	Major	4	Possible	2	8		Robust project management, strong governance in place, resource planning, funding requested in business case, clinical transformation programme in new Trust	06/10/23	Risk category updated from transaction to BAU. This risk is reported to Programme Team for information as it is a BAU risk. 18/4: Workforce SG to review this risk given possibility of need for tender process
R28	1/2/23	Workforce Steering Group	Transaction	Organisational change	There is a risk that staff could become disengaged due to the potentially different approaches in each Trust to organisational change	Major	4	Possible	2	8		Seeking clarity via Heads of Terms in respect of agreement over senior appointments and changes to T&Cs of employment	06/10/23	This risk is not reported to Programme Board as it is reflected in R01.

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R48	5/4/23	Clinical Steering Group	Transaction	Oversight of complaints/incidents	Potential to lose oversight of any open action plans/complaints/incidents across three organisations while we transition into single service/system	Major	4	Possible	2	8	⇔	Teams are fully aware of the risk and will put mitigation in place when it is clear the system that will be in use	06/10/23	
R53	9/9/23	Programme Director	Transaction	General election	Risk that general election is called and purdah delays ministerial approval of the Southern-Solent transaction	Major	4	Possible	2	8	⇔	Raised with NHSE on 04/09 who have discussed with DHCS. NHSE is reviewing the approvals timetable and will confirm Trust Board/CoG that would allow ministerial approval by 22 March (which would be before commencement of purdah assuming 2 May general election)	06/10/23	09/09: risk added
R54	1/8/23	Corporate Governance Steering Group	Integration - DD	Information flow between board and floor	Risk of unclear accountability / escalation, line of sight and effectiveness between operational delivery and governance	Major	4	Possible	2	8	New	Operating model being considered by OMAG following input from joint SLT and Clinical Services Integration Planning Sub-Group. Once known, the operational governance will be mapped to the corporate governance committee structure	06/10/23	
R56	1/8/23	Corporate Governance Steering Group	Integration - DD	Learning from litigation cases	Risk that learning from litigation cases is not embedded within the new Trust	Major	4	Possible	2	8	New	TBC	06/10/23	
R71	1/8/23	Digital Steering Group	Integration - DD	Information sharing - shared drives	There is a risk that we are unable to provide access to Solent shared drives for other Fusion partners	Major	4	Possible	2	8	New	TBC	06/10/23	

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R72	1/8/23	Digital Steering Group	Integration - DD	Subject Access Request process	There is a risk that the Subject Access Request process will not be merged prior to Day 1 with appropriate access to legacy systems and EPRs	Major	4	Possible	2	8	New	TBC	06/10/23	
R73	1/8/23	Digital Steering Group	Integration - DD	Additional cost for Solent technical system changes	There is a risk that the activities required to complete the technical activities are outside the scope of the Solent contracts and will therefore incur additional cost	Major	4	Possible	2	8	New	TBC	06/10/23	
R74	1/8/23	Digital Steering Group	Integration - DD	Contract end dates impact ability to transfer to new solutions	There is a risk that services will be impacted if there is insufficient time and funding to transfer to new solutions if decisions are driven by contract end dates	Major	4	Possible	2	8	New	Timescales and service impact to replace a digital service must be considered, not just when a contract expires. There must be sufficient time, funding and service engagement to transition a service before a contract expires. Key decisions around this will be made at the Digital Steering Group under the project fusion umbrella.	06/10/23	

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R75	1/8/23	Digital Steering Group	Integration - DD	EPR transition impacts clinical delivery	There is a risk that moving services to different EPRs based on assumed benefits may result in a degradation of digital services and loss of functionality impacting delivery of clinical services and national reporting.	Major	4	Possible	2	8	New	Currently no plans to migrate EPRs, rather interoperability is being scoped to provide greater collaborative working. The decision to migrate/ rationalise EPRs should be made by clinical colleagues and not the digital teams and will be factored in as part of the EPR and Digital Strategy Work. There should be a robust assessment and governance process to clearly identify benefits and disbenefits of service moves considering clinical service impact, business impact and cost.	06/10/23	
R76	1/8/23	Digital Steering Group	Integration - DD	IoW email solution	There is a risk that if IoW community & MHLD staff move away from NHSmail & the national tenant communication between other health & care professionals on the island may be problematic. There are likely to be costs to move from NHS.Net which are still to be determined. This also includes the consequence usage of Microsoft Teams which is widely used for multidisciplinary meetings/communication	Major	4	Possible	2	8	New	There is an opportunity via a larger organisation to pull on a wider expertise, pool of resources and contract negotiation. The work with Microsoft on long term solution needs to be included in the PTIP planning	06/10/23	

Risk ID	Date raised	Raised by	Risk category	Risk subject	Description. (inc reason & outcome)	Impact	Impact score	Probability	Probability score	Residual risk score	Trend	Controls in place/planned mitigating action	Date last reviewed	Updates / notes
R85	1/8/23	Estates Steering Group	Integration - DD	Term of Leases for St Mary's site (IoW)	There is a need to agree the lease term for properties that will be leased from IoW to the new Trust. Potential risk to either organisation if the term is not of sufficient length to provide each organisation with security.	Major	4	Possible	2	8	New	Discussions are underway with a view to agreeing a mutually agreeable term by the end of August.	06/10/23	
R86	1/8/23	Estates Steering Group	Integration - DD	IoW continuity of service (hard and soft FM)	There is risk of lack of continuity of Hard and Soft FM services from IoW Estate (including waste management, catering and transport)	Major	4	Possible	2	8	New	Placing suitable arrangements for transfers. Important to consider the 'Island Factor' when discussing and agreeing the future operating model.	06/10/23	

Appendix 12: Due diligence risks

Integration risks identified from due diligence with a score of 8 and over:

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Digital Steering Group	Integration - DD	IOW SystmOne continuity	There is a risk that IoW staff are not supported by resilient digital services.	Critical	4	Likely	3	12	Joint working underway to define SLA requirements, agreement SLA requirement will be minimal and required staff will TUPE transfer
Corporate Governance Steering Group	Integration - DD	Day 1 policies	There is a risk that staff are not aware of the policies in place on Day 1 and do not follow and this leads to an adverse outcome.	Major	4	Likely	3	12	Steering Groups have been allocated policies and agreed those for harmonisation on Day 1 and process for approval has been developed. Communication and training for staff.

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Digital Steering Group	Integration - DD	IOW SystmOne	Community & MHLD staff currently access all the IOW Trust's core clinical systems. These will move to TPP SystmOne by June '24 (current plan). However, there is a push led by technical infrastructure leads in Hampshire to take over all community/MHLD infrastructure from day 1. This creates complexity & workload that will necessitate temporary changes in order to provide continued access to legacy systems at go-live.	Major	4	Likely	3	12	Provide a managed service & SLA at day 1, with review after 12 months when Wave 4 & Frontline Digitisation investments are live. This will help avoid duplication of effort & increased costs.
Workforce Steering Group	Integration - DD	Embedding the new culture and values	If the creation of the new Trust values is not co-designed and embedded with staff and supported by managers, there is a risk that acceptance of the transition will be poor and will have a negative impact on the cultural alignment and identity of the new Trust.	Major	4	Likely	3	12	Shape Our New Trust staff engagement programme and Manager's Change Support pack and training offer. Further engagement planned on values, new Trust strategy and operational management structure. Series of pulse check surveys to measure how staff are feeling specifically relating to the Fusion change programme.

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Workforce Steering Group	Integration - DD	Temporary staffing model	There is a risk that a temporary staffing model is not put in place and operational teams cannot access temporary staffing from Day 1.	Major	4	Likely	3	12	Options appraisal regarding temporary staffing model to guide decision is being worked on for consideration at November programme team meeting. IoW & CAMHS staff from Sussex will need to join a roster by April 2024
Workforce Steering Group	Integration - DD	Statutory and mandatory training	There is a risk that compliance with stat/mand training reduces.	Major	4	Likely	3	12	Exec review of LMS options (October)
Corporate Governance Steering Group	Integration - DD	Management of coroners' cases	There is a risk that any changes to processes for managing coroners' cases as a result of integration may impact the outcome for the new Trust and the ability for learnings to be shared and addressed.	Moderate	3	Likely	3	9	Integration planning for coroners processes and quality governance to disseminate learnings. Maintaining links with IoW corporate team.

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Digital Steering Group	Integration - DD	Community & MH EPR migration	There is a risk that there are not enough resources to meet the Clinical Safety compliance requirements of the EPR/Fusion requirements	Moderate	3	Likely	3	9	Ensure reflected in the Operating Model for how Digital services are delivered moving forward. Clinical Safety Officer function can be procured from a third party company if required
Digital Steering Group	Integration - DD	Email admin accounts	There is a risk that if email admin accounts are not upgraded in a timely way this will adversely affect EPR functionality	Moderate	3	Likely	3	9	An assessment of impact and plan for remedial actions before 1st April 2024 is required.
Digital Steering Group	Integration - DD	New organisation details configured on templates	There is a risk that there is insufficient time to complete the necessary configuration changes in systems to reflect new organisation details e.g. EPR letter templates	Moderate	3	Likely	3	9	An assessment of impact and plan for remedial actions before 1st April 2024 is required
Digital Steering Group	Integration - DD	Smartcard management	There is a risk that smartcard management will be disrupted over the transition period due to required reconfiguration	Moderate	3	Likely	3	9	TBC

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Estates Steering Group	Integration - DD	Sufficient IOW EFM staff for Day 1	Insufficient IOW EFM staff available on Day 1 to ensure continued safe operations & inability to recruit and retain	Moderate	3	Likely	3	9	Working groups created to identify all functions, compare options for Day One delivery and implementation. Important to consider the 'Island Factor' when discussing and agreeing the future operating model.
Estates Steering Group	Integration - DD	Safety Committee	There is a risk that any delays to establishing the new organisation's Safety Committee could lead to delay for any urgent action required	Moderate	3	Likely	3	9	Ensure future org structure is fully compliant and change terms of reference for the H&S committee to ensure they have powers to act.
Estates Steering Group	Integration - DD	Hazardous substances	Hazardous substances - there is a risk of non-compliances due to fragmented approach within SHFT.	Moderate	3	Likely	3	9	COSHH awareness and training is being developed in estates. There is work being undertaken for training and management of COSHH. There is also collaboration with the H&S teams from Solent and the IOW who use a system called SYPOL. Extra licenses can be purchased and many of the substances will be the same.

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Estates Steering Group	Integration - DD	Fire Warden Training (IOW)	Existing levels of Fire Warden Training on IOW are low which could result in risk in relation to fire safety matters	Moderate	3	Likely	3	9	Include in scope for Compliance Working Group
Digital Steering Group	Integration - DD	Tenancy consolidation	There is a risk that, due to time constraints and resources, there will not be enough time to amalgamate/rationalise or consolidate tenancies prior to 1 Apr 24.	Minor	2	Very Likely	4	8	We will implement collaborative working features across tenancies as an interim solution. Decision on appropriate configuration of tenancies will be taken as part of Fusion governance process.
Digital Steering Group	Integration - DD	ODS Code	Changes to the ODS code will disrupt patient system operations e.g. eRS, electronic prescribing, RBAC management	Major	4	Possible	2	8	Engagement with NHSE to understand process and seek advice on how to manage this change. BCPs to be updated to reflect this.
Digital Steering Group	Integration - DD	Digital team capacity	There is a risk that the Digital team will be unable to complete the tasks required to support the transition due to the current level of vacancies	Major	4	Possible	2	8	Process in place for Steering Groups to request additional resource

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Corporate Governance Steering Group	Integration - DD	Information flow between board and floor	Risk of unclear accountability / escalation, line of sight and effectiveness between operational delivery and governance	Major	4	Possible	2	8	Operating model being considered by OMAG following input from joint SLT and Clinical Services Integration Planning Sub-Group. Once known, the operational governance will be mapped to the corporate governance committee structure
Corporate Governance Steering Group	Integration - DD	Learning from litigation cases	Risk that learning from litigation cases is not embedded within the new organisation	Major	4	Possible	2	8	TBC
Digital Steering Group	Integration - DD	Information Sharing - Shared Drives	There is a risk that we are unable to provide access to Solent shared drives for other Fusion partners	Major	4	Possible	2	8	TBC
Digital Steering Group	Integration - DD	Subject Access Request process	There is a risk that the Subject Access Request process will not be merged prior to Day 1 with appropriate access to legacy systems and EPRs	Major	4	Possible	2	8	TBC

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Digital Steering Group	Integration - DD	Additional cost for Solent technical system changes	There is a risk that the activities required to complete the technical activities are outside the scope of the Solent contracts and will therefore incur additional cost	Major	4	Possible	2	8	TBC
Digital Steering Group	Integration - DD	Contract end dates impact ability to transfer to new solutions	There is a risk that services will be impacted if there is insufficient time and funding to transfer to new solutions if decisions are driven by contract end dates	Major	4	Possible	2	8	Timescales and service impact to replace a digital service must be considered, not just when a contract expires. There must be sufficient time, funding and service engagement to transition a service before a contract expires. Key decisions around this will be made at the Digital Steering Group under the project fusion umbrella.

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Digital Steering Group	Integration - DD	EPR transition impacts clinical delivery	There is a risk that moving services to different EPRs based on assumed benefits may result in a degradation of digital services and loss of functionality impacting delivery of clinical services and national reporting.	Major	4	Possible	2	8	Currently no plans to migrate EPRs, rather interoperability is being scoped to provide greater collaborative working. The decision to migrate/rationalise EPRs should be made by clinical colleagues and not the digital teams and will be factored in as part of the EPR and Digital Strategy Work. There should be a robust assessment and governance process to clearly identify benefits and disbenefits of service moves considering clinical service impact, business impact and cost.

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Digital Steering Group	Integration - DD	IOW email solution	There is a risk that if IoW community & MHLD staff move away from NHSmail & the national tenant communication between other health & care professionals on the island may be problematic. There are likely to be costs to move from NHS.Net which are still to be determined. This also includes the consequence usage of Microsoft Teams which is widely used for multidisciplinary meetings/communication	Major	4	Possible	2	8	There is an opportunity via a larger organisation to pull on a wider expertise, pool of resources and contract negotiation. The work with Microsoft on long term solution needs to be included in the PTIP planning
Estates Steering Group	Integration - DD	Term of Leases for St Mary's site (IOW)	There is a need to agree the lease term for properties that will be leased from IOW to the new organisation. Potential risk to either organisation if the term is not of sufficient length to provide each organisation with security.	Major	4	Possible	2	8	Discussions are underway with a view to agreeing a mutually agreeable term by the end of August.

Raised by	Risk Category	Risk Subject	Risk Description. (inc. reason & outcome)	Impact	Impact Score	Probability	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
Estates Steering Group	Integration - DD	IOW continuity of service (hard and soft FM)	There is risk of lack of continuity of Hard and Soft FM services from IoW Estate (including waste management, catering and transport)	Major	4	Possible	2	8	Placing suitable arrangements for transfers. Important to consider the 'Island Factor' when discussing and agreeing the future operating model.

Patient Benefits 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

9 November 2023

Contents

Glossary 5

1 Introduction 8

2 Summary of patient benefits 16

3 Lived experience 28

4 Childrens and Adolescent Mental Health Services (CAMHS) 49

5 Older Persons Mental Health (OPMH) and dementia 85

6 Frailty and urgent response 125

Appendices 150

Supporting submissions 170

Figures

Figure 1: Main mental health and learning disability services by main NHS provider in Hampshire and Isle of Wight Integrated Care System 12
Figure 2: Main community services by main NHS provider in Hampshire and Isle of Wight Integrated Care System 13
Figure 3: The guideline that underpin the development of the clinical strategy 14
Figure 4: Rationale for priority selection 17
Figure 5: Summary of lived experience patient benefits 19
Figure 6: Summary of service level patient benefits 20
Figure 7: Benefits enabled by people changes 23
Figure 8: Benefits enabled by digital changes 24
Figure 9: Benefits enabled by estates changes 25
Figure 10: Principles for lived experience engagement work 36
Figure 11: Patient Story - Peer Support Worker 43
Figure 12: Lived experience benefits indicators 44
Figure 13: Summary of lived experience implementation plan 46
Figure 14: Risk register for lived experience 48
Figure 15: CQC ratings for Trusts 49
Figure 16: Patient story – CAMHS as it can be now 64
Figure 17: Patient story - CAHMS as it could be 65
Figure 18: CAMHS staff story - now and then 66
Figure 19: Benefits of CAMHS Academy 67
Figure 20: CAMHS Academy descriptions 67
Figure 21: iTHRIVE framework 74
Figure 22: Benefits indicators for CAMHS integration 79
Figure 23: Summary of CAMHS implementation plan 80
Figure 24: CAMHS timeline of priorities 82
Figure 25: Risk register for CAMHs 84
Figure 26: OPMH pathway tiers 86
Figure 27: High level gaps in provision of core services for OPMH and dementia 89
Figure 28: SWOT analysis for OPMH 93
Figure 29: Dementia diagnosis rates across HIOW 100
Figure 30: Compliance with urgent and routine waiting times 101
Figure 31: Impact of intensive support team in Portsmouth on functional beds 101
Figure 32: Impact of Intensive Support Team 102
Figure 33: Number of unique patients prescribed anti-dementia drugs and antipsychotics - June 2023 - EPACT2 103

Figure 34: Deployment of Crisis Cars 106
Figure 35:Male age specific suicide rates 107
Figure 36: Key metrics for OPMH wards 107
Figure 37: Patient Story - Person with Dementia 110
Figure 38: The six steps for the ICS OPMH and Dementia Board 118
Figure 39: Benefits indicators for OPMH 120
Figure 40: Summary of the OMPH implementation plan 122
Figure 41: Risk Assessment for OPMH 124
Figure 42: Total population over 60 years 126
Figure 43: Prevalence of moderate or severe frailty by district 127
Figure 44: Local service provision 130
Figure 45: Older patient at risk of an acute admission 131
Figure 46: Patient Story - integrated working between UCR, Virtual Wards and Community Teams 132
Figure 47: Virtual ward bed provision by area 133
Figure 48: HIOW Urgent Community Response Demand March 2021 - August 2023 138
Figure 49: Proposed frailty and urgent response patient pathway 141
Figure 50: Benefits indicators for Frailty and Urgent Response 146
Figure 51: Summary of frailty implementation plan 147
Figure 52: Risk Assessment for Frailty 149
Figure 53: Summary of community CAMHS provision at the Trusts in 2022/23 154
Figure 54: Summary of Inpatient Units in 2022/23 (all provided by Southern, definitions in accordance with NHS Benchmarking) 156
Figure 55: Detailed OPMH service provision information 158
Figure 56: Dementia diagnostic rates by GP practice 165
Figure 57: Hampshire UCR Referral and Compliance 167
Figure 58: HIOW High Intensity Community Virtual Ward Expected Admissions vs Actual Admissions 167
Figure 59: HIOW Virtual Ward data 168

Glossary

ABBREVIATION	MEANING
A&E	Accident and Emergency
ACP	Advanced Clinical Practitioners
ACT	Acceptance and Commitment Therapy
ADHD	Attention deficit hyperactivity disorder
AHP	Allied Health Professional
AIMS-OP	Accreditation for Inpatients Mental Health Services
AMH	Adult Mental Health
AMHP	Approved Mental Health Practitioner
ARFID	Avoidant Restrictive Food Intake Disorder
ARRS	Additional Roles and Responsibilities Scheme
BAME	Black, Asian and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDG	Clinical Delivery Group
CGA	Comprehensive Geriatric Assessment
CHC	Continuing Healthcare
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CRHTT	Crisis Resolution Home Treatment Team
CYP	Children and Young People
DBT	Dialectical Behavioural Therapy
DDP	Dyadic Developmental Psychotherapy
DDR	Dementia Diagnosis Rate DDR
Dorset HealthCare	Dorset HealthCare University NHS Foundation Trust
DOS	Directory of Services
DOT	Dementia Outreach Team
ECT	Electro-convulsive therapy
ED	Emergency Department
EIA	Equality Impact Assessment
EMDR	Eye Movement Desensitisation and Reprocessing
FBC	Full Business Case
FCAMHS	community forensic Child and Adolescent Mental Health Services
FT-AN	Family Therapy for Anorexia Nervosa
FTE	Full-time equivalents
GAU	General Adolescent Units
HAHTT	Holistic at Home Treatment Team

ABBREVIATION	MEANING
HEE	Health Education England
HIOW	Hampshire and the Isle of Wight
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
ICB (the)	Hampshire and Isle of Wight Integrated Care Board
ICM	Intensive Case Management Team
ICP	Integrated Care Partnership
ICS (the)	Hampshire and Isle of Wight Integrated Care System
IoW	Isle of Wight NHS Trust
IROR	In-reach/outreach teams
IST	Intensive Support Team
IT	Information Technology
LE	Lived Experience
LoS	Length of Stay
LTP	NHS Long Term Plan
LTP	Local Transformation Plans
MARC	Memory Assessment Research Centre.
MAS	Memory Assessment Service
MCI	Mild Cognitive Impairment
MDT	Multidisciplinary Team
MH	Mental Health
MHIS	Mental Health Investment Standard
MHIS	Mental Health Investment Standard
MHLDA	Mental Health, Learning Disability and Autism
MHST	Mental Health Support Teams
ND	Neurodiversity
NWD	No Wrong Door
OD	Organisational Development
OPMH	Older People’s Mental Health Services
OT	Occupational Therapy
PBS	Positive Behaviour Support
PC	Provider Collective
PCN	Primary Care Network
PICU	Psychiatric Intensive Care Unit
PROMs	Patient Reported Outcome Measure
PSW	Peer Support Worker
PTIP	Post Transaction Integration Plan
QI	Quality Improvement
QIA	Quality Impact Assessment

ABBREVIATION	MEANING
RAFT	Resilience Around Families Team
ReQoL	Recovering Quality of Life
SALT	Speech and Language Therapy
SCAS	South Coast Ambulance Service
SCC	Southampton City Council
SDEC	Same Day Emergency Care
SDEC	Same day emergency care
SEMH	Social Emotional and Mental Health
SEND	Special Educational Needs and Disabilities
SENDIASS	Special Educational Needs and Disability Information Advice and Support Service
SMI	Serious Mental Illness
Solent	Solent NHS Trust
Southern	Southern Health NHS Foundation Trust
SPA	Single Point of Access
SpCAMHS	Solent Specialist CAMHS
SPoC	Single Point of Contact
Sussex Partnership	Sussex Partnership NHS Foundation Trust
SWOT	Strengths, weaknesses, opportunities and threats analysis
ToCH	Transfer of Care Hub
Trusts (the)	Collectively, Southern Health NHS Foundation Trust, Solent NHS Trust and Isle of Wight NHS Trust
UCR	Urgent Community Response
UHS	University Hospital Southampton
VCSE	Voluntary Community and Social Enterprise
VW	Virtual Wards
YCP	Youth Crime Prevention
YOT	Youth Offending Team

1 Introduction

1.1 This Patient Benefits Case sets out specific patient benefits which illustrate the overall patient benefits expected to be delivered from the creation of a new Trust for community, mental health and learning disability services across Hampshire and the Isle of Wight. This Patient Benefits Case should be read in conjunction with the Full Business Case (FBC) for the creation of the new Trust.

1.2 This chapter provides background on the Hampshire and the Isle of Wight (HIOW) Integrated Case System (ICS) and summarises the current service provision and the clinical strategy for the new Trust. Further detail on the clinical strategy for the new Trust can be found in chapter 5 of the FBC.

1.3 Chapter 2 of this document summarises the patient benefits expected to be realised through the creation of the new Trust. The remaining chapters set out the detail of the specific patient benefits.

HIOW ICS

1.4 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. The ICS has an annual health and care budget of £3.8 billion.

1.5 Like many areas across the UK, there are significant variations in health needs across HIOW, with the most vulnerable people typically suffering poorer health, dying younger and experiencing poorer access to health and care services. Ethnic diversity varies across the HIOW footprint with a significantly higher minority ethnic population in Southampton and Portsmouth. Paired with a large number of traditionally 'hard to reach' populations, such as the Gypsy, Roma and Traveller community, care leavers, people living in economically deprived areas and people with specific conditions such as a neurodivergency, a learning disability or a serious mental illness (SMI), this can lead to health inequalities that have a significant impact on people's life expectancy and quality of life.

1.6 The four main providers of NHS community, mental health and learning disability services in the ICS are summarised in the table below. 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 £275m in 2022/23.
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 £455m in 2022/23.
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 £58m in 2022/23.
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 transferring services represent approximately 5% of operating income and 7% of the workforce as at February 2023.

1.7 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.

1.8 In February 2022, Carnall Farrar 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 chapter 3 of the FBC for further details).

1.9 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;
- 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.

1.10 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 the FBC. This new Trust will serve as an enabler for the other four recommendations and the success of this new Trust (and the realisation of the benefits) will be predicated on the system delivery of the other recommendations of the independent review.

1.11 Solent, Southern, IoW (jointly "the Trusts") 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 the services do not consistently experience high-quality person-centred care that meets their needs. This adversely impacts health and wellbeing outcomes.

3) **The four 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 the current model these smaller services also provide limited opportunity for career progression.

4) **The financial challenge is very significant.** The total cost of delivering NHS services in HIOW currently exceeds the available resources. 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; this is as opposed to through 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. 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. In approving the Strategic Case in March 2023, the four Trusts 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 HIOW system within the current organisational model and that organisational changes are required to exploit the opportunities for better care.

Mental health, learning disabilities and community services in HIOW

1.14 There are three main NHS providers of community[1], 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[2] in Southampton (with an annual contract value of c. £2m).

---

[1] Throughout this paper the term 'community services' is used to refer to physical health community services (as opposed to mental health community services).

[2] 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.

1.15 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.

1.16 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.

1.17 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.

1.18 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 the main mental health services by NHS provider across the ICS:

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

<table>
<tr><th>Mental health service</th><th>Isle of Wight</th><th>Portsmouth</th><th>South East Hampshire</th><th>Southampton</th><th>South West Hampshire</th><th>North and Mid Hampshire</th></tr>
<tr><td>CAMHS</td><td>IoW</td><td>Solent</td><td>Sussex</td><td>Solent</td><td colspan="2">Sussex</td></tr>
<tr><td>CAMHS inpatient</td><td colspan="6">Southern</td></tr>
<tr><td>Eating disorder OP (children's 0-17)</td><td>IoW</td><td>Solent</td><td>Sussex</td><td>Solent</td><td colspan="2">Sussex</td></tr>
<tr><td>Perinatal</td><td colspan="6">Southern</td></tr>
<tr><td>Adult inpatient</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Eating disorder IP (adult)</td><td colspan="6">Southern</td></tr>
<tr><td>Eating disorder OP (adult)</td><td>IoW</td><td colspan="5">Southern</td></tr>
<tr><td>IAPT</td><td>IoW (Isle Talk)</td><td>Solent (Talking Change)</td><td>Southern / Solent Mind (italk)</td><td>Dorset HealthCare (Steps2Wellbeing)</td><td colspan="2">Southern / Solent Mind (italk)</td></tr>
<tr><td>Community MH / crisis teams</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Older persons MH services</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Acute liaison</td><td>IoW</td><td colspan="5">Southern</td></tr>
<tr><td>Specialist and forensic</td><td colspan="6">Southern</td></tr>
<tr><td>Learning disabilities & autism</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Complex adults MH therapy</td><td>IoW - ECT</td><td colspan="5">Southern – ECT and rTMS</td></tr>
<tr><td>Crisis</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Southern (The Lighthouse)</td><td colspan="2">Southern</td></tr>
<tr><td>Urgent MH helpline (NHS 111)</td><td>South Central Ambulance Service</td><td>Solent</td><td colspan="4">Southern</td></tr>
<tr><td>Place of safety</td><td>IoW</td><td>Solent</td><td colspan="4">Southern (Parklands, Antelope and Elmleigh)</td></tr>
<tr><td>EIP</td><td>IoW</td><td>Solent</td><td colspan="4">Southern</td></tr>
</table>

1.19 There are three main NHS providers of community services: Solent, Southern and IoW[3], 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:

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

<table>
<tr><th>Community health service</th><th>Isle of Wight</th><th>Portsmouth</th><th>South East Hampshire</th><th>Southampton</th><th>South West Hampshire</th><th>North and Mid Hampshire</th></tr>
<tr><td colspan="7">Adult physical health</td></tr>
<tr><td>Community inpatients</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>Community – Integrated teams
• Urgent care
• Frailty</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Falls</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Pulmonary Rehab</td><td>IoW</td><td colspan="3">Solent</td><td></td><td>Solent</td></tr>
<tr><td>• Palliative and End of Life</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• MSK and Pain management</td><td>IoW</td><td colspan="3">Solent</td><td>Southern</td><td>Southern / HHFT</td></tr>
<tr><td>• Tissue Viability</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Long Covid</td><td>IoW</td><td>Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Sexual health services</td><td colspan="6">Solent</td></tr>
<tr><td>• Diagnostics</td><td>IoW</td><td>Portsmouth</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>• Speech and Language Therapy</td><td>IoW</td><td colspan="3">Solent</td><td colspan="2">Hobbs</td></tr>
<tr><td colspan="7">Children's physical health (excluding CAMHS and Learning Disabilities)</td></tr>
<tr><td>Health Visiting and School Nursing (LA funded)</td><td colspan="2">Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>Children's Health Information Service</td><td colspan="6">Southern</td></tr>
<tr><td>School Immunisations</td><td colspan="2">Solent</td><td>Southern</td><td>Solent</td><td colspan="2">Southern</td></tr>
<tr><td>Children's Community Nursing</td><td>IoW</td><td colspan="4">Solent</td><td>HHFT</td></tr>
<tr><td>Children's Continuing Care</td><td>N/A</td><td colspan="5">Various providers – commissioned according to need</td></tr>
<tr><td>Community Paediatrics and Therapies</td><td>IoW</td><td colspan="5">Solent</td></tr>
<tr><td>Specialist Children's Home Health – Swanwick lodge</td><td>N/A</td><td>N/A</td><td>Southern</td><td>N/A</td><td colspan="2">Southern</td></tr>
</table>

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

1.20 This complex system has developed through decades of organisational change, fragmented commissioning[4] and competition resulting in services moving between providers over time. Further detail on the system performance is set out in the Full Business Case.

Clinical strategy

1.21 The Clinical Transformation Group developed a set of guidelines to apply consistently across the workstreams. They are set out in figure 3 below, and formed the starting point for the creation of the clinical strategy:

Figure 3: The guideline that underpin the development of the clinical strategy

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

[4] 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.

1.22 The Clinical Steering Group was responsible for the development of the clinical strategy, and engaged with relevant stakeholders throughout, ensuring that the voice of lived experience was heard and reflected in the clinical strategy. The principal stakeholders involved in developing the clinical strategy were:

- Trust staff from clinical, operational, and corporate teams;
- System partners including the ICB, local authorities, voluntary sector and primary care colleagues;
- People who use services, their families and carers; and
- wider communities.

1.23 The strategy is structured around a clear ambition to deliver **high quality, safe and effective services to all people across HIOW, balancing the benefits of working at a large scale to drive out unwarranted variation, and working locally in order to respond to the needs of different communities.** In delivering safe services the new Trust will ensure it continues to address and learn from any quality reviews (e.g. CQC inspections). There are six key principles that will deliver this ambition which are described in more detail in chapter 5 of the Full Business Case.

1) Embed a culture and practice of continuous improvement, innovation and research;

2) Ensure that all clinical decisions benefit from both lived and learned experience;

3) Adopt a life course approach which removes barriers and provides greater emphasis on prevention and a pro-active approach;

4) Work alongside local communities ensuring that the Trust collaborate effectively to wrap services around the needs of individuals and measure the Trust according to outcomes that matter;

5) Provide effective clinical and professional leadership, and

6) The clinical strategy will be underpinned by a sustainable workforce.

2 Summary of patient benefits

2.1 The creation of the new Trust will realise benefits for patients and communities, staff and wider system partners, as well as financial benefits. These benefits are set out in the Full Business Case.

2.2 Patient benefits will be delivered by:

- **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 the combined transformation expertise and recognises the importance of both standardisation to reduce unwarranted variation and adaptation to meet the needs of place;
- **Ensuring people with lived experience have a strong voice in all the new Trust does**. This will include an enhanced voice through the new Trust's membership and the Council of Governors and an approach to community engagement which will enable the new Trust to work in coproduction with people who use services and to respond more effectively to the needs of the populations served; and
- Increasing **research opportunities** which provide benefits for patients

2.3 This chapter summarises the specific patient benefits set out in this Patient Benefits Case which illustrate the overall patient benefits expected to be delivered from the creation of a new Trust.

Identification of benefits

2.4 Prior to the development of the Strategic Case, the four Trusts had come together to accelerate clinical collaboration to address the most significant clinical risks in community and mental health services. Ten initial clinical priorities were identified, informed by system priorities, joint strategic needs assessments, equality impact assessments, community requirements and workforce, performance and quality data. A further cross-cutting priority, lived experience, was added as it emerged from the clinical strategy development engagement as a key theme. Each priority workstream 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 Transformation Group.

Mental health and learning disabilities priorities	Community service priorities
• Children and young people's mental health services (CAMHS) • 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 • Frailty and urgent response • Community health specialist services and long-term conditions • Supporting the sustainability and integration of primary care
Cross-cutting priorities	
• Lived experience	

2.5 Four of these priorities are described in detail in this Patient Benefits Case to illustrate the overall patient benefits expected to be realised through the creation of the new Trust. It is important to note that all eleven workstreams remain priority areas and work is continuing to progress transformation across all these areas with the full support of the Clinical Transformation Group.

Figure 4: Rationale for priority selection

Service	Rationale
Childrens and Adolescent Mental Health Services (CAMHS)	HIOW ICS is experiencing an increase in demand for CAMHS and, in some parts of the system, significant challenges associated with timely access to appropriate services.
Older Persons Mental Health (OPMH)	The current OPMH models in HIOW do not support the growing ageing population, including the current and expected demand or the changing clinical needs as a system to support older people.
Frailty and urgent response	Current service challenges include workforce recruitment and retention, the need for enhanced engagement with primary care and acute colleagues and a greater understanding of what is provided by community services. Recurrent funding is required to reflect the expected growth in population and to match increasing demand.

Service	Rationale
Lived experience	There is increasing evidence that decisions and interventions that are coproduced are more likely to be implemented, understood, accessed and utilised by those for whom they are intended. In addition, it leads to greater ownership of decisions, increased self-responsibility, improved priority setting and decision making, reduced power imbalances, reduced inequalities, reduced and transformed complaints that more effectively support learning, increased patient knowledge and recognition of their expertise, increased levels of service satisfaction, acknowledgement of rights, increased accountability, improved dignity and self-worth, increased patient and staff morale. Creation of the new Trust provides a real opportunity to embed this in the culture of the new organisation and is a key theme in the clinical strategy for the new Trust.

Co-creation

2.6 The clinical and operational leads for each workstream have co-created the case studies with the relevant clinical teams, as well as broader partners where appropriate. This is described in the chapter for each case study. In addition, the Fusion Communications and Engagement Steering Group has supported the workstreams to involve people with lived experience.

2.7 The community engagement teams are working with the workstreams to ensure that the voices of communities, service users and their families and carers are central to any changes and developments. The focus of support to the workstreams has been to ensure that the voices of seldom heard from groups are heard including, for example, conversations with people from minority ethnic communities, care leavers, young people, people living in economically deprived areas, people with learning disabilities and carers. Examples of engagement with service users and community partners include:

- Engaging directly with over 2,000 people across HIOW about their priorities for receiving services in the new organisation;
- Hearing from 180 community partners, service users, carers and family members about their experiences and priorities for Older People's Mental Health Services. The report from this is included in the supporting submission; and
- Hearing from 92 service users with Type 2 diabetes with a focus on people from minority ethnic groups, their families and carers. This is feeding into the long-term conditions workstream.

2.8 The community engagement teams will continue to work directly with the workstreams to bring them closer to service users, families and their carers to ensure that their priorities are met.

2.9 A timeline for the three clinical transformation projects is included in Appendix 1.

Cross cutting patient benefits

2.10 There are a range of cross-cutting benefits expected to be delivered from the creation of a new Trust for patients, carers, staff and the wider health and care system (as set out in chapter 9 of the Full Business Case). This Patient Benefits Case focuses on the patient benefits to be realised across the new Trust.

2.11 Alongside the clinical pathway patient benefits described below, there are also benefits which cut across all services such as embedding lived experience in the new Trust. Figure 5 provides a summary of these benefits with more detail provided in chapter 3.

Figure 5: Summary of lived experience patient benefits

Change	Patient benefit
Patients and family members / informal carers will be fully informed about options and engaged in making decisions	• This will result in more informed, activate and enabled patients, who are more likely to adhere to decisions, resulting in improved outcomes and reduced reliance on services • Higher levels of self-management will result in prevention of relapse, and reduced demand on urgent and emergency services
All care plans will be negotiated and reviewed in collaboration with the patient and family / informal carers	• This will reduce isolation and exclusion, enable a healthier lifestyle, and decrease loneliness. • Participation in personal recovery planning has positive outcomes for participants, quantifiable using comprehensive measures of self-perceived recovery.
The voices and expertise of people who use these services are at the heart of the new Trust at every level, including Board oversight	• This will allow services to become more appropriate, responsive, and more effective as they become more tailored to people's real needs. • Coproduction can reduce pay and non-pay costs

Service level benefits

2.12 Chapters 4 to 6 of this document describe three service level case studies which illustrate the patient benefits which are expected to achieve through the creation of a new Trust. The figure below summarises the benefits from these three service level case studies:

Figure 6: Summary of service level patient benefits

Change	Patient benefit
Childrens and Adolescent Mental Health Services (CAMHS)	
A more unified approach to ensuring the voice of the young person is heard	• This will ensure that young people are able to shape the services which they access, ensuring that it meets their needs and that of their families and carers. • Having care delivered which the young person has been able to shape means that they are more likely to follow the care plan, resulting in better outcomes for them.
Better integration of digital platforms and technologies will enable the sharing of patient data as well as allow more innovate care delivery	• Having the ability to share information across teams will reduce the need for the young person and their family to repeat information previously given to another clinician. • Introducing digital technologies will allow people to access care in different ways.
Clinical pathways will be streamlined and consistent	• Having the ability to bring the best of the existing services into a new, standardised set of pathways across HIOW, so that patients and their families will have the same, high quality care regardless of where they live.
Older Persons Mental Health (OPMH)	
Clinical pathways across all tiers will be streamlined and consistent	• To bring the best of the existing services into a new, standardised set of pathways across HIOW, so that patients and their families will have the same, high quality care regardless of where they live. • National targets will be met consistently across all areas.
Better alignment with primary care and physical health colleagues will ensure that the patient has holistic care	• More care will be able to be delivered closer to the person's home, in a place that is familiar to them.

Change	Patient benefit
Frailty and urgent response	
Clinical pathways will be streamlined and consistent	• To bring the best of the existing services into a new, standardised set of pathways across HIOW, so that patients and their families will have the same, high quality care regardless of where they live.
An integrated workforce will ensure that there are fewer gaps in staffing and offer more career opportunities for staff, ensuring that patients have the care they require close to home	• Integrated workforce planning, recruitment and retention will help identify areas of risk/need and match resources to gaps through reallocation of workforce. • Reduction of competition and movement of staff between Solent and Southern due to banding of posts, different service models and career opportunities will retain knowledge and expertise. • Integrated trusted assessment will reduce referrals, duplication and increase time to care.

Enablers

2.13 The new Trust will rely on efficient and effective enabling functions to support clinical services delivery. Three key enablers to delivery of the clinical strategy and the realisation of the patient benefits described in this document have been identified - people, digital and estates. These are summarised below and set out in greater depth in chapter 8 of the Full Business Case.

People

2.14 People, especially the staff, will be at the heart of all the new Trust does. Without supporting the staff to work in new and / or different ways, the new Trust will not realise the identified patient benefits.

2.15 The establishment of the new Trust will have a significant impact on staff and it is imperative that all staff are supported at all times. A series of organisational development interventions has therefore been developed that will support staff through this period of change, whilst helping deliver the desired culture of the new Trust. These interventions include:

- **Embedding the desired culture in the new Trust**
    - An appropriate warm welcome for all staff transferring into the new Trust; and

    - A cultural influencer programme to be designed and delivered to embed the new culture.

- **Creating leadership commitment to the culture**
    - Coaching support for individuals or teams, including leadership training, which will be designed around existing challenges; and
    - A range of directed learning tools, tools to help leaders run team away days, access to a facilitated team day, leadership programmes and a 'bitesize skills' offering.

- **Driving visible and sustainable change**
    - A talent management approach to be developed and implemented in the new Trust; and
    - Networking opportunities for leaders to provide opportunities to share and challenge ideas, supported by organisational development professionals.

2.16 The new Trust will have a single workforce plan. Whilst there are no immediate plans to redeploy staff, over time a single workforce plan will ensure that staff are deployed to the areas of greatest need. There will also be the opportunity to develop specialist services at scale (system-wide), complemented by locally delivered services. This will allow staff to be able to come together and work in new ways within larger teams and across traditional boundaries, whether that be geographical or professional.

2.17 The new Trust's retention strategy will focus on four key pillars:

- Pillar 1 - Supporting new starters e.g. rotational posts / mentoring from experienced professionals / insight days / induction and preceptorship support;

- Pillar 2 - Staff in mid careers e.g. flexible working / staff ambassadors / role transfers;

- Pillar 3 - Legacy mentorship / retire and return / campaign to celebrate careers of staff; and

- Pillar 4 - Stay interviews / itchy feet conversations.

2.18 A coordinated recruitment approach to vacancies and new roles will enable improved management of vacancies, ensuring recruitment activity is directed to the areas of most need.

2.19 The figure below sets out some the planned people changes that are relevant to this Patient Benefits Case and the associated benefits to patients and staff.

Figure 7: Benefits enabled by people changes

Change	Benefit
Pooling staff, and their expertise, across the new Trust	• To provide resilience within small teams, which would reduce the occurrences when services have not been able to be delivered due to someone on leave. For example, the ECT service described in paragraph 3.31 in the lived experience case study. • Staff will feel more supported and less isolated, resulting in fewer unplanned absences or the need to leave the service for promotion or other opportunities. For example, some of the issues encountered by the frailty team as described in paragraph 6.32.
Providing a more unified service offer	• By having staff within one speciality using the same methodology and to the same level of training, the patient and their families will have a less varied experience of care with more consistent outcomes. • The ability to review and create new governance structures for services such as OPMH which maintain strong local links as described in paragraph 5.44.
Implementing a single learning, development, educational and induction programme by end of year 1	• To create consistency and parity of experience and quality for staff across the new Trust, without having to leave their position, such as is currently being experienced in the CAMHS service (see paragraph 4.116). • The ability to share good practice and ideas amongst professionals in different areas (geographic and specialisms).
Aligning professional policies, protocols and staff contractual arrangements	• The ability to offer rotational posts across different services, for example between CAMHS teams within crisis, community, and inpatient provision as described in paragraph 4.80. This will provide opportunities for clinicians to develop their skills and experience in different settings, reduce the risk of staff burnout, reduce turnover and improve the ability of organisations to cover key workforce gaps.
The opportunity to work with the Deanery and Universities to provide a	• By combining teams, there will be a greater opportunity to provide

Change	Benefit
wider range of trainee placements, in a wider range of new roles	supervision and to support learners across the whole Trust. • The greater scale of the combined services will allow an increase in the number of placements in a wider range of specialism, providing better care for patients with an increase in numbers of staff within teams, such as described in paragraph 4.114.
The opportunity to shape the different services, taking forward the areas that work best	• Having an opportunity for staff, patients, users and families to reflect on the current provisions and define the new service will empower patients to shape a new service and staff will be more invested where they have had an input in building the vision for the new service. For example, see paragraphs 5.84-5.86.

Digital

2.20 An effective digital function in the new Trust will be crucial in supporting the changes envisioned by the clinical teams to improve patient care.

2.21 The figure below sets out some of the planned digital changes that are relevant to this Patient Benefits Case and the associated benefits.

Figure 8: Benefits enabled by digital changes

Change	Benefit
The ability to share information safely and securely between teams	• Having the different IT systems supported to effectively 'talk' to each other has many benefits including the patient only having to tell their story once and professionals will have current patient information resulting in a reduction in clinical risk, see for example paragraph 4.121. • Easier communication and information sharing will support informed decision making and better patient outcomes, see for example the information in the frailty case in paragraphs 6.34 and 6.48.
Due to a change in the scale of the Trust, there is the ability to introduce digital technologies to a variety of patient pathways	• Generically, digital technologies will support patients within the community, reducing their need to have an unplanned visit to hospital.

Change	Benefit
	• Standardised digital self-assessment tools support triage allowing patients to be directed to the correct support earlier in their care, such as described in the neurodiversity case study. • Standardisation will enable a more consistent experience for patients. For example, the joint procurement of a video appointment solution across the ICB will simplify access for patients.
The ability to align IT systems supporting workforce policies such as rotational posts across the Trust	• Rotational posts will allow for more opportunities for clinicians to learn new skills and to provide more consistency in care for patients.
Alignment of coding of data across the new Trust	• To have a standardise coded data across the Trust will allow better modelling for service changes at a level to support evaluation of changes, such as for OPMH as described in paragraph 5.36.

Estates

2.22 Effectively utilising the combined estate of the new Trust is a critical enabler to ensuring that care can be delivered close to people in appropriate settings.

2.23 The figure below sets out some of the planned estates changes that are relevant to this Patient Benefits Case and the associated benefits.

Figure 9: Benefits enabled by estates changes

Change	Benefit
By bringing together teams with colleagues across the whole system (such as primary care and VCSE) the Trust will be able to use the estate more effectively	• Care delivery, such as recovery and wellbeing courses, can be provided more locally to ensure that the local estate buildings are being fully utilised and increasing parity of access for people.
As the new Trust brings the estates together, there is the opportunity to co-locate of physical and mental health services within the same location	• Co-location of physical and mental health services will support the move towards holistic care of people, rather than focusing on one element of a person's health such as that described in paragraph 4.103.

Equality impact assessments

2.24 The Equality Duty has three aims, it requires public bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- advance equality of opportunity between people who share a protected characteristic and people who do not; and
- foster good relations between people who share a protected characteristic and people who do not.

2.25 An EIA is used to help better understand a new policy or service and the way decisions are made by:

- considering the current situation;
- deciding the aims and intended outcomes of a function or policy;
- considering what evidence there is to support the decision and identifying any gaps; and
- ensuring it is an informed decision.

2.26 Having ‘due regard’ to ‘advance equality of opportunity’ between those who share a protected characteristic and those who do not includes considering the need to remove or minimise disadvantages suffered by them. Having ‘due regard’ also means public bodies, such as the Trusts, must ensure steps are taken to meet the needs of such persons where those needs are different from the persons who do not have that characteristic, and encourage those who have a protected characteristic to participate in public life.

2.27 During the implementation phase, equality impact assessments will be undertaken in line with the new Trust’s policies or, if occurring prior to April 2024, in line with the policies of the relevant Trust(s).

Quality impact assessments

2.28 A Quality Impact Assessment (QIA) is a process of identifying the anticipated, actual or potential impact of a strategy, policy, plan or proposed plan, service change or intervention, on the areas of quality (patient safety, effectiveness, patient experience) to ensure any necessary mitigating action, is outlined, implemented and evaluated in a robust way.

2.29 Completion of QIAs helps decision makers fully think through and understand the consequences and potential impact of financial and operational initiatives. QIAs support evidence of fair and proportionate reasoning and a robust process for making challenging decisions about local healthcare services. They provide assurance that

actual or potential risks to patients have been sufficiently considered and mitigated, particularly for decisions that may be considered contentious. A QIA will also support the avoidance of false assurance regarding a scheme that may have been underpinned by anecdotal or subjective opinion. Undertaking a QIA requires close collaboration with clinicians and this supports a framework for engagement and strengthens the clinical rationale for the implementation of a scheme.

2.30 QIAs will be completed for the case studies described in this document at the appropriate point, and prior to implementation, in line with the policies and procedures of the new Trust, or, if occurring prior to April 2024, in line with the policies of the relevant Trust(s).

2.31 QIAs will be reviewed and updated during the implementation phase where the components of a scheme change and delivery is modified due to the emergence of new evidence or performance data.

Public consultation

2.32 The changes to services described in this document are not expected to constitute significant service changes requiring formal consultation with the public. If, as the proposals continue to develop, there is a need for formal public consultation, the Trusts will comply with all relevant requirements.

2.33 Regardless of the requirement for formal public consultation, service changes and redesigns are being co-designed with staff and people with lived experience to ensure that the benefits to patients are maximised (as described in paragraph 2.6 above).

Resources for change

2.34 The clinical priority workstreams are overseen by the Clinical Transformation Group which meets monthly and is jointly chaired by the Medical Directors of Solent and Southern. Each clinical priority workstream has an identified executive director who takes system-wide responsibility for leading the workstream. Each workstream has dedicated resource in the form of senior clinical and operational leads and project management and administration support.

2.35 Each workstream meets regularly and includes representatives from the three Trusts, with Sussex Partnership also included in the CAMHS workstream.

2.36 The workstreams are supported by the community engagement teams to carry out community engagement and ensure access to the voices and priorities of service users and communities. Additional community engagement resource to support this work has been put in place as part of the Fusion Communications and Engagement Steering Group.

2.37 As described in the Full Business Case, the integration costs reflected in the financial plans for the new Trust include costs to support implementation of the clinical strategy, which will include the ongoing work of the priority workstreams.

3 Lived experience

3.1 At the core of the new Trust will be full collaboration with people who have personal experience of living with health conditions and/or using services and their family members/informal carers and the staff. This will be embedded in the values of the new Trust. The contribution of experiential expertise will run through the new Trust - an essential element in all levels and areas of the new Trust.

3.2 There is increasing evidence that decisions and interventions that are coproduced are more likely to be implemented, understood, accessed and utilised by those for whom they are intended. In addition, it leads to greater ownership of decisions, increased self-responsibility, improved priority setting and decision making, reduced power imbalances, reduced inequalities, reduced and transformed complaints that more effectively support learning, increased patient knowledge and recognition of their expertise, increased levels of service satisfaction, acknowledgement of rights, increased accountability, improved dignity and self-worth, increased patient and staff morale.

3.3 However, the advantages run much deeper than this:

- Firstly, engaging with and valuing expertise deriving primarily from lived experience expands everyone's understanding of a context, issue and/or solution;
- Secondly, coproduction increases the status and influence of people who use services, reducing stereotypes of both service providers and service users; and
- Thirdly, and perhaps most importantly, engagement with people using services on an equal basis is a fair, ethical and democratic way of working.

3.4 A culture that values and actively understands and supports 'experiential practice'[5] and coproduction is core to delivering equality, improved quality of experience and effectiveness. Services that deliver high quality care take appropriate account of individual differences and an ethos of 'everyone counts' and equality is integral to quality.

Current arrangements

3.5 Southern, Solent and IoW have each adopted different approaches to embedding lived experience in their organisations and ways of working in terms of workforce, processes

[5] https://www.centreformentalhealth.org.uk/publications/humanising-health-care

and leadership. This lack of a consistent strategic approach has led to variation in practice and culture and a low level of resilience as each Trust is focussed on different priorities that are not aligned or embedded and each Trust's offer is too small to provide sufficient resilience in isolation.

3.6 One example of this is the ECT service in the Isle of Wight which has pioneered the use of Peer Support. However the scale of services means that this is only provided by a single person on a very part time basis. When that person is away there is no resilience within the service and there is no peer support available. Service user feedback for Peer Support in ECT has included: "Talking to the PSW before I began my ECT treatment really helped me…I don't know if I would've done it without her." This evidences that the lack of resilience has the potential for significant negative impacts on patient experience, care and outcomes. By pooling some of the staff's expertise and resource it is possible to combat this.

3.7 All three Trusts offer peer and carer support, community engagement and quality improvement with some elements of coproduction, albeit using different models. IoW does not currently have a recovery college offer but this is available within Southern and Solent.

3.8 Care planning is undertaken using different methodologies currently: Solent currently uses DIALOG+ and Southern is currently piloting this, with IoW also intending to implement this holistic approach to care planning. It is based on 11 domains of a person's life (eight life domains and three treatment aspects) and people rate their satisfaction on a 7-point scale.

Peer Support Work

3.9 Peer Support Workers (PSWs) are people who used their lived experience of mental health problems to support others. All three Trusts offer access to PSWs within mental health with a small offer in some learning disability and community services.

3.10 On average, NHS Trusts employ 1 PSW within their mental health teams when headcount data is benchmarked per 100,000 registered population, though this varies from 0 to 8 per 100,000 population across NHS organisations[6]. The three Trusts employee paid peers support worker between 2.34-18.62 per 100,00 registered GP population.

3.11 62% of provider Trusts reported employing PSW: All three Trusts either directly or indirectly employ peer support workers.

---

[6] https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/peer-support-workers

3.12 72% of respondents advised that their mental health PSW are directly employed, with only 10% of organisations accessing staffing solely through wider partnership arrangements with other providers. The remaining 17% employ a mix of both directly employed and partnership employment arrangements. IoW and Southern have a mixed model and Solent currently outsources all PSWs.

3.13 IoW employs 27 peer support workers across crisis and community-based mental health and learning disability services, including dementia crisis care and the primary / secondary care interface. This team is led by a peer support lead with support from a senior PSW. All PSWs currently receive Health Education England (HEE) accredited training from ImROC or With-You. Enhancements in the last two years have included the development of the lead for peer-delivered services role and PSWs progressing to trainee roles as mental health nurses, psychological wellbeing practitioners, primary care coordinators and health and wellbeing coaches. IoW has found that when PSWs move into these roles they take an empathetic, recovery focussed mindset with them and continue the culture change that they've contributed to in dedicated peer roles in their new teams.

3.14 Solent's peer support offer is delivered by 23 peer support workers employed by Solent Mind who are sub-contracted through the Trust. Their community peer recovery team is available to anyone in Portsmouth receiving support from Solent's mental health services. There is also a peer support offer across the interface between primary and secondary care. Solent Mind delivers in-house training for their PSWs.

3.15 There are 36 peer and carer support workers across inpatient and community mental health services in Southern including the perinatal mental health service for HIOW. The 23 internally employed staff are led by a peer support lead with support from a dedicated peer practice educator. All Southern-employed PSWs receive HEE accredited training from ImROC or With-You. Southern contracts with Solent Mind for 13 peer support services across Southampton including two crisis lounges, primary care networks and specialist mental health teams.

Community engagement and patient experience

3.16 Southern's corporate patient experience and engagement function works across community and mental health services and undertakes a wide variety of engagement with people who use services and their carers through, for example, carers forums, audits and surveys and in-reach into community groups and inpatient services. People with lived experience are also directly employed within the quality improvement (QI) function to act as QI coaches and to support coproduction.

3.17 The patient experience and engagement function incorporate patient experience and involvement, community engagement, carer involvement, volunteers, the Trust's charity - Brighterway, the carers' and patients' support hub, complaints team and PSW development. There are 17.5 WTEs delivering these areas.

3.18 Solent's community engagement and experience function is delivered separately to corporate communications and engagement. The community engagement team works

in partnership to incorporate the views of people with lived experience through the voluntary, community and social enterprise (VCSE) sector. The community engagement and experience team has the following functions:

- Experience of care which incorporates complaints and the patient advice and liaison service, experience of care insights including friends and family test, surveys and patient-led assessment of the care environment and voluntary services
- Inclusive communication, including accessible information standards
- Freedom to speak up
- Working with people and communities which encompasses community engagement and the community partner programme.

3.19 IoW's central communications and engagement team manages statutory and corporate level communications and engagement. Separately, the community, mental health and learning disabilities division employs 3.8 WTEs in a service user engagement team, all of whom are people with identified lived experience of services, who facilitate coproduction and service user involvement, including community partners and families and carers as well as people directly using services.

Recovery College and Recovery Education

3.20 Recovery education has a strong history, in the UK exemplified by the development of the 'Expert Patient Programmes' and in the US by 'Recovery Education Programmes' which pre-dates recovery colleges. These approaches introduced the importance of lived experience and education in the provision of wellness courses and developing tools to self-manage long term conditions, they often sit independently from mental health services and professionals.

3.21 Recovery colleges form a key part of the development of more recovery-focussed mental health services[7]. This intentional focus on driving change in organisations as well as students and communities, through coproduction within an educational approach has been a critical differentiator. Internationally positioned and evaluated, recovery colleges have a growing evidence base demonstrating that fidelity to six principles, interpreted at the local level, is a good predictor of success.

3.22 The purpose of a recovery college is to support people's recovery from mental health difficulties through learning and education that is coproduced by people with lived

[7] Perkins et al 2018

experience and people with professional expertise. Recovery colleges [8] are a specific method of delivering recovery education that must adhere to six core principles:

- Educational principles;
- Coproduction, co-facilitation and co-learning lie at the core;
- Recovery-focused and strengths-based;
- Progressive;
- Integrated with their community and with the mental health services – and can serve as a bridge between the two; and
- Inclusive and open to all.

3.23 Southern has established a recovery college which aims to help increase awareness and understanding of recovery and self-management whilst challenging stigma related to mental health. Educational courses about mental health recovery and self-management are co-developed, co-delivered and co-attended by people who have lived experience of mental health related issues, friends and family of those who use mental health services and those in a professional caring role. Southern directly employs peer trainers. Courses are open to Southern adult mental health staff, adult mental health service users and carers of people using adult mental health services.

3.24 Since 1 August 2022, 230 students have accessed a suite of 854 course options. The outcomes report is being collated for the most recent academic year. This is expected to be digitised and use ReQoL[9] in the future through an upgraded database.

3.25 Solent Mind delivers the Solent recovery college. Most of the peer trainers are previous students and three current students have signed up to do the training to become trainers. All the sessions delivered by the Solent recovery college are designed in partnership between Solent Mind's peer trainers, adult mental health staff from Solent and with the support of the University of Portsmouth, allowing those with lived experience of a mental health issue to share their experiences and skills side by side with mental health professionals. The Solent recovery college offers a range of courses to people who use mental health services in the Portsmouth and Southsea postcode

---

[8] https://imroc.org/resource/15-recovery-colleges-10-years-on/

[9] Recovering Quality of Life (ReQoL) questionnaire which is a Patient Reported Outcome developed by a team at the University of Sheffield to assess the quality of life for people with different mental health conditions.

areas, friends and supporters of those who use services and staff within the partnership organisations (including Solent staff).

3.26 Since August 2022, 112 students have attended courses at Solent's recovery college, totalling 998 hours of study. 34 students attended a graduation ceremony for achieving 10 or more hours of study. The students currently self-report on whether they have achieved their learning outcomes - 98.7% of learning outcomes were achieved in the last academic year. The College is also aiming to use ReQoL as an outcome measure in the next academic year.

3.27 There is no formal recovery college on the Isle of Wight. Some elements of a recovery education approach are incorporated within the island's NHS Wellbeing Service, currently delivered by the Isorropia Foundation. The IoW has recruited a recovery education lead to support with the development of a system-wide approach to recovery education. They will initially work with existing Southern and Solent recovery college leads to enable access to virtual courses and then develop a place based face to face offer. They will also develop a wider recovery education offer across the island's services, improving access to peer-delivered training for staff.

Challenges

3.28 The key challenges faced by the Trusts in relation to lived experience are:

- Embedding the lived experience positions within the Trusts;
- Lack of common approach, language or understanding of coproduction, peer support or lived experience leadership; and
- Requirement to develop 'living well'.

Embedding lived experience positions within the Trusts

3.29 Although there are now a variety of lived experience positions within the Trusts including PSWs, peer trainers and engagement and involvement roles, the new Trust must be more representative of the people who use its services.

3.30 People using the community health services do not currently benefit from this approach to the same extent as people accessing mental health and learning disability services. There is now an opportunity for the new Trust to develop an approach to support people using these services, across the life course. A lack of common approach, language or understanding of coproduction, peer support or lived experience leadership will impact in the effectiveness of this.

Lack of common approach, language or understanding

3.31 There is no common approach, language, understanding of coproduction, peer support or lived experience leadership across the organisations, which impacts on what each area's population can expect to receive. For example, many inpatient mental health services in Hampshire employ PSWs on the wards, however on the Isle of Wight there

is no peer support for inpatients. Conversely, the IoW's electroconvulsive therapy (ECT) clinic has provided peer support with clear positive impacts on patient engagement and experience, but this is not available in other ECT clinics across HIOW. This lack of a common approach also means that staff using lived experience have inconsistent experiences and this impacts on their own recovery journey as people who have accessed services.

3.32 Although coproduction has developed rapidly across mental health services, it has been slower to develop in services supporting physical health. The creation of a new Trust provides the opportunity to develop a shared understanding of coproduction across all services, recognising the different roles of lived experience leaders, PSWs and experience based practice in each setting. The value of peer support in relation to long term physical conditions has already been demonstrated in primary care[10], in specialist services[11][12] and in recovery colleges[13]. Additionally there are pockets of coproduction within secondary care community services across HIOW, e.g. the long term condition group on the Isle of Wight, condition specific 'Expert By Experience' groups in Southern and IoW and engagement forums for community services on the Isle of Wight. The challenge will lie in ensuring that coproduction is understood and implemented throughout the Trust as it relates to all services, care planning, and through to strategic decision making. Development of the staff will be a key component of the organisation development workstream supporting this culture change.

Requirement to develop 'living well'

3.33 The greatest opportunities for supporting the wellbeing of the population lie in the communities in which they live. Living well includes taking responsibility for personal wellbeing, engaging in meaningful activities, developing positive supportive relationships, finding ways of managing long term conditions and accessing confident, capable and inclusive community groups - these are the most effective ways of staying well, preventing crises and reducing the need for services. Being supported by people who have lived experience creates a greater opportunity for people to work through what living well could look like for them through a recovery approach.

---

[10] https://imroc.org/wp-content/uploads/2022/04/ImROC-Live-Well-Model-Paper.pdf
[11] https://imroc.org/resource/18-peer-support-for-people-with-physical-health-conditions/
[12] https://diabetesjournals.org/spectrum/article/20/4/214/70086/Overview-of-Peer-Support-Models-to-Improve
[13] https://imroc.org/resource/15-recovery-colleges-10-years-on/

3.34 The recent Hewitt review of Integrated Care Systems[14] highlighted the importance of empowering local leaders to work with and through their partners and local communities. The areas supported by each Trust currently have different strengths and gaps in their local systems, leading to variation in each community's ability to respond to local need.

Collaboration to date

Peer Support Work

3.35 There has been collaboration between IoW and Southern, who both directly employ PSWs, focussing on opportunities for shared training and induction planning, with the long-term aim of creating parity of experience and quality both for people accessing a Peer Support service and for the PSWs themselves. All of Solent's peer support offer is delivered by Solent Mind, who also deliver Southern's peer work in Southampton.

3.36 At a system level there is a regional peer support network which brings together the Integrated Care Board (ICB), local NHS Trusts and third sector organisations delivering peer support across Hampshire and the Isle of Wight. This network meets regularly to enable the sharing of good practice, training and innovation, a shared understanding of national guidance and policy and to provide a forum for discussing the development of peer roles. Staff from Southern, Solent, and IoW, including those with lived experience of mental health conditions and services, are all active members of this network and its steering group, as are key VCSE partners including Solent Mind and Isorropia Foundation. This has facilitated improved joint working and smoother transitions – for example IOW are working closely with Isorropia on a peer-delivered Transitions pathway for 16-25 year olds moving from CAMHS to adult services.

Community engagement and patient experience

3.37 Prior to Project Fusion there was limited collaboration, although the individual Trusts' engagement teams were aware of each other and had some dialogue about varying approaches.

3.38 The establishment of a community engagement sub-group, reporting into the Communications and Engagement Steering Group as part of the Fusion programme, has enabled the beginning of some joint working and a better understanding of the approaches used across the different organisations. Through this collaborative

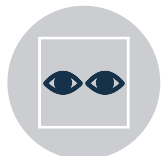
---

14 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1148568/the-hewitt-review.pdf

approach a set of principles has been agreed for engagement work relating to Project Fusion, along with a toolkit of shared resources, shared training and the bringing together of key community groups and partners from across the region.

Figure 10: Principles for lived experience engagement work

Inclusive – We want to hear everyone's voice Holding conversations with different parts of our communities – Invite us to any of your groups



Discovery approach – We don't have the answers – genuinely looking for your feedback

Recognise communities strengths – Harness exceptional strengths, knowledge, experience and skills. We must build on what's strong not what's wrong

Services created by communities – Our aim is to work in a way that ensures communities health create by themselves

Recovery College

3.39 A series of workshops led by ImROC have been completed to map the recovery college and recovery education resources across the areas served by IoW, Southern and Solent, including elements delivered by partner organisations.

3.40 The work has identified where there is alignment and how all the teams can work together to minimise duplication and share access in their current structure. The teams also put in a joint bid to no wrong door which included a lived experience position to drive the development of a single digital offer. The teams are also working jointly to develop questionnaire related to the opportunities people think Fusion will bring.

3.41 Through this work the teams have developed their own peer network to build their relationships and continue to learn from each other. Other work such as demand and capacity modelling will be shared across teams to ensure that there is minimal duplication of effort and parity of access to recovery college provision and other aspects of recovery education across the new Trust. The report 'HIOW Recovery College and Education Mapping Report May 2023 v2' is included in the supporting submission. A key workstream is to develop options for the development of a single recovery college.

What will change and how patients will benefit

3.42 The new Trust will set out its vision to improve and expand opportunities for people using their lived experience at all levels of the system – including governance and strategic leadership. This is in line with the national direction of travel and with the

available evidence about the impact of these roles on the quality and value provided by NHS services as described in the statutory guidance “Working in partnership with people and communities”[15].

3.43 Coproduction will be core to the new Trust’s approach. In line with the NHS Long Term Plan’s commitment to personalised care and supported self-management[16], patients and family members/informal carers will be fully informed about options and engaged in making decisions about all aspects of treatment, planning and ongoing support. A strengths and solution focused coaching approach will be routinely used. The benefits of this will include:

- More informed, activated and enabled patients, with improved outcomes;
- Decisions more likely to be adhered to, resulting in improved outcomes and reduced reliance on services;
- Higher levels of self-management line with the NHS Long term Plan resulting in prevention of relapse, and reduced demand on urgent and emergency services;
- Improved staff: patient communication, resulting in improved outcomes and improved staff and patient experience;
- Greater patient, family/carer and physician satisfaction; and
- Consistent cost savings due to lower inpatient and outpatient contacts where health coaching is used for conditions including depression and schizophrenia, in line with the comprehensive model of personalised care.

Collaborative care planning

3.44 All care plans will be negotiated and reviewed in collaboration with the patient and family/informal carers and all Trusts either already use DIALOG+, are piloting this or will be implementing this holistic approach to care planning. This will result in a clearer plan of action with agreed priorities and clear accountability and communication with patients and between clinicians and is expected to deliver large scale improvements in community care with better outcomes and improved cost effectiveness.

---

[15] https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/#b6-resources-and-learning
[16] https://www.england.nhs.uk/personalisedcare/supported-self-management/

3.45 In addition to a collaborative approach to overall care planning, joint crisis planning with actions identified to minimise crises if crises occur will be developed with full engagement of informal carers, primary and secondary care. This will support:

- Improved therapeutic relationships;
- Improved communication;
- Improved satisfaction with services; and
- Reduction in admissions - there is a greater than 78% probability that joint crisis plans are more cost effective than standardised service information in reducing the proportion of patients admitted to hospital[17].

3.46 Person-centred individualised care plans enable active engagement in plans to 'live well', care for self, and engage in activities and communities of people's choice. This reduces isolation and exclusion, enables a healthier lifestyle, and decreases loneliness. Participation in personal recovery planning has positive outcomes for participants, quantifiable using comprehensive measures of self-perceived recovery. Some patient feedback is included in Appendix 2.

Organisational and system level benefits

3.47 Expertise based on people's experience of services, care and conditions contributes a new perspective to decision making. It ensures that decisions consider the practical and emotional experience of people on whom they have greatest impact[18][19]. In order to achieve this at every level of the organisation, including in the Board of the new Trust, consideration will be given to ensuring that the voices and expertise of people who use these services are at the heart of the organisation at every level, including Board oversight. This will enable the implementation of a coherent strategy for all aspects of coproduction and the lived experience workforce, including:

- identification/selection of individuals;
- training;

---

[17] Flood C, Byford S, Henderson C, Leese M, Thornicroft G, Sutherby K, Szmukler G. (2006) Joint crisis plans for people with psychosis: economic evaluation of a randomised controlled trial. BMJ. Oct 7;333(7571):729. doi:

[18] The Kings Fund. Public engagement – pitfalls, barriers and benefits (2017) https://www.kingsfund.org.uk/blog/2017/10/public-engagement-pitfalls-barriers-and-benefits

[19] https://engage.hscni.net/

- supervision;
- governance;
- employment/deployment; and
- payment.

3.48 Coproduction groups will be set up in each 'place' to provide constructive challenge and contributions to decision making forums in the services where they have most experience, embedding coproduction as the "way we work".

3.49 Coproduction may lead to short-term increases in the use of services as it increases people's knowledge of and access to services. However, there are potential returns through prevention and early intervention when people's needs arise rather than when crises occur. Benefits include:

- New/alternative options and amendments to care plans, service improvements and local systems;
- Services become more appropriate, responsive, and more effective as they become more tailored to people's real needs; and
- Increased accountability of public services to the people who use them leading to increased confidence of the public in health services.

3.50 At system level, coproduction refers to collaborative working across all health and social care services with local communities, mainstream businesses and facilities, VCSE organisations and local citizens. There is evidence[20] that coproduction can:

- reduce labour costs by replacing employees input with citizens' input; and
- reduce costs of capital equipment, and facilities, supplies, utilities as coproducers' inputs replace government's inputs.

3.51 Evaluation of coproduction across five strategic programmes[21] including 58 local partnerships demonstrated measurable benefits at individual, staff, organisational and national level in all decisions made at every level. This overwhelmingly positive evaluation does not estimate cost or cost benefits.

---

[20] https://www.emerald.com/insight/content/doi/10.1108/JPBAFM-12-2018-0142/full/html#sec004

[21] https://www.tnlcommunityfund.org.uk/media/A-Meeting-of-Minds_How-co-production-benefits-people-professionals-and-organisations.pdf?mtime=20190919092658&focal=none

Employment of PSWs as an essential role in the workforce

3.52 PSWs working as part of an integrated MDT, enables the best use of everyone's specialist skills improving patient outcomes whilst also supporting improved clinical efficiency. The approach to PSWs will be developed based on best practice[22] and the new Trust will support this essential role through ensuring:

- People with lived experience are employed, directly or through sub-contracting, as peer support workers across services;
- All teams are supported to develop a distinct role for PSWs;
- PSWs are recruited, trained, supervised, and developed in line with best practice;
- PSWs are included in workforce and financial plans; and
- Grants and training for PSWs are accessed via NHS England.

3.53 There is evidence[23] that PSWs improve patient outcomes in terms of:

- improved self-efficacy, in line with the NHS Long Term Plan;
- reduced admissions and length of stay;
- greater community engagement, in line with the statutory guidance Working in Partnership with People and Communities; and
- driving forward positive patient centred changes in culture and practice.

3.54 The financial benefits[24] of employing peer support workers exceed the costs, in some cases by a substantial margin. It has been estimated that every £1 spent on peer workers is associated with savings in hospital bed use of £3. This in turn implies a net saving of £2 per £1 invested (i.e. gross savings of £3, less £1 spent on the peer support worker).

[22] https://imroc.org/resource/preparing-organisations-for-peer-support/
[23] https://eprints.lse.ac.uk/60793/1/Trachtenberg_etal_Report-Peer-support-in-mental-health-care-is-it-good-value-for-money_2013.pdf
[24] https://eprints.lse.ac.uk/60793/1/Trachtenberg_etal_Report-Peer-support-in-mental-health-care-is-it-good-value-for-money_2013.pdf

Extend recovery college offer across the whole system to become a community learning partnership

3.55 The vision is for the new Trust to have a single, open access recovery college, covering both community and mental health. To achieve this the new Trust will building more partnerships with VCSE organisations across localities to open access to recovery and wellbeing courses to the population, taking advantage of multiple funding sources and venues (libraries, sports, leisure, employment cultural and faith centres). This will ensure parity of access across the geography served as well as increasing access for people receiving physical health community health services.

3.56 The benefits of recovery education[25] include:

- improved understanding of living well and staying well;
- reduced discrimination;
- reduced inequalities;
- greater citizen participation and activation; and
- greater community engagement.

3.57 There have been no formal economic evaluations of recovery colleges but costing studies focusing on the extent to which they avert service use have reported an annual average saving per student of between £845 and £1,200 per year. RECOLLECT multisite research programme[26] is currently undertaking cost-benefit research.

Supporting culture change

3.58 The new Trust will take a coproduction approach to quality management systems, ensuring people with lived experience are involved in all aspects of defining quality standards, measuring against those standards, assurance systems and in quality improvement. Quality management systems rely on coproduction to be effective – this will enable the new organisation to deliver effective and reliable quality governance.

---

[25] https://imroc.org/resource/15-recovery-colleges-10-years-on/

[26] Hayes D, Henderson C, Bakolis I, Lawrence V, Elliott RA, Ronaldson A, Richards G, Repper J, Bates P, Brewin J, Meddings S, Winship G, Bishop S, Emsley R, Elton D, McNaughton R, Whitley R, Smelson D, Stepanian K, McPhilbin M, Dunnett D, Hunter-Brown H, Yeo C, Jebara T, Slade M. (2022) Recovery Colleges Characterisation and Testing in England (RECOLLECT): rationale and protocol. BMC Psychiatry. Sep 24;22(1):627. doi: 10.1186/s12888-022-04253-y. PMID: 36153488; PMCID: PMC9509550

3.59 The vision is to embed lived experience at all levels including in the Board, bringing lived experience (physical and mental health) and skills in critical and constructive challenge.

3.60 Lived experience will be rooted in the constitution of the new organisation to ensure the core principle of coproduction is embedded into the way the organisation functions. This will include:

- Recruitment of governors with lived experience;
- Development of a service user/patient and carer constituency;
- Ensuring people with lived experience are encouraged and supported to become members of the organisation; and
- Ensuring that coproduction is core to the functioning of the organisation will provide resilience to the cultural changes proposed.

Figure 11: Patient Story - Peer Support Worker

Stakeholder story - PSW Story

Ben is 45 and has depression and anxiety as well as multiple physical health conditions. He is prescribed various medications but struggles to take these and is unable to work. He finds it difficult to leave the house due to the impact of his physical health conditions, which in turn has a negative impact on his mental health.

How it can be now

Ben had been hospitalised due to physical health issues after he stopped taking medications due to concerns around side effects. Although he was supported by the psychiatric liaison team whilst an inpatient and referred to the local community mental health team, his anxiety and challenges with his physical health prevented him from attending scheduled appointments which led to him being discharged from the service back to his GP. He continued to have challenges taking his medications and was readmitted to hospital for one of his physical health conditions and his mental wellbeing had also deteriorated substantially.

How we want it to be

Whilst an inpatient in the hospital, the psychiatric liaison team contacted the community mental health team who assigned a community peer support worker to support Ben to access services and reduce any barriers to this. The peer support worker visited Ben in hospital to start to build a relationship so he felt supported on discharge and Ben felt it was easier to talk to someone who had used services and could understand what he was experiencing.

The peer support worker supported Ben to plan how to manage his own health and access the support he needs from services, and Ben is currently taking his medication and attending his appointments. Developing an empathetic, non-judgemental relationship with his PSW instilled a sense of hope in Ben, and empowered him to believe he could recover. His physical health has stabilised, in turn leading to an improvement in his mental health. He has accessed the local Wellbeing service to support him in his local community and has also become a student at the Recovery College.

Ben has now been discharged by the peer support worker and feels empowered to manage his own recovery journey going forward.

Benefits indicators

The indicators that will be used to assess progress in realising the expected benefits are set out in the figure below:

Figure 12: Lived experience benefits indicators

Measure	Source	Baseline			Target
		Southern	Solent	IoW	
Number of people attending recovery college courses	Recovery college database	230	112	0	1,650 - c.0.5% of the combined matrices listed below, achieved by year 5. Matrices: Approx. 310,000 people were identified in the mental health needs assessment in 2022 as also having long term conditions Approx. 18,440,000 people are listed on the Series Mental Health quality outcome framework register.
Recovery college outcomes	ReQuol	2023/24 academic year	2023/24 academic year	2023/24 academic year	TBC after evaluation of the ReQuol approach which is being undertaken in 2023/24
Access to Peer Support Workers	No. of PSWs per 100,000 registered population	2.3	10.5	18.6	Trust-wide to achieve a minimum of 10 per 100,000 registered population, by Year 5 (equivalent to +105 PSWs)
100% of Trust clinical transformation programmes coproduced	All programmes approved by Board have clear evidence of coproduction	Evaluation framework is being developed by the measurement and evaluation framework.			70% Year 1 85% Year 2 100% Year 3

Measure	Source	Baseline			Target
Lived experience leadership at Board level	Board composition data	0	0	0	Post developed Year 1 and open recruitment Q1 Year 2
Governors recruited with lived experience	Corporate governance team	No Service User and Carer constituency currently (although existing Governors may have lived experience)	N/A (not a Foundation Trust)	N/A (not a Foundation Trust)	New Service User and Carer constituency to consist of 6 out of 32 governors: Proceed to elections post Day 1
% recruitment panels with lived experience representation and involvement in the interview process	Baseline this 2023/24 and identify consistent approach	Not currently recorded			95% by Year 5

The coproduction of an evaluation programme will also include qualitative approaches to understand patient, service users, carers and families and staff experience as a result of this programme of work.

Implementation plan

3.61 The figure below sets out the key activities to realise the identified lived experience patient benefits. The detailed implementation plan is a supporting submission.

Figure 13: Summary of lived experience implementation plan

Year	Activities
Pre day 1	• Proposal for Trust-wide recovery college and education offer approved • Proposal for Trust-wide PWS approach approved • Lived experience infrastructure designed and approved • Lived experience strategy and plan developed to support clinical strategy • Core HR policies in place • Evaluation approach and plan coproduced and baseline measurements in place • Co production framework and training developed
Year 1	• Evaluation and reporting infrastructure implemented • Implementation of Trust recovery college and education proposal • Proposal for Trust-wide PWS approach approved and stage 1 mobilisation • Lived experience infrastructure recruited to (stage 1) • Capability and capacity programme to support coproduction mobilised • Coproduction training development and stage 1 roll-out
Year 2	• Progress with mobilisation
Year 3	• Progress with mobilisation

Interdependencies (internal or external) and how these will be managed

3.62 The lived experience work programme has identified the following key internal interdependencies and has representatives on the relevant Steering Groups and Working Groups, and vice versa, to ensure these interdependencies are managed effectively:

- The Organisational Development Steering Group: responsible for embedding lived experience and coproduction;
- The Workforce Steering Group: responsible for ensuring workforce planning, recruitment and selection and training reflect the lived experience vision and expansion; and

- The Constitution Working Group: to ensure that the development of the Trust's constitution, membership and board of governors reflect the vision for valuing lived experience.

3.63 The lived experience work programme has identified the following key external interdependency:

- Integrated Care Board: responsible for commissioning decisions. The workstream will manage this interdependency by ensuring that commissioners are included in any community engagement events and actively involved in the development of the services.

Key risks and mitigations

3.64 The lived experience work programme has identified the following risks with a risk score of 10 or more before mitigations:

Figure 14: Risk register for lived experience

Risk Description	Owner	Impact (score)	Probability (score)	Total Risk Score	Planned Mitigation Actions
Risk that attitudes and behaviours do not enable lived experience and coproduction to be embedded in all aspects of the Trust, leading to the Trust's ability to deliver sustained recovery being compromised	Director of Transformation	Critical (5)	Likely (3)	15	This is being mitigated through the establishment of a lived experience steering group that is supporting the development of the new organisation, including the clinical strategy, operating model, quality governance, corporate governance and OD planning.
Roles for PWS not made available through vacancies **Lack of resource to expand peer workforce**	Director of Operations – mental health and learning disabilities	Critical (5)	Unlikely (2)	10	Looking at both financing and workforce redesign to ensure the best use of available resource - this requires close work with the Workforce Steering Group.
Infrastructure not able to be financed to support the lived experience development and coproduction leading to compromising Trust's ability to deliver sustained recovery	Director of Transformation	Critical (5)	Unlikely (2)	10	Proposed lived experience structure and infrastructure options to be developed pre day 1 for approval.
There are not enough peer workers available to meet the vision	Lived Experience Lead	Critical (5)	Unlikely (2)	10	Staged mobilisation across services - workforce development plan to create a pipeline for developing and supporting people to become PSWs
Risk that there is not the appropriate funding available to undertake coproduction including reimbursement of people who are involved in these programmes	Director of Transformation	Critical (5)	Unlikely (2)	10	Development of coproduction revenue requirements for approval pre Day 1.

4 Childrens and Adolescent Mental Health Services (CAMHS)

Current service arrangements

4.1 Child and Adolescent Mental Health Services are currently provided by four NHS Trusts across HIOW ICS.

4.2 Community CAMHS is provided by IoW, Solent and Sussex Partnership. IoW provides community CAMHS for residents of the Island. Solent provides community CAMHS for the cities of Southampton and Portsmouth, in alignment with the geographical footprints of the local authorities. Sussex Partnership provides community CAMHS in Hampshire, currently aligned to the geographical footprint of Hampshire County Council. The community CAMHS service provided by Sussex Partnership is the only service currently provided by Sussex Partnership that will transfer to the new Trust. Southern provides the three CAMHS in-patient psychiatric hospitals situated in Hampshire. This is detailed further in sections below.

The latest CQC ratings for each provider are listed below:

Figure 15: CQC ratings for Trusts

	Southern	Solent	IoW	Sussex Partnership
Trust rating	Requires Improvement	Good	Good	Good
CAMHS specific rating	Good	Good	Good	Good

4.3 Additionally, there is an existing provider collaborative (PC) for the commissioning of provision of CAMHS in-patient care across HIOW and Dorset known as the Wessex and Dorset PC. Sussex Partnership is the lead provider. As part of this collaborative, Dorset HealthCare University NHS Foundation Trust, Solent, and Southern provide the Closer2Home Team in partnership across the geography. Closer2Home is an intensive home treatment service that enables children and young people (CYP) to remain living at home as an alternative to inpatient care, enabling them to remain engaged with family/carers, friends and education. The PC is responsible for commissioning Tier 4 inpatient care for CYP who require general adolescent units (GAU), specialist eating disorder beds, psychiatric intensive care (PICU) and low secure provision.

4.4 There is a CAMHS medium secure in-patient service provided by Southern which is commissioned separately via NHS England specialised commissioning arrangements.

Southern CAMHS

Inpatient psychiatric provision

4.5 There are three inpatient units provided by Southern. These are Bluebird House, a 12 bed medium secure inpatient unit, Leigh House, a 16 bed GAU and Austen House, a 14 bed low secure inpatient unit. These are currently fully staffed.

4.6 The PC and NHS England have approved the business case for Leigh House Hospital to move to a 10 bed GAU and to develop an eating disorder day service. This will provide an intensive day service programme for 10 young people at any one time experiencing an eating disorder who require this intensive highly specialist programme of care. This service is expected to be operational from 27 November 2023.

Solent CAMHS

Early help and partnership services

4.7 There are place-based CAMHS leadership arrangements within Portsmouth and Southampton with a Head of Service supported by Quality and Governance, Special Educational Needs and Disabilities (SEND) and Clinical Services leads and a Participation facilitator across all Solent CAMHS.

4.8 Solent CAMHS works closely with partners to deliver an early help Social Emotional and Mental Health (SEMH) offer to local communities. Outside of Solent-led CAMH Teams, both Cities have invested in early help and intervention through local authority section 75 arrangements. In Southampton this includes the provision of three CAMHS Clinical Leads who reach in to the 0 – 19 Early Help Service to provide supervision and case formulation to the Early Help teams. This service will be further developed during 2023/24 with 0-19 services delivering on the initial stepped care interventions of clinical pathways.

4.9 Solent CAMHS deliver early help and intervention services primarily though the Mental Health in Schools Teams (MHST) across the two Cities, offering individual work, consultation and whole schools' approaches.

4.10 There are currently three teams in Portsmouth offering full coverage across all schools in the city and four teams in Southampton which currently cover 90% of schools in Southampton.

4.11 The Mental Health in Schools Teams receive referrals directly from educational settings. Solent Specialist CAMHS (SpCAMHS) in the Cities operate a clinically led Single Point of Access (SPA) for the receipt and triage of all other referrals. In Southampton this includes a partnership with two voluntary organisations. In Portsmouth this is a single service approach.

4.12 The SPAs receive and triage referrals to the SpCAMHS Service. The service provides advice and consultation via telephone and email and representatives will attend CAMHS network meetings, develop and agree initial care plans, undertake risk

assessments and develop safety management plans and initial assessments to inform a plan of intervention. The team provide group work and workshops to enable early intervention. The SPAs were originally developed with the aim of delivering advice and consultation to referrers, however, with increasing number of referrals, and reduced levels of capacity, it has not been possible to consistently sustain this in a timely and responsive manner.

4.13 The service has been structured around the iTHRIVE (see figure 21 below) model and has introduced a stepped model of care which aims to support young people and families with the most appropriate clinical intervention according to the young person's assessed need. Where additional, higher intensity support is required, the young person will be offered higher intensity intervention through locality-based treatment teams.

Acute, crisis and eating disorder services

4.14 Solent NHS provides the in-reach CAMHS liaison teams in University Hospital Southampton (UHS) and Queen Alexandra Hospital in Portsmouth. In UHS this is alongside the UHS-led CAMHS liaison provision who take over clinical accountability for CYP who are admitted to the wards for more than 72 hours. The services run over seven days delivering biopsychosocial assessments to young people who present with acute mental health needs. The services oversee risk assessment and care plans for young people requiring ongoing admission in an acute setting.

4.15 For young people presenting in crisis and/or requiring more intensive levels of intervention to remain safe in the community Southampton hosts a multi-agency service – BRS (Building Resilience and Strength). This service acts as a sister service to SpCAMHS and bridges the front-line delivery across CAMHS and children's social care. However, Southampton City Council (SCC) is currently in the process of disinvesting in the BRS service. The ICB will continue with its contribution to this service and this will be redirected to develop the CAMHS crisis pathway to provide extended hours care to CYP in community. The plan is for transition to these arrangements in November 2023. Alongside this change SCC will reinvest funding into a separate specialist CAMHS provision to provide support, supervision and formulation for CYP in care, fostering and their vulnerable adolescent's service. In addition, the service is set to mobilise a short stay unit within the next 12 months with SCC at Westwood House.

4.16 The SpCAMHS Service in Portsmouth has recently received funding for 2.0 whole time equivalent (WTE) dedicated crisis care posts. These will work alongside the current WTE in service to deliver urgent assessments and immediate intervention for risk support when needed. Input from these workers will be short term to enable them to work in the flexible and responsive manner required.

4.17 Closer2Home is delivered in both Southampton and Portsmouth and works with locally delivered services (described in paragraph 4.4 above) to offer an alternative to young people who may otherwise require hospital admission.

4.18 Southampton and Portsmouth both provide a specialist pathway for CYP with an eating disorder. These pathways provide assessment and intervention for young people with eating disorders. In Southampton this is extended to include young people with disordered eating due to the nature of the team composition being integrated within wider SpCAMHS. In line with the National mode, neither service currently offers an Avoidant Restrictive Food Intake Disorder (ARFID) specific pathway.

Locality based community CAMHS Teams and digital services

4.19 Solent CAMHS has commissioned the use of 'Silver cloud' as a digital offer to young people and their families. This is utilised as psycho education as well as supporting treatment across the MHSTs and SpCAMHS services.

4.20 There are locality-based Specialist CAMHS community teams in Portsmouth and Southampton. These are full Multi-Disciplinary Teams consisting of Administrators, Allied Health Professionals, Mental Health Practitioners, Nurses, Psychiatrists, Psychologists, Therapists, Social Workers and Support Workers.

4.21 The main clinical care pathways are Anxiety, Self-Harm, Low Mood and Psychosis. A city-wide trauma pathway is currently under development in Portsmouth. In addition, there are a cohort of young people, Children in Care, who are supported by a specialist team in Portsmouth CAMHS who work closely with the local authority. Within Southampton the team have recently started the first ever yoga groups with young people which are being delivered by a qualified yoga clinician.

4.22 The locality-based community CAMHS Teams offer a range of therapies and interventions in accordance with the most relevant research, evidence base, clinical best practice and NICE guidelines. These include, but are not limited to:

- Cognitive Behavioural Therapy (CBT);
- Eye Movement Desensitisation and Reprocessing (EMDR);
- Dyadic Developmental Psychotherapy (DDP);
- Dialectical Behavioural Therapy (DBT);
- System Family Psychotherapy;
- Art Therapy;
- Play Therapy;
- Dramatherapy;
- Child and Adolescent Psychotherapy;
- Acceptance and Commitment Therapy (ACT); and
- Positive Behaviour Support.

4.23 Each SpCAMHS Service in Solent offers workshops and group work as part of evidenced base stepped care pathways. As the two CAMHS services in Portsmouth and Southampton have relatively recently come together under a single service line work has commenced to review and ensure consistency in care pathways across the teams under a shared, integrated senior leadership structure. This work will be aligned to the wider workstream across the HIOW CAMHS services being led by the Senior Leadership of each Trust.

Neurodiversity (ND) assessment

4.24 Solent offers ND assessment services in Southampton and Portsmouth for children under 18 years old who are registered with GPs in those geographies.

4.25 In Southampton attention deficit hyperactivity disorder (ADHD) assessment is offered as part of the core, specialist, CAMHS service. Referrals are made via the SPA for specialist CAMHS. Risk assessments are carried out as part of the triage process and children/young people are placed on a waiting list for ADHD assessment in chronological order of receipt of referral. Any associated mental health needs are triaged alongside and support is offered as appropriate.

4.26 It is expected that parents requesting an ADHD assessment for their child have attended a parenting course, an example of this is the New Forest Parenting programme.

4.27 Once a diagnosis of ADHD has been made, children or young people and their families are offered psychoeducation and if requested are placed on the waiting list for medication prescribing.

4.28 In Southampton the autism assessment service is a standalone service under the leadership of the SEND workstream in the CAMHS service line. Referrals for autism assessment are made directly to that team and can be made by professionals or directly by families, children, and young people.

4.29 The autism assessment service triages all referrals to ensure that children and young people that have autism assessments are those where there is evidence from more than one setting (e.g. home and school) of likely autism and where the possible autism diagnosis is impacting on their day-to-day functioning.

4.30 In Southampton children's community learning disabilities nursing is provided by the Jigsaw health team. This is an integrated team working with the children with disabilities social care team.

4.31 The Jigsaw team provides behaviour management support across several care pathways for children up to the age of 18 years. The team use a Positive Behaviour Support (PBS) approach.

4.32 In Portsmouth the learning disabilities CAMHS nursing team, as part of the specialist CAMHS provision, provide positive behaviour pathways management support for children and young people in special schools.

IoW CAMHS

4.33 There is a single community CAMHS team, based in Newport, supporting the population on the Isle of Wight.

4.34 The IoW CAMHS service operates an integrated mental health service offering high quality clinical care for children and young people up to the age of 18 who are registered with an IoW GP. The service uses the iTHRIVE model[27] based on the five key principles of Thriving, Getting Advice and Signposting, Getting Help, Getting More Help and Getting Risk Support to improve outcomes for children and young people's mental health and wellbeing.

4.35 Due to the nature of the geography on the Isle of Wight, CAMHS have developed strong inter-agency partnership arrangements with both the local authority and third sector organisations to support the SEMH agenda on the Island. The service works closely with service users (expert by experience team) and partner agencies including voluntary sector organisations such as the Youth Trust, Barnardo's, Autism Inclusion Matters (AIM), Isorropia to deliver support. Within the education setting there are close working relationships across Mental Health Support Teams (MHSTs), Special Educational Needs Department (SEND), Special Educational Needs and Disability Information Advice and Support Service (SENDIASS).

4.36 There are further relationships with Children's services through Early Help, Resilience and social work teams and Resilience Around Families Team (RAFT), paediatric services through Speech and Language Therapy (SALT), Occupational Therapy (OT) and acute care services and the youth justice system through, Youth Crime Prevention (YCP) and Youth Offending Team (YOT).

4.37 The service accepts referrals from primary care, school staff, other professionals as well as self-referrals from families and carers where there are significant concerns about the mental health of a child or young person. There is a daily triage of referrals and a weekly multi-agency referral meeting, attended by professionals from the CAMHS team and representatives from the voluntary sector such as the Youth Trust. This offers opportunities for the MDT to review referrals together and plan who can best meet the needs of the children. Children and young people with relatively mild mental health difficulties are signposted to other appropriate services such as the MHSTs (see paragraph 4.47 below) in a timely manner or can be accepted directly by voluntary services such as the Youth Trust to receive counselling services. Children

[27] http://implementingthrive.org/about-us/the-thrive-framework/

and young people with moderate to severe mental health difficulties are accepted by the community CAMHS team to plan an initial assessment.

4.38 The multidisciplinary community CAMHS team consist of Psychiatrists, Psychologists, Nurses, Family and Systemic Psychotherapist, Child and Adolescent Psychotherapist, cognitive behaviour therapists (CBT), associate and mental health practitioners from various backgrounds (social work, drama therapy, occupational therapy etc), support workers, students, team administrators and trainees who are supervised within their respective disciplines. Following assessment, the relevant team members offer evidence based therapeutic interventions and support to children and their families including working and consulting with other partner agencies.

4.39 The team has a crisis support team called ‘in-reach/outreach team’ (IROR) which supports children and young people who either present to the hospital setting, are in the community with acute mental health crisis or those who need urgent support. There is a HAHTT team (Holistic at Home Treatment Team) which offers community crisis intervention for those children with an eating disorder and with other complex presentations who may be at risk of hospital admission. The CAMHS team holds daily multi-professional risk meetings to discuss any child at risk of significant mental health deterioration, in crisis or at risk of hospital admission.

4.40 There is an all-age mental health liaison team based in the acute Trust that undertake initial assessments for anyone presenting in a mental health crisis, including out of hours. Under 18s are usually admitted to the paediatric ward for an overnight observation and referred to the IROR team the following day to ensure they have a period of reflection and are physically well enough for an assessment. IROR offers urgent assessments for children and young people presenting with a mental health crisis during the working day and can offer further intervention and monitoring for a limited period before transferring care to the generic CAMHS team or to primary care based on their assessment of need.

4.41 The CAMHS community eating disorder team is a small multidisciplinary team which works proactively with colleagues in both the community and CAMHS teams to offer consultation, joint assessments or to carry out specialist assessments. They also offer intervention to children and young people presenting with an eating disorder. The team works closely with the children’s ward, dietetics and paediatrics teams to ensure that children’s physical health is being monitored and supported where needed.

4.42 A private provider, Psicon is currently commissioned for ADHD and ASD assessments and ADHD treatment for under 18s.

4.43 There is no separate learning disability service for under 18s on the Isle of Wight. Young people who have a learning disability and comorbid mental health concern are supported under the psychology team within IoW CAMHS. This has been identified as a gap in the service. Colleagues across the HIOW system will scope different models and reviewing best evidence as separate or bespoke services are not currently funded for the IoW.

4.44 There is no inpatient psychiatric provision for under18s on the Isle of Wight and the CAMHS team works collaboratively with multi-professional colleagues to support children and young people presenting in crisis by involving IROR and/or HAHTT teams thereby reducing the need for a child to be admitted to an inpatient psychiatric bed on the mainland. Those young people who are admitted into a mainland psychiatric hospital bed are discussed in weekly risk meetings to proactively plan discharge and community support.

4.45 There is a monthly multiagency transition meeting to discuss young people who are approaching their 18th birthday and may need a referral to the adult mental health service. This meeting is attended by the transition consultant psychiatrist, colleagues from the adult community mental health teams (CMHT), clinical lead for Isle Talk (NHS Talking Therapies), CAMHS care coordinator, peer support workers, assistant operations manager and other staff as appropriate. This group is involved in reviewing young people transition care pathways and making significant improvements to ensure that young people with complex mental health needs receive timely mental health support by the most appropriate service.

4.46 CAMHS has recently employed two transitions PSWs through a joint bid between community CAMHS and the Youth Trust/Issoropia and support from the expert by experience team. The PSWs will be supporting young people with complex mental health difficulties who are under CAMHS and need support during their transition to adult mental health services. The PSWs work with the transition consultant psychiatrist to support 16–25-year old young people with significant mental health needs.

4.47 The service provides two mental health support teams (MHST) based in various schools on the island. The teams offer early intervention and support to children and young people struggling with mild mental health difficulties and those that have more significant or complex needs are referred to the community CAMHS team.

4.48 Psicon (private provider) is commissioned to deliver autistic spectrum disorder (ASD) and ADHD assessment service and treatment / follow up care for children and young people diagnosed with ADHD and needing medications. The CAMHS team works with Psicon to support children who have a diagnosis of ASD and / or ADHD who have additional or complex mental health difficulties.

4.49 HIOW community forensic CAMHS (FCAMHS) team (see paragraph 4.56 below) is available for consultation and joint working in complex young people posing risk to others and / or under the youth justice system.

Sussex Partnership CAMHS

Early Help and Partnership Services

4.50 Sussex Partnership has a dedicated Early Help and Partnerships Service. This part of the service is organised into three geographical areas (North, West and South East Hampshire). There are place-based leadership arrangements with Hampshire-wide oversight.

4.51 The SPA receives and triages all referrals to the service. The service provides advice and consultation to referrers via telephone and email, develops and agrees initial care plans, risk assessments and safety management plans, books initial assessments and, along with other parts of the service, undertakes a proportion of initial assessments.

4.52 The service has been structured around the iTHRIVE model and has introduced a stepped model of care, which aims to support young people and families with the most appropriate clinical intervention according to the young person's assessed need. The aim of the Early Help Service is to offer an initial assessment, workshop and group programme to most young people who are accepted by the service. Where additional, higher intensity support is required, the young person will be transferred to the appropriate locality-based community CAMHS team for higher intensity intervention.

4.53 The service provides Mental Health Support Teams in schools (MHSTs). There are currently 11 MHSTs across Hampshire which cover approximately 50% of Hampshire County Council schools, including four teams which are in training and will be fully live by April 2024[28].

4.54 The service is establishing a primary care children and young people's wellbeing service through Primary Care Networks (PCNs). The aim of the service will be to provide advice and consultation to GP practices and low intensity interventions to children and young people who have additional needs but do not require specialist CAMHS intervention. This will be achieved through the Additional Roles and Responsibilities Scheme (ARRS). 8 PCNs (out of 42) have been identified to date and it is anticipated that this will increase in future years.

4.55 There is a forensic service which is commissioned separately under a subcontract with the PCC on behalf of specialist commissioning with NHS England. This service provides advice, consultation and treatment to young people who are a significant risk to themselves or others and have a forensic/youth offending presentation. This is provided in partnership across Southern and Solent for the HIOW footprint and acts as single team.

Acute, crisis and eating disorder services

4.56 Sussex Partnership provides the paediatric psychiatric liaison services at Hampshire Hospitals NHS Foundation Trust (Winchester and Basingstoke sites). The team are

---

[28] The MHST train as a team on the job so are not fully operational during the first year of mobilisation.

on-site and provide full biopsychosocial assessments for young people who present with mental health concerns.

4.57 There is an intensive home treatment team (i2i) which provides additional support for young people in the community who are in crisis and are assessed as high risk. The team provides treatment within homes and in the community. The team undertakes same day assessments, supports delayed acute discharge pathways and discharges from inpatient provision and offers specific clinical care pathways using Dialectical Behaviour Therapy (DBT) approaches.

4.58 A dedicated county-wide Eating Disorder Service provides assessment and intervention for young people with an eating disorder predominantly using the Family Therapy for Anorexia Nervosa (FT-AN) treatment model. The service offers an ARFID pathway, following a successful national pilot several years ago.

Locality based community CAMHS Teams and digital services

4.59 A digital team has been established to provide clinical interventions for young people who have been waiting the longest to start treatment. The initial pathways prioritised were ADHD and low mood/anxiety pathways. The team will support the adoption of digital technologies and their rollout across the service.

4.60 There are seven locality-based community teams across Hampshire to deliver place-based care in the New Forest, Eastleigh, Winchester and Test Valley, Basingstoke, Fareham and Gosport, Aldershot and Havant and Petersfield. These are multi-disciplinary teams consisting of administrators, allied health professionals, mental health practitioners, nurses, psychiatrists, psychologists, therapists, social workers and support workers. The main clinical care pathways are ADHD, anxiety, autism, emotional regulation, low mood, psychosis (early Intervention in psychosis services provided by Southern), tics and tourettes and trauma. In addition, there are two cohorts of young people, children in care and children with learning disabilities who are supported with specific arrangements within each of the locality-based teams. These arrangements are currently embedded within localities rather than specific teams, but the long-term aim is that this is reviewed subject to the implementation of specific business cases in relation to these cohorts of young people.

4.61 The locality-based community CAMHS teams offer a range of therapies in accordance with the most relevant research, evidence base, clinical best practice and NICE guidelines. These include, but are not limited to, cognitive behavioural therapy (CBT), eye movement desensitisation and reprocessing (EMDR), dyadic developmental psychotherapy (DDP), dialectical behavioural therapy (DBT), system family psychotherapy, art therapy, play therapy, child and adolescent psychotherapy, and acceptance and commitment therapy (ACT).

4.62 There is also a multi-agency agreement with Hampshire County Council providing four specialist intensive worker hubs across Hampshire aligned to the County Council divisions. The service provides clinicians to work within these hubs. The main cohorts of young people supported through these hubs are young people being supported to

remain at home, or to return home or to stabilise placements (both fostering and residential placements). Hampshire County Council has agreed to expand the capacity of this provision but the business case has been delayed to 2024/25 due to financial pressures across agencies. There is work focusing on interagency support for young people with multiple service needs already in progress and aligned to both the ICB CAMHS Transformation Board's agenda and a priority for Fusion. There is additional information in the implementation plan.

4.63 A business case has been developed and approved by the ICB CAMHS Transformation Board to increase the provision available for young people with a learning disability and autism. Approximately one third of the funding has been approved in 2023/24 to start mobilising the new provision, with the expectation that further funding will be available to fully mobilise the model in future years. The model will increase the availability of training, advice, consultation, and interventions and has been developed using the iTHRIVE framework. The work through project Fusion has highlighted Autism as an area of priority for HIOW. The senior leadership teams across CAMHS have established a working party to understand unwarranted variation and review the clinical delivery model.

4.64 A recovery model will also be introduced in 2023/2024. This model will be introduced into each of the locality-based community CAMHS teams. Two recovery workers will be employed within each team and will focus on supporting the young person with their recovery.

Summary of CAMHS provision by Trust

4.65 A summary of the provision in 2022/23 across all four Trusts is provided in the figures in Appendix 3. This covers both community and inpatient services.

National context

4.66 Rates of probable mental disorders have increased since 2017: in 6 to 16 year olds from one in nine (11.6%) to one in six (17.4%), and in 17 to 19 year olds from one in ten (10.1%) to one in six (17.4%). The latest NHS CAMHS Benchmarking highlights the highest number of children and young people on waiting lists for CAMHS since the start of NHS Benchmarking. Latest figures (2022/23) show on average, 918 children and young people per 100,000 population were waiting for a first appointment, with a further 708 per 100,000 population waiting for a second appointment. There were 2,240 children and young people on caseload per 100,000 population, the highest since the start of the NHS Benchmarking. The increase in prevalence and the resulting demand for child and adolescent mental health services represents a significant challenge for all mental health providers, as well as wider system partners.

4.67 Since 2015, there have been several key national strategies to address the increasing need for effective and responsive child and adolescent mental health services.

4.68 Future in Mind[29] was published in 2015. Key themes from this report were:

- promoting resilience, prevention and early intervention;
- improving access to effective support – a system without tiers;
- care for the most vulnerable;
- accountability and transparency; and
- developing the workforce.

4.69 Local transformation plans (LTPs) were developed in each area setting out the local ambitions and improvements to children's mental health services. Funding was allocated nationally over several years to achieve these ambitions. This included increasing access to mental health services and introducing waiting time standards for eating disorder services. The LTPs have been reviewed annually since this date.

4.70 The Five Year Forward View for Mental Health[30] was published in 2016. Priorities for children and young people services included developing improved crisis provision and psychiatric liaison services and ongoing commitments to increasing access to mental health services for children and young people and ongoing priorities outlined in 'Future in Mind'.

4.71 In 2017 the Government published 'Transforming children and young people's mental health provision: a Green Paper'[31] which detailed proposals to create a network of support for children and young people and their educational settings. This led to the development of mental health support teams in schools and the establishment of a 'whole school approach' to mental health and wellbeing.

4.72 In 2019, the latest NHS Long Term Plan[32] was published setting out a five-year plan to improve NHS services. It established a new commitment that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending. In addition, there were ongoing commitments to expand access to community-based mental health services, continued increases in

[29] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf
[30] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[31] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf
[32] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

investment for eating disorder services, crisis services, the development of mental health support teams in schools and implementing a new approach for 18-25 services.

Local context

4.73 Locally, the HIOW ICS is experiencing the same challenges as nationally. There has been an increase in demand for child and adolescent mental health services and, in some parts of the system, significant challenges associated with timely access to appropriate services.

4.74 Since 2015, the strategic approach to developing, improving, and expanding child and adolescent mental health services has been facilitated through the development LTPs which have been refreshed annually.

4.75 Currently, the LTPs are developed at place (Hampshire, Southampton, Portsmouth and Isle of Wight). There is a CAMHS Transformation Board which includes partners from across the system to provide oversight of all the plans. This enables decisions to be made as to which priorities are delivered at scale, on a system-wide basis, and which priorities are delivered at place.

4.76 The priorities within each place-based LTP are centred around the following themes and reflect the priorities of the CAMHS Transformation Board:

- Improve access and waiting times for children and young people's mental health services - there national targets around improving access are being collectively met in HIOW, however due to growth in demand, the waiting times continue to grow;
- Improve access to Neurodiversity services;
- All children no matter what level of need will be supported to recover well locally, either at home with a personalised care and support package, or in an appropriate health or care facility;
- Promote resilience, building life skills and competencies through strong prevention and early intervention services in partnership with other key stakeholders; and
- Develop the workforce to provide high quality children and young people's mental health services.

Challenges

4.77 The key challenges faced by CAMHS in HIOW are:

- Workforce challenges;
- Increasing demand for child and adolescent mental health services; and
- Fragmented clinical care pathways.

Workforce challenges

4.78 There are significant gaps in workforce across all organisations within HIOW, which is reflected in CAMHS. There are also examples of high turnover rates within services, with staff leaving services for improved work-life balance, access to education and learning opportunities and promotion opportunities in neighbouring Trusts.

4.79 Each Trust has a separate workforce plan with its own organisational workforce priorities.

4.80 Historically, individual services have attempted to deliver rotational posts across different services, for example between crisis, community, and inpatient provision. This would provide opportunities for clinicians to develop their skills and experience in different settings, reduce the risk of staff burnout, reduce turnover and improve the ability of organisations to cover key workforce gaps. However, it has not been possible to achieve an embedded model, due to challenges associated with different policies, employee contractual arrangements and IT systems.

4.81 Learning, development, and educational opportunities for staff are currently inconsistent across the different organisations.

Increasing demand for child and adolescent mental health services.

4.82 The demand for child and adolescent mental health services has continued to increase. Since the start of the COVID-19 pandemic in 2020, demand has risen locally by over 30% and this has created additional challenges within the local system. Historically, there has been an under-investment in CAMHS, although this position is starting to change. In Hampshire, whilst investment is below the national average, it has started to increase at a faster rate than the national average.

4.83 Parts of the HIOW system are experienced in managing significant waiting lists and have developed approaches to forecasting demand and developing innovative clinical practice to reduce the adverse impact of children and young people waiting to access the interventions needed. Services have developed tools to model demand and its impact on capacity and latterly adopted tools developed by NHS England. Through the CAMHS Transformation Board there is a joint understanding of the pressures experienced by each of the NHS organisations providing child and adolescent mental health services. There does, however, continue to be inequity in the level of investment within each place.

Fragmented clinical care pathways

4.84 CAMHS provision is fragmented between different providers and across geographies. This fragmentation results in multiple hand-offs and different access requirements.

4.85 Inevitably, each organisation has developed their own clinical care pathways. Whilst there are examples of joint working, it remains the case that each organisation has developed their own arrangements in silos. For example, all four Trusts have adopted the iTHRIVE model differently and services such as AFRID were commissioned

differently, creating variations in delivery. Whilst there is a commitment to continue to provide services at place, ensuring that pathways are developed in accordance with local population need, there are opportunities to ensure pathways are consistent, where clinically appropriate, and thus reduce unwarranted variation and inefficiencies. Inefficiencies reduce the funding available to provide high quality services.

Patient story – How it can be now

4.86 A patient story (Frances's story) on the challenges being experienced currently and how these will be improved through the creation of the new Trust is detailed below:

Figure 16: Patient story – CAMHS as it can be now

Patient story – Frances

How it can be now

Late Friday afternoon, Senior Tier 4 CAMHS staff were made aware that 17-year-old Frances had been detained under Section 136 Mental Health Act (MHA) and taken to a designated Place of Safety (PoS) in a local adult mental health hospital (EPR – Southern RiO). Frances had been there for approximately 65 hours - she was admitted to the PoS Suite in the early hours of Wednesday morning.

Frances had attended the local emergency department on Monday evening following a self-inflicted laceration to her wrist and an overdose of ketamine. She had been assessed and then discharged home to the care of her parents on Tuesday morning (EPR – Solent System One). Southern and Sussex Partnership colleagues are unable to access these notes. On Tuesday evening, Frances took advantage of her mum leaving her alone for a few moments, left the home address via a window and made her way to a railway bridge with the expressed intent to end her life by jumping in front of a train. Police attended and, in liaison with NHS 111, decided to detain Frances on Section 136 mental health act (MHA) as she was unable to engage in a plan to keep herself safe.

Whilst in the PoS, Frances engaged in self-harming behaviours (cutting, headbanging), damaged fixtures and fittings, attempted to abscond, was verbally abusive to staff and physically assaulted them by throwing mouth wash at their eyes. Nursing staff administered lorazepam intramuscular (IM) under restraint to reduce agitation. She also began restricting food intake although continued to accept drinks of tea and water.

Community Mental Health Team (EPR – Sussex Partnership Care Notes) launched an unsuccessful local and national search for a hospital bed. Frances began to decline drinks as well as food, her forehead began to swell and formed an abrasion from the intensity of her headbanging and she complained of a headache and stomach-ache. Frances' parents were able to visit her on Thursday afternoon.

Frances' parents contacted their MP who asked the Trust's Executive team to expedite the search for a hospital bed for Frances due to her prolonged detention in the PoS. No appropriate bed was available, however there was considerable pressure from all parties to find a compassionate solution for the young person. Late Friday afternoon, the reluctant decision was taken to admit Frances to the least worst option of the local Low Secure Unit (LSU) for the containment of risk and all necessary arrangements and preparations made.

Frances received compassionate care during her emergency admission to the LSU – the staff team adapted positively in the unusual circumstances and made sure she was well cared for, however, the situation was unsatisfactory. Once Frances was in a hospital, there was a retreat from all parties who had applied pressure to make that happen – the LSU had been agreed as a brief admission for the containment of immediate risk, but it was not the right clinical environment for her assessment, treatment, or recovery, yet there was no longer any interest or urgency to appropriately place the young person.

Figure 17: Patient story - CAHMS as it could be

Patient story – Frances

How it could be

Frances attended the local emergency department (ED) on Monday evening following a self-inflicted laceration to her wrist and an overdose of ketamine. She was assessed and then discharged home to the care of her parents on Tuesday morning. The assessment and outcome are available for all CAMHS staff to view on one EPR system to inform decision making and improve the young person's experience.

Frances' Community Mental Health Team (CMHT) were alerted to her visit to the ED and were able to arrange to meet with her as urgent follow up. The visiting practitioners find Frances unwilling to engage with them or a plan to keep herself safe at home so they make an immediate urgent referral to the CAMHS Crisis service for more intensive support.

The CAMHS Crisis service, which acts as a gatekeeper to inpatient beds, can review all the clinical documentation on the shared EPR and contact Frances and her family the same day. Frances continued to express a wish to end her life and was again unwilling to engage with the Crisis service, so they arranged for her to access a community crisis bed for the night to provide her parents with some respite and to enable Frances some time and space to rest and reflect whilst ensuring her safety.

Frances spent two nights in the community crisis bed with the support of the CAMHS Crisis service. Her mental health and schooling had been significantly affected by the Covid pandemic restrictions and she was struggling with her role and identity within her family unit. Her younger sister was autistic and their parents were exhausted trying to ensure that both of their children are well-supported.

After leaving the community crisis bed, as well as having ongoing support from the Crisis service, Frances and her family were offered the input of a Family Therapist to support and address their complex needs. Frances' parents were also offered a carer support assessment to ensure that they had everything they were entitled to. The CMHT remained involved throughout to ensure that once Frances required less intensive support, her care could be seamlessly handed over.

4.87 A staff story on the challenges being experienced currently and how these will be improved under the new organisation is provided below.

Figure 18: CAMHS staff story - now and then

Staff Story

The Isle of Wight is a small island and therefore can struggle to recruit to roles particularly in regard to Psychology and Family Therapy. By merging with the other CAMHS service in Hampshire this will allow us to be part of the developing CAMHS Academy and this will have many positive benefits and be an exciting opportunity for Isle of Wight CAMHS.

The CAMHS Academy will allow us to access training and supervision across HIOW. It will allow teams to look at what they do well and share this with other teams and enable career progression which can often be limited on the Isle of Wight. The Academy wants to raise the profile of CAMHS as a positive and fulfilling career option and 'grow our own' workforce and access to high quality training and career development opportunities will very much support this aspiration.

Collaboration to date

4.88 Despite NHS child and adolescent mental health services being delivered by four separate NHS Trusts, there have been numerous positive examples of collaboration in recent years.

4.89 The Wessex and Dorset provider collaborative was established in shadow form in 2021/2022 and is a formal partnership between five organisations for the commissioning of inpatient psychiatric treatment across Wessex and Dorset. In addition to the commissioning of inpatient care, the provider collaborative has worked to jointly develop initiatives which support keeping young people in their home and community, rather than hospital provision. This includes new 'Closer2Home' teams, providing intensive community treatment to young people who would otherwise be in hospital, the mobilisation of community virtual wards for children and young people with eating disorders, the mobilisation of in-reach support for children and young people who have an extended length of stay within acute hospitals, the current mobilisation of an eating disorder day service within Leigh House and the development of a Family Ambassador Scheme for inpatient services.

4.90 The CAMHS Transformation Board includes partners from across the HIOW system and provides an opportunity for all parts of the system to consider strategic system-wide objectives and ensures a level of consistency between place LTPs. The Board has agreed to develop a CAMHS Academy to provide an integrated education, development and leadership system that will enable every CAMHS colleague to thrive, flourish and deliver their best work.

Figure 19: Benefits of CAMHS Academy

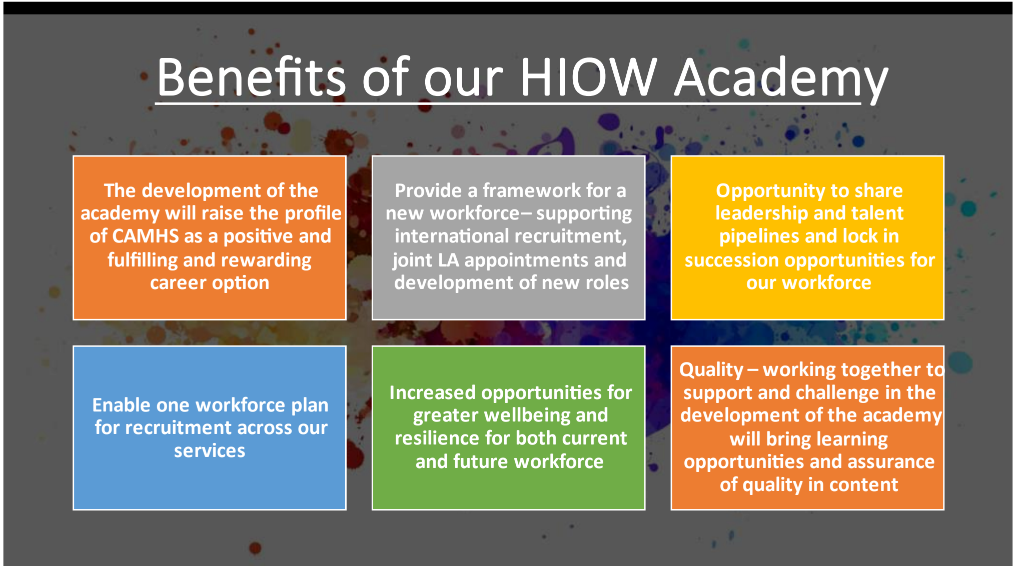
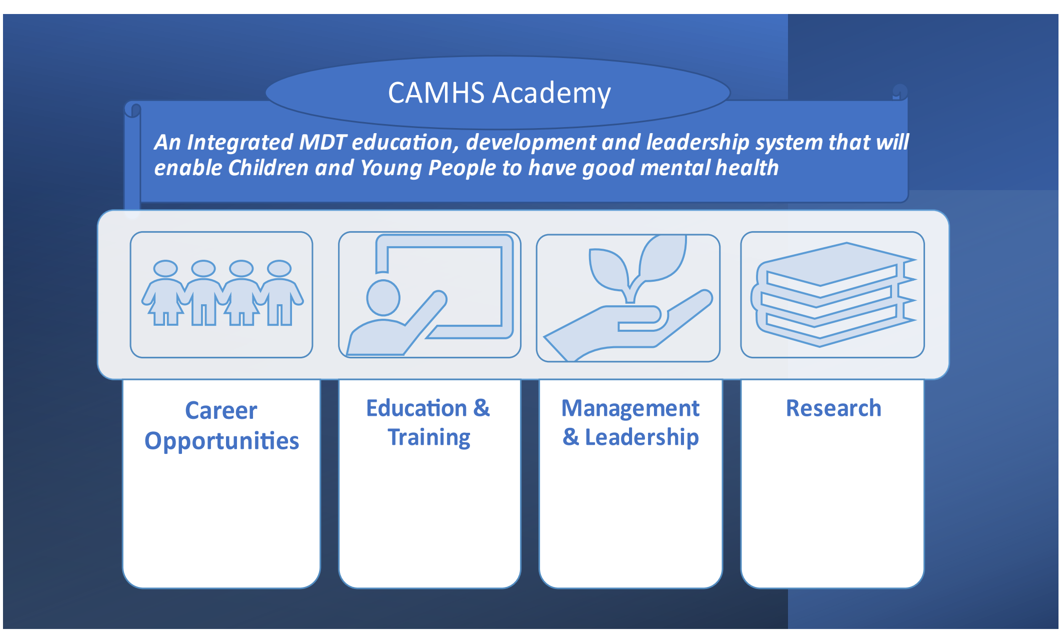


Figure 20: CAMHS Academy descriptions



4.91 The creation of the new Trust will enhance the opportunities for further collaboration between services and reduce the barriers which currently exist.

What will change and how patients will benefit

Vision

4.92 Project Fusion provides the opportunity to secure the benefits of integration in a way that has not been possible to achieve as separate organisations.

4.93 The vision for CAMHS across HIOW is for children and young people to be happy, resilient, safe, able to reach their potential, and experience good emotional wellbeing and mental health, both now and in the future.

4.94 Through a single HIOW children and young people's service there will be an increased access to timely, evidence-based, effective interventions for children and young people which are designed around the iTHRIVE framework and delivered in accordance with a stepped model of care.

Principles for the new Trust CAMHS

4.95 The creation of the new Trust provides the opportunity to introduce key principles for the delivery of services:

- Work together to promote sustainable change, improve early identification of potential mental health problems and to prevent escalation of a problem into a crisis;
- Promote emotional wellbeing and mental health, including how to look after your own mental and physical health and support others around you;
- Ensure that the voices of children and young people and parent/carers and practitioners are listened to and acted upon;
- Support children and young people at greater risk of poor mental health, recognising the need to address inequalities and disadvantage;
- Reduce stigma around mental health so that more people can ask for help
- Promote resilience amongst children and young people, families, and communities, increasing protective factors and reducing risk factors;
- Ensure that children and young people in HIOW have access to a confident and competent workforce, at the right level of service and/or support, at the right time; and
- Develop a whole school approach to mental health that delivers a positive learning environment and sense of belonging, enabling children and young people to achieve full potential, including academic success.

4.96 LTPs have been in place since 2015. The LTP's reflect the priorities of the ICB CAMHS Transformation Board and therefore fully align with the aims within project Fusion. The creation of the new Trust will support delivery of common key elements of these LTP and realise benefits for patients.

The following areas have been set as priorities:

- Virtual wards for Eating Disorder presentation;
- In-reach support for young people in Paediatric settings;
- Interagency Support for young people with multi-agency complex needs;

- CAMHS Academy to support workforce development;
- Reviewing resource available for Neurodiversity assessment and intervention;
- Mapping service deliveries with a focus on unwarranted variation and good practise;
- Eating Disorder Day Service;
- Development of Leigh House;
- Development of a Transition Service.

4.97 These areas of development will ensure quality and support delivery by ensuring the following:

Change	Outcome
Fully embedding the voice of the child / young person	Project Fusion has begun a programme of work to ensure that the new Trust fully embeds the voice of lived experience across the organisation and within services. This work will evolve. An engagement strategy has been developed by Project Fusion. A key element of this strategy is to establish clinical pathway-specific community engagement programmes. One of these programmes will be focused on CAMHS, with an initial engagement event planned for 30 October 2023, with others to follow as required. The outputs from these engagement events will inform methods of measuring impact and the coproduction approach as the new organisation develops. This will ensure that services better meet the needs of children, young people and their carers and families.
Digital transformation	Project Fusion is considering the strategic digital approach for the organisation. Hampshire CAMHS (currently provided by Sussex Partnership) will need to move to a new electronic patient record system. To mitigate risks and provide stability this will not happen prior to Hampshire CAMHS joining the new organisation but will need to take place by August 2024 (date for Sussex Partnership procurement process for a new EPR system). By this time, the digital strategy for the new Trust will have been further developed, including considering options for EPRs.

Change	Outcome
	Ultimately the new Trust will seek to realise the benefits of a single integrated EPR system which include enhanced patient experience, reduction in clinical risk and improved efficiency. In addition to the EPR system, the new Trust will realise the benefits of introducing digital technologies for families and professionals to access additional resources to support clinical care pathways. The four Trusts have come together to begin this work. This is exemplified by the development of a digital team to support the rollout of digital innovations across CAMHS. These approaches will continue in the new organisation. See 4.116-4.121 below for further detail.
Governance	The new Trust will have a single governance framework including a Board Assurance Framework (BAF), quality assurance, risk management, financial management, regulatory compliance, audit, quality improvement and performance management. This framework will apply to CAMHS and enable clear oversight at every level of the service in a consistent way. This will enable a culture of learning from best practise and incidents to be embedded within each area of service delivery. The clinical risks associated with the management of long waiting lists will be managed through one organisation, rather than four. This will allow development of consistent risk profiling arrangements and a shared view on clinical risk across CAMHS in HIOW and an equitable approach to mitigating risks.
Workforce planning	The new Trust will have a single workforce plan informed by the national workforce plan[33]. All staff being employed

[33] https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.2.pdf

Change	Outcome
	through one organisation will reduce the organisational barriers, including differences in systems, policies and procedures, which have historically made development of rotational posts challenging. The new Trust will continue to be supporting the development of the HIOW CAMHS Academy which will have a focus on recruitment and retention (see 4.115 below). See 4.110-4.115 below for further detail.
Clinical care pathways and optimising capacity	The new Trust will provide services using the iTHRIVE framework as the overarching model of delivery. This framework has already been adopted by the existing organisations and the HIOW ICB. Within the new Trust, the single CAMHS will consider the various clinical models in operation in each area and make informed decisions on which models offer the most efficient and effective treatment, reducing unwarranted variation, improving patient flow, optimising capacity, and enabling increased access to child and adolescent mental health services. Clinical care pathways will continue to be informed by evidence-based research and clinical best practice and staff will be supported to continue to develop the use of routine outcome measures to demonstrate impact. The national Patient Safety Incident Response Framework (PSIRF) (2022) will be rolled out and embedded across the whole system and will be a key aspect of retaining a focus on a patient safety culture and least restrictive practice. See 4.105-4.109 below for further detail.
Focus on population health, reducing inequalities	The new Trust will include both physical and mental health services for children and young people and provide opportunities to integrate physical and mental health in all geographies and take a population health approach to addressing inequalities.

Change	Outcome
	This will include improved partnership working with children's physical health community services, such as health visiting and school nursing.
Education and Training	Existing arrangements are in place to develop a CAMHS Academy across HIOW. This programme of work is being overseen by the CAMHS Transformation Board. The vision is to provide an integrated education, development and leadership system that will enable every CAMHs colleague to thrive, flourish and deliver their best work. Organisations have well established education and training packages which will contribute to this programme. The mandatory training requirements will be aligned through the creation of the new Trust and incorporated into the CAMHS Academy as a single education and training approach. The new Trust will seek to develop stronger links with local universities, which will be a particular benefit for Hampshire CAMHS which has historically been provided by a Trust in a different ICS (and therefore with relationships with Sussex, rather than Hampshire, universities). As a result of the creation of the new Trust there will be a reduced need for staff to move organisation to access an improved learning and development offer. Training and development opportunities will be consistent across HIOW CAMHS with the development of a system-wide learning and development workforce offer. There will be opportunities to pool learning and development resources, becoming more efficient and enabling improved learning and development for all clinicians, which will no longer be reliant on which organisation an individual works for.
Finance	Investment priorities are derived through place-based decision-making processes, informed by the LTPs (Isle of Wight, Hampshire, Portsmouth, and Southampton). This has led to inequities in investments across the system and challenges in local areas being able to meet local population needs. Whilst services will continue to be delivered at place, the LTPs will be combined and in future there will be one LTP

Change	Outcome
	covering the entire HIOW ICS. This will ensure equity of funding, based on local needs. A single provider will be working with the ICB to determine funding priorities, rather than four separate organisations competing for the same finite resources.
Estates	The new Trust will have a single estates strategy and will be able to review its long-term estates requirements. Historically, Hampshire CAMHS has leased all its buildings. Solent uses a mixture of owned and leased sites to deliver CAMHS There will be a continued need to offer locally based services due to the geographical size of HIOW. However, over time, there are likely to be opportunities to co-located services with physical health community services for children and young people. This could ultimately deliver financial benefits (which can be reinvested in services), alongside patient benefits from integration of physical and mental health services.

Clinical care pathways

4.98 The new organisation will provide services using the iTHRIVE framework (see figure 21 below) as the overarching model of delivery. This framework will enable existing services to be mapped and reflect gaps in provision between current providers. This framework has already been adopted by the existing organisations and the HIOW ICB to describe and understand clinical care pathways as well as to understand where and how resources are distributed and developed along with the interfaces between organisations. This will support benefits for children and young people using services by having clearer identification of the right service at the right time as well as more timely and joined up transitions.

4.99 The iTHRIVE Framework provides a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people and families.

4.100 The framework outlines groups of children and young people, and the sort of support they may need, and tries to draw a clearer distinction between treatment on the one hand and support on the other. It focuses on a wish to build on individual and community strengths wherever possible, and to ensure children, young people and families are active decision makers in the process of choosing the right approach.

Rather than an escalator model of increasing severity or complexity, it is suggested that a framework that seeks to identify somewhat resource-homogenous groups (it is appreciated that there will be large variations in need within each group) who share a conceptual framework as to their current needs and choices.

4.101 The iTHRIVE framework below conceptualises five needs-based groupings for young people with mental health issues and their families. The image on the left describes the input that is offered for each group and the image on the right describes the state of being of people in that group – using language informed by consultation with young people and parents with experience of service use. Each of the five groupings is distinct in terms of the:

- needs and/or choices of the individuals within each group skill mix required to meet these needs;
- dominant metaphor used to describe needs (wellbeing, ill health, support); and
- resources required to meet the needs and/or choices of people in that group.

Figure 21: iTHRIVE framework

4.102 Whilst each area has adopted the iTHRIVE framework, there continues to be variation as to how it is applied in each geography. This has led to fragmented pathways and, in some cases, unwarranted variation which has led to inequalities of access and variation in service provision. Whilst services will continue to be delivered at place, the service in the new Trust will adopt the tiered approach to service improvement:

(i) design and deliver once across the ICS;

(ii) design once and deliver at place; and

(iii) design and deliver at place and share learning.

It will therefore be possible to deliver services locally or at scale depending on the needs of the population.

4.103 The iTHRIVE model is fundamentally an outcomes-based approach to meeting the needs of children and young people. It recognises the need for a system approach to addressing the needs of children and young people, combining resources around groups of children and young people with the greatest need, such as vulnerable groups of children and young people, for example, children in care and children with learning disabilities. It recognises the importance of the interlinks between good physical and mental health. Providing community services under one organisation will help reduce artificial barriers between community services and offer an integrated approach to the provision of community physical and mental health services.

4.104 The CAMHS workstream is reviewing all child and adolescent mental health services provided across the system to map existing clinical care pathways, identify unwarranted clinical variation and develop a programme of work to align pathways where needed to address any unwarranted variation. This review is expected to be concluded by December 2023 and will inform the prioritisation and development of clinical care pathways for the new Trust.

Optimising capacity

4.105 The iTHRIVE framework recognises the importance of providing interventions suited to individual needs, through a stepped care approach, ensuring that children and young people receive the right level of support at the most appropriate time. iTHRIVE recognises that most young people can be supported to thrive through the support offered in local communities, such as through schools.

4.106 It is recognised that, in parts of Hampshire, there is a challenge with patient flow and the areas provide a higher level of contacts per case than other with IoW's contact rate per referral accepted as 13.65% and Solent's 16.98% (see Appendix 3). By taking this approach, it is anticipated that more young people will receive timely access to services and resources are allocated based on clinical need. In applying this framework consistently across HIOW, it is hoped that it will be possible to increase the number of young people accessing emotional wellbeing and mental health services.

4.107 The creation of a new Trust will not by itself realise the ambitions of the system to improve access and ensure children and young people receive timely access to effective services when needed. There is a continued need to ensure services operate effectively and efficiently.

4.108 Individually, the four Trusts have started a programme of work connected to the NHS England Mental Health Elective Recovery Programme. Within the new Trust this work will continue. This review will initially focus upon optimising capacity and improving patient flow workstreams, ensuring that the available resources are used most effectively.

4.109 Currently, individual Trusts have their own systems and processes for the management of capacity. These will include aspects such as job planning, caseload management and performance and quality reviews. Historically, different tools have been shared between organisations on an ad hoc basis. Within one organisation it will be possible to develop consistent approaches to optimising capacity, for example, using the same job planning tool.

Workforce Planning

4.110 The NHS Long Term Plan set out ambitions to expand the workforce by 27,460 WTE between March 2019 and March 2024 across several mental health and learning disability programme areas. Nationally, this programme is on track to deliver these increases and as a result the national workforce will increase to 159,380 WTE.

4.111 Health Education England has secured a new supply through education and training (c. 40,000 since 2016) and 55,000 staff upskilled and 8,000 staff in new roles. This is a fantastic achievement; however, demand is rising and as a result this expansion is not fully felt by service users or staff. In addition, nationally, 20% of staff leave within the first two years.

4.112 Each organisation has its own workforce strategy with its own organisational priorities although there are common themes in local CAMHS workforce strategies:

- increasing capacity through trainee placements and new roles;
- recruitment strategies;
- retention strategies, which include improving staff wellbeing; and
- staff feedback.

4.113 The new Trust will have a single workforce plan which will include CAMHS staff and is described in more detail in paragraphs 2.15-2.17.

4.114 The new Trust will be able to undertake an annual review of workforce requirements in relation to trainee placements and new roles, working with local education providers. Trainee placements and new roles will be placed according to the greatest need. Where there are barriers to accepting placements, such as ensuring appropriate supervision arrangements, there will be greater opportunity to address these through larger combined services, creating the potential for increasing the number of trainee placements and new roles within HIOW.

4.115 Ensuring comprehensive learning and development opportunities will improve retention., building on the existing plans to develop a CAMHS Academy across HIOW. All roles will have clear career pathways and fewer staff will leave the organisation to achieve their career aspirations.

Digital transformation

4.116 One of the HIOW Integrated Care Partnership Strategy aims is to develop a joint children's digital strategy. This will include introducing digital solutions and empowering people to use them, developing joint data, information, and insights to inform quality improvements and improving information sharing.

4.117 The new Trust will have a consistent approach to providing information and insights into the provision of CAMHS across HIOW. This will improve data quality and enable quality improvement decisions to be made on a solid understanding of the HIOW position.

4.118 Currently, mental health and community providers use different electronic patient record systems. The strategic approach to the use of electronic patient record systems is currently being considered as part of the development of the digital strategy for the new Trust. An ambition of the programme will be to harmonise systems over time where this makes clinical sense.

4.119 There are currently challenges in being able to share patient level information. This presents risks associated with patient safety and effectiveness of interventions (not being able to easily identify what clinical support had been provided and when) and patient experience (children, young people and their families needing to re-tell their story depending on which organisations the family has had contact with). Aligning the electronic patient record systems will help to address these risks.

4.120 Services across HIOW have started to develop digital solutions to support clinical care pathways. Digital solutions can enable services to engage with children, young people and families through different means. Digital solutions will not replace the therapeutic alliance between clinician and young person, but will enhance it. For example, the collection of routine outcomes measures through digital technologies is currently being piloted, alongside experience of service questionnaires. Digital technologies are also able to provide psychoeducation and can be interactive, such as submitting food and mood diaries.

4.121 Creation of the new Trust will enable the various approaches to be consolidated across HIOW. In parts of Hampshire, there is a quality improvement programme, through the Commissioning for Quality and Innovation (CQUIN) scheme, to increase the use of digital platforms. This will inform the use of such initiatives across HIOW as benefits are realised. It is anticipated that benefits will be seen in improved engagement and as well as accessibility of interventions and an additional benefit of reducing the elective backlog.

Benefits indicators

4.122 The indicators that will be used to assess progress in realising the expected benefits are set out in the figure below. Mapping of current baselines is continuing and targets for the new Trust will be agreed before 1st April 2024.

PROJECT
FUSION

Figure 22: Benefits indicators for CAMHS integration

Theme/Measure	Indicator	Source	Baseline	Target
Governance, structure and culture	• NHS Staff Survey results for CAMHS team	NHS Staff Survey	Tbc	tbc
Clinical care pathways	• Routine Outcome Measures (completed) • Routine Outcome Measures (reliable change) • Clinical Audit (% of cases meeting the minimum clinical standards) • Experience of Service Questionnaire (completed) • Experience of Service Questionnaire (outcome) • Community Mental Health Survey	tbc	tbc	tbc
Digital	• Number of patients using digital platforms as part of their clinical care pathway • Experience of Service Questionnaire	tbc	tbc	tbc
Workforce, education and training	• Staff Absence • Staff Turnover rate • Vacancy rate • Number of staff attending training sessions • Feedback questionnaires • Number of appointments to new roles • Number of trainee placements • Staff morale	Workforce data NHS Staff Survey	tbc	tbc

Implementation plans

4.123 The CAMHS Transformation Board, which includes partners from across the HIOW system, provides an opportunity for to consider strategic ICS wide objectives and ensures a level of consistency between place-based LTPs. The original incarnation of this Board started in 2015 and has developed since this time.

4.124 Through Project Fusion, a CAMHS Leadership Forum has been established, which consists of leaders from across the four NHS Trusts, which meets regularly to develop the initial CAMHS priorities for the new Trust. The group has identified a need to focus on:

- service mapping, to understand clinical care pathway configuration across each organisation;
- development of the CAMHS Academy;
- neurodevelopmental services; and
- inpatient clinical care pathways.

4.125 The CAMHS Leadership Forum will identify the actions needed to integrate services across HIOW and prioritise each area based on the greatest benefits associated with patient safety, effectiveness, and patient experience. This plan will continue to develop as part of the ongoing Project Fusion programme.

4.126 The figure below sets out the key activities to realise the identified CAMHS patient benefits followed by a timeline showing priorities over the course of the project. The detailed implementation plan is a supporting submission.

Figure 23: Summary of CAMHS implementation plan

Year	Activities
Pre day 1	• Leigh House Transformation with Phase 2 commencing, contract and standard operating procedures agreed • Day Service building work completion, recruitment and training of staff • Virtual Wards plans to be completed • Mobilisation of Reach into paediatric wards programme completed • Young person with multi-agency needs project completed and staff recruited • Due diligence and associated activities to support the Sussex Partnership transfer CAMHS to Southern on 1 February 2024
Year 1	• Leigh House Transformation with Phase 2 commencing along with recruitment phase • Opening of Day Service • Virtual Wards to be launched

Year	Activities
	• Evaluation of Reach into paediatric wards project • Young person with multi-agency needs project evaluation • CAHMS academy plans to be developed • Neurodiversity project to be agreed and developed
Year 2	• Progress with mobilisation
Year 3	• Progress with mobilisation

Figure 24: CAMHS timeline of priorities

Qtr 3, 2024			Qtr 4, 2024			Qtr 1, 2025			Qtr 2, 2025			Qtr 3, 2025			Qtr 4, 2025			Qtr 1, 2026
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr

Review and align safeguarding offer for CAMHS

Review and align incident reporting including Sis under PSIRF

Shadow board to be set up to embed principles

Design staff well-being temperature check

Shadow form set up from Oct 23 for all providers

EPG transfer for HIOW CAMHS and singular reporting

Complete demand and capacity

ROMs reporting and outcomes

Commence mapping work re place based county

Implementation of formal goverance arrangements for single service

Engage Trust quality team in review of SOPs and quality indicators

Establish a clinical oversight group

Establish the bespoke task and finish groups linked to the clinical oversight group

Clinical oversight group to review clinical delivery pathways and best evidence to establish prioritisation of change programme

Review progress against Q1 & Q2 objectives

Evaluate the effectiveness of the board

Define CAMHS organisationl and assurance structure for future delivery

Interdependencies (internal or external) and how these will be managed.

4.127 The CAMHS work programme has identified the following key internal interdependencies:

- Lived experience and community engagement teams: supporting the co-creation of new services and embedding the patients and their families voice in the care they receive;
- The Organisational Development Steering Group: responsible for supporting team integration;
- The Workforce Steering Group: responsible for ensuring workforce planning, recruitment and selection and training reflect the CAMHS vision and expansion; and
- The neurodiversity workstream: responsible for codesigning a single-all age service for people with neurodiverse conditions, working with the CAMHS teams where it relates to children and young people.

4.128 The CAMHS work programme has identified the following key external interdependencies:

- The Integrated Care Board: responsible for commissioning decisions on how the services will be delivered; and
- ICS digital team: support in developing consistent data and business insights for service lines, pathways, PCNs, places and ICS as a whole.

Key risks and mitigations

4.129 The CAMHS work programme has identified the following risks with a risk score of 10 or more before mitigations have been applied:

Figure 25: Risk register for CAMHs

Risk Description	Impact (Score)	Probability (Score)	Total Risk Score	Planned Mitigation Actions
Other workstreams such as the transfer of CAMHs services from Sussex Partnership will divert resources away from project Fusion.	Major (4)	Likely (4)	Very High (16)	
Availability of data and/or issues with the quality of data may make it challenging to identify areas of need within transformation priorities. It also impacts on ability to have consistent evidence/narrative in a case of change.	Moderate (3)	Likely (4)	High (12)	Work has started within Southern to standardise and align data captured within service lines. Changes to provide proof of concept for standardised reporting across organisation.

5 Older Persons Mental Health (OPMH) and dementia

Current service arrangements

5.1 OPMH specialist services across HIOW are provided by Southern, Solent and IoW. The services support people with dementia of any age (including those of young onset) and people aged over 65 or those under 65 with a need that would be best met by an OPMH care team.

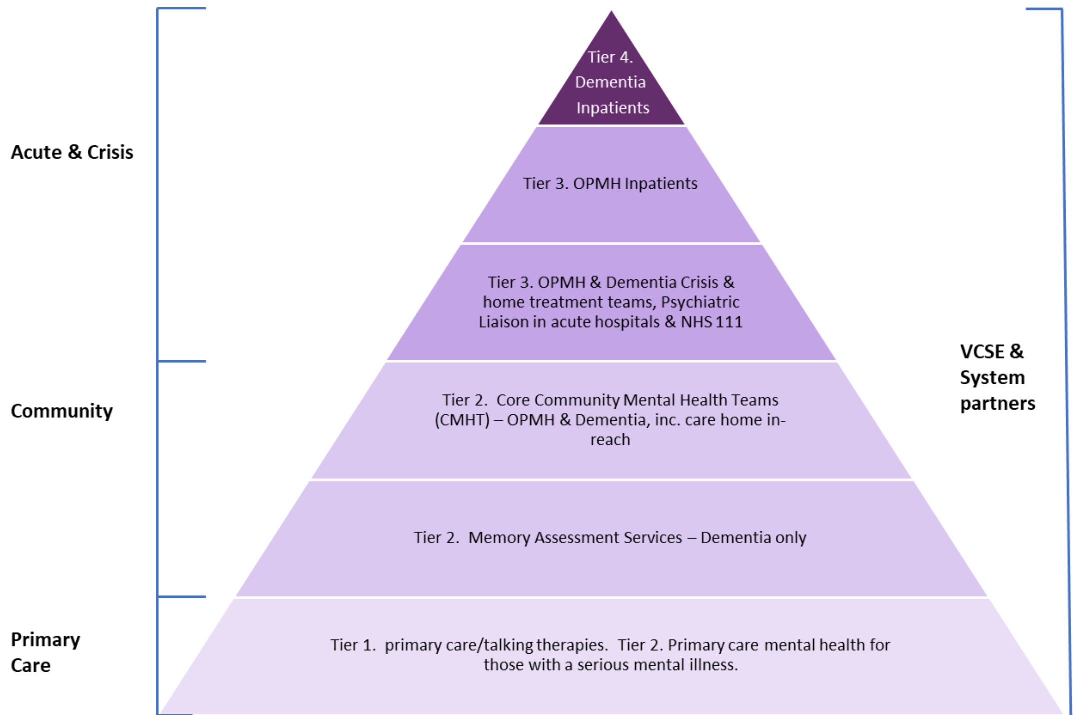
5.2 The UK has an aging population and in HIOW 22% of the population is aged over 65 years with the greatest older population in the Isle of Wight (29%). In HIOW this equates to around 306,000 people, of which around 8,500 are predicted to have a severe depression and almost 23,000 are predicted to have a dementia (diagnosed or otherwise); approximately 7.5% (circa 2000) of these people have young onset dementia. It is predicted that by 2030 25% of HIOW population will be aged over 65.

5.3 The current OPMH models in HIOW do not support the ageing population and do not respond to the current and expected demand or the changing clinical needs. The creation of the new Trust will bring together OPMH services across HIOW, allow sharing of best practice across teams and ensure that all services are delivering the full range of services to older people and their families with consistent high-quality outcomes, without unwarranted variation in provision, timeliness or quality.

5.4 Population modelling has not taken into account changes in OPMH populations within areas that are elevated by the introduction of new care homes and nursing homes. For example, Portsmouth's population of over 65's is about 34,000 which is higher than the predicted number for 2023 and its higher now than what was expected in 2025. The services provided have not adapted to such increases and resources across the system have not flexed on population health figures.

5.5 The OPMH and dementia workstream has focused on the whole mental health (MH) care pathway for those aged 65 or over with a serious mental illness (SMI) and those of any age with a dementia, recognising there is flexibility in criteria to ensure people access the right service regardless of age. The workstream considers the OPMH pathway in tiers, summarised in Figure 26.

Figure 26: OPMH pathway tiers



Tier 4: Highly specialist dementia mental health wards.

5.6 Providing short term acute mental health care (assessment, treatment, risk management and care planning) in an inpatient setting when people's conditions cannot be managed in the community tier 3 team. People with dementia (usually severe dementia only) will reside for a brief period, and when they no longer need the intensity of an inpatient stay, they will be supported by tiers 2 or 3 services to return to the community setting.

Tier 3: OPMH inpatient wards for severe mental illness.

5.7 If a person with mental health crisis or severe mental illness cannot be managed safely at home, a patient will be admitted to an inpatient ward until they can be supported again in the community with ongoing support from tier 3 community services.

5.8 ECT and neuro-modulation services are available where required on an inpatient or outpatient basis. There is also an option for referral to psychiatric intensive care and forensic wards where required and the person meets specific criteria on an all age basis.

Tier 3: Core Community: Community crisis and home treatment support

5.9 Short term, intensive (seven days a week) OPMH and dementia support for service users and carers. Tier 3 services aim to keep people at home where possible and prevent admission and to provide step-down support following an inpatient stay to allow

patients to receive care in the least restrictive environment. They will offer seven day intensive step up services

5.10 When assessments are required as per the Mental Health Acts this happens separately by the local approved mental health practitioner service (AMHP) on a referral basis by a relative or clinician.

5.11 Older people also have access to all age health-based places of safety where required.

Tier 3: Acute and Crisis: Liaison psychiatry in general hospitals.

5.12 These services are for people admitted to a general hospital that require joint medical and psychiatric assessment, care, or treatment or who attend A&E. This service provides an emergency or A&E assessment within one hour of hospital attendance and a routine assessment within 24 hours 75% of the time in CORE-24 model services across all inpatient areas. The service does not routinely provide outpatient appointments.

Tier 2: Core community pathway: CMHT and Care Home In-reach Pathways

5.13 These services offer specialist OPMH and dementia care that cannot be provided in tier 1 (or tier 2 primary care mental health teams).

5.14 Led by a consultant-led multi-disciplinary team (MDT), the OPMH CMHT care includes assessment, diagnosis, intervention, medication management, specialist psychological interventions, risk assessment and regular support at home for a defined period of treatment. People have access to adjunctive NHS Talking Therapies where required.

5.15 The Core Community: OPMH Care Home In reach Pathway team includes proactive and reactive care, education for those living in care homes, with a defined remit, working with partners.

5.16 The core community teams refer to or collaborate closely with local authorities where there is appropriate social care, housing needs or safeguarding issues requiring support from local authority expertise, usually on a referral basis.

5.17 A significant amount of broader holistic support is available through referral to local VCSE groups in each neighbourhood outside of core community specialist ‘health’ services. This may include support groups, churches or community engagement groups or events or post-diagnostic support services.

Tier 2: Memory assessment services

5.18 These services are for diagnosis of mild to moderate Dementia or Mild Cognitive Impairment (MCI). If a dementia is diagnosed, a bespoke package of support is coproduced with service users and their families including medication, holistic care plan, advanced care planning and support from VCSE specialist services.

5.19 Longer term carer and post diagnostic support is primarily provided by the VCSE sector rather than through specialist health pathways. There is variation in provision, quality, referral method and level of VCSE services across HIOW. This work often happens in a standalone capacity and separate to health care in statutory services.

5.20 People can also be referred for research through the Memory Assessment and Research Centre or for other local research centres.

5.21 Community diagnostic centres or acute hospitals provide scanning (e.g. dementia brain scans) where required. This is an integral part of this pathway to enable timely diagnosis. There are differences in timely access to outpatient scanning, reporting and re-reporting across HIOW.

Tier 2: Mental health secondary care working in primary care

5.22 Aligned to the No Wrong Door (NWD) model and providing support and intervention closer to the service users. This includes coaches, wellbeing practitioners, pharmacists, nurses, and practitioners supporting people in a primary care setting, as well as access to evidence based psychological therapies through self-referral or clinician referral to NHS Talking therapies.

Tier 1: Mental health conditions managed in primary care

5.23 MDT models, with access to evidence based psychological therapies through self-referral or clinician referral to NHS Talking therapies. Primary care signpost to VCSE and neighbourhood level services where available. Primary care may also provide longer-term support of people with dementia and serious mental illness over their lifetime.

OPMH services provision at the Trusts

5.24 Across all tiers of care, there is currently unwarranted variation in timely access, experience, range of core services available and clinical outcomes across HIOW in services for OPMH and dementia. The services have evolved differently at place level and with different priorities at Trust level and operate differently which does not always map to the demographics or local need. There is a significant opportunity to address this to improve patient experience and clinician satisfaction with the services they provide.

5.25 Figure 27 highlights the high level gaps in provision of key services for OPMH and dementia. See Appendix 4 for more detailed breakdown of services.

Figure 27: High level gaps in provision of core services for OPMH and dementia

	Southern Health				Solent	IOW
	Hampshire			Southampton	Portsmouth	IOW
	South West	Mid & North	South East			
Specialist Dementia Wards (Tier 4)	✓	✓	✓	✓	✓	☒
Acute OPMH Beds (Tier 3)	✓	✓	✓	✓	✓	✓
ECT (Tier 3)	✓	✓	✓	✓	✓	✓
	Provided by Southern Health in 2 sites					IOW provision
OPMH & Dementia Crisis 24/7 (Tier 3)	☒	☒	✓ Dementia & functional - 9-5, 7 days	☒	✓ Dementia & functional - 9-5 Mon-Fri	✓ Dementia only - 8-6pm, 7 days
Crisis Drop In / Safe Haven (Tier 3)	✓	✓	✓	✓	☒	☒
	Little use by over 65's					
24/7 Liaison Psychiatry (Tier 3)	✓	✓	✓	✓	✓	✓
NHS 111 MH Crisis - All age (Tier 3)	✓	✓	✓	✓	✓	✓
OPMH CMHT (Tier 2)	✓	✓	✓	✓	✓	☒ Ageless CMHT functional, no dementia CMHT, separate MAS
IAPT Talking Therapies (Tier 1)	✓	✓	✓	✓	✓	✓
	Not meeting access targets for over 65's					
	Southern Health			Dorset Healthcare	Solent	IOW

5.26 Tier 4: The Tier 4 bed provision would not be required to the same extent if there were alternatives to admission and tier 3 seven day acute and crisis services to step people out of acute hospitals, to support people in care homes experiencing acute challenges and to support people and their families in their own homes. There are opportunities to right size the bed model and invest in tier 3 seven day acute and crisis OPMH services as a more effective model of care providing care in people's own homes.

5.27 Tier 4 should be seen as specialist provision (similar to PICU) and provided by a few sites with specialist and resilient models of care serving the whole ICS. This will enable patients who are the most unwell with dementia to get the most expert and high quality care by specialist hospital teams and in specialist ward environments meeting accreditation standards. Currently wards do not meet accreditation standards and one of the potential benefits of investing in Tier 3 crisis services 7 days a week will mean that less beds are needed as patients are able to be maintained within the community for longer. This will allow the current ward environments to be improved to meet national standards (Accreditation for Inpatients Mental Health Services – AIMS-OP).

Improvements are required across a number of areas within the accreditation process, including general provisions, timely and purposeful admission, safety, environment and facilities, and therapies and activities. There have been significant improvements in some wards but further capital investment is needed to deliver this. This will improve both staff and patient experience.

5.28 Tier 3: The Southampton, Hampshire, Portsmouth and Isle of Wight services lack a comprehensive seven day OPMH service for acute crisis and home treatment. There is a five day 9am-5pm service (Intensive Case Management Team - ICM) in Portsmouth, a seven day 9am-5pm service (Intensive Support Team - IST) in South East Hampshire only and a dementia seven day service 8am-6pm (Dementia Outreach Team – DOT,) in the Isle of Wight. There is need to have a HIOW core commissioned provision of a seven day OPMH acute and crisis service serving people with both dementia and OPMH needs in all the places with a standardised name and service offer. This will prevent restrictive hospital care, reduce the use of the Mental Health Act and offer an alternative to admission.

5.29 Tier 3: The IoW Tier 3 model was created from closing an inpatient facility and developing a new model of acute and crisis dementia care. Having a seven day a week, dementia crisis and outreach support (DOT) model has demonstrated its benefit and has led to a permanent reduction in the need for specialist dementia mental health beds on the Isle of Wight. The DOT model has significantly reduced the amount of mental health bed use and reduced the average length of stay for people detained under the Mental Health Act from 313 days in 2021 to 62 days in 2023. This service model has demonstrated significant patient benefits in reducing the use of the most restrictive inpatient care for people with dementia and delivering a high quality, safe service. There is learning from this for the HIOW acute and crisis tier 3 community provision. The DOT model also demonstrated through a quality improvement approach that a more extended hours service was not required on the Isle of Wight.

5.30 However, there is a need for more prescribing support. All acute and crisis offers need to include as an essential component access to medical and non-medical prescribing in line with GMC guidance around prescribing[34].

5.31 Tier 3 and 4: There is unwarranted variation currently in access to seven day bed management across HIOW. The Isle of Wight model offers ageless (18+) mental health wards which older people can access. The other places have specialist OPMH wards. There is an opportunity to review bed management as a resilient seven day service

---

[34] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices

with AMH or as part of an integrated part of OPMH acute and crisis services. A workshop is being planned to develop these plans with Southern, Solent and IOW teams, alongside acute and crisis care work. This will support people needing an OPMH bed to access timely admission to an inpatient bed seven days a week whether from acute hospitals or community settings. This may reduce the need for on-call practitioners to partake in bed management activities and better use that senior resource in clinical services out of hours.

5.32 Tier 3: For those in acute hospitals, there has been considerable investment between 2019 and 2023 in developing CORE-24 services in Hampshire, Southampton and Portsmouth to deliver CORE-24 national standards. This offers a specialist OPMH service and a 24/7 liaison psychiatry service. There has not been the same investment in IoW and there is an ageless service without a specialist OPMH service or consultant input as in the other areas. A new role as Head of Liaison Psychiatry has been developed to review strategically on behalf of the ICS acute and crisis board the provision of Liaison Psychiatry across all age ages and diagnoses, including those with learning disabilities.

5.33 Tier 3: On the phone, 111 MH services support people who are older with high levels of self-management, there are also crisis cars that can provide support to people where required although this resource is limited in both numbers and hours of operation (see below 5.69 for more information). Case studies have demonstrated good experience and quality of care, however for more older people to access this and to meet the needs of the ageing population greater provision in a joined up way as part of an acute and crisis OPMH pathway is needed.

5.34 Tier 2 and 3: In the community setting, all-age crisis alternatives such as crisis cafes and safe havens developed for adults have limited reach to older people or people with dementia, with data showing that they do not use these resources often and are not aware of them. Crisis cafes and safe havens have not been effectively integrated into pathways of care in part due to the gaps in acute and crisis provision in OPMH as a whole. The ICS has an external review of safe havens planned and the OPMH workstream plans to link in with this when the analysis is completed so that there is an opportunity to better enable older people to access these services.

5.35 Tier 2: All the core community CMHT services have only a five day core hours provision (9am-5pm). Most perform a crisis function to some extent within their working hours but do not have access to OPMH crisis service out of hours. CMHT services do not have AMH shared care, bank holiday, extended hours or weekend provision. There is access from CMHT to adult crisis resolution home treatment team (CRHTT) on a named patient basis in some, but not all areas. Better adult CRHTT overnight and at weekends (usually by phone) would enable safer 24/7 provision for older people.

5.36 Tier 2: The Isle of Wight does not include people with dementia into their CMHTs provision. This is unwarranted variation that has occurred due to historical differences in delivery and commissioning and taking into account some of the unique challenges around workforce within the IoW. A standard operation procedure for all (OPMH)

CMHTs should not exclude people with dementia. A dementia outreach team does not replace the need for some people to have their care supported over a longer period in the community by a CMHT. There is an opportunity to improve access on the Isle of Wight for people with dementia to CMHT care and to ensure specialist OPMH is available equitably across all places. However, this is noted in the context that there are different models and thresholds for care, home in-reach functions and CMHT functions and whether memory assessment services are integrated or separate across all places.

5.37 Tier 2 Memory Assessment Services: There is a pilot in West Hampshire OPMH division to separate Memory Assessment Services (clinic based dementia diagnosis and treatment services) from CMHTs. This enables an efficient, high volume, low complexity service to be delivered in a clinic setting, more akin to a physical health clinic. HIOW does not currently meet and is not on the trajectory to meet dementia diagnosis rates and in particular in the areas with the greatest number of older people and people expected to have dementia (Isle of Wight, Mid and North Hampshire, SW Hampshire). This pilot is to address this and to enable equitable resourcing based on an understanding of demand and capacity. Currently there are significant long waits in many areas, which is hard to quantify by Trust as each one records the information different. This means that many people are turning to the private sector to access support in a more timely way. Separating out MAS will allow CMHTs to focus on community models of care with lower volumes and greater complexity. People accessing memory assessment services will get a more skilled and professional service and CMHTs can focus on the people where they can make the biggest difference and improve people's quality of lives.

5.38 Tier 2 Care Home In-reach OPMH Services: There is a need for a review of this pathway. This is a significant piece of work which is expected to start after April 2024 so that the impacts of the MAS and CMHT changes can be evaluated to identify the gap in unmet need following optimisation of those pathways. Potential options include an integrated OPMH and frailty/primary care team (including system partners) standardised model to bring together the overlapping roles between various teams such as Care Home Teams, Medicines Optimisation, Delirium Teams, Primary Care, Geriatric and Frailty Teams and OPMH. An integrated team could serve the thousands of people in care homes with sufficient resilience as a service model and a broad skill mix to deliver high quality care. This would support some of the frailest people in the population to have a good quality of life and would support better anticipatory care planning and reduce unscheduled care. Care homes in some areas of HIOW have 20% of people with dementia prescribed anti-psychotics which can cause stroke and are linked with high risk of mortality. Although this is lower than the national average of 28% in 2021/22, it remains high and with clinical challenges. See also figure 30

below[35]. There are medicines optimisation projects and oversight at primary and local care level at place. An improved system service offer for those people particularly with dementia living in care homes would likely lead to reductions in prescribing and polypharmacy improving wellbeing and reducing prescribing costs to allow investment in other parts of the pathway.

5.39 Tiers 2-4: There are differing levels of challenge for OPMH services across HIOW to access high quality clinical community estate that supports efficient and clinic-based care. There are significantly different level of waits for assessment and evidence based treatment, in part due to inefficiency of teams offering home visits due to lack of clinic provision. In addition, there is a need to bring all the OPMH wards to national environment accreditation standards.

5.40 Tier 1 and 2: There are four different NHS talking therapy services with different names and referral processes supporting older people in HIOW. There is an opportunity as part of the NHS Talking Therapies review to simplify this offer which may increase self-referral and referral to these valuable services, currently not reaching the older population (65+) to the same extent as adults of working age. In most places (except Portsmouth), there is above regional average anti-depressant prescribing and below average NHS Talking therapies referrals. Improving the uptake of NHS Talking Therapies may lead reduce the number of people requiring medium term antidepressant prescription and reduce prescribing costs.

Challenges and opportunities

5.41 A strengths, weaknesses, opportunities and threats (SWOT) analysis has been undertaken to identify the key challenges faced by OPMH services:

Figure 28: SWOT analysis for OPMH

Strengths	Weaknesses
Commissioning and Investments • OPMH Clinical and operational leadership driving the programme across HIOW footprint through Clinical Delivery Group (CDG) team. • Service user and carer engagement activities and discovery work.	Commissioning and Investments • No identified funding stream specifically for OPMH quality improvement or the CDG work plan (not outlined in system investment plans). • Lack of parity for OPMH and dementia services in investment. Dementia not

[35] https://pharmaceutical-journal.com/article/feature/how-covid-19-has-increased-antipsychotic-prescribing-in-care-homes.

Strengths	Weaknesses
• Effective links with HIOW OPMH Clinical Network group. • Ambitious and innovative programme referencing national best practice and accreditation of services. • Significant progress and momentum in Year 0 (prior to fusion). • ICS OPMH and Dementia Board set up and engaged in the system work.	part of MHIS (Mental Health Investment standard). • Historic commissioning at place level not HIOW led to unwarranted variation in investment, service specifications and services delivered (see Appendix 4). Hampshire has significantly less MH investment spend compared to other places (see Appendix 6) and this will impact on OPMH as IOW and Hampshire has oldest populations. • Lack of single commissioning or organisation/management structure means that resources are not aligned population health management data.
Organisational: • Opportunities through fusion to address structure, data, business insights and leadership capacity issues.	Organisational • Multiple organisations (Southern, Solent, IOW) and multiple management structures within Southern (OPMH within four separate geographical divisions with different senior management in each division) that match previous commissioning boundaries has further contributed to unwarranted variation. • Inconsistent data processes leading to data quality issues and variation across providers and geographical teams. • Limited operational and leadership capacity to deliver the scale of transformation required at pace as currently six separate senior OPMH management teams across HIOW.
Tier 1 • HIOW ICB Medicines Management team are reviewing strategic approach to antipsychotic prescribing issue. • Opportunity to re-procure dementia post diagnostic support services to include those diagnosed in all pathways (acute Trusts, primary care etc). Working group with the ICB commissioner progressing this.	Tier 1 • Lack of accessibility to single point of access which uniformly meets the needs of older people. • Not meeting IAPT access targets for OPMH. • Not coding dementia diagnoses. • Not providing universal carer and psychoeducation support. • Different prevention and wellbeing strategies across four local authorities. • Local authorities having to make difficult funding choices which may impact on older peoples services.

Strengths	Weaknesses
	• Overprescribing of antipsychotics for people with dementia and insufficient system holistic approach for supporting people with dementia.
	Tier 2 • Not meeting Dementia Diagnosis Targets (see Appendix 5 for rates by GP surgery). • Inconsistent pathways for diagnostic scanning and waiting times. • Not able to differentiate dementia diagnostic data from other CMHT data consistently across organisations. • Unwarranted variation in evidence-based approaches to assessment, treatment, holistic and social care access, research and other innovations leading to different CMHT models, waiting times and staff structures across teams. • Different joint working and collaboration with local authority across HIOW. • Around 1/3 of people referred to OPMH services currently not meeting access standards in Hampshire and Southampton impacting over 900 people waiting and over 100 people waiting over 18 weeks.
Tier 3 • CORE-24 Liaison Psychiatry services covering older peoples mental health 24/7 in all acute Trusts in Hampshire.	Tier 3 • Limited alternatives to hospital admission for support in a MH crisis – teams in three of the six areas to provide some crisis support. • Limited number of people being discharged home due to lack of intensive support teams across HIOW to support discharge to homes – unwarranted differences across teams due to availability of intensive support/crisis teams. • Increasing demands for care homes • High CHC costs, impacting on ICS finances. • Differential LoS and Delayed Discharges across teams – linked to differences in Tier 3 support.

Strengths	Weaknesses
Tier 4 • Further OPMH ward upgrades in 2022/23 and 2023/24 which support ensuring a therapeutic environment for those who require admission in more wards. This supports the strategic direction of achieving RCPsych ward accreditation.	Tier 4 • Small number of specialist Dementia care home providers. • Limited number of people being discharged home due to lack of intensive support teams across HIOW to support discharge to homes compared to physical health acute hospital pathways. • Workforce challenges and economies of scale on IOW create challenges to local delivery, especially seen in inpatient model.

Opportunities	Threats
Commissioning • Working with VCSE and other providers as develop the programme and whole pathway. • Build on engagement momentum to build Coproduction mechanism.	Commissioning • Known rising demand and aging population without increased funding or transformation will lead to a reduction in the core offer for all.
Organisational • Develop phased approach to implementing pathway changes – starting with programmes that release savings in the system to allow savings to be invested in the next phase of the model to release further system savings. Use evidence already within system of these savings to evidence the approach. • Explore digital solutions across HIOW. • Opportunity to develop new leadership structures within new organisation to allow single clinical and operational senior management of OPMH services – reduce unwarranted variation between teams, allow sharing of expertise and staffing.	Organisational • Organisations internal infrastructure to deliver change at pace – dependent on new organisational structure as to whether a threat or opportunity. • Engaged OPMH clinical leadership but no formal roles within organisational leadership structure (OPMH representation ward to board). • Competitive recruitment market and challenge to attract to over stretched teams and create appealing roles across all professions. • Challenged financial situation across ICS leading to failure to invest or support invest to save initiatives. • Opportunities of pathways to transform to reduce S117 and CHC spend will likely just address ICS deficit and not be re-invested into OPMH provision.

Opportunities	Threats
Tier 1 • Targeted use of Mental Health Investment Standard and No Wrong Door funding into OPMH pathways (Tier 1 and 2).	
Tier 2 • Access to training to support advance practice and upskilling staff to deliver modern models of care • Better joined up working with Community Physical Health teams, particularly an integrated care home model. • Utilisation of renowned Memory Assessment Research Centre (MARC).	
Tier 3 • Change in clinical model will be less bed based – right size bed capacity across HIOW, financial savings would enable enhanced crisis and community services to further reduce the reliance on beds – both MH inpatient, acute inpatient, care homes and Continuing Healthcare (CHC). • Aligned discharge processes across new Trust linked in to local authority partners.	
Tier 4 • Further collaboration with local authorities for integrated health and social care pathways. • Right size bed capacity across HIOW to invest in OPMH crisis care, learning from IOW, Portsmouth and South East Hampshire. • CHC and acute hospital savings with investment community services to reduce reliance on acute placements.	

UK's aging population and growth trajectory

5.42 Challenge - The UK's aging population and HIOW growth trajectory (25% of Hampshire's population will be aged over 65 by 2030) results in an increasing prevalence of common and serious mental illness and dementia. This is a particular consideration with corresponding incremental demand on services expected year on year for both dementia, multi-morbidity and mental ill health. The current service models cannot manage current demand and older people are not getting the care they need at the right time and in the right setting. With an aging population it is expected to see a growing demand which without additional resource or system transformation will lead to increased waits or the need for higher thresholds into services to meet the demand.

5.43 Opportunity - Bringing together OPMH services across HIOW provides the opportunity to undertake the system transformation set out in this case for change to manage current demand and plan for future demand. Previous investment in OPMH has likely not aligned with the current population health data, demographic changes and demand. Without investment in OPMH and dementia services and significant transformation there will be reductions in the quality, safety and timeliness of the support available.

Differences in leadership, funding, prioritisation and commissioning across HIOW

5.44 Challenge - There have been differences in:

(1) organisational leadership and structure for OPMH from Board to floor between Trust providers and also within Trusts across divisions and teams;

(2) funding and prioritisation within MH funding;

(3) commissioning across HIOW between places (old CCGs, of which there were seven in HIOW); and

(4) the corresponding local authority, VCSE and wider partners' approaches and prioritisation for OPMH and dementia support at place.

This has led to inequities in service provision for older people and people with dementia with variation in core service levels resulting in an over-reliance on the most restrictive and expensive inpatient models of care. Patient and carer discovery work (see paragraphs 5.85-5.86 below) found that patient and carers report less broad partner support for older people and their families with mental ill health, compared with dementia.

5.45 Opportunity – The creation of a new Trust within HIOW gives the opportunity to develop a new structure for OPMH to enhance integrated services, sharing of expertise across OPMH teams and reduction in unwarranted variation. In order to achieve this there are a number of things that need to be considered including the structure of the new organisation for OPMH which includes a single management structure that maintains strong local geographical links.

Lack of parity of OPMH and dementia services

5.46 Challenge - There is a lack of parity in provision between mental health and physical health services. Furthermore, AMH and OPMH CMHT services have not benefited from the mental health investment historically in community or acute and crisis services to the same extent. OPMH services have not benefited in a proportionate way to the investment in the HIOW No Wrong Door programme and ARRS roles in primary and local care, which serves both adults and older adults but as part of the national criteria it excludes people with dementia. OPMH services include both dementia and functional illness and so a programme that excludes Dementia means that part of the patients that access CMHT service via primary care are not able to access these additional roles. Within HIOW the resource has so far been very centred around AMH clinical resource and so this has again caused a perceived lack of parity. This programme has the opportunity to deliver high quality mental health interventions at primary and local care level (tier 1 and 2) and offer considerable benefit to people over 65 (22% of the population).

5.47 Opportunity - This programme is now working alongside the No Wrong Door programme to review the needs of older adults within this workstream and look at future funding opportunities.

Challenges in Tier 1

5.48 Challenge - There are four different NHS talking therapy services with different names and referral processes supporting older people in HIOW.

5.49 Opportunity - There is an opportunity as part of the NHS Talking Therapies review to simplify this offer which may increase self-referral and referral to these valuable services, currently not reaching the older population (65+) to the same extent as adults of working age. In most places (except Portsmouth), there is above regional average anti-depressant prescribing and below average NHS Talking Therapies referrals. Improving the uptake of NHS Talking Therapies may lead reduce the number of people requiring medium term antidepressant prescription and reduce prescribing costs.

Challenges in Tier 2

5.50 Challenge - Performance against the national metric for Dementia Diagnosis Rate (DDR). Current models of care are not meeting the demand in the population, with variable dementia diagnosis rates across HIOW, ranging from 51.8% in IOW to 64.7% the South East (see figure below, with further information in Appendix 5). This has been linked with capacity within teams, different pathways and delays in imaging capacity across HIOW. It is difficult to gather demand and capacity data as data on waiting times for dementia diagnosis is embedded within CMHT referral and waiting time data.

Figure 29: Dementia diagnosis rates across HIOW

Area		Apr-23	May-23	Jun-23	Jul-23
England		63.20%	63.10%	63.50%	63.80%
South East		61.70%	61.50%	61.90%	62.10%
Hampshire and Isle of Wight ICS	**Actual**	**61.50%**	**60.70%**	**60.90%**	**61.10%**
Hampshire	Actual	62.00%	61.00%	61.50%	61.60%
North and Mid	Actual	*59.10%*	*59.50%*	*60.20%*	*60.40%*
South East	Actual	*67.30%*	*64.40%*	*64.60%*	*64.70%*
South West	Actual	*58.90%*	*58.70%*	*59.20%*	*59.40%*
Isle of Wight	Actual	51.90%	51.60%	51.40%	51.80%
Portsmouth	Actual	65.60%	65.40%	65.00%	64.30%
Southampton	Actual	63.80%	63.70%	63.40%	64.30%

5.51 Opportunity – A Memory Assessment Service (MAS) pilot project (to separate MAS and OPMH CMHT) is underway in West Hampshire OPMH division and will inform the optimal model for HIOW. The pilot will measure the impact of the service on increasing dementia diagnosis, provide evidence on demand and capacity for dementia diagnosis and enable equitable resourcing. The creation of a pathway based on demand and capacity for timely assessments, imaging and interventions, with the level of resource needed in each part of the pathway is required to meet the population needs equitably across HIOW. Currently there are significant waits in many areas within CMHTs. Separating out MAS will allow CMHTs to focus on community models of care with lower volumes and greater complexity. People accessing memory assessment services will get a more skilled and professional service and CMHTs can focus on the people where they can make the biggest difference and improve people's quality of lives.

5.52 Opportunity - Work has begun as part of fusion to develop the use of CDCs for imaging capacity to remove some of the unwarranted variation between waiting times for imaging across the acute hospitals.

5.53 Opportunity – Sharing of best practice across areas: the Isle of Wight has a whole place dementia training including care homes to support people to care for people with dementia better. Aim to embed this across HIOW.

5.54 Challenge - failure to meet national targets and metrics in OPMH for CMHT waiting times. Figure 30 below illustrates the differences in compliance with urgent and routine waiting times across four CMHT's within Southern. Not only does the figure illustrate the differences between teams but it also further highlights the differences in processes across divisions, for example Southampton and South West data is showing very low numbers of referrals classified as urgent on information systems. Comparison of South East and Mid and North illustrate significant differences in 12 month performance on

seeing routine referrals within seven weeks – from 68% compliance to 95% compliance.

Figure 30: Compliance with urgent and routine waiting times

% compliance	01/08/22 to 01/07/23 South East	North and Mid	Southampton	South West
Urgent (24 hours)	**51.04%**	**45.49%**	**18.75%**	**45.45%**
Routine (7 weeks)	**94.96%**	**68.10%**	**89.03%**	**87.91%**
Total urgent referrals	288	266	32	11
Total routine referrals	3535	27.43	12.31	35.06

Of those four divisions only the South East team have an Intensive Support Team to provide crisis care and step up and step down capacity. In the other three divisions there is no crisis team and so this function has to also be performed by CMHT staff. Figures 31 and 32 show the impact of the intensive support team.

Figure 31: Impact of intensive support team in Portsmouth on functional beds

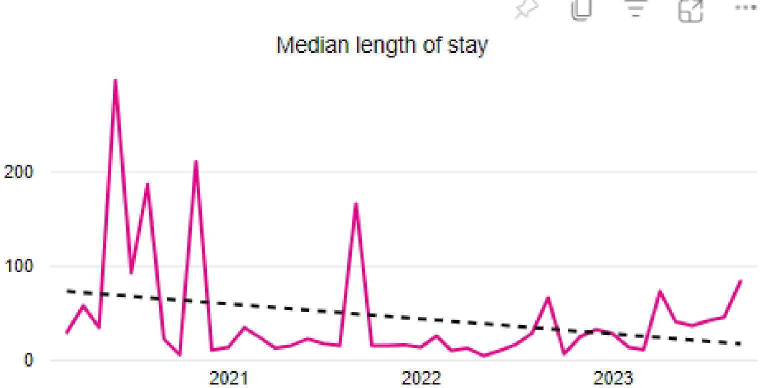
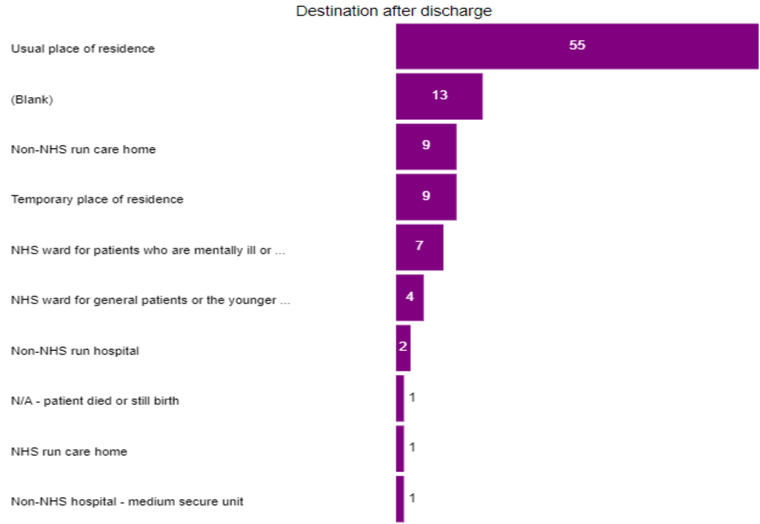


Figure 32: Impact of Intensive Support Team



5.55 Challenge - different models of care and workforce structures. There is unwarranted variation in evidence-based approaches to assessment and treatment with OPMH and dementia between places, Trusts and within teams (individual clinician and team approaches).

5.56 There is unwarranted variation in access to consultant led care, specialist psychology and allied health professional expertise, advanced practice clinicians and Additional Roles Reimbursement Scheme (ARRS) roles (such as social prescribing, coaches and carer support) across a number of services. For example, at individual CMHT service level there is significant variation within the same locality of funded psychology posts between OPMH and Adult Mental Health (AMH) CMHTs, which is not justified by clinical need alone. This is perceived as a lack of parity between AMH and OPMH services. For example, there is currently only one OPMH consultant serving the Isle of Wight (population of 140,000), which is an outlier to the other OPMH teams.

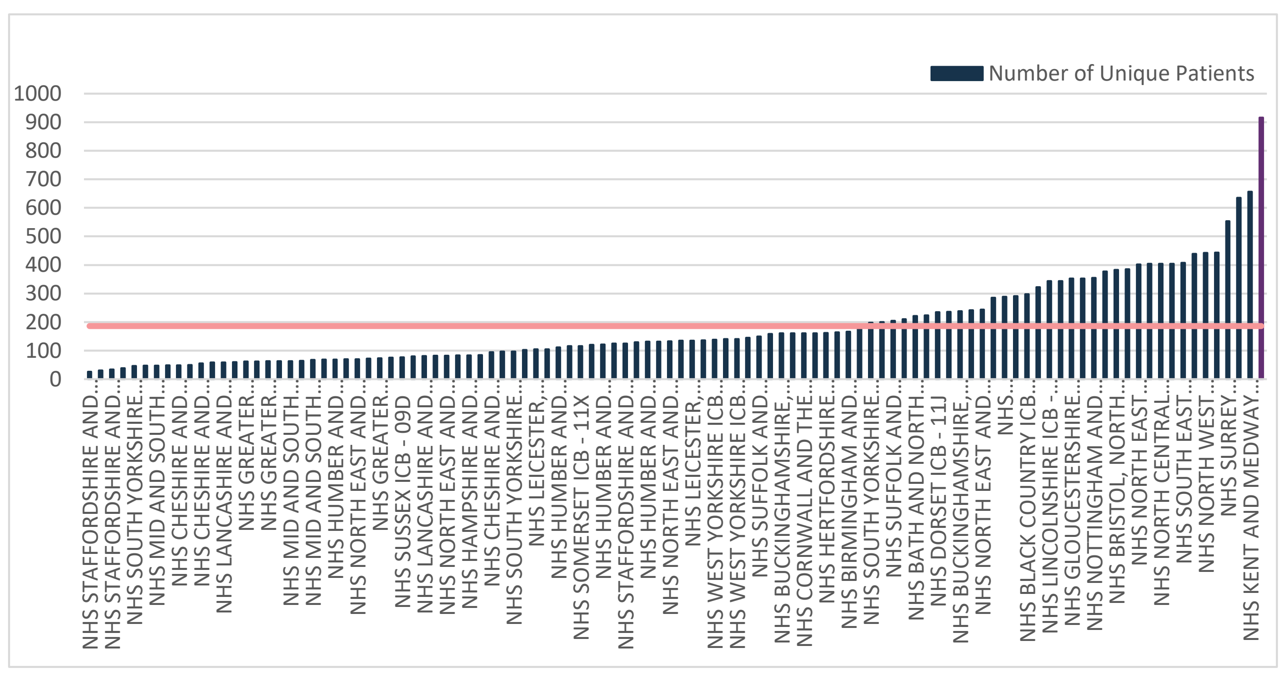
5.57 The Isle of Wight does not include people with dementia into their CMHTs provision. This is unwarranted variation that has occurred due to historical differences in delivery and commissioning and taking into account some of the unique challenges around workforce within the IoW. A standard operation procedure for all (OPMH) CMHTs should not exclude people with dementia. A dementia outreach team does not replace the need for some people to have their care supported over a longer period in the community by a CMHT. There is an opportunity to improve access on the Isle of Wight for people with dementia to CMHT care and to ensure specialist OPMH is available equitably across all places. However, this is noted in the context that there are different models and thresholds for care, home in-reach functions and CMHT functions and whether memory assessment services are integrated or separate across all places.

5.58 Opportunity - as part of the OPMH programme, OPMH Core Community pathway work, workforce mapping will be undertaken and a review the variations in workforce and pathways across OPMH teams. This will include a comparison to AMH services, benchmarking against the Community Mental Health Framework for Adults and Older Adults and in line with the NHS England good practice for Older Adults in the wider MH programme.

5.59 Challenge – Different models and in-reach OPMH services in care homes with a review of this pathway required.

5.60 Care homes in some areas of HIOW have 20% of people with dementia prescribed anti-psychotics which can cause stroke and are linked with high risk of mortality. There are medicines optimisation projects and oversight at primary and local care level at place. An improved system service offer for those people particularly with dementia living in care homes would likely lead to reductions in prescribing and polypharmacy improving wellbeing and reducing prescribing costs to allow investment in other parts of the pathway. The following data shows that HIOW ICB are an outlier for antipsychotic prescribing in dementia. This is important as it suggests people may be receiving medications that are not licenced or indicated for long periods and not getting their holistic dementia needs met in other ways.

Figure 33: Number of unique patients prescribed anti-dementia drugs and antipsychotics - June 2023 - EPACT2



Key: The red bar indicating prescriptions for HIOW.

5.61 HIOW has the sixth oldest population as an ICS nationally but even allowing for the population's age and dementia prevalence HIOW is a significant negative outlier nationally on this indicator. This is important for people with dementia to improve, as antipsychotics in dementia are only licenced for six weeks duration (so most are on unlicensed prescriptions) and prescription is associated with increased stroke risk and mortality, so should be used only when meeting strict clinical criteria called target symptoms and reviewed either in primary or secondary care.

5.62 Opportunity - This is a significant piece of work which is expected to start after April 2024 so that the impacts of the MAS and CMHT changes can be evaluated to identify the gap in unmet need following optimisation of those pathways. Potential options include an integrated OPMH and frailty/primary care team (including system partners) standardised model to bring together the overlapping roles between various teams such as Care Home Teams, Medicines Optimisation, Delirium Teams, Primary Care, Geriatric and Frailty Teams and OPMH. An integrated team could serve the thousands of people in care homes with sufficient resilience as a service model and a broad skill mix to deliver high quality care. This would support some of the frailest people in the population to have a good quality of life and would support better anticipatory care planning and reduce unscheduled care.

Challenges in Tiers 3 and 4

5.63 Challenge – unwarranted variation in OPMH crisis services. The Southampton, Hampshire, Portsmouth and Isle of Wight services lack a comprehensive seven day OPMH service for acute crisis and home treatment. There is:

- a five day 9am-5pm service (Intensive Case Management Team - ICM) in Portsmouth;
- a seven day 9am-5pm service (Intensive Support Team - IST) in South East Hampshire only; and
- a dementia seven day service 8am-6pm (Dementia Outreach Team – DOT) in the Isle of Wight.

There is need to have a HIOW core commissioned provision of a seven day OPMH acute and crisis service serving people with both dementia and OPMH needs in all the places with a standardised name and service offer. This will prevent restrictive hospital care, reduce the use of the Mental Health Act and offer an alternative to admission.

5.64 For those areas without crisis and home treatment teams they only have a five day core hours provision (9am-5pm). Most perform a crisis function to some extent within their working hours but do not have access to OPMH crisis service out of hours. CMHT services do not have AMH shared care, bank holiday, extended hours or weekend provision. There is access from CMHT to adult crisis resolution home treatment team (CRHTT) on a named patient basis in some, but not all areas. Better adult CRHTT overnight and at weekends (usually by phone) would enable safer 24/7 provision for older people.

5.65 Opportunity - Evidence from the Portsmouth Intensive Support model (Solent) has shown a reduced OPMH bed use and offered less restrictive high quality safe care closer to home, with lower length of stays (22 days vs national mean of <64 days and 76.5 days in Southern beds and 45 days in IOW beds). See figure 34 below. The service will undertake a full review of all three crisis teams to build a preferred model within HIOW.

5.66 The IoW Tier 3 model was created from closing an inpatient facility and developing a new model of acute and crisis dementia care. Having a seven day a week, dementia crisis and outreach support (DOT) model has demonstrated its benefit and has led to a permanent reduction in the need for specialist dementia mental health beds on the Isle of Wight. The DOT model has significantly reduced the amount of mental health bed use and reduced the average length of stay for people detained under the Mental Health Act from 313 days in 2021 to 62 days in 2023. This service model has demonstrated significant patient benefits in reducing the use of the most restrictive inpatient care for people with dementia and delivering a high quality, safe service. There is learning from this for the HIOW acute and crisis tier 3 community provision. The DOT model also demonstrated through a quality improvement approach that a more extended hours service was not required on the Isle of Wight.

5.67 The benefit of investing in seven day community acute and crisis services will allow no further increase in bed numbers as the demographic changes (over 65s increasing) and potentially fewer beds incrementally in some places as the investment in seven day acute and crisis services is embedded. This is beneficial as this is the inpatient provision is the most expensive and workforce intensive part of the OPMH care pathway and it will free up both workforce and investment for other parts of the pathway incrementally. It will also offering higher quality wards (environmentally and on meeting quality standards for those that need inpatient care), subject to further capital investment.

5.68 A shift from reliance of OPMH beds for all acute and crisis care to a greater provision of acute care in the community and not under the Mental Health Act will have a positive impact for patients and carers to be supported closer to home in a less restrictive way. It will likely reduce and certainly not increase mental health act use. This is important as S117 aftercare is a significant system cost pressure which impacts on investment in other areas. Currently where there are community acute and crisis dementia teams in the IOW place this has reduced the need for OPMH beds and MHA use dramatically with high quality outcomes.

5.69 OPMH has however benefited from the investment in and access to 111 MH (all age service) and the CORE-24 Liaison Psychiatry through the acute and crisis programmes. This has led to good user feedback and improved timeliness of assessment and care within these pathways. This investment has been through all age or adult (including older adult) investment. The 111 MH services provided in HIOW is being accessed by older people and the crisis cars that work alongside the 111 teams are being deployed to older adults. Figure 34 below shows that 8.4% of deployments for the crisis cars were for individuals aged 61-80 and 0.8% for 81+ age range. This

equated to 67 of the 725 deployments from July 2022 – June 2023. There are two crisis cars that cover 2pm-2am, seven days a week.

Figure 34: Deployment of Crisis Cars

	Age Range								
Year/Month	**0-6**	**07-Oct**	**Nov-17**	**18-24**	**25-40**	**41-60**	**61-80**	**81+**	**Unknown**
Jul-22	0.00%	1.60%	3.20%	20.60%	42.90%	25.40%	3.20%	0.00%	3.20%
Aug-22	0.00%	0.00%	7.70%	15.40%	34.60%	23.10%	11.50%	0.00%	7.70%
Sep-22	0.00%	1.40%	13.00%	8.70%	31.90%	31.90%	7.20%	1.40%	4.30%
Oct-22	0.00%	0.00%	7.10%	14.30%	35.70%	39.30%	3.60%	0.00%	0.00%
Nov-22	0.00%	2.40%	14.30%	11.90%	40.50%	23.80%	4.80%	0.00%	2.40%
Dec-22	0.00%	0.00%	12.30%	14.00%	15.80%	38.60%	15.80%	0.00%	3.50%
Jan-23	0.00%	0.00%	8.20%	18.40%	24.50%	26.50%	10.20%	4.10%	8.20%
Feb-23	0.00%	0.00%	13.60%	11.40%	31.80%	27.30%	9.10%	0.00%	6.80%
Mar-23	0.00%	0.00%	12.70%	11.10%	23.80%	33.30%	11.10%	0.00%	7.90%
Apr-23	0.00%	0.00%	6.20%	11.10%	27.20%	18.50%	12.30%	1.20%	23.50%
May-23	0.00%	0.00%	5.10%	13.90%	19.00%	13.90%	7.60%	0.00%	40.50%
Jun-23	0.00%	0.00%	13.80%	7.70%	27.70%	10.80%	3.10%	3.10%	33.80%
Grand Total	**0.00%**	**0.60%**	**11.30%**	**12.30%**	**27.60%**	**25.80%**	**8.40%**	**0.80%**	**13.20%**

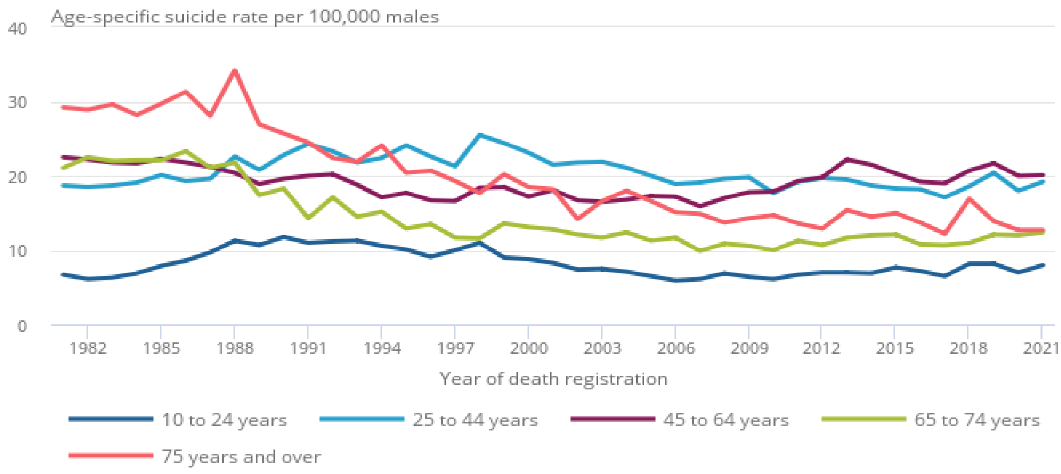
5.70 Case studies have demonstrated good experience and quality of care for 111 MH service and crisis cars, however for more older people to access this and to meet the needs of the ageing population greater provision in a joined up way as part of an acute and crisis OPMH pathway is needed.

5.71 For those in acute hospitals, there has been considerable investment between 2019 and 2023 in developing CORE-24 services in Hampshire, Southampton and Portsmouth to deliver CORE-24 national standards. This offers a specialist OPMH service and a 24/7 liaison psychiatry service. There has not been the same investment in IoW and there is an ageless service without a specialist OPMH service or consultant input as in the other areas. A new role as Head of Liaison Psychiatry has been developed to review strategically on behalf of the ICS acute and crisis board the provision of Liaison Psychiatry across all age ages and diagnoses, including those with learning disabilities.

5.72 Alongside this demonstratable need for crisis provision for older people there is also national evidence to show that completed suicide is more common in older adults than in those aged less than 25 years (see figure 35).

Figure 35:Male age specific suicide rates

Age-specific suicide rates by broad age groups, males, England and Wales, registered between 1981 and 2021



Source: Office for National Statistics – Suicides in England and Wales

5.73 Opportunity - The ICS has an external review of safe havens planned and the OPMH workstream plans to link in with this when the analysis is completed so that there is an opportunity to better enable older people to access these services and link in with the overarching review of crisis services for OPMH.

5.74 Challenge – differences in acute Tier 3 and 4 acute bed services and models of care. There are differing levels of length of stay (LoS), discharge support and delayed transfers of care from OPMH wards across HIOW. The average LoS within Solent OPMH wards is 22.2 days compared to an average of 76.5 days within Southern inpatient units (see figure 36 below).

Figure 36: Key metrics for OPMH wards

March 2022	Southern	Solent	IOW	National mean
Beds Per 100K	24.2	50.9	18.6	26.6
LOS	76.5 days	22.2 days	45 days	<64 days
Admissions per 100K	84.4	416.8	93.2	<107.1
Occupied Bed Days	85%	59.60%	86%	85%
RCPsych Accreditation	No	No	No	20%

5.75 Although there are many factors contributing to these differences, some common ones identified include:

- whether there is a S75 agreement or an integrated place based local authority; and
- access to an OPMH acute and crisis team to support timely and safe moves back to the community.

This impacts on use of specialist OPMH inpatient resource and impacts the experience of people often living in their last 1000 days. In some OPMH wards, people spend 100 days (LoS) or more days on an OPMH ward, for large parts not requiring acute MH care. As an example, in Beaulieu ward based in Southampton there are differences in average LoS between residents that reside in Southampton verses those that reside in Hampshire. Southampton have a S75 in place which contributes to reducing the delays in facilitating discharge whereas Hampshire County Council services are not integrated within the CMHT and this creates delays. The inpatient wards within Solent benefit from a S75 with the local authority and a OPMH crisis team that in reaches into inpatient wards to help facilitate earlier discharge as well as providing the support to reduce the need for admission.

5.76 There is unwarranted variation currently in access to seven day bed management across HIOW. The Isle of Wight model offers ageless (18+) mental health wards which older people can access. The other places have specialist OPMH wards.

5.77 Opportunity - There is an opportunity to review bed management as a resilient seven day service with AMH or as part of an integrated part of OPMH acute and crisis services. A workshop is being planned to develop these plans with Southern, Solent and IOW teams, alongside acute and crisis care work. This will support people needing an OPMH bed to access timely admission to an inpatient bed seven days a week whether from acute hospitals or community settings. This may reduce the need for on-call practitioners to partake in bed management activities and better use that senior resource in clinical services out of hours.

5.78 Opportunity - The intention of the transformation is to have the right size of OPMH and dementia beds for HIOW which all meet Royal College of Psychiatrists accreditation standards[36].

---

[36] https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/older-adults-mental-health-services

5.79 The bed provision would not be required to the same extent if there were alternatives to admission and tier 3 seven day acute and crisis services to step people out of acute hospitals across all of HIOW, to support people in care homes experiencing acute challenges and to support people and their families in their own homes. There are opportunities to right size the bed model and invest in tier 3 seven day acute and crisis OPMH services as a more effective model of care providing care in people's own homes. Tier 4 should be seen as specialist provision (similar to PICU) and provided by a few sites with specialist and resilient models of care serving the whole ICS. This will enable patients who are the most unwell with dementia to get the most expert and high quality care by specialist hospital teams and in specialist ward environments meeting accreditation standards.

5.80 Currently wards do not meet accreditation standards with one of the potential benefits of investing in Tier 3 crisis services seven days a week will mean that less beds are needed as patients are able to be maintained within the community for longer. This will allow the current ward environments to be improved to meet national standards (Accreditation for Inpatients Mental Health Services – AIMS-OP), see 5.27 above, improving both staff and patient experience.

5.81 The patient story in Figure 37 illustrates some of the challenges within the system but also how the story should be, this is taken from examples that have happened within HIOW but is not a real life case study. The combination of a clear vision and careful, structured planning and implementation will realise these patient benefits.

Figure 37: Patient Story - Person with Dementia

Patient Story - Person with Dementia:

John is a retired engineer living in Hampshire. He notices after Christmas that he felt much more disorientated when staying with his daughter and struggled to use the unfamiliar TV controller, microwave and felt unsure where he was on waking at her house. When he returned home, he saw his GP who arranged some blood tests and found no abnormalities and completed a screening test for his memory. John didn't do as well as he expected, and he agreed to a memory clinic referral.

How it can be now:

He went to the clinic and saw a nurse, who then said she'd need to speak to a doctor about a scan. A few weeks later, John got a phone call a scan would be arranged. About 3 months later he got a scan appointment which is daughter took him to. After another few months, he got a letter about a memory clinic appointment. It had now been over 6 months since Christmas, and he attended anxious to hear the result. He was told it looked like Alzheimer's dementia. He was started on a tablet and discharged with some leaflets, after care phone numbers and discharged back to GP care. Over the pandemic, he didn't receive any annual reviews of his dementia and he became increasingly isolated, forgetful and at times, left the gas on, forgot to feed the dog, was struggling to heat the microwave meals his daughter arranged for him, who lives two hours away so sees him once a month. On an August morning, he woke up at 6am and thought it must be bin day, he got up in his pyjamas and slippers and put the bin out. He then took a walk and got lost. He was found that night about 8 miles from his house near a busy dual carriage way by the Police, who couldn't decide if best to take him to the hospital or a S136 as he became aggressive and agitated when approached and seemed hugely confused as to why they were concerned. He was taken to the general hospital. No medical cause is found, and he is admitted for discharge planning, whilst a safeguarding alert was made. He spends 4 weeks on the wards, getting a hospital acquired infection mid-way through which delays his discharge, and is discharged to a D2A in a different part of the county away from his networks of friends and not near his family. He loses contact with his GP surgery of 40 years.

How we want it to be:

The GP in the first instance arranged a brain scan, which he had at his local community hospital within 4 weeks and then receives a letter for a memory clinic specialist. He is seen at specialist memory clinic and has a one stop shop appointment, having assessment, treatment, being introduced to information about advanced care planning (wills, LPOA) and is started on evidence-based memory medication. He receives a menu of options for post diagnostic support and chooses to attend singing for the brain as he would prefer an activity rather than a talking group. He also accepts a referral to the memory research centre and joins a trial over the next 2 years which helps him to be feel supported. Over the coming years, he becomes well connected to dementia support networks, receives annual review of his dementia and when things start to progress his daughter knows to ring the services and they re-assess for the next step of his memory medication. He also accepts a referral for some assessment for aids and decides after to speaking to the OT and reflecting with his daughter that his large house and garden are becoming too difficult. He makes a choice to move within his market town to a flat with a warden and on-site activity, stimulation, and support. He thrives, meeting people there he has known for many years in the town and finding new joy in life. He lives there for a further 5 years and passes away in his own home, surrounded by his dog and family.

Collaboration to date

5.82 The planned creation of a new Trust has enabled more progress to be made with OPMH transformation owing to the joint senior leadership approach and focus and dedicated capacity through the OPMH workstream leadership team (executive sponsor, clinical lead, operational lead, project management and business support) which has been in place since October 2022.

5.83 The OPMH and dementia workstream has worked with ICB colleagues to set up an ICS-wide OPMH and Dementia Board to bring together all partners, including the Trusts, the ICB, GP clinical leads, public health and local authorities, to support the work and report into the ICB MH Partnership Board, alongside No Wrong Door, Children and Young People's Mental Health and Acute and Crisis Mental Health.

5.84 The workstream links with the OPMH Clinical Network on a monthly basis to inform, drive, check and challenge the planned transformation of OPMH and dementia services. This was previously a Trust network but has been opened up as a HIOW clinical network with good broad engagement across the three Trusts.

Service users and carers

5.85 Over the last two years, the OPMH services in the respective organisations have sought to understand the experience of using services from the perspectives of service users and their carers to inform the direction of the OPMH workstream and co-design future services to improve health outcomes and reduce inequality. This engagement is described as "discovery work" to understand where the gaps in current services are and to understand the current experiences for older people using them and their carers.

5.86 The initial discovery work met with users, family members and VCSE organisations supporting people in HIOW. The face to face groups engaged a broad group of people, but there was under-representation from those living in care homes and those with a BAME background. To address this and broaden the discovery work, in March and April 2023, the Solent Community Engagement Team completed a piece of engagement work focusing on seldom heard communities, namely those from minority ethnic communities which included a mixture of people using the Trusts' services and those that have not, and those resident in care homes. The team engaged with 180 people living in HIOW and provided the OPMH group with a full report including recommendations. See the attached report 'OPMH Feedback Report' for feedback from the BAME communities and care home residents.

5.87 Service users and carers told the Trusts (paraphrased, not verbatim):

- *Advance care planning is important for people, whilst they still have capacity.*
- *Carers need to be involved in care coordination and treatment discussions.*
- *Assessment for dementia needs to be holistic, not just based on scores from a memory test, it needs to consider an individual's "usual state" and history.*

- *Post-diagnostic support in more important than the diagnosis*
- *Many people would prefer to stay where they are (whether in their own home or residential/care home) and receive care in a familiar environment.*
- *"Seeing somebody regularly, having an appointment in my diary is important to me… "knowing I'm seeing somebody soon helps when I'm having a dip"*
- *Apart from Andover Mind, it does not feel like there is much in the community to support those with a functional illness. Either groups aimed at younger people or groups aimed at those with dementia and/or their careers.*
- *Mental Health crisis should be treated with the same urgency as a physical health crisis.*
- *Liked the idea of more mental health support and social prescribers for older people in GP surgeries, in general the older population are engaged with their GP surgery.*
- *Service users in crisis are more likely to call carers support (Andover mind). They like the idea of talking to somebody they know and trust.*
- *Transition from AMH to OPMH - Once you are across the 65 years age threshold to OPMH, the services seem to have more focus on dementia and services sign posted for dementia rather than functional illnesses.*
- *Transition between services could be smoother, discharged from secondary care to VSCE or back to Primary care, can feel confusing.*
- *Working in silos - Communication between services can be a barrier with professional boundaries that are ridged. Some service users see several people a week in their home, it does not always feel like the teams are coordinated and never should one work with or support the other.*
- *Carers feel overlooked and ignored by clinicians with a considerable number reporting that often clinicians did not take on board their concerns. This was particularly problematic where English was not the carer's first language. Carers reported that translators are often made available for the person being cared for but not the carer. Translators did not take their contributions into account.*
- *It can be difficult for carers from minority ethnic carers to move their loved ones in to care homes etc. as culturally this is not an option. It was felt that more needs to be done to support carers and those with ill mental health to stay in their homes.*
- *Families including both carers and services users can find themselves very isolated with no were to turn to as often they cannot find this support within their own communities.*

Workforce engagement

5.88 The OPMH and dementia workstream held a virtual workforce engagement session on 16th May 2023. The aim of the session was to provide context and background to the work to date, share ambitions for OPMH and dementia services across HIOW and invite colleagues to share what is important to them and ask questions.

5.89 Approximately 70 people attended from across all three Trusts. The key questions posed to the group were:

- *What would make OPMH attractive and sustainable work in for the next decade?*
- *In the last five years, how have the needs of patients and carers changed?*
- *What are the best bits about your OPMH services?*
- *What would you change about your OPMH services?*

5.90 The outputs from this session will inform the workforce development plans for the combined service.

5.91 The feedback received to date from carers, those using these services, the community and the workforce has informed the priorities for the workstream and the ambition is to create a coproduction mechanism to design models of care to ensure the services meet the needs of local communities now and in the future. The OPMH services are committed to ensuring coproduction with staff, service users, carers and VCSE partners becomes embedded in service design and delivery. The programme of priorities have been identified from feedback from patients, carers, stakeholders and staff. As new engagement is undertaken plans are shaped and priorities added to take into account feedback and ensure that this programme of delivery is driven by engagement and coproduction.

5.92 Following this the team have created a video interview with communications team to share with staff. This involved senior members of the OPMH programme explaining the aims of the workstream.

Vision for OPMH services

5.93 The below programme vision statement was coproduced by service users, carers and VCSE partners, and is the guiding statement for the programme.

"Older people in Hampshire & Isle of Wight have timely access to specialist mental health services where care is informed by evidence based best practice. Health, Social and Voluntary care services work together with service users and carers to create a package of care that is centred around individual needs, enabling them to recover and live well."

5.94 The aims of the programme are to:

- Set the direction and vision of Older People's Mental Health and dementia services for the next decade for HIOW;
- To ensure flexible health and care pathways from primary care (Tier 1) to the most specialist MH care (Tier 4) to meet the needs of the ageing population;
- To transform services across the OPMH pathway, reducing unwarranted variation and reducing barriers for example due to age, postcode or diagnosis; and
- To ensure services and workplaces are great places to train, work, innovate and research.

5.95 The workstream aims to take a collaborative approach to identifying the future needs of the predicted older population and the subsequent preferred clinical model required to include:

- Love the Problem: Understand the data/problem in the context of the system. Developing a coherent overall vision and strategy (including OPMH and Dementia) with all stakeholders considering best practice, research, and innovation locally and nationally.
- Developing a model of care for those requiring acute or crisis care for dementia or OPMH needs. Ensuring parity of access to acute care and with high quality alternatives to admission and the most restrictive care.
- Developing innovative models of enhanced health care, health prevention and education that support people and those that care for them living in care home settings. Supporting admission avoidance to both acute and MH settings, where not required.
- Developing models of care that meet the demand, linked to high quality research, innovation, and education that reduces unwarranted variation across HIOW across all Tiers of OPMH provision.
- Develop organisational model of operational and clinical management for OPMH that spans across HIOW to reduce variation, ensure continuity in priorities, investment and staffing across HIOW.

What will change and how patients will benefit

5.96 Within the new Trust, the ambition is to create equitable pathways for older people and people with dementia, developing new services where there are gaps in provision and looking at best practice nationally and locally to determine the best models of care for patients based on the population needs at a local level.

5.97 It is recommended that in the new Trust, OPMH and dementia services are brought together under single leadership with a single vision and the ability to share best practice and standardise approaches where appropriate. A single service will ensure

that any differences in delivery are warranted and that patients can expect the same outcomes even if the services are delivered differently to meet the population needs.

5.98 A shared approach to quality governance will further enable and sustain these changes. In particular, stronger mechanisms for shared learning across HIOW will support continuous improvement and learning between services (including between OPMH CMHT and OPMH inpatient).

5.99 There is an opportunity to create a community mental health system approach to workforce design, recruitment, development, and retention, working in collaboration with AMH and frailty pathways and to take a more consistent and effective approach to commissioning VCSE contributions to the pathway.

5.100 The table below sets out the key elements that will support the vision for OPMH and dementia services:

Change	Outcome
Easy and timely access to dementia diagnosis	• Ensuring that access to diagnostic scans is timely and built into standard assessment pathway. • Ensuring that there is sufficient capacity within teams to meet national standard of six weeks referral to diagnosis in MAS pathways with no unwarranted variation. • Earlier diagnosis enables safety planning (e.g. driving/shotgun licences), advanced planning, access to medications that can slow the progression, access to research and reduces distress and uncertainty caused by protracted diagnostic pathways to both the patient and their family/carers. • Service users have opportunity to participate in research and trials through MARC.
Enact changes in information systems to capture dementia data separately and consistently	• To enable accurate monitoring of dementia prevalence across HIOW. • Enabling resources to be targeted in the correct places.
Formal dementia diagnosis and package of care	• More people with a dementia in HIOW will have a formal diagnosis, meeting the DDR of 67%; which in turn allows them to access a formal package of personalised support to help them live well and plan for the future. Figure 29 shows the current diagnostic rates.

Change	Outcome
	• Productive, consistent and high quality and timely MAS pathways that include post diagnostic support will be available to all HIOW's population including minority ethnic populations and rural populations, linking in with VCSE partners across HIOW with no unwarranted variation in service offer. Services will have strategic planning taking into account changing demand and capacity.
Equitable mental health (MH) crisis / intensive home treatment support and MH inpatient services	• MH crisis / intensive home treatment support for older people with dementia and functional illness that is designed to respond to the needs of service users and their families 24 hours a day, 7 days a week - including liaison psychiatry and NHS 111 MH team, see paragraph 5.69 for more information. • Access to local acute mental health beds both functional and dementia – meeting RCPsych CORE-24 accreditation standards and acute and crisis OPMH community pathways. • Equitable provision of acute and crisis care regardless of age across HIOW. • Equitable provision of OPMH inpatient provision serving the whole of HIOW as a seamless pathway with seven day community acute and crisis OPMH services (see Appendix 4 for current OPMH bed baseline). • The immediate priority for the workstream is equitable community acute crisis provision across all of the services seven days a week.
Standardised care pathways across HIOW **The new Trust will:** **(1) develop and roll-out standardised care pathways across HIOW – reducing waiting time for core CMHT referral for 4 weeks referral to assessment;**	• This will lead to increased outcomes for patients, decreased variation in services, reduction in antipsychotic medication for dementia and increased access to psychological therapies.

Change	Outcome
(2) drive out unwarranted variations in practice within OPMH and between OPMH and AMH. This will include variation in MAS, Core Community and Acute and Crisis Care pathways; **(3) establish a shared evidence based clinical framework, in consultation with AMH core community services and other key inter-dependent programmes, to include increased access to psychological therapies, teams aligned to local PCNs, proactive care home in-reach in collaboration with physical health teams, consultation and advice for community hospitals and hospices and access to pharmacy teams; and** **(4) develop an approach to quality governance and organisational structure that ensures services are working to a consistent set of coproduced quality, performance, and clinical outcome standards**	
Holistic Care both to mental and physical health by transforming CMHT and introducing crisis services across HIOW	• Enabling teams to focus more effectively on the needs of older people with complex or challenging needs, intervening earlier, and improving outcomes. • Facilitate admission avoidance and earlier discharge where admissions are needed.
Creation of integrated care home teams	• Enabling support to people within care home in a crisis, with timely access to support and care leading to less 1:1 support and need for hospital admissions. • This will impact on patient outcomes and also create system savings across health and social care.
Seamless transitions from Adult Mental Health (AMH) services	• The creation of the new Trust will mean that all AMH and OPMH services in HIOW are delivered by a single provider. Seamless transitions from Adult Mental Health (AMH) services is an important focus. The team are

Change	Outcome
	working closely with AMH colleagues to ensure the new service deliver a single seamless pathway of care over the whole life course, but recognising the need to have services for older people with the expertise in both functional and dementia. • Eliminating patient hand-offs and providing a better experience for service users.

OPMH workstream development

5.101 The ICS OPMH and Dementia Board has agreed a six step process as follows:

Figure 38: The six steps for the ICS OPMH and Dementia Board

1. Loving the Problem
2. Acute and Crisis Care
3. Memory Assessment Service (MAS)
4. Care Home Sector
5. OPMH Core Community
6. Tier 1 pathways/ Working with other clinical workstreams

The steps are described in more detail in the table below. Step 1 has been completed and Steps 2 and 3 are in progress as priorities for 2023/24 and in preparation for creation of the new Trust.

Step	Description
Step 1: **Loving the problem, Relationships and Networks. Vision, Strategy, Consultation**	Understanding the data/problem in the context of the system. Developing relationships, networks and people aligned to work streams. Developing a coherent overall vision and strategy (including OPMH and dementia) with all stakeholders considering best practice, research, and innovation locally and nationally.

Step	Description
Step 2: **HIOW Acute and Crisis OPMH Model including Specialist MH Inpatient beds, ECT, Home Treatment/Intensive Support/Crisis (LP,111, Crisis Cars, Safe havens) & Bed Management (Tier 3 and 4)**	HIOW Acute and Crisis for OPMH (Tiers 3 and 4 Care). Developing a model of care for those requiring acute or crisis care for dementia or OPMH needs. Ensuring parity of access to acute care and with high quality alternatives to admission and the most restrictive care**.**
Step 3: **HIOW Care Home Sector focus- including In-reach/Care Home Support & Education (Tier 3)**	Developing innovative models of enhanced health care, health prevention and education that support people and those that care for them living in care home settings. Supporting admission avoidance to both acute and MH settings, where not required.
Step 4: **HIOW Memory Assessment Services (MAS) and post-diagnostic support for people with dementia (Tier 2)**	Developing models of care that meet the demand, linked to high quality research, innovation and education.
Step 5: **OPMH Core Community teams**	Align to No Wrong Door priorities/programme and timeframes and part of full community transformation review.
Step 6: **HIOW Primary Care, IAPT, PCN, CMHT, Community Hospitals/Hospices (PH) and 'Community' pathways (Tier 1)- OPMH focus**	HIOW Primary Care, IAPT, PCNs, Community Hospitals/Hospices (PH) and 'Community' pathways (Tier 1) - OPMH focus. Working with other clinical workstreams to ensure high quality OPMH care for a broad group of the community.

Benefits indicators

5.102 The indicators expected to be used to assess progress in realising the expected benefits are detailed in the figure below:

Figure 39: Benefits indicators for OPMH

Theme/Measure	Indicator	Source	Baseline	Target
Variation in service delivery: seven day access to acute and crisis community OPMH care	tbc			
Variation in service delivery: OPMH five day core community pathways (not MAS)	Patients seen within 4 weeks of referral in the community and have started a period of assessment or treatment at that time using a skilled MDT approach	MH Data set	Variable across area, e.g., IoW average 4 months, Portsmouth CMHT – 7 weeks, ICM (Crisis) – 3 days	95% to be seen within 4 weeks in year 3.
Variation in service delivery: Inpatient Acute and Crisis	The percentage of wards meeting RCPsych Accreditation standards The rate of admission to acute mental health beds and physical acute beds for OPMH or dementia needs compared to per 100,000 over 65 population The Length of stay in acute mental health beds The number of lost bed days due to delayed Transfers of Care in OPMH and Specialist dementia beds and in acute hospitals The percentage stepped down to an acute and crisis OPMH team			

Theme/Measure	Indicator	Source	Baseline	Target
	The percentage returning to their own home			
Requirement to meet national for dementia rates: Memory Assessment Service Pathway	Length of wait to be assessed Length of wait until neuroimaging Timely access to post diagnosis support		tbc	Year 1 – all PCNs to achieve 50% of national average in each indicator.

Implementation plans

5.103 The figure below sets out the key activities to realise the identified OPMH patient benefits. The detailed implementation plan is a supporting submission.

Figure 40: Summary of the OMPH implementation plan

Year	Activities
Pre day 1	• Undertake a data and mapping • Develop vision and strategy along with stakeholders • Complete discovery work and collate feedback • Review HIOW specialist dementia beds, functional bed and review bed management across HIOW • Review crisis community model • Develop business cases / new SOPs for bed management and the expansion of the OPMH community model • Test new models of care in pilot areas for MAS, crisis teams and bed model on Isle of Wight • Develop business case for creating an OPMH CMHT on Isle of Wight
Year 1	• Develop OPMH dashboard • Develop OPMH and dementia leader development, VCSE network development and advanced practitioner network • Finalise OPMH and dementia bed model • Develop Trust-wide plans to achieve OPMH and dementia ward accreditation • Agree MAS model and KPIs • Implement enhanced dementia scanning service within Community Diagnostic Centres
Year 2	• Progress with mobilisation
Year 3	• Progress with mobilisation

Interdependencies (internal or external) and how these will be managed.

5.104 Interdependencies with other workstreams (all mental health workstreams and the frailty workstream) have been mapped out and are managed through the Clinical Transformation Group meetings.

5.105 The OMPH work programme has identified the following key internal interdependencies:

- Community Engagement Team: supporting community events to help shape new services;

- Lived Experience Team: responsible for developing methodology for use by OPMH;
- Organisational Development Steering Group: responsible for supporting team integration;
- Workforce Steering Group: responsible for ensuring workforce planning, recruitment and selection and training reflect the OPMH vision and expansion;
- The Executive Team: responsible for agreeing how OPMH will be structured in the Trust moving forward;
- Clinical Transformation Group: responsible for driving the programme across HIOW; and
- Other clinical priority workstreams: the OPMH workstream works closely with community mental health framework (‘no wrong door’ programme) which is focusing on CMHT development across AMH, the mental health acute and crisis workstream for AMH and the frailty and urgent response workstream.

5.106 The OMPH work programme has identified the following key external interdependencies:

- The development of the Joint OPMH and Dementia Board across the ICS ensures that the workstream is embedded into the commissioning priorities across the system and is linked in with other key partners;
- The Integrated Care Board: responsible for commissioning decisions on how the services will be delivered; and
- ICS digital team: support in developing consistent data and business insights for service lines, pathways, PCNs, places and ICS as a whole.

Key risks and mitigations

5.107 The OPMH work programme has identified the following risks with a risk score of 10 or more:

Figure 41: Risk Assessment for OPMH

Risk Description	Owner	Impact (Score)	Probability (Score)	Total Risk Score	Planned Mitigation Actions
Resource restrictions make it more challenging to mobilise transformation work and realise future models.	Consultant in OPMH Liaison Psychiatry, Southampton	Major (4)	Likely (4)	Very High (16)	1. Transformation board sitting at ICS level so will be well linked with broader transformation plans/funding 2. Transformation work will exploit reinvestment/reallocation of existing funding within services where possible.
Risk that without sufficient engagement and coproduction that future models do not fully meet the needs of the older population.	Programme Manager	Major (4)	Possible (3)	High (12)	1. Service user & public engagement events held and additional planned. 2. coproduction group in planning. 3. Additional support requested from ICS engagement lead.
Availability of data and/or issues with the quality of data may make it challenging to identify areas of need within transformation priorities. It also impacts on ability to have consistent evidence/narrative in a case of change.	Operations Director / Consultant in OPMH Liaison Psychiatry, Southampton	Moderate (3)	Likely (4)	High (12)	Work has started within Southern to standardise and align data captured within service lines. Changes to provide proof of concept for standardised reporting across organisation.

6 Frailty and urgent response

Introduction and Overview

6.1 Frailty is a common long-term condition which increases with age, in which multiple body systems gradually lose their in-built reserves, resulting in an increased risk of unpredictable deterioration from minor events. The consequences of escalating frailty are adverse outcomes such as falls, disability and its consequences, frequent hospital admissions and increasing demand for long-term social care support. Early management of frailty can be optimised with good holistic care. A comprehensive framework for frailty includes prevention, proactive case management, rehabilitation, and end of life care. Frailty is a population challenge and not solely represented in one area of service provision. Caring for older people living with frailty resides in all areas of community provision and is not a silo pathway impacting physical health. This chapter focuses on looking after the older person living with frailty during an acute episode of ill health.

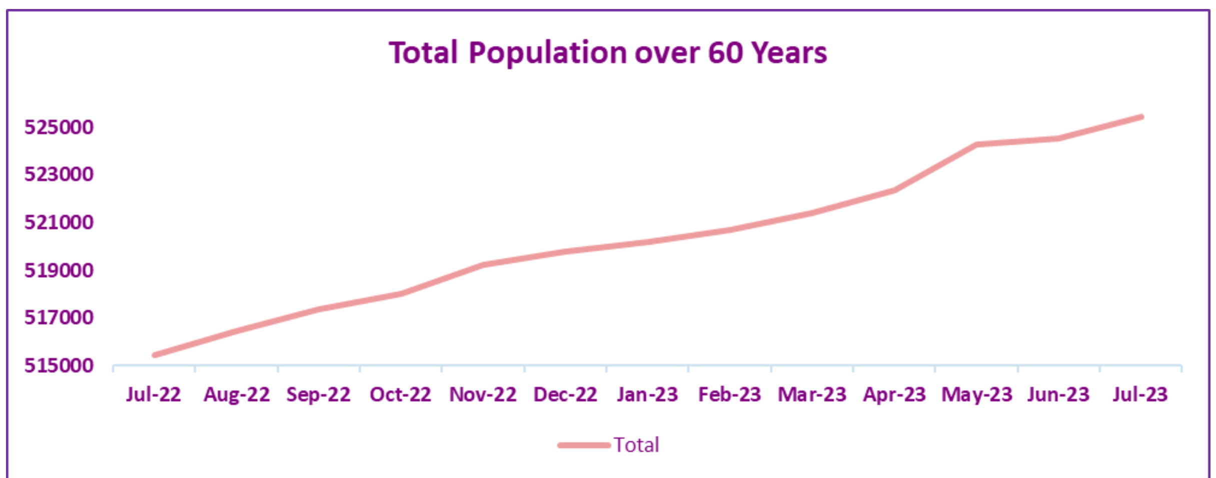
6.2 IoW, Solent and Southern provide one of the cornerstones of this wider frailty framework through the delivery of frailty urgent response, supporting complex care needs, people living with frailty and more than one long-term condition, who spend the most time in healthcare. Moving the delivery of their care to community-based single model of delivery will deliver greater equity of access and outcomes across the whole population of HIOW.

Overview

6.3 The population in HIOW is ageing and living with increasing frailty and multiple health needs, especially in rural areas, particularly west Hampshire and the Isle of Wight. In Hampshire, people aged 70 years and over make up 16.6% of the population compared to 13.4% nationally and 1.4% are in the 'oldest old' over 90 years population age group compared to 0.9% in England. The age of people living on the Isle of Wight is similar to other places popular with retirees, but more people live alone[37].

[37] Hampshire and Isle of Wight Joint Forward Plan

Figure 42: Total population over 60 years



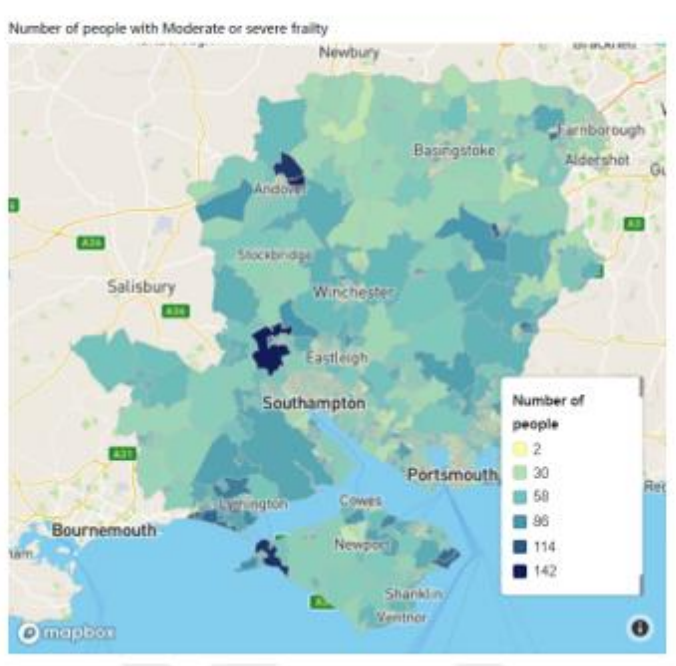
6.4 Growth of the older population is set to continue with those districts with the largest increases set to rise by over 30% by 2027. The national prevalence of all frailty is 43.7% of adults aged 65 and over. The prevalence of moderate or severe frailty in HIOW is set out in figure 43 below.

Figure 43: Prevalence of moderate or severe frailty by district

Prevalence of Moderate or severe frailty by district

Area	People	Prevalence
Basingstoke and Deane	3,744	11.2%
East Hampshire	3,696	12.1%
Eastleigh	3,161	11.4%
Fareham	3,317	11.9%
Gosport	2,033	11.7%
Hart	2,459	11.9%
Havant	3,730	12.1%
New Forest	6,566	12.3%
Rushmoor	1,785	11.2%
Test Valley	3,657	11.7%
Winchester	3,356	12.0%
Total	**37,505**	**11.8%**

Area	People	Prevalence
Isle of Wight	4,594	11.2%
Portsmouth	3,554	11.4%
Southampton	4,547	11.9%



Source: Hampshire Joint Strategic Needs Assessment 2021

6.5 As a result, the development of frailty services across HIOW is a priority for the ICB as part of its Joint Forward Plan. In addition, nationally around 47% of hospital inpatients aged over 65 are affected by frailty[38] and HIOW system has seen an increase in emergency activity, occupied bed days and delays in discharges over and above 2019/20 levels and is currently 8% higher than the nation average. Prevention and reversal of frailty enables people to live independently for longer and helps to reduce demand for emergency care and long-term support. Sub-optimal management of frailty is costly, and it has been estimated that the annual cost to the healthcare system per person with mild to severe frailty ranged from £561-£2,108, using 2013/14 reference costs [39].

[38] Ageing Research Reviews. Sep;80:101666. doi: 10.1016/j.arr.2022.101666

[39] British Geriatric Society (2023) Joining the Dots A blueprint for preventing and managing frailty in older people

6.6 There are several key interventions focused on frailty rapid response, including Urgent Community Response and Virtual Wards.

6.7 **Urgent Community Response** (UCR) is a community-based service provided by a multi-skilled team to people in their usual places of residence, delivering urgent care for those that require a response within two hours. UCR is designed to prevent hospital admissions for people with complex health needs (largely long-term conditions and/or frailty). The current preferred service model is to provide a single, integrated service that covers urgent, crisis response care, as well as re-enablement care which is delivered at place. UCR implementation was initially mandated in the 2022/23 NHS operational planning guidance [40].

6.8 **Virtual Wards** (VWs) provide acute clinical care at home for a short duration (up to 14 days) as an alternative to care in hospital. They are accessed through UCR if they have been under their care for longer than 48 hours or via the single point of referral for community teams requiring an urgent response. As per national guidance, patients admitted to a virtual ward have their care reviewed daily by a consultant practitioner (including a nurse or allied health professional (AHP) consultant) or suitably trained GP or via a digital platform that allows for the remote monitoring of a patient's condition and escalation to the most appropriate clinician where necessary. As detailed in the NHS England Supporting information: Virtual ward including Hospital at Home report: Virtual wards are supported by a growing evidence base that demonstrates patient, system, and public benefits, and has broad clinical support:

6.9 Feedback from patients is positive and suggests that virtual wards support increased patient choice and personalised care, allowing patients to be treated in a more comfortable home environment.

6.10 Virtual ward models have reduced emergency department (ED) presentations and hospital admissions through the provision of timely multidisciplinary care. Supporting patients to be supported with the right care in the right place. NHS England and NHS Improvement analysis of hospital admission data suggests that a virtual ward of 50 beds could deliver the equivalent of 31 additional secondary care physical beds through more effective utilisation of staff. Admission avoidance models have the potential to release greater benefit in terms of bed days saved than models that focus on early supported discharge.

[40] NHS England (2022), *Supporting information Virtual ward including Hospital at Home.* Available at: https://www.england.nhs.uk/wp-content/uploads/2021/12/B1478-supporting-guidance-virtual-ward-including-hospital-at-home-march-2022-update.pdf [Accessed 28.07.23]

6.11 Virtual wards improve staff experience by enabling for a more flexible use of existing workforce, creating opportunities for staff to work more flexibly and undertake blended roles, i.e. a mixture of in-person clinical care and provision of virtual clinical care. Additionally, this way of working can benefit staff who are unable to undertake patient-facing activities for health and wellbeing reasons.

Current provision

Overview

6.12 Southern, IoW and Solent each provide models of care for rapid response functions, that incorporate care for the older person living with frailty, with an acute exacerbation of their frailty condition. This is predominantly provided via UCR, VWs and core community services. Whilst the overall patient pathways are similar, they are delivered through different 'place based' service and workforce models designed to meet the needs of the local population and to work effectively alongside other locally commissioned and delivered services. There is significant disparity in frailty virtual wards and rapid response functions, driven by historical commissioning and funding arrangements.

6.13 To meet the requirements of the NHS England operational planning guidance for 2023/24, all community providers across HIOW expanded and enhanced UCR offers and implemented High Intensity Virtual Wards, focusing on the frail and respiratory cohort.

6.14 Services are provided in the community across HIOW for patients with decompensated frailty, enabling them to be treated at home. Patients are admitted to the service to treat their decompensating frailty presentation and are managed in their own home until the acute episode of illness is over or until they are discharged, either with or without ongoing health or care needs. There are two referral routes, either via place-based or HIOW single point of access into the frailty pathways. Referrals are primarily generated from South Coast Ambulance Service (SCAS) or IoW Ambulance Service, GPs, 999/111, community services, care homes, outpatients and step-down from hospitals (although the level of step-down provision varies across the geography).

6.15 All UCR and VW services across HIOW are supported by a single point of contact (SPoC), there are also place based referral routes available to UCR services, referring to the area-specific direct phone line that takes callers through to clinical triage. The SPoC enables a clinician-to-clinician discussion at an appropriate level of expertise to enable the right decision making and admission to the most appropriate clinical service. The SPoC provides direct access to the high intensity frailty virtual ward for patients who require more intensive support in the community avoiding unnecessary admissions.

6.16 A patient is seen by a senior clinician and then receives a holistic assessment by the team across their 'stay', based around a comprehensive geriatric assessment (CGA). As part of this process, any unmet need is also assessed and treated. Once treated, most patients will be better and will stay at home. A smaller proportion will

either go on to require a hospital admission or will have unmet needs requiring ongoing equipment or care. The figure below summarises the differing 'journeys' a patient may take.

Figure 44: Local service provision

Local service provisions across HIOW as defined by current standard operating procedures - 2023

South-East
Portsmouth
South-West
Mid & North
IOW
Southampton

Referrers
Primary Care
Community services
Outpatients
111/999
Acute SDEC
Self-referrals (new pt's)
UCR SPoC
Referral inclusion criteria
Urgent equipment provision
Unpaid carer breakdown
Delirium
Frailty/decompensation of
Falls
Catheter problems
Respiratory infection
Discharged back to primary care
Non-Admitted
Admitted
Ambulatory care
Acute diagnostics referral
Discharged home
Rings individual consultants
Rings SDEC
Requires primary care referral
Community SDEC
Virtual Ward
LOS not limited to 14 days
Patient is visited at home throughout VW admission
14 days max.
Ease of communication with primary care/CCT's through technology
Daily MDT's
Further deterioration
Recovery
Admitted to hospital
Escalated to community
Partial - continued monitoring with VW
Full recovery - discharged

Current activity for HIOW frailty and urgent response is set out in Appendix 7.

Figure 45: Older patient at risk of an acute admission

Patient story – impact of current service challenges

Background: *The patient lived with his wife, he was normally independent with his activities of daily living, but his wife was not managing to care for him whilst he was unwell, and he remained in bed. There were concerns that this gentleman was at risk of admission to an acute hospital.*

Situation*: An 88-year-old gentleman called for a paramedic due to feeling unwell and collapsing. He was diagnosed as having a urinary tract infection and tested positive for Covid. Antibiotics were prescribed due to the infection and the Urgent Community Response Team were contacted.*

Assessment*: A full holistic assessment was completed by the Urgent Community Response Team within 2 hours of referral.*

Outcome*: From the physical observations there was a noted increase in the patient's temperature and a decrease in oxygen saturations due to Covid where advice was given. Equipment was provided and fitted to support independency with getting in and out of bed and mobilising. The physiotherapist gave advice on breathing exercises and hydration, and a package of care was arranged, which started the same day to ensure the patient had support with washing and dressing twice daily and prompting medications.*

The following day the gentleman's physical observations had improved, he was mobilising with the use of a Zimmer frame and assistance of one person upstairs, the physiotherapist provided a chair exercise programme to avoid deconditioning and he was managing well with the carers visiting.

Within two weeks of receiving the referral the gentleman had recovered from Covid and from the Urinary Tract Infection, he was independently mobile on the stairs and no longer required the care package that had been provided.

Recommendation*: The GP was asked to organise an x-ray for the gentleman due to ongoing unreported hip pain, his care has been passed back to the GP now that he is back to baseline.*

Service Challenges*: The distance that the Urgent Care Team are travelling can be considered a service challenge. There is currently no digital technology provision to monitor patients remotely, resulting in patients needing to be seen more regularly via home visits. Staffing and training provision is also an ongoing challenge for the service as staff need to attend specific courses at advanced nursing level to upskill the workforce. The ongoing financial position remains a challenge as the service cannot be developed without the correct funding allocation.*

Other Considerations: *Unique to Southern Health are the Enhanced Recovery Service (ERS) who support packages of care for patients who require an urgent community response, removing some reliance on adult social care to provide this urgent response. This should be taken into consideration with the ongoing financial position.*

Figure 46: Patient Story - integrated working between UCR, Virtual Wards and Community Teams

Patient story – highlighting the integrated working between UCR, Virtual Wards and Community Teams

98 year old male who lives with his wife was admitted to the emergency department, patient independent and full-time carer for his wife at home. He was functionally independent with a frailty score of 4.

***Referral Reason**: Admitted due to a fever and rigors (fitting). He presented with an acute infection whose primary source was unknown and started on antibiotics. Patient collapsed the previous week prior to admission and had an abnormal ECG on arrival.*

***Initial Assessment**: Cardiovascular observations showed an elevation in line with an infection. The patient was alert and lucid, able to make informed choices about his care. His white cell count and other infection markers were raised, indicating an acute infection.*

***ED plan**: Admit for 24-hour monitoring into the medical assessment unit.*

***Patient plan:** Patient declined to stay in hospital and wanted to get home as soon as possible, patients' wife has dementia, and he was insistent that he did not want to stay in hospital as he was her primary carer.*

Plan Revised:

Urgent Community Response (UCR) contacted by the hospital and referral made for clinical welfare check the same day.

UCR team accepted referral / patient discharged home with advice.

Patient assessed at home by the UCR team and due to his clinical presentation was admitted to the community frailty virtual ward for ongoing monitoring.

Patient safely managed at home with the support of the UCR team in collaboration with the ongoing community nursing team support.

Evaluation Feedback:

Patient happier as he was able to access the support he needed and ensure his wife was ok. Both remained safely at home.

Community team happy as able to manage this gentleman at home with consultant oversight and guidance.

Hospital satisfied that the patient could be cared for outside the hospital, saving an inpatient/ Same Day emergency care bed.

Local differences

6.17 The general principles for frailty services, provided through UCR and VWs are broadly the same across HIOW. There are, however, different operating and workforce models in place to deliver these services locally.

Operating model differences

6.18 There are several differences between the operating models which are outlined below:

- Self-referrals for new patients are only accepted from the Isle of Wight and South East Hampshire;
- Different admission/discharge criteria are in place. Referrals for urgent catheter problems, for example, are not accepted by Southampton or Mid and North Hampshire but are accepted by other teams and respiratory infections are not accepted by Southampton, Mid and North Hampshire, Portsmouth and South West Hampshire. These are covered by other services;
- Unpaid carer breakdown is not supported by the Mid and North team;
- In all areas, except Southampton, patients' virtual ward length of stay is not limited to 14 days;
- The IoW does not have systems in place for referral to same day emergency care (SDEC) if required and diagnostics may require an ED or primary care referral; and
- Different ratios of virtual ward beds as a result of local commissioning decisions and funding availability as shown in figure 47.

Figure 47: Virtual ward bed provision by area

Region	Population Data	Nationally required VW beds per 100,000 population	Number of VW Beds in operation in HIOW
Southampton	293,606	3	12
Portsmouth	235,042	4	15
South East	430,518	5	30
South West	578,810	6	58
Mid and North	231,694	4	20
IoW	147,338	2	26

Workforce

6.19 Most services provide UCR and VW activity from a range of teams within their community services currently. This is a result of historical commissioning

arrangements. In practice it allows services to flex the workforce to meet urgent need. It is therefore difficult to quantify the exact workforce capacity that supports UCR and VW activity. IoW and South West Hampshire localities have dedicated frailty teams unlike other areas across HIOW. The South West and South East Hampshire localities are also supported by community geriatricians, whereas in all other areas senior clinical oversight is provided by nurse or AHP consultant/advanced practitioners.

6.20 The workforce models vary with current roles covering a range of the following:

- Consultant practitioners for frailty
- Advanced clinical practitioners (ACP)
- Nursing
- Occupational therapy
- Physiotherapy
- Healthcare Assistant (HCA)/Rehab assistants
- Consultant geriatricians
- Administrators
- Social workers
- Voluntary Sector

Digital

6.21 There is varying access to primary care records – Southampton and Portsmouth teams do not have access. IoW have a shared care record with community and primary care utilising SystmOne.

6.22 In addition, each team is trialling different technology to support patient self-monitoring – ‘Doccla’ is used in Portsmouth and Southampton, ‘Wearables’ are used in South East Hampshire and IoW, Mid and North and South West Hampshire use ‘Whzan’ Digital Health Softwear blue boxes.

Collaboration to date

6.23 As part of local system working the general pathway and service principles have been developed jointly.

6.24 A central point of contact across HIOW has been established to provide ease of access for referrers and ensures patients are being supported by the most appropriate team in a timely way. This feeds into local place-based teams who provide clinical triage, decision making and admission to the most appropriate clinical service.

6.25 A single communications strategy has been implemented across HIOW, supported by an education video for referrers[41]. The communication strategy was developed to alleviate barriers to referral and access perceived by those referring. The strategy aids referrers, such as SCAS, to understand the consistent elements that UCRs are providing across HIOW and helps educate around the type of complex patient that UCRs can support.

6.26 HIOW services have a single directory of services (DOS) which has been developed and is updated collaboratively.

6.27 The frailty and urgent response workstream of the Clinical Transformation Group is developing a unified vision, aligning pathways and considering opportunities to align workforce, education and training.

Key challenges

6.28 There are several key challenges that the workstream has identified in relation to frailty and urgent response services.

Different operating frameworks and multiple patient pathways

6.29 Different operating frameworks and multiple patient pathways have led to variation of care offer for patients and inequity in outcomes as follows:

- Referrers have a limited understanding of the range of community interventions provided for patients with frailty;
- Whilst there is a central point of contact, there remain multiple referral routes, e.g. via UCR, Single Points of Access, Transfer of Care Hub (ToCH)) with varying criteria, and different levels of access to other services such as SDEC, diagnostics etc;
- Different levels of integration with social services in different geographies, some of which are supported by section 75 agreements and others require formal referral mean that a number of people do not get timely support leading to crisis and admission to acute hospital or negative impact on family carers;
- Operating times and out of hours provision varies and further funding reductions in some areas will create greater disparity of service provision; and

[41] https://www.youtube.com/watch?v=ZZi4jo_GiBg.

- Differing staffing models are in place across UCR and VW teams which are often based on local service need and provision, building on the principle of utilising scarce and valuable workforce expertise in the most efficient way possible. Workforce gaps in various roles are a feature across all parts of the system.

6.30 Care models with a focus on supporting acute demand management because of increases in emergency attendances, admissions and delayed discharges. This has resulted in less focus/resources directed at prevention and proactive management and individual patient need. Earlier intervention and a proactive management plan reduce the risk of multiple attendances at ED and avoidable hospital admissions[42]. A focus on managing urgent needs and medical crises has reduced the opportunity to take a more holistic approach and therefore to deliver sustainable improvements in outcomes and reducing health inequalities. Generally there is an opportunity to make community based care the focus and utilise wider community assets to support this.

6.31 Different service models and organisational governance arrangements alongside access to senior clinical decision makers reduces the ability to manage increased levels of risk and share learning from safety incidents effectively or in real time.

Workforce discrepancies

6.32 Disparity of workforce resources, knowledge base, competencies, training and roles leads to a lack of continuity of care for patients, variation in service delivery and access to specialist skills as follows:

- Recruitment and retention is a challenge across HIOW leading to significant vacancies in particular teams and geographies. Solent currently has a 23% vacancy rate with Southern community teams at 6%, with IoW has a 10% vacancy rate within their core community nursing and UCR teams combined, which results in staff needing to be redeployed to cover core services. IoW are also unable to recruit to any medical posts. Staff are pulled from different services to support which leads to inconsistencies in the service offer and increased waiting times in other services. There is also a challenge to provide cover at weekends. As a result there is a reliance on bank and agency staff to cover posts;
- Increased and consistent focus on competencies and capabilities of the workforce in the UCR and VW space is required, for example, the development of sustainable

[42]Adrian Hopper (2021) General Medicine: GIRFT Programme National Speciality Report. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/09/Geriatric-Medicine-Sept21h.pdf

out-of-hospital models requires a workforce able to safely treat and care for older people living with frailty with acute care needs to continue [43];

- Being a relatively new service means there is not a readily available, appropriately trained workforce. The roles are specialist and require significant training to be able to hold an increased acuity outside of secondary care. Training for advanced clinical practitioners takes three years and funding for this educational degree is provided by HEE. The challenge sits in scoping and funding this educational pathway to keep up with the acuity demand. Once trainees are within the service, the senior practitioners need to provide significant amounts of time for close supervision and training, impacting on the clinical time senior practitioners can provide;
- A lack of a standardised frailty service model means that there is not a clear career structure for staff and therefore distinct opportunities for advancement;
- Across the services there are different roles e.g. community geriatricians, consultant practitioners, advanced clinical practitioners, who provide similar clinical outcomes, but with a different professional focus. The overarching goal is to provide a comprehensive geriatric assessment from all professionals but this is not currently achieved; and
- There are different employment contracts in place across organisations this currently leads to competition and costly movement of staff between the different organisations in HIOW.

Different funding and commissioning arrangements

6.33 Funding and commissioning arrangements are not aligned and have often been based on short term plans and non-recurrent funding. In addition, historical commissioning has meant that generic community services have been adapted in an unplanned way to incorporate new initiatives over time:

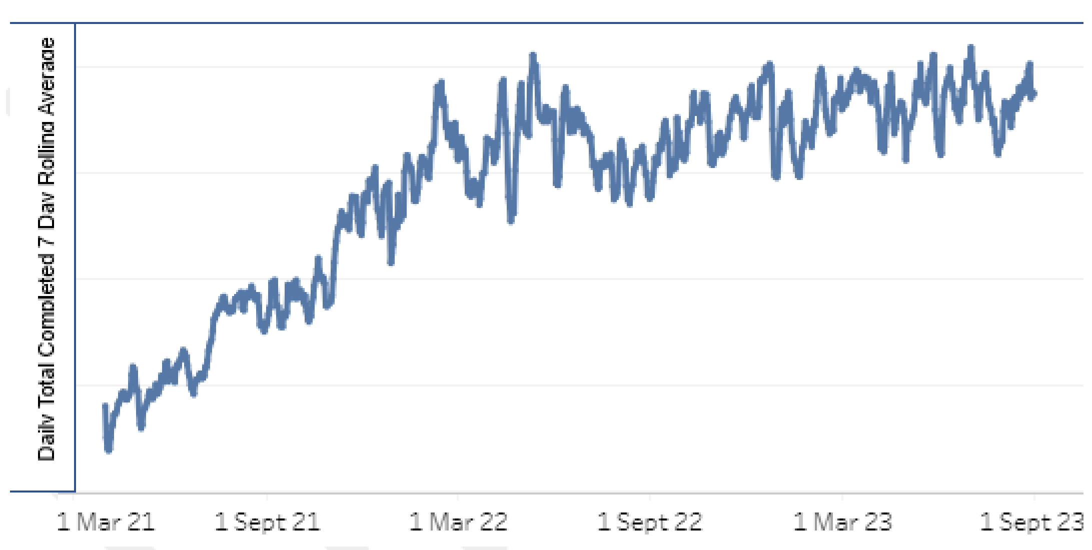
- Different historic commissioning arrangements have created disparity of provision and meant some teams have multiple functions/ focus and others a single focus on frailty and urgent response. For example, Solent provides social care and supports dementia needs in some teams but this is not replicated elsewhere;

---

[43] The dynamics of frailty development and progression in older adults in primary care in England (2006-2017): a retrospective cohort profile - PubMed (nih.gov) Carole Fogg *et al* and The Frailty Dynamics study team

- Requirement of the services is rapidly changing and developing which means a need to be responsive to changing asks which leads to variation and lack of clarity for referrers;
- Non recurrent funding has been used to set up, enhance and support in some areas. Some parts of the service are therefore unsustainable in their current form;
- There is a requirement for recurrent funding to ensure services are sustainable to match population growth; and
- UCR demand is increasing and as a result there is an increasing impact on the integrated team's ability to prioritise planned care to prevent deterioration. Services have been developed to respond to immediate challenges such as acute demand as seen in figure 48, rather than population health modelling based on future demand profiles.

Figure 48: HIOW Urgent Community Response Demand March 2021 - August 2023



Digital challenges

6.34 Technology and information challenges include interoperability of different systems and therefore timely access to information and responsiveness to patient need. Data across key organisations is currently reviewed in silo. This presents challenges in the triangulation of data to identify trends, to effectively inform decisions or to demonstrate impact/benefit;

- Currently staff are trained on multiple different systems. The inability to access patient data and up to date medical records across different services and areas slows referral times, takes up clinical time and can cause stress/ duplication for patient and family when having to organise the transfer of patient information. This also has a particular

impact for patients on boundaries of the geographical patches but within the HIOW footprint;

- Various digital technologies have been trialled to support patients in their own home. As yet, no one technology has provided the solution required by the service and multiple solutions are being used across HIOW;
- From an operational perspective there is limited baseline data and limited ability to be able to track historic data as services have evolved over time; and
- Recording of frailty is not routine within community services and therefore there is no clarity on the number of patients with frailty unless they are in a frailty specific service.

Future frailty and urgent response model

6.35 The Trusts' aim is to implement personalised care for people across HIOW in line with the commitment set out in the NHS Long Term Plan. Working with partners, the Trusts will support people to build their knowledge, skills and confidence in managing their health condition and help them to live as independently as they wish, with timely care provided as close to home as possible.

Vision

6.36 The workstream has articulated a clear vision for frailty across the ICS with the aim of creating a unified and patient-centred model for use across HIOW, given the complexity of the current provision across the ICS. The workstream is seeking to identify and work to eliminate unwarranted variation in outcomes aligned to a strategic vision for the next five years.

Proposed model

6.37 Figure 49 on the next page summarises the proposed frailty and urgent response patient pathway for the new Trust. This model is currently being refined and work is ongoing with the ICB to fully develop the model.

6.38 The figure illustrates a model of care which allows initial assessment of patients at a place level, to ensure that patients are only admitted to hospital when their clinical condition requires it and urgent assessments are informed by local knowledge of patients held within local teams. Often the decision to admit is a function of the understanding of each patient and their background, rather than just their clinical condition.

6.39 The virtual ward component allows for appropriate oversight of patients experiencing a crisis at home, with medical support, meaning that clinical progress can be monitored and treatment decisions reviewed regularly. Such a system reduces the pressure on initial assessments and enable patients to be safely supported at home.

6.40 Secondary care is a key component for access to rapid diagnostics and specialist assessment, when there is diagnostic uncertainty and urgent specialist assessment is

required. Same day emergency care service (SDEC) is important for enabling such assessment, with rapid discharge and home support when appropriate.

Figure 49: Proposed frailty and urgent response patient pathway

Recognition | Diagnostics | Treatment | Discharge

Initial presentation

Patients' initial presentation via traditional entry point and subsequent referral to the clinical communicationscentre for decision on appropriate pathway

111/999

Primary Care

Community Services

Care Homes (supported by RESTORE 2)

Outpatients

Emergency Department

Urgent Community Response

Applying clinical judgement

Integrated care assessment initiated

HIOW SPOC:
Who: Integrated virtual MDT
What: Clinical assessment of patients symptoms
Outcome: Patient referred into Virtual Ward Pathway, managed by community services, discharged back to GP care or sent in to hospital

Admitted

Ambulatory care

Discharged home

Non-admitted

Community SDEC

Non-admitted

Discharged back to Primary Care

Virtual Ward

Clinician

Patient admitted to Virtual Ward, onboarded onto remote monitoring if appropriate/required

Clinician reviews diagnostic results and can speak to the patient as with any inpatient

Clinician decides the next step for the patient based on results

Patient is visited at home by virtual ward pathway admitting service completes initial diagnostics (e.g. examination/bloods/ultrasound) and provides remote monitoring equipment

Patients condition worsens and flags

Patient visited by clinician for face-to-face assessment and treatment (e.g. prescribing).

Further deterioration and admitted to hospital

Further deterioration and escalated to the community

Improved recovery and continued virtual monitoring with analysis to alert Primary Care

Full recovery and virtually discharged back to home of residency without needing to go physically to hospital

Virtual Health

Virtual Care

Care Home telemedicine support

Specialist Clinical Input

Geriatrician

Community team

Specialist Teams

Daily MDTs

Key aims for the service in the new Trust

6.41 The true power of frailty and urgent response resides in how well it supports primary care to manage patients at home. It is not primarily an admission avoidance effort, but how GPs are able to manage greater complexity and severity at home.

6.42 These services are operated by an expert workforce

6.43 There will be placed based variation in delivery based on patient need and alignment with related community and integrated services (e.g. community nursing, therapies, social care reablement offers).

6.44 Frailty and urgent response appropriately supports patients from emergency departments and SDECS to prevent admission. This work complements the existing work established over several years to improve and support flow of patients out of acute wards.

6.45 The long-term impact of frailty and urgent response will be the way it feeds back into proactive and advanced care planning for patients between primary care and community teams. This creates a virtuous circle between crisis management and long-term care planning in the community. Done well over time, it reduces the number and range of problems that are referred to secondary care, within a system that becomes better at learning from crises, sharing that learning about individual patients and planning future care with patients and their families actively. As a result, the frailty offer becomes less medicalised and mores focused on meeting patient's needs as people reach the end of their natural lives, framing medical decisions accordingly.

6.46 Advanced care planning is an iterative process and systems are required that allow shared knowledge about patients to be captured and inform future care.

6.47 SDECs are a key component in supporting community services to jointly decide on the most appropriate place for the best treatment to be delivered.

6.48 SDECs complement the high intensity virtual wards, allowing for rapid assessment, access to urgent imaging, improving the speed of diagnostics for patients to be supported at home. Clinical decision making will always sit within the advanced planning for individuals in this cohort and link with primary care

6.49 The frailty high intensity VWs will provide a different and distinct offer to step down remote monitoring of patients from acute hospitals.

6.50 The new Trust will continue explore the use of technologies that allow face-to-face visits to be augmented with digital monitoring of symptoms. This is a rapidly evolving sector and offers the potential for increased numbers of patients to be supported in the future without a significant increase in staffing provision.

Benefits

6.51 Below are the patient benefits expected to be realised through the planned changes.

Change	Outcome
Single HIOW system care model, aligned and streamlined pathways and protocols and consistent utilisation of evidence-based practices	• Equity of access for all patients across the ICS will reduce inequality of access across some geographies. • Timely access to the right clinician leading to improved patient outcomes. • Improved access to services based on population need rather than historical commissioning. • Direct access to same day assessment and diagnostics closer to home. • Direct referral route to UCR and VW services for all partners will ensure timely referrals to the right care, reduce duplication, whilst allowing internal services to make use of local knowledge. • Fewer handoffs, re-referrals and delays will reduce acute length of stay and avoidable admissions and therefore improved continuity of care providing better patient experience and outcomes.
Patient defined outcomes and care based on individual need	• Utilising local community resources including third sector to support patients to stay well at home. • Retention of community connections supporting patients holistically. • Addressing urgent as well as longer-term needs, supporting patients' long term care planning. • Care is less medicalised/interventional which will reduce avoidable admissions and support better management of conditions. • Improved patient/family experience of their care and treatment. • Patient engagement and feedback will shape the transformation of services enabling services to better meet patients' needs.
Improved proactive and advanced care planning	• Improved patient outcomes and experience.

Change	Outcome
The treatment of people closer to home	• Improved patient experience and outcomes (evidenced through improved patient reported outcome measure (PROMs) scores).
Collective management of risk	• Improved patient safety and quality oversight through: ○ Shared governance arrangements ○ Shared learning from incidents. • Increased access to support from senior clinical decision makers.
Integrated frailty workforce	• Integrated workforce planning, recruitment and retention will help identify areas of risk/need and match resources to gaps through reallocation of workforce. • Reduction of competition and movement of staff between Solent and Southern due to banding of posts, different service models and career opportunities will reduce spend on recruitment processes and retain knowledge and expertise. • Reduced agency reliance and therefore improved patient safety and continuity of care. • Integrated trusted assessment will reduce referrals, duplication and increase time to care.
Comprehensive MDT offer	• Increased ability to manage a higher clinical acuity in the community and therefore support care closer to home through: ○ Better connection to the wider health and care team to support patient care. • Greater cross cover by specialists.
Competent, well trained multi-professional teams	• Improved continuity of care/ expertise and experience for patients, and increased recruitment and retention of staff through: ○ Consistent education and training implemented across HIOW ○ Shared learning and best practice. ○ ACP training programme maximised. ○ Improved ability to recruit and retain staff. • Common understanding of the competencies and requirements of different roles across teams.

Change	Outcome
More efficient and effective utilisation of resources	• Improved caseload utilisation ensuring right skills support patient cohort, reduced duplication and creation of streamlined processes increases time to care. • Better alignment of demand and capacity will improve productivity and increase patient-facing workforce. • Fully exploited technology opportunities and ability to support across a larger footprint. This will enhance self-management (allowing more people to remain in their own homes) and increase workforce capacity. • Support to smaller and physically isolated populations such as Isle of Wight.
Integrated digital offer	• Timely access to information improves responsiveness to patient need. • Modern, reliable and fast digital equipment and solutions enables more time to care, improves productivity. • Easier communication and information sharing will support informed decision making and better patient outcomes.
System representation	• Shared single voice within system conversations leading to improved representation of community provision. This will improve ability to respond when system pressures increase.

6.52 Expected benefits indicators are as follows and will be confirmed once the ICB requirements are further developed:

Figure 50: Benefits indicators for Frailty and Urgent Response

Theme/Measure	Indicator	Source	Baseline	Target
Integrated workforce, retention and training of staff providing high quality patient care	Reduction in staff turnover within frailty teams Reduction in the use of agency or bank staff Number of Trusted Assessors in post All staff groups have the same training competency requirements in their terms of employment	Workforce reports	tba	tba
Effective and efficient use of resources allowing for spread of best practice and delivering better outcomes for patients	Number of incidents who had access to a senior clinical decision maker during incident Alignment of MDT performance with consistent skill sets across HOIW Consistent clinical approach to alignment – one model of care Learning from incidents is shared with the wider team			

Implementation plan

6.53 The figure below sets out the key activities to realise the identified frailty patient benefits. The detailed implementation plan is a supporting submission

Figure 51: Summary of frailty implementation plan

Year	Activities
Pre day 1	• Commence baseline assessments and review of best practice models • Commence clinical strategy and operating model • Develop and review service specifications for VW • Undertake patient engagement events • Commence workforce review and identify gaps • Undertake team integration workshops and continue OD programme
Year 1	• Continue patient engagement events and evaluate findings • Develop competencies and training programmes for staff • Explore opportunities to integrate further with social services and extend partnership with other organisations. • Implement frailty service (including training and working with staff and patients to define outcomes) • Agree access to care records and information sharing protocols • Review programme and map priorities for years 2 and 3
Year 2	• Review frailty service
Year 3	• To be agreed

Interdependencies (internal or external) and how these will be managed.

6.54 The frailty work programme has identified the following key internal interdependencies:

- The lived experience Team: responsible for developing methodology for use by frailty;
- The Workforce Steering Group: responsible for ensuring workforce planning, recruitment and selection and training reflect the frailty vision and expansion; and
- Other clinical priority workstreams: the frailty workstream works closely with OPMH, Community Hospital, specialist community services and primary care workstreams.

6.55 The frailty work programme has identified the following key external interdependencies:

- The Integrated Care Board: responsible for commissioning decisions on how the services will be delivered;
- Training providers such as HEE: responsible for the training of a variety of courses and professionals including the frailty framework of core capabilities training and advance practice;
- VCSE partners: providing a range of services and support for patients and their families; and
- ICS digital team: support in developing consistent data and business insights for service lines, pathways, PCNs, places and ICS as a whole.

Key risks and mitigations

6.56 The frailty and urgent response workstream has identified the following risks with a risk score of 10 or more:

Figure 52: Risk Assessment for Frailty

Risk Description	Impact (Score)	Prob	Total Risk Score	Planned Mitigation Actions
Reduction in Funding from ICB for 2023-2024	Major (4)	Likely (4)	Very High (16)	
Reduction in Funding from ICB for 2024-2025	Major (4)	Likely (4)	Very High (16)	
Non recurrent Funding - 6.33 Funding and Commissioning arrangements are not aligned and have often been based on short term plans and non-recurrent funding. In addition, historical commissioning has meant that generic community services have been adapted in an unplanned way to incorporate new initiatives over time. Additionally, Non recurrent funding has been used to set up/ enhance and support in some areas. Some parts of the service are therefore unsustainable in their current form	Major (4)	Likely (4)	Very High (16)	September 30, Letters have been issued to Commissioners to only undertaken commissioned work.

Appendices

Appendix 1: Clinical timelines……………………………………………………….…………152

Appendix 2: Lived Experience patient feedback…………………………………..………...153

Appendix 3: Summary data for CAMHS provision……………………………………………..155

Appendix 4: Detailed Service Provision across HIOW…………………………….…………..159

Appendix 5: Dementia diagnostic rates…………………………………………...……….166

Appendix 6: HIOW ICB MHLDA Finance Information (August 2023) ……………..………167

Appendix 7: Frailty activity data sets……………………………………………………………168

Appendix 1: Clinical timelines

2023 | 2024 | 2025 | 2026 | 2027

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

OPMH

Tier 3 & 4	Develop
	Deliver
MAS Tier 2	Develop
	Pilot
	Deliver

CAMHS

- Leigh house transformation
- Day service development
- Virtual wards development
- In reach delivery

Frailty

Best Practice model	Develop
	Pilot
	Deliver
	Evaluate
Frailty Operating Model	Develop
	Deliver
	Evaluate
Virtual Wards	Develop
	Pilot
	Deliver
	Evaluate

Appendix 2: Lived experience patient feedback

This appendix contains two elements - a collection of feedback comments received from people who have been on different recovery courses and a summary of some lived experience conversations which have led to a change in practice.

Patient feedback examples

Source of feedback	Feedback received
Crisis Planning Course	I just wanted to say a big thank you to both Vicky and Natalia for running this course today. I have been struggling but this course has really helped open my eyes and made me think of the things out there to help support me whilst reminding me of the steps and goals I can take.
WRAP seminar 2 (4 day accredited facilitator course)	Facilitators made me feel safe and able to achieve what I did this week. I learned a lot and would highly recommend it to people. Opportunity to practice in a safe space. Everyone is on their own individual journey, to try and harvest that from the group you are facilitating.
Delivering Your Recovery Story course.	Let me just say that this is the most powerful course I have ever done in respect of my mental health. Due to this course, I am moving on. For the last 28 years I have been living in my illness. Now having written my story I no longer have to do that, I have let those years go. I feel well. This course will help me to live without the CMHT. I can now see life without the CMHT.
Delivering Your Recovery Story course.	Rosie and Steve are fantastic facilitators. They are passionate about recovery. This was a very emotional course for all involved and that aspect was really well managed by Rosie and Steve. It was really good that they themselves were seen to be emotionally involved. The honesty in the room was astounding, and critical to the development of the recovery stories.

ECT	Talking to the PSW before I began my ECT treatment really helped me…I don't know if I would've done it without her.

A selection of outcomes from lived experience projects

Carers' experiences of hospital discharge

The findings were grouped into key themes and recommendations were coproduced. The three carers are now leading a steering group including senior members of staff at Southern to monitor delivery of actions against the recommendations.

OPMH users' experiences and priorities for older people's mental health

This focused on two groups that had not heard from in previous engagement exercises - carers from minority ethnic communities and residents in care homes.

180 people gifted the team with insights into areas that they felt should be addressed in the delivery of OPMH services and these shaped the recommendations for future priorities.

Transformation of IOW mental health services

Over the last three years a significant amount of transformation work has taken place in Mental Health services on the Isle of Wight. Integral to this has been experience from people with lived experience of services, who have been included in working groups from the outset. This has contributed to more responsive services, improvements in CQC ratings, and improved culture and attitudes amongst staff.

Appendix 3: Summary data for CAMHS provision

The figures below detail the current community and inpatient CAMHS activity.

Figure 53: Summary of community CAMHS provision at the Trusts in 2022/23

	Southern	Solent	IoW	Sussex Part'ship
Referrals				
Total referrals accepted	N/A	4,352	508	5,870
Number of referrals signposted	N/A	1,667	66	4,498
Number of referrals declined	N/A	N/A*	199	1,304
Total referrals received	N/A	6,019	773	11,673
% of referrals received that were marked as 'urgent' or 'emergency'	N/A	19.6%	3.2%	18.6%
Caseloads and Waiting List				
Number of patients on caseload as of 31 March 2023	N/A	3,327	378	5,854
Number of patients on the waiting list awaiting 1st appointment on 31st March 2023	N/A	79	75	2,997
Number of patients on the waiting list awaiting 2nd appointment on 31st March 2023	N/A	332	49	2,836
Total number of children and young people seen	N/A	6,114	719	9,414
Contacts				
Total number of contacts	N/A	73,916	6,936	86,301
Of the patients discharged in 2022/23, the average number of contacts they received	N/A	12.16	6	16.80

	Southern	Solent	IoW	Sussex Part'ship
Overall DNA rate %	N/A	6.1%	9%	7.1%
Waiting Times				
Mean waiting time from referral to 1st appointment for routine appointments (weeks)	N/A	3.4	6	23
Median waiting time from referral to 1st appointment for routine appointments (weeks)	N/A	0	4	12
Mean waiting time from referral to 2nd appointment for routine appointments (weeks)	N/A	18.8	13	51
Median waiting time from referral to 2nd appointment for routine appointments (weeks)	N/A	13	8	36
Demographics				
Number of patients on caseload as of 31 March 2023 by ethnicity of patient				
White/White British	N/A	2,291	216	4,381
Black/Black British	N/A	26	0	14
Asian/Asian British	N/A	35	1	37
Mixed	N/A	102	9	151
Other	N/A	33	3	55
Not Stated	N/A	640	142	1,032
Not known	N/A	200	7	184
Total patients	N/A	3,327	378	5,854
Number of patients on caseload as of 31 March 2023 by gender of patient				

	Southern	Solent	IoW	Sussex Part'ship
Male	N/A	1,833	125	3,214
Female	N/A	1,404	252	2,613
Nonbinary/other	N/A	90	1	27
Total patients	N/A	3,327	378	5,854
Additional indicators, not identified within the NHS Benchmarking				
Number of patients on caseload as of 31 March 2023 that are a child in care	N/A	215	27	382
Number of patients on the caseload as of 3 March 2023 that have a learning disability or learning difficulties	N/A	Unable to accurately report	Unable to accurately report	351

Note - * donates a different service model whereby people who have been referred to the service have already had an intervention.

Figure 54: Summary of Inpatient Units in 2022/23 (all provided by Southern, definitions in accordance with NHS Benchmarking)

	Austen House	Bluebird House	Leigh House
Total number of inpatient episodes	12	5	14
Total number of inpatient episodes where patient was detained under Mental Health Act at point of admission	12	5	9
Available bed days	5,110	5,110	3,176
Occupied bed days (including leave)	3,789	2,673	2,830

	Austen House	Bluebird House	Leigh House
Occupied bed days (excluding leave)	3,739	2,618	2,752
Average length of stay (including leave based on discharged patients)	254	138	169
Admissions by ethnicity of patient			
White/White British	9	3	12
Black/Black British		1	
Asian/Asian British			
Mixed			1
Other	3	1	1
Not Stated			
Not known			
Total patients	12	5	14
Number of admissions during 2022/23 by gender of patient			
Male		2	0
Female	12	3	13
Nonbinary/other			1
Total patients	12	5	14

Appendix 4: Detailed Service Provision across HIOW

Figure 55: Detailed OPMH service provision information

Tier	Service	Provider	Operating Hours	Location and Provider					
				South East	South West	Mid and North	Southampton	Solent	IOW
Tier 4 – Acute MH Beds (Dementia)	Acute Dementia Beds	Southern/ Solent/ IOW	24 hours a day, 7 days a week	Poppy ward (14 beds) Gosport War Memorial Hospital		Elmwood Ward (18 beds) Parklands Hospital, Basingstoke	Beaulieu ward (14 beds) Western Hospital, Southampton	Brooker (14 beds) The Limes, St James Hospital, Portsmouth	Afton Ward (2 beds) 4 Dementia section
Tier 3 – Acute OPMH Beds and ECT	Acute OPMH Beds	Southern/ Solent/ IOW	24 hours a day, 7 days a week	Rose Ward (14 beds) Gosport War Memorial Hospital	Snowdrop Ward (14 beds) Melbury Lodge, Winchester	Beechwood Ward (18 beds) Parklands Hospital, Basingstoke	Berrywood ward (14 beds) Western Hospital, Southampton	Brooker (8 beds) The Limes, St James Hospital, Portsmouth	Afton Ward (4 frailty beds)
	ECT	Southern				Parklands Hospital, Basingstoke	Antelope House, Southampton	Southern Provision	Seven acres, St Marys, IOW.

Tier	Service	Provider	Operating Hours	Location and Provider					
				South East	South West	Mid and North	Southampton	Solent	IOW
Tier 3 – OPMH Community Crisis (Dementia and/or functional). Liaison Psychiatry and NHS MH111	OPMH Community Crisis (Dementia and/or Functional)	Southern/ Solent/ IOW	Mon – Friday 9am until 5pm	Intensive Support Team – Aerodrome House (Gosport) and Havant Health Centre – 7 days a week, 9am until 5pm	Provided by CMHT during core hours	Provided by CMHT during core hours	Provided by CMHT during core hours	Intensive Case Management (ICM) Team. During core hours	Dementia Outreach 7 days a week 8am–6pm (Dementia Only)
	Crisis Resolution and Home Treatment Team (Functional Patients Only)	Southern AMH teams		CRHTT across all areas. Support given to OPMH functional patients outside of core hours. No Dementia Crisis provision outside of core hours.				CHRT outside of core hours limited No Dementia Crisis provision out of hours.	Home Treatment Team – 7 days a week 9am–10pm (Functional Only)

Tier	Service	Provider	Operating Hours	Location and Provider					
				South East	South West	Mid and North	Southampton	Solent	IOW
	Crisis houses (all age adults)	Southern/VCSE		The Adults' Safe Haven (Havant): Safe Haven, The Hub, Leigh Park, Dunsbury Way, Havant, PO9 5EW 6pm – 10pm, 365 days a year	The lookout (Winchester). Kennel Lane, Littleton (SO22 6PT). 24 hours a day, 7 days a week Wells Place Eastleigh. virtual model aim May 23 and physical opening late summer 23	Safe Haven (Basingstoke). Andover Mind Wellbeing Centre, 3 Vyne Road, Basingstoke, RG21 5NL. 6pm – 10pm, 365 days a year	The Lighthouse: 147 Shirley Road, Options wellbeing, The Annexe, Southampton, SO15 3FH 4:40pm – 12:00am seven days a week Bittern Southampton – due to open very soon – had some IT parts waiting for	none	none

Tier	Service	Provider	Operating Hours	Location and Provider					
				South East	South West	Mid and North	Southampton	Solent	IOW
	Approved Mental Health Professionals (AMHP)	Hampshire County Council, Southampton City Council, Portsmouth City Council, IOW Council		Hampshire County Council			Southampton City Council via CRHT	Portsmouth City Council via CRHT	Via Isle of Wight Council. 24 hours a day, 7 days a week
	Liaison Psychiatry	Southern	24 hours a day, 7 days a week	PHU	HHFT		UHS	QA Hospital provided by Southern	IOW St Mary's – MHLD Integrated Liaison. 24 hours a day, 7 days a week
	NHS MH111	Southern	24 hours a day, 7 days a week						10pm – 7am crisis calls

Tier 2 – Core community inc. in–reach. MAS	Core Community (CMHT)	Southern		Fareham and Gosport: Aerodrome House, Aerodrome Road, Gosport PO13 0GY Havant and Waterlooville: Havant Community Hospital, Civic Centre Road, Havant PO9 2AY Petersfield and Borden: Petersfield Community Hospital, Swan Street, Petersfield GU32 3LB	Eastleigh and Romsey: Newtown House, 2A, 2B, 2 Newtown Road, Eastleigh SO50 9DB New Forest East: Rushington Business Park, Chapel Lane, Totton, Southampton SO40 9LA New Forest West: The Fairway, Barton on Sea, New Milton BH25 7AE	Andover: Andover Community Hospital, Charlton Road, Andover SP10 3LB Winchester: Avalon House, Chesil Street, Winchester SO23 0HU Basingstoke: New Town House, 27 New Road, Basingstoke RG21 7PJ	Southampton West: Western Hospital, William Macleod Way, Southampton, SO16 4XE Southampton East: Moorgreen Hospital, Botley Road, Southampton SO30 3JB	Block E, St Marys Hospital, Milton, Portsmouth	CHMS – Chantry House, Newport Functional only

Tier	Service	Provider	Operating Hours	Location and Provider					
				South East	South West	Mid and North	Southampton	Solent	IOW
	Care home in–reach	Southern		As above	As above	As above	As above	Provided by Solent Adults, Portsmouth Division	Dementia Outreach 7 days a week 8–6pm
	Memory Assessment Services	Southern		As above	As above	As above	As above	Block E, St Marys Hospital, Milton, Portsmouth	Memory Service, South Block, St Marys Hospital, Milton, Portsmouth Monday – Friday, 9am – 5pm
Tier 1 – Primary Care/NHS Talking Therapies	NHS Talking Therapies	Southern		iTalk			Steps to Wellbeing	Talking Change (Portsmouth)	Talking Therapies, The Gables, Newport

Tier	Service	Provider	Operating Hours	Location and Provider					
				South East	South West	Mid and North	Southampton	Solent	IOW
VCSE	Dementia Post–Diagnostic Support	Andover Mind and Alzheimer's Society		Andover Mind: Remote Support and home visits.			Alzheimer's Society: Remote Support and home visits.	Remind	Memory Service, South Block, St Marys Hospital, Milton, Portsmouth Monday – Friday, 9am – 5pm

Appendix 5: Dementia diagnostic rates

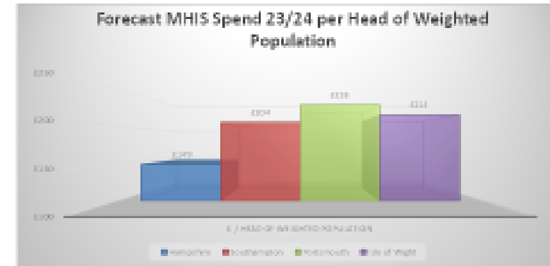
Figure 56: Dementia diagnostic rates by GP practice

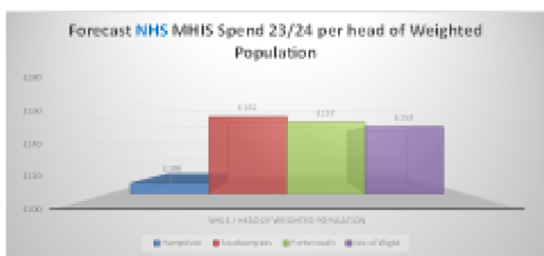
Practice	code	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Jul-23		Achieving 66.7% of estimated		Compare to previous months	
														Dementia register 65+	Estimated Prevalance	No of patients (66.7%)	No of additional dementia patients to be diagnosed	3 months	6 months
A31 GROUP PCN	U72748	71.80	72.04	73.47	72.99	72.87	71.81	70.95	71.72	71.38	72.99	74.58	74.32	407	548	366		2.94	2.51
ANDOVER PCN	U15164	55.92	55.77	47.23	47.99	47.12	46.94	47.48	47.72	56.04	56.11	55.98	56.17	421	750	500	79	0.13	9.23
AVON VALLEY PCN	U84277	63.75	64.09	63.62	64.24	63.56	61.59	62.26	63.51	63.79	63.41	64.63	64.51	556	862	575	19	0.72	2.91
B-CONNECTED CARE PCN	U64232	60.98	61.70	61.14	61.18	61.27	60.33	62.01	62.39	63.60	62.47	61.31	61.96	99	160	107	8	-1.64	1.63
CAMROSE, GILLIES & HACKWOOD PARTNERSHIP PCN	U98116	66.14	65.21	68.43	67.46	67.23	67.54	66.43	66.96	66.36	66.38	68.15	67.72	341	504	336		1.36	0.19
CENTRAL & WEST (IW) PCN	U24247	55.40	55.72	55.02	55.65	54.75	54.48	53.75	53.20	52.88	51.91	51.74	52.86	481	910	607	126	-0.02	-1.62
CHANDLER'S FORD PCN	U88279	54.87	54.92	54.96	56.51	56.00	54.62	54.45	54.60	54.67	53.86	54.38	53.07	276	520	347	71	-1.60	-1.55
COASTAL (WEST HAMPSHIRE) PCN	U56140	72.22	72.74	72.19	73.98	73.20	71.65	71.34	72.12	73.33	74.15	74.93	74.90	670	895	597		1.57	3.25
COASTAL FAREHAM & GOSPORT PCN	U21972	59.76	59.58	59.53	58.79	55.09	55.47	54.45	54.48	55.42	54.82	55.41	55.69	436	783	522	86	0.27	0.22
EAST HANTS PCN	U87221	67.76	66.81	66.52	65.88	65.44	63.45	62.20	61.41	60.20	58.99	59.01	58.16	718	1,234	823	105	-2.04	-5.29
EASTLEIGH HEALTH PCN	U40164	41.58	40.48	41.20	42.69	42.52	43.17	43.72	41.33	42.30	41.81	41.87	42.84	142	331	221	79	0.54	-0.33
EASTLEIGH SOUTHERN PARISHES PCN	U63233	63.23	62.61	63.66	63.59	63.14	61.89	64.39	64.39	64.47	64.63	66.32	66.54	316	475	317	1	2.08	4.65
FAREHAM & PORTCHESTER PCN	U30563	60.16	60.13	59.76	60.52	60.25	59.16	59.50	61.00	61.28	62.94	62.76	62.63	515	822	549	34	1.35	3.48
GOSPORT CENTRAL PCN	U20871	77.44	78.28	79.96	78.73	77.72	77.85	77.30	77.17	74.30	75.79	75.31	75.32	537	713	476		1.02	-2.53
GOSPORT WEST PCN	U16896	58.06	58.68	60.00	61.07	61.03	60.70	60.74	59.68	86.03	55.51	55.40	55.91	287	513	343	56	-30.12	-4.79
HAVANT AND WATERLOOVILLE PCN	U46389	60.32	60.64	61.35	61.92	61.30	60.52	60.45	59.84	63.77	58.13	58.07	57.64	568	985	657	89	-6.13	-2.88
HAYLING ISLAND & EMSWORTH PCN	U90861	69.02	68.10	69.26	69.26	68.33	66.96	67.73	66.68	66.27	66.30	66.94	67.83	545	804	536		1.56	0.86
MOSAIC HEALTHCARE PCN	U26844	55.15	55.54	56.57	56.61	56.45	56.51	54.39	53.23	54.62	55.36	55.84	54.63	251	459	307	56	0.01	-1.88
NEW FOREST PCN	U26059	55.72	55.59	56.90	59.07	57.64	56.96	57.75	58.73	57.39	56.77	57.41	58.19	545	937	625	80	0.81	1.24
NORTH & EAST (IW) PCN	U75079	56.20	56.39	55.99	55.56	54.88	52.56	51.70	53.39	53.03	52.75	52.80	52.86	516	976	651	135	-0.17	0.30
ROMSEY & NORTH BADDESLEY PCN	U17081	51.25	51.05	51.58	52.45	52.20	52.11	52.91	52.40	52.03	51.59	51.88	52.67	419	796	531	112	0.63	0.56
RURAL WEST PCN	U10995	44.69	45.28	44.92	45.74	44.89	42.98	43.31	42.99	43.10	42.98	42.39	43.31	250	577	385	135	0.21	0.32
SOUTH (IW) PCN	U01198	53.44	53.08	53.35	53.09	52.08	51.14	50.77	50.88	49.57	50.03	49.45	49.47	430	869	580	150	-0.10	-1.67
SOUTHAMPTON BITTERNE PCN	U97340	51.85	50.43	50.64	49.99	49.93	48.51	48.13	48.69	48.75	48.29	49.08	51.11	203	397	265	62	2.36	2.60
SOUTHAMPTON CENTRAL PCN	U18986	69.81	69.22	69.55	69.20	67.77	67.85	67.48	71.35	70.80	71.85	70.89	70.57	251	356	238		-0.23	2.71
SOUTHAMPTON LIVING WELL PARTNERSHIP PCN	U08561	61.50	62.63	64.34	92.16	90.64	58.45	59.23	63.89	64.28	63.20	63.72	65.43	335	512	342	7	1.15	6.98
SOUTHAMPTON NORTH PCN	U91385	54.13	52.25	53.61	52.24	50.75	50.39	49.95	51.29	51.04	52.31	48.96	49.62	97	195	131	34	-1.42	-0.77
SOUTHAMPTON WEST PCN	U47004	68.38	68.91	71.34	71.18	70.24	70.03	70.03	71.83	71.36	71.23	71.03	71.06	629	885	591		-0.30	1.03
SOUTHAMPTON WOOLSTON & TOWNHILL PCN	U53997	58.32	60.58	60.39	62.08	61.01	58.99	59.70	62.60	61.04	61.31	60.78	62.87	260	414	276	16	1.83	3.88
SOVEREIGN PCN	U92600	69.00	69.24	70.78	70.21	69.21	68.77	68.16	65.04	65.89	66.77	68.12	69.37	342	493	329		3.48	0.60
STRAWBERRY HEALTH PCN	U22092	81.67	83.58	85.27	86.29	87.75	87.45	87.70	89.51	89.83	89.67	90.75	91.45	549	600	401		1.61	4.00
TOTTON PCN	U29246	50.55	50.48	51.96	52.72	52.37	54.19	53.89	56.49	57.05	55.84	55.15	56.02	319	569	380	61	-1.03	1.83
WATERSIDE PCN	U86774	52.68	52.70	53.72	53.95	52.20	51.57	52.02	53.88	53.10	53.61	53.76	53.54	394	736	491	97	0.44	1.97
WHITEWATER LODDON PCN	U34184	82.00	82.35	82.56	82.80	80.33	80.20	81.51	83.76	84.45	85.55	84.62	85.91	393	457	305		1.46	5.72
WINCHESTER CITY PCN	U95672	59.34	59.41	58.39	57.70	58.27	57.15	58.03	58.33	59.93	59.53	60.41	60.24	492	817	545	53	0.31	3.09
WINCHESTER RURAL NORTH & EAST PCN	U46154	42.06	41.82	41.62	41.46	40.65	41.44	41.70	42.85	43.53	44.02	44.55	45.41	342	753	503	161	1.88	3.97
WINCHESTER RURAL SOUTH PCN	U11181	53.84	53.21	42.96	44.12	44.31	43.59	43.05	44.47	56.13	56.56	58.33	58.85	508	863	576	68	2.72	15.26
SHAKESPEARE ROAD MEDICAL PRACTICE	Unallocated	100.06	99.82	-	-	-	-		-	102.89	105.13	108.00	#######	116	109	73		3.10	105.99

Appendix 6: HIOW ICB MHLDA Finance Information (August 2023)

The mental health, learning disability and autism data set shows that there is an £79/head less spend per person on all age Mental Health in Hampshire Place compared to Portsmouth Place. The oldest populations and those most likely to need OPMH services are in the Isle of Wight and Hampshire places, where there is the oldest populations and greatest proportion aged over 65.

MHIS Spend per head of weighted population



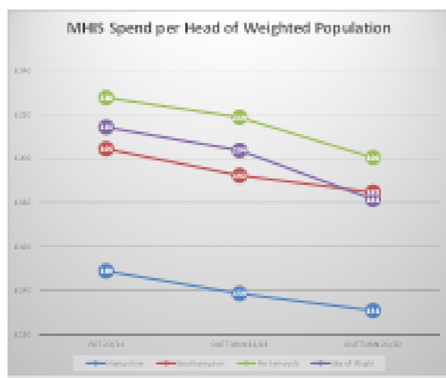


The MHIS spend per head of weighted population for 23/24 varies from £149 in Hampshire to £228 in Portsmouth, which is a range of £79.

Specifically, the NHS MHIS spend per head of weighted population for 23/24 varies from £108 in Hampshire to £161 in Southampton, which is a range of £53.

The average growth in MHIS spend per head of weighted population over the period 21/22 to 23/24 is 14%, with the highest growth in the Isle of Wight (18%) and the lowest growth in Southampton (11%).

It is important to note that whilst there is significant variance in spend per head across places this gives not consideration to the level of outcomes achieved

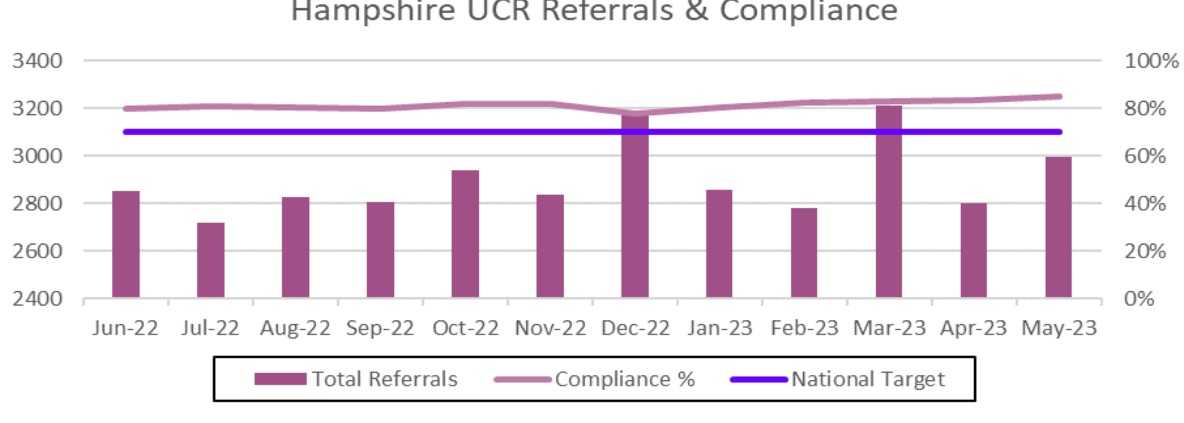


Appendix 7: Frailty activity data sets

HIOW UCR Referrals and Compliance against targets

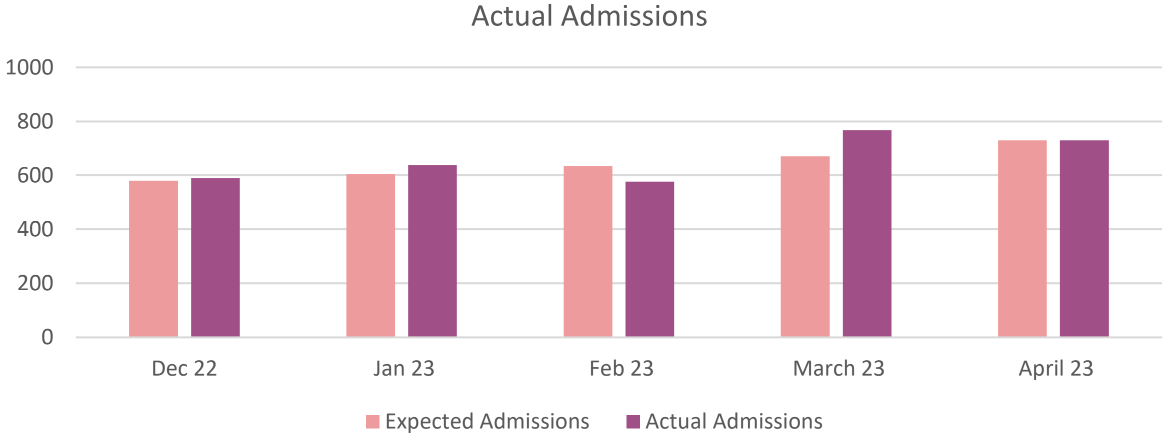
Under the NHS operational planning guidance for 2022/23, UCR providers needed to reach at least 70% of patients referred to them within two hours by December 2022. The figure below shows compliance with this target.

Figure 57: Hampshire UCR Referral and Compliance



Virtual Wards

Figure 58: HIOW High Intensity Community Virtual Ward Expected Admissions vs Actual Admissions



HIOW Virtual Ward Admissions Data 2022-2023

Figure 59: HIOW Virtual Ward data

South East Hampshire		Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
	Number of VW Beds	12	17	20	25	30	35
	Expected Admissions	50	75	90	110	135	155
	Total Admissions	85	135	127	119	202	187
	Average LOS	3.3	2.8	3.7	3.4	2.5	2.5
	Average Utilisation %	77%	76%	73%	57%	54%	45%
Portsmouth		**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
	Number of VW Beds	11	12	13	14	15	15
	Expected Admissions	45	50	55	60	65	65
	Total Admissions	42	57	70	56	73	77
	Average LOS	5.3	5.1	4.8	6.1	6.7	3.8
	Average Utilisation %	70%	81%	112%	96%	103%	82%
	UCR Referrals to VW Admission			22%	22%	22%	21%
Southampton		**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
	Number of VW Beds	12	12	12	12	12	12
	Expected Admissions	50	50	50	50	50	50
	Total Admissions	61	98	81	95	134	100
	Average LOS	3.1	2.8	3.1	2.7	2.5	2.2
	Average Utilisation %	75%	106%	107%	117%	127%	117%

	UCR Referrals to VW Admission			30%	26%	42%	26%
South West		**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
	Number of VW Beds		48	48	48	48	57
	Expected Admissions		215	215	215	215	255
	Total Admissions		123	190	175	195	163
	Average LOS		7.7	7.1	6.3	6.3	7.4
	Average Utilisation %		61%	74%	67%	61%	67%
North and Mid		**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
	Number of VW Beds	20	20	20	20	20	20
	Expected Admissions	90	90	90	90	90	90
	Total Admissions	121	123	128	82	118	145
	Average LOS	4.6	4.3	4	4.8	3.6	5.1
	Average Utilisation %	37%	41%	53.%	47%	48%	53%
IoW		**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
	Number of VW Beds	22	23	24	25	26	26
	Expected Admissions	95	100	105	110	115	115
	Total Admissions	33	54	43	50	45	58
	Average LOS	10.3	10.4	9.7	8.8	6.6	8.8
	Average Utilisation %	54%	83%	59%	59%	41%	69%

Supporting submissions

Lived experience

- HIOW Recovery College and Education Mapping Report May 2023 v2
- Solent Recovery College report – Big Numbers and Pretty Pictures
- Detailed implementation plan

CAMHS

- Detailed implementation plan

OPMH

- OPMH feedback report following patient consultation in May 2023
- Detailed implementation plan

Frailty and urgent response

- Detailed implementation plan

Post Transaction Integration Plan 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

9 November 2023

Contents

1. Executive summary 5
2. Introduction 8
3. New Trust strategy 14
4. Benefits 20
5. Integration approach 27
6. Integration governance 32
7. Integration overview 46
8. Operating model 144
9. Benefits realisation 158
10. Stakeholder engagement 162
11. Appendices 167

PROJECT FUSION

Glossary

ABBREVIATION	MEANING
AC	Appointments Committee
AHP	Allied Health Professional(s)
BAF	Board Assurance Framework
BAU	Business As Usual
BI	Business Intelligence
BSID	Business Support, Intelligence and Development
CAMHS	Child and Adolescent Mental Health Services
CD	Controlled Drug(s)
CEO	Chief Executive Officer
CF	Carnall Farrar
CMHLD	Community, Mental Health and Learning Disability
CMHT	Community Mental Health Team
COG	Council of Governors
CQC	The Care Quality Commission
CQUIN	Commissioning for Quality and Innovation, a framework that supports improvements in the quality of services and the creation of new, improved patterns of care
CSU	Commissioning Support Unit, provides administrative and analytic support to NHS organisations
CTG	Clinical Transformation Group
Day 1	01 April 2024
DIPC	Director of Infection Prevention and Control
DPIA	Data Protection Impact Assessment
DPO	Data Protection Officer
EDIB	Equality, Diversity, Inclusion and Belonging
EIA	Equality impact assessment
EPR	Electronic Patient Record
ESR	Electronic Staff Records
FAQ	Frequently Asked Question
FBC	Full Business Case
FTE	Full Time Equivalent, a measure of workforce numbers
FTSU	Freedom to Speak Up
HIOW	The geographic area covered by the Hampshire and Isle of Wight ICS, covering Hampshire (excluding north-east Hampshire, which forms part of the Frimley ICS), Southampton, the Isle of Wight and Portsmouth
HMRC	His Majesty's Revenue and Customs
ICB	Integrated Care Board; the statutory organisation of the ICS
ICS	The HIOW Integrated Care System
IEN	Internationally Educated Nurse(s)
IOW	Isle of Wight NHS Trust
IPG	Integration Planning Group
KPI	Key performance indicator

ABBREVIATION	MEANING
LDS	Learning Disability Service
LMS	Learning Management System
LNC	Local Negotiating Committee
MAS	Memory Assessment Service
NED	Non Executive Director
OD	Organisational Development
OHWB	Occupational Health and Wellbeing
OMAG	Operating Model Advisory Group
OOH	Out of Hours
OPMH	Older Peoples' Mental Health
PALS	Patient Advice and Liaison Service
PBC	Patient Benefits Case
PMO	Project Management Office
PTIP	Post Transaction Integration Plan, this document
ROAG	Responsible Officer Advisory Group
SBS	NHS Shared Business Services: provides back office services such as accounting, procurement, payroll and managed IT to NHS organisations
SFI	Standing Financial Instruction
SIRO	Senior Information Risk Officer
SMART	Specific, Measurable, Achievable, Realistic, Time Bound
Solent	Solent NHS Trust
SOP	Standard Operating Procedure
Southern	Southern Health NHS Foundation Trust
SC	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
Sussex Partnership	Sussex Partnership NHS Foundation Trust
The Trusts	Collectively Southern Health NHS Foundation Trust, Solent NHS Trust and Isle of Wight NHS Trust
TUPE	Transfer of Undertakings (Protection of Employment) regulations 2006 and its amendment in 2014
UKVI	UK Visas and Immigration Authority, an agency of the Home Office
VAT	Value Added Tax
VCSE	Voluntary, community and social enterprise
WRES	Workforce Race Equality Standard

1. Executive summary

1.1. Southern Health NHS Foundation Trust (Southern), Solent NHS Trust (Solent) and the Isle of Wight NHS Trust (IOW) (collectively, the Trusts) have developed a Full Business Case (FBC) for the creation of a new, community, mental health and learning disabilities Trust across the Hampshire and Isle of Wight (HIOW) Integrated Care System (ICS).

1.2. The new Trust will be created through the acquisition of Solent by Southern as a statutory transaction under section 56 of the NHS Act 2006 and the transfer of services from IOW as a statutory transfer under section 69A of the NHS Act 2006 on Day 1. Sussex CAMHS services will transfer from Sussex Partnership NHS Foundation Trust (Sussex Partnership) on 1 February 2024. Although technically the new Trust will be created through a merger by acquisition and a transfer of services into an existing Trust, it is the intention of the Trusts that this feels like a 'new' organisation (and hence it is described as such throughout this document). The name of the new Trust will be Hampshire and Isle of Wight Healthcare NHS Foundation Trust.

1.3. This Post Transaction Integration Plan (PTIP) sets out the Trusts' plans that will ensure the safe and legal creation of a new Trust on 1 April 2024 (Day 1) and deliver the integration of clinical and corporate services. The PTIP is supported by detailed integration plans, which are live documents and will continue to be developed and iterated up to and beyond Day 1.

1.4. All Solent staff and relevant individuals from IOW identified through the segmentation process will transfer from the employment of Solent and IOW respectively to Southern on existing terms and conditions under the Transfer of Undertakings (Protection of Employment) (TUPE) regulations 2006 and its amendment in 2014 (TUPE).

Integration planning approach

1.5. The Trusts have developed a set of integration principles to maximise the benefits of integration without jeopardising 'business as usual' activities. The focus for Day 1 will be for the new Trust to be safe and legal - this is expected to involve minimal (if any) change to the way clinical services are delivered on Day 1.

1.6. The Trusts have used a workstream approach (with each workstream led by a Steering Group) to develop this PTIP. The programme is led by an independent Programme Director, with in-house resources utilised as far as possible to develop the detailed integration plans in order to maintain ownership, retain knowledge and keep costs down.

1.7. The integration plans will be delivered in four phases:

- Activities required on or before Day 1;
- Activities required by Day 100;
- Activities required within Year 1; and
- Activities required in Years 2 and 3.

1.8. For Day 1, the priority is to ensure that any patient safety risks arising from the integration are mitigated appropriately, that the new Trust can operate legally and for there to be no adverse impact on delivery of clinical and corporate services. Work

will have commenced to develop clinical transformation plans on a phased basis, and to establish integrated clinical and corporate services.

1.9. The focus for the first 100 days will be to deliver the initial benefits from creation of the new Trust and to maintain momentum in the immediate post-Day 1 period. Integration of the four clinical priorities and the implementation of integrated team structures for the majority of corporate services will commence during this phase.

1.10. During year 1 the focus will be on delivering the benefits that do not require complex and/or transformational change, which are expected to be delivered during years 2 and 3.

Day 1 preparedness

1.11. Designate members of the new Trust's Board will take up their posts on Day 1. A proposed Board committee structure has been developed and will be refined, including determining membership, to allow Terms of Reference to be in place on Day 1.

1.12. The new Trust will have quality and operational governance, systems and processes, organisational structures, roles and responsibilities established on Day 1. An organisational development (OD) programme will be in place to ensure the desired culture emerges in the new Trust.

1.13. There will be some integration of digital systems by Day 1, with the emphasis placed on implementing interim arrangements that provide a single look and feel to priority systems, such as Microsoft infrastructure, and ensuring that the new Trust's staff will be able to access the correct Electronic Patient Records system (EPR) from any of the new Trust's digital devices.

Integration governance

1.14. The Trusts have established programme governance arrangements to oversee the development of robust integration plans that will enable the creation of the new Trust and are aligned with the programme's integration principles. This includes the establishment of a Programme Board to direct the work of the programme, a Programme Team to lead on operationalise the agreed operating model and an Integration Planning Group (IPG) to provide oversee the work of the Steering Groups in developing and implementing the integration plans.

Stakeholder engagement

1.15. A comprehensive communications and engagement plan has been developed to inform and support communications and engagement for the creation of the new Trust.

1.16. The Trusts engaged with patients, communities, staff and partners on key matters relating to the development of the new Trust through a "Shape Our New Trust" engagement programme. This has been supplemented by local engagement activities led by the programme's Steering Groups. In addition, a community engagement working group has been set up to ensure the voice of local communities continue to be represented.

1.17. A programme of enhanced communications and engagement in the first year is being developed to build a sense of team for the new Trust and ensure that the new Trust's staff are informed about ongoing developments in the new Trust. The new Trust's leaders will be equipped with communications and OD change support toolkits to support their conversations with staff.

2. Introduction

Purpose of the Post Transaction Integration Plan

2.1. This PTIP summarises Southern, Solent and IoW's plan to establish a new, single community, mental health and learning disabilities provider.

2.2. This PTIP presents the process and detailed plans that will take the Trusts from their current states to the new Trust. It incorporates all necessary activities, including post-transaction delivery of the benefits resulting from the creation of the new Trust. The detailed integration plans for each Steering Group are attached as appendices and signposted in the document.

2.3. As well as providing an understanding of the detailed integration activities, the PTIP describes other key elements of transaction planning including programme governance, programme risks and risk management processes and the stakeholder engagement strategy for the programme.

2.4. The PTIP has been developed through an iterative programme that brings together the strategic objectives set out in the FBC and the detailed planning activities that have been undertaken by the Programme's Steering Groups. The process by which the PTIP has been developed is set out further below.

2.5. This PTIP should be read in conjunction with the FBC which describes the case for change, expected benefits and strategic rationale for the creation of a new Trust.

2.6. For the purposes of this document, the date of completion of the proposed transactions (i.e. Day 1) is assumed to be 1 April 2024. At the time of writing, creation of the new Trust is subject to the following approvals:

- Approval of the FBC at Trust Boards-in-common (13 November 2023);
- NHS England (risk rating expected in late February/early March 2024);
- Approval by Trusts Boards and Southern Councils of Governors (March 2024); and
- Secretary of State approval (for acquisition of Solent by Southern – March 2024).

Structure of the Post Transaction Integration Plan

2.7. The PTIP is split into the chapters shown in the table below:

Figure 1: Structure of the PTIP

Chapter	Contents
3. New Trust strategy	Case for change driving the creation of the new Trust Vision for the new Trust, clinical and key enabling strategies
4. Benefits	Main benefits to patients and populations, staff, the wider health and care system, and financial
5. Integration approach	Approach that has been taken to develop the integration plan
6. Programme governance	Objectives, roles and responsibilities, structure and resources of programme governance
7. Integration overview	Key activities that will deliver the integration plan and the expected benefits from the creation of the new Trust
8. Operating model	Governance, systems and processes, organisation structures and roles and our capabilities, culture and behaviours
9. Benefits realisation	Key benefits from the creation of the new Trust, and the process for benefits realisation
10. Stakeholder engagement	Key programme stakeholders, issues raised to date and processes for ensuring robust ongoing engagement
11. Appendices	Steering Group working group scopes Risk scoring matrix Clinical services in scope

Background

HIOW Integrated Care System

2.8. The HIOW ICS is the tenth largest of the 42 health and care systems in England, covering a resident population of 1.9 million people across Hampshire (excluding north-east Hampshire, which forms part of the Frimley ICS), Southampton, the Isle of Wight and Portsmouth. The ICS has an annual health and care budget of £3.8 billion.

2.9. The ICS covers four upper tier local authorities (Portsmouth City Council, Hampshire County Council, the Isle of Wight Council and Southampton City Council), ten district and borough councils, three acute trusts, one ambulance trust, two community, mental health and learning disabilities trusts (Solent and Southern) and one integrated trust providing acute, mental health, community, learning disabilities and ambulance services (IoW), as well as primary care and voluntary, community and social enterprise (VCSE) partners.

Overview of mental health, learning disabilities and community services in HIOW

2.10. There are three main NHS providers of community, 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 talking therapies for anxiety and depression in Southampton (with an annual contract value of c.£2m).

2.11. The services provided by the Trusts in HIOW are summarised in the figure below.

Figure 2: overview of services provided by the Trusts

Provider	Services provided for HIOW 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 HIOW. Solent employs 3,908 Full Time Equivalents (FTEs) (at March 2023), is rated 'good' by the CQC and reported operating income of £274.8m in 2022/23.
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 employs 5,999 FTEs (at March 2023), is rated 'requires improvement' by the CQC and reported operating income of £455.0m in 2022/23.
Isle of Wight NHS Trust	• 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 FBC. The community services and mental health services employ 937 FTEs. The IOW income related to these services totalled £56.9m in 2022/23.
Sussex Partnership NHS Foundation Trust	• Services for people with mental health problems and learning disabilities across Sussex, and a range of specialist services across south-east England. The Trust is rated 'good' by the CQC. Only the Child and Adolescent Mental Health Services (CAMHS) for Hampshire provided by Sussex Partnership are in scope for FBC. This service employs 390 FTEs (as at September 2023) and the income associated with this service was £28.6m in 2022/23.

Existing collaboration

2.12. In advance of the Fusion programme commencing, the four Trusts were already collaborating to address the most significant clinical risks in community, mental health and learning disabilities services. Ten clinical priorities have been identified (see figure 3, on the next page), each with an executive director who takes system-

wide responsibility for leading the workstream, supported by senior clinical and operational leads.

Figure 3: Existing collaboration clinical priorities

Mental health and learning disabilities priorities	Community services priorities
• Children and young people's mental health services • Neurodiversity pathways • Older people's mental health (OPMH) services • 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

2.13. The Trusts have added 'lived experience' as an additional cross-cutting workstream as it has emerged as a key theme in the development of the clinical strategy for the new Trust.

2.14. These transformation workstreams are overseen by a Clinical Transformation Group (CTG) 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 Integrated Care Board (ICB).

2.15. The work of the CTG 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 Barnado's on behalf of the system;
- Development of shared pathways; and
- Membership of provider collaboratives.

Creation of the new Trust

2.16. In developing the Strategic Case (SC) an options appraisal was undertaken. A long list of ten options, plus a counterfactual status quo option, to address the case for change were identified.

2.17. Three options were taken forward for more detailed appraisal:

- Lead provider(s) model;
- Group model; and
- Single trust for community, learning disabilities and mental health services.

2.18. The Trusts concluded that the preferred way forward was 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 better community and mental health services to be provided for the HIOW population whilst also achieving the benefits of scale.

2.19. The new Trust will be one of the largest community, learning disabilities 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.

2.20. See chapter 3 for further details on the case for change and FBC chapter 3 for further details on the options appraisal.

2.21. The new Trust will be created through:

- CAMHS currently provided by Sussex Partnership[1] will be transferred to Southern on 1 February 2024. This will be transacted as a contractual change by commissioners;
- Southern will acquire Solent on 1 April 2024. This will be transacted as a statutory transaction under section 56 of the NHS Act 2006; and
- Community, learning disabilities and mental health services provided by IOW will be transferred to Southern on 1 April 2024. This will be transacted as a statutory transfer under section 69A of the NHS Act 2006, introduced by the Health and Care Act 2022 as a new form of statutory transaction.

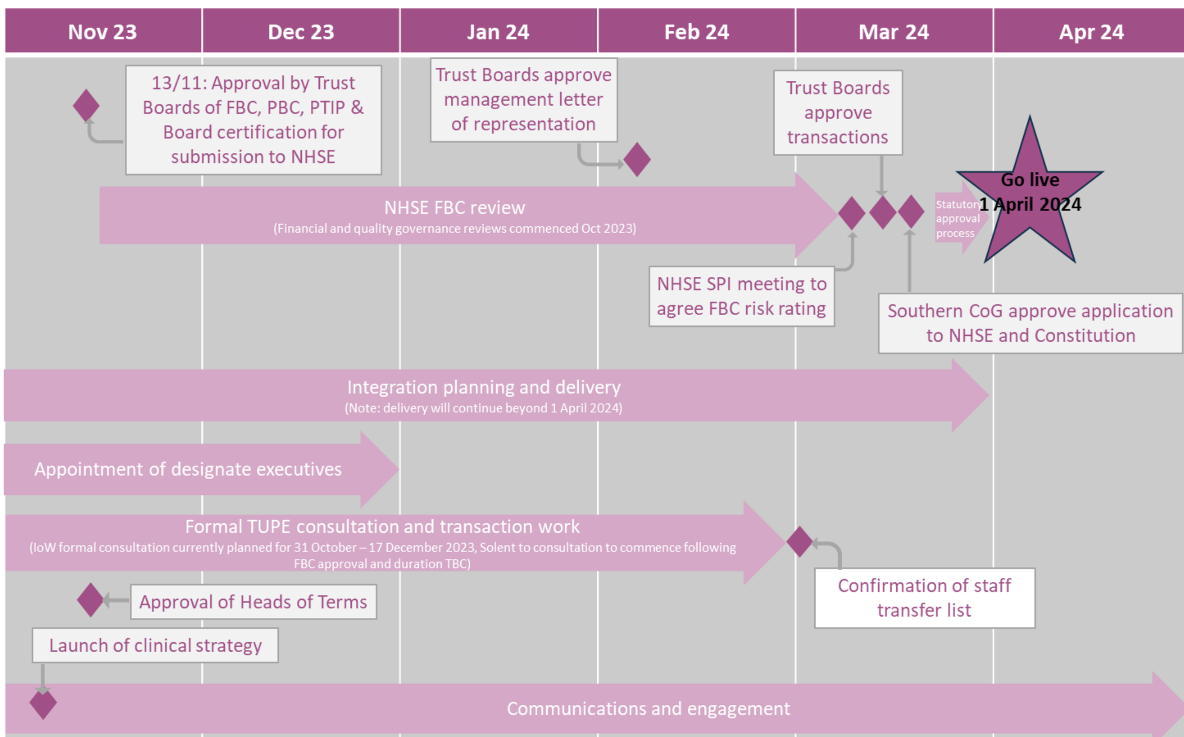
2.22. The name of the new Trust will be Hampshire and Isle of Wight Healthcare NHS Foundation Trust.

Programme timelines

2.23. Figure 4 on the next page sets out the overall programme timeline.

[1] Sussex Partnership provides services for people with mental health needs and learning disabilities across Sussex and a range of specialist services across south east England. Only Sussex Partnership's CAMHS in Hampshire are being transferred: those in the geographic area covered by the HIOW ICS are being transferred to the new Trust, whilst those covered by the Frimley ICS are being transferred to Surrey and Borders NHS Foundation Trust.

Figure 4: overall programme timeline as at November 2023



2.24. After submission of the FBC, Patient Benefits Case (PBC), PTIP and Board certification to NHS England, the programme's Steering Groups will continue to lead the development and delivery of integration plans, in order to:

- Ensure that all activities which are required to ensure any patient safety risks arising from the integration are mitigated appropriately, that the new Trust can operate legally, and for there to be no adverse impact on operations have been identified and implemented;
- Align responsibility for the continued development of integration plans prior to Day 1 with responsibility for delivery of the integration plans after Day 1 as far as possible; and
- Preserve engagement from across all Trusts in integration planning to retain organisational memory wherever possible.

2.25. Recognising the increasing impact that the creation of the new Trust will have on staff, the frequency and reach of the programme's engagement with staff will increase in the approach to Day 1, including:

- The provision of tailored interventions and support packages for managers and teams, to help staff understand the change process and lead teams through the stages of change;
- Specific communication activities for those staff who will transfer under TUPE into the new Trust;
- A communications campaign, to build a sense of team for the new Trust, aligned to the emerging Trust strategy, clinical strategy, vision, and the name of the new Trust; and
- The development of a Day 1 support pack for staff as well as a welcome letter, lanyard and ID badge.

3. New Trust strategy

Context and case for change

3.1. In February 2022, Carnall Farrar 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 FBC chapter 3 for further details).

3.2. 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;
- 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.

3.3. 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 the FBC. This new Trust will serve as an enabler for the other four recommendations and the success of this new Trust (and the realisation of the benefits) will be predicated on the system delivery of the other recommendations of the independent review.

3.4. The Trusts have identified four key challenges that they believe cannot be addressed by any one organisation:

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

3.5. In developing the SC an options appraisal was undertaken. A long list of ten options, plus a counterfactual status quo option, to address the case for change were identified. These were on a continuum from maintaining the current ways of working through closer collaboration between providers to creating a new, merged Trust for mental health and learning disabilities services and a new Trust for community services.

3.6. The options appraisal process allowed the Trusts to conclude that the preferred way forward was to bring NHS community, learning disabilities and mental health services together through the creation of a new Trust. Combining the expertise, experience and resources from all four organisations will enable the Trust to provide

better community, learning disabilities and mental health services for the population it serves whilst also achieving the benefits of scale.

3.7. The transfer of community, learning disabilities and mental health services from IOW into a new provider for all community, learning disabilities 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.

3.8. 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. However, the Trusts believe this option provides the best opportunity to respond positively and realise benefits for the population it serves.

Vision for the new Trust

3.9. The emerging vision and strategic objectives for the new Trust have been developed through engagement with staff and partners, in particular through the 'Shape Our New Trust' programme (see paragraphs 10.7 and 10.8). The emerging vision and strategic objectives have been developed to respond to the case for change and reflect the national and local strategic context as described above. The strategic objectives align with the clinical strategy (see paragraphs 3.15 to 3.19).

3.10. Further work is required to refine the vision and strategic objectives and develop these into the strategy for the new Trust. This will commence following the approval of the FBC and will include:

- Further engagement to share, test and listen to feedback on the emerging vision and strategic objectives;
- Refining the emerging vision and strategic objectives to ensure they are comprehensive, accessible, measurable and reflective of the benefit priorities. This includes demonstrating how they are fully aligned with system plans and strategy;
- Considering how the objectives will be measured and progress demonstrated; and
- Development of a strategy for the new Trust to deliver the vision and strategic objectives.

3.11. The emerging vision statement for the new Trust is: "Together we deliver outstanding care that supports people to live their best and healthiest lives".

3.12. The emerging strategic objectives for the new Trust are:

- Deliver high quality, safe and effective services to all people to improve health and wellbeing and reduce health inequalities;
- Leverage the strategic benefits of working at scale to deliver in local communities;
- Embed and sustain an inclusive culture of co-production, collaboration and continuous improvement;
- Facilitate change within the system, working collaboratively to transform clinical pathways for the benefit of our population;
- Be a great pace to work, supporting and providing opportunities for staff; and

- Improve value for money.

3.13. The OD Steering Group has undertaken a series of engagement sessions (described in chapter 7) to develop the desired culture, values and behaviours of the new Trust. This is an ongoing piece of work, with further activities planned.

3.14. The desired culture of the new Trust will:

- Be compassionate and empowering;
- Be anchored in having respect; and
- Create unity and cultivate innovation.

Clinical strategy

3.15. The aim of the new Trust's clinical strategy is to provide a clear framework for integrating and transforming clinical services. It has been developed in preparation for the launch of the new Trust and is intended to form a foundation to be built on as the new Trust develops. The new Trust's clinical strategy is detailed further In the FBC chapter 6.

3.16. Development of the clinical strategy has been led by the Clinical Steering Group, which has engaged with relevant stakeholders throughout, ensuring that the voice of lived experience was heard and reflected in the clinical strategy. The principal stakeholders involved in developing the clinical strategy were:

- Trust staff from clinical, operational, and corporate teams;
- System partners including the ICB, local authorities, voluntary sector and primary care colleagues;
- People who use services, their families and carers; and
- Wider communities.

3.17. The clinical strategy is structured around a clear ambition to deliver high quality, safe and effective services to all people across HIOW, balancing the benefits of working at a large scale to drive out unwarranted variation, and working locally in order to respond to the needs of different communities. In delivering safe services the new Trust will ensure it continues to address and learn from any quality reviews (e.g. CQC inspections). There are six key principles that will deliver this ambition:

- Embed a culture and practice of continuous improvement, innovation and research;
- Ensure that all clinical decisions benefit from both lived and learned experience;
- Adopt a life course approach which removes barriers and provides greater emphasis on prevention and a pro-active approach;
- Work alongside our communities ensuring that we collaborate effectively to wrap services around the needs of individuals and measure ourselves according to outcomes that matter;
- Provide effective clinical and professional leadership; and
- The clinical strategy will be underpinned by a sustainable workforce.

3.18. Implementing the clinical strategy will support realisation of the benefits and carers identified in chapter 9 of the FBC, and summarised in chapter 4, including:

- Improvements to patient experience from improved accessibility of services, Improved continuity of care and simplified pathways;
- Improvements to patient safety and outcomes by providing the right care first time, supporting people more effectively at home and in the community, strengthening the alignment of capacity and need, maintaining safe staffing levels, and developing a culture that values the voice of lived experience; and
- Providing benefits for research teams, which will ultimately support improvements in patient care.

3.19. Implementation of the clinical strategy will be achieved through:

- Adopting a phased and prioritised approach to the integration of clinical services, initially focussing on the ten clinical priority areas identified in chapter 2:
- Designing the new Trust's operating model and enabling strategies to support delivery of the clinical strategy; and
- Developing an OD programme to embed the culture change required from the Trust Board and through all parts of the new Trust.

Enabling strategies

3.20. The new Trust will rely on efficient and effective support functions to ensure that the new Trust is properly integrated and that the clinical strategy is implemented fully.

3.21. This section describes how these support functions and associated enabling strategies will support successful delivery of the transaction and integration.

People and Organisational Development

3.22. The aim of the people and OD strategy is to:

- Ensure the desired culture emerges in the new Trust;
- Describe how the new Trust will attract, recruit, develop and retain staff in order to deliver services across a broader footprint; and
- Provide the new Trust's staff with the tools, capacity and knowledge to deliver the change programme.

Culture

3.23. Development of the people and OD strategy has been led by the OD and Workforce Steering Groups, which have followed the approach set out in NHS England's Culture and Leadership Programme to develop a four-phase approach to OD to ensure the desired culture emerges in the new Trust. The approach has included:

- A cultural analysis, involving a comparison of staff survey results for the People Promise theme;
- Developing the desired culture, values and behaviours for the new Trust;
- Planning the approach and interventions that will embed the desired culture; and
- Developing a series of OD interventions that will support staff through this period of change, whilst helping deliver the desired culture of the new Trust.

People strategy

3.24. The workforce challenges faced by each of the four Trusts and mirrored nationally, highlight the need to put the new Trust's people first. Attracting, recruiting, and

retaining high quality, engaged staff is key to the successful delivery of the clinical strategy and improved outcomes for patients and families.

3.25. The new Trust will aspire to be the employer of choice for those with a desire to work in mental health, learning disabilities and community services. Delivery of the people strategy will create a compelling offer for new staff and a colleague experience that recognises and values the contribution all staff make in providing services to patients.

3.26. The people strategy for the new Trust will incorporate the best elements of each Trust's existing people strategy. The people strategy will describe how the new Trust will attract, recruit, develop and retain staff in order to deliver services across a broader footprint. The people strategy and priorities will be aligned to national and ICS strategies and will also be developed and informed by insights from engagement with the Trusts' staff.

3.27. The people strategy will place staff involvement and continuous engagement at its core and will ensure the voice of a broad range of staff and stakeholders is heard and reflected. A communications and engagement plan will support the launch of the new Trust's people strategy, describing how staff can get involved in helping to shape and deliver the strategy.

Change management

3.28. The new Trust's integrated OD teams will have significant broad and deep experience from different industry sectors and with relevant academic and vocational qualifications. This includes colleagues with skills in either OD, organisation design and transformation and change management.

3.29. These existing skilled and experienced staff will be used to support change management activities such as:

- helping staff understand the change process and lead their team through the stages of change;
- helping design, facilitate and deliver team away days to support teams integrating into the new Trust;
- support for designing changes to team operating models and developing associated restructuring plans; and
- support for designing the leadership framework, appraisal framework, values, and behaviours framework for the new Trust.

Digital

3.30. The Digital Steering Group has led on developing the digital strategy for the new Trust. In developing the digital strategy, the Digital Steering Group has sought to combine elements of the existing digital strategies of each Trust, particularly areas of commonality (e.g. improving digital literacy), in a way that best supports delivery of the clinical strategy for the new Trust. The resulting strategy was then aligned with local and national digital strategies, will be developed into a draft strategy ahead of Day 1, and will be refined throughout the first year of integration.

3.31. Delivery of the digital strategy will empower patients and clinicians to improve services through:

- the use of telehealth to support out-of-hospital care and remote monitoring;
- The adoption of Patient Portal to improve patient access to all services' relevant information;

- Integration through the NHS App wherever possible to simplify access to services for patients; and
- Standardisation across HIOW footprint, meaning more consistent experience for patients.

3.32. The digital function of the new Trust has been designed to deliver the digital strategy whilst providing direct support to clinical and corporate services. The role of clinical leadership within digital functions is particularly important to ensure that the digital strategy remains relevant and aligned to service needs; each digital team will therefore include representation for clinical leadership wherever relevant.

Estates

3.33. The new Trust's vision for estates and facilities is: "To provide, service and maintain highly effective, high quality, best value and fit for future physical assets in which to support and deliver world class community, mental health and learning disability services".

3.34. The new Trust's emerging estates strategy focuses on creating a highly efficient and interoperable networks of locations. It will support the NHS Long Term Plan[2], The ICB's Joint Forward Plan[3] and ICS partnership strategy to deliver place-based care by integrating technologies that support the elimination of geographic boundaries. More specifically it will:

- support community-based outpatient, acute and diagnostic treatment, reducing the pressure on the acute hospital estate;
- deliver best value, efficient and fit for future accommodation, integrating with and supporting primary care to reducing the need for acute admission;
- establish the community estate as the 'nurses station' for community-based care, providing effective 24/7 support for staff and patients, and developing supportive environments in place of outdated inflexible and expensive primary and community-built environments; and
- support the next generation of healthcare provider, in carbon neutral, socially conscious and environmentally positive surroundings.

3.35. The new Trust's strategy will be developed in parallel to the development of the ICB's estates strategy, which will be developed through the following process:

- Identify common themes and variations across existing estates strategies
- Assess estate performance across members, based on factors such as physical condition, functional suitability, space utilisation, quality, statutory compliance and environmental management; and
- Identify particular areas of focus for each organisation.

3.36. The ICB has established a monthly Estate Director Forum to inform members on county wide estates matters and to find ways to collaboratively work together on matters such as backlog maintenance and common operating models such as six facet surveys. This forum includes representation from providers across the HIOW system as well as quarterly membership from Hampshire County Council, Community Health Partnerships and NHS Property Services.

---

[2] See chapter 3 of the FBC for further details
[3] See chapter 5 of the FBC for further details

4. Benefits

Overview

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

4.2. These benefits are across 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.

Benefits for patients and carers

4.3. This section sets out the benefits for patients and carers, and describes how the new Trust will deliver them.

Improvements to patient experience

4.4. **Improved accessibility of 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.

4.5. **Improved continuity of care** by aligning the geographic coverage of service teams and reducing the number of interfaces across care pathways.

4.6. **Simplifying pathways** and reducing hand-offs so that a single Trust will be the single point-of-contact across the ICS for a patient to contact. Reducing the inter-organisational boundaries along patient pathways will also improve communication with patients, their carers, and across clinical teams, as these boundaries can act as barriers to the provision of consistent and complete information.

Improvements to patient safety and outcomes

4.7. **Providing the right care first time**: the new Trust will adopt a tiered approach to service improvement, innovation and transformation that utilises existing transformation expertise and recognises the importance of standardisation to reduce unwarranted variation and adaptation to meet the needs of place, as set out in the figure on the next page.

Figure 5: Tiered approach to service improvement, innovation and transformation

Scale	Approach
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

4.8. The new Trust will have a view of performance and outcomes across HIOW, collating datasets to allow benchmarking between different geographies both within and beyond the ICS and inform transformation programmes to reduce unwarranted variation.

4.9. **Supporting people more effectively at home and in the community:** the new Trust will strengthen links between mental and community services in local communities and ensure that services are tailored to specific local needs.

4.10. **Strengthening the alignment of capacity and need:** the new Trust will be able to better match capacity of services to the level of need in different geographies and patient cohorts within HIOW. This requires a framework for assessing the level of patient need and flexibility in service provision to match that need. It will be easier for to deploy staff flexibly through adoption of common service models.

4.11. The new Trust will **improve 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.

4.12. The new Trust will **develop a culture that values the voice of lived experience,** from every clinical interaction to the design and delivery of services. The culture will support recovery and coproduction resulting in improved safety, outcomes and experience for patients.

Research

4.13. The new Trust will also provide benefits for research teams, which will ultimately support improvements in patient care:

- 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 Solent and Southern 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

Tackling recruitment and retention challenges

4.14. The new Trust will adopt a single approach to tackle recruitment and retention challenges and fill 'hard to fill' posts, including developing new innovative roles where traditional recruitment has been challenging. This will build on existing collaboration, including in international recruitment where the Trusts have been working together since 2022. This will reduce vacancies, which will also help reduce operational pressures on staff and improve staff satisfaction.

4.15. Increasing the scale of the recruitment team will provide capacity to spend more time partnering with services to understand their workforce plan needs, design recruitment strategies, develop more targeted and tailored recruitment campaigns and host more recruitment roadshows to attract new candidates.

4.16. Recruitment and retention benefits will be measured by monitoring vacancy rates and temporary staffing, agency, and locum costs, which will be reported to the Board of the new Trust through the Integrated Performance Report, as described In the FBC chapter 6.

Career progression and development

4.17. The greater scale of the new Trust will reduce the need for staff to move between organisations to progress their careers and thereby will improve talent retention, career progression and development opportunities. The creation of a shared training function will offer improved professional development and training opportunities, including strengthened access to support, advice, and supervision, providing high quality and consistent training that is accessible and equitable.

4.18. The new Trust will develop a talent management strategy to enable effective career progression pathways, succession planning to retain talent and strong leadership. This will help to increase staff retention rates.

4.19. Apprenticeship teams will be aligned in order to improve the new Trust's ability to 'grow our own' at scale. This brings the opportunity to look at innovative ways of working and building on T-levels education through to employment with community colleges, to strengthen the attraction and pipeline of resource into the new Trust and wider health and care system.

4.20. Career progression and development benefits will be measured by monitoring the NHS staff survey, particularly focusing on appraisal sub-scores, we are always learning and the meaningful appraisal rating. Other measures include the uptake on Learning Management System (LMS) courses, training course feedback evaluation forms, apprenticeship retention rates, 'T-level' (a technical alternative to A-levels) programme retention rates, preceptorship data, staff turnover rates and exit interview data.

Improving job satisfaction

4.21. Staff will be supported by the people function that builds on the best of the existing ways of working across people directorates of existing Trusts and the existing wellbeing offers for staff. For example, the new Trust will implement the national NHS health and wellbeing framework that has recently been adopted by Solent. Health and wellbeing are closely linked to job satisfaction and this framework provides a model for creating a health and wellbeing culture through addressing the key factors that drive the design and delivery of interventions that improve staff wellbeing.

4.22. Job satisfaction benefits will be measured by looking at the NHS staff survey, in particular: staff engagement, staff morale, staff advocacy sub score, satisfied with Organisation for good work, we are safe and healthy, I always know what my work responsibilities are, I am trusted to do my job, thinking about leaving sub score, my immediate manager cares about my concerns, my immediate manager listens to challenges I face, my immediate manager works with me to understand problems. Other measures will include staff turnover rates and exit interview data.

Continued development of an inclusive, open culture

4.23. The new Trust will develop an open, inclusive culture, that promotes learning and continuous improvement by strengthening professional, clinical, and operational peer networks and creating opportunities for shared learning wherever possible. The new Trust will use accessible and inclusive language in all people policy processes and frameworks, values and behaviours. Working with freedom to speak up, health and wellbeing colleagues, and assessing culture on an ongoing basis will be integral to measure this benefit and a cultural assessment tool has been identified to enable this.

4.24. A human-centred approach in the management of all people practices will ensure staff are treated with compassion. A restorative and Just culture will be embedded in all people policies and processes and this will benefit a reduction in employee relation cases such as formal resolution cases (grievances), with managers feeling supported to navigate employee relation matters compassionately, improving staff job satisfaction and health and wellbeing.

4.25. These benefits will be measured by looking at the NHS staff survey, specifically: we are compassionate and inclusive, we each have a voice that counts, we are always learning, as well as the results from the Medical Workforce Race Equality Standard and Bank Workforce Race Equality Standard (WRES) staff survey. Other measures will be the national WRES and WDES 18 indicator scores, the Equality delivery system 3 domains, workforce EDI profiling data, and freedom to speak up (FTSU) concerns raised, employee relation number of formal cases.

Improve service resilience

4.26. The creation of the new Trust will improve service resilience and reduce professional isolation, particularly of smaller services.

Benefits for the wider health and care system

4.27. The creation of the new Trust will deliver benefits for the health and wider care system:

- **Tackling health inequalities:** the new Trust will be better placed to work with system partners to address health inequalities, for example by strengthening leadership and accountability and accelerating prevention.
- **Responding to local communities:** The new Trust will respond to the system priorities identified through engagement with local communities, in particular:
    - People want more joined up services, from GPs to hospitals to social care, education and housing;
    - People want to be more involved in how their care is delivered, to have better communication with health and care services, and be clearer about what is available to them; and

    - Access is an issue, with people identifying the need for more specialist access and shorter waiting times, and more consistent support services across our geography.

- **Delivery of health and wellbeing strategies:** each of the places (Hampshire, Isle of Wight, Portsmouth and Southampton) has a Health and Wellbeing Board which sets the strategy for its population;
- **Aligned planning**: the new Trust will develop a single operational plan, working closely with commissioners to ensure it is aligned to system priorities;
- **Effective system assurance**: the ICB and new Trust geographies will be coterminous allowing streamlining of system assurance processes;
- **Transformed models of care**: large-scale transformation is needed across the ICS, including new models of care and rebalanced health investment;
- **Renewed focus on population health**: the new Trust will work with system partners on population health management, thereby helping to improve the health and care for the population across HIOW; and
- **Being a strong and consistent voice** for community and mental health and learning disability services across the ICS, working with partners at neighbourhood, place and system levels to achieve the system's aims.

Benefits for the population of the Isle of Wight

4.28. In addition to the wider benefits articulated above, there are benefits specific to the population of the Isle of Wight which include:

- Strengthening the resilience of sub-scale community, mental health and learning disabilities services on the Island;
- Addressing the highest risks in community, mental health and learning disabilities services in HIOW through a collaborative programme of clinical transformation. The transformation programme aligns well with the highest clinical priorities and risks from an Isle of Wight perspective, including the provision of frailty services and development of a HIOW neurodiversity pathway;
- Enabling community, mental health and learning disabilities-specific opportunities for training, development and career progression that are not currently available for IOW staff; and
- Reducing the professional isolation that arises from delivery of sub-scale services in a geographically isolated location by ensuring IOW staff have access to resilient peer networks.

Financial benefits

4.29. Each of the Trusts already have significant savings plans to deliver in both 2023/24 and 2024/25. In addition, the overall ICS is not in financial balance and is undertaking a system recovery plan as part of the oversight requirements of being in SOF4. Existing plans for 2023/24 already assume a level of corporate reduction and productivity improvements as well as an estimate of the minimum savings that will be required in 2024/25. This context has been taken into account when identifying financial benefits to avoid any double-counting of cost reductions.

Corporate savings

4.30. Corporate savings have been identified in the following areas:

- **Corporate funding transferring from Sussex Partnership** without associated staff members has been partially assumed as a saving. This will be achieved by absorbing some of the corporate workload into existing teams with minimal additional cost. No such saving has been assumed from the IOW corporate services as the costs transferring fairly reflect the additional corporate overhead and the scale of this workload cannot be absorbed by existing teams.
- **Corporate benchmarking:** a review of corporate benchmarking for 2021/22 showed that matching the median for the sector would suggest annual costs of approximately £54m for the functions of the new Trust. An estimate of the comparative cost base in 2021/22 suggested actual costs were approximately £57m. The new Trust will aim to reduce costs to below the sector median from year two, as a benefit from increased economies of scale. £2.1m of this £3m cost reduction has already been identified. A review of the 2022/23 corporate benchmarking is planned for each of the Steering Groups, once it is made available (expected in late September 2023).
- **Agency premium savings:** There are currently high levels of agency spend within the existing Trusts, mainly within mental health services and with high reliance on medical agency locums. Although the existing CIP plans for the standalone organisations include agency reductions, such as eliminating Health Care Support Workers agency costs, increasing bank fill and the conversion of agency to substantive employees, the new Trust is aspiring to be the employer of choice for those with a desire to work in Community, Mental Health and Learning Disability (CMHLD) services and this should provide opportunities by year 3 to reduce agency costs further. An assumption of reducing agency spend by 5% by year 3, on top of existing CIP plans will reduce agency premium costs by £350k per annum.

4.31. Further potential savings linked to key leadership posts that will be duplicated within the corporate structure of the new Trust have not yet been assessed. As the organisational structure is implemented for the new Trust and the clinical strategy is launched, corporate structures will be established to support services and clinical teams. In some areas, implementing these structures will release further savings over time, with additional potential savings anticipated to be in the region of £1m-£2m. Potential savings from key leadership posts and corporate structures have not been included in the financial projections of the FBC.

Figure 6: Financial benefits of the transaction

Financial Benefits	2024/25 £000	2025/26 £000	2026/27 £000
Corporate services and organisational overheads	2,409	3,170	3,780
Agency premium savings	-	-	350
Total recurrent benefits	**2,409**	**3,170**	**4,130**

Indirect financial benefits to system partners

4.32. The creation of the new Trust will create a range of indirect financial benefits to system partners, as it begins to act and plan as a single entity.

4.33. Through the harmonisation of eligibility criteria and processes to access services, system partners will experience improvements within their operational processes,

helping to free up resources. A reduction in delayed transfers of care from acute settings will result from the improved consistency across services provided by the new Trust, improving patient flow and reducing expenditure on surge capacity.

4.34. Reducing the number of organisations in the system will reduce the administrative burden for commissioners and other system partners associated with contracting and partnering. Decision making and implementing initiatives will become faster, reducing variability in adaptation and creating an environment that is able to be more agile to the shifting economic environment.

5. Integration approach

Development of the Post Transaction Integration Plan

5.1. The programme established an IPG in March 2023 to provide assurance over the development of the integration plans and activities required to deliver the new Trust on 1 April 2024. Further details on the programme's governance structure are set out in chapter 6.

5.2. The PTIP has been developed through a bottom-up process based on detailed planning activities undertaken by the programme's Steering Groups.

5.3. The detailed planning activities have been framed by the emerging clinical strategy which was outlined in the SC and is set out In the FBC chapter 5 and summarised in paragraphs 3.15 to 3.19.

5.4. Steering Groups were provided with a comprehensive integration planning workbook in May 2023. This provided staff, clinical leaders, managers and transformation teams with a standardised framework to ensure that a consistent and robust approach was taken to planning integration activities.

5.5. The IPG undertook a cycle of "deep dives" into each of the Steering Groups' integration plans in July and August 2023 in order to obtain more granular assurance over the development of detailed integration plans.

5.6. The first draft of the PTIP was presented to the Programme Board on 21 August 2023 and Boards of the Trusts in early September 2023. Updated versions were presented to the Programme Board on 18 September and 16 October 2023, and the Boards of the Trusts in early October 2023.

5.7. The detailed integration plans developed by the Steering Groups are "living" documents which will continue to be updated up to and beyond Day 1 to:

- Reflect the progress made towards the integration of CAMHS to be transferred from Sussex Partnership to Southern;
- Reflect completion of integration activities in line with the integration plans; and
- Respond to any additional risks, issues and opportunities that are identified.

Approach to integration

5.8. It will take time and resource to fully integrate the Trusts and establish the operating model. Designing an effective implementation strategy is key to the success of the new Trust and delivery of the clinical strategy.

5.9. From the outset, the programme has been developing its integration plans with a focus on maximising the benefits of integration without jeopardising 'business as usual', as set out in the integration principles in paragraph 5.16.

5.10. Integration planning activities have been split into four categories:

- **Activities required on or before Day 1** to ensure any patient safety risks arising from the integration are mitigated appropriately, that the new Trust can operate legally, and for there to be no adverse impact on delivery of clinical and corporate services;

- **Activities required by Day 100** to deliver the initial benefits from creating the new Trust and maintain momentum in the immediate post-Day 1 period;
- **Activities required within the first year** (i.e. by 31 March 2025) to deliver the benefits from creating the new Trust that do not require complex and/or transformational change; and
- **Activities required in Years 2 and 3** to deliver the benefits from creating the new Trust that require complex and /or transformational change.

5.11. The integration planning process has included specific activities to ensure that the Trusts' policies and procedures are effectively harmonised. The Corporate Governance Steering Group has established a programme-wide process for oversight of policy harmonisation, which includes the requirement for:

- Staffside input to be obtained on specific policies, as agreed with Staffside representatives, through a policy harmonisation working group established by the Workforce Steering Group; and
- Equality Impact Assessments (EIA) to be undertaken as required.

5.12. In addition, each Steering Group has:

- Identified the policies and procedures of the existing Trusts that are within the scope of its work;
- Agreed appropriate timescales for harmonisation of these policies and procedures, including identifying policies and procedures that must be harmonised by Day 1; and
- Established processes to ensure that harmonised policies and procedures for the new Trust have been developed and approved, and staff have carried out appropriate training, to meet the required timescales. This process has included cross-referencing all relevant external guidance to ensure harmonised policies remain compliant with national guidance and regulatory requirements.

5.13. The Corporate Governance Steering Group has established authority levels for the approval of harmonised policies, with:

- Steering Groups authorised to approve policies with no material changes or financial impact;
- A Policy Forum in Common to be empowered to approve policies which have a material change from one or more of the Trusts' policies;
- The Programme Board to recommend approval of policies which have a material financial impact to the appropriate body in the Trusts' governance frameworks; and
- A small number of policies which are reserved for the Trusts' Boards to be approved by the appropriate Trust Board at the time of implementation.

CAMHS mobilisation plans

5.14. A separate mobilisation plan for the transfer of Hampshire CAMHS from Sussex Partnership to Southern has been developed by the two ICBs (Frimley ICB and HIOW ICB) and three affected providers (Surrey and Borders Partnership NHS FT, Southern and Sussex Partnership).

5.15. Following the transfer of CAMHS from Sussex Partnership on 1 February 2024:

- Rapid reviews will be undertaken after one week and one month to identify lessons learned and opportunities to improve the programme's integration plans, including the delivery of Day 1 priorities; and
- The outstanding mobilisation plan activities will be reviewed to consider if they should be transferred to the programme's integration plans.

Integration principles

5.16. In order to support the development of integration plans that are focussed on delivery the strategic objectives of creating the new Trust, the Programme Board has developed a set of overarching integration principles as follows:

- **Integration plans will seek to address the challenges identified in the case for change in the SC and deliver improved outcomes for patients and carers,** as well as for staff and our partners. Integration plans will be informed by the findings of due diligence to address key risks. Integration plans will bring together the best from across the partner Trusts to ensure existing best practice is not lost and also take an evidence-based approach to identify best practice beyond the partner Trusts.
- **The Trusts will aim for all staff to feel part of a single organisation with a single vision from Day 1**. The Trusts will support staff in the period leading up to Day 1 and encourage joint working between the Trusts. The Trusts' aim will be that, wherever possible, staff have a positive experience of this integration.
- **The focus for Day 1 will be for the new Trust to be safe and legal and for there to be no adverse impact on clinical and corporate service delivery.** This is expected to involve minimal (if any) change to the way services are delivered on Day 1. Longer term clinical transformation will need to be reflected in integration plans to the extent it will deliver benefits articulated in the FBC.
- In developing plans for the services and functions of the new Trust, **the Trusts will need to be mindful of the scale and geographical spread of the new Trust,** including provision of services to an island population.
- **The new Trust will retain expertise and leadership talent and there will not be any compulsory redundancies arising from the creation of the new Trust.**
- **Opportunities to streamline corporate services (for example through vacancy management and natural turnover) to deliver value for money are anticipated.** Steering Groups are expected to consider opportunities to bring corporate services together in advance of Day 1 where there are opportunities to deliver productivity savings and increase operational resilience.
- No financial benefits from reductions in the cost base for clinical services have been assumed. However, **the Trusts recognise that services will need to be transformed to ensure they are clinically and operationally sustainable and deliver equitable outcomes informed by population need.**

5.17. Integration plans also reflect the agreed approach to segmentation of the IOW in preparation for the transfer of CMHLD services to the new Trust, namely:

- To improve the provision of community, mental health and learning disability services to the IOW population;
- To release efficiencies for the HIOW system; and

- To not deteriorate the underlying financial position of IoW.

5.18. The Programme Board will continue to consider the sufficiency of these principles as the programme is developed and implemented and will update the integration principles as required.

Approach to clinical integration

5.19. The programme is taking a phased and prioritised approach to integrating clinical services, with an initial focus on the ten clinical priorities set out In the FBC paragraph 5.3. This approach focuses on the areas where there are significant risks that need to be addressed and where patient and workforce benefits can be delivered.

5.20. Each priority workstream is led by a clinical and operational lead. Workstreams are engaging with clinical teams, people with lived experience, staff and partner forums and drawing on best practice to develop their plans.

5.21. The workstreams have engaged with clinical teams, staff and partner forums, and drawn on best practice to shape clinical integration plans and inform the expected benefits of integrating clinical services at scale across the new Trust.

5.22. The design of clinical integration plans involves:

- Identifying the optimum scale and setting for services to meet the needs of the local population;
- Agreeing the best service delivery model and pathways;
- Working with clinicians and operational leads to set priorities and the timeline for integration; and
- Where beneficial, integrating services into single pathways with a single waiting list. For example, a hub and spoke approach to specialist nursing services (e.g. for Parkinson’s disease or multiple sclerosis) will help address current workforce pressures, whilst delivering services as close to home as possible.

5.23. Clinical leadership of clinical service integration is essential to deliver the potential benefits. Clinical integration work is therefore being driven by the clinical service teams themselves, with support from operational leads to:

- Develop clinical integration guides that document the:
  - Vision for the integrated service;
  - Patient pathway;
  - Clinical and operational leadership; and
  - Relevant policies and procedures, including the approach to management of a unified waiting list, reporting processes and budgets
- Monitor the implementation of integration plans and delivery of benefits, as set out in chapter 9; and
- Evaluate the impact of any planned changes through the use of EIAs.

5.24. A phased approach is being taken to the integration of clinical services, which is set out in more detail in the Clinical Services section of chapter 7.

Quality improvement

5.25. The new Trust will implement an approach to quality improvement that uses evidence-based methodologies to support integration of clinical services and corporate functions, and embed a culture of continuous improvement. The quality improvement approach will implement:

- Quality planning: understanding the needs of the population and codesigning an approach that meets their needs with measurable outcomes
- Quality control: measuring quality outcomes and using this information to identify and address emerging problems.
- Evidence-based methodologies: using methodologies based on evidence to ensure effective solutions based on the best available research.

5.26. The new Trust will combine the knowledge, experience and resources of the existing Trusts to drive quality and innovation benefits for staff, patients and communities. Training and development programmes for staff are already in place as well as dedicated resources to support the delivery of collaborative quality improvement projects. The new Trust will refer to the NHS England Delivery and Continuous Improvement Review to guide the further development of the quality improvement approach.

5.27. In addition, quality improvement will be one of the principal components of the new Trust's quality management system that is based on the 'learning health system' approach, along with quality planning and quality control.

6. Integration governance

6.1. The Trusts have established programme governance arrangements which are set out in paragraphs 6.4 to 6.28.

6.2. Following approval of the FBC, PTIP and PBC by the Trust Boards in November 2023, the Trusts intend to evolve the programme governance arrangements, as described in paragraphs 6.29 to 6.47.

6.3. The Trusts have also developed programme governance arrangements for the new Trust, which will be implemented on Day 1. These arrangements, which are set out in paragraphs 6.37 to 6.47, reflect the new Trust's proposed governance arrangements (described In the FBC chapter 6).

Pre-approval integration governance

Objectives of pre-approval integration planning

6.4. The programme governance arrangements set out in this section will remain in place until approval of the FBC, PTIP and PBC by the Trust Boards in November 2023.

6.5. The key objectives of this phase of the programme are to:

- Develop robust integration plans that:
    - Will enable creation of the new Trust, including ensuring that effective processes are in place to manage transaction risks; and
    - Are aligned with the integration principles set out in paragraph 5.16 and the benefits realisation approach set out in paragraphs 9.9 to 9.11, with a particular emphasis on Day 1 and Day 100 priorities; and
- Establish effective transitional programme governance arrangements to manage delivery of the Pre-Day 1 integration plan.

Structure of the pre-approval programme governance

6.6. Figure 7 on the next page sets out the governance arrangements which have been established for this phase of the programme.

Figure 7 – pre-approval programme governance structure

Sussex Partnership NHS FT Trust Board

Solent NHS Trust Trust Board

Southern Health NHS FT Trust Board

Isle of Wight NHS Trust Trust Board

Programme Board
Chair: NED rotation

ICB View

Regulator view

Integration Planning Team
Chair: Deputy CEO, Southern Health NHS FT

Programme Team
Chair: CEO, Solent NHS Trust

Operating Model Advisory Group
Independent Chair

Clinical Transformation Group

Clinical Steering Group

Business Support, Intelligence and Development Steering Group

Finance Steering Group

Workforce Steering Group

Communications and Engagement Steering Group

Digital Steering Group

Estates Steering Group

Organisational Development Steering Group

Corporate Governance Steering Group

6.7. The governance arrangements set out above are an evolution of the governance arrangements which were in place prior to the approval of the SC in March 2023. Recognising the need for enhanced programme governance to support development of the FBC, PTIP and PBC, in April 2023 the Programme Board established:

- The OMAG to lead on the process to develop the vision and values for the new Trust and the Organisational structures and leadership model; and
- The IPG to support collaboration in integration planning and manage inter-dependencies between Steering Groups.

Roles and responsibilities for pre-approval integration planning

Council of Governors

6.8. The Council of Governors (COG) has been kept informed of progress on the proposed creation of the new Trust at their meetings since April 2022. All governors were invited to observe the confidential Board meetings, as well as meetings held in public, where there have been regular updates on the programme. Governors were also invited to observe Board Committee meetings, including those where due diligence reports and FBC content were reviewed.

6.9. Governors have also been involved in the transaction by delivering their statutory duties, including the appointment of designate Chair, designate NEDs and approval of the appointment of the designate Chief Executive Officer (CEO). The governors also led the Constitution Review Group, including three meetings to develop the constitution for the new Trust, including the composition of the COG for the new Trust.

Trust Boards

6.10. The Trusts' Boards have been provided with regular programme updates since autumn 2022. These updates have covered programme status, risks and timeline including major milestones. The three Trust Boards will approve this PTIP at a public Boards-in-common meeting on 13 November 2023.

Programme Board

6.11. 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 Chief Strategy and Transformation of Officer of the ICB is in attendance.

6.12. 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 NHS England.

6.13. Meeting notes are taken for each Programme Board meeting, and the status of all actions points is considered as a standing item in each meeting. The Programme Director submits an update report to each Programme Board which covers programme status, key risks and items escalated by the Programme Team. Any items to be communicated to the Steering Groups and all staff are also considered as a standing item on the Programme Board agenda.

Programme Team

6.14. The Programme Team meets on a fortnightly basis and is chaired by the CEO of Solent. The membership of the Programme Team comprises the Chair, a

representative from each of the Steering Groups, the Programme Director and the Programme Manager.

6.15. The Programme Team leads on operationalising the agreed operating model, 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.

6.16. Action points and key decisions from each Programme Team meeting are documented in a control log, along with a schedule of key assumptions, that is included in the papers for the next meeting. The status of all actions, key risks, updates from each Steering Group and the Programme Board, and items for escalation to the Programme Board are tabled as standing items on the Programme Board agenda.

Integration Planning Group

6.17. The Integration Planning Group meets on at least a fortnightly basis and is chaired by the Deputy CEO and Finance Director of Southern. The membership of the Integration Planning Group comprises the Chair, nominated representatives from each of the Steering Groups, the Programme Director and Programme Manager.

6.18. The Integration Planning Group provides assurance around the integration plans and activities required to deliver the new Trust on 1 April 2024, including supporting the Steering Groups to manage interdependencies across the programme. The Integration Planning Group reports progress and escalate issues to the Programme Team.

6.19. Action points from each IPG meeting are documented in a control log that is included in the papers for the next meeting. Matters for escalation to the Programme Team is included as a standing item on the Integration Planning Group agenda.

Operating Model Advisory Group

6.20. The OMAG meets as required to fulfil its advisory role, typically on a monthly basis, and has an independent chair. The membership of the OMAG comprises the Executive Director members of the Fusion Programme Board from Southern, Solent and IoW, the Southern Chief People Officer and the Programme Director.

6.21. The OMAG has led, on behalf of the Programme Board, the process to develop the high-level operating model for the new Trust for articulation in the FBC. The OMAG fulfils an advisory role, making recommendations about the future operating model to the Programme Board and to the leadership team of the new Trust (once appointed). The OMAG works closely with the Clinical Steering Group (of which two members are also members of the Operating Model Advisory Group) to ensure that the recommended new operating model supports the delivery of the emerging clinical strategy.

Steering Groups

6.22. Nine Steering Groups report into the Programme Team, as set out in figure 7 above. Each Steering Group meets regularly (at least monthly) with a standard agenda and captures agreed actions for follow up.

6.23. Each Steering Group has determined the governance and supporting resources needed to deliver its scope of work. In some cases, Steering Groups have established working groups to oversee progress on the development of integration plans at a more granular level. These working groups are set out in Appendix 1.

Pre-approval programme resources

6.24. The programme is led by an independent Programme Director, supported by a Programme Manager.

6.25. The Programme Director oversees the overall programme, including coordinating the work of the Steering Groups and ensuring interdependencies are managed. The Programme Director leads on the drafting of the FBC, PTIP and PBC, using content provided by the Steering Groups. The Programme Director also liaises with key external stakeholders including the ICB and NHS England to ensure the agreed timetable is met.

6.26. 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.

6.27. The Trusts have used a workstream approach (with each workstream led by a Steering Group) to develop this PTIP. The Trusts have used in-house resources as far as possible, to maintain ownership, retain knowledge and keep costs down. Each Steering Group identified the resources it needs to prepare its integration plans, which primarily comprises back-fill to release existing staff to support due diligence and integration planning, including:

- More than 20 Full Time Equivalents (FTEs) in Southern and Solent to support the programme across the Steering Groups; and
- 17.5 FTEs in IOW to support its strategic change programmes.

6.28. The Trusts have additionally procured expert legal advice and specialist consultancy support to help prepare the detailed content for the FBC, PTIP and PBC.

Pre-Day 1 integration governance

Objectives of pre-Day 1 integration planning

6.29. The key objectives of this phase of the programme are to ensure:

- The continued development and iteration of robust integration plans, as set out in paragraph 6.5;
- The delivery of Day 1 integration activities;
- Responsibility for the development of integration plans prior to Day 1 is aligned with responsibility for their delivery after Day 1 as far as possible;
- Continuity of ownership for integration plans is preserved and organisational memory is retained whenever possible; and
- The establishment of effective programme governance arrangements in the new Trust to oversee delivery of the integration plan from Day 1.

Structure of the pre-Day 1 programme

6.30. Following approval of the FBC for submission to NHS England, the programme governance arrangements will be updated to reflect the progress that has been made towards delivery of the Day 1 integration plans. In particular:

- **Designate Board**: The designate Board will hold development sessions/ workshops to develop the following aspects of the new Trust: strategic objectives, financial plan, Board development programme, evolving quality management system approach and Board and Committee governance (including terms of reference for committees and membership);
- **Programme Board**: the CTG will report directly into the Fusion Programme Board, to ensure that clinical transformation drives change within the new Trust,

and that this is enabled by the way the new Trust is created, including its structures and culture, and a newly established Clinical Reference Group will report to Programme Board. In addition to nominated NED representatives, NEDs who will be NEDs in the new Trust on Day 1 will be invited to attend the Programme Board in order to help build their knowledge of the new Trust;

- **Programme Team**: The Programme Team's chair will be the designate Chief Operating Officer (COO) once appointed. Membership of the Programme Team will comprise the chairs of the programme's Steering Groups;
- **IPG**: the chair of the IPG will be the designate executive with responsibility for integration, once appointed. A representative from the Clinical Transformation Group will sit on the IGP. The IPG will meet on a weekly basis from January 2024, with the Steering Group highlight reporting refreshed to reflect the increasing focus on delivery of integration plans;
- **OMAG** was stood down at the end of October 2023, with responsibility for operationalising the agreed operating model to sit with the Programme Team; and
- **Steering Group** chairs will transition to the designate executives with responsibility for the services within scope of each Steering Group. Membership of the Steering Groups is otherwise expected to remain the same.

6.31. At a joint Boards seminar in October 2023 the Trusts agreed to seek external support to explore opportunities to further develop the programme governance to allow the existing Trusts to have a single voice wherever possible in advance of Day 1. The Trusts also established a fortnightly Chairs and CEOs forum.

Clinical Reference Group

6.32. At a joint Boards seminar in October 2023 the Trusts agreed to establish a multi-disciplinary Clinical Reference Group (CRG) to:

- Support implementation of the clinical strategy;
- Provide clinical and professional advice to the Steering Groups;
- Provide clinical and professional advice regarding any significant changes to services, including reorganisation or service redesign, that is necessary to deliver in advance of the development of the new Trust;
- Provide a forum to resolve issues and highlight new opportunities to ensure that issues are satisfactorily resolved in the development of the new Trust;
- Enable effective communication with and engagement of clinical and professional staff across all services; and
- Design the structures required in the new organisation to ensure the clinical and professional workforce have a strong voice in decision making.

6.33. The CRG will be chaired by the IoW Director of CMHLD (with independent facilitation support as required). Members will include the CMOs and CNOs of Solent and Southern Health and the next in lines to clinical executives. Membership will be reviewed on a regular basis. The CEO designate, and other designate execs, as they are appointed, will also be invited to attend as required. Where possible meetings will be face to face in order to build trusted relationships and develop psychological safety in the group. The first meeting of the Clinical Reference Group is being arranged to take place in November 2023.

6.34. The figure on the next page sets out the governance arrangements which have been established for this phase of the programme.

Figure 8 – pre-Day 1 programme governance structure

Solent NHS Trust Trust Board

Southern Health NHS FT Trust Board

Isle of Wight NHS Trust Trust Board

Sussex Partnership Trust Board

Programme Board
Chair: NED rotation

ICB view

Regulator view

Clinical Transformation Group
Chairs: Southern and Solent CMOs

Programme Team
Chair: Designate Chief Operating Officer (once appointed)

Clinical Reference Group
Chair: IoW Director of CMHLD

Integration Planning Group
Chair: Designate Exec with responsibility for integration (once appointed)

Clinical Steering Group

Business Support, Intelligence & Development Steering Group

Finance Steering Group

Workforce Steering Group

Comms & Engagement Steering Group

Digital Steering Group

Estates Steering Group

Organisational Development Steering Group

Corporate Governance Steering Group

Pre-Day 1 programme resources

6.35. Each Steering Group regularly reviews the resources that it needs to prepare and implement its integration plans and, where required, additional programme resources are requested from the programme's Finance Steering Group.

6.36. Following the IPG meeting held on 11 October 2023, a small increase in FTEs in Southern and Solent is planned to enhance the programme's capacity and increase back-fill to allow existing staff to provide more support to integration planning activities.

Post-Day 1 integration governance

Objectives of post-Day 1 integration

6.37. The key objectives of this phase of the programme are to:

- Provide assurance over the delivery of the integration plans and realisation of the identified benefits; and
- Ensure that integration plans appropriately:
    - Address the four key challenges that have led to the creation of the new Trust; and
    - Respond to additional risks, issues and benefits identified during the implementation phase.

Roles and responsibilities for post-Day 1 integration

Trust Board oversight

6.38. Learning from previous transactions has been taken into account to inform our governance and oversight arrangements leading up to, and post, transaction. Establishing effective and robust non-executive oversight processes is necessary to provide assurance of successful delivery of the integration plans after Day 1.

6.39. The programme will determine appropriate Board oversight processes which is likely to be through an additional Board committee or dedicated time at Trust Board meetings.

6.40. The Trust Board will receive reports on the implementation of integration plans on a monthly basis for the first six months after Day 1, after which the frequency of reporting will be reviewed to take into account the overall status of the programme and the outstanding actions in integration plans.

6.41. The Trust Board will additionally receive reports on the outcomes of post-Day 1 impact evaluations, as set out in paragraph 9.20, which will set out the actual benefits realised compared to expected benefits and the main lessons learned.

Executive Team

6.42. The new Trust's executive team will be responsible for directing the work of the integration programme.

Integration Planning Group

6.43. The IPG will continue to provide assurance around the continued development and delivery of integration plans and activities, including supporting the Steering Groups to manage interdependencies across the programme. The IPG will report progress and escalate issues to the new Trust's executive team.

Post-Day 1 programme resources

6.44. The programme will be led by the executive with responsibility for integration, with appropriate programme management support.

6.45. The executive lead will oversee the overall programme, including coordinating the work of the Steering Groups, ensuring interdependencies are managed and effective processes are established to measure the benefits realised.

6.46. The programme management support will coordinate the papers for the IPG, executive team and Board, including collating and quality assuring Steering Group highlight reports and ensuring risks are identified and mitigated.

6.47. The programme's Steering Groups will lead delivery of integration plans, utilising in-house resources as far as possible to maintain ownership, retain knowledge and keep costs down.

Risk management and mitigation

Pre Day 1 risk management

6.48. The Trusts' risk management strategies set out the key responsibilities for managing risk within the organisations, including the ways in which risks are identified, evaluated and mitigated. Business as usual risks arising from the Trusts' ongoing activities are captured on the Trusts' individual risk registers.

Risk identification

6.49. Risk have been identified from a number of sources including:

- Due diligence reports which were prepared between May and July 2023 and reviewed by Trust Boards in September 2023;
- Individual Steering Groups' risk registers;
- External sources, such as in relation to policy changes; and
- The development of the SC and FBC.

6.50. The Steering Groups identify risks to the delivery of these integration plans. These are captured in a programme-wide risk register by the programme manager, and are escalated on the basis of the scoring assigned and mitigating action required.

6.51. Each Steering Group additionally maintains an issues log, which documents the expected impact of identified issues after taking into account mitigating actions required or taken. Significant issues are escalated to the Integration Planning Group.

Risk categorisation

6.52. Risks have been categorised as transaction risks (risks to creation of the new Trust on 1 April 2024), integration risks (risks arising from bringing the Trusts and services together) or business as usual (BAU) risks (relevant risks arising from the Trusts' ongoing activities which may impact on the programme).

6.53. **Transaction risks** are those which may impact on the creation of the new Trust on 1 April 2024. If transaction risks are not effectively mitigated then the proposed creation of the new Trust may be delayed or cancelled – or potentially significant issues may require retrospective remedy after the Day 1.

6.54. Transaction risks include:

- Regulatory risks, such as approval for the creation of the new Trust and registering with the CQC;

- Financial risks, such as in relation to the costs and benefits of the programme and the valuation of contingent liabilities; and
- Cultural and human resources risks, such as the capacity required to deliver the programme and increased vacancy rates.

6.55. **Integration risks** are those which may impact on the delivery of the PTIP and integration of clinical services and corporate functions. If integration risks are not effectively mitigated then the benefits of creating the new Trust may not be achieved.

6.56. Integration risks include:

- Operational, including patient safety, risks such as risks arising from policies and procedures not being harmonised;
- Financial risks, such as in relation to the robustness of benefit calculations and the forecast costs of integrated services;
- Cultural and human resources risks, such as in relation to aligning different ways of working and managing vacancy rates;
- IT and technology risks, such as in relation to running multiple reporting systems.

6.57. **BAU risks** are those arising from the existing Trusts' ongoing activities which may impact on the programme. BAU risks are included in the programme risk register for information but are not owned or managed by the programme.

Risk scoring

6.58. Risks have been scored in accordance with the matrices set out in the tables in Appendix 2. The risk scoring matrix is broadly consistent with those used in the Trusts' risk management processes.

Risk management and mitigation

6.59. 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. A risk assessment matrix is used to ensure a consistent approach is taken to assessing and responding to identified risks.

6.60. The programme risk register includes the following information:

- Source of the risk
- Risk category
- Risk subject and description
- Impact description and score (in accordance with the risk scoring matrix)
- Probability description and score (in accordance with the risk scoring matrix)
- Residual risk score (impact x probability)
- Trend (in risk score)
- Description of controls in place and planned mitigating actions
- Date identified and last reviewed

6.61. Steering Groups consider their own risk registers and escalate risks if they are scored (in accordance with the risk scoring matrix) as follows:

- Above 8 (medium-high), to the Programme Team; and
- Above 10 (high) to the Programme Board.

6.62. Board oversight of risks is carried out through:

- The Non-Executive Director chair and members of the Programme Board (as set out in paragraph 6.11);
- The periodic progress updates submitted to Trust Boards by the Programme Director (as set out in paragraph 6.13)
- The Trusts Boards' reviews of the SC, FBC and PTIP, which contain key risks.

6.63. The Integration Planning Group provides a forum to discuss and resolve any risk management issues arising from interdependencies between Steering Groups.

Key programme risks

6.64. The programme risk register was last reviewed by the Programme Board at its most recent meeting on 16 October 2023. Programme risks with a post-mitigation score of above 10 as at 30 October 2023 (excluding BAU risks) are summarised in figure 9 below. This figure shows the revised presentation of risks that has been adopted from November 2023 and categorises risks by theme.

Figure 9 Programme risks (extract from programme risk register)

Risk	Impact	Probability	Mitigated score
Transaction			
IoW does not have resource to support the programme alongside demands from ither strategic programmes.	3	4	12
If there is insufficient time, capacity or capability to undertake thorough integration planning there is a risk that critical path activities are not completed and the planned Day 1 is not achieved.	4	3	12
Risk that identified benefits do not outweigh risks and costs and FBC does not contain sufficient detail to assure Boards (for example in respect of patient benefits) and the FBC is not approved by Trust Boards	5	3	15
People			
Reduced staff morale leads to loss of staff during the period of transition, impacting productivity and potentially destabilising services leading to incidents and reputational damage.	4	4	16
Potential disparity in remuneration approaches for staff across the different Trusts could result in inequities that could negatively impact on staff morale if not dealt with in a timely and agreed way.	4	4	16
Risk that a temporary staffing model is not put in place and operational teams cannot access temporary staffing from Day 1.	4	3	12
If the creation of the new Trust's culture, behaviours and values does not address concerns raised and is not co-designed and embedded with staff and supported by managers, there is a risk that acceptance of the transition will be poor, we will not create the positive conditions for a healthy culture and staff turnover rates will increase.	4	4	16
Risk that compliance with statutory and mandatory training reduces.	4	3	12
Quality, safety and performance			
Risk that ICS financial position puts pressure on programme budget, resulting in sub-standard delivery or delay, ultimately leading to benefits not being realised.	4	4	16
Risk that 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
Risk that staff are not aware of or trained in the policies in place on Day 1, potentially leading to adverse outcomes.	4	3	12
Risk that quality governance, quality assurance and quality improvement arrangements may be ineffective if the new organisational structure, governance arrangements, design and clinical service models do not take account of the size and scale of the new Trust, resulting in adverse impact on Board oversight and assurance, patient safety and risk management, as well as compliance and regulatory requirements.	4	3	12

Risk	Impact	Probability	Mitigated score
Potential risk of harm to patients if the integration planning and wider full business case process misses any critical components or fails to recognise the significance or unintended consequences of any actions taken.	4	3	12
Risk that creating the new Trust leads to “levelling down” of services in some areas and/or loss of local focus and existing strengths resulting in loss of Board to ward connection and negative impact on patient experience and outcomes.	4	3	12
Governance			
Risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16
Risk that community services resource may be lost following the disaggregation of IoW, due to the acute integration with PHU.	4	3	12
Risk that if safeguarding processes, supervision models, learning from incidents, governance and systems are not aligned effectively to the structure of the new Truust and preserve the place-based requirements, there could be a negative impact on staff wellbeing, morale, recruitment and retention which could impact on safeguarding activities.	4	3	12
Infrastructure			
There is a risk that staff are not supported by resilient digital services and progress to new infrastructure solutions is not maintained.	4	3	12
Risk that if impact assessments and requirements for Day 1 access to digital systems are not completed and in place in time, clinical care and patient safety could be impacted as staff may not be able to access key systems and historical data or be able to document essential information.	4	3	12

6.65. The programme risk register is a live document which will be kept updated as the programme progresses, including to take account of identified during the continued development and implementation of detailed integration plans.

Post-Day 1 risk management

6.66. Prior to Day 1, the new Trust's designate Board will develop a clear and aligned risk management vision statement, strategic aims, risk appetite and tolerance to inform the development of the risk management strategy and BAF for the new Trust. Following agreement of the Trust's strategic objectives, the Corporate Governance Steering Group will support the designate Board in identifying the principal risks to delivery of the strategic objectives and developing the BAF.

6.67. The BAF, and highest scoring risks from the corporate risk register, will be reviewed by the relevant Board Committees on a quarterly basis, and in consolidated form quarterly by the Audit Committee and Board of Directors. The ongoing management of the BAF will be led by the corporate governance function in the new Trust.

6.68. The risk management processes for the new Trust will be supported by the quality governance teams and the transitional processes will be overseen via the Clinical Steering Group.

6.69. The Trusts plan develop a risk management strategy and policy framework for the new Trust by the end of January 2023 to ensure that patients, visitors, employees, contractors and other members of the public are not exposed to unnecessary risks. This will be supported by a single risk matrix and risk register template.

6.70. The proposed structure for the quality governance function includes a risk manager post to work across the new Trust and support effective risk management.

7. Integration overview

Overview

7.1. This chapter describes the overarching plan for integration by setting out:

- The key integration milestones;
- The key integration activities which will have taken place in advance of, or on, Day 1;
- The processes which have been established by the programme to manage interdependencies between its Steering Groups; and
- The processes by which the new Trust's Board members have been (or will be) appointed.

7.2. This chapter also summarises the detailed integration plans developed by the programme's Steering Groups including:

- Key activities which will be undertaken during implementation of the integration plans; and
- Key milestones and benefits which will be realised through implementation of the integration plans.

Integration Plan Timelines

7.3. A critical path timeline for priority Day 1 integration activities has been developed by the programme team, based on the detailed integration plans developed by the programme's Steering Groups.

7.4. Delivery of these critical path activities, which will continue to evolve in line with the programme's detailed integration plans, will be monitored by the IPG.

7.5. The critical path timeline is shown as figure 10 on the following pages. The key milestones for each of the Steering Group's detailed integration plans are shown further below as figure 11.

Figure 10: Pre-Day 1 critical path activities

ID	Task Name	Start	Finish	% Comp	Chart label (Jul 2023 – Jul 2024)
1	**Fusion Programme Plan - Day 1**	**Tue 01/08/23**	**Mon 01/04/24**	**18%**	
2	**Gateway review 1 (interim review)**	**Mon 20/11/23**	**Mon 20/11/23**	**0%**	20/11/23
3	**Gateway review 2 (interim review)**	**Mon 18/12/23**	**Mon 18/12/23**	**0%**	18/12/23
4	**Gateway review 3 (interim review)**	**Mon 15/01/24**	**Mon 15/01/24**	**0%**	15/01/24
5	**Gateway review 4 (penultimate review)**	**Mon 19/02/24**	**Mon 19/02/24**	**0%**	19/02/24
6	**Gateway review 5 (final readiness review)**	**Mon 11/03/24**	**Mon 11/03/24**	**0%**	11/03/24
7	**Critical Path Activities**	**Tue 01/08/23**	**Mon 01/04/24**	**18%**	
8	Agree key changes to constitution	Tue 01/08/23	Fri 18/08/23	10...	Corporate Governance SG
9	Articulate Board committee structure	Tue 01/08/23	Thu 31/08/23	10...	Corporate Governance SG
10	Recommend name of new Trust	Tue 01/08/23	Wed 15/11/23	85%	Programme Board
11	Confirm mechanism for Isle of Wight transfer	Tue 01/08/23	Mon 18/09/23	10...	Programme Board
12	Prepare draft constitution	Tue 22/08/23	Mon 18/09/23	10...	Corporate Governance SG
13	Confirm Board composition including Executive and NED portfolios	Tue 01/08/23	Mon 30/10/23	90%	Corporate Governance SG
14	Isle of Wight segmentation confirmed	Tue 01/08/23	Fri 29/12/23	40%	Finance SG
15	Confirm medium term (3 year) financial plan for new Trust (inc in FBC)	Tue 03/10/23	Mon 13/11/23	95%	Finance SG
16	Agree clinical strategy for the new Trust	Fri 01/09/23	Thu 12/10/23	10...	Clinical SG
17	Design and carry out 'As is' cultural review	Wed 02/08/23	Mon 18/09/23	10...	OD SG
18	Design and carry out 'Shape our new Trust' engagement activities	Wed 02/08/23	Mon 18/09/23	10...	OD SG
19	Articulate high level vision and values for new Trust in FBC	Fri 01/09/23	Thu 12/10/23	10...	Comms SG
20	Create and launch change pack of resources for managers	Mon 11/09/23	Mon 06/11/23	75%	OD SG
21	Confirm Day 1 approach for clinical and corporate systems	Fri 01/09/23	Fri 10/11/23	66%	Digital SG
22	Confirm process for confirming appointments to the Senior Leadership Team	Fri 01/09/23	Mon 20/11/23	50%	Programme Board
23	Confirm Board Committee portfolios and TORs	Wed 01/11/23	Mon 15/01/24	0%	Corporate Governance SG
24	Review and update business continuity plans for all services	Mon 23/10/23	Wed 28/02/24	0%	All SG
25	Prepare all policies required for Day 1	Fri 01/09/23	Mon 04/03/24	20%	All SG

Figure 10: Pre-Day 1 critical path activities (continued)

ID	Task Name	Start	Finish	% Comp	2024: Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar, Apr, May, Jun, Jul
26	Approve new policy governance arrangements (Policy in Common Forum)	Tue 07/11/23	Tue 07/11/23	0%	07/11/23
27	Approve all policies required for Day 1	Mon 04/12/23	Mon 01/04/24	0%	All SG
28	Boards in Common approve FBC, PTIP, PBC and Board Certification	Mon 13/11/23	Mon 13/11/23	0%	13/11/23
29	Submit FBC, PTIP, PBC and Board Certification to NHSE for review	Fri 17/11/23	Fri 17/11/23	0%	17/11/23
30	Define and agree Quality Assurance Framework	Thu 02/11/23	Mon 05/02/24	0%	Clinical SG
31	Develop corporate branding	Wed 27/12/23	Mon 05/02/24	0%	Comms SG
32	Implement single recruitment system (Oleeo)	Fri 01/09/23	Thu 01/02/24	0%	Workforce SG
33	Agree and implement arrangements for temporary staffing	Fri 01/09/23	Fri 29/03/24	0%	Workforce SG
34	Implement single payroll provider (Salisbury)	Fri 01/09/23	Wed 31/01/24	0%	Workforce SG
35	Determine Learning Management System arrangements for Day 1	Mon 23/10/23	Mon 20/11/23	0%	Workforce SG
36	Implement Mass Organisation Change Process (MOCP) on ESR for IOW staff	Mon 20/11/23	Fri 29/03/24	0%	Workforce SG
37	Roster system (Allocate) manual build (IOW) and alignment to common roster day	Wed 01/11/23	Fri 29/03/24	0%	Workforce SG
38	TUPE consultation and transaction work (Isle of Wight staff)	Mon 30/10/23	Fri 29/03/24	0%	Workforce SG
39	TUPE consultation and transaction work (Solent staff)	Mon 20/11/23	Fri 29/03/24	0%	Workforce SG
40	Confirm names of Executive Directors	Thu 30/11/23	Fri 29/12/23	0%	Programme Board
41	Confirm day 1 operational management structure	Tue 02/01/24	Mon 12/02/24	50%	Programme Board
42	Confirm names of Senior Leadership Team (inc nationally mandated post such as DIPC) and register as required	Tue 02/01/24	Fri 15/03/24	0%	Programme Board
43	Confirm new Organisation Code	Thu 28/09/23	Mon 27/11/23	75%	IPG
44	Finalise Heads of Terms (based on Partnership Agreement)	Mon 02/10/23	Fri 17/11/23	63%	Programme Team
45	Design and implementation of a new finance report for the new organisation	Mon 02/10/23	Thu 30/11/23	80%	Finance SG
46	Prepare and agree with ICB 2024/25 Operational Plan for the new Trust	Mon 09/10/23	Fri 29/03/24	5%	Finance SG

Figure 10: Pre-Day 1 critical path activities (continued)

ID	Task Name	Start	Finish	% Comp	Resource (Gantt)
47	Confirm corporate and clinical team structures for Day 1	Thu 26/10/23	Thu 01/02/24	0%	All SG
48	Launch policies / train staff in priority policies for Day 1	Thu 01/02/24	Fri 29/03/24	0%	All SG
49	Establish initial combined Cyber Security Assurance Framework	Mon 12/02/24	Fri 22/03/24	0%	Digital SG
50	Register Data Security and Protection Toolkit	Mon 11/03/24	Fri 15/03/24	0%	Digital SG
51	Register new Trust with the ICO	Mon 11/03/24	Fri 15/03/24	0%	Digital SG
52	Complete CQC de-registration for Solent and registration for the new Trust	Tue 02/01/24	Wed 13/03/24	0%	Clinical SG
53	Agree, document and communicate out of hours on call arrangements	Mon 12/02/24	Mon 18/03/24	0%	Clinical SG
54	Design and implement statutory performance reporting for new Trust (inc reporting period and history)	Mon 30/10/23	Fri 29/03/24	0%	BSID SG,Clinical SG
55	Ensure all BI users have access to required systems to ensure safe operation of services	Mon 30/10/23	Fri 29/03/24	0%	BSID SG
56	Implement changes to enable collaborative working on existing Microsoft tenancies	Mon 30/10/23	Thu 29/02/24	0%	Digital SG
57	Align legacy networks to allow staff to connect from any site	Fri 27/10/23	Thu 29/02/24	0%	Digital SG
58	Define and agree performance governance framework	Mon 30/10/23	Fri 29/12/23	0%	BSID SG
59	Implement single financial ledger	Wed 01/11/23	Fri 22/03/24	0%	Finance SG
60	Agree clinical governance/patient safety processes in line with NICE and regulatory requirements	Mon 04/12/23	Wed 14/02/24	0%	Clinical SG
61	Agree IOW estate arrangements inc hard and soft FM, utilities, etc	Tue 02/01/24	Fri 02/02/24	0%	Estates SG
62	Develop joint Patient Safety Incident Response Plan for Day 1 (PSIRP)	Mon 08/01/24	Fri 01/03/24	0%	Clinical SG
63	Establish and implement single intranet solution	Mon 04/09/23	Mon 11/03/24	20%	Comms SG
64	Establish and implement new public website	Mon 04/09/23	Mon 18/03/24	15%	Comms SG
65	Approve estates non-pay spend (e.g. signage)	Tue 12/12/23	Tue 12/12/23	0%	12/12/23
66	Implement changes to Ulysses Risk & Incident system	Mon 20/11/23	Wed 28/02/24	0%	Clinical SG

Gantt timeline: Jul, Aug, Sep, Oct, Nov, Dec, 2024 Jan, Feb, Mar, Apr, May, Jun, Jul

Figure 10: Pre-Day 1 critical path activities (continued)

ID	Task Name	Start	Finish	% Comp	Gantt label
67	Merger of third party continuation of supplies systems	Mon 18/12/23	Mon 25/03/24	0%	BSID SG
68	Ensure all appropriate supply contracts are covered from Day 1	Mon 08/01/24	Mon 25/03/24	0%	BSID SG
69	Agree standing orders, Scheme of Delegation and Standing Financial Instructions for approval by new Trust	Mon 27/11/23	Fri 29/03/24	0%	Corporate Governance
70	Review and agree legacy claims liabilities with NHS Resolution	Mon 18/12/23	Thu 29/02/24	0%	Clinical SG
71	Develop and implement new BAF	Tue 02/01/24	Fri 29/03/24	0%	Corporate Governance
72	Agree headquarters of the new Trust	Tue 02/01/24	Mon 11/03/24	0%	Designate Board
73	Rapid review of learnings from Hampshire CAMHS mobilisation	Thu 01/02/24	Thu 08/02/24	0%	Programme Board
74	Trust Boards approve the Management Letter of Representation	Mon 05/02/24	Wed 07/02/24	0%	Trust Boards
75	Follow up review of learnings from Hampshire CAMHS mobilisation	Fri 09/02/24	Thu 29/02/24	0%	Programme Board
76	Finalise transaction agreement	Mon 12/02/24	Wed 13/03/24	0%	Programme Team
77	Establish Go Live command centre for 1 week pre- go live and 2 weeks post-go live	Mon 19/02/24	Fri 15/03/24	0%	Clinical SG
78	Install any new signage required for Day 1	Mon 18/03/24	Fri 29/03/24	0%	Estates SG
79	NHSE Strategy Planning and Investment Committee agree risk rating for the transaction	Tue 12/03/24	Tue 12/03/24	0%	12/03/24
80	Trust Boards review of outcome of NHSE FBC review (letter confirming risk rating) and approve the transaction	Thu 14/03/24	Fri 15/03/24	0%	Trust Boards
81	Council of Governors approve Constitution (inc new Trust name) and written application to NHSE	Fri 15/03/24	Mon 18/03/24	0%	Council of Governors
82	Submit written application to NHSE	Mon 18/03/24	Mon 18/03/24	0%	18/03/24
83	Prepare and issue Day 1 welcome pack (inc ID badge, etc)	Fri 01/03/24	Thu 28/03/24	0%	Comms SG
84	New Trust go live	Mon 01/04/24	Mon 01/04/24	0%	01/04/24

Timeline: Jul, Aug, Sep, Oct, Nov, Dec, 2024 Jan, Feb, Mar, Apr, May, Jun, Jul

Figure 11: Integration Plan milestones

2023: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec | 2024: Jan, Feb, Mar, Q1, Q2, Q3 | 2025: Q4, Year 2 | 2026: Year 3

Activity Name
Clinical Services
Ensure business continuity plans are in place for all services
Align escalation processes and establish on call arrangements
Prepare Day 1 clinical reference guides
Develop a Go Live Command Centre for the first two weeks post-Day 1
Agree chain of command and clinical organisational structures
Identify all digital systems used by the Trusts' clinical services
Agree and prioritise the new Trust's clinical services' digital requirements
Review and develop CAMHS Day Service
Agree CAMHS Leigh House Transition Service contract variation
CAMHS Leigh House Transition Service Service go live
Southampton CAMHS / UHS - Virtual Wards Go live
Develop mobilisation in Reach into Peadiatric Wards
Develop CAMHS career pathways and rotational nurse programme
Pilot frailty best practice model
Roll out updated Frailty best practice model
Roll out frailty clinical strategy and operating model
Pilot virtual ward model
Roll out revised virtual model model
Develop OPMH Dashboard
Develop OPMH tier 3 & 4 proposals, including AMH/OPMH options
Develop OPMH crisis community model expansion proposals
Develop plan to meet OPMH & Dementia ward accrediation
Agree funding for environmental improvements to OPMH wards
Implement divisional Memory Assessment Service pilot
Implement agreed model of MAS across HIOW
Implement primary care neuroimaging in MAS pathways
Appoint OPMH & Dementia CDG leads
Develop Recovery College and Education model
Plan Recovery College implementation phase 1
Plan Recovery College implementation phase 2
Plan Recovery College implementation phase 3
Develop Peer Support model
Plan phased Peer Support model implementation
Appoint interim Lived Experience Board lead
Appoint permanent Lived Experience Board lead

Figure 11: Integration Plan milestones (continued)

Activity Name	2023									2024						2025		2026
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	Year 2	Year 3
Clinical Governance																		
Update and replace existing PGDs for the new Trust																		
Complete job appraisals for all medical staff																		
Complete joint job planning activities for all medical staff																		
Establish an integrated ROAG for the new Trust																		
Ensure compliance with requirements for safe working hours																		
Establishment a combined Clinical Ethics forum																		
Appoint Caldicott Guardian																		
Review and agree legacy claims liabilities with NHS Resolution																		
Develop and implement Mental Health Act legislation processes and structures																		
Develop Safeguarding function team structures, policies and processes																		
Develop Safeguarding Allegations Management Advisor portfolio																		
Review existing IPC policies and draft integrated IPC policy																		
Ensure appointment of Director of Infection Prevention and Control																		
Ensure SLAs are in place for the provision of IPC services on the IOW																		
Agree processes for IPC Incident reporting and investigation																		
Develop operational risk management frameworks and policies																		
Develop an integrated risk management strategy																		
Establish joint patient safety meetings																		
Develop joint Patient Safety Incident Response Plan for day 1																		
Ensure the new Trust is correctly registered with the CQC																		
Review existing CQUINS and develop a joint CQUIN plan																		
Establish shared CQC engagement meetings																		
Confirm the new Trust's rating with CQC																		
Develop support offer for families and carers																		
Develop a single complaints policy for the new Trust																		

Figure 11: Integration Plan milestones (continued)

Timeline: 2023 (Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec); 2024 (Jan, Feb, Mar, Q1, Q2, Q3); 2025 (Q4, Year 2); 2026 (Year 3)

Activity Name
Corporate Governance
Agree new Policy and SOP governance process
Agree Board committee structures and Terms of Reference
Develop new Governor constituencies, CoG composition and election process
Hold elections for vacancies for Governor posts
Refresh membership strategy
Draft and obtain approval for new Trust's constitution
Agree standing orders, Scheme of Delegation, and SFIs
Publish Annual Reports and Annual Governance Statements
Agree composition of Board of Directors
Agree NED porfolios
Undertake Fit and Proper Person Test for new Board Directors
Finance
Develop plan to achieve OneNHS Finance accreditation
Approval of the new Trust's financial plan
Implement a single finance ledger
Establish Financial Accounting standards and processes
Agreement of 2024/25 financial budgets
Obtain approval for the new Trust's financial report templates
Create a single financial recovery plan for the new Trust
Develop new integrated finance team structure
Implement new integrated finance team structure
Approval of 2024/25 Capital Programme
Negotiate and agree commissioner contracts
Obtain approval for the new Trust's financial strategy
Commercial
Implement commercial service models
Implement commercial team structures
Merge system for e-tendering solution
Merger of third party continuation of supplies systems
Integration of e- cataloging virtual stock
Set up of new Trust on contracts system
Test and validate integrated PMO / planning system
Harmonisation of processes, policies and procedures
Development of forward plans
Develop interim category management strategies
Ensure all appropriate supply contracts are covered from Day 1

Figure 11: Integration Plan milestones (continued)

Activity Name
BI & Performance
Design and implement statutory reporting processes
Design and implement safety related information processes
Implement unified data system
Define and agree performance governance framework
Design BI & Performance team structures
Implement BI & Performance team structures
Digital
Provide network connectivity for Hampshire CAMHS locations
Implement VRF networking enhancements
Create Infrastructure transformation strategy
Implement single WAN/LAN/WiFi configuration
Create a single digital Service point of Contact
Agree phased digital infrastructure and systems integration timescales
Solent achieve DCB1596 accreditation for securemail
Enable collaborative working on existing Microsoft tenancies
Implement final Microsoft tenancy configuration
Implement single email system
Create Clinical Systems Strategy
Develop clinical systems transformation programme
Establish combined DPIAs Process
Registration with ICO
Establish combined Cyber Security Assurance Framework
Develop IG & Cyber Communication Plan
Develop digital governance and operating model
Implement digital team structures
Establish single process for initiation of new Digital projects

Figure 11: Integration Plan milestones (continued)

2023: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec | 2024: Jan, Feb, Mar, Q1, Q2, Q3 | 2025: Q4, Year 2 | 2026: Year 3

Activity Name
Organisational Development
Design and carry out 'As is' cultural review
Design and carry out 'Shape our new Trust' engagement activities
Embed recommendations from the Shape our Trust Engagement
Design and launch a leadership survey
Create an internal 360 feedback tool
Creation of a universal appraisal framework
Create a change pack of resources for managers
Design an appropriate warm welcome pack
Develop a programme of networking opportunities for leaders
Develop engagement measurement and support tool
Develop People Pulse feedback tools
Design and deliver a cultural influencer programme
Embed values and culture into employee lifecycle, processes and policies.
Workforce
Harmonisation of electronic learning platform
Establish Day 1 Payroll and Pensions provision
ESR system integration
Allocate systems alignment
Design Workforce team structures
Implement Workforce team structures
TUPE: agree measures
TUPE: Deliver staff consultations
TUPE: Agree TIER 1 ER Contractual Policies and toolkits
TUPE: Agree employee relation case management processes

Figure 11: Integration Plan milestones (continued)

Activity Name	2023: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec; 2024: Jan, Feb, Mar, Q1, Q2, Q3; 2025: Q4, Year 2; 2026: Year 3
Communications and Engagement	
Develop Communications Strategy for new Trust	
Develop a new brand identity	
Align and develop internal and external communication channels	
Align and develop online spaces	
Align public relations activities, including media	
Align communications policies, processes and procedures	
Implement two way engagement processes	
Develop a compelling organisational narrative	
Develop an internal engagement campaign	
Develop SOPs to ensure that the support provided to families is consistent	
Align payments policy for service users and involvement of communities	
Codesign and coproduce community engagement approaches	
Developing a single feedback system	
Develop and agree our approach to volunteers	
Estates	
Develop capital programme and key principles of the strategic estates plan	
Main signage replaced and Wayfinding strategy in place	
Estates Strategy agreed and approved	
Agreement on future arrangements for occupation of IoW St Mary's site	
Single green plan in place	
Novate and consolidate waste contract	
Agree Hard FM agreements for IOW transferring estate	
Medical devices policy aligned	
Complete transfer of Solent buidings	
Complete transfers of IoW buildings	
Novate and consolidate waste water contracts	
Approve aligned H&S polices	
PLACE, ERIC and PAM Reports for 2023/24 (Solent and SHFT)	
PLACE, ERIC and PAM reports for 2024/25 (new Trust)	
Aligned estates Helpdesk Go Live	
Complete SFG20 Health Derogations	
Approve CAFM SLAs for IOW Transferring Estate	
Implement outcome of CAFM Strategic Review	
Implement Soft FM SLAs for IOW Transferring Estate	
Approve insurance strategy	
Phased Go Live of estates IT Systems	
Ligature Management Policy approved	

7.6. The overarching integration plan has been developed from the detailed integration plans of the programme's Steering Groups (the Steering Group Integration Plans). These are summarised from paragraphs 7.22 to 7.190 and the detailed integration plans are included as supporting submissions. The Steering Group Integration Plans are live documents and will continue to be developed and iterated up to and beyond Day 1.

Day 1 preparedness

7.7. As set out in chapter 5 of this PTIP, the Programme Board has identified that the focus for Day 1 will be for the new Trust to be safe and legal and for there to be no adverse impact on operation of clinical services.

7.8. The table below sets out the key integration activities which will have taken place in advance of, or on, Day 1 in line with to ensure this integration principle will be delivered:

Figure 12: Day 1 integration priorities

Integration Plan	Day 1 integration priorities
Clinical Services (Clinical Steering Group) [4]	• Ensure business continuity plans and escalation processes are in place for all services • Establish and communicate Senior Manager on Call arrangements • Prepare reference guides for clinical services to ensure clarity around key functions • Develop requirements for a Go Live Command Centre for the first two weeks post-Day 1, including staffing levels and operating hours, to provide support and guidance for operations teams • Develop escalation and cascade arrangements for the Go Live Command Centre • Communicate line management based on Day 1 operational management structures • Agree and prioritise the new Trust's clinical services' digital requirements, including those required for Day 1
Quality Governance (Clinical Steering Group)[4]	• Review, update and replace existing Patient Group Directives for the new Trust • Establish an integrated Responsible Officer Advisory Group[5] (ROAG) for the new Trust • Ensure that any processes are in place for day to day managing of medical cases outside of ROAG • Establish interim joint working processes to ensure the contractual requirements for safe working hours of doctors in training are met • Align existing Terms of References to enable the establishment of a combined Clinical Ethics forum • Appoint Caldicott Guardian

[4] In order to improve clarity in this document over the integration actions relating to the integration of clinical services and those relating to establishment of integrated quality governance processes, the Clinical Steering Group's Integration Plan has been split into two sections (Clinical Services and Quality Governance).

[5] The ROAG provides input to decision making with regard to appraisal, revalidation, performance concerns about doctors, employment processes, and any other aspects relevant to the Responsible Officer function

Integration Plan	Day 1 integration priorities
	• Review and agree legacy claims liabilities with NHS Resolution • Establish integrated filing systems and single portal arrangements with NHS Resolution to allow for seamless management of claims • Develop and implement Mental Health Act legislation processes and structures for the new Trust • Develop Safeguarding function team structures, processes and ways of working • Appoint Director of Infection Prevention and Control (DIPC / IPC) • Ensure SLAs are in place for the provision of IPC services where required • Agree processes for IPC Incident reporting and investigation, including agreeing the criteria for priority incidents with the ICB • Develop operational risk management frameworks • Establish joint patient safety meetings • Develop joint Patient Safety Incident Response Plan for day 1 • Establish shared CQC engagement meetings, ensure the new Trust is correctly registered with the CQC, and confirm rating • Develop a joint CQUIN plan • Develop Standard Operating procedures (SOPs) to support delivery of the new Trust's support for families and carers offering to individuals • For policies identified as requiring harmonisation for Day 1, review existing policies to identify good practice and opportunities for improvement and develop new Trust policy
Corporate Governance	• Establish Board and executive committee structures • Appoint Board of directors and agree portfolios • Align BAF processes and establish a process for the new Trust • Align Fit and Proper Persons Test processes and establish process for the new Trust • Write new constitution • Review insurance policies and arrange cover for the new Trust • Coordinate drafting of the Trusts' 2023/24 annual reports and governance statements
Finance	• Liaise with HMRC and banks to ensure all requirements met • Review existing contracts for services and appoint single suppliers for internal audit, external audit, counter fraud and VAT liaison • Harmonise financial procedures including Standing Financial Instructions (SFI)
Commercial (BSID Steering Group)[6]	• Agree a process for the development of a single operating plan for 2024/25 • Alignment of Project Management Office (PMO) / Transformation work programmes and agree priorities with CDGs • Notify NHS Supply Chain of service start date and set up of new Trust District including IOW segmented services • Ensure third party continuation of supplies (BSG) review current methods and agree set up and processes in readiness for the new Trust

[6] In order to facilitate the development of appropriately focussed integration plans, the BSID Steering Group has developed separate integration plans for its Commercial and its Performance and BI services.

Integration Plan	Day 1 integration priorities
	• Agree interim governance processes for joint decisions prior to Day 1 • Review and update SOPS, governance, DPIA protocols and delegated approval / authority levels • Review and agree systems/databases for new organisation. • Develop interim category strategies • Map all anticipated income contracts (including leases) to agreed service specifications and planning activities for no overlap or gaps • Establish review process to ensure ongoing operational changes are included • Review current contracts to identify those likely to need novating and those which are likely to need to remain at IOW as part of P2P/SLA • Establish Contractual relationship and progress contract documentation with IOW for all items required to be delivered to Fusion by IOW • Ensure suppliers are set up on NHS Shared Business Services (SBS) and have new invoicing instructions • Novate contracts and waivers • Send letter to all suppliers communicating changes to the Trusts and creation of the new Trust • Ensure that all appropriate existing supply contracts are covered by the statutory instrument that legally establishes the new organisation from Day 1
Workforce	• Agree measures for TUPE and create documents needed for TUPE consultations • Develop and agree standard contract of employment for the new Trust • Deliver staff consultations for TUPE out staff • Harmonise and complete EIA for the new Trust's people policies on a prioritised basis, and support other Steering Groups to undertake EIA assessments on the new Trust's policies • Develop and implement integrated FTSU processes and policies • Plans to establish a single payroll system will have been approved, although existing payroll processes will remain in place for the first 100 days • Provide amended certificates of sponsorship in line with UK Visas and Immigration Authority (UKVI) guidelines
Performance and BI (BSID Steering Group)[5]	• Scope out mandatory and statutory requirements impacted and review current delivery models to identify good practices and opportunities for improvement • Identify mandatory and statutory requirements that must be combined by Day 1, and whether full integration / de-duplication is required, aggregate reports can be simply combined, or individual submissions can continue • Agree roles and responsibilities for each mandatory and statutory reporting requirement and implement solutions • Liaise with Digital Steering Group to ensure all current Performance and BI systems and infrastructures will continue to be accessible on Day 1
Digital	• Agree timetables for the phased implementation of integrated digital infrastructure, systems and policies on a prioritised basis

Integration Plan	Day 1 integration priorities
	• Ensure network connectivity at all locations • Agree key interim digital arrangements, including door access, Out of Hours (OOH) on-call, clinical risk management and SecureMail accreditation • Ensure all organisation specific code-based functions (e.g. SBS, EPRs) will continue to operate safely in the new organisation • Align key digital policies, processes and training programmes, and information governance structures • Develop and agree interim digital team structure, appoint to nationally mandated posts, such as Senior Information Risk Officer (SIRO) and Sata Protection Officer (DPO) • Registration with Information Commissioners' Office
Estates	• Develop and approve interim Business Continuity Plans for estates services and functions • Implement operational adjustments for estates services and functions • Commission and complete 6 Facet Surveys for Solent Buildings • Prepare and agree all necessary agreements and documentation for the transfer or occupation of the incoming IOW estate on Day 1
Communications and Engagement	• Develop options and agree the Trust's name, in consultation with Governors, system partners and NHS England • Jointly identify and agree Day 1 intranet requirements, with Digital and BSID colleagues, including content and pages, and new visual identity • Jointly identify and agree Day 1 external website requirements with Digital and BSID colleagues • Develop and approve communications Business Continuity Plans, and ensure staff communication processes are in place in relation to organisation-wide BCPs.

7.9. In accordance with the agreed integration principles (see paragraph 5.16), there will be minimal (if any) change to the way clinical services are delivered on Day 1. The integration of corporate services in advance of Day 1 will have commenced in some cases where there are opportunities to deliver productivity savings and increase operational resilience, including:

- The establishment of a shared resource for the recruitment of Internationally Educated Nurses (IEN) at Southern and Solent. By establishing a joint team through the use of honorary contract arrangements, which was led by Solent with interim funding arrangements agreed by both trusts, risks to the continuation of the IEN programme at Southern were mitigated whilst also providing Solent with a pipeline of activity to support investment in the international recruitment team; and

- The joint design of a resource pack, by the Trusts' OD teams, to help the new Trust's leaders develop their change leadership capability and support themselves, their services, and their teams through the period of transition. By drawing on the shared expertise of the Trust's OD teams, the shared support offer will sustainably increase operational resilience, by improving staff health, wellbeing and retention.

7.10. The table below summarises the planned level of integration on Day 1, which is set out in more detail in the corresponding sections of this chapter.

Figure 13: Day 1 integration status

Integration Plan	Day 1 integration status
Clinical Services	• Minimal (if any) changes to the way clinical services are delivered are expected on Day 1 • Business continuity plans will be in place for all clinical services on Day 1 and key information, such as Senior Manager on Call arrangements, will have been communicated to staff through reference guides • A "Go Live" command centre will have been established to provide support and guidance for operational teams over the first two weeks • Day 1 line management based operational management structures will have been agreed and communicated to staff to ensure clarity of service management and escalation processes.
Quality Governance	• Two main pharmacy teams to initially run in parallel from Day 1, with harmonised controlled drugs policy and function in place • A Research and Improvement Strategic Board will be established, with research and improvement staff working as a combined team • Job planning activities will have been completed for all medical staff • An integrated Responsible Officer Advisory Group will have been established • Joint Guardian of safe working processes will have been established • A combined Clinical Ethics forum will have been established • The new Trust's Caldicott Guardian will have been appointed and proposals for the delivery of the Caldicott Guardian function will have been developed • Processes and resources will be in place for the management of inquests, including support for staff called to inquests • Policies and processes in relation to the new Trust's obligations under Mental Health Act legislation, including advice and guidance mechanisms, will have been developed and implementation will have commenced on a prioritised basis • Aligned safeguarding processes and ways of working will have been established, and the implementation of an integrated safeguarding function will have commenced • Aligned electronic operational risk management platforms will have been implemented • Joint patient safety meetings will have been held prior to Day 1 • An agreed incident management process will be in place • The new Trust's DIPC will have been appointed, the IPC Group and the Antimicrobial Stewardship Committee will have been established, an integrated IPC service offering will have been developed, and an integrated IPC policy will have been drafted • IPC priorities, audit plan, reporting processes and data collection processes will have been agreed • A joint CQUIN plan will have been developed • SOPs will be in place to support delivery of the new Trust's support for families and carers offering to individuals, and plans will be in place to ensure individual policies and action plans are consistent with the new Trust's support offering

Integration Plan	Day 1 integration status
	• A joined-up approach to engagement with communities will be in place
Corporate Governance	• Designate Board members will take up their substantive posts on Day 1 • Terms of references for Board Committees will be drafted for approval at the first Board meeting of the new Trust in April 2024
Finance	• A single finance ledger will be in place, supported by an integrated financial reporting process • A financial strategy and single financial plan will be in place, supported by agreed commissioner contracts and an agreed financial recovery plan • Harmonised financial processes, timetables, templates and guidance documents will be in place • Activities to establish the structure, roles and responsibilities of the integrated finance function structure will have commenced
Commercial	• The procurement, contracting, commercial, planning, transformation and PMO service offering for the new Trust will have been agreed • The new commercial team structure will have been designed • Procurement leads will have agreed a process for merging e-tendering systems • Interim governance processes will have been established for joint commercial decisions prior to Day 1 • SOPs, governance, DPIA protocols and delegated approval / authority levels will have been reviewed and updated • An integrated list of suppliers will have been set up on SBS and have received new invoicing instructions • Outdated schedules/ contracts will have been reviewed, demand and capacity modelling will have been started in some areas with Commissioners • Agreed policies will be harmonised
Workforce	• Roles, responsibilities and interim procedures will have been agreed for mandatory and statutory reporting requirements • All current Performance and BI systems and infrastructures will continue to be accessible on Day 1 • Roles, responsibilities and interim procedures will have been agreed for prioritised joint reporting requirements (such as the Integrated Performance Report and operational reporting of national priority areas) • An options appraisal will have been carried out to establish processes for bringing together existing data sources, and a data migration / warehouse implementation plan will have been developed • Day 1 service delivery models will have been agreed for the BI and analytics team and for roles supporting the Performance Governance Framework • Team structures, roles and responsibilities will have been designed for the integrated BI and analytics team and for roles supporting the Performance Governance Framework
Organisational Development	• Actions will have been taken to ensure that there are meaningful opportunities for inclusive involvement in the design of the 'to be' culture • The new Trust's cultural ambitions will have been described

Integration Plan	Day 1 integration status
	• Interventions and support packages to enable achievement of the new Trust's cultural ambitions will be in place, including a range of resources to support team away days • A trust-wide appraisal framework, which enables reflection on the Trust values, will have been created
Performance and BI	• Roles, responsibilities and interim procedures will have been agreed for mandatory and statutory reporting requirements • All current Performance and BI systems and infrastructures will continue to be accessible on Day 1 • Roles, responsibilities and interim procedures will have been agreed for prioritised joint reporting requirements (such as the Integrated Performance Report and operational reporting of national priority areas) • An options appraisal will have been carried out to establish processes for bringing together existing data sources, and a data migration / warehouse implementation plan will have been developed • Day 1 service delivery models will have been agreed for the BI and analytics team and for roles supporting the Performance Governance Framework • Team structures, roles and responsibilities will have been designed for the integrated BI and analytics team and for roles supporting the Performance Governance Framework
Digital	• A service level agreement to enable the provision of digital support services to IOW will be in place • Interim arrangements will be in place to provide a single look and feel to priority systems, such as Microsoft infrastructure, and the new Trust's staff will be able to access the correct EPR from any of the new Trust's digital devices. • Prioritised Information Governance processes will have been implemented, supported by an interim integrated digital team structure
Estates	• Buildings and leases will be transferred to the new Trust on Day 1 • A prioritised capital plan will have been agreed; existing projects will continue to be delivered in line with current plans • Medical engineering, premises management and compliance processes will have been integrated. Interim operational adjustments will be in place to ensure the continuation of other services, including a single helpdesk contact. • Harmonised ligature risk assessment and management procedures will have been established.
Communications and Engagement	• Communications priorities, including launch communications for Day 1, will be in place, supported by stakeholder group communication tactics • A new intranet will have been created for all of the new Trust's staff • An interim landing page will have been launched for the new Trust's external website, with existing website content updated for the new Trust's visual identity • Staff communication lists will be created, with all staff receiving a new Trust email address (delivered by the digital integration plan)

Integration Plan	Day 1 integration status
	• An engagement plan to continue to bring staff on the journey for first 100 days will be launched • Interim communications and engagement team structures will be established • A new complaints policy will be in place, and a review of user feedback systems and procedures will have started • Core priorities for working together as place-based engagement teams will have been agreed • Resources will have been identified to review support provided to carers and families including through the lenses of the Pascoe report

First 100 days

7.11. In order to maintain momentum after Day 1, the programme's steering groups have identified a number of key activities for delivery in the first 100 days after Day 1. These activities include:

- The commencement of planning, scoping and development activities for the integration of the seven clinical service priorities not included as case studies in the PBC (as identified by the CTG, see paragraph 2.12);
- The establishment of a number of integrated corporate service team structures, as set out in the following sections of this chapter; and
- The launch of the new Trust's people plan supported by a compelling organisational narrative that is linked to the new Trust's vision and values.

Dependency management

7.12. Interdependencies have been identified by the programme's Steering Groups as part of detailed integration planning. Interdependencies have been categorised as being:

- Internal to the Steering Group's integration plan, such as those arising from the sequencing of integration activities for a particular Steering Group;
- Internal to the programme, principally relating to the sequencing of integration activities between Steering Groups; and
- External to the programme, such as regulator decisions.

7.13. In order to support the effective management of interdependencies across the programme's Steering Groups, the Integration Planning Group led a structured process to:

- Collate a schedule of the interdependencies identified by the Steering Groups;
- Agree the required timescales for information to be provided to enable delivery of integration plans; and
- Reflect these timescales within the detailed programme plan, which is maintained by the Programme Manager.

7.14. Steering Groups are responsible for managing their identified interdependencies. Dependencies which cannot be effectively managed by the Steering Groups are escalated to the IPG for resolution.

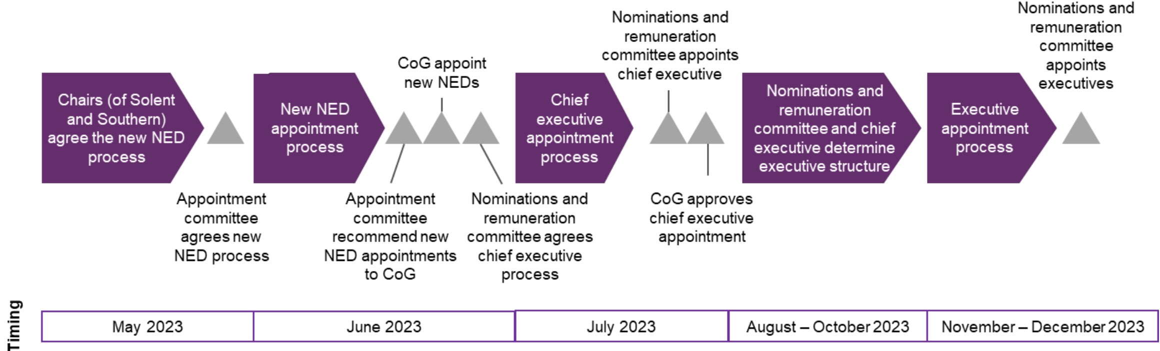
7.15. External dependencies are managed by the Programme Board, including through:

- The inclusion of ICB colleagues in relevant Steering Groups and the Programme Board's meetings;
- Regular meetings with NHS England colleagues to manage the dependency on regulatory processes; and
- Oversight of the programme risk register, as set out in paragraph 6.62.

Board appointment processes

7.16. The process to appoint designate members of the new Trust's Board for Day 1 is set out in figure 14 below. The process was developed based on the Partnership Agreement[7] and to comply with Southern's Constitution and the Code of Governance.

Figure 14: new Trust Board appointment process



7.17. Following an appointment process in accordance with the Partnership Agreement, the designate Chair for the new Trust (Lynne Hunt, the current Chair of Southern) was appointed by the COG in May 2023.

7.18. Southern's Appointments Committee[8] (AC) then determined the process to appoint new NEDs to the Board of the new Trust. Following that process, the COG appointed three designate NEDs in June 2023 – two current NEDs of Solent (Mike Watts and Gaurav Kumar) and one current NED of IOW (Sara Weech).

7.19. Southern's Nominations and Remuneration Committee[9], including the three designate NEDs, agreed the process to appoint the designate CEO. Following that process, the Nominations and Remuneration Committee appointed Ron Shields (the current CEO of Southern) as the designate CEO. This appointment was approved by the COG.

[7] A Partnership Agreement (based on NHS England's Heads of Terms template) was signed by Southern, Solent and IOW in April 2023 setting out how the Trusts would work together in the development of the FBC.
[8] The Appointment Committee is a Committee of Southern's COG and makes recommendations to Southern's COG on the appointment of the Chair and Non-Executive Directors. The Appointment Committee consists of a NED (Chair) and at least three public Governors, one Staff Governor and one Appointed Governor (provided there is always a majority of Public Governors). All members of the Appointments Committee are from Southern's COG and Trust Board.
[9] The Nominations and Remuneration Committee is a committee of the Southern Board. The Nominations and Rumination Committee is responsible for appointing the CEO and Executive Directors. The membership of the Nominations and Rumination Committee is all Southern NEDs and CEO, except for the appointment of the CEO when the CEO of Southern is not a member.

7.20. The Nominations and Remuneration Committee has determined the structure of the new Trust's executive team, and will now proceed to appoint the designate executive directors by the end of December 2023[10].

7.21. All designate Board members will take up their new roles on Day 1 of the new Trust.

[10] Where the Nominations and Remuneration Committee determines that national competition is required, the appointment process is expected to be completed by the end of December 2023.

Clinical services

Introduction

7.22. This section sets out the approach that the programme has taken to developing plans to integrate clinical services in the new Trust (the Clinical Integration Plan). The section describes:

- The functions and services in scope of the Clinical Integration Plan;
- The vision for clinical services in the new Trust, as described in the new Trust's clinical strategy;
- The key objectives of the Clinical Integration Plan;
- The main milestones of the Clinical Integration Plan, including delivery of the benefits set out in the PBC; and
- The main benefits to be realised through implementation of the Clinical Integration Plan.

7.23. The **scope** of the Clinical Integration Plan includes:

- The **service groups** set out in the table below:

Figure 15: Clinical Service Groups[11]

Services	
Children and Families	Specialist services
Adult Inpatient – Physical Health	Musculoskeletal, Pain and Podiatry
Adult Inpatient – Mental Health	Primary Care
Adult Community Services – Physical Health	Single Clinical Services
Adult Community Services – Mental Health and Learning Disability	

- Clinical **IT systems**;

7.24. Key **exclusions** from the scope of the Clinical Integration Plan includes Quality Governance services and functions, which are included in the scope of the Quality Governance Integration Plan

7.25. The Clinical Steering Group has developed the Clinical Integration Plan through:

- An initial planning workshop, led by the COOs of Solent and Southern and the IOW Director of Operations Community and attended by senior clinical and operational representatives from across the Trusts, to design the structure of clinical service integration plans; and
- A series of workshops with frontline service representatives from the Trusts to:
  - Identify the required integration activities to ensure clinical services are safe and legal on Day 1;
  - Identify the potential opportunities, benefits and risks arising from the integration of clinical services; and
  - Identify risks and develop mitigation plans through considering emergency planning scenarios.

7.26. Further workshops are planned from autumn 2023 onwards to develop service transformation plans for Years 2 and 3 of the integration process.

[11] See Appendix 3 for the full list of the Trusts' current services which are in scope

7.27. The Clinical Steering Group has established 11 working groups, set out in Appendix 1, to lead the development and implementation of the Clinical Integration Plan objectives, integration priorities and detailed integration plans.

7.28. In parallel to this overarching approach, clinical and operational teams for the clinical service priorities articulated in the PBC (OPMH, CAMHS and frailty and urgent response) have been developing implementation plans to support realisation of the identified benefits.

7.29. The Clinical Steering Group has identified five **overarching** objectives for the Clinical Integration Plan:

- Continuing to deliver safe and legal high-quality services to patients across HIOW;
- Identifying the optimum scale and setting for our services to meet the needs of our local populations;
- Providing equity of access to services across HIOW;
- Delivering care close to home; and
- Creating an informed and supported integrated staff team.

7.30. The Clinical Services Integration Plan prioritises ensuring that the new Trust's services will be safe on Day 1 with no adverse impact on operations. This is expected to involve minimal (if any) change to the way services are delivered on Day 1.

7.31. The Clinical Integration Plan sets out a structured approach to the development and subsequent implementation of longer-term service transformation plans which will deliver the benefits articulated in the FBC.

7.32. The approach to clinical integration is set out in paragraphs 5.19 to 5.27. A phased approach will be taken to the implementation of the Clinical Services Integration Plan:

- Initial focus has been the development and delivery detailed integration plans for four of the clinical priorities (OPMH, CAMHS and frailty and urgent response, and Lived Experience);
- The next phase will be the development and delivery detailed integration plans for the seven remaining clinical service priorities (as identified by the CTG, see paragraph 2.12); and
- This will be followed by the development and delivery detailed integration plans for all other clinical services.

7.33. Figure 16 on the next page sets out indicative timescales for the delivery of clinical service integration plans:

Figure 16: Indicative clinical service integration timescales

2023 2024 2025 2026 2027

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

OPMH

Tier 3 & 4 — Develop, Deliver

MAS Tier 2 — Develop, Pilot, Deliver

CAMHS

Leigh house transformation

Day service development

Virtual wards development

In reach delivery

Frailty

Best Practice model — Develop, Pilot, Deliver, Evaluate

Frailty Operating Model — Develop, Deliver, Evaluate

Virtual Wards — Develop, Pilot, Deliver, Evaluate

7.34. The Clinical Steering Group has identified the following **benefits** that will be delivered through implementation of the Clinical Integration Plan by:

- 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 the combined transformation expertise and recognises the importance of both standardisation to reduce unwarranted variation and adaptation to meet the needs of place;
- Ensuring people with lived experience have a strong voice in all the new Trust does. This will include an enhanced voice through the new Trust's membership and the COG and an approach to community engagement which will enable the new Trust to work in coproduction with people who use services and to respond more effectively to the needs of the populations served; and
- Increasing research opportunities which provide benefits for patients

7.35. The PBC describes four case studies which illustrate the patient benefits which will be realised through the creation of a new Trust. Figure 17 below summarises the benefits from these case studies:

Figure 17: PBC case study benefits

Change	**Patient benefit**
Lived experience	
Patients and family members / informal carers will be fully informed about options and engaged in making decisions	This will result in more informed, activate and enabled patients, who are more likely to adhere to decisions, resulting in improved outcomes and reduced reliance on services Higher levels of self-management will result in prevention of relapse, and reduced demand on urgent and emergency services
All care plans will be negotiated and reviewed in collaboration with the patient and family / informal carers	This will reduce isolation and exclusion, enable a healthier lifestyle, and decrease loneliness. Participation in personal recovery planning has positive outcomes for participants, quantifiable using comprehensive measures of self-perceived recovery.
The voices and expertise of people who use these services are at the heart of the new Trust at every level, including Board oversight	This will allow services to become more appropriate, responsive, and more effective as they become more tailored to people's real needs. Co-production can reduce pay and non-pay costs
Childrens and Adolescent Mental Health Services (CAMHS)	
A more unified approach to ensuring the voice of the young person is heard.	This will ensure that young people are able to shape the services which they access, ensuring that it meets their needs and that of their families and carers.

Change	**Patient benefit**
	Having care delivered which the young person has been able to shape means that they are more likely to follow the care plan, resulting in better outcomes for them.
Better integration of digital platforms and technologies will enable the sharing of patient data as well as allow more innovate care delivery.	Having the ability to share information across teams will reduce the need for the young person and their family to repeat information previously given to another clinician. Introducing digital technologies will allow people to access care in different ways.
Clinical pathways will be streamlined and consistent.	Having the ability to bring the best of the existing services into a new, standardised set of pathways across HIOW, so that patients and their families will have the same, high quality care regardless of where they live.
Older Persons Mental Health (OPMH)	
Clinical pathways across all tiers will be streamlined and consistent.	To bring the best of the existing services into a new, standardised set of pathways across HIOW, so that patients and their families will have the same, high quality care regardless of where they live. National targets will be met consistently across all areas.
Better alignment with primary care and physical health colleagues will ensure that the patient has holistic care.	More care will be able to be delivered closer to the person's home, in a place that is familiar to them.
Frailty and Urgent Response	
Clinical pathways will be streamlined and consistent.	To bring the best of the existing services into a new, standardised set of pathways across HIOW, so that patients and their families will have the same, high quality care regardless of where they live.
An integrated workforce will ensure that there are fewer gaps in staffing and offer more career opportunities for staff, ensuring that patients have the care they require close to home.	Integrated workforce planning, recruitment and retention will help identify areas of risk/need and match resources to gaps through reallocation of workforce. Reduction of competition and movement of staff between Solent and Southern due to banding of posts, different service models and career opportunities will retain knowledge and expertise. Integrated trusted assessment will reduce referrals, duplication and increase time to care.

Priority integration activities

Pre-Day 1

7.36. The table on the next page sets out the key pre-Day 1 activities in the Clinical Integration Plan

Case Study / Activity
Continue to deliver safe and legal high quality services to patients
Review existing business continuity plans and confirm plans are in place for all services
Align escalation processes, with reference to the new Trust's chain of command and organisational structure and the Go Live Command Centre
Establish and communicate Senior Manager on Call arrangement
Develop operational requirements for a Go Live Command Centre for the first two weeks post-Day 1, including reference guides, staffing levels and operating hours, to provide support and guidance for operations teams
Develop escalation and cascade arrangements for the Go Live Command Centre
Agree Day 1 line management based operational management structures
Agree patient communication requirements (jointly with the Communications Steering Group)
Lived experience
Proposal for Trust-wide recovery college and education offer approved
Proposal for Trust-wide Peer Support Worker approach approved
Lived experience infrastructure designed and approved
Lived experience strategy and plan developed to support clinical strategy
Core HR policies in place
Evaluation approach and plan co-produced and baseline measurements in place
Co-production framework and training developed
Proposal for Trust-wide recovery college and education offer approved
Child and Adolescent Mental Health Services
Leigh House Transformation with Phase 2 commencing, contract and SOPs agreed
Day Service building work completion, recruitment and training of staff
Virtual Wards plans to be completed
Mobilisation of Reach into paediatric wards programme completed
Young people with multi-agency needs project completed and staff recruited
Older People's Mental Health services
Undertake data and mapping
Develop vision and strategy along with stakeholders
Complete discovery work and collate feedback
Review HIOW specialist dementia beds, functional bed and review bed management across HIOW
Review crisis community model
Develop business cases / new SOPs for bed management and the expansion of the OPMH community model
Test new models of care in pilot areas for Memory Assessment Service (MAS), crisis teams and bed model on Isle of Wight
Develop business case for creating an OPMH Community Mental Health Team (CMHT) on Isle of Wight
Frailty and urgent response
Commence baseline assessments and review of best practice models
Commence clinical strategy and operating model
Develop and review service specifications for VW
Undertake patient engagement events
Commence workforce review and identify gaps
Undertake team integration workshops and continue OD programme

Post-Day 1

7.37. The table below sets out the key post-Day 1 activities in the Clinical Integration Plan:

Case Study / Activity	Timescale
Continue to deliver safe and legal high quality services to patients	
Devise an integrated clinical services strategy	Year 1

Case Study / Activity	Timescale
Embed the outputs from the 10 priority workstreams into clinical practice	Year 1
Identify the optimum scale and setting for our services to meet the needs of our local populations	
Identify the baseline of current service scales and settings	Year 1
Identify the optimum scale of each service, through engagement with clinical teams and use of external benchmarking	Year 1
Develop plans to define the approach to moving to the optimum scale and setting of each service	Year 1
Develop and agree criteria for the phasing / prioritisation of the implementation of clinical optimisation plans	Year 1
Phased implementation of clinical optimisation plans	Years 2-3
Provide equity of access to services across HIOW	
Identify the baseline of current service provision	Year 1
Develop assessment criteria for scoping the scale and setting of services, and the measurement of equity of access	Year 1
Design and develop integrated specialist services, utilising hub and spoke delivery models to ensure delivery of care is close to home	Year 1
Develop and agree criteria for the phasing / prioritisation of the implementation of clinical optimisation plans	Year 1
Phased implementation of clinical optimisation plans	Years 2-3
Utilise digital systems to deliver service improvements	
Agree plans and timetables for the phased implementation of integrated digital systems for the new Trust's clinical services	Year 1
Phased implementation of integrated digital systems for the new Trust's clinical services	Years 2-3
Lived experience	
Evaluation and reporting infrastructure implemented	Year 1
Implementation of Trust recovery college and education proposal	Year 1
Proposal for Trust-wide PW approach approved and stage 1 mobilisation	Year 1
LE infrastructure recruited to (stage 1)	Year 1
Capability and capacity programme to support coproduction mobilised	Year 1
Co-production training development and stage 1 roll-out	Year 1
Progress with mobilisation	Years 2-3
Child and Adolescent Mental Health Services	
Leigh House Transformation with Phase 2 commencing along with recruitment phase	Year 1
Opening of Day Service	Year 1
Virtual Wards to be launched	Year 1
Evaluation of Reach into paediatric wards project	Year 1
Young people with multi-agency needs project evaluation	Year 1
CAHMS academy plans to be developed	Year 1
Neurodiversity project to be agreed and developed	Year 1
Progress with mobilisation	Years 2-3
Older People's Mental Health services	
Develop OPMH dashboard	Year 1
Develop OPMH and dementia leader development, VCSE network development and advanced practitioner network	Year 1
Finalise OPMH and dementia bed model	Year 1
Develop trust-wide plans to achieve OPMH and dementia ward accreditation	Year 1
Agree MAS model and Key Performance Indicators	Year 1

Case Study / Activity	Timescale
Implement enhanced dementia scanning service within Community Diagnostic Centres	Year 1
Progress with mobilisation	Years 2-3
Frailty and urgent response	
Continue patient engagement events and evaluate findings	Year 1
Develop competencies and training programmes for staff	Year 1
Explore opportunities to integrate further with social services and extend partnership with other organisations.	Year 1
Implement frailty service (including training and working with staff and patients to define outcomes)	Year 1
Agree access to care records and information sharing protocols	Year 1
Review programme and map priorities for years 2 and 3	Year 1
Review frailty service	Years 2-3

Risks

7.38. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the Clinical Steering Group are set out in the table on the next page.

Detailed integration plan

7.39. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

Figure 18: Clinical services transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/22	Leadership burn out / distraction	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 will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
5/4/23	Resources	With the disaggregation of the IOW Trust there is a risk the community services resource may be lost due to the acute integration with PHU	4	3	12	IoW segmentation (reported to through IoW segmentation governance and to Fusion Programme Board) will ensure clarity on clinical resources that are/aren't transferring to the new Trust. Integration planning to mitigate any risks arising from agreed position.
30/11/22	Levelling down of services	If quality governance arrangements in the new Trust are not designed and implemented effectively there is a risk of a loss of Board to ward connection and negative impact on patient experience and outcomes.	4	3	12	Partners are supporting implementation of other CF recommendations. Maintaining local focus will be key consideration in development of operating model. 'Best in class' approach to developing integration plan. Provider involvement in emerging commissioning and funding plans
30/8/23	Digital systems readiness	There is a risk that if impact assessments and requirements for day 1 access to digital systems are not completed and in place by 1st April 2024 there is a risk that clinical care and patient safety will be impacted as staff may not be able to access key systems, historical data and be able to document essential information to support patient care.	4	3	12	Digital Steering Group has collated a list of systems which has been issued to all steering groups to ensure clarity on digital support for systems transitions for Day 1 and beyond.
30/8/23	Quality governance	If the new organisational structure, governance arrangements, design and clinical service models do not take account of the size and scale of	4	3	12	A core outcome of project fusion will be the developing and designing of the governance framework for the new organisation

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
		the new organisation, then there is a risk that quality governance, quality assurance and quality improvement arrangements may be ineffective resulting in adverse impact on Board oversight and assurance, patient safety and risk management, as well as compliance and regulatory requirements.				
30/8/23	Integration planning	There is a potential risk of harm to patients if the integration planning and wider full business case process misses any critical components or fails to recognise the significance, or unintended consequences of any actions taken.	4	3	12	Robust programme governance is in place and being followed to ensure the production and management of detailed workstream based integration plans that consider all interdependencies.
30/11/22	Loss of corporate memory on IOW	Disaggregation (of IoW) results in loss of corporate memory in relation to transferring services (clinical and support.)	3	3	9	Due diligence exercise completed to identify risks and inform integration planning. These will be further refined once there is clarity on transferring services/individuals.

Quality governance

Introduction

7.40. This section sets out the approach that the programme has taken to developing plans to integrate the Trusts' Quality Governance functions and services in the new Trust (the Quality Governance Integration Plan). The section describes:

- The functions and services in scope of the Quality Governance Integration Plan, and any major exclusions that are in scope of other Steering Groups;
- The vision for the Quality Governance function in the new Trust, as described in the new Trust's clinical strategy;
- The key objectives of the Quality Governance Integration Plan;
- The main milestones towards implementation of the Quality Governance Integration Plan; and
- The main benefits to be delivered by the Quality Governance Integration Plan.

7.41. The **scope** of the Quality Governance Integration Plan covers the functions which are the responsibility of the Chief Medical Officer, and the Chief Nursing Officer and Director of Allied Health Professionals (AHP), including:

Chief Medical Officer	Chief Nursing Officer and Director of AHPs
Medicine Management, including Pharmacy services	Clinical, Regulatory and Organisational Assurance
Research and Improvement, including clinical audit and NICE	Patient / Carer Lived Experience and Patient Advice and Liaison Service (PALS) function
Medical Education	Safeguarding
Guardian of Safe Working	Governance, Risk and Patient Safety
Caldicott Guardian and Ethics	Infection Prevention and Control
Legal team	Quality Improvement
High profile cases	
Mental Health Legislation	
Medical Local Negotiating Committee	

- The Emergency Preparedness, Resilience and Response **function**, which is the responsibility of the COO; and
- Clinical **IT systems**;

7.42. Key **exclusions** from the scope of the Quality Governance Integration Plan include:

- Clinical services, which are included in the scope of the Clinical Integration Plan; and
- The Chief Clinical Information Officer function, which is included in the scope of the Digital Steering Group.

7.43. In developing the Quality Governance Integration Plan, the Clinical Steering Group has undertaken extensive stakeholder engagement, including holding focus groups with senior clinical and operational leaders, reviewed the due diligence reports and ensured that identified risks are mitigated through the integration plan where appropriate.

7.44. The Clinical Steering Group has established 22 working groups, set out in Appendix 1 to lead the development and implementation of the Quality Governance Integration Plan objectives, integration priorities and detailed integration plans.

7.45. The key **objectives** of the Quality Governance Integration Plan are to:

- Ensure that quality governance structures are in place, to support delivery of safe clinical services;
- Ensure there is no disruption to the effective operation of the Quality Governance function; and
- Establish an integrated quality governance service for the new Trust.

7.46. Establishing an integrated Quality Governance function for the new Trust will enable delivery of:

- Financial benefits, through achieving economies of scale;
- Benefits to patients and population, through:
  - Creating a flexible and responsive quality governance model that indirectly improves patient safety, patient experience and clinical outcomes
  - Enhancing the new Trust's ability to work collaboratively with partner organisations across the health and social care system
- Benefits to staff, by improving career progression and development opportunities, attracting and retaining strong leadership, and improving team resilience.

Priority integration activities

Pre-Day 1

7.47. The table below sets out the key pre-Day 1 activities in the Quality Governance Integration Plan:

Activity
Medicines Management (including Pharmacy)
Map current staffing and service offering
Develop options appraisal for potential interim team structure
Review and determine most appropriate proposal for Interim team structure and operational model, to include Controlled Drugs Accountable Officer, Medication Safety Officer, and Superintendent in posts
Review list of clinical policies and guidelines relating to pharmacy to identify Day 1 harmonisation priorities
New Controlled Drugs (CD) policy for new Trust to be in place with full implementation plan in effect
Develop combined CD audit tool with aligned dates
Review list of Patient Group Directives and confirm which of these are in current use and which expire before Day 1
Update and replace existing Patient Group Directives for the new Trust
Align pharmacy / medicines management assurance frameworks and processes
Map out current mechanisms of stock medicines supply in place across each organisation
Compare and combine Pharmacy / Medicines Management Risk Registers from all Fusion partners
Research and improvement (including clinical audit & NICE)
Ensure ability to gain access to other's sites and logon
Agree structure for integrated research and improvement team
Understand joint budgets, and ensure transfer of grant funding contract
Prepare and agree comms relating to support offer for new Trust
Establish Research & Improvement Strategic Board for the new Trust
Medical HR, GMC and responsible officer function
Review Post-graduate medical education administrative resources
Develop proposals to integrate post-graduate medical education and medical HR administrative resources

Activity
Ensure there is a clear understanding of whether up to date appraisals and job plans are in place for all medical staff
Complete appraisals for all medical staff where an up-to-date appraisal is not in place
Agree plans to complete joint job planning activities for all medical staff, where an up-to-date job plan is not in place, within the first 100 days
Establish a medical appraisal and job planning group for the new Trust
Review existing Responsible Officer Advisory Group processes to identify good practices and improvement opportunities
Southern and Solent to attend each other organisational ROAG meeting
Establish an integrated ROAG for the new Trust
Ensure that any processes are in place for day to day managing of medical cases (outside of ROAG)
Medical Education
Ensure all clinical workstream activities include doctors in training
Establish joint presence at medical trainee induction sessions
Review and establish integrated medical trainee induction sessions
Establish and implement communications plan, including with Health Education England and trainee representatives
Guardian of safe working
Establish interim joint working processes to ensure the contractual requirements for safe working hours of doctors in training are met, equitable workloads, utilisation of experience and problem-solving expertise, and to establish working relationships with the Directors of Medical Education
Review interim joint working processes to identify good practices and opportunities for improvement
Caldicott and Ethics
Review existing Clinical Ethics forum membership and processes
Align existing Terms of References to enable the establishment of a combined Clinical Ethics forum
Assess the responsibilities and requirements of the Caldicott Guardian and develop proposals for delivery of these in the new Trust
Appoint Caldicott Guardian (either as a discrete post or within the responsibilities of another appropriate post)
Legal team
Review claims policies and procedures for the management of claims, and establish harmonised claims policies and procedures
Review and agree legacy claims liabilities with NHS Resolution
Prepare options appraisal for the establishment of an integrated electronic management system for the management of claims, including the consolidation of historical claims data
Establish integrated filing systems and single portal arrangements with NHS Resolution to allow for seamless management of claims
Review existing processes for sharing the learning from claims to identify good practices and opportunities for improvement
Develop and implement processes for sharing the learning from claims in the new Trust
Review existing processes and support resources for the management of inquests, and establish processes and support resources for the new Trust (including support for staff called to inquests)
Agree processes for supporting staff called to inquests relating to events which took place prior to Day 1
Brief all Coroner offices of merger and ensure they are aware of points of contact for new Trust
High profile cases
Develop proposals for the expansion of Southern's high profile cases oversight function and associated processes for the new Trust

Activity
Mental Health Act Legislation
Review existing Mental Health law governance processes and structure to identify good practice and opportunities for improvement
Draft the proposed Mental Health law governance processes and structure for the new Trust
Review existing Mental Health Act, Deprivation of Liberty Safeguards and Section 49 Mental Capacity Act administration services and resources, including in relation to CAMHS, to identify good practice and opportunities for improvement
Develop Mental Health Act, Deprivation of Liberty Safeguards and Section 49 Mental Capacity Act administration services and resources, including in relation to CAMHS, for the new Trust
Review existing advice and guidance mechanisms to identify good practice and opportunities for improvement
Develop advice and guidance mechanism for the new Trust
Review existing Mental Health Law Training and Education functions to identify good practice and opportunities for improvement
Develop Mental Health Law Training and Education function for the new Trust
Review existing MHA governance processes and structures to identify good practice and opportunities for improvement
Develop MHA governance processes and structures for the new Trust
Review existing ICB-wide advice and guidance and education and training offering to identify good practice and opportunities for improvement
Develop the new Trust's ICB-wide advice and guidance and education and training offering
Medical / Local Negotiating Committee (LNC)
Agree unified LNC roles for the new Trust
Elect to unified LNC roles for the new Trust
Safeguarding
Review existing Adults and Children Safeguarding function resources, policies, processes and ways of working, including with reference to safeguarding health inequalities, to identify good practices and opportunities for improvement
Develop Safeguarding function team structures, policies, processes and ways of working, including with reference to safeguarding health inequalities, for the new Trust
Align existing safeguarding processes and ways of working
Review and agree the Safeguarding Allegations Management Advisor lead role and portfolio
Commence implementation the new Trust's safeguarding function team structures, processes and ways of working
Develop a unified Joint Agency Response offer, including a single point of contact for external partners
Align existing safeguarding training offers
Infection Prevention and Control
Review existing IPC policies and draft integrated IPC policy
Ensure appointment to the new Trust's DIPC post
Review and integrate IPC Group and Antimicrobial Stewardship Committee terms of reference, including escalation routes, and establish new meetings
Establish the new Trust's IPC priorities and programme for 2024/25
Review existing IPC audit plans and agree integrated 2024/25 audit schedule
Agree audit tools for April 2024, including hand hygiene audit tool
Review existing audit data collection and reporting processes to identify good practice and opportunities for improvement
Develop a single audit data collection and reporting processes for the new Trust
Review existing IPC service levels and offerings to identify good practice and opportunities for improvement

Activity
Develop a single IPC service level and offering for the new Trust
Ensure SLAs are in place for the provision of Consultant Microbiologist and AMS Pharmacist on the IOW
Develop and agree plan for the new Trust to report on antimicrobial prescribing trends, audits and competency and training
Review microbiological specimen processes requirements and ensure SLA(s) are in place to provide service microbiological sampling across the new Trust
Establish single points of telephone and email contact for the IPC team, and are accessible on the new Trust's intranet
Ensure Health Education England's annual on-line IPC training is accessible to clinical and non-clinical staff on the new Trust's Learning System
Review and establish IPC training requirements for each staff group
Review existing Patient Safety Incident Response Framework tools for IPC incidents to identify good practice and opportunities for improvement
Agree processes for IPC Incident reporting and investigation, including agreeing the criteria for priority incidents with the ICB
Review and agree IPC uniforms for the new Trust
Review existing IPC record keeping systems to identify good practice and opportunities for improvement
Develop a single IPC record keeping system for the new Trust
Establish IPC Link advisor contact details and meeting arrangements (including Terms of Reference) for the new Trust
Review existing IPC hand hygiene competencies to identify good practice and opportunities for improvement
Develop a single IPC hand hygiene competency for the new Trust
Review existing IPC team structures to identify good practice and opportunities for improvement
Develop IPC team structures for the new Trust
Governance, risk and patient safety
Review existing operational risk management frameworks and policies to identify good practice and opportunities for improvement
Develop operational risk management frameworks and policies for the new Trust
Evaluate options for alignment of electronic operational risk management platforms
Implement aligned electronic operational risk management platforms, including the consolidation of data and agreement of single operating processes (timescales subject to the outcomes of options appraisal and implementation planning)
Review existing risk management strategies and develop an integrated risk strategy for the new Trust
Establish joint patient safety meetings
Review patient safety training offerings and develop options for joint training
Evaluate options for the establishment of integrated incident management systems
Implement an integrated incident management system (timescales subject to the outcomes of options appraisal and implementation planning)
Develop joint Patient Safety Incident Response Plan for day 1
Review existing patient safety and learning team structures to identify good practice and opportunities for improvement
Develop patient safety and learning team structures for the new Trust
Clinical Regulation and Quality Assurance
Ensure the new Trust is correctly registered with the CQC, including locations, regulated activities and Statements of Purpose
Review existing CQUINS and develop a joint CQUIN plan for the new Trust, including identifying potential benefits from sharing good practices
Review existing CQC inspection data capture methodologies to identify good practice and opportunities for improvement

Activity
Agree CQC inspection data capture methodologies for the new Trust
Establish shared CQC engagement meetings
Confirm the new Trust's rating with CQC
Review existing clinical regulation and quality assurance structures to identify good practice and opportunities for improvement
Develop and implement clinical regulation and quality assurance structures for the new Trust
Experience of Care
Review existing support for families and carers to identify good practice and opportunities for improvement
Develop the new Trust's support for families and carers offering
Develop SOPs to support delivery of the new Trust's support for families and carers offering to individuals
Review individual policies and action plans to identify improvements required and ensure consistency with the new Trust's support offering
Review existing payments policy for working with service users and involvement or our communities including through research, to identify good practice and opportunities for improvement
Develop payments policy for the new Trust
Review and identify potential areas for joint community engagement
Review existing approaches and principles for engaging with different communities to identify good practice and opportunities for improvement
Review existing processes for gathering patient feedback to identify good practice and opportunities for improvement
Develop and implement a single system for gathering patient feedback for the new Trust
Review existing complaints process and Parliamentary and Health Service Ombudsman recommendations to identify good practice and opportunities for improvement
Develop a single complaints policy for the new Trust

Post-Day 1

7.48. The table below sets out the key post-Day 1 activities in the Quality Governance Integration Plan:

Activity	Timescales
Medicines Management (including Pharmacy)	
Implement interim team structure	100 Days
Align FP10 and/ ODS code documents and processes	100 Days
Review and determine most appropriate proposal for integrated team structure and operational model	Year 1
Implement integrated team structure	Years 2-3
Medical HR, GMC and responsible officer function	
Integrate post-graduate medical education and medical HR administrative resources	100 Days
Complete job planning activities for medical staff where an up-**to-date** job plan was not in place on Day 1	100 Days
Guardian of safe working	
Establish new ways of working for the new Trust	Year 1
Caldicott and Ethics	
Implement Caldicott Guardian function and appoint to additional function roles (if required)	100 Days
Legal team	
Establish integrated electronic management system management system (subject to options appraisal)	Year 1
Safeguarding	

Activity	Timescales
Fully implement the new Trust's safeguarding function team structures	100 Days
Develop a 3 Year Safeguarding Strategy for the New Organisation	100 Days
Agree unified clear Safeguarding governance and assurance process including reporting pathways.	Year 1
Agree a Section 11 Action Plan by developing one action tracker for New Organisational audit work	Year 1
Develop and embed a family approach to safeguarding practices across the new Trust	Commencing in Year 1
Agree a collective 4LSAB Organisation Self-Audit by developing one action tracker	TBC
Align Data Capturing Systems Currently Used for Safeguarding	TBC
Infection Prevention and Control	
Standardise IPC policy across the trust	Year 1
Agree Committee Membership IPCG and AMS	Year 1
Review the process to collect IPC audit data and reporting process, and any reports required across the new organisation and standardise to one approach across the Trust	Year 1
Agree strategy for the new organisation to include AMS training and competency assessment for medical prescribers and non-medical prescribers	Year 1
Agree topics for IPC competencies and agree	Year 1
Agree an IPC Competency tool which covers the agreed competency topics	Year 1
Work with Learning and Development to provide a facility for IPC competency certificates to be uploaded to the Learning Management System	Year 1
Review and update IPC information on the new Trust's intranet	Year 1
Agree plan for sharing learning from IPC incidents across the new Trust	Year 1
Provide standardised patient information sheets about hand hygiene and IPC topics	Year 1
Governance, risk and patient safety	
Develop a safety strategy for the new Trust	Year 1
Experience of Care	
Implement identified improvements to individual policies and action plans to ensure consistency with the new Trust's support offering	Year 1
Extend the delivery of Patient and Carer Hubs across the New Organisation	TBC

Risks

7.49. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the Clinical Steering Group are set out in the table on the next page.

Detailed integration plan

7.50. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

Figure 19: Quality Governance transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/22	Leadership burn out / distraction	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 will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
5/4/23	Resources	With the disaggregation of the IOW Trust there is a risk the community services resource may be lost due to the acute integration with PHU	4	3	12	IoW segmentation (reported to through IoW segmentation governance and to Fusion Programme Board) will ensure clarity on clinical resources that are/aren't transferring to the new Trust. Integration planning to mitigate any risks arising from agreed position.
30/11/22	Levelling down of services	If quality governance arrangements in the new Trust are not designed and implemented effectively there is a risk of a loss of Board to ward connection and negative impact on patient experience and outcomes.	4	3	12	Partners are supporting implementation of other CF recommendations. Maintaining local focus will be key consideration in development of operating model. ‘Best in class’ approach to developing integration plan. Provider involvement in emerging commissioning and funding plans
30/8/23	Digital systems readiness	There is a risk that if impact assessments and requirements for day 1 access to digital systems are not completed and in place by 1st April 2024 there is a risk that clinical care and patient safety will be impacted as staff may not be able to access key systems, historical data and be able to document essential information to support patient care.	4	3	12	Digital Steering Group has collated a list of systems which has been issued to all steering groups to ensure clarity on digital support for systems transitions for Day 1 and beyond.
30/8/23	Quality governance	If the new organisational structure, governance arrangements, design and clinical service models do not take account of the size and scale of	4	3	12	A core outcome of project fusion will be the developing and designing of the governance framework for the new organisation

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
		the new organisation, then there is a risk that quality governance, quality assurance and quality improvement arrangements may be ineffective resulting in adverse impact on Board oversight and assurance, patient safety and risk management, as well as compliance and regulatory requirements.				
30/8/23	Integration planning	There is a potential risk of harm to patients if the integration planning and wider full business case process misses any critical components or fails to recognise the significance, or unintended consequences of any actions taken.	4	3	12	Robust programme governance is in place and being followed to ensure the production and management of detailed workstream based integration plans that consider all interdependencies.
30/8/23	Safeguarding	There is a risk that if safeguarding processes, supervision models, learning from incidents, governance and systems are not aligned effectively to the structure of the new organisation and preserve the place-based requirements there could be a negative impact on staff wellbeing/morale/ workforce recruitment and retention which could impact on safeguarding activities.	4	3	12	Safeguarding leads meeting regularly to map current processes and understand any differences to ensure service is aligned to requirements for 1 April 2024.
30/11/22	Loss of corporate memory on IOW	Disaggregation (of IoW) results in loss of corporate memory in relation to transferring services (clinical and support.)	3	3	9	Due diligence exercise completed to identify risks and inform integration planning. These will be further refined once there is clarity on transferring services/individuals.

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
30/8/23	Complaints processes	There is a risk that transition to the new Trust's complaints policies and procedures results in a failure to respond in a proactive, timely and comprehensive way to concerns and complaints that are in the process of being responded to on Day 1.	3	3	9	Complaints teams meeting regularly to map current processes and understand complaints and their statuses in preparation for 1 April 2024.

Corporate governance

Introduction

7.51. This section sets out the approach that the programme has taken to developing plans to integrate Corporate Governance in the new Trust (the Corporate Governance Integration Plan). The section describes:

- The functions in scope of the Corporate Governance Integration Plan, and any major exclusions that are in scope of other Steering Groups;
- The vision for Corporate Governance in the new Trust;
- The key objectives of the Corporate Governance Integration Plan;
- The main milestones of the Corporate Governance Integration Plan; and
- The main benefits to be realised through implementation of the Corporate Governance Integration Plan.

7.52. The **scope** of the Corporate Governance Integration Plan includes:

- Board, Committee and COG governance;
- The Corporate Governance **teams** of Solent and Southern Health; and
- Strategic risk management, corporate assurance, statutory registers and reporting, Foundation Trust membership, legal services and general Corporate Governance **functions.**

7.53. Key **exclusions** from the scope of the Corporate Governance Integration Plan include:

- The Freedom to Speak up function, which is included in the scope of the Workforce Integration Plan;
- Operational Risk management functions, which are included in the scope of the Quality Governance Integration Plan;
- Freedom of Information requests, which are included within the scope of the Digital Steering Group;
- Legal claims and inquests, which are included within the scope of the Clinical Steering Group (quality governance section); and
- Corporate Governance IT systems, which are included in the scope of the Digital Integration Plan.

7.54. The **vision** for the integrated corporate governance function in the new Trust is to:

- Provide a comprehensive corporate governance and corporate affairs function to support regulatory compliance; and
- Provide a proportionate governance framework for the new organisation, its Board, Committees, COG and membership, recognising the importance of "place".

7.55. The Corporate Governance Steering Group has identified five overarching objectives for the Corporate Governance Integration Plan:

- To agree organisation-wide policy governance arrangements for the new Trust (including management and oversight processes);

- To agree Board, Committee and COG governance infrastructure, roles and responsibilities, and associated administration processes;
- To agree the revised membership of the COG, associated election and ongoing support processes and membership management;
- To establish effective corporate governance and strategic risk management processes and resources to deliver these; and
- To establish appropriate structures and resources to support the Board of Directors in providing effective leadership.

7.56. The governance infrastructure established for the new Trust must:

- Facilitate systems and processes that will both ensure and demonstrate that the new organisation is taking timely and evidence-based decisions;
- Ensure corporate decision making is service user focused and is the product of co-producing decisions with people with lived experience and reflect the new organisation's vison and values; and
- Ensure that the timetable for regular corporate reporting and accountability empowers and enables local place-based assurance as the building block of the new organisation's corporate governance.

7.57. The Corporate Governance Steering Group has identified the following main **benefits** that will be generated from delivery of the Corporate Governance Integration Plan:

- Benefits to the wider health and care system, from:
    - Creating an expanded COG that represents the interests of members and the public across the ICS, and holds the Non-Executive Directors to account for the performance of the Board;
    - Building on existing best practice corporate governance, and developing additional support for the new COG, to indirectly improve clinical outcomes, financial and operational performance; and
    - Establishing a single leadership team that provides a strong and consistent voice and works with partners at neighbourhood, place and across the wider ICS.
- Financial benefits, from reducing the overall cost base of the corporate governance function by allocating resources to reflect the responsibilities, scope and objectives of the new team and achieving economies of scale
- Benefits to staff, by improving career progression and development opportunities, attracting and retaining strong leadership, and improving team resilience.

Key integration activities

Pre-Day 1

7.58. The table below sets out the key pre-Day 1 activities in the Corporate Governance Integration Plan:

Activity
Establish Board, Committee and **COG** structures
Establish corporate reporting cycles
Appoint Board of directors and agree portfolios
Write new constitution
Establish a Board development programme

Activity
Agree new membership constituencies and COG composition with COG Working Group
Undertake Governor election process
Develop and commence implementation of members' engagement programme
Agree new policy and SOP templates and associated governance processes
Develop and agree new team structures
Develop detailed implementation plan with timescales for establishment of new team structures
Align BAF processes and establish a process for the new Trust
Agree the risk appetite for the new Trust
Align Fit and Proper Persons Test processes and establish process for the new Trust
Update and agree Board and COG code of conduct
Review insurance policies and arrange cover for the new Trust
Coordinate drafting of the Trusts' 2023/24 annual reports and governance statements

Post-Day 1

7.59. The table below sets out the key post-Day 1 activities in the Corporate Governance Integration Plan:

Activity	Timescales
Review and update Board code of conduct	First 100 Days and periodically thereafter
Review and update Board development programmes	First 100 Days and periodically thereafter
Align NHS Provider license processes and establish process for the new Trust	First 100 Days
Coordinate drafting of the new Trust's 2024/25 annual report and governance statement	Year 1

Risks

7.60. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the Corporate Governance Steering Group are set out in the table on the next page.

Detailed integration plan

7.61. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

Figure 20: Corporate Governance transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/22	Leadership burn out / distraction	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 will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.
1/8/23	Day 1 policies	There is a risk that staff are not aware of or trained in the policies in	4	3	12	Steering Groups have been allocated policies and agreed those for

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
		place on Day 1 and do not follow and this leads to an adverse outcome.				harmonisation on Day 1 and process for approval has been developed. Communication and training for staff.
1/8/23	Management of coroners' cases	There is a risk that any changes to processes for managing coroners' cases as a result of integration may impact the outcome for the new Trust and the ability for learnings to be shared and addressed.	3	3	9	Integration planning for coroners' processes and quality governance to disseminate learnings. Maintaining links with IOW corporate team.
30/11/22	Loss of corporate memory on IOW	Disaggregation (of IoW) results in loss of corporate memory in relation to transferring services (clinical and support.)	3	3	9	Due diligence exercise completed to identify risks and inform integration planning. These will be further refined once there is clarity on transferring services/individuals.

Finance

Introduction

7.62. This section sets out the approach that the programme has taken to developing plans to integrate the finance functions in the new Trust (the Finance Integration Plan). The section describes:

- The functions in scope of the Finance Integration Plan, and any major exclusions that are in scope of other Steering Groups);
- The vision for the finance function in the new Trust;
- The key objectives of the Finance Integration Plan;
- The main milestones of the Finance Integration Plan; and
- The main benefits to be realised through implementation of the Finance Integration Plan.

7.63. The **scope** of the Finance Integration Plan includes:

- The finance **teams** of Solent and Southern Health;
- Southern and Solent's charities;
- Financial, management and capital accounting, financial (including business partnering) and treasury management, and financial planning, income, contracting and costing (including service line reporting and patient level costing) **functions**; and
- The financial ledger and transactions, and asset register management **IT systems**.

7.64. Key **exclusions** from the scope of the Finance Integration Plan includes Commercial services and functions, which are included in the scope of the Commercial Integration Plan

7.65. The **vision** for the integrated finance function in the new Trust is to create a unified, fully integrated, professional finance team providing insight to drive value for the new Trust, patients and populations and the wider health and care system, by:

- Continuously investing to develop, retain and attract the highest quality talent in a culturally diverse team;
- Embracing the latest technology to provide efficient, standardised and automated processes;
- Providing an effective financial awareness programme to strengthen compliance, financial control and financial acumen throughout the new Trust, from ward to Board; and
- Providing an effective business partnering service, that produces, understands and interprets data quickly and accurately to facilitate robust and effective decision-making, and works in collaboration with our system partners.

7.66. The Finance Steering Group has developed the vision and integration plan through:

- Facilitated discussions during a joint away day, attended by the Southern and Solent finance functions and representatives of the IOW finance function;
- The establishment of 16 working groups, set out in Appendix 1, to the development and implementation of integration plans at a more granular level;

- Discussions at regular finance senior leadership group and joint deputy finance directors meetings;

7.67. The establishment of processes to enable the Finance Steering Group to act as a forum for:

    - Obtaining assurance over the development of detailed integration plans and activities by the working groups; and
    - The resolution of concerns and issues escalated by the working groups.

- The development of shared internal communications processes

7.68. The Finance Steering Group meets every three weeks, and is attended by the Director of Finance and Deputy Chief Executive of the ICS.

7.69. The Finance Steering Group has identified four overarching **objectives** for the Finance Integration Plan:

- Establishing an integrated finance function for the new Trust
- Embedding integrated core finance processes within the new Trust's activities
- Establishing harmonised financial reporting for the new Trust; and
- Strengthening financial sustainability and resilience

7.70. The Finance Steering Group has identified the following main **benefits** that will be delivered from implementation of the Finance Integration Plan:

- Increasing the value for money of services provided by an integrated finance function, through:
    - Reducing the overall cost base of the finance function by achieving economies of scale for in-house services and delivering synergies on contracted services;
    - Increasing the quality of service provision by enhancing skills in key positions; and
    - Enhancing the new Trust's ability to deliver its financial plan, including through the development of an optimised financial recovery plan that maximises the impact of existing schemes across the new Trust
- Improving recruitment and retention by improving career progression and development opportunities, attracting and retaining strong leadership, and improving team resilience

Key integration activities

Pre-Day 1

7.71. The table below sets out the key pre-Day 1 activities in the Finance Integration Plan:

Activity
Develop internal communications plan for the development and agreement of a new team structure
Develop new ways of working based on existing best practices
Develop and agree new team structure
Develop a detailed plan for the implementation of the new team structure, including any interim arrangements
Commence implementation of new team structure
Commence procurement process and award supplier for new a Financial Planning system
Negotiate and agree commissioner contracts for the new Trust

Activity
Merge existing financial recovery plans, including rolling out existing schemes and transaction financial benefits
Agree financial strategy
Prepare standalone and new Trust financial plans, including financial recovery plan and capital priorities, aligned with NHS England and ICS planning principles
Allocation of budgets to services
Review existing costing systems, data feeds and national data collection return arrangements and determine best practice going forward
Develop harmonised processes, timetables, templates and guidance documents in relation to: • Financial planning • Budget setting (priority items) • Monthly / annual closedown • Capital programme management • Productivity monitoring
Document all current financial reporting requirements and responsibilities
Agree financial reporting requirements and responsibilities for the new Trust
Develop and implement template financial reports, including information processes, for the new Trust
Co-develop project plan with the Trusts' financial systems provider (SBS) to implement a single financial ledger
Establish a single financial ledger for the new Trust (through delivery of the project plan), including the transfer of balances
Review existing contracts for services and appoint single suppliers for internal audit, external audit, counter fraud and VAT liaison
Review and harmonise accounting policies, including identifying the financial impact of harmonisation
Harmonise financial policies and procedures including SFIs
Liaise with HMRC and banks to ensure requirements met
Ensure that the Trusts' charities and all appropriate charitable funds are appropriately registered with the Charity Commission, with the correct corporate trustee in place
Review Charitable Funds Committee terms of reference at the penultimate meeting of the committee prior to transaction
Ensure the appropriate transfer of charitable funds to the correct locations
Establish a team of technology champions
Develop plans to achieve OneNHS Finance level 2 accreditation, based on a gap assessment of existing processes

Post-Day 1

7.72. The table below sets out the key post-Day 1 activities in the Finance Integration Plan:

Activity	Timescales
Complete implementation of new team structure	First 100 days
Develop harmonised processes, timetables, templates and guidance documents in relation to: • Financial forecasting • Budget setting	First 100 Days
Assess effectiveness of new team structure	Ongoing, commencing in Year 1
Develop a financial awareness programme to train all staff on new controls including budgetary controls and responsibilities	Year 1

Activity	Timescales
Develop a programme of work to increase technology awareness throughout the teams	Year 1
Review existing costing systems, data feeds and national data collection return arrangements and determine best practice going forward	Year 1
Implement plans to achieve OneNHS Finance level 2 accreditation	TBC, dependent on outcomes of gap analysis.

Delivery resources

7.73. Integration costs related to the one-off costs of establishing a single finance ledger have been included in the FBC.

Risks

7.74. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the Finance Steering Group are set out in the table on the next page.

Detailed integration plan

7.75. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

Figure 21: Finance transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/22	Leadership burn out / distraction	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 will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
5/12/22	Segmentation - IOW deficit and stranded costs	Given underlying deficit at IoW there is a risk that apportionment of costs makes new Trust unsustainable and there is a risk of stranded costs as well inadequate level of resources for the IOW to operate as a single legal identity. Specifically, we do not have details of the income, corporate non-pays costs and expenditure linked to the P2P contract.	3	3	9	Monthly Partnership Interdependencies Group with representatives of Southern, Solent, IoW and PUH and Programme Director in place to ensure alignment of IoW/PUH group and Fusion programmes. Detailed segmentation exercise with full engagement from all parties.
30/11/22	Loss of corporate memory on IOW	Disaggregation (of IoW) results in loss of corporate memory in relation to transferring services (clinical and support.)	3	3	9	Due diligence exercise completed to identify risks and inform integration planning. These will be further refined once there is clarity on transferring services/individuals.

Commercial

Introduction

7.76. This section sets out the approach that the programme has taken to developing plans to integrate the commercial functions in the new Trust (the Commercial Integration Plan). The section describes:

- The functions in scope of the Commercial Integration Plan, and any major exclusions that are in scope of other Steering Groups;
- The vision for the Commercial function in the new Trust;
- The key objectives of the Commercial Integration Plan;
- The main milestones of the Commercial Integration Plan; and
- The main benefits to be realised through implementation of the Commercial Integration Plan.

7.77. The **scope** of the Commercial Integration Plan includes:

- The commercial, transformation and planning teams of Solent, Southern Health and relevant elements of IOW;
- The new Trust's procurement, contracting, commercial, planning, transformation and PMO functions; and
- The Procurement and Contracts management IT systems

7.78. The **vision** for the new Trust's integrated commercial functions is to provide efficient and consistent, best practice business functions and solutions that enable clinical services to provide safe, effective, high-quality care to the new Trust's patients and population.

7.79. Development of the Commercial Integration Plan is within scope of the Business Support, Intelligence and Development (BSID) Steering Group. The BSID Steering Group has developed the Commercial Integration Plan through a programme of regular steering group meetings supported by regular information sharing events with the teams in scope.

7.80. The BSID Steering Group has established six Commercial working groups, set out in Appendix 1, to the development and implementation of integration plans at a more granular level. Each working group contains subject matter expert representatives from Southern, Solent and IoW.

7.81. The BSID Steering Group has identified three overarching **objectives** for the Commercial Integration Plan:

- Establish an integrated commercial function (procurement, contracting, commercial, planning, transformation and PMO) for the new Trust.
- Embed integrated core commercial governance, processes and systems within the new Trust's activities; and
- Develop a forward-looking commercial work programme, establishing plans for:
    - Business planning, transformation, PMO contracting, commercial and procurement activities; and
    - Ensuring health care and expenditure contracts are maintained to ensure continuity of service provision and supplier payments.

7.82. The BSID Steering Group has identified the following main **benefits** that will be delivered from implementation of the Commercial Integration Plan:

- Increasing the value for money of services provided by an integrated commercial function, through:
    - Reducing the overall cost of non-pay expenditure through building on existing best practices, achieving economies of scale and increased buying power; and
    - Reducing the overall cost base of the commercial function by achieving economies of scale for in-house services and delivering synergies on contracted services; and
- Improving recruitment and retention by increasing development opportunities to support career progression, attracting and retaining commercial expertise, strong leadership, and improving team resilience.

Key integration activities

Pre-Day 1

7.83. The table below sets out the key pre-Day 1 activities in the Commercial Integration Plan:

Activity
Review current procurement, contracting, commercial, planning, transformation and PMO delivery models to identify gaps, good practices and opportunities for improvement
Define and agree procurement, contracting, commercial, planning, transformation and PMO service offering for the new Trust
Review current commercial team structures and ways of working to identify gaps, good practices and opportunities for improvement
Design new commercial team structure, including consideration of new roles to support new offer and business results
Onboard new staff onto commercial systems and SBS
Procurement leads to agree when and how to merge system for e-tendering solution (Atamis/BRAVO)
Third party continuation of supplies (BSG) - review current methods and agree set up and processes in readiness for the new organisation
Notify NHS Supply Chain of service start date and set up of new Trust District including IOW segmented services
Review existing materials management delivery locations, requisition points, users and administrators and update for the new Trust
Set up of new Trust on es-tendering / contracting database system (Atamis)
Plan for the transfer of contracts to integrated new Trust contracts database
Review existing governance, processes, policies and procedures across partner organisations once Trust Structure, Scheme of Delegation and SFIs have been confirmed
Agree interim governance processes for joint decisions pre-Day 1
Review and update SOPS, governance, Data Protection Impact Assessment (DPIA) protocols and delegated approval / authority levels
Agree approach to future operation of Travel Desk, develop processes and communicate to service users
Develop category strategies for the interim/transition
Map all anticipated income contracts (including leases) to agreed service specifications and planning activities for no overlap or gaps. Establish review process to ensure ongoing operational changes are included.
Identify current contracts and which ones are likely to need novating from Solent, SHFT, IOW and SPT. Including which contracts need to remain at IOW (not novated) as part of

Activity
P2P/SLA rather than separate contract and establish Contractual relationship with IOWHCT for all items required to be delivered to Fusion by IOWHCT
Ensure suppliers are set up on SBS and have new invoicing instructions
Draft and agree interim approval of joint activities prior to merger to include contracts, procurements and bid opportunities.
Novate contracts/waivers
Send letter to all suppliers communicating changes to the Trusts and creation of the new Trust
Ensure that all appropriate existing supply contracts are covered by new statutory instrument which legally establishes the new organisation from Day 1
Working with Finance Steering Group to allocate all contracted costs and income into Services to allow identification of excess or deficit by service
Work with Commissioners to jointly review outdated schedules, contracts and perform demand and capacity modelling across services.
Refresh supplier assurance processes through a 'Contract Management and Assurance' project
All ongoing IOW funding (Income) contracts and specifications to be reviewed and transferred as appropriate to new Trust.

Post-Day 1

7.84. The table below sets out the key post-Day activities in the Commercial Integration Plan:

Activity	Timescales
Set up workshops and face to face events to develop the commercial team vision, values and strategic objectives, aligned to the new Trust's vision and values	100 Days
Agree the commercial team's vision, values and strategic objectives	100 Days
Audit/review/archive of files and folders across organisations as agreed by parameters and consider interdependencies	100 Days
Implement new commercial team structure	100 days
Development of a single procurement workplan	Year 1
Development of a single contracting workplan	Year 1
Development of a single commercial workplan (business development)	Year 1
Development of a single planning workplan (Strategy)	Year 1
Development of a single PMO workplan	Year 1
Implement procurement, contracting, commercial, planning, transformation and PMO service offering for the new Trust	Years 1-3

Delivery resources

7.85. Costs related to the integration of e-tendering systems and support the development of single workplans during Year 1 have been included in the FBC.

Risks

7.86. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the BSID Steering Group are set out in the table on the next page.

Detailed integration plan

7.87. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

Figure 22: Commercial transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/22	Leadership burn out / distraction	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 will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.
30/11/22	Loss of corporate	Disaggregation (of IoW) results in loss of corporate memory in relation	3	3	9	Due diligence exercise completed to identify risks and inform integration

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
	memory on IOW	to transferring services (clinical and support.)				planning. These will be further refined once there is clarity on transferring services/individuals.

Workforce

Introduction

7.88. This section sets out the approach that the programme has taken to developing plans to integrate the People function in the new Trust and to lead delivery of the TUPE process for Solent, IOW and Sussex Partnership staff (the Workforce Integration Plan). The section describes:

- The functions in scope of the Workforce Integration Plan, and any major exclusions that are in scope of other Steering Groups;
- The shared vision for the People function, comprising OD and Workforce teams in the new Trust;
- The key objectives of the Workforce Integration Plan;
- The main milestones of the Workforce Integration Plan; and
- The main benefits to be realised through implementation of the Workforce Integration Plan.

7.89. The **scope** of the Workforce Integration Plan includes:

- The People **teams** of Solent and Southern Health, and relevant individuals from IOW identified through the segmentation process;
- The **functions** set out in the table below; and

Figure 23: People functions

Function	Sub-services[12]
Diversity and Inclusion	Staff networks, Chaplaincy
Occupational Health and Wellbeing	Mental Health services, Menopause services, Physiotherapy and Musculoskeletal services, annual flu programme
People Partnering	Workforce Intelligence and Planning, Employee relations and performance management,
People Services	Pay and Reward, Attraction and Recruitment, Temporary Staffing, E-Rostering, Registration Authority (Smartcards), Medical Staffing and workforce systems
Organisational Development	
Learning and Development	All clinical and non-clinical Education and Training (excluding medical), Library services
Freedom to Speak up	

- Workforce **IT systems**, as set out in the table below;

[12] The allocation of sub-services is representative of the Trusts' current people function structures and is not necessarily representative of the structure of the new Trust's people function due to the ongoing development work.

Key Workforce IT systems[13]	
Occupational Health Management	Recruitment Management Systems
Electronic Staff Records (ESR)	Expenses Management Systems
Learning Management Systems	Staff benefits/Health and Wellbeing platforms
Rostering	

7.90. Key **exclusions** from the scope of the Workforce Integration Plan include:

- OD activities related to the creation of the new Trust, which are included in the scope of the OD Integration Plan; and
- Medical education, medical revalidation, maintaining high professional standards cases for medical workforce, Professional Body referrals and Deanery issues, all of which are included in the scope of the Clinical Steering Group

7.91. The **vision** for the integrated People function is to:

- Always put people first and to be an enabler of the positive employee experience through the NHS people promise;
- Help to drive aspirational thinking and compassionate leadership on a wider platform;
- Create a safe place to be treated fairly, creating, and providing opportunities for people to make a difference by using their skills and doing what they do best;
- Create a place where people feel truly valued and somewhere they belong; and
- Create a place that is representative of the communities the new Trust serves.

7.92. The Workforce Steering Group has developed the Workforce Integration Plan through a process involving the identification and mitigation of risks, sharing expertise and prior learning, and engaging workforce staff in the development of the emerging People function's vision, team structure and future ambitions.

7.93. The Workforce Steering Group is co-chaired by Southern's Deputy Chief People Officer and Solent's Associate Director for People Services (the programme's Workforce & OD Transformation Programme Director). Membership includes workforce and service leads from across Trusts as well Trade Union and Staffside chairs.

7.94. The Workforce Steering Group has established seven working groups, set out in Appendix 1, to support the development and implementation of integration plans at a more granular level.

7.95. The Workforce Steering Group has identified five overarching objectives for the Workforce Integration Plan:

- To ensure that integration and change process underpinning in the creation of the new Trust are both legally secure and compassionate in approach;
- To integrate People Services in the new Trust;
- To deliver Occupational Health and Wellbeing (OHWB) services in line with the national NHS health and wellbeing framework across the new Trust;
- To provide integrated Learning and Development services across the new Trust; and

[13] See the supporting submission for a full list of IT systems within scope of the Workforce Steering Group.

- Establish an integrated People function[14] for the new Trust.

7.96. The Workforce Steering Group has identified the following main **benefits** that will be delivered from implementation of the Workforce Integration Plan:

- Enabling the provision of better care through aligning processes and sharing clinical resources more effectively to maintain safe staffing levels, out-of-hours medical rosters and reducing gaps in specialist clinical knowledge
- Addressing recruitment and retention challenges by:
    - Reducing vacancies by developing a single approach to tackle recruitment and retention challenges;
    - Improving career progression and development opportunities, attracting and retaining strong leadership, and improving team resilience;
    - Continuing to develop an open, inclusive culture, that promotes learning and continuous improvement;
    - Realising the positive impact of an integrated OHWB service, in line with the national OHWB workforce development plan; and
    - Implementing a consistent and compassionate standardised approach to management of people practices; and
- Increasing the value for money of services provided by an integrated people function, through:
    - Reducing the overall cost base of the people function by achieving economies of scale for in-house services and delivering synergies on contracted services and systems; and
    - Improving workforce planning by sharing clinical resources more effectively

7.97. Implementation of the Workforce Integration Plan will enable the People function to:

- Ensure an engaging, safe and legal integration for people in the new Trust, through delivery of the TUPE process for Solent, IOW and Sussex Partnership staff.
- Enable the development of a strategic workforce planning framework, through the alignment of the workforce intelligence and workforce planning activities;
- Align recruitment attraction, interviewing, selection and onboarding processes, including for domestic and international recruitment;
- Integrate people policies, processes and systems, including on a prioritised basis for Day 1;
- Deliver a standardised pay, reward and pensions offer through a single payroll provider;
- Establish a safe, effective, appropriate and standardisation single OHWB service that protects and improves staff health, prevents cases of occupational disease, and increases workforce productivity and performance; and
- Provide colleagues with access to the appropriate training, education, and learning and development resources for their role.

[14] The People and OD Steering Groups are considering the appropriate team structures, roles and responsibilities for delivery of People and OD functions in the new Trust. At the time of writing, no decision has been made over whether combined or separate People and OD functions will be created.

TUPE process

7.98. Staff will be transferred from Solent, IOW and Sussex Partnership to Southern under the TUPE regulations. TUPE regulations protect individual's rights as an employee when they transfer to a new employer. A TUPE transfer happens when an organisation, or part of it, is transferred from one employer to another a service is transferred to a new provider.

7.99. Staff will transfer under TUPE to Southern from:

- Sussex Partnership at midnight on 31 January 2024; and
- Solent and IOW at midnight on 31 March 2024.

7.100. The lists of employees being transferred and any employee liabilities must be confirmed 28 days before the TUPE transfer

7.101. Before a TUPE transfer, by law both the old and new employers must inform and consult with a recognised trade union or employee representatives. There is no minimum period to inform about a TUPE transfer, or to consult on any planned changes to working practices ("measures"), but it should be meaningful and in good time.

7.102. IOW commenced its TUPE consultation with staff side representations (trade unions) on 30 October for a period of 7 weeks, concluding on 17 December. This is to ensure the duty to inform, and consult occurs in 'good time' and reduces uncertainty for staff over the festive period and expected increased operational pressures after the festive period. Solent is expected to commence its TUPE consultation following Board approval of the FBC.

Key integration activities

Pre-Day 1

7.103. The table below sets out the key pre-Day 1 activities in the Workforce Integration Plan:

Activity
Agreement of the scope of the full OHWB services to be delivered for the new Trust's staff on the IOW
Migrate IOW staff records into ESR and OHWB IT systems
Agree plan for expansion of OHWB service to include Sussex Partnership staff
Review and harmonisation of staff networks via collaboration
Agree and co-create Equality, Diversity, inclusion and Belonging (EDIB) Policy with staff networks
Undertake EIAs for the new Trust's workforce policies on a prioritised basis
Agree and scope EDIB priorities and plan and offer for the new Trust
Review and agree harmonised Day 1 priority workforce policies: organisational change, pay protection, redeploy, appeals, sickness, grievance, conduct, bullying and harassment, maternity/paternity
Agree on the corporate induction for new starters who join the new trust
Development of options appraisal for the harmonisation of electronic learning platforms
Agree and an integrated create essential skills training offer
Establish Clinical inductions for Junior doctors, undergraduates, Newly Qualified Paramedics, Healthcare Support Workers
Confirm and agree operating model for training and education for the new Trust, creating a single point of contact for all organisations.

Activity
Identify T Level[15] process in order to maximise T levels placements
Understand and map all placements process including work experience
Identify Nursing and AHP undergraduate process in order to maximise placements for multiple student groups
Agree joint strategy for Payroll and Pensions provision for the New Trust
Award Payroll and Pensions service provider contracts to deliver services to all parts of the new Trust
IOW / Sussex Partnership join the Southern payroll as a part of an ESR mass organisational change process
Solent & Southern ESR merger approved
Appointment of Salisbury as new payroll service provider for Solent (results in Southern and Solent having the same payroll service provider)
Employee Liability information/ detailed staff due diligence to be provided by IOW and Southern in agreed format to ensure all non-standard pay arrangements accounted for
Harmonise pay, reward, and pensions policies and processes
Design a pay philosophy/strategy for the new trust
Set up a Pay and Pensions sub working group to establish a single payroll provider for the new Trust
Move the admitted body status for the Local Government Pension Scheme pension to the new Trust
Pension arrangements to be complete and up to date prior to April 2024.
Develop and implement integrated FTSU processes and policies
Establish integrated workforce planning approach and processes, aligned with the clinical strategy
Set up clear and defined single leavers process in ESR
Agree and harmonise recruitment and selection policies and processes, including IT systems
Junior Doctor Rotations set up for new Trust, including engagement with Deanery & LNC
Provide amended certificates of sponsorship in line with UKVI guidelines
Provide training to new / transferred staff on the new Trust's recruitment Applicant Tracking System
Agree timescales and change plan for the use of the new Trust's recruitment Applicant Tracking System by all functions
Agree the new Trust's temporary staffing model
Set up the new Trust's temporary staffing operating model
Review the Trusts' people functions' processes to identify opportunities for improvement and good practices
Hold People function workshops to explore options for the new operating model
Review model hospital and internal corporate benchmarking data to help inform future people function structure
Design the new Trust's people function operating model

7.104. The table below sets out the key pre-Day 1 activities in the Workforce Integration Plan specifically associated with delivery of the TUPE process for Solent, IOW and Sussex Partnership staff.

Activity
TIER 1 Employee Relation Contractual Policies and toolkits
Agree measures for TUPE

[15] T Levels were launched in September 2020. They are 2-year courses which are taken after GCSEs and are broadly equivalent in size to 3 A Levels. T Levels offer students practical and knowledge-based learning at a school or college and on-the-job experience through an industry placement of at least 315 hours – approximately 45 days.

Activity
Create documents needed for TUPE consultations (i.e. consultation paper, manager toolkit, letters, Frequently Asked Questions (FAQ), scripts)
Develop and agree standard contract of employment for the new Trust
Agree and establish employee relation case management processes
Carry out data verification and provide the required information in standard template for Employee Liability Information data
IOW segmentation exercise for staff in scope of TUPE
Engagement activity for Southern (around new organisation)
Deliver staff consultations for TUPE out staff (IoW, Solent and Sussex Partnerships, timings will differ for Sussex Partnerships)
Creation and quality assurance of the list of staff being transferred
Confirmation of list of staff being transferred
Confirmation of employee liability information

Post-Day 1

7.105. The table below sets out the key post-Day 1 activities in the Workforce Integration Plan:

Activity	Timescales
Develop and agree the new Trust's people strategy, to align with the NHS People Promise	100 Days
Harmonisation of electronic LMS	TBC – dependent on outcome of options appraisal
Migrate workforce data into a single data warehouse & visualisation environment	Year 1
Implementation of single payroll process	Year 1
Socialise and embed the new Trust's Health and Wellbeing plan	Year 1
Agree and establish the new Trust's delivery of education offer	Year 1
Implement a single ESR system and processes for the new Trust, with hierarchies aligned to the new Trust's operating model	Year 1
Implement single Allocate[16] systems and processes for the new Trust	Year 1
TIER 2 ER (highly used non-contractual) Policies and toolkits	Year 1

Delivery resources

7.106. Costs related to the robust migration and validation of ESR, recruitment and OHWB data and systems, including one-off contract termination costs resulting from the establishment of single suppliers for workforce IT systems, have been included in the FBC.

Risks

7.107. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the Workforce Steering Group are set out in the table on the next page.

Detailed integration plans

7.108. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

[16] Allocate are the supplier of a number of Workforce IT systems including Healthroster, Insights, eRota,eJob Planning - AHPS, Medics, EOL/MOL. See supporting submission for further details.

Figure 24: Workforce transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
30/8/23	Disparity in remuneration	There is a risk that disparity in remuneration approaches for staff across the different Trust could result in inequities and variations that could negatively impact on staff morale if not dealt with in a timely and agreed way.	4	4	16	TUPE measures and evaluation of the salaries must be assessed, and any risks worked through, and options appraisals presented to the new Board to decide on a fair and equitable decision.
1/8/22	Leadership burn out / distraction	Leadership burn out or distraction of integration activities results in detrimental impact on performance/quality of the new Trust and benefits not being	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

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
		realised (and ultimately patient harm).				activities. Benefits realisation approach will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.
1/8/23	Temporary staffing model	There is a risk that a temporary staffing model is not put in place and operational teams cannot access temporary staffing from Day 1.	4	3	12	Options appraisal regarding temporary staffing model to guide decision is being worked on for consideration at November programme team meeting. IoW & CAMHS staff from Sussex will need to join a roster by April 2024
1/8/23	Statutory and mandatory training	There is a risk that compliance with statutory and mandatory training reduces.	4	3	12	Exec review of LMS options (October)
30/11/22	Loss of corporate memory on IOW	Disaggregation (of IoW) results in loss of corporate memory in relation to transferring services (clinical and support.)	3	3	9	Due diligence exercise completed to identify risks and inform integration planning. These will be further refined once there is clarity on transferring services/individuals.

Organisational development

Introduction

7.109. This section sets out the approach that the programme has taken to developing plans to develop the new Trust's OD programme and the steps that will be taken to ensure the desired culture emerges in the new Trust (the OD Integration Plan). The section outlines:

- The scope of the O Integration Plan, and any major exclusions that are in scope of other Steering Groups;
- The key objectives of the OD Integration Plan;
- The main milestones of the OD Integration Plan, and
- The main benefits to be delivered by the OD Integration Plan

7.110. The **scope** of the OD Integration Plan includes the new Trust's OD programme and the steps that will be taken to ensure the desired culture emerges in the new Trust.

7.111. The OD Steering Group has established a four-phase **approach** to OD for the new Trust: Scoping; Discovery; Design; and Delivery. Further details on the approach to OD are set out in Chapter 8 of the FBC

7.112. The OD Integration Plan has been developed through regular meetings of the OD Steering Group, reviews of the 'As Is' cultures, consulting across the organisations and with senior leaders, the development of the 'To Be' culture and values, and the development of activities to embed the new Trust's culture.

7.113. The OD Steering Group has established seven working groups, set out in Appendix 1 to lead the development and implementation of the OD Integration Plan objectives, integration priorities and detailed integration plans.

7.114. The OD Steering Group is co-chaired by Southern's Chief People Officer and Southern's Associate Director of OD. The membership of the Steering Group includes representatives from each of the Trusts'

- OD professionals
- Lived experience and Equality, Diversity, Inclusion, and Belonging teams;
- Change and transformation professionals; and
- Staffside groups.

7.115. The OD Steering Group has identified overarching **objectives** for each phase of the OD Integration Plan:

- Scoping: Understand the new Trust's cultural ambitions and the actions required to achieve them;
- Discovery: Ensure that there are meaningful opportunities for inclusive involvement in the design of the 'to be' culture;
- Design: Describe the interventions and support packages which will be led and delivered through the OD implementation plan; and
- Delivery: Deliver interventions and support packages to embed the new Trust's culture.

7.116. The Trusts' OD teams will also:

- Provide support across the programme for designing changes to team operating models and developing associated restructuring plans, when considered appropriate by the Workforce Steering Group; and
- Design the new Trust's leadership, appraisal, and values and behaviours frameworks.

7.117. The OD Steering Group has identified the main **benefit** that will be delivered from implementation of the OD Integration Plan Is reducing recruitment and retention challenges by:

- Generating a positive experience of change and creating a culture that is based on the workforce's views; and
- Providing increased talent management, career progression and personal development opportunities from an expanded suite of development offers.

7.118. Delivery of the OD Integration Plan will be undertaken by the new Trust's integrated OD function. The OD function will contain significant expertise in OD, organisation design, and transformation and change management, with experience in a range of industry sectors.

7.119. Paragraphs 8.8 to 8.15set out the approach to embedding cultural change in the new Trust.

Key integration activities

Pre-Day 1

7.120. The table below sets out the key pre-Day 1 activities in the OD Integration Plan:

Activity
Scope 'As Is' cultural review
Undertake 'As Is' cultural review
Undertake and embed recommendations from the 'As Is' cultural review
Hold focus groups on the new Trust's values across the organisations to understand what they mean to staff and how they can be embedded across all areas of staff experience and employee lifecycle
Clarify the new Trust's talent strategy, ambitions, approach and scope
Undertake and embed recommendations from the Shape our Trust Engagement
Participation in engagement events, roadshows and communications activities
Design and launch a leadership survey to the Trusts' senior leadership teams to gain insight into their engagement so far and needs going forward.
Create a range of directed learning tools, tools to help leaders run team away days, access to a facilitated team day, leadership programmes and a 'bitesize skills' offering.
Create a triage / decision making process to support team away days.
Scope, design and deliver a collaborative Chartered Management Institute Level 5 qualification in Professional Coaching for leaders who wish to gain this qualification and re-invest their skills back in the workforce.
Review existing feedback tools and create a 360 feedback tool for the new Trust which enables feedback to be given in line with the new Trust's values
Develop and establish a combined new manager induction process (in addition to the corporate induction)
Create a trust-wide appraisal framework, which enables reflection on the Trust values, a focus on the individual's workplace experience of each element of the People Promise, and a robust conversation about career aspirations and developing potential
Develop a detailed delivery plan that sets out the interventions and support packages which comprise the Fusion change programme
Establish feedback process to enable the Fusion change programme to respond to changes in requirements

Activity
Identify the staff survey questions that need to be asked to measure embedding of the new Trust's culture
Creation of a single version of administrator competencies to inform subsequent activities on training offerings.
Create a Day 1 welcome email, expanding development offer within the new organisation.
Design an appropriate warm welcome for any staff who transfer into Solent or Southern ahead of the establishment of the new Trust. Activities are likely to include opportunities for joining staff to meet support service colleagues, as well as support for team away days to help create new relationships and define new shared team purpose statements;
Design and deliver a cultural influencer programme to be designed and delivered to embed the new culture. Supporting change sessions have been added to the OD offer to better equip managers and leaders to support teams through the change process.
Coaching support for individuals or teams, including leadership training, which will be designed around emerging challenges
Develop a programme of networking opportunities for leaders to provide opportunities to share and challenge ideas, supported by OD professionals
Fusion focused events such as Leading Live: Month of training and Continuing Professional Development opportunities for staff - focused on Fusion

7.121. A change support package offering for managers, including signposting to resources, facilitated support for groups and leadership development, will be shared with managers in November 2023.

7.122. The OD function will deliver of the overarching change support across the programme, which includes providing a bespoke offering based on the needs of each steering group and broader support for the entire workforce of the new Trust.

Post-Day 1

7.123. The table below sets out the key post-Day 1 activities in the OD Integration Plan:

Activity
Lead interventions and support packages that are tailored to specific steering group needs to help staff understand the change process and lead teams through the stages of change
Helping to design, facilitate and deliver team away days to support teams integrating into the new Trust
Offering support across the programme to embed the new Trust's vision, values and behaviours in a systematic, inclusive and considered way
obtain feedback during the Delivery phase through staff survey and pulse survey metrics, and post- training course evaluations: this feedback will be regularly reviewed and inform adjustments to the Fusion change programme to better meet identified needs.
Consider how to use the People Pulse in January 2024 to gauge feedback

7.124. An agile approach will be taken supporting the new Trust's staff through the remainder of the programme and the first 12 months recognising that the varying impact and timescales of implementing the Fusion integration plan.

7.125. The OD Steering Group will measure the effectiveness of the Fusion change programme through the NHS staff survey and internal pulse survey metrics, Employee Relations cases, and levels of access to wellbeing support, and internal workforce data such as turnover and absence rates.

Delivery resources

7.126. The OD Steering Group has identified the following resources for implementation of the OD Integration Plan:

- Senior leadership will be provided by an Associate Director of OD, the Fusion Transformation Director and a Fusion Project Lead, all of whom have 50% of their working week assigned to implementation of the OD delivery plan; and

- Delivery of the support packages will be led by the new Trust's OD team, supported by the new Trust's Learning and Development teams and supplemented by additional resources focussed on implementation of the delivery plan.

7.127. The costs of these resources are being met from the existing OD functions' budgets.

Risks

7.128. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the OD Steering Group are set out in the table on the next page.

Detailed integration plans

7.129. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

Figure 25: Organisational Development transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/22	Leadership burn out / distraction	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 will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/23	Embedding the new culture and values	If the creation of the new Trust's culture, behaviours and values does not address concerns raised and is not co-designed and embedded with staff and supported by managers, there is a risk that acceptance of the transition will be poor, we will not create the positive conditions for a healthy culture and staff turnover rates will increase.	4	3	12	Shape Our New Trust staff engagement programme and Manager's Change Support pack and training offer. Further engagement planned on values, new Trust strategy and operational management structure. Series of pulse check surveys to measure how staff are feeling specifically relating to the Fusion change programme.
30/11/22	Loss of corporate memory on IOW	Disaggregation (of IoW) results in loss of corporate memory in relation to transferring services (clinical and support.)	3	3	9	Due diligence exercise completed to identify risks and inform integration planning. These will be further refined once there is clarity on transferring services/individuals.

Performance and Business Intelligence

Introduction

7.130. This section sets out the approach that the programme has taken to developing plans to integrate Performance and Business Intelligence (BI) functions in the new Trust (the Performance and BI Integration Plan). The section describes:

- The functions in scope of the Performance and BI Integration Plan, and any major exclusions that are in scope of other Steering Groups;
- The vision for Performance and BI functions in the new Trust;
- The key objectives of the Performance and BI Integration Plan;
- The main milestones of the Performance and BI Integration Plan; and
- The main benefits to be realised through implementation of the Performance and BI Integration Plan.

7.131. The **scope** of the Performance and BI Integration Plan includes:

- The BI, Clinical Coding and Performance **teams**;
- Data management, analytics, data assurance, product development and performance reporting **functions**; and
- The Data Warehousing, Reporting and Data Visualisation IT systems.

7.132. Key **exclusions** from the scope of the Performance and BI Integration Plan include:

- All other IT systems, including systems which collect the data processed and analysed by the BI and Performance functions and services (such as EPR), which are included in the scope of the other integration plans;
- Governance reporting, which is included in the scope of the Corporate Governance Integration Plan; and
- Statutory HR reporting, which is included in the scope of the Workforce Integration Plan.

7.133. The **vision** for the new Trust's integrated BI and Performance functions, is to provide efficient and consistent, best practice business functions and solutions that enables clinical services to provide safe, effective, high-quality care to the new Trust's patients and population.

7.134. Development of the Performance and BI Integration Plan is within scope of the BSID Steering Group. The BSID Steering Group has developed the Performance and BI Integration Plan through a programme of regular steering group meetings supported by regular information sharing events with the teams in scope.

7.135. The BSID Steering Group has established four Performance and BI working groups, set out in Appendix 1, to the development and implementation of Performance and BI integration plans at a more granular level. Each working group contains SME representatives from Southern, Solent and IoW.

7.136. The BSID Steering Group has identified three overarching **objectives** for the Performance and BI Integration Plan:

- To establish a consistent BI and Performance offer for the new Trust;

- To embed integrated core Performance Governance processes within the new Trust's activities; and
- To establish a unified information system for the new Trust

7.137. The BSID Steering Group has identified the following main **benefits** that will be delivered from implementation of the Performance and BI Integration Plan:

- Enabling the provision of better care through improving the Trust's understanding of services and outcomes to inform the provision of better quality and more consistent patient care;
- Improving recruitment and retention by improving career progression and development opportunities, attracting and retaining strong leadership, and improving team resilience; and
- Increasing the value for money of services provided by an integrated BI and Performance function, through:
  - Reducing the overall cost base of the BI and Performance function by achieving economies of scale for in-house services and software licence consolidation;
  - Increasing the quality of service provision by enhancing skills in key positions; and
  - Enabling the provision of more cost-effective care, through an improved understanding of the Trust's services and outcomes.

7.138. Implementation of the BI Integration Plan will enable the BI and Performance function to:

- Achieve and maintain compliance with statutory reporting requirements through robust governance and reporting processes;
- Ensure the new Trust receives the information that it needs to provide safe, high quality, consistent and cost-effective care;
- Develop and embed performance governance processes within the new Trust's activities; and
- Develop longer-term plans to establish a single data and reporting solution for the new Trust.

Key integration activities

Pre-Day 1

7.139. The table below sets out the key pre-Day 1 activities in the Performance and BI Integration Plan:

Activity
Scope out mandatory and statutory requirements impacted and review current delivery models to identify good practices and opportunities for improvement
Identify requirements that must be combined by Day 1, and whether full integration/deduplication etc. is required, aggregate reports can be simply combined, or individual submissions can continue
Explore solutions to fulfil each individual reporting requirement
Agree roles and responsibilities for each reporting requirement and implement solutions
Liaise with Digital Steering Group to ensure all current systems and infrastructures will continue to be accessible on Day 1

Activity
Investigate changes to Microsoft Active Directory login and how this will impact Insights from Day 1, in terms of the control of permissions and access to sites and functionality on the network
Identify priorities where joint reporting is required from Day 1 (such as the Integrated Performance Report and operational reporting of national priority areas)
Explore solutions to fulfil priority joint reporting requirements
BI & Performance Sub-Group to review proposed solutions and collectively agree way forward for each joint reporting requirement
Agree roles and responsibilities for joint reporting requirements and implement solutions
Consider utilising CSU Data Model to provide intermediate solution for bringing together existing data sources
Carry out options appraisal to establish whether existing warehouses are suitable solutions or whether a procurement exercise is required
Develop data migration / warehouse implementation plan
Evaluate the new Trust's BI and analytics service requirements, including review of current delivery models to identify good practices and opportunities for improvement
Develop a new BI and Analytics service offering, taking into consideration available budget and the new Trust's operating model
Agree Day 1 BI and Analytics service delivery model
Scope out Performance Governance requirements and review current delivery models to identify good practices and opportunities for improvement
Define and agree new Performance Governance Framework for new organisation (after Board Committee structure and Clinical Strategy for the new Trust are confirmed)
Review of current team structures and roles that support delivery of the Performance Governance Framework, including identifying good practices and opportunities for improvement
Arrange staff engagement sessions related to changes to team structures
Design new Performance Governance team structure, including consideration of new roles to support new offer, business results and the new Trust's operating model
Identify functions/tasks that could be merged pre go live date

Post-Day 1

7.140. The table below sets out the key post-Day activities in the Performance and BI Integration Plan:

Activity	Timescales
Work with the new Trust's Executives to define new Performance Governance reporting / governance processes in line with timescales for service integration	100 Days
Implement new BI and analytics team structure, roles and responsibilities	100 Days
Develop a forward plan for the improvement of performance, carrying out a Quality Improvement review to ensure new processes are streamlined and efficient	Year 1
Implement new Performance Governance team structure, roles and responsibilities	Year 1

Delivery resources

7.141. Costs relating to the delivery of integrated statutory reporting from Day 1, implementation of a single reporting portal across the new Trust, and the establishment of integrated reporting processes as the new Trust's clinical workstreams transform have been included in the FBC.

Risks

7.142. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the BSID Steering Group are set out in the table on the next page.

Detailed integration plans

7.143. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

Figure 26: Performance and BI transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/22	Leadership burn out / distraction	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 will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.
30/11/22	Loss of corporate	Disaggregation (of IoW) results in loss of corporate memory in relation	3	3	9	Due diligence exercise completed to identify risks and inform integration

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
	memory on IOW	to transferring services (clinical and support.)				planning. These will be further refined once there is clarity on transferring services/individuals.

Digital

Introduction

7.144. This section sets out the approach that the programme has taken to developing plans to integrate Digital functions and IT systems in the new Trust (the Digital Integration Plan). The section describes:

- The functions in scope of the Digital Integration Plan, and any major exclusions that are in scope of other Steering Groups;
- The vision for the Digital function and IT systems in the new Trust;
- The key objectives of the Digital Integration Plan;
- The main milestones of the Digital Integration Plan; and
- The main benefits to be realised through implementation of the Digital Integration Plan.

7.145. The **scope** of the Digital Integration Plan includes the **functions** set out in the table below.

Function	Key responsibilities	
Digital Contracts	Contract management and coordination	
Corporate Systems	Microsoft and other supporting infrastructure apps (Email, SharePoint)	
Operations	Infrastructure Networks Hosting Telephony	End User Devices Service Desk Training
Governance	Strategy - Technology - Information - People/human factors	Policies & Procedures Operating Model Co-ordinate Due Diligence activity
Clinical Systems	EPR National applications e.g. SCR, ERS	Interfaces/Access to partner EPRs Registration Authority
Data and Insights	Enabling infrastructure	
Information Governance	Freedom of Information Subject Access Requests Cyber Security	Data Security Protection Toolkit
Digital Clinical Engagement	Clinical Safety	

- The **IT systems** within scope of the Digital Integration Plan are set out in a supporting submission.

7.146. Key **exclusions** from the scope of the Digital Integration Plan include:

- Clinical Coding services and functions, which are included in the scope of the BI and Performance Integration Plan; and
- A number of corporate IT systems, which are included in the scopes of the Steering Group to which the software product belongs (see supporting submission for further details). The Digital Steering Group is supporting these Steering Groups to develop their integration plans for these IT systems.

7.147. The **vision** for integrated digital services in the new Trust is to co-produce, in conjunction with the new Trust's patients, workforce and ICB partners a rationalised,

combined and suitable digital provision for community and mental health services that:

- Provides user experienced, human-centred solutions; and
- Delivers cost effective value to harness the power of information and technology to deliver outstanding treatment and care that improves lives.

7.148. The Digital Steering Group has established eight working groups, set out in Appendix 1 to lead the development and implementation of Digital Integration Plan objectives, integration priorities and detailed integration plans. For each Working Group, the Digital Steering Group has reviewed:

- The scope, to ensure complete coverage of the Steering Group's scope and prevent duplication of responsibilities across working groups; and
- The membership, to ensure SME representation from each of the Trusts.

7.149. The Digital Steering Group has identified the following overarching **objectives** for the Digital Integration Plan:

- To consolidate digital systems and infrastructure, ensuring that patient care and clinical service delivery are not compromised; and
- To establish an integrated digital function for the new Trust, including the new Trust's information governance functions

7.150. Development of the Digital Integration Plan has been informed by the following key planning assumptions:

- Stakeholders should be included in the development of digital proposals and in the sub-working groups' decision-making processes wherever possible to ensure they benefit from any changes; and
- The identification of Digital solutions will be driven by an objective assessment of user requirements, which balances the scale of improvement to patient safety, service effectiveness, user experience or costs with the ease of implementation and strategic alignment (including with reference to national and ICS digital priorities) of proposed changes.

7.151. The Digital Steering Group has led a discovery process with the other Fusion Steering Groups to identify all IT systems which are in use across the Trusts, including "shadow" IT systems[17]. All systems requiring integration, including for Day 1, will have been agreed by 31 December 2023. The IT systems identified through this process are set out as a supporting submission.

7.152. The Digital Steering Group has identified the following main **benefits** that will be delivered from implementation of the Digital Integration Plan:

- Enabling the provision of better care through:
    - Improving collaborative working across clinical service teams and community connectivity; and
    - Improving mental health digital care pathways by increasing interoperability between systems and clinical access to EPR;
- Improving recruitment and retention by improving career progression and development opportunities, attracting and retaining strong leadership, and improving team resilience; and

17 "Shadow" IT systems are those deployed and managed by the Trusts' non-digital departments

- Increasing the value for money of services provided by an integrated digital function, through:
    - Reducing the overall cost base of the digital function by achieving economies of scale for in-house services and delivering synergies on contracted services and systems;
    - Increasing the quality of service provision by enhancing skills in key positions; and
    - Achieving economies of scale on the cost of investment in development requests, by establishing a single set of priorities for Community, Mental Health and Learning Disabilities services across the ICS.

7.153. The Digital Steering Group is working to establish a digital roadmap, which has two main phases:

- Introduce greater interoperability and collaborative working between legacy organisations for Day 1 by, providing access to appropriate software and systems across legacy organisations, ensuring networks and infrastructure are aligned, and consolidating corporate systems where essential; and
- Develop a series of options for consolidating software and systems in the new Trust, leading to the development of a roadmap for the convergence and /or rationalisation of systems.

7.154. The digital roadmap will enable the new Trust's staff to work seamlessly side by side, with access to the right systems – in particular EPR – from Day 1, with little change to established ways of digital working.

Key integration activities

Pre-Day 1

7.155. The table below sets out the key pre-Day 1 activities in the Digital Integration Plan:

Activity
Identify all digital infrastructure, systems and policies used by the Trusts
Agree and prioritise the new Trust's digital requirements, including those required for Day 1
Agree timetables for the phased implementation of integrated digital infrastructure, systems and policies
Ensure network connectivity at all locations
Create single Service Desk contact details and online portal
Agree key interim digital arrangements, including door access, OOH on-call, clinical risk management and SecureMail accreditation
Ensure all organisation specific code-based functions (e.g. SBS, EPRs) will continue to operate safely in the new organisation
Establish key interim joint business processes, including in relation to business planning and digital contract reviews
Align key digital policies, processes and training programmes
Develop and agree interim digital team structure
Develop information governance structures, for implementation on Day 1
Register with the ICO
Implement interim team structure, including appointments to nationally mandated posts, such as SIRO and DPO
Implement a single 'feel of desktop experience for the new Trust, including a new email address
Provide a single mechanism for staff to be trained on digital systems
Agree SLA to enable the provision of digital support services to IoW

Post-Day 1

7.156. The table below sets out the key post-Day 1 activities in the Digital Integration Plan:

Activity	Timescales
Review sustainability of interim digital arrangements and provide roadmap for convergence of appropriate systems.	First 100 days
Implement changes to enable collaborative working on existing corporate systems (e.g. Microsoft)	First 100 days
Implement rationalised video appointments solution	Year 1
Develop common ways of working within digital services	Year 1
Develop a clinical systems integration plan and transformation strategy for the new Trust	Year 1
Develop a common digital infrastructure implementation plan and a transformation strategy for the new Trust	Year 1
Implementation of harmonised DPIAs and Subject Access Request process	Year 1
Implementation of harmonised information governance policies and SOPs	Year 1
Implementation of combined access control processes	Year 1
Approval of Cyber Security Assurance Framework for the new Trust	Year 1
Approval of SIRO Risk Register for the new Trust	Year 1
Implement clinical systems integration plan	Commence in Year 1
Implement common digital infrastructure plan	Commence in Year 1
Develop and agree final digital team structure	Commence in Year 1
Transfer network, telephony, systems support, infrastructure support and management of IT devices from the IOW SLA to the new Trust's core IT service offering	Years 2-3
Commence implementation of clinical systems transformation strategy	Years 2-3
Commence implementation of digital infrastructure transformation strategy	Years 2-3
Migrate hosting services to the cloud where appropriate	Years 2-3

Delivery resources

7.157. Costs related to the deployment of collaborative working initiatives, the rationalisation of networks and systems, and the establishing interoperable, rationalised and consolidated EPRs have been included as integration costs in the FBC.

Risks

7.158. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the Digital Steering Group are set out in the table on the next page.

Detailed integration plans

7.159. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

Figure 27: Digital transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/23	IOW SystmOne continuity	There is a risk that staff are not supported by resilient digital services and progress to new infrastructure solutions is not maintained.	4	3	12	Joint working underway to define SLA requirements, agreement SLA requirement will be minimal and required staff will TUPE transfer
1/8/22	Leadership burn out / distraction	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 will be articulated in the

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
						PTIP and will inform plans for the new organisation, including resource requirements.
1/8/23	Community & MH EPR migration	There is a risk that there are not enough resources to meet the Clinical Safety compliance requirements of the EPR/Fusion requirements	3	3	9	Ensure reflected in the Operating Model for how Digital services are delivered moving forward. Clinical Safety Officer function can be procured from a third party company if required
1/8/23	Email admin accounts	There is a risk that if email admin accounts are not upgraded in a timely way this will adversely affect EPR functionality	3	3	9	An assessment of impact and plan for remedial actions before 1st April 2024 is required.
1/8/23	New organisation details configured on templates	There is a risk that there is insufficient time to complete the necessary configuration changes in systems to reflect new organisation details e.g. EPR letter templates	3	3	9	An assessment of impact and plan for remedial actions before 1st April 2024 is required
1/8/23	Smartcard management	There is a risk that smartcard management will be disrupted over the transition period due to required reconfiguration	3	3	9	TBC
30/11/22	Loss of corporate memory on IOW	Disaggregation (of IoW) results in loss of corporate memory in relation to transferring services (clinical and support.)	3	3	9	Due diligence exercise completed to identify risks and inform integration planning. These will be further refined once there is clarity on transferring services/individuals.

Estates

Introduction

7.160. This section sets out the approach that the programme has taken to developing plans to integrate the estate of and Estates function in the new Trust (the Estates Integration Plan). The section describes:

- The functions in scope of the Estates Integration Plan, and any major exclusions that are in scope of other Steering Groups;
- The vision for the Estates function in the new Trust;
- The key objectives of the Estates Integration Plan;
- The main milestones of the Estates Integration Plan; and
- The main benefits to be realised through implementation of the Estates Integration Plan.

7.161. The **scope** of the Estates Steering Group includes:

- Property management, hard and soft services and other related functions, as set out in Appendix 1; and
- The **IT systems** set out in the table below

Estates IT systems	
Hotdesk and Room Booking systems	Catering Management
Door Security	Building Management Systems
Staff Personal Safety	Facilities Management
Digital Signage	

7.162. The **vision** for the integrated estates function in the new Trust is aspire to become an exemplar provider of all Estates and Facilities services within the NHS, with service users and staff firmly at the heart of the function's activities and drive for excellence in skills, services and solutions. Underpinned by its values of integrity; professionalism; respect; and creativity, the Estates function will:

- Strive to deliver and maintain future-proofed, sustainable environments for the new Trust's staff, service users, families and visitors to maximise health outcomes in places which delight;
- Aim to deliver an estate that will offer exceptional quality, safe and therapeutic environments, that are cost-effective;
- Embrace latest thinking and digital technologies to provide modern, flexible spaces that are efficient and able to respond to changing clinical needs
- Consider the current and future wellbeing needs of staff as paramount to the service
- Use master planning to provide roadmaps to shape the strategy for excellent healthcare environments and achieving Net Zero Carbon on a remodelled estate for the next generation

7.163. The Estates Steering Group has established a Programme Team and 19 working groups, structured around five functional areas, (set out in Appendix 1) to the development and implementation of integration plans at a more granular level. The estates working groups have generally met on a fortnightly basis, with support provided by members of the Estates Programme Team who attend each working group meeting.

7.164. For each Working Group, the Estates Steering Group has reviewed:

- The scope, to ensure a complete coverage of the Steering Group's scope and prevent duplication of responsibilities; and
- The membership of each Working Group to ensure SME representation from each of the Trusts.

7.165. The integrated estates function's vision has been developed by Estates Steering Group, with input from the Trusts' estates functions obtained through a shared awayday in April 2023. This vision has been refined through an Estates Working Group Forum, which is held every two weeks.

7.166. In line with the programme's Integration Principles, the focus of the Estates' Integration Plan on Day 1 will be to maintain safe and legal operations, with a focus on establishing effective services and functions for the incoming IOW estate. The development and establishment of integrated estates services for the new Trust will commence shortly after Day 1.

7.167. The Estates Steering Group has identified two overarching key **objectives** for the Estates Integration Plan:

- Establish an integrated Estates function; and
- Develop an integrated estates strategy for the new Trust.

7.168. The Estates Steering Group has identified the following main **benefits** that will be delivered from implementation of the Finance Integration Plan:

- Providing better care for patients and populations, by providing higher quality, more therapeutic environments, and improved space utilisation, reducing costs that can be directed towards better patient care;
- Improving recruitment and retention by improving career progression and development opportunities, attracting and retaining strong leadership, and improving team resilience; and
- Increasing the value for money of services provided by an integrated estates function, through:
    - Reducing the overall cost of the new Trust's estate through a programme of estate optimisation; and
    - Reducing the overall cost base of the estates function by optimising service delivery models, achieving economies of scale for in-house services, and delivering synergies on contracted services.

Key integration activities

Pre-Day 1

7.169. The table below sets out the key pre-Day 1 activities in the Estates Integration Plan:

Activity
Undertake options appraisals for transfer of IOW estate and services
Prepare and mobilise for Day 1 all estates services and functions for the incoming IOW estate.
Agree interim or permanent operational adjustments for estates services and functions to ensure statutory compliance
Develop and approve interim Business Continuity Plans for estates services and functions
Implement interim operational adjustments (including harmonisation of key policies) for estates services and functions

Activity
Confirm current St Mary's estate occupation and complete options appraisal on future arrangements
Prepare and agree all necessary agreements and documentation for the transfer or occupation of the incoming IOW estate on Day 1
Commission and complete 6 Facet Surveys for Solent Buildings
Confirm extent of backlog liabilities for new estate
Review and Integrate the Trusts' capital priorities

Post-Day 1

7.170. The table below sets out the key post-Day activities in the Estates Integration Plan:

Activity	Timescales
Develop and agree new estates team structure	100 Days
Develop and approve operational strategies for estates services and functions	100 Days
Develop and approve workforce strategies for estates services and functions	100 Days
Develop and approve Business Continuity Plans for estates services and functions	100 Days
Develop and approve Capital Programme	100 Days
Develop and approve Strategic Estates Plan / Key Principles	100 Days
Develop detailed implementation plans for operational and workforce strategies	Year 1
Implement operational and workforce strategies	Year 1
Implement new estates team structure	Year 1
Develop and approve Wayfinding strategy	Year 1
Establish regular programme of 6 Facet Surveys	Years 2-3
Integrated Estates Strategy agreed and approved	Years 2-3
Commence implementation of Wayfinding[18] strategy	Years 2-3

Delivery resources

7.171. Costs related to updating the new Trust's signage and workforce uniforms to match the new Trust's brand identify, ensuring that the new Trust's assets are appropriately secured through the use of asset surveys and asset tags, mobilising facilities management services on the IOW, and consolidating IT systems have been included as integration costs in the FBC.

7.172. The Estates Steering Group has identified the potential for additional resources to be required to deliver estate infrastructure and IT system optimisation. Options appraisals and business cases will be developed during years 2 and 3 to demonstrate the financial impact of delivering the new Trust's strategic estates plan.

Risks

7.173. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the Estates Steering Group are set out in the table on the next page.

Detailed integration plans

7.174. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

---

[18] Wayfinding is the name for the information systems that guide people through a physical environment and enhance their understanding and experience of the space – such as signage and visual clues.

Figure 28: Estates transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/22	Leadership burn out / distraction	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 will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
10/05/23	Building compliance	Until we know the condition of all properties, there is a risk that environments do not meet statutory minimum.	3	3	9	Commission aligned 6 facet surveys for buildings where they currently don't existing or are out of date
10/05/23	Estates backlog	Completion of 6 Facet Surveys on properties could output a larger envelope than the sum of parts depending on application of Survey Guidance and approach to risk assessed evaluation	3	3	9	Make appropriate allowances against latent backlog issues - say 20% - until surveys are complete. Surveys due to take place by end June (will use same company as have done surveys for IOW and SHFT)
1/8/23	Sufficient IOW EFM staff for Day 1	Insufficient IOW EFM staff available on Day 1 to ensure continued safe operations & inability to recruit and retain	3	3	9	Working groups created to identify all functions, compare options for Day One delivery and implementation. Important to consider the 'Island Factor' when discussing and agreeing the future operating model.
1/8/23	Safety Committee	There is a risk that any delays to establishing the new organisation's Safety Committee could lead to delay for any urgent action required	3	3	9	Ensure future org structure is fully compliant and change terms of reference for the H&S committee to ensure they have powers to act.
1/8/23	Hazardous substances	Hazardous substances - there is a risk of non-compliances due to fragmented approach within SHFT.	3	3	9	COSHH awareness and training is being developed in estates. There is work being undertaken for training and management of COSHH. There is also collaboration with the H&S teams from Solent and the IOW who use a system called SYPOL. Extra licenses can be purchased and many of the substances will be the same.
1/8/23	Fire Warden Training (IOW)	Existing levels of Fire Warden Training on IOW are low which	3	3	9	Include in scope for Compliance Working Group

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
		could result in risk in relation to fire safety matters				
30/11/22	Loss of corporate memory on IOW	Disaggregation (of IoW) results in loss of corporate memory in relation to transferring services (clinical and support.)	3	3	9	Due diligence exercise completed to identify risks and inform integration planning. These will be further refined once there is clarity on transferring services/individuals.

Communications and Engagement

Introduction

7.175. This section sets out the approach that the programme has taken to developing plans to integrate the Communications and Engagement functions in the new Trust.

7.176. Whilst the Communications and Engagement Steering Groups have agreed a joint scope and developed a shared vision, separate integration plans have been developed for Communications (the Communications Integration Plan) and Engagement (the Engagement Integration Plan).

7.177. The section describes:

- The functions in scope of the Communication and Engagement Integration Plans, and any major exclusions that are in scope of other Steering Groups;
- The vision for the Communications and Engagement functions in the new Trust;
- The key objectives of the Communications and Engagement Integration Plans;
- The main milestones of the Communication and Engagement Integration Plans; and
- The main benefits to be realised through implementation of the Communication and Engagement Integration Plans.

7.178. The **scope** of the Communications and Engagement Integration Plans includes:

- The Communications and Engagement **teams**;
- The **functions** set out in the table below; and

Figure 29: Communications and Engagement function services

Functions	
Community development, engagement and patient experience	Experience of Care Insights
Complaints and PALS, Carer and Patient Support Hub	Inclusive communication
Voluntary Services	Peer support, including the new Trust's charities

- The **IT systems** set out in the table below:

Figure 30: Communications and Engagement IT systems

Communications and Engagement IT systems
Websites and Staff Portal/Intranet
Engagement and Feedback tools
Social Media Management tools

7.179. The shared **vision** for integrated Communications and Engagement functions in the new Trust is to work creatively and inclusively to be the authentic, meaningful and informative voice of, and for, our people and our communities so that they can be at their best, and lead their healthiest lives.

7.180. The Communications and Engagement Integration Plans have been developed through joint work to understand current ways of working, develop relationships and define shared aspirations. This process has included joint team development away time and planning sessions.

7.181. The Communications and Engagement Steering Groups have established seven working groups comprising members from the Trusts' functions, with each working group each focussing on overseeing the development and implementation of integration plans at a more granular level in a way which encourages buy in and enables subject matter experts to inform and define integration activities. The Communications and Engagement working groups are set out in Appendix 1.

7.182. The Communications and Engagement Steering Group includes communications, engagement and community engagement representatives from the four provider organisations plus ICB representation.

7.183. The Communications and Engagement Steering Group has identified the overarching **objectives** shown in the table below for the Communications and Engagement Integration Plans:

Figure 31: Communications and Engagement Integration Plan objectives

Communications	Engagement
To develop a communications strategy for the new Trust, including brand identity	To develop and agree a joined-up approach to engagement
To create a sense of Team for the new Trust	To develop and agree an approach to supporting families, carers and volunteers
To align and develop communications processes, channels and activities for the new Trust	To develop and agree a joined-up approach to feedback and complaints
To establish integrated Communications and Engagements functions for the new Trust[19]	

7.184. The Communications and Engagement Steering Group has identified the following main **benefits** that will be delivered from implementation of the Communications and Engagement Integration Plans:

- Enabling the provision of an improved experience for patients and population through:
  - Reducing inequity of access to services, by working with communities to address barriers to accessing health and care services;
  - Learning from experience of care insights, by reducing variations in responses to feedback;
  - Identifying opportunities for communities to create health for themselves, by building and acting on trusting relationships with the community;
  - Ensuring the provision of consistent and accurate information, by establishing a unified approach to external communication and stakeholder engagement;
  - Improving the clarity and consistency of messaging, reducing complexity and potential for duplication, through establishing a single calendar of events and campaigns;
- Increasing the value for money of services provided by an integrated Communications and Engagement function, through reducing the overall cost base of the functions by allocating resources to reflect the responsibilities, scope and objectives of the new team, and achieving synergies across contracts and economies of scale; and

19 The Communications and Engagement Steering Groups are considering the appropriate team structures, roles and responsibilities for delivery of Communications and Engagement functions in the new Trust. At the time of writing, no decision has been made over whether combined or separate Communications and Engagement functions will be created.

- Improving recruitment and retention by:
  - Developing a compelling narrative and communications approach to capitalise on the benefits of being a larger organisation, to maximise the attraction and recruitment potential of the new organisation;
  - Creating a sense of Team throughout the new Trust through the establishment of a communications strategy for the new Trust, a single calendar of events, and unified communications channels and portals; and
  - Improving career progression and development opportunities, attracting and retaining strong leadership, and improving team resilience.

7.185. Implementing the Communications and Engagement Integration Plans will:

- Deliver co-ordinated communications and engagement activity;
- Support the delivery of timely and meaningful community and employee engagement programmes, led by each Trust's 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; and
- Create a brand identity for the new Trust that meaningfully reinforces the values, and reflects and represents the geography, communities and workforce.

Key integration activities

Pre-Day 1

7.186. The table below sets out the key pre-Day 1 activities in the Communications an Engagement Integration Plans:

Activity
Develop communications priorities for Day 1
Develop options and agree the Trust's name, in consultation with Governors, system partners and NHS England
Scope out current communication and engagement channels in use across partner organisations (including social media channels)
Propose and develop approach to communication and engagement channels, covering platforms, audience and frequency, and including merging existing channels where appropriate
Develop shared content calendar for channels
Jointly identify and agree Day 1 intranet requirements, with IT and commercial colleagues, including content and pages, and new visual identity
Develop intranet content ready for launch, including agreed 'day one' systems and processes
Jointly identify and agree Day 1 external website requirements with IT and commercial colleagues
Create solution for day 1 of new organisation (interim landing page with new identity).
Review processes for handling media (linking with agreed media policy) - logging, alert system, on call, media management
Create and agree approach to media handling, including setting up media logging system, sign off processes, statement and release templates, media database, round ups
Understand the new Trust's designate executives' media training requirements and arrange for media training
Align stakeholder databases and Customer Relationship Management systems

Activity
Agree stakeholder communication tactics (Stakeholder newsletter frequency, approach to MP and council engagement)
Align and approve media policy and social media policy
Align and agree guidance and standard operating procedures - including mapping out all current guidance, SOPs and aligning Business Continuity Plans, and OOH arrangements
Agree approach and process for the development of patient information for the new Trust
Set up communications email address and develop all staff distribution list, manager distribution list
Develop engagement plan to continue to bring staff on the journey for first 100 days including:
Design and communicate interim communications and engagement team structures
Implement interim communications and engagement team structures
Identify independent resource to review existing complaints policies and carry out gap analysis
Develop and approve the new Trust's complaints policy, including through engagement with key internal stakeholders
Identify resources to review support provided to carers and families including through the lenses of the Pascoe report[20] and reviews of action plans
Identify core priorities for working together as place-based engagement teams, recognising the different approaches we may need to take for our local communities.
Review existing and new service user feedback systems and processes to inform options appraisal for the new Trust's processes, including consideration of digital patient experience data systems

Post-Day 1

7.187. The table below sets out the key post-Day activities in the Communications and Engagement Integration Plan:

Activity	Timescales
Channels - communicate agreed set of channels to raise awareness	100 Days
External website - Map out content and pages which need to be included on new website	100 Days
External website - Develop skin and site map	100 Days
Implement launch plan as set out in Fusion Communications and Engagement Plan	100 Days
Develop a compelling organisational narrative with a golden thread.	100 Days
Develop and approve communications strategy	Year 1
Develop brand identity and tone of voice guide	Year 1
Develop and agree requirements and content for new Trust's external website	Year 1
Launch new Trust external website, archive old websites	Year 1
Develop and agree policies on VIP visits, sponsorship and advertising	Year 1
Implement engagement plan	Year 1
Develop an internal campaign which connects people to a common purpose and the strategic narrative, ensuring employee engagement in the development	Year 1

20 An independent report, authored by Nigel Pascoe KC, into the care of five patients who died whilst under the care of Southern's services between 2011 and 2015, as well as the subsequent investigations and liaison with the patients' families. See paragraphs 2.41 and 2.42 of the FBC for further details.

Activity	Timescales
Design, engage and implement the new Trust's integrated communications and engagement team structures	Year 1
Develop and implement processes that incorporate recommended improvements to support provided to families and carers and ensure the support provided to families and carers is the same across all of the Trust's communities	Year 1
Develop and implement policy / guidance in relation to the new Trust's payments policy for service users and involvement of our communities, that recognises differences in the Trusts' existing policies and approaches	Year 1
Implement integrated service user feedback systems and processes	Year 1

Delivery resources

7.188. Costs related to the creating a single intranet and external website for the new Trust, and providing materials such as lanyards and badges to match the new Trust's brand identify have been included as integration costs in the FBC.

Risks

7.189. Integration risks (see paragraph 6.55) scoring more than 8 which have been identified by the Communications and Engagement Steering Group are set out in the table on the next page.

Detailed integration plans

7.190. The detailed integration plan is a supporting submission. The detailed integration plan includes all planned activities with owners and timescales and benefits register.

Figure 32: Communications and Engagement transaction risks (extract from Programme risk register)

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
1/8/22	Reduced staff morale	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	Communications and engagement plan in place and key messages issued weekly. OD plan being developed. FAQs developed and available. Programme of joint senior leaders events has been in place since Oct 2022. Clinical Transformation Group workstreams mobilised to deliver clinical transformation. Staff survey and senior staff surveys planned in autumn 2023 to monitor staff engagement.
15/8/23	Post day 1 senior leadership arrangements	There is a risk that uncertainty over organisational form and SLT including future portfolios and portfolio leadership will delay efficiency improvements and team cohesion.	4	4	16	Exec structure and high level portfolios have been developed. Further engagement on operational management structure is planned
1/8/22	Leadership burn out / distraction	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 will be articulated in the PTIP and will inform plans for the new organisation, including resource requirements.
30/11/22	Loss of corporate	Disaggregation (of IoW) results in loss of corporate memory in relation	3	3	9	Due diligence exercise completed to identify risks and inform integration

Date raised	Risk Subject	Risk Description.	Impact Score	Probability Score	Residual Risk Score	Controls in Place/Planned Mitigating Action
	memory on IOW	to transferring services (clinical and support.)				planning. These will be further refined once there is clarity on transferring services/individuals.

8. Operating model

8.1. This chapter describes the operating model (governance, systems and processes, organisation structures and roles and capabilities, culture and behaviours) of Southern, Solent and IOW and the proposed operating model for the new Trust. The operating model for the new Trust is set out in more detail in chapter 6 of the FBC.

Current operating model

Governance, systems and processes

8.2. Southern currently has a Council of Governors, as a required mechanism for foundation trusts to be held accountable to their members.

8.3. The COG at Southern meets quarterly and on an ad hoc basis where required. Four additional governor development sessions are also held each year, along with ad hoc webinars as required.

8.4. Solent's Trust Board meets every two months. Southern's Trust Board meets six times each year in public and holds four public Focus meetings with confidential sessions held (following resolution to exclude public) for matters as required. Board Focus meetings are dedicated to discussing and exploring one or two important strategic items in detail. Ten Board seminars are held each year (with one or two held jointly with Governors) and three Board development sessions. IoW's Trust Boards meets every two months.

8.5. The figure below sets out the Board roles at Southern, Solent and IoW.

Figure 33: Trust Board roles at Southern, Solent and IoW

Southern	Solent	IoW
Executive Board roles		
• Chief Executive Officer • Deputy Chief Executive Officer and Chief Medical Officer • Chief Financial Officer • Chief of Nursing and AHP • Chief Operating Officer • Acting Chief People Officer (non-voting) • Chief Strategy and Transformation Officer (non-voting)	• Chief Executive Officer • Deputy Chief Executive and Finance Director • Acting Chief Medical Officer • Director of Nursing and AHP • Chief Operating Officer • Chief People Officer • Director of Strategy and Infrastructure Transformation	• Chief Executive Officer • Chief Medical Officer • Finance Officer • Chief Nurse • Chief Officer IWT • Chief Officer PHU (non-voting) • Chief Transformation Officer (non-voting) • Chief Research Officer (non-voting) • Group Director CMHLD (non-voting) • Chief People Officer (non-voting) • Chief Strategy Officer (non-voting)
Non-executive roles		
• Acting Chair and four further NEDs	• Chair and eight further NEDs and an associate NED	• Chair (joint with Portsmouth Hospitals NHS Trust), five further NEDs and one associate NED

Organisation structures and roles

8.6. The figure below sets out the committees that report into the Trust Boards of Solent, Southern and IoW.

Figure 34: Trust Board committees at Southern, Solent and IoW

Southern	Solent	IoW
Statutory Committees		
• Audit and Risk Committee – quarterly plus a private meeting to consider the Annual Report and Accounts • Remuneration and Nominations Committee – at least twice per year and as required • Charitable Funds Committee – three times per year	• Audit, Risk and Assurance – quarterly and a private meeting • Nominations and Remuneration (for Execs) – annually and ad hoc • Charitable Funds – three times per year	• Audit Committee – up to six per year • Remuneration and Nominations Committee – as required • Charity Committee (separate legal entity) – quarterly

Southern	Solent	IoW
Other Committees		
Designated committees: • Mental Health Act Scrutiny Committee – quarterly • Quality Assurance Committee – every two months • Finance and Infrastructure Committee – every two months • People Committee – every two months • Strategy and Partnership Committee – every two months	Committees required by the foundation trust constitution: • Quality and Safety – eight times per year • People – six times per year • Health, Ethics and Law – quarterly • Finance and Performance – six times per year	Designated committees: • Quality and Performance Committee – monthly • People and Organisational Development Committee – monthly • Finance and Infrastructure Committee – monthly • The Trust also has a combined Community and Mental Health and Learning Disabilities Divisional Board.

8.7. In addition, the AC for Southern, a statutory Committee of the COG, meets on an ad hoc basis as required.

Culture and behaviours

8.8. Understanding organisational culture, both the existing (as is) and the desired (to be) for the new Trust, increases the likelihood of successful change management and the harmonising of four existing legacy cultures. To establish the 'as is' culture states, an internal 'cultural analysis review' was conducted, utilising existing expertise and enabling the learning opportunities to be retained by our staff.

8.9. The OD Steering Group identified processes for understanding, measuring and analysing the Trust's existing cultures, and agreed the scope of the cultural analysis review:

- to complete a desk research-based analysis of the cultures of the merging organisations & services; and
- to seek to understand the Trust's cultures through highlighting similarities, differences, risks and areas of best practice.

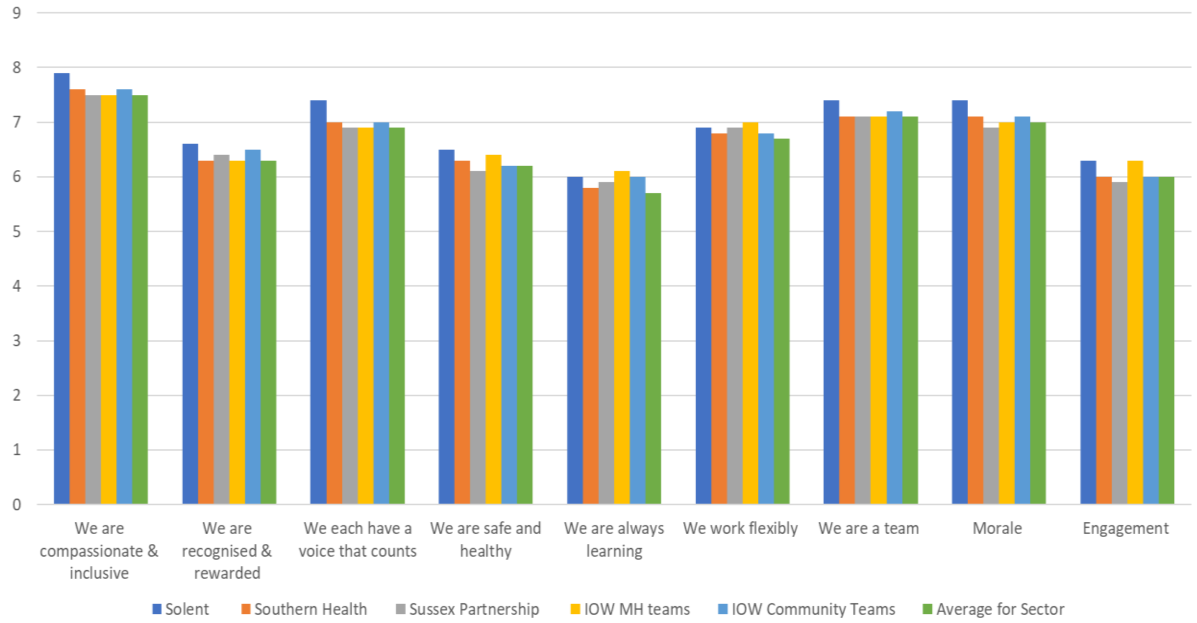
8.10. Information and data sources used to inform the cultural analysis review included:

- NHS Staff Survey 2022 data (including Response rates, Morale, Staff Engagement, Staff recommending as a place both to work and to receive care and treatment and People Promise Themes);
- Trust Workforce Metrics (including turnover, vacancy rates, appraisal, and statutory and mandatory training compliance);
- Employee relation case numbers and themes;
- FTSU concerns raised and themes;
- Trust Diversity, inclusion, and belonging themes (including WRES and WDES reporting Hate Crime reporting);
- Exit Interview Survey reports (where available);
- Trust Recognition frameworks;

- Trust Governance frameworks;
- Trust Communication and Engagement channels;
- Trust Vision, Values & Behaviour frameworks; and
- Model Hospital data.

8.11. The relevant data from analysis of the NHS Staff Survey People Promise themes is summarised in the figure below:

Figure 35: Analysis of staff survey scores across the Trusts on themes of the NHS People Promise



8.12. The OD plan has been designed to support the change transformation journey that will bring the new Trust's desired culture to life. The OD plan has been aligned to the new Trust's emerging vision and the clinical strategy.

8.13. Diverse stakeholders' views have been obtained to ensure co-production of the OD plan and enable shared ownership for the achievement of the objectives of the OD plans. Engagement has been secured from clinical, patient safety, lived experience, digital, quality improvement, research, communications and engagement staff groups, as well as staff networks, the ICS, and the Trusts' executive directors and Boards.

8.14. Figure 36 on the next page summarises the approach to embedding cultural change in the new Trust.

Figure 36: The approach to embedding cultural change in the new Trust

8.15. The OD Integration Plan, set out in chapter 7, sets out the short- and long-term activities which will help create and embed the new Trust's culture into everyday ways of working, policies and procedures. These visible signals, summarised in figure 37 below, will set expectations and highlight change, reinforcing the importance of change to achieve the desired outcomes.

Figure 37: Overview of activities to create and embed the culture of the new Trust

Activity	Start	End
Embedding the desired culture in the new Trust		
• Work with executive colleagues to ensure **culture and values are clearly defined** and included in new Trust's mission and vision.	Oct-23	Mar-24
• Create a **behavioural framework** for the new Trust which translates the values into a set of core behaviours.	Dec-23	Mar-24
• **Warm welcome 1.0**: Day 1 welcome communication from the new Board, including reference to staff having equal access to learning and development opportunities to support their skills, knowledge and behaviours. Also included will be an FAQ to help staff know how things will be working if they have changed.	Nov-23	Mar-24
• **Warm welcome 2.0**: Plan welcome activities to ensure staff can access to support for team events including meet and greets and away days, to help create new relationships and define new shared team purpose statements.	Nov-23	Mar-24

Activity	Start	End
• **Warm welcome 3.0**: Design a warm welcome for Sussex Partnership CAMHS staff. Activities to include monthly Senior Leadership Team events, TUPE support for staff, welcome sessions, marketplace events to showcase support offer available, adapted version of change support offer, welcome pack for Day 1.	Aug-23	Feb-24
• **Cultural influencer programme:** recruit people who demonstrate the values be role models in everyday behaviours, promote the OD change management offer, signpost staff to support, and encourage staff to engage with comms and surveys.	Nov-23	Mar-24
• **Preparing for Change insight sessions:** to enable members of the People Directorate teams to engage across the Fusion organisations, sharing updates around: key messages and decisions made to date about the OD and workforce workstreams, opportunities to get involved and support available. They will also listen to what staff are experiencing and answer questions.	Nov-23	Mar-24
Creating leadership commitment to the culture		
• **Coaching support:** as well as BAU coaching offerings, scope, design and deliver a collaborative Chartered Management Institute Level 5 qualification in Professional Coaching for leaders who wish to gain this qualification.	Sep-23	Mar-24
• **Create and combine existing content** made up of self-directed learning tools, tools to enable away day running by leaders, access to a facilitated away day, leadership programmes and bitesize skills.	Jun-23	Mar-24
• **Design and deliver a change support package** offering for managers, including signposting to resources, facilitated support for groups and leadership development.	Aug-23	Mar-24
• **Harmonising leadership competencies** and aligning with clinical strategy lived experience, continuous improvement, new Trust values, reflective practise, trauma informed approach.	Nov-23	May-24
• **Leadership development programme** to upskill senior managers in managing during change.	Nov-23	Mar-24
Driving visible and sustainable change		
• **Talent Management**: design a strategy that incorporates appraisal framework, talent definition, skills, knowledge, continuous improvement competencies, diversity and talent, succession planning, talent development offering, executive development, insight tools. All linked to the values of the new Trust.	Nov-23	Jul-24
• **Develop a programme of networking opportunities** for leaders to provide opportunities to share and challenge ideas, supported by organisational development professionals.	Oct-23	Mar-24
• The **internal cultural measurement tool** created by Southern to measure staff engagement, and structure support around behaviours and cultural domains, will be adapted to be fit for the new Trust.	Oct-23	Mar-24
• Work with **reward and recognition** colleagues to develop a recognition scheme linked to how well staff display the value.	Dec-23	Mar-24
• Work with workforce colleagues to embed values and culture into employee lifecycle and employee relations **processes and policies**.	Dec-23	Mar-24
• Use **of staff survey and Pulse surveys** to measure engagement and receive feedback.	Sep-23	Mar-24

Governance, systems and processes for the new Trust

Council of Governors

8.16. In May 2023 a Constitution Review Group was established to develop proposals to amend the overall composition of the COG (see FBC chapter 6 for further details). Changes to the constitution relating to the composition of the COG will come into effect from Day 1, with transitional provisions in place relating to some of the amendments to the appointed governors.

8.17. The public constituencies will be increased from five to seven, with two governors per public constituency area (except for 'rest of England', where there will be one governor). Transitional provisions will apply to allow a reduction from three to two Governors in the existing Southern public constituencies at the natural end of term where there are three governors in post as at Day 1.

8.18. The creation of a service user and carer constituency is proposed, with six governor posts proposed for this constituency, and no classes thereof. Eligibility criteria for membership of this constituency will be defined in the constitution and will require an individual to have used any of the Trust's services as a patient or have been a carer of anyone using the Trust's services within the three years immediately preceding the date of an application.

8.19. The classes of the staff constituency will be increased from four to six and the number of staff governor posts will increase from Day 1 from four to six. Staff membership will be expanded on Day 1 as a result of the automatic opt-in provision for staff members.

8.20. Proposed changes to the appointed governors include the expansion of the local authority governors from two to four, to add Portsmouth City Council and Isle of Wight Council.

8.21. Elections for vacancies on the COG are planned shortly after Day 1, with work undertaken in advance to ensure that there is an adequate membership of each of the revised constituencies to enable elections to be held.

8.22. The COG will continue to meet four times per year, with additional quarterly sessions dedicated to governor development, and supplemented by a programme of governor webinars, as has been in place within Southern.

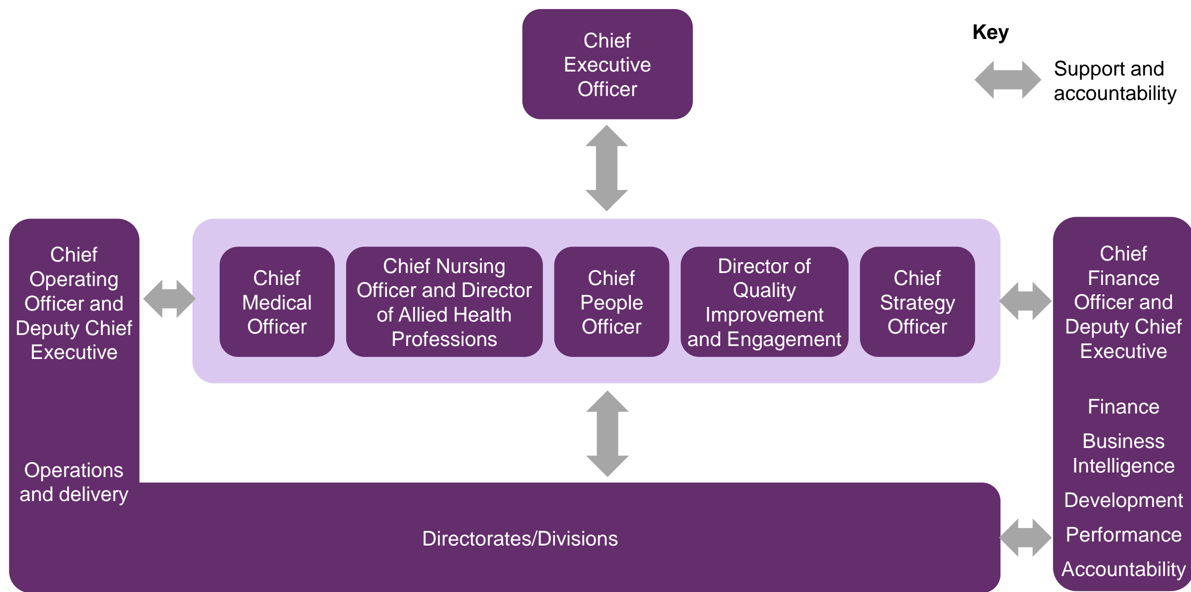
8.23. Southern currently has a Governor Agenda Planning Group, and it is proposed that this will continue into the new Trust. This group will be involved in designing the programme of Governor Development support.

Trust Board

8.24. The process to appoint designate members of the new Trust's Board is set out in paragraphs 7.16 to 7.21.

8.25. The figure below sets out the new Trust's executive director structure:

Figure 38: Executive director structure

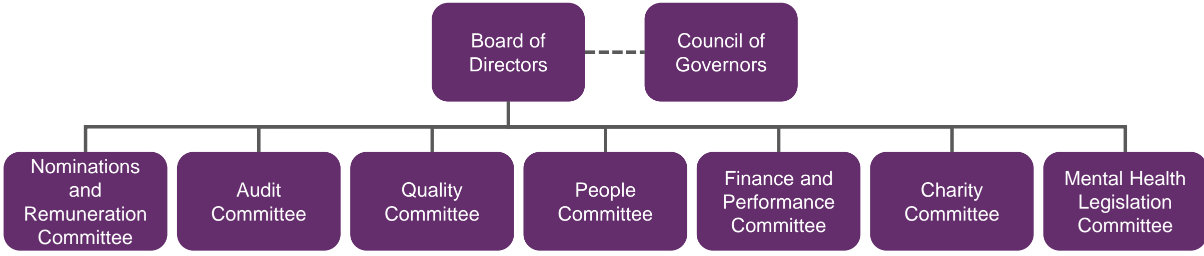


Committee structure

8.26. The Corporate Governance Steering Group has reviewed the committee structures within Solent, Southern and the IOW to support the development of the committee structure for the new Trust. The existing Committee structures of the organisations, and purview of the Committees are largely consistent, with the principal difference being the approach to performance oversight.

8.27. The outline of the proposed Committee structure for the new Trust is set out below. This will be refined, including agreeing the names and memberships of the Committees, to allow Terms of Reference to be in place for Day 1 of the new Trust.

Figure 39: The proposed committee structure for the new Trust



8.28. Approval of the establishment of the Board Committee and appointments to these Committees will be in line with the provisions of the Constitution and Standing Orders; this includes the discretion for the Board to be able to establish any other Committees of the Board required.

8.29. Once the Board composition has been finalised, including the Executive portfolios, a process will be agreed with the Chair designate to review the skills matrix for Board members to inform the membership of Committees and appointment of Committee Chairs. Appointments to Committees will, where possible, take account of tenures of Non-Executive Directors to ensure stability is maintained within Committees through the transitional period and beyond into the first year of the new Trust.

8.30. The Corporate Governance Steering Group will design, through detailed integration planning, the approach and templates for Board and Committee administration. This will include, but is not limited to, agendas, minutes (including house style), action

logs, reports, escalation reports from committees to the Board of Directors and the process for the annual committee effectiveness review process. The approach will be to adopt areas of good practice from existing Trusts and beyond. The Corporate Governance Steering Group will ensure that all actions attributed to the Board and Committees from the Trusts are transferred into the new governance framework and allocated accordingly for Committee oversight to ensure that these are seen through to completion.

8.31. Quality and performance reports to the Trust Board and committees will enable clear visibility of operational performance throughout the organisation and will be presented in a format that supports identification of trends and highlights areas for improvement. Trust level reporting will encompass operational performance across all sites and cover all statutory national performance standards, alongside other indicators of patient quality, safety and patient experience.

Risk management and Board Assurance Framework

8.32. During Quarter 4 2023/24, the designate Board will develop a clear and aligned risk management vision statement, strategic aims, risk appetite and tolerance to inform the development of the risk management strategy and Board Assurance Framework (BAF) for the new Trust.

8.33. Following agreement of the Trust's strategic objectives, the Corporate Governance Steering Group will support the designate Board in identifying the principal risks to delivery of the strategic objectives and developing the BAF.

8.34. The BAF models in use within the Trusts are broadly similar in their style in that they follow the recognised good practice model which sets out the principal risks to delivery of the strategic objectives, the controls in place to mitigate these risks, the assurance as to the effectiveness of the roles and any required actions to address any gaps in controls or assurance.

8.35. The BAF, and highest scoring risks from the corporate risk register, will be reviewed by the relevant Board Committees on a quarterly basis, and in consolidated form quarterly by the Audit Committee and Board of Directors.

8.36. The ongoing management of the BAF will be led by the corporate governance function in the new Trust.

8.37. All Trusts have effective processes in place for the identification, reporting and management of clinical and non-clinical risks via the corporate risk register. The risk management processes for the new Trust will be supported by the quality governance teams and the transitional processes will be overseen via the Clinical Steering Group.

8.38. The risk management processes in each Trust are based on the National Patient Safety Agency risk matrix developed in 2008. Both Solent and Southern utilise the same electronic system to record and monitor risks. As part of the transition arrangements, risks relating to mental health and community services within the Isle of Wight will be transferred into the Ulysses system prior to Day 1. Additionally, any risks identified by workstreams that relate to post-transaction implementation beyond Day 1 will be included within the risk register for the new Trust.

8.39. The Trusts will develop a risk management strategy and policy framework for the new Trust by 31 January 2024 to ensure that patients, visitors, employees, contractors and other members of the public are not exposed to unnecessary risks. This will be supported by a single risk matrix and risk register template.

8.40. The proposed structure for the quality governance function includes a single risk manager post to work across the new Trust and support effective risk management.

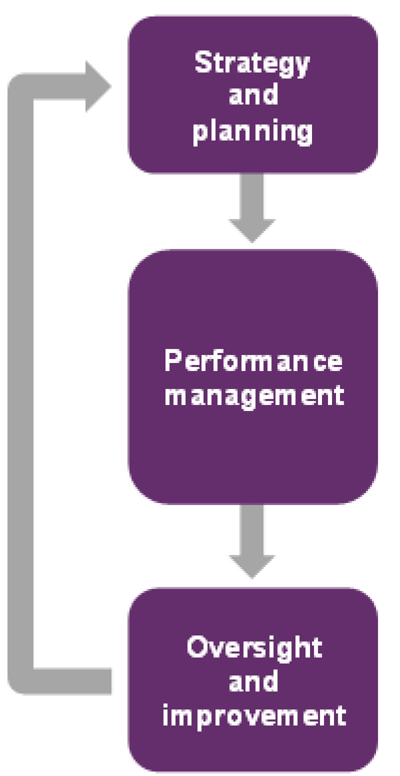
Performance management

8.41. The performance framework for the new Trust has been designed to improve decision-making and the execution of the new Trust's strategy through measurement, reporting, analysis and oversight. This framework requires individuals, services, localities, specialisms and the Trust to report, explain and improve performance against agreed standards and targets. These standards and targets reflect best practice and focus on delivering high quality outcomes. Oversight of performance enables identification of areas where further support for improvement is required.

8.42. The new Trust will use performance information to improve services, ensuring that:

- Staff can assess performance against targets and predict future performance, enabling decisions to be made around performance improvement. Relevant information will be made available to all staff in a number of ways, but predominantly through the new Trust's automated business intelligence (BI) platforms;
- Strategic decisions support continuous improvement and are informed by evidence;
- Internal benchmarking of services and localities/specialisms against core standards is undertaken and reported to Board;
- External benchmarking is used to assess and improve services; and
- Sharing good practice across services and localities/specialisms is embedded within business-as-usual processes.

Figure 40: the performance process for the new Trust



- Define strategic priorities and set performance deliverables and KPIs
- Set targets and thresholds at individual, service, locality/specialism and Trust level
- Agree monitoring and reporting mechanisms

- Collate and report through the Trust's automated BI platforms and other required mechanisms
- Undertake formal performance reviews at individual, service and locality/specialism levels
- Provide internal reports for oversight and assurance through Board and committees
- Provide external performance reports as required to commissioners and regulators

- Identify and implement corrective action for services requiring additional support
- Review and challenge at Executive/Trust Board level as well as externally with commissioners and NHSE
- Implement individual support and review through appraisal and supervision processes

8.43. The performance governance structure for the new Trust is summarised in the table below:

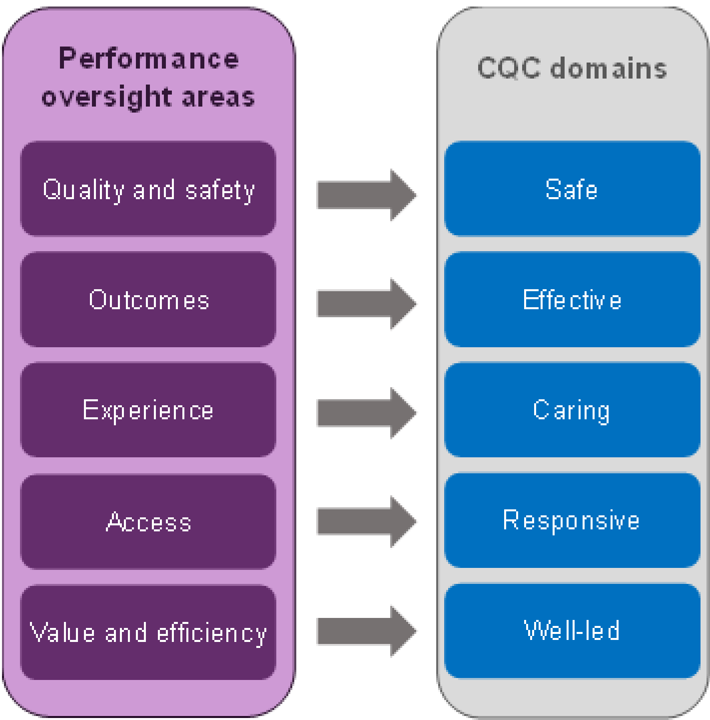
Figure 41: Governance structure for performance management in the new Trust

Meeting	Content	Benefit	Frequency
Trust Board	Presentation of the Integrated Performance Report (IPR) containing performance exceptions in metric and narrative format	Oversight by Board Directors, assurance, and approval	Bi-monthly
Executive Performance Oversight Group	Escalations of performance exceptions in metric and narrative format from the following: • Locality/specialism performance reports • Corporate teams performance reports • Trust-wide financial Reports • Trust-wide quality Reports • Trust-wide workforce Reports	Triangulation, review and challenge by Executive Directors Action planning and delivery	Bi-monthly
Locality/ Specialism Performance Oversight Group	Review of services and overall locality/ specialism to include: • Review of performance against the five oversight areas • Evidence-based performance hotspots • Snapshot report of key metrics • Performance actions plans (as appropriate) • Escalations from locality/specialism operational boards • Commissioner attendance for oversight and constructive challenge	Internal assessment of performance, analytics, decision-making, benchmarking, sharing good practice	Bi-monthly
Locality/ Specialism Operational Boards	• Review of operational performance at service level within each locality/specialism • Review of performance against the five oversight areas, with specific content defined by each locality/specialism	Internal assessment of performance, decision-making, benchmarking, sharing good practice	Monthly
Service specific meetings	• Review of service level performance data • Specific content defined by each locality/specialism or individual service	Operational management and action planning	Individually defined
Individual performance reviews (1:1s)	• Review of individual performance • Personal Development Plans	Accountability for performance throughout the Trust	Monthly/ annually

Meeting	Content	Benefit	Frequency
	• Individual activity/assurance reports from the Trust's automated BI platforms		

8.44. Measurement of performance is largely influenced by national and local priorities and the NHS Oversight Framework[21]. These metrics, paired with a range of internally identified measures that can be reviewed at various levels of the Trust, from individual service to Board, inform decision-making, highlight best practice, provide oversight and support risk management. The identified metrics are set out under five key oversight areas, which are broadly aligned to the CQC domains:

Figure 42: The five performance oversight areas for the new Trust



8.45. Metrics will be monitored at service and locality/specialism levels and reported by exception through the performance framework governance structure, however a standard set of metrics (outlined below) will be reported routinely within the IPR to provide an overview of performance across the oversight areas, utilising NHS England's Making Data Count[22] methodology to identify significant trends and variation which require further scrutiny. This represents the starting point that will ensure safe and effective delivery of care from Day 1 and the new Trust collaborate with the ICB to review the metrics used for CMHLD over the following two years, linked to the work arising from the transformation programmes.

Operational management structure

Operational management structure

8.46. In July and August 2023, an options appraisal was undertaken to inform the design of the operational management structure and to establish principles for its development. This options appraisal involved staff from across the Trusts and took into account

[21] https://www.england.nhs.uk/nhs-oversight-framework
[22] https://www.england.nhs.uk/publication/making-data-count

what already works well in each Trust. The conclusions of the options appraisal include:

- The final operational management structure needs to be flexible, recognising that some services are better delivered at HIOW scale and others organised around local geographies;
- Rigid operational management structures, for example all HIOW community and mental health services organised in local geographical directorates, or all services managed at scale across HIOW, should be discounted;
- Many services suit delivery in local geographical divisions, with some best organised around acute hospital footprints (Local Delivery System (LDS) level) and others organised around local authority boundaries (Place);
- Other services, particularly specialist services, are better organised at HIOW scale;
- A flexible matrix, or hybrid operational management structure is preferable, which will enable services to be delivered at the optimum scale for the best patient outcomes; and
- To support the case for change, whether services are organised in local geographical directorates or at HIOW scale, clear mechanisms are needed to ensure learning across HIOW and reduce unwarranted variation.

8.47. Following the options appraisal, a workshop was held with attendees from all four Trusts. The following was agreed at the workshop:

- The definition of service groupings for HIOW community and mental health services;
- The proposed delivery scale for each service: PCN, local authority boundary (Place), acute boundary (LDS) or HIOW boundary;
- It was also noted that many IOW services are small scale and currently managed together to provide resilience (e.g. liaison services for adults, children and LD). This may change the recommendations for grouping/scale of some IOW services during the implementation planning stage; and
- Further work is needed to list and map all Trust services to a greater level of detail. Clinical and operational leads from across the Trusts should be involved in this and work being undertaken by clinical transformation workstreams needs to be taken into account, once available.

8.48. The principles for the organisational management structure for the new Trust, which are detailed further In the FBC chapter 6, are: Consistency and safety; Leadership and governance; Population and system needs; Integration and partnership working; New ways of working; and Sustainability.

8.49. The organisational management structure will be designed to enable the delivery of the clinical strategy, recognising the importance of a matrix approach to leadership that enables the organisation to maximise the benefits of working at place, while at the same time driving out unwarranted variation.

8.50. Southern, Solent and IOW have different operational management structures. The IOW CMHLD division has two Directors of Operations, one for community services and one for mental health services. Solent has eight Clinical Directors based on its service line structure. The eight Clinical Directors report to the COO. Each Clinical Director is supported by an Operations Director and these Operations Directors have a dotted line into the Deputy COO (who reports to the COO). Southern has five

Operations Directors and two Clinical Directors currently, all of whom report to the COO.

8.51. On Day 1 it would not be practicable for the COO of the new Trust to have eighteen direct reports (two from the IoW, eight Clinical Directors and a Deputy COO from Solent and five Operations Directors and two Clinical Directors from Southern). It is therefore expected that the COO of the new Trust will need to be supported by deputy COOs in the interim period before the Trust adopts its new operational management structure. Following appointment of the designate COO in early November 2023, the designate COO will work with the existing operational leads to agree the interim structure including the number and responsibilities of deputy COOs. The interim operational management structure will ensure services are managed safely from Day 1 with very limited change in terms of reporting arrangements.

8.52. The next steps to develop the operational management structure are detailed service mapping work and engagement with clinical teams where there are different options to consider. In October 2023 the designate CEO wrote to leaders and managers across all three Trusts seeking feedback on how services should be grouped in the new Trust by 1 December 2023. The intention is to agree the operational management structure by the end of December 2023.

9. Benefits realisation

Benefits realisation approach

9.1. Chapter 3 sets out the context for the creation of the new Trust and chapter 4 sets out the significant benefits that can be achieved through the creation of a new Trust for community, mental health and learning disabilities services across the ICS.

9.2. This chapter describes the process by which the new Trust will ensure that these benefits are realised. An approach to benefits realisation has been developed which will allow us to continually identify, deliver and measure the benefits from the creation of a new Trust, as set out in the table below:

Figure 43: Benefits realisation approach

Activity
Define benefits: Identify and articulate the specific benefits that are expected to be achieved as a result of the creation of the new Trust
Establish metrics: Select measurable KPIs that will be used to track progress and outcomes. Ensure that KPIs are aligned with the defined benefits.
Baseline measurement: Capture the baseline performance of the relevant metrics
Set targets: Define the target values for each metric and timescales for delivery (trajectories) based on the planned timescales of integration activities
Implementation and monitoring: Implement the integration plan and monitor progress Regularly track and report the actual performance of against the defined metrics and targets
Performance management: Analyse the reasons for shortfalls against delivery of benefits Take corrective actions as needed
Identify lessons learned: Capture lessons learned and best practice for future projects

Benefits definition and categorisation

9.3. For the purposes of this document, a benefit has been defined as a positive outcome or improvement that can be delivered as a result of creating the new Trust, which can be measured (using the SMART terminology[23]).

9.4. The table below defines the four main benefit categories:

Figure 44: benefit definitions by category

Patients and carers	Workforce	Wider health and care system	Financial sustainability
Changes to the way in which services are delivered that results in improved	Changes to the way in which the Trust operates that creates a better place to work	Changes to the way in which the Trust engages with stakeholders that leads to improved	Changes to the Trust's cost base that improves financial sustainability

[23] Specific; Measurable; Achievable; Time Bound; Measurable

Patients and carers	Workforce	Wider health and care system	Financial sustainability
outcomes for patients and carers		partnership working and benefits for the wider health and care system	

Benefits identification and quantification

9.5. The process of identifying potential benefits has been a bottom-up process, led by the programme's Steering Groups.

9.6. In order to ensure the identified benefits meet the overarching definition set out in paragraph 9.3, Steering Groups have been provided with a standard integration plan workbook which requires the following information to be specified for each benefit:

- The outcome(s), which result from the delivery of integration plan activities;
- The benefit(s), which arise from the specified outcome(s);
- The beneficiaries of the specified benefit(s);
- The quality, operational and / or financial metrics, which will demonstrate the delivery of the benefit; and
- The improvement trajectories for each metric, including establishing the existing performance baseline and timescales for achieving the target performance.

9.7. Assurance over the completeness of identified benefits has been obtained by:

- Each Steering Group, by drawing on the expertise and best practice knowledge of the subject matter experts from each of the Trusts;
- The Integration Planning Group, by carrying out in-depth reviews of each Steering Group's identified benefits through "deep dives";
- The Programme Board, through reviewing the key benefits set out in the FBC, PTIP and PBC; and
- The Trust Boards, through reviewing the key benefits set out in the FBC, PTIP and PBC.

9.8. In relation to financial benefits, the Finance Steering Group undertook some high-level benchmarking to identify potential synergies. This informed discussions with the other Steering Groups to identify and quantify benefits, supported by the Finance Steering Group.

Benefit realisation

9.9. To ensure that the realisation of benefits is embedded within delivery of the overall programme, plans to realise the identified benefits are an integral part of each Steering Group's integration plans. These integration plans are described in chapter 7.

9.10. Benefits realisation will be an ongoing process and, as additional benefits are identified, Steering Groups will continue to define and refine the relevant metrics. This will include the development of metrics down to a service delivery level, in conjunction with the staff responsible for delivering affected services, and responding to improvement opportunities identified during implementation.

9.11. Prior to Day 1, the individual Steering Groups are responsible for delivery of the integration plans, with oversight provided by the Programme Board. After Day 1, oversight will be passed to the Programme Team, in line with the expected changes to programme governance set out in paragraphs 6.37 to 6.47.

Benefits reporting

9.12. The oversight and assurance processes related to delivery of the integration plans are set out in chapter 6.

9.13. The programme is currently developing a suite of metrics to track overall progress and delivery of key benefits as a result of creating the new Trust. Reporting of the benefit realisation plans will be aligned to the new Trust's operating model (as summarised in figure 45 below) and to the new Trust Board every other month for six months and then moving to a quarterly basis.

Figure 45: Post-Day 1 benefits reporting

Benefit category	Oversight
Patients and populations	Quality Committee and Quality Oversight Group
Staff	People Committee
Wider Health and Care System	Trust Board
Financial	Audit Committee

9.14. Realisation of key **benefits to patients and populations** will be monitored by the Quality Oversight Group. The QOG will be led by the Chief Nursing Officer and Director of Nursing and AHPs, the Chief Medical Officer and the Deputy Chief Executive Officer, Operations and Delivery.

9.15. The QOG will report into the Quality Committee, which will be chaired by a NED and will report directly to the Trust Board where matters require escalation.

9.16. Realisation of key **benefits to staff** will be monitored by the People Committee, which will be chaired by a NED and will report directly to the Trust Board where matters require escalation.

9.17. Realisation of key **benefits to the wider health and care system** will be monitored by the Trust Board.

9.18. Realisation of key **financial benefits** will be monitored by the audit committee, which will be chaired by a NED and will report directly to the Trust Board where matters require escalation.

9.19. The proposed Committee structure for the new Trust will be refined, including agreeing the names and memberships of the Committees, to allow Terms of Reference to be in place for Day 1 of the new Trust.

Post Day 1 impact evaluation

9.20. The new Trust will undertake post-Day 1 evaluations to assess the actual benefits realised compared to expected benefits during the implementation of the integration plans. These evaluations will be used to identify lessons learned and, where appropriate, inform updates to integration plans.

9.21. The new Trust will undertake evaluations:

- Approximately one month after Day 1 to identify any learning arising from the first month, including in relation to the process of creating the new Trust; and

- On an annual basis for three years to identify any learning arising from the continued implementation of the integration plans, including understand the sustainability of reported benefits.

9.22. Ongoing evaluations of the actual benefits realised compared to expected benefits will also take place in line with performance management processes set out above.

10. Stakeholder engagement

Introduction

Context

10.1. A comprehensive communications and engagement plan has been developed to inform and support communications and engagement for the creation of the new Trust. The plan sets out the aims, principles, key messages, audiences and approach to communications and engagement. The strategy is delivered through a phased action plan, which is set out in Chapter 12 of the FBC.

10.2. The approach to communications and engagement is aligned to NHS England's statutory guidance on working in partnership with people and communities[24] strategy.

Objectives

10.3. The objectives of the communications and engagement strategy 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 engagement and HR and OD 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.

Key audiences and stakeholder groups

10.4. It is important to have a clear understanding of the programme and new Trust's stakeholders, and how the Trusts will communicate and engage with them throughout the process of creating the new Trust.

10.5. Each stakeholder will have differing interests, roles, needs and expectations and these will need to be managed accordingly. The table below represents a high-level stakeholder map for the programme:

Table 42: Stakeholder map

Internal stakeholders	External stakeholders
Boards	Borough and County Councils / Councillors
Governors	Commissioners
Internal leaders	General public
Medical workforce – doctors, consultants, surgeons	GPs
	Health Overview and Scrutiny Committees
Medical workforce – nurses & midwives, healthcare assistants, AHPs	Media
	MPs
	Patient representative Groups
Non-medical workforce – support functions	Patients

24 https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/

Internal stakeholders	External stakeholders
Trade Unions	Regulators – NHS England, CMA, CQC
Volunteers	Health and Wellbeing Board
	Healthwatch
	Southern foundation trust members
	Voluntary sector

10.6. A more detailed analysis of stakeholders needs, and how the programme plans to communicate and engage with them has been undertaken and is maintained by the Communication and Engagement Steering Group.

Stakeholder engagement

Internal Stakeholders

10.7. Engagement with internal stakeholders at a programme level has primarily been through the "Shape Our New Trust" programme, which was run for six weeks in May and June 2023. Each of the Trusts ran a series of surveys, meetings and events to seek views about key aspects of the new Trust. Questions were asked about the vision, values, clinical priorities and the operating model of the new Trust, as well as seeking suggestions for what the new Trust could be called.

10.8. The key themes that arose from this programme were:

- The need for services to be organised around communities and based on communities' needs, but recognising the need for consistent care across the Trust, reducing any 'postcode lottery';
- Better access, with reduced waiting times and a better response when in crisis, have all been emphasised as important;
- A further theme to emerge was ensuring people receive clearer information about support and the services that are available and how they can access these;
- Generally, people felt the clinical priorities discussed were the right ones, but that these needed to be communicated using simpler and more everyday language; and
- When it comes to the values of the new Trust, the most prominent words that have recently emerged are those of 'compassion', 'respect' 'accountability' and 'trust'.

10.9. The "Shape Our New Trust" programme has been supplemented by local engagement activities, led by the programme's Steering Groups and outlined in Chapter 7.

10.10. The frequency and reach of engagement with staff will increase in the approach to Day 1 focussing on:

- Specific communication activities for those staff who will transfer under TUPE into the new Trust;
- Progress around the integration programme to merge systems, processes, policies and operations and the process around the formal establishment of the new Trust;
- Building a sense of team for the new Trust, aligned to the emerging Trust strategy, clinical strategy, vision, values and key cultural elements and the name

of the Trust. This will take the form of a communications campaign and events/meetings, aligned to the work of the OD Steering Group; and

- Launch communications for Day 1, ensuring staff are informed, empowered and supported to do their jobs. This will include a ‘Day 1 welcome pack’ as well as welcome letter, lanyard and ID badge. A launch video will be produced to thank staff, reinforce the benefits of the new Trust and capture the hopes of staff at every level about what the future holds.

10.11. The new Trust’s leaders and managers will be crucial to this part of the journey. They will be equipped with toolkits and guidance to support their conversations with staff, as set out in paragraph 7.121.

Governor Engagement

10.12. A number of specific engagement sessions on the creation of the new Trust have been held with Southern’s Governors and these are ongoing. Individual Governors are also involved in a number of specific workgroups related to the programme, particularly around regulatory and constitutional issues. Individual Governors are also involved in a wider Stakeholder Panel. Dedicated briefing material has been prepared for Governors and is regularly updated.

External Stakeholders

10.13. The programme’s approach to community engagement is designed to ensure that the voice of local communities actively informs the development of the new Trust. The approach recognises local communities as an asset, with strengths, knowledge, experience and skills that should be used to support programmes of change

10.14. The community engagement programme comprises the following components:

- Development of an understanding of the key characteristics of a great Trust from a community’s perspective by reviewing available evidence, insights and feedback from routine engagement and experience from existing services.
- Focussed work with communities whose voice was not yet present, which included carrying out engagement sessions with groups, organisations and representatives of people from Chinese, black and southeast Asian communities, people living in residential and nursing homes, young people, carers and people living with mental ill health and other long term conditions. Sessions were also held with services users and the wider public to ensure feedback was gathered from a wide spectrum of our communities across the whole region.
- Supporting the CTG workstreams in their development and design of clinical pathways, carrying out community engagement to ensure access to the voices and priorities of service users and communities.
- Community engagement has also been carried out as part of the ‘Shape Our New Trust’ engagement programme in relation to:
    - The name of the new Trust;
    - Values and behaviours for the new Trust;
    - Vision for the new Trust; and
    - Structure and governance for the new Trust.

10.15. A Community Engagement working group (reporting into the Communications and Engagement Steering Group) has been set up to ensure the voice of local communities continue to be represented and that engagement continues to meet their priorities. The group is made up of a diverse number of community members

and organisations, including Healthwatch, representatives of currently unrepresented communities and partner community engagement leads.

10.16. Engagement activities with communities across Hampshire, Southampton, Portsmouth and Isle of Wight have involved direct conversations with over 2,000 people from diverse backgrounds.

Key themes arising from internal and external engagement

10.17. There are some prominent themes from the engagement sessions undertaken to date:

- Many people have expressed their concerns regarding the potential impact of the new Trust on accessibility of services. A priority of local communities is the need to have services close to home or place-based, particularly for communities on the Isle of Wight. Communities are concerned about travel costs should people be required to travel further to access services.
- A desire from communities to see better communication between teams and service, for example better transition to adult mental health services.
- Ensuring equitable access to all services across the region and the provision of better information about how to access services.
- The need to see the new Trust address inequalities between different groups so that diverse communities can have equal access to support and are not disadvantaged, for example because of their ethnicity or disability.
- Services should work more effectively to address waiting lists.

10.18. Feedback is being provided to the Communications and Engagement Steering Group and where responses are required these are being actioned by the group or through local contact. Feedback is regularly reported to the Programme Team through highlight reports. Specific feedback relating to clinical priority workstreams is fed back through the CTG.

10.19. Key themes from the Shape Our New Trust exercise have also been shared with staff through the monthly e-newsletter and plans are underway to share the outcome of the operating model, visions and values work that the feedback has influenced.

Ongoing engagement

10.20. The communications and engagement strategy for the new Trust will ensure that the Trust will operate essential communications activity and also an enhanced programme of ‘new Trust’ activity, recognising that things will not be ‘business as usual’ from Day 1. This will require enhanced communications and engagement in the first year of the new Trust, with detailed plans to deliver activities such as:

- Launch activities to raise awareness internally and externally about the new Trust and firmly establish the new brand identity across our communities;
- Highly visible and far-reaching communications materials to raise awareness and engage audiences in the new Trust vision, values and other key elements of the strategy;
- A programme of regular roadshows and events to provide opportunities for colleagues to come together;
- A unified reward and recognition programme including a single Trust award ceremony in year one;

- Regular communications via Trust channels to ensure staff feel supported to navigate any changes as they arise; and
- Ongoing communications and engagement programme to support the development of the new Trust, clinical services transformation and integration activities.

10.21. A comprehensive two-year communications and engagement strategy will be developed during Year 1, the high-level aims of which are expected to be:

- To help position the new Trust regionally and nationally as a leading provider of community, mental health and learning disability services.
- To lead the narrative of out of hospital care, raising the profile of community services
- To develop an organisation with a strong sense of team and a positive culture where people thrive and are at their best whilst at work
- To ensure the new Trust is seen as an attractive NHS employee within the region
- To communicate in a way which is culturally relevant and positive to a wide
- To engage with a range of diverse audiences, using a multichannel approach to reach a multigenerational audience

10.22. The communications and engagement strategy will establish a three-pronged approach to support the ambition by raising awareness of the Trust brand and our services, managing the reputation of the Trust and engaging our people through effective use of communication channels and messaging.

10.23. Key messages and materials will be developed to meet the needs of key audience groups, and communicated through a range of channels, including:

- Staff (including volunteers) and their respective representatives;
- Representatives of local communities, such as scrutiny committees, councillors and MPs;
- People who use the new Trust's services, their carers and the public;
- Voluntary, community and patient groups (including PPGs, governors and patient and community partners) and Healthwatch;
- Health and care system partners; and
- The local media

11. Appendices

Number	Title
1	Steering Group working groups and scopes
2	Risk scoring matrix
3	Clinical services in scope

Appendix 1: Steering Group working groups and scopes

Figure 46: Clinical Steering Group working groups (Clinical Services)

Working Group
COO portfolio and overarching structure for clinical services
Emergency Preparedness, Resilience and Response (EPRR)
Childrens and Families
Adult Inpatients - physical health
Adult inpatients - mental health
Adult community services - physical health
Adults Community mental health and learning disabilities
Specialist services
MSK, Pain, Podiatry
Primary care
Integration Plan for Single Clinical services HIOW (Dental, Sexual Health, SPA)

Figure 47: Clinical Steering Group working groups (Quality Governance)

Working Group
Safeguarding function (including Adults and Children)
Infection Prevention and Control function
Governance, Risk and Patient Safety function (including Operational Risk Management, Patient Safety and Learning / Patient Safety Incident Response Framework, Incident and Investigation, Quality Priorities / Quality Account, and Family Liaison)
Clinical Regulation and Quality Assurance
Patient/Carer Lived Experience and PALS function
Quality Improvement function
Policies and Procedures alignment
Clinical and Professional Leadership
Medicines management (pharmacy)
Research, improvement (including clinical audit & NICE)
Medical HR, GMC and responsible officer function
Medical Education
Guardian of safe working
Caldicott & ethics
Legal team
High profile cases
Mental health legislation
Medical / LNC
Clinical audit
Physical health transformation
CCIO
Safety & Quality

Figure 48: Finance Steering Group working groups

Working Group	Scope
Finance Team	Develop communications plan, joint away days, forums, and meet and greet, orientation and training sessions Develop new ways of working Continually review workload, resources, backfill
Accreditation	Undertake gap assessment against OneNHS Finance level 2 Agree next steps to achieving level 2, including identifying quick wins
Financial Planning	Implement new financial planning system Develop 2024/25 financial plan and budget setting approach.
Finance Ledger	Work with SBS to establish single ledger for the new Trust
Financial Accounting / Services	Contracts (internal audit, external audit, counter fraud) Payments for payroll and suppliers; Bank and cash Transfer of balances; debtors, creditors, other assets and liabilities; VAT; relevant policies and procedures.
Financial Management	Log and monitor transaction costs and benefits; Develop harmonised month end processes and timetable; Create a harmonised approach for budgetary control, budget clinics and budget handbook and any other relevant policies and procedures.
Financial Reporting	Review existing arrangements and develop new reports.
Financial Recovery Programme	Merge existing financial recovery plans Harmonise processes including quality impact assessment templates Assess quick wins of rolling out existing plans.
Costing, PLICs & Benchmarking	Review existing costing systems, data feeds and national data collection returns (including benchmarking) arrangements and determine best practice going forward.
Financial Awareness Programme	Review existing financial training, select best aspects to create a harmonised financial training programme.
Charities	Establish internal management processes with Corporate Governance and Comms & Engagement Steering Groups. Ensure the trust charity has appropriate corporate trustee(s) and is registered with the Charity Commission, with the correct corporate trustee in place Ensure appropriate internal governance
Finance Team Structure, Business Partnering & System Collaboration	Establish new structure to align with clinical and trust-wide operating model Review existing business partnering model and select the best aspects to develop a new model ensuring effective system collaboration and partnering.
Capital	Review existing capital programme (including policies and procedures) and develop plan to merge into a single programme for the merged organisation.
Income	Work with commissioners / provider collaboratives / local authorities / and other 3rd parties to agree new contracts for merged organisation.
Financial Strategy	Lead the development of the new Trust's financial strategy
Technology	Establish file structure, naming conventions, platforms. Support other working groups to embrace technology.

Figure 49: BSID Steering Group working groups (Commercial)

Working Group	Scope
Delivery model and structure	Develop and agree an offer and structure for the delivery of procurement, contracting, commercial, planning, transformation and PMO activities •
Ethos, vision and values	To have an agreed team ethos, vision and set of values •
Systems	Integration of systems, databases, files and folders and e-tendering solutions •
Governance	To have an agreed common approach to governance, processes, policies and procedures. •
Forward plans	To have a set of agreed forward plans for procurement, contracting, commercial, planning, transformation and PMO activities in the new Trust
Contract management	To manage the healthcare and expenditure contracts to ensure there is no break in service and supplier payments are maintained

Figure 50: Workforce working groups

Working Group	Scope
Pay and Reward	To have a standardised pay and reward, and pensions offer delivered through a single payroll provider To identify and oversee delivery of actions required to safely TUPE staff identified in scope from Sussex Partnership and IOW Trusts on or before 1 April 2023. Consideration of any inter related activity in respect of payroll provision for Solent pre and post April 2023. Standardised pay and reward offer Harmonisation of pay and reward policies Consideration of any interrelated activity in respect of current payroll provision across Trusts
Recruitment	To deliver proactive and creative resource solutions across the new organisation to ensure we attract and provide the best candidates To provide a temporary staffing workforce solution
HR systems and data	To integrate HR systems that allows us to understand and provide high quality data to enable us to report on our workforce and plan effectively
TUPE	To ensure that integration and change process underpinning in the creation of the new Trust are both legally secure and compassionate in approach
Policies and Employee Relations	To create an inclusive environment to enable every person to bring their authentic self to work
Training and Education	Clarity is provided to ensure colleagues have access to training, education, and development required for their role
Occupational Health and Wellbeing	Establish agreement of scope of the OH services starting 1st April to be delivered for IOW. Establish the wellbeing plan for the new trust from 1st April 2024.
People function	To deliver a new people function and integration of people and teams

Figure 51: Organisational Development working groups

Working Group	Scope
Change management	3 step model for change – Lewin Blended learning, Self-directed, Courses, Curated Pathways Leading self and others through change Change Curve – Kubler Ross Cultural Influencers Organisational Design support Measuring Effectiveness Changing mindsets
Clinical and professional leadership	Leadership Competencies: To design & include strategic lived experience Values-based Leadership: To design & align with clinical strategy & new trust values Performance Quality / Reflective practise: To embed for evidence-based practise Trauma-Informed approach: Educate and raise awareness & understanding for all staff Equity of professions: Honouring professional leadership at all levels / EDIB Professional Isolation: To establish and support these needs Leadership & Management Standards: To design and implement, rooted in values Manager Induction: To design and implement, rooted in values
Developing ways of working	Agile & Flexible Working for everyone – ambitious policy for the new Trust Agile & Flexible Working for everyone – ambitious policy for the new Trust Agile & Flexible Working for everyone – ambitious policy for the new Trust Anchor Institution – connects to place and scale, taking stress out of life, connects with LA, housing, schools etc Developing Mindsets to support matrix-working
Talent management strategy	Talent Management Assessment Scope of Growth, org & system level Talent definition to agree Talent development offers – equal access Executive Development Succession / workforce planning Diversity and talent Insight tools/ 360 feedback Skills, behaviour and knowledge Appraisals
Equality, diversity, inclusion and belonging	Establish inclusive recruitment across all protected characteristics Agree a joint approach relating to early resolution Enable the voice of lived and learned experience from colleagues in the networks that represent staff with disabilities. Develop networks to ensure the voices of those who come from Black and Minority Ethnic backgrounds and have disabilities and long term health conditions have a collective voice. Support the development of Education Awareness and Allyship to ensure people have a sense of Belonging.

Working Group	Scope
	Ensure there is Board commitment of intrinsically embedding the principles of a 'just' and learning culture that is founded on civility and respect.
Culture, values and behaviours	Gain new Trust Executive Leadership Commitment & buy-in Bringing Values to Life Measuring Culture, Cultural Integration / Benefits Realisation Health and Wellbeing plan

Figure 52: BSID Steering Group working groups (Business Intelligence)

Working Group	Scope
Mandatory and Statutory Requirements	Have a solution in place to ensure statutory requirements are in place from day one • Scope out mandatory and statutory requirements impacted • Understand how these are currently delivered within each organisation • Identify Day 1 requirements • Explore solutions to fulfil each individual requirement • Agree roles and responsibilities for each requirement and implement solutions
Day 1 reporting	Ensure the organisation continue to receive the information they need to provide safe services • Liaise with Digital Steering Group to ensure all current systems and infrastructures will continue to be accessible on Day 1 • Investigate changes to AD login and how this will impact Insights from day 1 • Identify priorities where joint reporting is required from day 1 • Explore solutions to fulfil priority joint reporting requirements • Agree roles and responsibilities for each requirement and implement solutions
Unified data solution	Have a unified solution containing data from all the organisations information systems • Consider utilising CSU Data Model to provide intermediate solution for bringing together data • Carry out options appraisal on the current providers existing warehouses are suitable solutions (or whether a procurement exercise is required)
Performance Governance	To work within a unified Performance Governance Framework • Scope out current performance governance frameworks • Evaluate what works well within each organisation • Define and agree new Performance Governance Framework for new organisation once confirmation of Board Committee structure and Clinical Strategy for new Trust are received • Identify Day 1 position against new framework

Figure 53: Digital working groups

Working Group	Scope
Digital Contracts	Contracts that are managed by Digital/Technology teams Identification of 'Shadow IT' contracts held in other parts of the organisation
Corporate Systems	Microsoft and other supporting infrastructure apps (Email, SharePoint)
Operations	Infrastructure Networks (Wired, WiFi, Mobile) Hosting Telephony End User Devices Service Desk Training
Governance	Strategy - Technology - Information - People/human factors Policies & Procedures Operating Model Co-ordinate Due Diligence activity
Clinical Systems	Electronic Patient Records National applications e.g. SCR, ERS Interfaces/Access to partner EPRs Registration Authority
Data and Insights	Enabling infrastructure
Information Governance	Freedom of Information Subject Access Requests Cyber Security Data Security Protection Toolkit
Digital Clinical Engagement	Clinical Safety

Figure 54: Estates Working Groups

Functional Area	Working Group	Scope
Property Management	Property Management	Leases / Licences / Freeholds / Moves / Property database / Billing / Payments / Occupancy / Compile and maintain list of sites
	IOW St Mary's	To reach agreement on the treatment of spaces occupied by the IOW Community and Mental Health / Learning Disability Teams at St Mary's, Newport.
	Utilities	Water / waste water / gas / electricity / fuel for generators
Hard Services	Hard FM / Buildings	Fabric / services / condition / backlog / assets (define) / 6 facet surveys (regularise / commission if not exist). Asset collection / reactive maintenance / PPM actions / estates vehicles / asbestos management / insurances (relating to Hard FM equipment)
	Computer Assisted FM	QFM / SFG20 / Record Drawings / As builts / Asset Tagging / Helpdesk / PPM tasking and recording / Room booking
Soft Services	Soft FM	Cleaning / Portering / Security / Window cleaning / pest control / grounds and gardens (note big link across with 15 Estates contracts) / gritting / post (Split)
	Catering	Inpatient / staff & visitor restaurants / staff teas, coffees / corporate
	Premises Management	Reception / Post (split) / Cashier / Building Operations / Minor moves / Access Control
	Travel and Transport	"Carpark management / ANPR / staff permits / patient parking / fleet / insurance / active travel and information / bikes and scooters Note: This excludes IOIW St Marys
	Waste Management	Domestic / clinical / recycling / confidential / compactors / waste contracts
Projects and Other	Projects	Moves / Organisational change / Capital projects > £5k / capital requests and business cases / project delivery and assurance / major projects / construction contracts
	Medical Engineering	Medical devices / medical gases - cross over with Hard FM
	Green Plan / Sustainability	Green plan / energy consumption / net zero / renewables / re-use / reporting
	Ligature Management[25]	Ligature risk assessment and management process.
	Compliance	Health and Safety / Fire Safety / Security
Cross-programme	Estates Contracts	Contract strategy /All Hard and Soft FM contracts / Courier services (joint group with Procurement)
	Assurance Reporting	ERIC / PAM / PLACE / Model Hospital / Surplus land (linked to 09 Property Management)
	Estates IT systems	All estates IT systems (on Estates VLAN in Solent): QFM / Occupeye / Net 2 / Matrix / BEMS / COWIN Panels / Ulysses / etc)

25 Ligature Management has been included as an Estates working group to reflect the nature of actions which will be required to ensure a safe environment for patients on the new Trust's estate. The new Trust's Chief Nursing Officer and Director of AHPs is expected to be responsible for the new Trust's ligature risk assessment and management process.

Figure 55: Communications and Engagement working groups

Working Group
Informed workforce
Media
Patient Information
Portal
Procedures
Reputational
Website

Appendix 2: Integration risk impact scoring matrix

Figure 56: Risk scoring matrix

5: Critical	5	10	15	20	25
4: Major	4	8	12	16	20
3: Moderate	3	6	9	12	15
2: Minor	2	4	6	8	10
1: Negligible	1	2	3	4	5
	1: Unlikely	2: Possible	3: Likely	4: Very Likely	5: Extremely Likely

Figure 57: Probability scoring

	1: Unlikely	2: Possible	3: Likely	4: Very Likely	5: Extremely Likely
% Probability	< 20%	20% - 39%	40% - 59%	60% - 79%	> 80%
Frequency / how likely to happen	This probably will never happen/recur	Do not expect it to happen/recur, but it is possible it may do so	Will probably happen / recur, but is not a persisting issue or circumstance	Very likely to happen / recur; possibly frequently	Extremely likely to happen / recur on a very regular basis

Figure 58: Impact scoring – Transaction Risks

	1: Negligible	2: Minor	3: Moderate	4: Major	5: Critical
Impact description	Has little effect	May delay delivery / affect quality of one or more deliverables	Project milestone delayed / affects timescales	Will delay achievement of programme	Objective no longer achievable

Figure 59: Impact scoring – Integration Risks

	1: Negligible	2: Minor	3: Moderate	4: Major	5: Critical
Impact on the safety of the patient, staff or public (physical / psychological harm)	Minimal injury requiring no/ minimal intervention or treatment	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention	Incident resulting serious injury or permanent disability/incapacity	Incident resulting in fatality or multiple fatalities
	No time off work	Increase in length of hospital stay by 1–3 days	Increase in length of hospital stay by 4–15 days	Increase in length of hospital stay by >15 days	An event which impacts on a large number of patients
			RIDDOR/agency reportable incident	Mismanagement of patient care with long-term effects	
			An event which impacts on a small number of patients		
Quality	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service
Complaints / audit	Informal complaint/ inquiry	Formal complaint (stage 1)	Formal complaint (stage 2)	Multiple complaints / independent review	Gross failure of patient safety if findings not acted on Inquest/ ombudsman inquiry
		Local resolution	Local resolution (with potential to go to independent review)	Low performance rating	Gross failure to meet national standards
		Single failure to meet internal standards	Repeated failure to meet internal standards	Critical report	
		Minor implications for patient safety if unresolved		Major patient safety implications	
		Reduced performance rating if unresolved			
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff	Uncertain delivery of key objective / service due to lack of staff	Non-delivery of key objective/service due to lack of staff
			Unsafe staffing level or competence (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence

	1: Negligible	2: Minor	3: Moderate	4: Major	5: Critical
			Low staff morale	Loss of key staff	Loss of several key staff
			Poor staff attendance for mandatory/key training	Very low staff morale	No staff attending mandatory training / key training on an ongoing basis
				No staff attending mandatory / key training	
Statutory duty / inspections	No or minimal impact or breech of guidance / statutory duty	Informal recommendation from regulator.	Single breech in statutory duty	Enforcement action	Multiple breeches in statutory duty / Prosecution
		Reduced performance rating if unresolved.	Challenging external recommendations / improvement notice	Multiple breeches in statutory duty	Complete systems change required
				Improvement notices	Zero performance rating
				Low performance rating	Severely critical report
				Critical report	
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation.
		Elements of public expectation not being met			MP concerned (questions in the House)
					Total loss of public confidence
Business objectives / projects	Insignificant cost increase/ Schedule slippage of a day	<5 per cent over project budget	5–10 per cent over project budget	10–25 per cent over project budget	>25 per cent over project budget
		Schedule slippage of a week	Schedule slippage of two to four weeks	Schedule slippage of more than a month	Schedule slippage of more than six months
				Key objectives not met	Key objectives not met
	Negligible loss	Loss of less than £10,000	Loss of between £10,000 and £100,000	Loss of between £100,000 and £1 million	Loss of major contract / payment by results

	1: Negligible	2: Minor	3: Moderate	4: Major	5: Critical
Finance including claims			Failure to meet CIPs or CQUINs targets of between £10,000 and £50,000	Purchasers fail to pay promptly	Loss of more than £1 million
				Failure to meet CIPs or CQUINs targets of between £50,000 and £0.5 million	Failure to meet CIPs or CQUINs targets of more than £0.5 million
Service / business interruption	Loss/interruption of >1 hour	Loss / interruption of >8 hours	Loss / interruption of >1 day	Loss / interruption of >1 week	Permanent loss of service or facility
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
Information Governance	Minor breach of confidentiality.	Breach with potential for theft, loss or communicating/sharing inappropriate information with between 20 – 50 people affected	Breach with potential for theft, loss or communicating/sharing inappropriate information with over 50 – 100 people affected	Serious breach with potential for theft, loss or communicating/sharing completely inappropriate information with over 100 - 500 people affected	Major breach with potential for theft, loss or communicating/sharing completely inappropriate information with over 500 people affected
	Single individual affected	Theft, loss or clinical information of up to 20 people affected (unencrypted media)	Loss or misuse of very sensitive / confidential information relating to 2-5 persons	Loss or misuse of very sensitive / confidential information relating to 5-20 persons	Loss or misuse of extremely sensitive / confidential information relating to over 20 people (e.g. sexual health information, along with names and addresses)
				Damage to an organisation's reputation/	Damage to NHS reputation/ National media coverage due to IG breach
				Local media coverage due to IG breach	

Appendix 3: Clinical services

Children and Families
Solent CAMHS
Solent Childrens physical health
Solent 0-19 and school age immunisation
Solent community paediatric medical service
Solent Childrens community nursing
Solent family nurse partnership
SHFT Childrens & families
SHFT CAMHS
SHFT Austen House
SHFT Bluebird House
SHFT Leigh House
IOW children and young people's service
Sussex CAMHS
IOW Children and Young People Speech and language
IOW Children and Young People physio
IOW Children and Young People Occupational Therapy
IOW CAMHs
IOW mental health support team
IOW transition and oversight planning

Adult Inpatients - physical health	Adult inpatients - mental health
Solent Adults Southampton inpatient nursing	Solent MH Unplanned care (inpatient and 136 suite)
Solent Adults Portsmouth inpatient and PCAT	SHFT OPMH (MAS)
SHFT inpatient nursing	SHFT Southampton OMPH inpatient
SHFT physical health nursing and AHP	SHFT inpatient mental health
Community hospitals	SHFT Mid & North inpatient and ECT
IOW – acute therapies	SHFT mid & North mental health inpatient
IOW - stroke therapies	SHFT Mid & North liaison services (Winchester and Basingstoke)
IOW – community unit and day unit	SHFT Mid & North OPMH inpatient
IOW – occupational therapy	SHFT PSEH OPMH inpatient
	SHFT PSEH acute care pathway inpatient
	SHFT secure/forensic services
	SHFT Ravenswood house
	SHFT OPMH CMHTs
	SHFT 136 suite
	SHFT Southampton ECT TMS
	SHFT MBU Perinatal
	SHFT Psych liaison Portsmouth

Adult Inpatients - physical health	Adult inpatients - mental health
	SHFT Psych liaison Southampton
	SHFT Rehab
	IOW mental health inpatient teams inc. Nursing, Medical and AHPs (Afton, Osborne, Seagrove)
	IOW ECT
	IOW Integrated Liaison Team
	IOW MHA/MCA/DOLs

Adults Community mental health and learning disabilities	
Solent MH recovery and planned care	SHFT Southampton AOT
Solent Mental health psychology	CMHT Southampton integrate Section 75
Solent learning disabilities	SHFT 111 mental health service
Solent Mental health access (CRHT and A2i)	Recovery colleges
SHFT Southwest Psychological therapies	IOW all age adult community mental health team
SHFT Southampton Psychological therapies	IOW access to intervention
SHFT Mid & North Psychological therapies	IOW secondary psychological therapies
SHFT Mid & North CMHT	IOW dementia outreach team
SHFT Mid & North Acute care including crisis	IOW memory service
SHFT PSEH Mental health acute and crisis	IOW eating disorders
SHFT PSEH mental health community	IOW recovery service
SHFT PSEH eating disorders	IOW community learning disabilities team
SHFT PSEH CMHT	IOW transfer of care hub
SHFT psychological therapies	IOW home treatment tam
SHFT learning disabilities	IOW Talking Therapies
All service EIP	IOW IEP
All service IAPT/talking therapy	

MSK, Pain, Podiatry	Primary Care
Solent Pain	Solent TB service
Solent Podiatry	Solent GP Surgery
Solent Physiotherapy	Solent Homeless Healthcare
Solent IMATs, SMSK, CPS	SHFT GP Surgery
SHFT Southwest Podiatry	SHFT Primary care mental health services
SHFT Southwest Physio & Pain	
SHFT Southwest Orthopaedic Choice	
IOW podiatry	
IOW prosthetics	
IOW pain	
IOW MSK Physio	
IOW multi-professional triage team	
IOW first contact practitioner	

Specialist Services	Single Clinical Services
Solent Southampton Neuro	Solent Access to communication
Solent Southampton Adults community services (LTCs)	Solent Single point of access
Solent Adults Southampton Community Neuro	Solent Sexual health
Solent Southampton Speech and Language	Solent specialist care dentistry
Solent Adults Portsmouth Specialist Services (LTCs)	SHFT ISPA
SHFT Southwest Diabetes	
SHFT Southwest Respiratory	
SHFT Southwest Tissue Viability	
SHFT Endoscopy	
SHFT Continence	
SHFT WHENs service	
SHFT Posture management	
SHFT PSEH Palliative care	
IOW central rehab	
IOW prehab services	
IOW community dietetics and nutrition	
IOW care home support	
IOW cardiac	
IOW pulmonary rehab	
IOW community equipment store	
Clinical Diagnostic Centre	

Board certification

The Boards are required to approve a Board certification to be submitted alongside the Full Business Case to NHS England. The table below sets out the sources of assurance for the Boards.

Board certification (From Appendix 7 of NHSE England's Transactions Guidance)	**Sources of assurance**
The trust board(s) is (/are) satisfied that it has (/they have):	
General	
• considered a detailed options appraisal before deciding that the transaction delivers benefits for patients and the trust	**Full Business Case** – options appraisal is included in chapter 3 (3.53 to 3.81)
• conducted appropriate enquiry about the probity of any partners involved in the proposed transaction, taking into account the nature of the services provided and the likely reputational risk	The Trusts have been working closely together for over a year, initially through the Clinical Transformation Group and since autumn 2023 through Project Fusion to develop the Strategic Case and then Full Business Case. **Due diligence reports** were reviewed by Trust Boards in September. The due diligence approach is set out in chapter 11 (11.31 to 11.34) of the **Full Business Case** with significant risks and mitigations also captured in the programme risk register also summarised in chapter 11 (11.30).
• received appropriate external advice from independent professional advisers with relevant experience and qualifications	**Legal advice** has been commissioned on the most appropriate legal mechanism for the transfer of services from the Isle of Wight NHS Trust and this was be shared with Trust Boards in September. This is described in chapter 11 of the **Full Business Case** (11.39 to 11.42).
• taken into account the good practice advice in NHS England's transaction guidance or commented by exception where this is not the case	The structures for the Full Business Case and Post Transaction Integration Plan were developed to reflect the key lines of enquiry in NHS England's transaction guidance. These structures were reviewed by the Programme Board in March 2023. The due diligence scopes were developed based on the indicative scopes in NHS England's transaction guidance (11.31). NHS England's culture and staff engagement guidance and was considered in developing our approach to cultural integration and organisational development which are described in chapter 8 of the **Full Business Case** (8.1). NHS England's digital integration guidance was considered in the ongoing development of our digital strategy for the new Trust and approach to digital integration which is described in chapter 8 of the **Full Business Case** (8.55). NHS England's patient benefits guidance informed the development of the structure for the Patient Benefits Case (9.3), the

Board certification (From Appendix 7 of NHSE England's Transactions Guidance)	**Sources of assurance**
	structure was shared with NHS England in June 2023 and received positive feedback.
• considered the implications of the proposed transaction on the Oversight Framework segment.	The HIOW system, including all providers, is in segment 4 and this is not anticipated to change before approval of the Full Business Case. Creation of the new Trust is expected to provide the platform for the clinical transformation that is required for the Trust to move out of segment 4.
Quality and patient benefits delivery	
• developed detailed plans to deliver demonstrable and achievable benefits to patients and the wider population	Chapter 9 of the **Full Business Case** sets out the expected benefits from the creation of the new Trust, including patient and carer benefits. Staff benefits and benefits for the wider health and care system. Plans to realise these are articulated in the **Patient Benefits Case**.
• ensured that plans are ambitious for patients by considering a range of potential opportunities for benefits, including through reference to benchmarking data and views of system partners	The Clinical Transformation Group, which includes ICB representation, identified ten workstreams which have formed the basis for the **Patient Benefits Case**.
• engaged and collaborated with system partners to ensure transaction plans are aligned to ICB priorities	Creation of the new Trust is one of three key strategic programmes for the ICB (the other two programmes are Hampshire Together and Isle of Wight sustainability). Chapter 5 of the **Full Business Case** describes how the new Trust's clinical strategy aligns with the Integrated Care Strategy (5.41 to 5.45) and the ICB's Joint Forward Plan (5.46 to 5.49).
• carried out a robust prioritisation process to determine which services require integration sooner, including a clear programme to integrate lower priority services at a later date	The Clinical Transformation Group, which includes ICB representation, identified ten workstreams and these will be the initial priorities for transformation. The new Trust's quality improvement approach, which will support integration, is articulated in chapter 7 of the **Full Business Case**.
• conducted an appropriate level of clinical due diligence relating to the transaction, which has enabled an understanding of quality risks associated with the transaction or inherent in the transacting organisations	**Due diligence reports** (including clinical due diligence) were reviewed by Trust Boards in September. The due diligence scopes were developed based on the indicative scopes in NHS England's transaction guidance.
• identified and mitigated to the extent possible quality risks, both pre-existing and arising from the transaction	Risks (including quality risks) identified through due diligence have been reflected on the programme risk register (with the most significant risks documented in chapter 11 of the **Full Business Case** (11.30)) and mitigations incorporated in integration plans (which are appended to the **Post Transaction Integration Plan**) where appropriate

Board certification (From Appendix 7 of NHSE England’s Transactions Guidance)	Sources of assurance
• involved senior clinicians at the appropriate level in transaction planning, including involvement in the creation of patient benefits proposals	The Fusion Programme Board includes clinicians (Chief Medical Officer from Solent and Director of Community, Mental Health and Learning Disabilities Services from IoW). The Clinical Steering Group has led on clinical services (and quality governance) integration planning and is co-chaired by the Directors of Nursing from Southern and Solent. Patient benefits have been developed by the workstreams of the Clinical Transformation Group, each of which has a clinical lead (as well as an operational lead and an exec sponsor). Chapter 5 of the **Full Business Case** (5.1 to 5.9) describes how clinicians have been involved in developing the clinical strategy for the new Trust.
• assured itself that senior clinicians have been fully engaged and involved in developing the business plan and all the changes and improvements to clinical services, including integration and new configurations or models of delivery, and that there is no clinical practice reason to object to the plans	See above. Note that no changes to clinical service delivery are planned on 1 April 2024.
• effective governance arrangements that safeguard quality, for the purpose of monitoring and continually improving the quality of healthcare provided by the enlarged trust to its patients, including: – ensuring required standards are achieved (internal and external) – investigating and taking action on sub-standard performance – planning and managing continuous improvement – identifying, sharing and ensuring delivery of best practice – identifying and managing risks to quality of care – establishing robust quality governance procedures for the enlarged organisation.	This is articulated in chapter 7 of the **Full Business Case**.
Integration delivery:	
• developed a comprehensive plan to complete the transaction, integrate the organisations and transform services, including mitigations to associated risks	The **Post Transaction Integration Plan** describes these plans and the key risks and mitigations.
• developed robust cultural integration and staff engagement plans that will enable the establishment of an integrated culture	Chapters 8 and 12 of the **Full Business Case** describe our approach to cultural integration and organisational development and staff engagement.

Board certification (From Appendix 7 of NHSE England's Transactions Guidance)	Sources of assurance
• developed robust digital integration plans that will ensure the safe, effective transition of key systems	Our approach to digital integration is described in chapter 8 of the **Full Business Case** (8.51 to 8.53) with the detailed plans developed by the Digital Steering Group appended to the **Post Transaction Integration Plan**.
• developed a robust operating model for the enlarged organisation, based on careful consideration of a range of options	Chapter 6 of the **Full Business Case** (6.68) sets out the operating model for the new Trust, including the options considered.
• ensured that staff have the capacity and capability to deliver the transaction and the benefits associated with it	Chapter 11 of the **Full Business Case** (11.12 to 11.15) describe the integration resources to deliver the transaction and realise the associated benefits.
• conducted a robust programme of non-clinical due diligence that is consistent with the plan set out at strategic case stage and has enabled the identification and mitigation of material risks	**Due diligence reports** were reviewed by Trust Boards in September. The due diligence scopes were developed based on the indicative scopes in NHS England's transaction guidance, as described in the Strategic Case approved by Boards in March 2023.
• complied with all necessary regulatory and legal requirements	NHS England's Transactions Guidance identifies the following key lines of enquiry: • Has an appropriate consultation process been undertaken, if required? Consultation is not required and this is articulated in chapter 11 of the **Full Business Case** (11.43). • Have trusts complied with the Public Sector Equality Duty (PSED) in relation to the transaction? This is described in chapter 11 of the **Full Business Case** (11.47 to 11.48) • If a revised/new constitution is applicable for the enlarged organisation, has it been provided and does it meet all legal requirements? A Governor Working Group has considered amendments to the constitution and these are articulated in chapter 6 of the **Full Business Case** (6.24 to 6.30) (with the draft constitution included as a supporting submission) • Are there sufficient plans in place to obtain appropriate governor approval? Governors have been involved throughout the programme as described in the **Full Business Case** (11.9) • Are there plans in place to grow a representative membership? This is articulated in chapter 6 of the **Full Business Case** (6.39 to 6.40) • Will the post-transaction trust board maintain a register of interests and are no material conflicts of interest anticipated for the post-transaction board? Corporate governance integration plan (appended to the **Post**

Board certification (From Appendix 7 of NHSE England's Transactions Guidance)	Sources of assurance
	Transaction Integration Plan) includes activities to ensure a register of interest is in place on Day 1 and no material conflicts of interest are anticipated • Have commissioners confirmed any changes to commissioner requested services (CRS) arising from the transaction? None of the Trusts have any commissioner requested services In addition the Clinical Steering Group is liaising with the CQC regarding registration and this is reflected in their integration plan appended to the **Post Transaction Integration Plan**.
• addressed any legal issues arising from the transaction, including those associated with the transfer of staff	**Legal advice** has been commissioned on the most appropriate legal mechanism for the transfer of services from the Isle of Wight NHS Trust and this was shared with Trust Boards. Legal advice was also commissioned to support the TUPE process.
• in the case of a contract for a specified period, ensured appropriate legal protection in relation to staff, including on termination of the contract	Not applicable.
• complied with any consultation requirements	No changes to clinical service delivery are planned for 1 April 2024. The Trusts have kept the relevant Health and Overview Scrutiny Committees informed of progress to date and these Committees have confirmed that formal public consultation is not required.
• established the reporting lines, processes and accountabilities to deliver the planned benefits of the proposed transaction	The benefits realisation approach is articulated in chapter 9 of the **Post Transaction Integration Plan**.
• ensured that the board and senior management of the enlarged trust have the capability, capacity and experience to deliver the transaction successfully and lead the enlarged trust	Chapter 6 of the **Full Business Case** articulates the development of the Trust Board and describes the relevant skills and experience required on the Board to lead the new Trust (including integration experience). The designate Chair and CEO have been appointed and both have relevant transaction experience.
• engaged with system partners to determine how all parties will work together to ensure the successful delivery of the transaction and the realisation of benefits.	Chapter 9 of the **Post Transaction Integration Plan** describes how the Trust will work with system partners to realise benefits.
Finance:	
• developed a plan in which the deliverable financial benefits of the transaction outweigh the costs over the medium term	The financial benefits and costs are set out in chapter 10 of the **Full Business Case**.

Board certification (From Appendix 7 of NHSE England's Transactions Guidance)	**Sources of assurance**
• ensured that plans are ambitious by considering a range of potential opportunities for financial benefits, including through reference to benchmarking data	The approach to identifying financial benefits is set out in chapter 10 of the **Full Business Case** (10.50).
• identified robust mitigating actions against short-term financial deterioration	Mitigations in the event of short-term financial deterioration are set out in chapter 10 of the **Full Business Case** (10.66).
• prepared a robust medium-term financial plan	NHS England has provided a three year financial template which has been populated and the key inputs and outputs described in chapter 10 of the **Full Business Case**.
• made provision for the transfer of all relevant assets and liabilities	All Solent's assets and liabilities will transfer to Southern on 1 April 2024. The assets and liabilities transferring from IoW to Southern will be set out in schedules.
• resolved any accounting issues relating to the proposed investment or divestment and its proposed treatment	The initial review and conversations held during due diligence identified no material issues. Further discussions with auditors are planned for November to confirm the position.
• reviewed the working capital requirements of the enlarged trust, taking into account the new and existing working capital facilities, and is satisfied that the working capital available to the enlarged trust is sufficient to meet the trust's requirements for at least 12 months from the transaction date	Work was undertaken through the financial due diligence and subsequent cash flow modelling which shows the new Trust will have sufficient cash to meet its requirements for at least 12 months after the transaction date, with a cash balance of £56m (27 operating days cash) at the end of year 1 with no significant seasonality issues anticipated.
• established financial reporting procedures that provide a reasonable basis on which to reach proper judgement as to the financial position and prospects of the enlarged trust	The Finance Steering Group has developed an integration plan (which is appended to the **Post Transaction Integration Plan**) which will ensure robust financial reporting procedures are in place for the new Trust.

Summary from the Isle of Wight NHS Trust Board discussion on Thursday 12th October:

- All documents were accepted as appropriate for submission to NHSE in order to achieve the 1 April 2024 transaction date, supported by a number of comments for reflection at 23 October Joint Board session and to inform the work of Fusion partners between now and 31 March 2024.
- Achieving 1 April transfer for IWT services was viewed as critical in order to deliver the intended benefits for the IWT population in relation to community, mental health and LD services, as well as enabling the delivering of the benefits associated with the PHU/IWT Group of acute and ambulance services. Any delay would significantly adversely impact on the staff transferring to the new organisation, the leadership and governance arrangements for IWT from 1 April 2024 and the step change in financial performance in 24/25 anticipated through the Group model.
- The significant progress related to the segmentation of IWT services has been reflected in the FBC and the Board are content with the assumptions in the case. However, there is a £4.5M risk to IWT of stranded costs which requires further joint work with Fusion partners to reduce and minimise. We expect this to be resolved in line with the segmentation principles agreed with Fusion partners. It is not appropriate for this to be subsumed within the cost savings of the Group as that would reduce the overall financial benefit for HIOW system of these transactions.
- The Board noted the good practice examples of the existing IWT services reflected throughout the documents, particularly the Patient Benefits case and was concerned to ensure that there was no 'levelling down' of service provision for any population served by the new, larger organisation. This related to three key areas; the level of integration between acute and community mental health services and integrated provision across acute hospital, mental health and community services; performance including waiting list size and waiting time and patient benefits as delivered from existing service models.
- The Board were content with the direction of travel in the PTIP (noting the further work required) and are committed to continue to work with Fusion partners over the next phases of implementation and integration; now until 31 March and from 1 April onwards. The Board noted the risk of delayed benefits realisation due to the 'safe on day one' approach and sought further information in relation to timeline for benefits realisation as a commitment to ongoing focus on transformation and improvement.
- IWT are committed to working in partnership at Place to realise the benefits of the transactions related to the organisation now and beyond 1 April 2024.
- The Board wished to see a commitment to working at Place with the island reflected as a Place in the leadership and governance arrangements of the new organisation to reflect the complexity of the community (despite its size) and the commitment to the development of the Integrated Health and Care Partnership.
- The Heads of Terms require all parties to advise of any changes to Board accountability - since 1 September 2023, with the appointment of Group executives across PHU and IWT, there have been a number of changes in accountable executives which will be advised to the Programme. IWT continue to assume that transaction costs will be recoverable.

Statement from the Solent Board re. Project Fusion

09 November 2023

On 06 November 2023 at a meeting of the Solent Trust Board, the Project Fusion Full Business Case (FBC), Post-transaction Integration Plan (PTIP) and Patient Benefits Case were given further consideration. At the meeting, the following Board resolution was formed, and subsequently agreed:

The Board of Directors restated their commitment to the merger and confirmed approval of the FBC, PTIP and Patient Benefits Case for onward consideration by NHS England. The Board welcomed the additional work completed over recent weeks, including:

- *Reaffirmation of our joint commitment to the collaborative ways of working as set out in our Partnership Agreement, and agreement to work with independent advisors to develop a baseline and forward plan of work to support future cultural development and new ways of working.*
- *Further work to define and test the critical path activities which are essential to ensure safety and effectiveness from day one of the new organisation, and confirmation of the next steps associated with this.*
- *The strategic risk analysis and heat map work undertaken to date, and confirmation of the additional work that partners will complete together.*
- *Further work on the Isle of Wight segmentation and the intention to complete this by the end of December, for consideration by partners.*
- *Definition of a Clinical Reference Group which will provide a forum for addressing clinical and operational concerns and ensure clinical leadership of programme decision making going forward.*

The Board defined and wished to share a number of critical 'conditions for success' which will provide the necessary Board assurance going forward. These are:

1. *Transparency, appropriate governance and clear, aligned communication around processes and decision making, particularly those which impact the current operations of existing organisations or influence the shaping of the new Trust.*
2. *Ensuring key decisions about the new organisation (for example interim and future operational structures) are informed by our clinical and operational leaders and multi-disciplinary teams, through the Clinical Reference Group and other engagement opportunities.*
3. *Further, detailed engagement and co-production with system stakeholders, particularly local authority colleagues, as part of integration planning and implementation.*
4. *Commitment to working together in an open and positive culture where any concerns raised are acknowledged and resolved through partnership working; with a clear process for how partners hold each other to account.*
5. *Clear line of sight of progress against the emerging critical path and its development, supported by robust project management arrangements, project management office (PMO) tracking, and reporting to existing Boards through monthly gateway review.*
6. *Regular review points with all stakeholders that assure we have made the progress necessary to have a clear line of sight on risks (especially those at risk of increasing as a result of the change process), and understanding of the mitigating actions and expected impact, to provide assurance that we are able to land safely on the target date for the new organisation.*
7. *In recognition of the challenging timescale we have set ourselves, an open, honest approach to delivery, with early warning of issues that could lead to delay of the timeline.*
8. *Finalisation of Heads of Terms which reflect these conditions of success and set out processes to work together to resolve issues and take action if Boards are not content that sufficient progress has been made to ensure safe transition to a new organisation.*