Strategic Plan Document for 2014-19

Hampshire Hospitals NHS Foundation Trust

Strategic Plan Guidance – Annual Plan Review 2014/15

The cover sheet and following pages constitute the strategic plan submission which forms part of Monitor's 2014/15 Annual Plan Review.

The strategic plan must cover the five year period for 2014/15 to 2018/19. Guidance and detailed requirements on the completion of this section of the template are outlined in Section 5 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good strategic plan should cover (but not necessary be limited to) the following areas, in separate sections:

1. Declaration of sustainability
2. Market analysis and context
3. Risk to sustainability and strategic options
4. Strategic plans
5. Appendices (including commercial or other confidential matters)

As a guide, we would expect strategic plans to be a maximum of fifty pages in length.

As a separate submission foundation trusts must submit a publishable summary. While the content is at the foundation trust's discretion this must be consistent with this document and covers as a minimum a summary of the market analysis and context, strategic options, plans and supporting initiatives and an overview of the financial projections.

Please note that this guidance is not prescriptive. Foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans (Years one and two of the five year plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

1.1 Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

Name	David French
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Date	**29 May 2014**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Elizabeth J. Padmore

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Mary Edwards

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	David French

Signature

1.2 Declaration of sustainability

The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.	Confirmed

HHFT has developed this plan to maintain financial, operational and clinical sustainability over the five year planning period.

In reaching this assessment, the FT has identified significant threats to sustainability which this Plan seeks to address through a programme of significant clinical reprovision. The proposed reprovision is to support a new model of service delivery which is required to deliver safer, more sustainable services and better outcomes for patients. The proposal is compatible with the national and local strategies which emphasise the benefits to patients of receiving 24/7 care from a trained specialist.

The proposed clinical model will allow maintenance of a better and more sustainable medical workforce with 24/7 consultant cover and further specialisation leading to a higher retention of staff. It will allow rationalisation of estates at both the Winchester and Basingstoke sites with the closure of unfit estate and better utilisation of newer facilities. The model also brings much needed improvements in capacity and quality of facilities for the sickest patients.

The proposed clinical model will provide increased opportunities for more efficient service delivery through the elimination of duplicate high cost facilities and equipment, with centralisation of services such as critical care, out-of-hours theatres provision and in-patient paediatric care. These efficiencies outweigh the additional costs of the service model and provide a solution to the long term financial sustainability of the FT.

The FT recognises that the delivery of the proposed clinical model involves the alignment of processes, agencies and organisations outside its direct control. The FT is working with all stakeholders to reach a successful outcome in line with this plan.

Finally, this Plan supports the strategic objectives of the FT which are:

- **Sustaining excellence: provide high quality, readily accessible services delivered by the best quality staff.**
- **Strategic improvement: provide flexible, modern facilities for our patients and staff.**
- **Strategic improvement: improve financial performance in order to fund better facilities and services.**
- **Strategic improvement: exploit technology in order to transform our services and make us more efficient.**
- **Strategic improvement: improve patient experience through ‘operational excellence’ in administrative processes.**

1.3 Market analysis and context

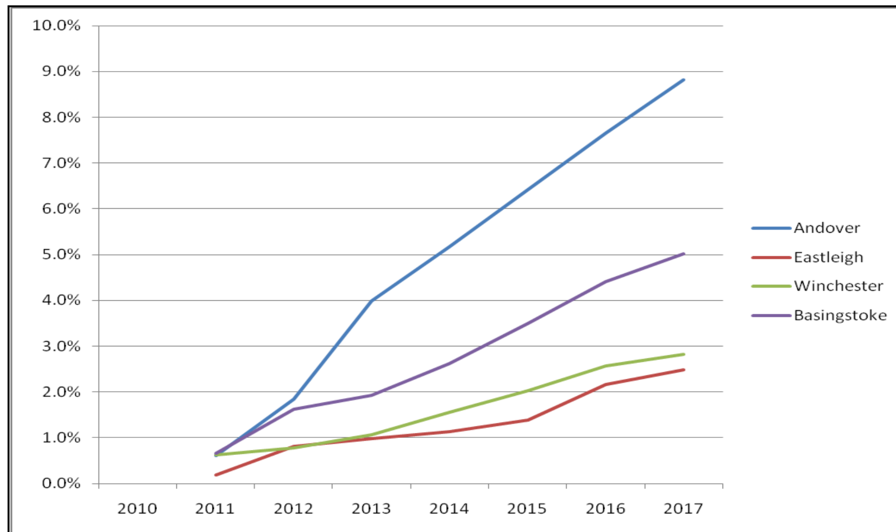
The approximate population served by HHFT is 587,000. Analysis of current referral patterns shows that the majority of HHFT's patients live in North Hampshire, part of North East Hampshire, the northern half of Havant, Waterlooville and East Hampshire, the majority of West Hampshire down to Fareham and Gosport in the South, and Romsey in the South West.

In 2011, the population of Hampshire was estimated to be 1.759 million. This figure includes Southampton and Portsmouth and a mixture of urban and rural areas. The population of Hampshire is predicted to rise by approximately 2.3% by 2017. This is taken from the government comparison of 2011 census and the Small Area Population Forecast (SAPF) for Hampshire. The overall future population growth for Hampshire is lower than both the South Central region and England averages.

The table below shows population growth forecasts for the four major population clusters served by HHFT.

	2010	2011	2012	2013	2014	2015	2016	2017
Andover	40,936	41,186	41,693	42,568	43,055	43,563	44,068	44,549
Eastleigh	68,190	68,321	68,742	68,860	68,960	69,136	69,665	69,883
Winchester	45,138	45,425	45,489	45,616	45,843	46,052	46,299	46,411
Basingstoke	97,389	98,039	98,970	99,259	99,949	100,797	101,683	102,269
Total	251,653	252,971	254,894	256,303	257,807	259,548	261,715	263,112

The population figures are those of the electoral wards constituting the town and city boundaries as defined by Hampshire County Council. These represent just under half of HHFT's total catchment population. The cumulative growth over this period highlights significant variation in population growth rates between the four areas; Winchester and Eastleigh are both predicted to grow by just 2.8% and 2.5% respectively. However, Basingstoke and Andover are predicted to grow at much higher rates of 5% and 8.8%, with consequent implications for strategic planning.

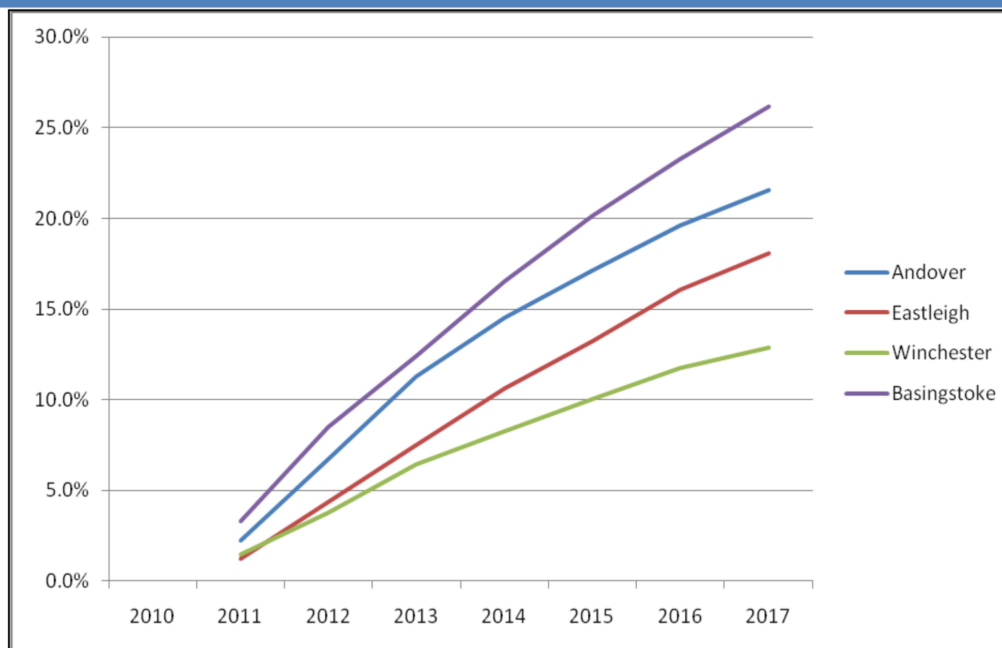


Cumulative percentage of population growth (2011-2017)

The population predictions for those aged 65 and over for the same four towns are shown in the table below, with the graphs showing this growth as a cumulative percentage. All four areas experience a steeper percentage increase in this age bracket when compared with the total population growth, with Andover and Basingstoke growing at higher rates of 21.6% and 26.2% respectively.

	2010	2011	2012	2013	2014	2015	2016	2017
Andover	6,143	6,281	6,558	6,834	7,036	7,195	7,349	7,469
Eastleigh	10,847	10,979	11,320	11,662	12,002	12,281	12,592	12,808
Winchester	7,982	8,098	8,282	8,494	8,641	8,782	8,918	9,010
Basingstoke	13,283	13,720	14,409	14,933	15,476	15,960	16,375	16,761
Total	38,255	39,078	40,569	41,923	43,155	44,218	45,234	46,048

Population predictions of those aged 65yrs and over (2010-2017)



Cumulative percentage of population growth of those aged 65yrs and over (2011-2017)

Across the overall population, the potential loss of business from the South of the organisation (Winchester and Eastleigh) is a real risk if market share trends are not addressed by the preservation or development of services for that population. However the likely future demand of a rapidly growing population in Basingstoke and Andover will also need to be addressed through careful service planning. Furthermore, the sharp increase in those aged 65 and over across most of HHFT's catchment area adds an additional factor to how HHFT should plan services in the future. This also gives further credence to the vision that care should be delivered even closer to home in the medium to longer-term.

The overall population is generally affluent and healthy with a high proportion of people economically active. Good health outcomes and life expectancy are significantly higher than the average for England. Overall levels of socio-economic deprivation are low and this can make it difficult to identify and tackle the pockets of health and social inequalities that are known to exist. A significant proportion of the population is affected by poor geographical access to services and, despite this relative affluence, just over 10% of children are growing up in poverty.

The health and wellbeing of children and young people is generally very good but given the relative affluence of the population there is still significant room for improvement:

• Too many women are still smoking when they deliver their babies;

• Only 50-60% of babies are being breastfed at 6-8 weeks;

• Too many children are overweight and obese;

• There are inequalities in oral health;

• Immunisation rates for MMR and dTaPIPV and school leaver booster do not reach the WHO 95% target to ensure herd immunity.

Infant mortality rates are lower than the England average as would be expected for an affluent population. Child mortality rates are not available for local populations but it is known that the UK lags behind Europe in reducing mortality rates for children from asthma, meningitis, pneumonia and diabetic ketoacidosis. The population of disabled children using services is increasing, alongside increasing complexity of physical

disability and associated need, as is the number of vulnerable adults with physical and learning disabilities requiring support from adult social services. A&E attendances for children and young people are higher than average for the mid Hampshire population with a below average rate of emergency admissions. This is reversed for the North Hampshire population with lower than average A&E attendances and a higher rate of admissions. This suggests that many families with children may not be accessing unplanned health advice in the most appropriate way and that there is a need to review paediatric urgent care pathways to address this.

The estimated smoking prevalence amongst adults in all local authority areas in mid Hampshire is below the England average of 20% while it is in line with the national figure in Basingstoke and Deane.

Obesity rates in adults are similar to England except for Winchester district where they are significantly lower. Too many people have an unhealthy weight (about six in ten) and indications are that rates will continue to rise.

Estimates of the proportion of people who are drinking more alcohol than the government recommended level are lower than for England. There is a persistent upward trend in alcohol related admissions.

Modelled estimates suggest that there is significant under recording/under diagnosis of all long term conditions. There are likely to be significant numbers of people with undiagnosed coronary heart disease, stroke, chronic obstructive pulmonary disease and diabetes.

In contrast to England, cancer incidence rates have been stable in Hampshire in recent years. They are higher than average in North Hampshire and lower than England in mid Hampshire, where lung cancer rates are significantly lower. More people are surviving cancer and the number is predicted to continue to increase, reflecting improved life expectancy and improved survival from cancer. The needs of cancer survivors are becoming increasingly important.

About 1 in 6 of the adult population experiences mental ill health at any one time and 10% of children have a mental health problem. Half of lifetime mental illness is present by the age of 14. Many people with a long term condition have poor mental health, accounting for 12-18% of the NHS spend on managing these conditions.

The recorded prevalence of dementia in mid Hampshire is 0.74% which is significantly higher than the national average while the prevalence is lower than average in North Hampshire (0.48%) reflecting the different population age structures. It is estimated that only about half of people with dementia are diagnosed. The number of people diagnosed with dementia is predicted to increase by about 30% by 2020.

The overall rate of hospital admissions as a result of falls and fall injuries in people aged 65 and over is lower in mid Hampshire than in North Hampshire while rates of hip fracture are similar.

Cancer was the leading cause of death accounting for 30% of deaths compared to 28% from circulatory disease in 2011. All-cause mortality across the area is significantly lower than the national rate but is higher in North Hampshire than in mid Hampshire. The trajectory continues downwards.

2 Capacity requirements

The sharp rise in the 65+ population served by HHFT, an increase (reflected nationally) in the numbers of patients accessing emergency care services, and the challenges of maintaining clinical and workforce sustainability to meet the needs of the population described above, combine to mean that our current clinical and geographic configuration is not sustainable in the medium and longer terms.

HHFT is therefore proposing to centralise the more specialised emergency and urgent care services. The proposal forms part of a reconfiguration of community, primary care, social care and hospital based services in North and Mid Hampshire. The new model of care also features the retention of the existing District General Hospitals in Basingstoke (Basingstoke and North Hampshire Hospital) and Winchester (Royal Hampshire County Hospital) and the Andover War Memorial Hospital to provide local, “front of house” emergency services and planned (or elective) inpatient, day case and outpatient care.

The proposals offer a unique opportunity to substantially restructure the delivery of hospital based clinical care for the next 20 years. In doing so HHFT and commissioners seek to secure continued (and better) high quality care and care outcomes, meet expected changes in demand for health care (including population changes), optimise the application of the skills within the workforce and assure long term sustainability of the services.

A detailed overview of these proposals is included later in this document.

3 Funding analysis based on historic trends and likely commissioning intentions

Commissioning intentions for the coming 24 months are not consistent with current and historical activity growth levels, with CCGs assuming significant activity reductions being delivered through QUIPP schemes, in line with their assessment of financial affordability. Increased clinical engagement in demand management schemes is helping to ensure activity levels more closely match reimbursement but historically these QUIPP schemes have not delivered in line with commissioners’ expectations.

The CCGs are also preparing for large budget reductions for acute providers in 15/16 as part of the Better Care initiative. Whilst we are not yet assured of the plans to deliver activity reductions in line with the proposed reduced budget, we have incorporated a sustained reduction in both income and capacity in 15/16 to acknowledge the impact of this initiative.

From both a commercial and capacity perspective, HHFT needs traction on all initiatives to reduce unscheduled care due to the demographic growth of the elderly population described above. The volume of activity being performed above the non-elective threshold at a marginal rate of 30% continues to increase (non-elective episodes in our Medicine division increased by 6% in 13/14 compared to 12/13) and this is now unsustainable from both a financial and capacity perspective. The marginal reimbursement of non-elective activity has historically been absorbed by the FT, but increasing financial pressure means this cannot be sustained. Attempts by the FT in this year’s round of contracting were unsuccessful in addressing this, however we have assumed some improvement in future years.

The FT faces continued pressure from tariff deflation (4% gross, 1.5% net) which contributes to a CIP challenge throughout the planning period. Identifying and delivering significant CIP savings is becoming increasingly challenging and the FT has recently engaged PwC to advise on potential opportunities, particularly in years three and four of this five year Plan which appear to present the greatest financial challenge.

4 Competitor analysis

HHFT regularly undertakes market soundings to ensure that the commercial structure and arrangements for the strategic direction and more particularly the critical treatment facility are viable and attractive, both from the perspective of the Trust itself, the patient and commissioner. For HHFT this means the strengthening of population critical mass, continuous improvement of service quality and increase in referrals. In strategic and clinical terms, this creates a more sustainable activity base.

5 Opportunities and challenges

5.1 Workforce sustainability
Attracting, rewarding, motivating and retaining an excellent workforce is a crucial part of the HHFT plan for success now and in the future. This is at the heart of HHFT's ability to deliver quality in patient experience and outcomes. In common with all acute hospital organisations, HHFT faces a number of challenges in the changing nature of its medical workforce:

- Reduction in availability and available service commitment in all training grades
- Increasing specialisation of the consultant workforce
- Need for 24/7 cover of clinical specialities
- Increasing consultant delivered care

The clinical strategy and clinical reprovision project described later aims to reduce service dependency on doctors in training and to centralise the provision of rotas that require 24/7 specialist consultant availability.

5.2 Private patients
Since the inception of Foundation Trusts, there has been a restriction in securing private income no greater than a proportion of total income in base year (2002/3) or, now for HHFT, 1.2% of income. Now that the cap has been lifted HHFT took the opportunity to expand into the market of private health care, in order to generate additional income to improve our services.

Approximately 16% of the UK population currently has private health insurance and unsurprisingly, penetration levels are the highest amongst those belonging to upper income groups. Local research for the catchment area around Basingstoke has shown that there is a much higher uptake of private patient cover with as much as 22% of the local population having private health insurance.

There has been support from consultants to develop private patient services at the Trust specifically on the Basingstoke site and a new and dedicated private patients unit opened early in 2014. There are clear synergies between private and NHS work conducted on adjacent sites with immediate access available to the full range of diagnostic and support services.

5.3 Specialist Services
The FT has built an enviable reputation for its national surgical services for pseudomyxoma peritonei and peritoneal carcinomatosis. The FT encourages the development of these services and activity levels are forecast to grow through this planning period to provide a meaningful income stream separate from local CCG contracts. Aswell as its financial advantages, the FT benefits from the reputational 'halo' effect it brings, particularly in the recruitment of high quality clinical staff.

5.4 Tenders
Commissioners (both health and social care) are increasingly using open-market tender exercises to drive efficiencies and introduce innovative ways of working. As an FT this brings opportunities to develop our commercial expertise and HHFT is confident that we will minimise any downside impact

In the last year HHFT took part in several tender exercises for NHS and non-NHS business, two of which were from local CCGs. HHFT secured the contract to provide geriatric rapid response services to West Hampshire but the extent of reduced income for potential tender losses is likely to leave stranded costs. The pattern of stranded costs is a risk with any loss of work through competitive tender and the adaptability of the organisation is critical to provide flexible responses to either winning or losing these tenders.

5.5 Other Income Sources
As an FT, HHFT continues to maintain profitable relationships with other clients such as local private hospital providers and the local community NHS provider for such services such as pathology and EFM services. These other sources of income are subject to pricing pressure and loss of work for long-

standing clients who in turn are under pressure to terminate local contracts in favour of nationally negotiated agreements. In response to this, HHFT has strengthened its commercial function to protect existing contracts and seek new opportunities.

The diversification of income will also be important in light of the current and future financial challenges faced in the NHS. Developments such as private income and the broadening of service provision represent valuable opportunities, but only if they are managed appropriately through processes that are adaptable, flexible and rigorous in their market research.

5.6 Change in Market Share

Following the acquisition of Winchester and Eastleigh Healthcare NHS Trust, the FT has reviewed referral patterns across its geographic area to monitor relative market share compared to other providers. In overall terms within the context of increasing referral volumes across our entire geography, there has been little change of *relative* GP practice referral patterns over the past two years.

6 Forecasted position in a 'do nothing' scenario

Projects such as the private patient facility (in part addressing income challenges) and the phase 1 Cancer Centre (helping to address the expansion of services closer to patients' homes) have now been completed. Whilst developing these sources of future sustainability forms an important part of HHFTs strategy it is the development of the clinical reprovision project that now forms the major component of our strategy for the next five years. Our strategic review emphasises the need for local services in Hampshire to respond to the rapidly changing demands, requirements and expectations of health care services in the 21st century.

If local services do not respond to this challenge the impact will include:

• There will be a lost opportunity to redesign, wholesale, local hospital and community based health and social care services to improve the quality and continuity of care; and ensure effective use of resources available;

• Individual specialist services in each hospital will have insufficient critical mass to continue to deliver (evidence based) best practice. This could result in obligatory closure of some local services;

• Continued cross site working will increasingly dilute availability of expertise and perpetuate inefficient staff deployment;

• Duplication of services and facilities leading, in some cases, to under-used capacity;

• Poor clinical adjacencies will remain which hinder optimum care and efficient use of limited resources (including unnecessarily longer stays in hospital);

• Hospital environments will continue to fall short of current quality and design guidance standards;

• Resources in the local health system will increasingly struggle to meet demand as the population increases, medical advances will expect to be funded and financial efficiency requirements on all public sector services continue.

In financial terms, we have created a do nothing or 'base case' scenario to which we have added the impact of the clinical reprovision project over the five year planning period. We therefore have two scenarios driven by an analysis of the difference between the two.

In both scenarios, the financial assumptions made around, for example, continued tariff deflation means that long-term financial forecasts, with or without investment decisions, make for gloomy reading. Although not included in our forecast numbers, we are optimistic that the sustained period of tariff deflation will end at some point as the effect of year-on-year decreases are destabilising an increasing number of previously solvent organisations.

This combination of sustained tariff deflation and above inflation cost increases (increased nurse staffing, 24/7 consultant led care) means the CIP / efficiency required is both harder to find and increasingly challenging to deliver. The FT has seen declining profitability and, absent the successful delivery of the clinical reprovision project, the 'do nothing' scenario forecasts profitability falling steadily over the planning period. In this scenario, profitability and financial sustainability declines in a slow death potentially triggering reconfiguration conflicting with the FT's strategic objectives.

7 Alignment of plans with local health economy partners

The CCGs serving West and North Hampshire are working together to consider both the national and local challenges which need to be addressed to ensure safe and sustainable health services for the local population. Each CCG has created a five-year Strategic Plan setting out how it will improve the health and health care of everyone living in its area, supported by the two-year operating plan, which is updated every April on a rolling basis. Priorities for local CCGs include:

- Development of primary and community services to provide more care closer to home and reduce demand for emergency admissions;
- Redesign of local hospital services ensuring that hospital services remain effective for those who most need them;
- Effective integrated care across health and social care which will increasingly be consistently provided 7 days a week (particularly for children, elderly, those with long term conditions and those requiring mental health services);
- Ensuring the local health economy is financially sustainable (for both commissioners and providers).

The clinical reprovision project proposed by the FT aligns well with commissioner priorities and is a major development requiring detailed planning of the reconfiguration of services provided. To ensure a collaborative approach between HHFT and its main commissioners (North Hampshire CCG, West Hampshire CCG and NHS England (Wessex)), a joint steering group and programme board for clinical reprovision has been established.

1.4 Risk to sustainability and strategic options

The following strategic themes were considered in the development of this proposal:

• Improving the quality of care and health care outcomes: Public and political expectations, developing clinical expertise and scope of modern interventions together with the promotion of the importance of addressing unevenness in the provision of healthcare all cultivate the need to maintain and improve quality of care and health outcomes;

• Achieving required standards of safety and clinical governance: Medical care for hospital patients has traditionally been largely delivered by doctors in training led by specialist consultants. Medical education is increasingly insisting that doctors in training will be separated from service delivery and clinical care increasingly demands specialist/consultant delivered, rather than led, services. While the application of the European Working Time Directive (see also bullet point to consultants is becoming vaguer at present, there are professional and risk management drivers for greater scrutiny of and an overall reduction in consultant working hours. A movement towards more specialisation within the consultant sub-body means smaller organisations will be unlikely to be able to sustain the necessary number of specialist consultants required to be competitive in future markets. Advances in clinical governance are placing greater demands upon a number of specialties/treatment categories to meet higher volumes of patient throughput

to maintain institutional and individual competence. This has been associated with improved outcomes in terms of morbidity, mortality and error rates.

• Restructuring urgent and emergency care: Sir Bruce Keogh, National Medical Director of NHS England, has proposed a fundamental shift in the way urgent care is provided, with more extensive, highly responsive, effective and personalised services provided outside of hospital for people with urgent but non-life threatening needs. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. People with more serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

Four levels of support for patients seeking unscheduled care:

- Self-care with support from NHS choices, voluntary sector etc.
- Urgent care accessed via 111 or direct contact Primary Care including GP and pharmacy. It may involve patients being seen at an Urgent Care Centre in primary care or at home by paramedics.
- Emergency Centre - These units are below a highly specialised level but are able to assess and treat the majority of patients. They will be able to stabilise and transfer those that require more specialist care.
- Major Emergency Centres (MEC) which will have access to the full range of specialty and serve a population of over 1 million.

Locally commissioners are seeking to simplify access for patients with less serious illness or injury to local Urgent Care Centres rather than Emergency Centres. In doing so it will be important to design an integrated urgent care system across primary care, community and social care and A&E services which will feature care pathways for common conditions to facilitate care closer to home (particularly for children).

• Specialisation leads to better clinical outcomes: There has been a growing recognition, nationally and internationally, that greater specialisation leads to better patient outcomes. As a consequence there is a move away from 'generalists with a specialist interest' to specialists and the employment of in-house consultant staff where previously a service may have relied on visiting specialists. This principle applies to the majority of medical specialties, particularly those required by the most acutely sick, including access to consultant obstetricians for higher-risk pregnancies that require medical intervention.

• Concentration of various specialist services into fewer centres: Sir Bruce Keogh and a succession of Royal College reports have highlighted strong consensus and compelling evidence for the need to concentrate various specialist services into fewer centres. These would allow multi-disciplinary teams to be assembled, collocated with appropriate interdependent services, in order to provide a better environment to develop clinical skills and experience through treating large numbers of similar patients. They would also provide an opportunity to be more flexible with rotas and increase the scope to deliver 24 hour a day, seven-day care with highly specialised consultants always available. An adverse effect of this change is the potential loss of activity and local delivery where there is not a critical mass of patients to sustain the number of specialists required for full 24-hour cover. However the benefits of centralisation have to be counter balanced by the need to offer a suitable, comprehensive range of local services through DGH (as indicated by Simon Stevens, CEO of NHSE).

• Supporting patient choice: Services need to be designed to ensure that the opportunity for patients to choose treatment, location and health care professional are maintained and enhanced through providing choice and information to allow an informed decision to be made.

• Population growth and more people living longer: Demand for NHS services is expected to increase not just from the overall growth in the population but also as a consequence of people living longer with more long-term chronic illnesses and periods of acute illness. The NHS therefore needs to be able to change

and adapt, offering a range of services to meet these needs. This is likely to include providing care closer to home, integrated health and social care, as well as ensuring 24/7 acute hospital care is available (see below).

• Greater efficiency and provision of care outside hospitals: "NHS Call to Action 2012" sets out how the NHS must change to survive. There is an opportunity to fundamentally change existing services to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. Within the hospital setting this could involve providing discrete, efficient and local elective services, the promotion of Day case surgery where possible and the development of the role of community based multidisciplinary teams. There also needs to be a refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific requirements.

• Better integrated care and access to health and social care: National policy promotes the development of integrated services along care pathways both within the NHS and across health and social care. Locally, Better Care Fund proposals in Hampshire anticipate a transformational step forward in the integration of community care with 25% of the fund being predicated on achievement of substantial reductions in Non-elective admissions and acute length of stay (LOS). The expectation is that whilst those who are critically ill can anticipate 24/7 consultant care, those who are less ill would receive more community based assessment and treatment, or rapid hospital assessment and initiation of treatment and turnaround back home. As a result it is anticipated that the numbers of people admitted with critical illness to remain the same, but for those with non-critical illness or injury, admissions should fall by 10-20%.

• 7 day health and social care: Everyone Counts: Planning for Patients 2014/15 to 2018/19 focuses on the achievement of excellent outcomes and the delivery of high quality care that is safe, clinically effective; available when people need it and provides as good an experience for the patient as possible. Seven day services in health and social care is expected to move from aspiration to reality. Delivery of these ambitions requires fundamental 'transformational' change in the way that health services are delivered, including better integrated care and support across health and social care.

• Impact of complying with the European Working Time Directive EWTD): The EWTD applies to all staff. It makes the maintenance of sustainable rotas for junior doctors in smaller organisations increasingly untenable. It is also well recognised that, due to changes in working pattern (initiated by the European Working Time Directive), trainee doctors are less experienced. This, together with other evidence, strongly suggests that care is best led by consultants and specialists, and delivered by this group where possible. Recent papers by the NHS Confederation and many of the Royal Colleges emphasise these points.

• Financially sustainable local health care community: The costs of healthcare are constantly growing as medical technology and treatments advance and are provided to more people. The need to ensure that the local health economy can manage increasing costs whilst funding is plateauing is crucial; therefore change needs to be delivered in a financially-responsible manner.

To address these strategic challenges and the FT's sustainability risks described above, the three main commissioners and HHFT have worked together to identify a range of solutions that could meet the challenges raised by the drivers for change and also the concerns and issues raised by local people in the listening programme held from September to November 2013. The list of options was also informed by clinical workshops and in discussion with the stakeholders and the clinical and medical teams.

1.5 Strategic Plan - Clinical Reprovision project

1.5.1 Executive Summary

The recent review by Sir Bruce Keogh, Medical Director for the NHS in England, has summarised the key challenges facing the NHS in delivering high quality urgent and emergency care across England. His vision is that people with urgent but non-life threatening needs should be able to access care as close to home as possible; people with serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities to reduce risk and maximise their chances of survival. Implementing this vision is crucial for the residents of Hampshire. The opportunities posed by the national policy to develop integrated services across health and social care are well-timed and supportive. Implementing integrated services at the same time will facilitate us delivering better services for urgent and emergency care.

HHFT has been working closely with commissioners on plans to ensure we continue to deliver the high-quality services our population requires and deserves, particularly for urgent and emergency care.

The joint work undertaken by commissioners and HHFT has involved very detailed analysis of each hospital specialty with review by hospital consultants, other hospital clinical staff and local GPs to ensure any proposed change has clinical support. The review has taken account of workforce issues, clinical evidence on best quality care and patient outcomes, as well as the need to ensure long-term financial sustainability for the local health economy.

This detailed review of the evidence indicates that there are real benefits in providing some services closer to patients' homes whilst providing some of the most complex emergency services in just one place for our region. These benefits include:

- Guaranteeing consultant-delivered care for the sickest and most at risk patients 24 hours a day, 7 days a week. This will lead to safer care and better outcomes for all.
- Delivering care in the most appropriate facility and facilitating integration with community and social care services.
- Providing local services for communities outside Winchester and Basingstoke such as Eastleigh, Andover, and Alton. This will reduce travelling distances and provide a better experience for patients.

The key proposals for change are as follows:

- **To centralise some aspects of our acute services**

It is proposed to centralise and co-locate the elements of hospital services that are required for the sickest and most at risk hospital patients (about 15% of our patients). This will include, for example, services for heart attacks, acute strokes, trauma, emergency surgery, critical care, and very sick children. This will also include expectant mothers who require obstetric care in labour as well as those who choose to deliver in a co-located birthing centre. There is a strong relationship between these services in that they all have the same potential need for life-saving support services including critical care (ITU) and specialist interventional radiology. There is also strong evidence to show that these services should be delivered by fully-trained specialist consultants 24 hours a day, 7 days per week.

- **To deliver two general hospitals in Basingstoke and Winchester**

The majority of patients (approx. 85%) do not require the life-saving interventions and support outlined above. The remaining patients require urgent access to walk-in front of house services (eg with a broken arm), rapid assessment service (eg following GP referral), outpatient consultation, diagnostic services (x-

ray scanning and pathology), planned medical and surgical interventions (eg endoscopy, surgery), rehabilitation or maternity services (including birthing centres for delivery). These patients can be much better cared for in the appropriate environment of a general hospital where relevant partner organisations work together to deliver appropriate services. Partners include HHFT, local GPs, community providers including Southern NHSFT and HCC Adult Services. The majority of patients would be treated in these hospitals where we are continuing to develop the services.

- **To expand the services delivered in other localities including Andover, Eastleigh and Alton**

For patients who do not live close to the Winchester and Basingstoke, a large proportion of their care needs can be met closer to home in community facilities. Again working with partners, HHFT is developing a range of services in the other main towns using fixed and mobile services to deliver walk-in urgent care, outpatient consultation, diagnostic services and some planned medical and surgical interventions. Some services also reach into patients' homes, for example maternity and community children's services.

Much of patients' care and treatment will continue to be delivered from our two general hospitals in Basingstoke and Winchester (Basingstoke and North Hampshire Hospital and the Royal Hampshire County Hospital). This will be where approximately 85% of care will be provided. This will include:

- A&E 24 hours a day urgent care for self-presenting patients
- Medical assessment for patients referred by local GPs
- Paediatric rapid assessment facilities for sick children needing assessment
- Maternity centre including outpatient maternity facilities
- Most planned surgery, day case and short-stay inpatient beds
- Medical beds including care of the elderly, rehabilitation and medical specialty facilities. This will include on-going care and treatment for patients returning to the general hospital closest to home once stabilised by the critical treatment hospital
- Outpatient and diagnostic facilities (eg blood tests, scans, x-rays)

1.5.2 History of the proposal:

The creation of HHFT in January 2012 (following the integration of Winchester and Eastleigh Healthcare Trust and Basingstoke and North Hampshire NHS Foundation Trust) was driven by the recognition that a population of at least 500,000 people was needed to maintain and further develop the most acute and specialist elements of our service. This would include centralising some services where it is necessary for patient safety and improved clinical outcomes, while working hard to provide services that are as close to people's homes as possible for the majority of care. The size of the combined organisation was expected to provide an opportunity to operate more efficiently, increase income, provide a sustainable workforce and respond to political and economic drivers for change.

The case for change for the creation of HHFT was agreed by the commissioners at that time (Hampshire PCT), the Strategic Health Authority, the NHS Transaction Board, Monitor and the FT. The FT envisaged the following two-stage development programme post-integration:

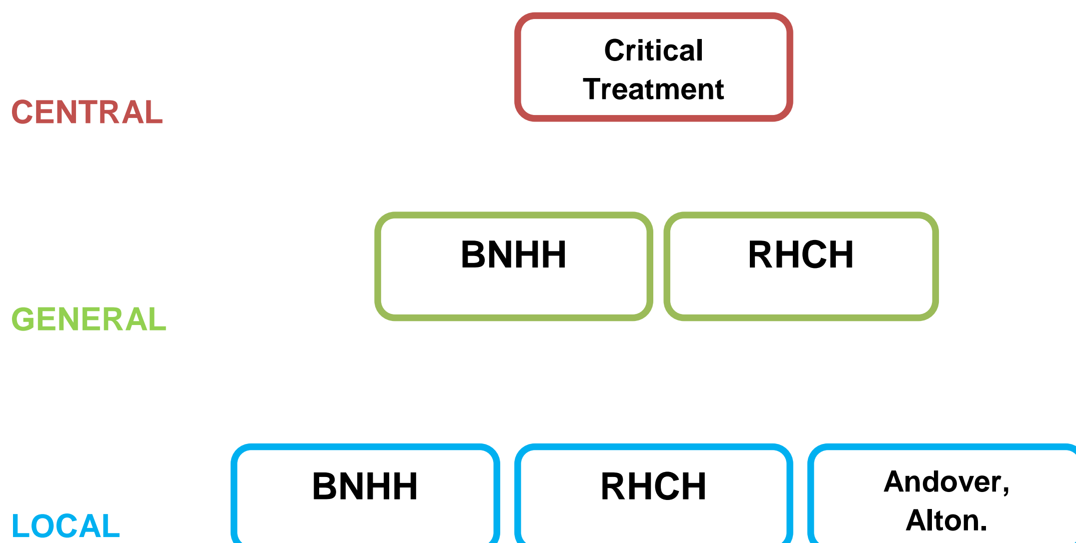
• Stage 1 Stabilisation: to reorganise some acute services and provide them on one site (e.g. hyper acute stroke and interventional cardiology) to ensure 24 hour provision of consultant-delivered care for very sick patients;

• Stage 2 Development: to develop a service model that would ensure 24 hour availability of consultant-delivered acute care for all residents of North and Mid Hampshire. In addition, delivery of more elements of services closer to patients' homes where access time is less pressing.

1.5.3 The Clinical Model

An overview of the clinical model is provided below. It has been refined, critically reviewed and improved following detailed collaboration with a wide range of other organisations in health and out with health particularly West and North CCGs, the primary care teams including local GPs, Public Health, South Central Ambulance Service NHS FT, University Hospital Southampton NHS FT, Southern Health NHS FT, Local Authorities, charities and voluntary groups. Public engagement has also moulded the planning. Although the model requires further refinement and detail, the proposed draft model now has the support of HHFT clinicians, the CCG's and Public Health specialists.

The model of care features a discrete centre for critical care supported by two local DGH providing other general secondary care services and local services alongside Community Hospitals.



The clinical model is based firmly upon improving quality and safety whilst delivering equitable and accessible care for our population. The clinical model includes some centralisation but this is balanced by delivering care close to home where possible in line with the evidence base for clinical quality and outcome measures.

a) Central (critical care) services will be delivered on a single site. Critical services are those that can only be provided on one site due to limitations in numbers of staff with appropriate skills if the service is to be delivered safely 24 hours a day; 7 days a week. A service is more likely to be critical if it requires specialist assessment, emergency intervention or round-the-clock access (though many emergency and specialist activities will still be maintained on the existing DGH and community hospital sites). The central facility will provide equality of access as far as possible across the extended geographic area with the clinical focus on 24/7 access and comprehensive medical cover for the sickest and most complex patients (except neurosurgery and complex thoracic surgery) but no long stay/rehabilitation. The proposed profile of services to be offered at the facility is provided in the table below.

Central		
Elective	**Non-elective**	**Diagnostics/Support**
Complex and specialist surgery Inpatient paediatrics	Critical emergencies (blue light or triage) Short stay Paediatric Assessment Unit Diagnostic assessment unit ITU (Level 2/3) Neonatal unit (Level 2) Obstetric-led maternity unit Birthing unit Emergency surgery/orthopaedics Trauma Specialty inpatient medical units (eg CCU, stroke, acute GI) Inpatient paediatrics; Inpatient oncology Cancer centre (a separate development which will include radiotherapy)	Theatres and anaesthetics Procedure laboratories/rooms eg Interventional Radiology; cardiac catheterisation; endoscopy 24/7 complex medical imaging clinical support eg pathology; pharmacy; therapies

b) General hospital services will continue to run on the Basingstoke and Winchester hospital sites. The majority of elective surgery will be run on a short-stay and day case surgical model. The sites will offer the majority of outpatient services and on-going acute and routine inpatient and outpatient care for patients not in a life-threatening condition, including those who may require hospital-based rehabilitation and support. The table, below, summarises the range of proposed General hospital services.

General – Basingstoke and Winchester		
Elective	**Non-elective**	**Diagnostics/Support**
Non-complex Day case Short stay Inpatient Pre-assessment Outpatients	Ambulatory emergency access 24/7 (self-presenting) AAU 24/7 (sent) Short stay PAU in hours (sent/regular) Speciality medical and surgical units e.g. elderly care; rehabilitation; Rapid access clinics	Anaesthetics and theatres Therapies/rehabilitation

	Fracture clinic Critical care outreach/retrieval 24/7 Inpatient beds Palliative care beds Chemotherapy All ambulatory maternity services including midwifery-led birthing unit	Clinical diagnostics and support eg pathology, pharmacy, radiology.

Greater integration of services with other providers on the general hospital sites would significantly enhance the care delivered from these sites and in the community. This development of the Winchester and Basingstoke sites as "community facing hospitals" has enormous potential to be able to deliver true integrated care, especially in specialist rehabilitation and care of the elderly. It would allow these sites to become a hub or campus for closer working between primary care, secondary care, social services and voluntary sectors. Increasing rapid access clinics, in reach from primary and outreach from secondary care with effective social services will benefit the increasing numbers of the elderly who need complex, holistic joined up management. It will also enable patients to be as close to home as possible and as independent as possible.

c) Local hospital services will be delivered as close to patients' homes as possible and will include outpatient and diagnostic services, and mobile facilities such as chemotherapy, breast screening and mobile MRI scanning. These services may be delivered in a range of facilities, for example in a community hospital, health centre or similar setting, and in patients' homes. Further detail is provided in the table below.

Local – Andover, Eastleigh, Alton			
All	**Andover**	**Eastleigh**	
Outpatients Diagnostics Mobile services e.g.MRI / Chemotherapy Palliative care outreach	Minor Injuries Unit Birthing units Inpatient beds (Rehabilitation) Hospice Day case interventions Endoscopy	Outpatients Diagnostics Phlebotomy Therapies	

1.5.4 Other Strategic Initiatives

Radiotherapy Cancer Centre

The National Radiotherapy Advisory Group states that patients should not have to travel for longer than 45 minutes to access radiotherapy treatment. Many of the cancer patients in Hampshire currently have travel times that significantly exceed this recommendation. This travel time combined with difficulty in parking and the average length of a course of treatment being 16 sessions (range 1-35) significantly impacts on patients as evidenced by the many comments on the National Cancer Patient Experience Survey 2010. As a result some patients decline this treatment option, which would be beneficial to them, due to practical difficulties.

There is significant evidence highlighting that enhancing the hospital environment and offering a conventional treatment in a pleasant, interesting and innovative building, benefits patients and greatly

improves the outcome of their treatment. In addition, patients and their families also benefit from receiving care from a single hospital team, rather than a number of different teams in different locations. Having a single care team minimises the risk of lack of continuity in care and communication which may complicate an already stressful and potentially distressing treatment plan. These reasons have led to the vision of an integrated cancer care centre.

Milestones

This scheme is in two phases. A temporary radiotherapy unit to cater for HHFT's population is shortly to become operational with an intention to replace it with a state of the art Cancer Centre to be operational in 2017/18.

Phase 1 – Temporary centre

Completed; will be operational in Q2 14/15. Approximately 50% of the local population requiring radiotherapy will be treated through one linear accelerator (LINAC), within one year of the unit opening. The unit is located at BNHH to benefit those patients who currently travel the furthest to receive their treatment.

Phase 2 - Permanent Cancer Centre

In conjunction with a charitable fund raising initiative, it is proposed to replace the temporary centre with an integrated Cancer Centre to open in 2017/18. Up to 92% of the local patients requiring radiotherapy treatment will be treated at the centre (with two LINACs) within one year of its opening. Outpatient chemotherapy will also be provided within this setting, as well as a wide range of complementary therapies and cancer support service, such as psychological support, courses and information.

Appendices