Building a sustainable NHS in
Portsmouth and South East Hampshire

Portsmouth and South East Hampshire Sustainability Plan

Refresh June 2012

Ratified by PSEH Sustainability Board on 4 July 2012

1 Executive Summary

1.1 A Sustainability Plan was first developed by NHS organisations operating in the Portsmouth and SE Hampshire area during 2009/10, setting out the programme of activities local health and social care partners would deliver together to address the challenges faced by the local health economy. The plan has been refreshed annually, in 2010 and 2011.

1.2 Over the last three years, progress has been made towards to the goal of a sustainable NHS in Portsmouth and SE Hampshire. However, it continues to be the case that the scale and pace of change needed requires the delivery of transformational change in how services are delivered, across the health system. This document summarises a refresh of the Portsmouth & SE Hampshire Sustainability Plan at the beginning of 2012/13.

1.3 Our current estimate of the affordability gap over the next three years if we do nothing is £154m, or 15% of the local NHS resources. We are clear that in order for the local NHS to be in balance and sustainable, there are three key challenges we must address together:

a) Redesigning how we deliver unscheduled care, especially for frail elderly people and those with long term conditions (including dementia) so that the system achieves upper quartile emergency admission rates, shorter acute hospital lengths of stay and improved patient experience and outcomes

b) Redesigning how we deliver planned care, so that we improve access for patients, provide clinically relevant cost effective care, and as a system reduce planned admission rates and interventions to match the best performing health systems in the country.

c) Rationalising our estate and fixed infrastructure costs.

1.4 The area where we see the greatest opportunity to transform care is for the frail elderly and those with long term conditions, including dementia. Within our system a wide range of services and activities have been commissioned and provided to support frail elderly people and those with long term conditions. However well delivered these individual services are, they don't operate sufficiently well as an effective system – and don't consistently have the full support, ownership and confidence of clinicians and patients.

1.5 Our aim is to transform care for frail elderly people and those with chronic conditions, improving community provision for these patients and ensuring that we deliver effective urgent and emergency care. This transformation involves the creation of a much more integrated health and social care system in Portsmouth and SE Hampshire. We will focus energy on developing integrated models of care, built around primary care ('primary care plus') where:

- Primary care, community care (physical and mental health) and social care working more closely together at practice level to manage the health and wellbeing of the practice population - integrated teams identifying those patients at greatest risk of deterioration and proactively managing their health and social care needs
- We identify and respond to patient's needs in a seamless way, offering a rapid and tailored response at the most appropriate care setting and provide high quality and consistent community support for those with multiple pathologies, particularly dementia. This will include the development of new approaches to community based admission avoidance

- The artificial historical barriers that exist between elements of the system are broken down, with the aim of providing a single, co-ordinated service for patients
- Elderly care clinicians, specialists in older people's mental health, GPs, community care staff and social care work together to provide care for frail elderly people and those with long term conditions when they experience an acute deterioration of their health & social circumstances

1.6 In order to drive the level of transformation required in our system, we have supplemented delivery focussed activities with work to bring together partners to agree a common view about the design of integrated services that we are seeking to create together. We expect that, by October 2012 commissioners in Portsmouth and SE Hampshire will be in a position to commission an integrated model of service delivery for 2013/14 which reflects the model designed through this process. This is likely to involve a formal procurement process, with the intent that an integrated service will be procured from a single entity, which may be a range of organisations working together as one, to deliver the specified model.

1.7 We are also working to create the culture, behaviours and environment within which the transformation can occur successfully:

- A contracting strategy and approach which puts in place the right incentives and mechanisms to enable organisations to work together to achieve our common aims
- Building confidence and Trust at a clinical level and organisational level that the new models work, in order to change behaviour
- Strong programme governance with clear milestones and KPIs
- Ensuring the system has and makes maximum use of technology as an enabler to service redesign and delivery

1.8 QIPP plans have been developed at CCG level. Each provider has a well-developed cost improvement plan that enables each organisation to deliver its financial targets, focused on improving productivity and service transformation that supports and complements the strategic direction of the local health system. As well as this, Portsmouth Hospitals NHS Trust and Solent NHS Trust are developing long term financial models to support their Foundation Trust applications. Both organisations are working with commissioners to ensure assumptions align with the strategic priorities of the system, as well as supporting organisational aspirations.

1.9 Portsmouth Hospitals NHS Trust financial plan assumes a reduction in emergency attendances and admissions as a result of the strategy to integrate health and social care, built around primary care. Portsmouth Hospitals FT application will reflect the impact of the system redesign on the Trust, and the new models of care PHT will be part of delivering – for example deploying some of its workforce outside of the hospital in community settings, and extending integrated models of service delivery for adults and older people.

1.10 This refresh of the Sustainability Plan was ratified by the Portsmouth & SE Hampshire Sustainability Board on 4 July 2012.

2 Background and Context

2.1 The NHS in Portsmouth and South East Hampshire serves a population of approximately 600,000 people living in the predominantly urban areas of Portsmouth City, Fareham, Gosport and Havant, as well as more rural communities in and around the Petersfield and Bordon areas. Portsmouth and SE Hampshire includes some areas of affluence as well as some of the most deprived communities in the south of England.

2.2 A Sustainability Plan was developed by NHS organisations operating in the Portsmouth and SE Hampshire area during 2009/10. The plan built on work undertaken with McKinsey & Co in 2009 which identified that in order to achieve financial sustainability the Portsmouth & SE Hampshire health system needed to generate savings in the order of £220m over a five year period, and that to achieve this, change was necessary on a scale and with a pace that had not been achieved previously, requiring a much more assertive and integrated programme across organisations, with strong clinical leadership and ownership.

2.3 The Sustainability Plan, which was developed by NHS Portsmouth, NHS Hampshire, Portsmouth Hospitals NHS Trust and NHS South Central, with local health and social care partners, described:

- The challenge facing the SE Hampshire health economy of how to deliver high quality, safe care for the local population within the available financial resources
- The programme of activities planned to meet this challenge, structured into eight workstreams, and the governance arrangements designed to drive delivery of the necessary changes.

2.4 The eight workstreams were:

- Four workstreams associated with improved productivity and efficiency within PCTs, Portsmouth Hospitals, community & mental health services and within primary care
- Three workstreams seeking to transform planned care, unscheduled care and estate use through working more collaboratively across the system
- A workforce workstream seeking to manage HR issues on a system wide basis to support the other workstreams

2.5 The Sustainability Plan was refreshed at the beginning of 2011/12. At this stage, Solent NHS Trust, Southern Health NHS FT, Hampshire County Council, Portsmouth City Council and SCAS were more closely engaged as full partners in the refreshed Plan. The refreshed plan:

- Revised the scale of the financial challenge utilising PCT QIPP plans and financial modelling undertaken by Portsmouth Hospitals. This confirmed the size of the challenge to be £214m over the four year period to 2014/15
- Clarified the main objectives of each of the workstreams
- Ensured that momentum was maintained as the system moved into year 2 of delivery of the plan

2.6 At this stage, whilst the programme continued to monitor all eight workstreams, the focus of effort and attention was shifted to three key programmes – transforming unscheduled care, transforming planned care and estate reconfiguration.

2.7 Chairmanship of the programme board moved to a GP and the governance arrangements were simplified, so that each of the three transformation workstreams reported directly to the

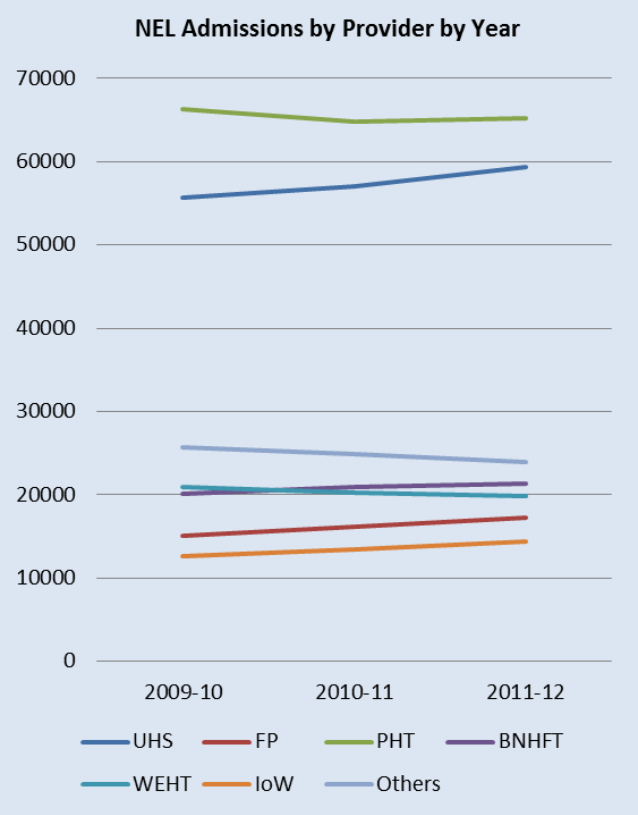
programme board. Work to drive internal efficiency and productivity continued within organisations including:

- Portsmouth Hospitals internal turnaround plan to build a sustainable provider and achieve FT status
- Arrangements to reduce PCT running costs, driven through the creation of the SHIP PCT cluster (NHS Hampshire, NHS Southampton, NHS Portsmouth and NHS Isle of Wight)
- Improving prescribing and sharing best practice in primary care, driven through CCGs

2.8 During 2011/12 the Portsmouth and SE Hampshire health system made good progress delivering against the challenging redesign and efficiency programme. All organisations achieved or exceeded their financial targets. Whilst PCTs achieved their QIPP savings targets, this was not in all the areas originally planned. Efficiencies related to reductions in emergency admissions did not deliver to plan.

2.9 In terms of operational performance in Portsmouth & SE Hampshire, at the end of 2011/12, the system is making progress towards its objectives:

- Unlike other acute providers across the SHIP area, Portsmouth Hospitals Trust has received a stable level of non-elective admissions over the course of the past 3 years. This is illustrated in the graph opposite.
- A similar pattern can be seen in elective care, with an underlying reduction in 1st outpatient attendances of 13% over the last 3 years
- Reportable delayed transfers of care have been significantly reduced over the course of the past 3 years, from an average of 38 per week to 12 (source PHT weekly DTOC reports)
- The most notable activity movement in the past 3 years has been the 2.8% growth in type 1 ED attendances at QAH. In overall terms, ED attendances in PHT rose by 5.6% over the last three years, compared to an average growth rate of 5.9% across South Central.



2.10 Within Portsmouth & SE Hampshire there are differences in admission rates and in the rate at which those rates are changing. In the past 30 months, SE Hampshire has seen a systematic reduction in GP outpatient referrals to PHT, by around 6.8%, whereas Portsmouth GP referrals declined less, by around 2.7% over the same period. Emergency admissions to PHT have remained relatively unchanged over the past 2-3 years, but those from Portsmouth patients (where emergency admission rates remain above average, taking account of need), have reduced by around 3%.

2.11 Importantly, the local NHS landscape also began to change significantly in 2011/12.

- Three **Clinical Commissioning Groups** (CCGs) were formed, NHS Portsmouth CCG, NHS Fareham & Gosport CCG and NHS South Eastern Hampshire CCG each serving a population of approximately 200,000 people. All three CCGs have prepared operating plans for 2012/13 which are strongly aligned, are progressing their plans to achieve authorisation and have agreed arrangements that enable them to work together through a Compact across the Portsmouth and SE Hampshire health system.
- **Portsmouth Hospitals NHS Trust** are developing their Foundation Trust application in line with their Tripartite Formal Agreement, with an application due to be submitted to the DoH by March 2013 at the latest.
- **Solent NHS Trust**, formed on 1 April 2010 from the provider arms of Portsmouth City and Southampton City PCTs, is developing a Foundation Trust application, due for submission by August 2012. Solent's Integrated Business Plan sets out how the Trust plans to develop services, working in partnership to keep people independent, safe and well in, or close to, their home. Approximately 42% of Solent NHS Trust's business is the delivery of community and mental health services within Portsmouth City.
- **Southern Health NHS Foundation Trust**, formed in April 2011 through the merger of Hampshire Community Health Care and Hampshire Partnership NHS FT, is pursuing a strategy of developing integrated care, working with Portsmouth Hospitals and Solent to redesign care for elderly people & with GPs to integrate primary/community care service delivery.

2.12 The local CCG plans and this refreshed Sustainability Plan are designed to support the FT applications of Portsmouth Hospitals and Solent NHS Trusts

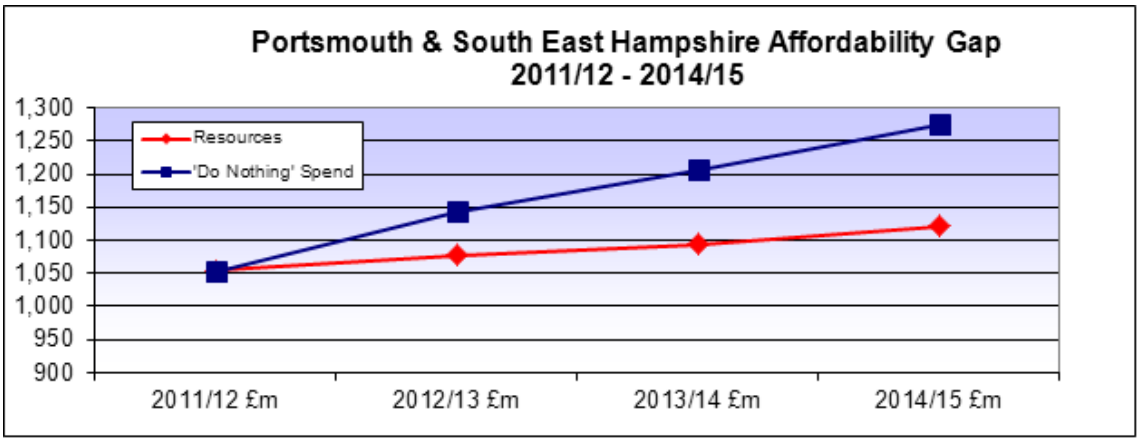
2.13 Whilst progress is being made towards to the goal of a sustainable NHS in Portsmouth and SE Hampshire, it continues to be the case that the scale and pace of change needed requires the delivery of transformational change in how services are delivered, across the health system. This document summarises a refresh of the Portsmouth & SE Hampshire Sustainability Plan at the beginning of 2012/13. It describes

- The challenge the local health system has to address over the next 3-5 years
- The key strategies we are pursuing to transform healthcare and address this challenge
- The mechanisms and approaches we will use to drive delivery of the plan, ensuring a focus on action, and the cultural change needed to enable it
- The summary financial plan
- The impact on providers and commissioners in Portsmouth & SE Hampshire
- The key risks and how we are mitigating them

3 The challenge for the Portsmouth & SE Hampshire health system 2012/13 – 2014/15

3.1 Demand and healthcare costs are rising at an unsustainable rate across Portsmouth and SE Hampshire. Our current estimate of the affordability gap over the next three years if we do nothing is £154m, or 15% of the local NHS resources, as set out in the table and figure below:

Organisation	2012/13 £m	2013/14 £m	2014/15 £m	Total £m
NHS Portsmouth CCG	18.8	15.4	14.4	**48.6**
NHS South Eastern Hampshire CCG	20.0	14.7	12.3	**47.0**
NHS Fareham & Gosport CCG	18.8	13.8	11.6	**44.2**
Portsmouth Hospitals NHS Trust	26.9	18.2	17.8	**62.9**
Solent NHS Trust (Portsmouth City)	4.1	4.3	3.8	**12.2**
Southern Health NHS FT (SE Hants)	2.4	2.4	2.4	**7.2**
Total	**91.0**	**68.8**	**62.3**	**222.1**
Less 'system overlaps'	-18.4	-18.1	-18.1	**-54.6**
Gross System Challenge	**72.6**	**50.7**	**44.2**	**167.5**
Less marginal cost reduction of reductions in demand	-6.5	-3.7	-2.6	**-12.8**
Net system challenge	**66.1**	**47.0**	**41.6**	**154.7**



3.2 As a result of all of the analysis, whole system planning and joint working undertaken over the last three years, the health system in Portsmouth and SE Hampshire is clear that in order for the local NHS to be in balance and sustainable, there are three key challenges we must address together:

a) **Redesigning how we deliver unscheduled care, especially for frail elderly people and those with long term conditions (including dementia) so that the system achieves upper quartile emergency admission rates, shorter acute hospital lengths of stay and improved patient experience and outcomes**. Our levels of non-elective admissions are higher than our peers and we fail to consistently achieve clinical indicators for A&E services. Through the development of integrated models of out of hospital care our system could support significantly greater numbers of older people, adults and children to receive more appropriate high quality care in the community and bring our urgent and emergency care system into balance

b) **Redesigning how we deliver planned care, so that we improve access for patients, provide clinically relevant cost effective care, and as a system reduce planned admission rates and interventions to match the best performing health systems in the country.** Significant progress has been made in ensuring that the appropriate level of planned care activity is provided for our population. However, there remain some specialties for which the levels of intervention are higher than that which we would expect for our population. We also have planned admission rates which are higher than we can afford. By redesigning services across the system so that care is provided by the most appropriate professional in the right setting in a timely manner, we will improve performance against access targets, deliver a model of care which has affordable levels of demand for planned treatments and interventions and improve outcomes and experience for patients.

c) **Rationalising our estate and fixed infrastructure costs.** Our system has more estate than it needs or can afford and as we redesign our unscheduled care and planned care systems, we can reduce the number of sites and facilities we occupy, make better and more intensive use of our remaining facilities, and drive down our estate running costs.

3.3 Our sustainability plan focusses our energy and effort on creating a system which supports significantly more patients in primary and community care leading to fewer acute hospital admissions for planned and for unscheduled care – and which does so from a smaller and more intensively used estate, in a model with very efficient primary care, community, mental health and acute care providers. **Our overarching challenge is therefore to create a system with the right leadership, behaviours, models of care and contracting incentives to achieve this goal.**

3.4 The following sections of this document set out in more detail our transformation plans for unscheduled care for frail elderly people and those with long term conditions, for planned care and for the rationalisation of our estate.

4 Redesigning care for the frail elderly and those with long term conditions including dementia

4.1 Reducing demand for acute care is core to our strategy to improve quality and create a sustainable health system in Portsmouth & SE Hampshire.

4.2 As described in paragraph 2.9, we have been making progress – there have been significant reductions in delayed discharges achieved over the past year and there have been increases in ambulance non-conveyance rates. We have also piloted new models of service delivery such as the Older Persons Assessment Service at PHT, which are demonstrably making tangible improvements for patients. However, in overall terms we are, at best, containing growth. The numbers of attendees to the Emergency Department, and overall non-elective admissions have remained broadly the same year on year for the past 3 years, there is no change in the re-admission rate to hospital, and we consistently see higher non-elective activity than plan which is reflected in regular pressures at Portsmouth Hospitals NHS Trust.

4.3 Our conclusion is that this inability to leverage real reductions in non-elective admissions is primarily caused not by an absence of out of hospital capacity and capability, but by limited understanding, co-ordination, integration and confidence on the part of health, social care and third sector partners in the out of hospital care model, particularly for the frail elderly and those with long term conditions.

4.4 The issues we face relate to urgent and emergency care for children, for adults and for older people, and we have actions in place relating to each of these population groups within the system. However, the area where we see the greatest opportunity to transform care is for the frail elderly and those with long term conditions, including dementia. We know that

- More than half of the inpatient beds in our system are occupied by the 10% of patients who stay in hospital for more than 2 weeks and 3 out of every 5 admissions are for patients who have been admitted before within 12 months.
- Approximately 3000 of our patients have had 4 or more hospital admission within the last year – and account for a staggering 25% of bed use in the system.
- Patients with mental health needs are twice as likely to have a long hospital length of stay
- Many of the patients being admitted to hospital, or enduring long hospital stays, could have been better supported elsewhere, including in their home or community setting (subject to the appropriate services being available)
- Frail elderly patients and those with long term conditions often experience disjointed poorly coordinated care and poor customer service – we are providing inadequate support in the community for patients with chronic conditions
- Significant numbers of patients being admitted for acute care from nursing homes could have been managed in the community with a different model of care
- Despite a strong delayed discharge position, there remain significant numbers – up to 100 at any one time – medically fit patients in inpatient beds within Portsmouth Hospitals
- A higher than average proportion of our emergency and urgent care attendances at hospital occur outside of the normal working day

4.5 Within our system a wide range of services and activities have been commissioned and provided to support frail elderly people and those with long term conditions. However well delivered these individual services are, they don't operate sufficiently well as an effective system – and don't consistently have the full support, ownership and confidence of clinicians and patients.

4.6 Our aim is to transform care for frail elderly people and those with chronic conditions, improving community provision for these patients and ensuring that we deliver effective urgent and emergency care. This transformation involves the creation of a much more integrated health and social care system in Portsmouth and SE Hampshire. We will focus energy on developing integrated models of care, built around primary care ('primary care plus') where:

- Primary care, community care (physical and mental health) and social care working more closely together at practice level to manage the health and wellbeing of the practice population – integrated teams identifying those patients at greatest risk of deterioration and proactively managing their health and social care needs
- We identify and respond to patient's needs in a seamless way, offering a rapid and tailored response at the most appropriate care setting and provide high quality and consistent community support for those with multiple pathologies, particularly dementia. This will include the development of new approaches to community based admission avoidance
- The artificial historical barriers that exist between elements of the system are broken down, with the aim of providing a single, co-ordinated service for patients
- Elderly care clinicians, specialists in older people's mental health, GPs, community care staff and social care work together to provide care for frail elderly people and those with long term conditions when they experience an acute deterioration of their health & social circumstances

4.7 Our vision for the transformed system is summarised in the figure below:

Our vision for a sustainable health & social care system in Portsmouth & SE Hampshire

An integrated health and social care system

Breaking down the artificial historical barriers that exist between elements of the system with the aim of providing a single, co-ordinated service for patients

Desired outcomes of an integrated care system

A local health & social care system where more effective out of hospital care leads to:

- Fewer hospital attendances
- Fewer hospital readmissions
- Fewer long term care placements
- Reduced burden of clinical need
- Fewer patients with long hospital stays

…and a more affordable service

A local health and social care system in which patients experience:

- Joined up and co-ordinated care
- More people maintaining their independence in their own home for longer
- Excellent customer service
- Feeling supported to manage their own health and wellbeing
- Reduced duplication and waste

4.8 We already have a programme of work underway which is embedded in CCG and provider operating plans for 2012/13 (attached at Appendix A) and is beginning to take effect, including:

a) The Older Persons Partnership, a partnership between Portsmouth Hospitals, Southern Health and Solent to deliver integrated community care, dementia care and acute care for

older people has led to a decrease in daily hospital admissions and a higher proportion of patients discharged within 48 hours from the QAH medical assessment unit

b) 111 service commissioned across the whole of Portsmouth & SE Hampshire which provides call handling, clinical assessment at point of contact and appropriate referral to other NHS services. This is expected to reduce the number of 999 incidents and A&E attendances
c) Extending those identified as being 'at risk' to include a wider cohort of individuals including frequent flyers, and improving case management with primary care
d) Improved anticipatory care plans with more useful information to avoid conveyance
e) Strengthened capacity and reliability of virtual wards

4.9 In order to drive the level of transformation required in our system, we are supplementing these delivery focussed activities with a programme to bring together partners to agree a common view about the design of integrated care in Portsmouth and SE Hampshire that we are seeking to create together. The concept of 'Integrated care' is agreed in principle as the way forward – but each partner currently describes it differently. We have therefore established, in parallel with the ongoing work to deliver our existing redesign activities, a time-limited clinically led design group in order to define the blueprint for the future delivery of care to frail elderly people and those with multiple morbidities whose needs require joined up solutions across primary and acute care, community services and social care. The group will:

- Look at the evidence of what works (nationally, internationally)
- Agree the outcomes we want to commission and deliver for our population
- Design the levers and incentives of the integrated care system of pathways and services required now and into the future
- Specify to the Integrated & Urgent Care Programme Board what needs to be delivered within the resources available
- Define the optimum performance of the system
- Ensure our leadership and organisational behaviours are 'correct' to deliver this vision
- Develop a service design proposal which has the support of commissioners and providers

4.10 This Design activity commenced in April 2012 and is due to complete by the end of September 2012. Our system wide work to manage the transformation of care for the frail elderly and those with long term conditions will be driven through the Integrated and Urgent Care Programme Board. This is the group through which we collectively check that all of our plans are delivering and addressing the non-elective care challenge. This programme board will also take the outputs of the design work and incorporate these into the delivery programme. The governance arrangements and programme structure for the Sustainability Programme are set out in section 7 of this document.

4.11 We expect that, by October 2012 commissioners in Portsmouth and SE Hampshire will be in a position to commission an integrated model of service delivery for 2013/14 which reflects the model designed over the coming 6 months. This is likely to involve a formal procurement process, with the intent that an integrated service will be procured from a single entity, which may be a range of organisations working together as one, to deliver the specified model.

4.12 The key milestones for our work to redesign unscheduled care are:

- Design of an integrated service model for frail elderly and LTCs completed – Oct 12
- Process to commission this agreed model commenced – November 12
- New model in place within Portsmouth & SE Hampshire – April 13

5 Redesigning how we provide planned care

5.1 Our intention is to maintain the progress we have made to date in redesigning how we deliver planned care, improving access for patients, provide clinically relevant cost effective care, and as a system reduce planned admission rates and interventions to match the best performing health systems in the country.

5.2 Our levels of planned admission rates are currently higher than we can afford. By redesigning services across the system so that care is provided by the most appropriate professional in the right setting in a timely manner, we will improve performance against access targets, deliver a model of care which has affordable levels of demand for planned treatments and interventions and improve outcomes and experience for patients.

5.3 A strategy for the commissioning of planned care services for the Portsmouth, Fareham & Gosport and South Eastern Hampshire CCGs has been developed, covering the period 2012-15. As a system we will continue to drive performance and productivity improvements using measures such as the *Better Care Better Value* indicators.

5.4 Our system wide work (set out in detail in Appendix B) is designed to

- Put in place primary and community care based alternatives to secondary care referrals, where this is in the interest of patients and promotes quality, access and sustainability
- Improve access to diagnostics
- Enable sustained delivery of the 18 week referral to treatment waiting time target
- Promote increased utilisation of Choose and Book and continue the roll out of Advice and Guidance for clinicians

5.5 Our strategic improvement priorities are:

Service	Priority activities
Ophthalmology Services	Commissioning/reviewing existing pathways, with a particular focus on minor eye conditions, glaucoma and cataracts
Dermatology Services	Commissioning/reviewing existing pathways, with a particular focus on minor skin procedures and chronic skin conditions such as Eczema, Psoriasis and Acne
Urology Services	Commissioning/reviewing existing pathways, with a particular focus on LUTS (male), acute urinary retention, haematuria, PSA pathway, and recurrent urinary tract infection. In these areas the potential exists to remove up to 25% of outpatient referrals from the system through improved management in community/primary care and education and feedback to referrers.
Rheumatology Services	Commissioning/reviewing existing pathways, with a particular focus on follow ups
Minor Oral Surgery	Developing an 'Any Qualified Provider' approach for minor oral surgery and a referral management system to ensure that education, training and feedback is given to GDPs to reduce inappropriate referrals
Pain Services	The current chronic pain service is proposed to be decommissioned from the local acute provider with specific interventions re-commissioned. This will be supported by the development of a local chronic pain self management service for of the local CCGs. Cancer and acute pain services will remain unaffected. A chronic pain online self management pilot will be run, funded by SHA grant, across all three CCGs to support the range of options offered to patients

Musculoskeletal Services	Reviewing existing pathways to ensure optimisation of the current model, further development of Advice and Guidance, and develop the concept of an integrated model of provision/Prime vendor model across secondary care and community, involving the two MSK triage models currently running across the three CCGs. This is proposed to be implemented in 13/14, pending the outcome of the modelling and stakeholder feedback
Cancer Services	Review current chemotherapy provision; working in partnership with the Central South Coast Cancer Network to understand activity and costings for cancer pathways, benchmarking against neighbouring organisations and making full use of the e-prescribing facility. Work between primary and secondary care to improve discharge information for cancer patients. Review palliative care involvement in MDT decision making processes. Working with Portsmouth Hospitals NHS Trust to implement an acute oncology service.

5.6 Patients in Portsmouth and SE Hampshire currently enjoy a wide choice of providers for secondary care, with neighbouring hospitals in Southampton, Winchester, Basingstoke and Chichester, as well as local independent providers. As part of its planned care strategy, Portsmouth Hospitals Trust intend to encourage a greater number of local patients and GPs to choose PHT as their elective care provider, rather than other local centres. The local CCGs note and understand this repatriation strategy, acknowledging that there will be competition from all providers for planned care activity. In overall terms changes in patient flows for planned care need to be cost neutral for commissioners, through the application of consistent referral thresholds and patient pathways. Commissioners will seek to ensure that patients in the local health economy continue to benefit from a choice of high quality providers.

5.7 The local CCGs view AQP as an important tool to drive service change in areas where services can be more effectively provided in community settings; AQP will be implemented in line with national guidance and will be initially focused in the areas of continence services and hearing aids. Locally the CCGs would also wish to undertake AQP for the commissioning of minor oral surgery extractions. Where existing service models have led to fragmented service provision, such as in MSK services, commissioners intend to seek to commission single integrated services from a lead provider.

5.8 The table below summarises the work programme milestones for the planned care strategy.

	2012/13				2013/14				2014/15			
SCHEME	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Ophthalmology												
Dermatology												
Urology												
Rheumatology												
Minor Oral Surgery												
Online Pain Management Pilot												
Pain												
Musculoskeletal												
Individual Funding Requests												
Cancer												
AQP												

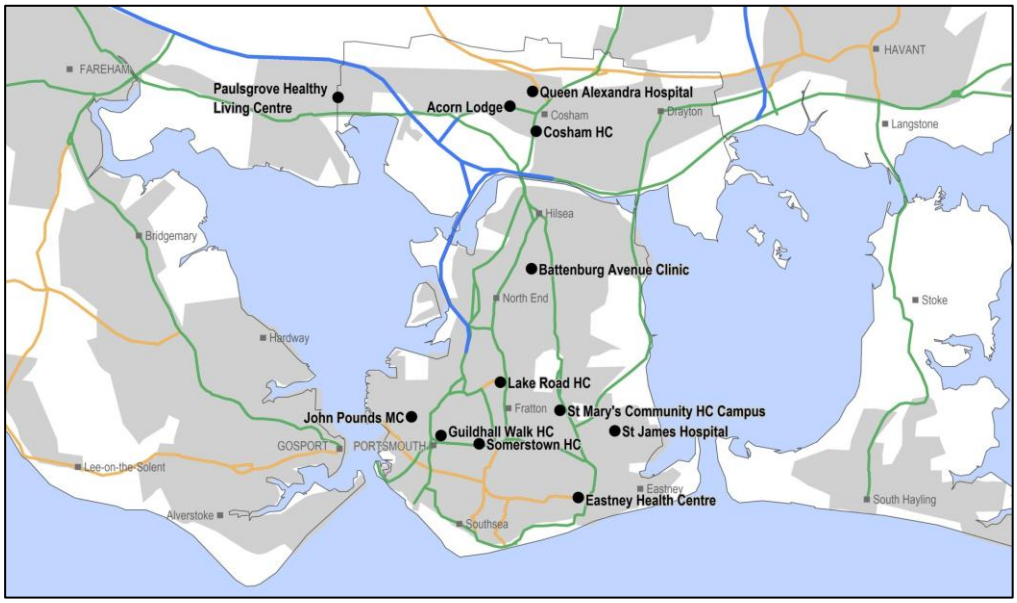
KEY	
lead time	
Implement/revise	
Review	

6 Estate Cost Rationalisation

6.1 The Portsmouth and SE Hampshire health system has more estate than it needs or can afford to deliver the current and future planned model of care. Total estate running costs are estimated to be approximately £80m for the system.

6.2 A core component of our sustainability plan is to reduce estate costs through rationalisation of sites and facilities, and by making more intensive use of all recently developed estate, including the Queen Alexandra Hospital (QAH) site, Fareham Community Hospital and St Mary's Healthcare Campus. All parties recognise the significant fixed costs of the PFI hospital and are committed to ensuring that where possible, any space released from the acute activity taking place there is filled with other services thus releasing estate costs from other parts of the system.

6.3 The maps below show the current key clinical infrastructure in Portsmouth City (first map) and SE Hampshire (second map).



6.4 The delivery of the unscheduled care strategy will result in a reduction in the number of beds at Queen Alexandra Hospital used for emergency activity. This will be as a consequence of a reduction in length of stay and a reduction in admissions. PHT intend to utilise some of this capacity for planned care through the repatriation strategy described in paragraph 5.7, but given the high proportion of planned care delivered on a day case basis, the impact of this sustainability plan is to render some beds at QAH vacant by 2015. PHT are in the process of quantifying this impact. These changes will release significant costs for PHT but will leave the residual cost of the fixed asset.

6.5 Our approach to addressing this issue has three elements:

a) the movement of staff and services from non-PFI estate onto the QAH site where this is consistent with our clinical strategy (eg relocation of the School of Nursing to the QAH site)
b) the development of commercial and non-commercial alternative uses of vacant capacity by PHT. This will include private patient services, increased commercial footprint and partnership solutions (eg pathology expansion, pharma and research opportunities)
c) the potential inclusion of residual stranded PFI costs within the contracting framework for integrated unscheduled care delivery.

6.6 In this context, a strategic estates review has been undertaken. Its aims and objectives were to deliver a minimum of £6m recurrent revenue savings by 2013/14 (7.5% of the estimated £80m total occupancy costs) through:

- Improving utilisation and maximising income to ensure the best return on assets and to support the delivery of health care in line with commissioning intentions
- Ensuring that services are provided in the most appropriate facilities, in line with the strategy to deliver care in localities, whilst recognising the implications of fixed costs presented by strategic sites
- Optimising the utilisation of the estate owned and leased by all partners
- PHT to maximise the utilisation of accommodation at QAH whilst maintaining the integrity of clinical adjacencies (i.e. optimal configuration).
- PHT to review its use of non-PFI estate and rationalise where appropriate e.g. Fort Southwick; SMH Education Centre; Dermatology
- NHS Portsmouth and NHS Hampshire to establish the optimal estate configuration to optimise operational effectiveness
- NHS Portsmouth and NHS Hampshire look at the quality and utilisation of the estate, clinical adjacencies and any potential for space reduction.

6.7 An implementation plan (attached at Appendix C) has been agreed and is being delivered to achieve the desired objective. Key projects within this implementation plan are summarised in the following table

NHS Hampshire led projects	a) Maximise use of Headquarters; b) Re-provide Primary Care accommodation into NHS owned estate e.g. Fareham and Gosport War Memorial Hospital; c) Reduce LIFT unitary charge cost; d) Cancelled Oak Park Community Hospital; community activity re-provided from existing estate e.g. Oak Park Children's Service Centre reconfigured into Oak Park Community Clinic

Portsmouth Hospitals NHS Trust led projects	a) Relocate Dermatology from St. Mary's Community Health Campus to QAH; b) Finalise demolition & disposal of the back of the SMH land – site declared as surplus to requirements following the opening of the new QAH; c) Relocate School of Nursing and School of Midwifery from St. Mary's Community Health Campus to QAH; d) Reduce unitary charge PFI costs; e) Relocate office staff to QAH to release office accommodation at Fort Southwick for re-use by the wider system; f) Opportunities for commercial letting at QAH (Private Health Care and retail income)
NHS Portsmouth and Solent NHS Trust led projects	a) Re-utilisation/ land disposal (in part) of the St. James site to transfer on services and provide commercial income and disposal of other community estate; b) Re-utilisation/ land disposal (in part) of the St. Mary's Community Health campus site to transfer on services and provide commercial income and disposal of other community estate

6.8 In conjunction with these activities a series of further opportunities are being investigated to identify further income streams, including identifying external partners to support in delivering additional third party income to strategic health sites and recommending a route for developing further savings for combined energy usage across the Portsmouth and South East Hampshire health system.

6.9 The following tables illustrate the high level summary for the total savings to be delivered as a result of this programme in 2012/13 and 2013/14, in addition to the £4,665k realised in 2011/12. These savings will deliver the minimum target of £6m recurrent revenue savings to be realised by 2013/14.

Savings to accrue to:	**Value £'000's**
Portsmouth Hospitals NHS Trust	3,133,000
NHS Hampshire	478,000
NHS Portsmouth	1,819,000
NHS Portsmouth/ Solent NHS Trust	109,000
NHS Hampshire/ Southern Health NHS Foundation Trust	500,000
Total	**6,039,000**

7 Delivering our Sustainability Plan

7.1 Our aim is to create the culture, behaviours and environment within which the transformation can occur successfully. There are four major components of our approach to delivering our plan:

a) A contracting strategy and approach which puts in place the right incentives and mechanisms to enable organisations to work together to achieve our common aims

7.2 The NHS in Portsmouth & SE Hampshire operates within a complex system of contractual relationships. Our intention is simplify the contractual arrangements and put in place approaches which align incentives for providers to support them to act and behave in ways which contribute directly to achievement of the agreed system goals. We will ensure that contractual arrangements don't stand in the way of joint working.

7.3 We expect and need providers to continue to innovate, creating new models of service delivery which more effectively support our system ambitions. We expect and need commissioning arrangements to reinforce and support these innovations through contracts.

7.4 Within 2012/13 contracts, CQUIN payments are at risk for Portsmouth Hospitals, Solent and Southern Health if the planned non-elective reduction in activity is not delivered. A LES is in place as part of the strategy to create incentives for primary care to contribute to this objective. We expect to extend these types of arrangements so that the financial success of individual organisations in the system is dependent on the success of the system, and the quality of the partnerships in it.

7.5 A key issue for the future is about putting in place a process through which the desired integrated system and planned care system – designed by partners – will be secured. It is the aspiration of commissioners to contract through a single entity for the provision of integrated care for the frail elderly and those with long term conditions, based on outcome of the design work, as described in section 4 of this document. Prime vendor models and AQP will be used to create the desired systems for planned care.

b) Building confidence and Trust at a clinical level and organisational level that the new models work, in order to change behaviour

7.6 A crucially important part of our plan is the building of confidence between clinicians in different parts of the system, and between organisations in the system, that the new models we put in place can be trusted and do work. If we fail to achieve this, then new models simply get added on top of existing models – rather than leading to redesign, improvement and overall cost reduction. Changing behaviours is therefore key to achieving our objectives.

7.7 We have demonstrated through the work we have already undertaken when teams have begun to redesign primary and community services at practice level and at system level that by focussing on strengthening relationships and building trust, clinicians and organisations gain confidence in each other, enabling behaviours to change and new models to be more effective.

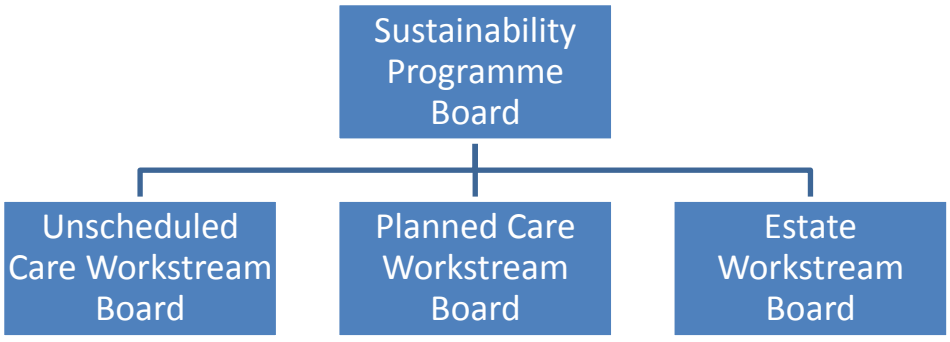
7.8 As a system, in our redesign activity, we will invest in leadership approaches which build confidence and trust. This includes, for example, supporting GPs to trust and have full confidence in community and nursing therapy services (and vice versa), and supporting hospital clinicians to have confidence that they can discharge patients and the necessary arrangements will be in place in the community.

c) Strong programme governance with clear milestones and KPIs

7.9 The sustainability programme is managed through a Programme Board where commissioners and providers in Portsmouth & SE Hampshire work together to provide clarity, leadership and to solve and unblock system issues. This is the group through which the senior leaders in the local system will drive the delivery of the sustainability plan. The membership of the Programme Board includes:

- CCG Chairs
- Executive leads for Work Programmes
- PCT Cluster Directors for SE Hants and Portsmouth City
- Cluster Chief Financial Officer
- CEOs of PHT, Solent, Southern Health, SCAS
- Director of Adult Social Care for Portsmouth
- Director of Adult Social Care for Hampshire
- Chair of Clinical Leaders Group
- Public Health representation

7.10 The Programme Board is supported by three Workstream Boards, as illustrated below.



7.11 The key milestones for the unscheduled care and planned care redesign projects have been summarised in sections 4 and 5 of this document. The key milestones for the estate reconfiguration project are set out in Appendix C.

7.12 The Portsmouth and SE Hampshire health system current monitors a series of detailed indicators of performance in order to assess progress in delivery of its sustainability programme (attached at Appendix D). These include overall A&E attendance rates, emergency admission rates, length of stay, delayed transfers of care, and referral rates.

7.13 Increasingly in future, at system level, the sustainability board will monitor a higher level set of a smaller number of indicators, each one underpinned by a series of more detailed supporting metrics, which will enable the board to take an overall view of the progress being made against

the its objectives. Each metric will have targets set, based on national benchmarking. These high level system metrics include:

a) The extent to which the system is successfully **identifying and proactively case managing those patients at greatest risk**, and is successfully preventing health crisis. This could include increasing to 5% the proportion of the population included within risk stratification programmes, and monitoring the number of people being case managed (or who are known to community services) who are admitted to hospital, and the number of people admitted to hospital who are known to community services
b) The extent to which the system is effective in **avoiding hospital admissions when individual patient's health and social care circumstances deteriorate**. This could include numbers of rapid response referrals seen within an hour, the proportion of these referrals which are then referred to A&E or admitted
c) The progress being made to **reduce attendances and admissions to PHT**. This would include the proportion of A&E attendances referred by GPs (compared to norms for Hampshire), conversion rates from A&E attendance to admission, readmission rates within 28 days, and the already agreed system wide CQUIN and LES metrics for unscheduled activity
d) The effectiveness of the system in **managing patient flows through PHT**. This would include overall emergency lengths of stay, lengths of stay for frail elderly people triaged through OPAS, lengths of stay in MAU, numbers of medical outliers within PHT, A&E waiting times, and the numbers of (and reasons for) medically fit patients in hospital
e) The extent to which the system is effective in **delivering paediatric urgent care**. This would utilise the agreed system wide CQUIN metrics.
f) The extent to which the system is **reducing overall system demand for planned care** and achieving waiting time targets

7.14 The reporting structure for KPIs and achievement against milestones is as follows:

- Key system financial and non financial indicators are reported to Programme Board
- Key work streams report a lower level of detail to their boards
- Individual projects are monitored within existing Programme Management Offices (PMOs)

d) <u>Ensuring the system has and makes maximum use of technology as an enabler to service redesign and delivery</u>

7.15 Underpinning the delivery of the programme of redesign of urgent and emergency care and of planned care is the work taking place across our system to deliver a step change in the utilisation of technology as an enabler to service redesign and delivery.

7.16 Our system wide IM&T programme is designed to:

- Ensure the comprehensive use of the Hampshire Health Record – the local combined electronic health record which brings together information in individual patient health records from across Hampshire into a single combined record. The Hampshire Health Record can be viewed wherever patients are treated and is a key component of our plan

to provide clinicians with the information they need to make informed decisions about the care they provide

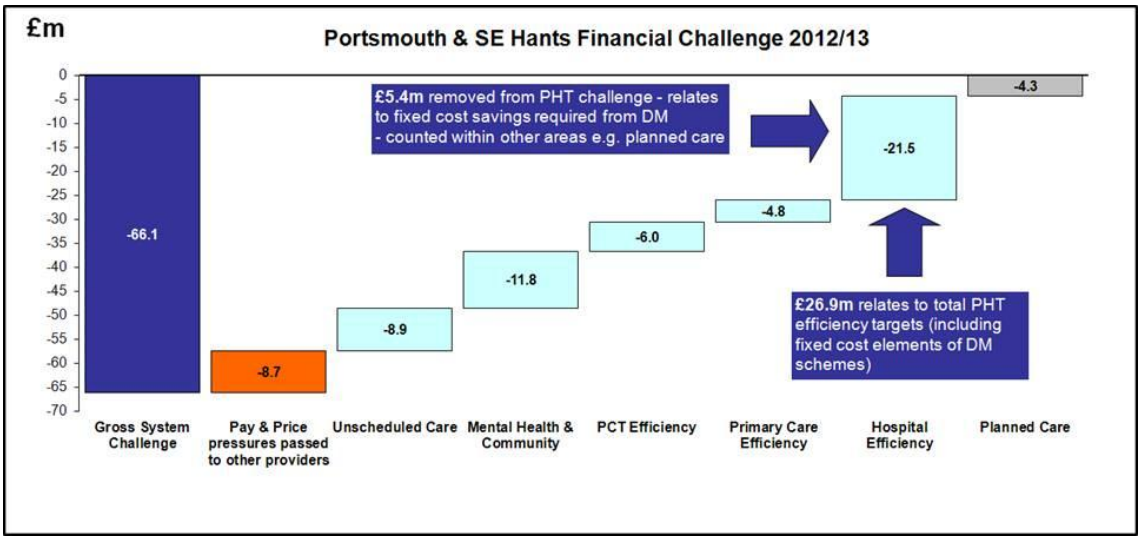
- Making greater and more effective use of information to monitor and manage the performance of the system in a timely way. This involves providing managers and clinicians with the up to date, and historical information they need to assess the performance of the system and to proactively deal with and tackle issues as they arise

- Utilise the information we have to systematically identify and proactively manage, on a day to day basis, the patients in Portsmouth and SE Hampshire who are at greatest risk of deterioration – enabling integrated clinical teams to intervene and reduce that risk

- Enable us to extend the use of tele-health and remote monitoring technologies, providing early identification of potential patients at risk and enabling more patients to be managed and supported independently in community settings, rather than in hospital

8 The financial plan

8.1 The 'waterfall' diagram below summarises the financial challenge across the health system.



8.2 Each organisation has a financial plan which builds on the health system vision for Portsmouth and South East Hampshire, whilst at the same time delivering its own organisational requirements.

8.3 Although PCTs are still in existence in 2012/13, QIPP plans have been developed at CCG level and the level of challenge is set out below:

	Fareham & Gosport £m	South Eastern Hampshire £m	Portsmouth City £m	Total £m
2012/13 QIPP challenge	**10.3**	**11.1**	**9.2**	**30.5**

8.4 The key QIPP schemes to meet this challenge are summarised below:

	Fareham & Gosport £m	South Eastern Hampshire £m	Portsmouth City £m	Total £m
Community	-	-	0.1	0.1
Continuing Care	0.3	0.3	0.5	1.1
Long Term Conditions	1.2	1.2	1.5	3.9
Mental Health Primary Care	0.1	0.1	0.6	0.8
Primary Care Prescribing	1.5	1.7	1.6	4.8
Planned Care	1.4	1.3	1.6	4.3
Running Costs	0.2	0.2	-	0.4
Staying Healthy	0.1	0.1	0.6	0.8
Urgent & Unscheduled Care	0.8	1	2.3	4.1
Other enablers	1.5	2.3	1.7	5.5
Unidentified	3.2	2.9	-1.4	4.7
Total	**10.3**	**11.1**	**9.1**	**30.5**

8.5 At the beginning of April 2012, Fareham & Gosport and South Eastern Hampshire still had circa £3m of QIPP savings to be identified. Whilst this is being addressed as part of a Hampshire wide financial management plan, it is essential for the local system and the establishing CCGs to rapidly close this gap.

8.6 The key workstreams that underpin the success of the CCG's QIPP savings are Unscheduled Care & LTC, and Planned Care (which are the focus of this sustainability plan) and Primary Care Prescribing.

8.7 Each provider has a well-developed cost improvement plan that enables each organisation to deliver its financial targets, focused on improving productivity and service transformation that supports and complements the strategic direction of the local health system. As well as this, Portsmouth Hospitals NHS Trust and Solent NHS Trust are developing long term financial models (LTFM) to support their Foundation Trust applications. Both organisations are working with commissioners to ensure assumptions align with the strategic priorities of the system, as well as supporting organisational aspirations.

8.8 Portsmouth Hospitals NHS Trust financial plan assumes a reduction in emergency attendances and admissions as a result of the strategy to integrate health and social care, built around primary care. The impact is currently being modelled and discussed with commissioners, but is consistent with the expectation that transformation of unscheduled care will reduce demand for inpatient activity by 10 -20%. The plan also assumes an expansion in planned care activity in targeted specialties, the detail of which is still being scoped.

8.9 Solent NHS Trust's financial plan reflects the continuing downward pressure on public finances for the next five years, assumes no changes to clinical income related to price or activity changes, but assumes activity delivered will increase (1% per annum). As part of the Foundation Trust application process, commissioners will undertake further work with Solent regarding alignment of plans.

Incentivising Change

8.10 Redesigning our health system requires all partners to change, and it is important that this change is adequately supported financially through contracts and partners are equally incentivised. In 2012/13, this is happening in a number of ways. Firstly, a local CQUINs worth 1.5% of contract value have been agreed with Portsmouth Hospitals, Solent and Southern as set out in section 7. Secondly, is to support providers where reductions in activity under QIPP plans may lead to a reduction in income under Payment by Results, but costs can only be reduced in a phased way. Where appropriate, a providers will receive a one-off payment to manage the transitional cost of change, allowing the provider time to reconfigure services and reduce its cost base. Other risk sharing arrangements between commissioners and provider are also in place.

9 Impact of sustainability plan on providers

9.1 This section describes the impact of this plan on Portsmouth Hospitals, community and mental health providers and primary care providers in Portsmouth & SE Hampshire. The sustainability plan is designed to support the FT applications of Portsmouth Hospitals and Solent NHS Trust during 2012/13.

Impact on Portsmouth Hospitals NHS Trust

9.2 Portsmouth Hospitals has a central role to play as a partner in integrated service delivery in Portsmouth & SE Hampshire. Delivery of the sustainability plan will enable PHT to exert more consistent control over its inpatient beds. Through the transformation of unscheduled care and planned care, demand for acute inpatient activity is expected to fall by 10-20%. Portsmouth Hospitals FT application will reflect the impact of the system redesign on the Trust, and the new models of care PHT will be part of delivering – for example deploying some of its workforce outside of the hospital in community settings, and extending integrated models of service delivery for adults and older people.

Impact on community and mental health providers

9.3 The sustainability plan envisages significant further redesign of community and mental health services to create an effective integrated care system built around primary care. Community services will develop such that there is:

- Much greater integration of community nursing and therapy services and older people's mental health services **with primary care** to enable the development of high quality, robust services based around practices and groups of practices, supporting them to proactively identify and manage the needs of the vulnerable patients in the practice population
- Much closer integration of service delivery **with social care**, so that community teams and social care teams work effectively together, providing joined up health and social care to patients
- Much closer integration between community & mental health services **and services in Portsmouth Hospitals**. Developing new approaches to service delivery that have the confidence and trust of clinicians and which provide alternatives to acute hospital admission and enable earlier discharge of patients to community settings.

9.4 Community and mental health providers will continue to ensure that mental health services are appropriately integrated with physical health community services, ensuring that frail elderly people and those with long term conditions receive care that meets their mental as well as physical health needs.

Impact on primary care

9.5 As we focus on the development of much more integrated out of hospital care, General Practices will be increasingly involved in the provision of extended primary care and community services ('Primary Care Plus') in order to make a step change in the care the system provides for frail elderly people, those with long term conditions and those in need of planned care services.

9.6 The sustainability plan envisages primary and community care staff working together to meet the needs of the population they serve, and we will identify approaches which ensure primary care clinicians involved in supporting patients in the community over and above existing GMS contracts are appropriately remunerated.

9.7 In order for this model to operate effectively for the system and for patients, and for providers to align across pathways effectively, GPs will increasingly be finding ways to work together beyond individual practices. This will be necessary in order that GPs can consistently provider high quality 'super GMS' activities across extended working days. This 'federation' of primary care is a key enabler to the development of the new 'wrap around' or 'primary care plus' models of integrated care envisaged in the transformation of services in Portsmouth & SE Hampshire. Commissioners will seek to encourage and incentivise the development of such models.

10 Key risks and mitigating action

Key Risks	Mitigation
1. Creation of 3 CCGs increases potential for disconnected system commissioning	▪ Single commissioning support team established serving the 3 CCGs ▪ Single committee established to support single strategic interface with provides ▪ Single approach to planning and performance adopted across the three CCGs
2. Contractual arrangements between commissioners and providers create perverse incentives and don't support collaborative working	▪ CQUIN being used to drive collaborative behaviour ▪ Contractual arrangements being redesigned and simplified so that the success of individual organisations depends on the success of the system ▪ Formal procurement process for frail elderly and LTC, and MSK pathways
3. Insufficient trust between clinicians and organisations across the system results in behaviours which prevent effective integration and joint working	▪ Investment in leadership and approaches to drive desired behaviours ▪ Investment in partnership building activities to increase trust in the system ▪ Partnership working with LAs on 'complimentary commissioning' ▪ Greater system collaboration in the design and delivery of QIPP schemes ▪ Providers and commissioners jointly designing frail elderly pathway
4. The system fails to identify sufficiently significant levels of redesign and efficiency to close the financial gap	▪ Agreement across the system to the key actions to be taken ▪ Task and finish group established to develop and monitor delivery of closing the gap ▪ Overall programme delivery being managed through Hampshire Commissioning Group
5. Agreed schemes within the sustainability programme don't deliver the planned activity reductions and/or financial savings	▪ Higher levels of collaboration in the design and delivery of individual schemes ▪ CQUIN and contracts used to ensure greater integration and collaboration ▪ Schemes include detailed milestones and KPIs ▪ Local committees in place across the system to monitor performance ▪ Greater ownership in primary care of challenge through CCG leadership, LES & QOF
6. The sustainability programme has unintended consequences on the system eg. on the viability of providers	▪ Commissioners financial planning assumptions broadly aligned with those being used by PHT in FT application ▪ Sustainability plan and key workstreams being developed and managed with providers

Appendices:

Appendix A – Unscheduled Care delivery plan

Appendix B – Planned Care delivery plan

Appendix C – Estates rationalisation implementation plan

Appendix D – System level indicators and reports used to monitor performance