



Emsworth's Healthcare Futures: A Discussion Document.

The Emsworth Neighbourhood Forum: Healthcare Group.

Introduction and Purpose:

Emsworth Neighborhood Forum (ENF)¹ together with its partnering community organizations² believes that the long overdue replacement of the Emsworth Medical Practice (EMP) building provides a unique opportunity to get primary and community based health services right for the future.

In this sense we do not think the issues are just about the lynchpin replacement Surgery building (important though this is). It is much more about systemic change and the redesign of a 'joined up' 21st century primary and community care service that will address the population-driven demand challenges (predominantly ageing and disease group changes) over the future short, mid and long term.

For over ten years Emsworth has patiently waited while services have diminished and faltering proposals to replace the EMP Surgery and reuse the community sensitive Victoria Cottage Hospital (VCH) site have come and gone. Despite public commitments the local NHS comprising – the commissioners of services - now S.E. Hampshire Clinical Commissioning Group (SEHCCG) and, the main GP provider of service - Emsworth Medical Practice (EMP), and Southern Health – Community services providers have not published (to our knowledge) any specific funded action plans for developing local services.

SEHCCG published their ambitious Five Year Strategy in 2014/15.

However, it appears to be more aspirational than practical. In line with NHS received wisdom it commits to rebalance the secondary hospital and primary care continuum emphasizing the development of local community and near home provided services by 2020 which will have major implications for the EMP. At the time of writing and with under 2.5 years to go (i.e. half way through the Strategy period) – regrettably - nothing much has happened on the ground – possibly because there were never any funded action plans.

Throughout 2015-2016 SEHCCG have stated publically that plans for a c£4.5m purpose built surgery (an NHS funded capital development on the EVCH site) are in an advanced state - but alas - ENF have heard nothing more. We are told that the required business agreement with the existing EMP has not been concluded (GP's are independent contractors to the NHS). These arrangements are commercial in confidence and therefore not ENF's concern other than to say we are aware of the potential for conflict of interest between business and local health care needs). ENF had hoped that the much anticipated publication in 2017 of the wider health economy's integrated Sustainability and Transformation Plans (STPs) would update this situation and provide opportunity for the promised public engagement. However, the STPs are essentially the same in terms of objectives and direction, but unfortunately have not yet been accompanied by the publication of any local implementation plans.

Nature abhors a vacuum and ENF commissioned this discussion document to focus community views on the potential future shape of primary and community based healthcare in Emsworth. It is designed to stimulate a conversation between 'stakeholders'. The worst of all worlds would be to miss this opportunity to radically reshape primary and community services (notwithstanding that this will necessitate flexible implementation - as resources permit).

Emsworth Surgery. (EMP).



Victoria Cottage Hospital



¹ The Emsworth Neighbourhood Forum (ENF) is an approved Neighbourhood Forum under the Localism Act 2011. It brings together local residents, businesses and organisations to create a Neighbourhood Plan for the future development of Emsworth. The Forum aims to promote the social, economic and environmental well being of the Emsworth neighbourhood. The Emsworth Business Association: The Emsworth Residents Association; The Friends of Victoria Cottage Hospital; The Community Association, etc.

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At the outset ENF wishes to make it clear that though the conversation may prove challenging our views are not intended to be confrontational or critical. ENF members have the highest regard for the EMP GPs commitment. Neither are we under any illusions as to the difficult job SEHCCG does in balancing competing priorities given the exceptionally difficult NHS financial climate.

However, ENF believes that the days of paternalistic NHS 'top down' planning (where bureaucracy and the professions know best) are gone. We therefore reject the notion that any 'engagement' with stakeholders risks criticism, delay or even cancellation. More so we believe that inputting responsible, constructive, informed professional and local opinion will strengthen the planning and encourage innovation.

The greatest enemy is poverty of ambition. What we are looking for - and have not seen yet - is a 'can do attitude' and real commitment to the primary / community care service of the future and not the past. After all SEHCCG's 2014-15 Strategy states....*"...Putting patient voices at the heart of decision-making..."*. This, is therefore not a 'one off' intervention but part of an ongoing campaign for better and futuristic local health services.

Summary Main Points:

The NHS's proposals to replace the EMP building present a unique opportunity, which cannot be missed. Namely, to act as a catalyst to plan a 21st century local health services of the future - one that integrates primary, community, local specialist and social care services. ENF want to see an approach, which is about a 'joined up' service not an isolated plan for a building replacement.



SEHCCG 5 Year Forward Look Strategy (to 2019/20) nails its colours to the mast – that it must rebalance and redesign local health economies in order to address the inexorable pressures for change within the next ten years plus. More so, that it must engage with local community stakeholders. However, as yet it has not said how.

The pressures for change are national with a strong local impact. They center on local housing development, which will increase population by up to c73% by the 2030s.

Demand will increase not just proportionately but exponentially given the high level of elderly in our population with a predominance of (multiple) long-term conditions and with higher quality performance expectations. Moreover, the NHS policy proposals on hospital earlier discharge, admission avoidance and substitution in care location could generate a further wave of demand to be met by primary care. Local primary care capacity cannot contain this it needs to develop new locally led services (e.g. intermediate care / COE) which will requires significant investment. This major change requires commitment and therefore engagement between stakeholders.

What Emsworth Wants From Primary Care:		Short Term 2016 - 21	Mid Term 2021 - 2026.	Long-Long Term 2026 - 2036.
20 Strategic Objectives / Aspirations:				
Improving Existing Core GP Services:		✓	✓	✓
1.	Development of a More Responsive Urgent Care & Same Day Service.	✓	✓	✓
2.	Development of a Fully Integrated Local Out of Hours Service (OoHS).		✓	✓
3.	Development of Better Access to Personalised Routine Care (Named GP).	✓	✓	✓
4.	Development of Case Management Approaches & Targeted Care.		✓	✓
5.	Development of Nurse at al Practitioner Led (general & specialist) Services.	✓	✓	✓
6.	Development of an Extended Role for Pharmacy and Pharmacist Practitioner.	✓	✓	✓
New Integrated Local Specialist Services (Non - Core):			✓	✓
7.	Development of a Specialist Local Care of the Elderly Services.		✓	✓
8.	Development of a Specialist Local Diabetic Service.		✓	✓
9.	Development of a Specialist Local Women's' & Children's' Service.		✓	✓
10.	Development of a Specialist Local Cardio-Respiratory Service.		✓	✓
11.	Development of a Specialist Local (Pro-Active) Cancer Care Services.		✓	✓
12.	Development of a Specialist Local Neuro-Degenerative Care Services.		✓	✓
13.	Development of Healthy Living / Wellbeing Services.		✓	✓
14.	Develop of Local Musculo Skeletal and Rehabilitation Services.		✓	✓
15.	Integration of Local Mental Health Services with Primary Care.		✓	✓
New Primary Care Infrastructure in a new future-proofed phased Building:			✓	✓
16.	Development of a local Fast Turnaround Diagnostic Service.		✓	✓
17.	Development of Local Minimally Invasive Diagnostic & Treatment Service.		✓	✓
18.	Development of Joint Services with Social Care and Nursing Homes.	✓	✓	✓
19.	A Makeover of ICT & Business Management Infrastructure.	✓	✓	✓
20.	Healthcare Related Practitioners and Retail – Possible joint Ventures.		✓	✓



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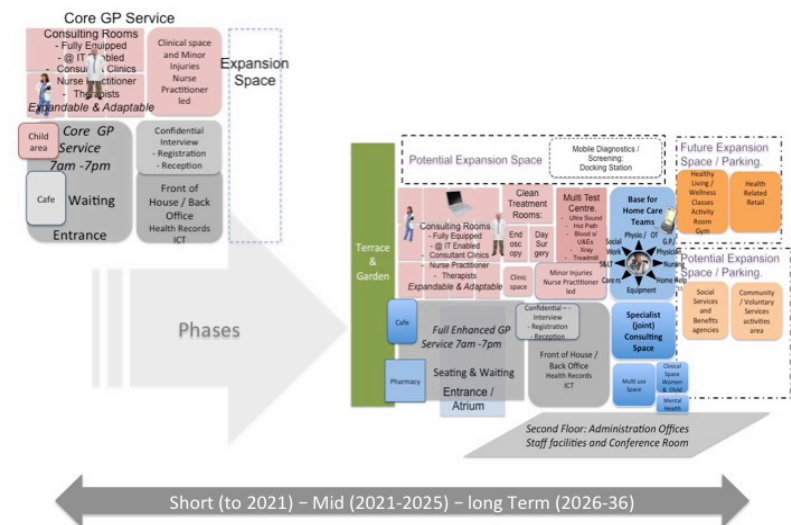
ENF have put on the table 20 objectives – a 20 point plan - for a future primary care that will grow an integrated local health and social care services, which will address the pressures for change. They are not immutable but debatable.

We are well aware of the unprecedented financial pressure on the NHS but do not believe that poverty of ambition should stifle debate. By examining the possibilities and looking at a 10-20 year short, mid, long and long/long term these objectives can become affordable as well as inevitable. As the pressures are unstoppable - ignoring them will ensure a steady melt down in local care provision.

The 20 objectives can be 'sliced and diced' and combined with different building solutions and timescales to generate a wide array of options which illustrate what the future could look like. We can learn something from this modeling. Four options are presented in order to stimulate debate:

1. **A Do Minimum – Replacement of a GP Services Building Only.** A short-term fix – it would deliver major improvements to core GP services only and thus deliver less than half of the 20 objectives. This would soon become outdated and prove more expensive to adapt. However, it could represent a transition to the long term.
2. **Major Primary Care Centre (On One Site – e.g. EVCH).** A long-term solution built in one or two phases. Initially more expensive but less so overall and far less disruptive than multi phased solutions. It also delivers benefits quickly meeting all objectives, which address all the pressures for change with flexibility.
3. **Main Site (VCH or other) Plus Satellite Site.** A primary care centre (EVCH) delivering core and non-core services in two phases quickly. And a satellite core GP service in North Emsworth delivered at a later (long term) phase. As a multi phased and multi site option this would be more expensive overall as well as disruptive. It delivers benefits in phases eventually meeting all objectives. A slower spend rate may be more affordable but it will be more expensive in the long term. However, the option is flexible.
4. **Two Equal Main Sites as Primary Care Centres.** This option is duplicatory involving two half sized practices (c8,500 – 10,000 patients each) and as such would be very expensive in capital and revenue terms. It lacks economies of scale. It delivers benefits at a good pace, meets all objectives and is not too disruptive. One possible variant would be to adapt the Oak Park Community Care Centre if capacity exists as it would be near the area of population expansion in the long/long term. The option is thus highly flexible.

Illustrative Options – From Replacement Surgery to a 21Century Local Care.



A spectrum of options which deliver objectives exist - from 'minimum' to 'maximum' solutions. The options could be approached in an 'evolutionary' or 'revolutionary' way. Option 1 'do minimum' (modernizing GP services only) could be the first phase of Option 2 'do maximum' a big bang approach going quickly to a one site fully integrated primary care centre. The options have different cost and benefit dimensions. They expose the basic dilemma between: the 'evolutionary approach' - i.e. more phases equates to slower benefits delivery, higher capital and revenue costs overall and more disruption; and, the 'revolutionary approach' - i.e. one / two phase equates to the opposite of this and delivers benefits more quickly at initial higher cost but with less disruption.

The illustrative options driven by the 20 objectives (which in turn address the pressures for change analysis - particularly population driven demand) are provided to stimulate debate. One thing is clear (locally as much as nationally) and that is that the current systems cannot deliver the type of NHS, which



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the public demands. Not only does demand have to be met somewhere – in hospitals or the community (and if in the community on one or more site) - but service performance and quality have to be addressed simultaneously. What's right will be what is right locally.

We cannot duck these issues by dismissing the analysis as speculative or the objectives and options as a wish list that is ridiculously unaffordable. What is needed is a can do positive attitude - real commitment and leadership - to take this conversation to the next level of meaningful engagement and specific project planning.

Context:

Scope: What do We Mean By Primary Care Services: For the purposes of this report we are defining primary care services as:

1. Core GP services. Physician led family based services – the first point of contact with the majority of the public (c330m contacts p.a. as opposed to c23m hospital contacts p.a.).
2. Non-Core and new specialist services provided locally involving GP coordinated shared care with hospital consultants and allied professions practitioners. And, an expanded repertoire of healthcare preventative, educative, diagnostic, treatment and specialist care services.
3. These services are provided on an emergency, urgent and elective ambulatory and home care basis-necessitating liaison with many other government and voluntary agencies.
4. GPs are private not public organisations that contract with the NHS and work in very close partnership with it. They are funded on a per capita (list size / population) and item of service based national formula and through locally commissioned services. (There are major issues about the level of funding needed to keep pace with demand). Capital funding is often by GPs themselves owning the assets of their practices or NHS funded – mainly through NHS Prop Co - either directly or by private financed schemes – relying on commercial lease terms agreed by the NHS with GPs.

Approaches:

In the following analysis 'Emsworth' is defined geographically as:

1. Emsworth Ward of Havant Borough Council (HBC) also used as the basis for ONS population statistics.
- And,
2. Emsworth Medical Practice (EMP) catchment, which is wider than the Ward covering parts of Westbourne, Southbourne and Rowlands Castle, et al.

This causes some methodological problems in data comparison but our approaches allow for where there is likely to be overlaps with neighboring GP services (either in and out flows from these catchments or use of potential other local GP capacity), which could figure in considering future solutions for Emsworth residents

In general ENF does not have the resources or access to technical data to research and 'micro' plan in detail. However the 'macro' information in the public domain is sufficient for our purposes. It paints a clear picture of the challenges facing the local health economy in general and primary and community care services in particular.

Components of the Integrated 21st Century Primary & Community Care Services.





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The potential solutions emerging from the evidence are not immutable but illustrative. They enable us to ask a number of 'what if' questions and offer some informed answers (based on what other NHS primary care services are considering) and also to articulate local opinion. We believe this is a valuable contribution, which will evolve as more detail becomes available and as the conversation moves on.

Emsworth Neighbourhood Forum (ENF) Role:

The Forums legitimacy stems from the Government's intention to give a greater voice to communities under the Localism and Communities Act 2011. ENF has specific planning powers to expedite projects (further planning powers are pending) and it is responsible for developing the Neighborhood Plan, which will be subject to consultation and referendum and include healthcare. It will then form a statutory part of the Havant Borough Council Local Plan.

The Forum also surveys local opinion and stakeholder organisations - recently on what Emsworth wants from primary care and the replacement of the EMP surgery building with a unanimous response that the public wished to see an expanded primary / community care service hub at EVCH.

The Forum tried unsuccessfully to encourage dialogue with EMP and SEHCCG throughout 2016. This may be because the NHS has little tradition of planning engagement (more so 'after the event' consultation) and because ENF (which is new) and not recognized as politically important or representative of community stakeholders.

SEHCCG Five-Year Strategy (2014/15 – 2019/20):

The Strategy emphasizes the fundamental importance of investing in future better 'joined up' primary and community services with social care and hospital specialist care. It's objectives are to improve the health of the population by concentrating on the determinants of health and wellbeing; educate to prevent ill health; more appropriately manage it; and, improve the effectiveness and quality of health care interventions. It therefore proposes to do this by fundamentally redesigning and rebalancing the local care model.

..... ***"In order to deliver our vision and ambitions for local people we believe we must focus on 5 core objectives.***

- Work with local people and their communities to prevent the causes of ill health, support healthy lifestyles, reduce health inequalities and to give children the best start in life.***
- Integrate primary care, community care, social care and voluntary services to deliver a range of care, close to home that allows people with complex needs and the most vulnerable to stay healthy and feel in control of their health.***
- Ensure a range of easily accessed and responsive urgent and emergency care to support people in a crisis.***
- Commission consistently high quality planned care services that work with patients to deliver the best outcomes possible.***
- Patients using local health services will experience reduced variation in treatment and care standards; they will notice increasing consistency in the quality of services across all care providers."***

ENF believes that the Strategy is good on 'What' but poor on 'How'. There is no mention of the replacement of the EMP Surgery (or any other local primary care services). Meanwhile, the Victoria Cottage Hospital building deteriorates and EMP manages in inadequate facilities. SEHCCG's position is concerning as it has been stated that the replacement of the Surgery is - just that - a minimal cost building replacement. We don't see how this squares with their Strategy.





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Emsworth Medical Practice: What's Right or Wrong with the Current Service? *(Please refer to Appendix 1: Profile of EMP).*

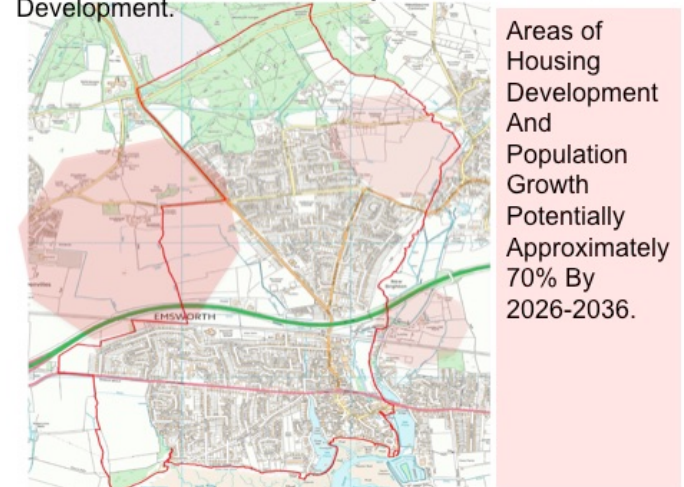
As stated, Emsworth residents hold the current GP service high regard. It is therefore important to acknowledge the achievements of EMP:

- Achieves 'good' CQC inspection score for all domains – 2nd highest group.
- Treats record numbers of patients (EMP is a large practice).
- Achieves above average UK health outcomes – most disease groups.
- Is top scoring in the QOF for treatment / diagnosis / referral rates.
- High patient satisfaction rates.
- Great commitment to patient care and teamwork.
- Is coping with growing demand pressure of the high proportion of the elderly in the population (often with multiple LTCs).

However, the current service faces the following challenges:

- Premises are not fit for purpose / don't meet future clinical and privacy / confidentiality standards e.g. reception / interview and disabled facilities.
- High performance is hard to maintain e.g. the time it takes to get named GP appointments is slipping.
- There are GP vacancies and difficulties in recruiting (even though the area is desirable).
- List sizes are growing adding pressure - potentially reducing patient consultation time.
- There is an unmet / unfunded need for a greater range of locally provided specialist services e.g. Diabetes - joint GP / consultant clinics.
- 'Intermediate care' admission avoidance and early discharge services for the elderly is under developed / minimal – e.g. elderly care home visits.
- Inability to move to extended opening hours at present resource levels.
- A less personal (and not well liked) out of hours deputizing services and reliance on a remote 111 service.
- Limited diagnostic capabilities and sub optimal turn around times.
- Limited ICT whereas the potential is vast e.g. paper systems still predominate; no patient / GP email communication. EMP ICT is old and not joined up to hospital and social care systems, et al.
- Funding restrictions and pressures, which prevent the funding of new non-core, services e.g. healthy living, rehabilitation services, etc.
- Inability to respond to growing population changes, which will be driven by known housing developments and could possibly nearly double the size of the practice.

The EMP Catchment Area & HBC Planned Housing Development.



Emsworth Medical Practice (EMP): Key Facts: 2016. (Source NHS Eng).

Emsworth Surgery: Registered Persons	13,082
NHS South Eastern Hampshire CCG	8,432 (average)
England	7,324 (average)
EMP Quality Outcome Framework. Score	545.4 (out of 559)
Male / Female life expectancy	80.7 years / 84.2 years
Services – general medical / some diagnostics	No specialist services
% of patients that would recommend EMP	88.0%
Appointment routine / same day satisfaction	87% / 40% falling
Deprivation Score:	Lower Decile / 10%
Ethnicity Estimate:	1.1% mixed, 1.1% Asian
No. GPs	8 (3 P/T 5 F/T). ? Vacancies
Practice Nurses	4 / 2 Practitioners
Community Home Care Team. Southern Health	Shared Area team



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Where Are we Now? And What's Changing?

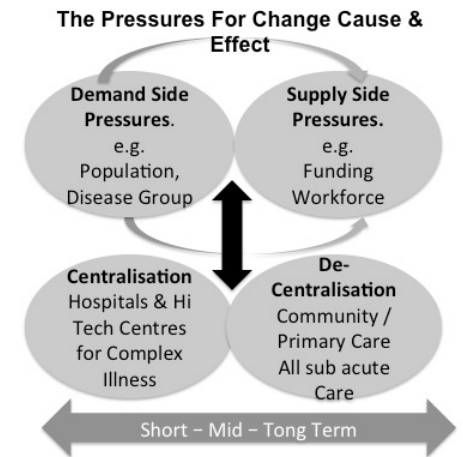
The Pressures for Change:

Health care demand is growing at a rate beyond the ability of the NHS to meet it. The insatiable 'demand side' pressures is driven mainly by population growth, longevity, lifestyle determined illness, clinical technological advances and above all public expectation and consumerism. It is limited by the 'supply side' pressures such as availability of a suitably skilled workforce, training of the future workforce, hospital sector capacity and the government funding both revenue and capital.

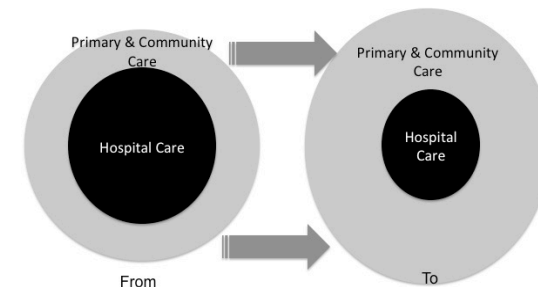
Clinical technological and ICT changes are disruptive technologies and increasingly are enabling a fundamental rebalancing of the currently silo'd and polarized healthcare system which is skewed towards hospitals and secondary care. People can now often be treated in a clinically more appropriate way and possibly in a less expensive way – at home and in their communities – especially those with long term conditions requiring periodic or continuing care and support. Encouraging a healthy population, preventing illness and treating ill health at an early stage close to people's homes will ultimately reduce pressure on expensive hospital resources which should in turn focus on the growing demand for high-tech interventions for injury and complex illness.

Over the last fifteen years demand for emergency hospital services has been rising by between 3%-4%pa for the last 20 years or so and elective services by between 1-2%pa. A/E attendances have been growing by 5% pa. And, primary care growing by between 2%-5% pa (compounded). SEHCCG acknowledge this in their Strategy.....

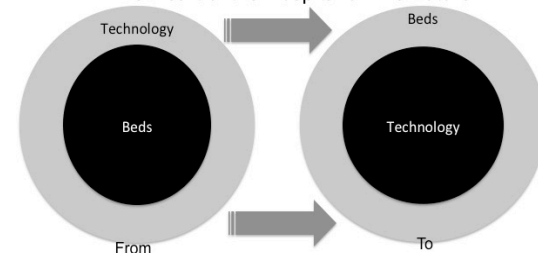
- "...We know that across the country there is likely to be an increase in the number of people needing help with complex health problems in the years ahead, creating a need for a range of integrated support away from traditional hospital settings.....
- The number of people with more than one long-term condition is estimated to rise nationally by three million to 18 million patients by 2025. This will account for at least half of all GP appointments. Locally we also know that we have an ageing population and expect to see a rise of 10% in the number of people aged over 75 in our area by 2019.....
- Additionally there will be a 31% increase in the number of people over the age of 85 in ten years' time and it is estimated that 57% of those over 85 years of age are in contact with a district nurse. These people with complex health needs currently account for 70% of the overall health and social care spend. They are proportionally higher users of health services representing 60% of outpatients and Emergency Department attendances and 70% of inpatient bed Use.
- More than half of hospital inpatient beds are occupied by 10% of patients who stay in hospital for more than two weeks and three out of every five admissions are for patients who have been admitted before within the previous 12 months. These older, more complex patients with co-morbidities and their carers have told us that they often experience disjointed, poorly coordinated care."



The Changing Health Care Model



The Changing Role of Hospitals
The Heart of the Hospital of The Future





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NHS expenditure (c£120bn budget) has not kept pace with demand. The Government's pledged additional +£8 to +£10bn by 2020 (which maybe as low as +£4bn) is no real rise when taking out £20-22m (Landsley / Hunt) savings. Also over the last eight years 'austerity' has eaten into social care budgets the total expenditure on which has fallen. This has had a serious knock on effect to health services and is manifest in delayed discharges and bed crises.

These unprecedented pressure for change have two major effects. They are polarizing care centralizing high tech complex illness and decentralizing care for many more lower acuity conditions best treated outside of Hospitals.

The changes needed to cope with this increasing demand and polarisation involve rebalancing as well as integrating the hospital – primary care model. It has been NHS policy - for nearly 30 years - to develop enhanced primary and community care services. But in reality successive governments and the NHS has found it very difficult to free resources from the secondary sector or to fund new investment necessary to achieve integrated community care. The belief is that it can happen in an evolutionary self-funding way without up-front investment. This has proved completely fallacious.

Primary care is thus under extreme pressure because of both demand increases and the lack of any funded national strategy and effective planned investment. However, we can expect a renewed effort to reduce hospital demand and focus on primary care with the recent Government initiative requiring health economies to produce Sustainability and Transformation Plans - as there is no other choice.

Demand Side Pressures:

How will these influences play out locally? Forecasting what will change in the future requires a systematic examination of the pressure for change that will impact on the NHS and Emsworth health services in particular. Our start point focuses on the impact of population and disease group changes on potential demand for EMPs services over the short, medium and long term. We do this by scaling up patient demand figures on the changes in population, which can be further adjusted for the various pressures for change factors (Please refer to Figure ?). We thus arrive at some forecasting scenarios that provide a good view of what is likely to happen and in what timescale.

Population Changes:

- There will be significant population growth largely driven by housing development which could result of c+36% by 2026 and c+73% rise in by 2036. This is largely driven by new housing development within the EMP catchment.
- Havant Borough Council's (HBC) Housing Statement forecasts 2,500 houses will be built by 2036 of which 1,600 will be between Denville's and North Emsworth, bounded by Southleigh Rd.

Emsworth's Potential Population Increases Scenarios. (Consequent Impact on Healthcare Demand).

Scenarios (Estimated) Population Increases.	Baseline 2015. (SAPF Based).	Scenario A Short Term 2016-21. (6 Years).	% Population Increase And % Proportion Includes SPAF to 2021.	Scenario B Mid Term 2021-26. (10 Years).	% Population Increase And % Proportion	Scenario C Long Term. 2026-2031. (20 Years).	% Population Increase And % Proportion	Scenario D Long / Long Term. 2031-2036. (20 Years).	% Population Increase And % Proportion
(See Assumptions).		+25% of New Housing (+1,875).		+50% of New Housing. (+3,750).		+75% of New Housing. (+5,625)		+100% of New Housing. (+7,500)	
Total Ward Population. (Increases in total)	10,339	12,214 (+1,875)	+25%	14,089 (+3,750)	+50%	15,964 (+5,625)	+75%	17,838 (+7,500)	+100%
Young (>20 Years). (Increases in Proportion).	1,964 (18.9%)	2,199 (+244)	= 20%	2,956 (+995)	= 21%	3,512 (+1,548)	= 22%	4,103 (+2,139)	=23%
Elderly (> 65 Years). (Decreases in Proportion).	3,108 (30%)	3,664 (+556)	= 30%	4,086 (+978)	= 29%	4,470 (+1,362)	= 28%	4,816 (+1,708)	-27%

Assumptions and Notes:

- 1) Baseline SAPF: Total population forecasts increase of +5% or +536 by 2021. But SAPF is a Pre HBC Housing Development Statement
- 2) HBC Housing Statement: Allocates 2,500 new dwellings at Emsworth by 2036. An Increase of 52% over 2011, 4,794. (Pre HBC Housing Statement SAPF forecast 5,038 by 2021).
- 3) Assume 3 x persons per dwelling. Therefore additional 7,500 population. (Please note: It is possible to model differences assumptions of number of persons per see Table?).
- 4) Total Population (Emsworth Ward): Increase is c17,838 by 2036 or c72.5% post housing development by 2036.
- 5) The population rate of change is therefore 3.75% per year.
- 6) Young age group: Population rises to 23% of total (SAPF assumption) as development zone focuses on family houses. (Other scenarios can be modeled).
- 7) Elderly age group: Currently represents c30% of the population possibly reducing to c27%, but unlikely to reduce demand on health and social care (given disproportional impact).
- 8) Short Term: (5 years to 2021): +25% of forecast population growth (1,875).
- 9) Mid Term: (10 years to 2026): +50% of forecast population growth (3,750)
- 10) Long Term: (15 years to 2036): +75% of forecast population growth (5,625).
- 11) Long / Long term: (20 years to 2036): +100% of forecast population growth (7,500).
- 12) The full impact could occur earlier and the total could change upwards over the long term – it being difficult to plan this far out with certainty.
- 13) Further Scenarios of new population / housing developments orientating to EMP or away from it can be modeled in total and in timing terms.



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- For modeling purposes it is assumed there could be 3 persons per household indicating c7,500 additional population or c73% increase on the 2015/16 10,339 Population.
- The Elderly (65+ years) comprise c30% of the population and the Young (under 20 years) c20%. These proportions +/- a few % points will endure into the mid to long term. The much higher than UK average elderly population will generate much more pressure.
- There is a potential for a large margin of error in forecasting 20 years ahead (2016 to 2036) therefore 3 scenarios have been modeled ranging through 100%, 70% and 50% of the total anticipated population increases. This allows for assumptions that could see part of the increased population orientating to neighbouring GPs. From minimum to maximum this could result in a wide range from +9% to +73%. However, we can be reasonably sure that the population increase forecast in the long term is probably a minimal. More could follow given the National Planning Policy Framework (NPPF) pressures on local authorities to meet rising targets for housing development. The baseline modeled uses the impact of 100% of the increase being met locally by EMT in order to illustrate the maximum effect. The options illustrated in the following section demonstrates the effect of applying the full range of population scenarios..

Disease Group Changes:

- Age determines the prevalence of most of the major disease groups known as long term conditions (LTCs) whereby the longer we live the more we live with one or more of these LTCs. These account for 2/3 of NHS expenditure. Diabetes alone is estimated to account for c15% of NHS expenditure and is growing. Advances in clinical technology are enabling us to manage LTCs. The key is to add healthy living to these extra years by managing illness effectively and improving independence in community / home settings.
- Given the elderly make up 30% of the population EMPs will see many more LTCs (than average practices) such as coronary heart disease (CHD); cardio vascular disease (CVD); strokes / TIAs; most major cancers; musculo skeletal (MSK) – arthritis and joint replacement and mental health / dementia. At the same time, EMP will see more life style diseases such as obesity-induced diabetes. This will be more resource intensive – putting added pressure on local services.

Impact of Demand:

- Assumptions have to be made about both volume and timing of housing developments and it's impact on population and therefore on healthcare demand. For modeling purposes we have assumed a smooth trajectory of increased population driven demand over the short to long term (up to 2036). In reality the

'What If' Demand Forecasts Based on Scenario A (100% of increase in population treated by EMP): Increases in Specific Disease Group Demand. (Based on 5 Year Trends Projected in Proportion to Population Increases).					
Key Long Term Conditions. Disease Groups. Comprising 44% of EMP Patients	2016 – 2021 Short Term	2021 - 2026 Mid Term	2026 - 2031 Long Term	2031 - 2036 Long / Long Term	Comment
Emsworth Baselines: * Population Changes % * Population 2016 is 10,339. * EMP Patients c13,100.	+18% 12,214 15,458	+36% 14,089 17,816	+54% 15,964 20,174	+73% 17,838 22,663	Increase +7,500 or +73% of Emsworth 2015 population. Proportions = Elderly 30% – 28%. Young 19% - 23%. Basic forecast assumes all increases orientate to EMP. Other assumptions model patient outflows to other GPs.
All Cancers EMP % Prevalence: * 2015 = 3.6% (472 of patients) * 2010 = 2.4%	4.8% (+742)	6.0% (+1,064)	7.2% (+1,348)	8.4% (+1,904)	Prevalence rates preceding 5 years rose and were above SEHCCG 2.8% and England average of 2.3%. Growing rates and numbers as same large proportion of elderly in a growing population.
Coronary Heart Disease: EMP % Prevalence: * 2015 = 5.0% (655 of patients) * 2010 = 5.0%	5.0% (774)	5.0% (886)	5.0% (936)	5.0% (1,133)	Prevalence rates preceding 5 years were stable but above SEHCCG 3.7% and England average of 3.2%. Same rates, same large proportion of elderly in a growing population therefore numbers grow.
Heart Failure: EMP % Prevalence: * 2015 = 0.8% (105) * 2010 = 0.8%	0.8% (+124)	0.8% (+142)	0.8% (+150)	0.8% (+181)	Prevalence rates preceding 5 years were stable but above SEHCCG 0.7% and England average of 0.7%. Same rates, but growing numbers as same large proportion of elderly in a growing population.
Diabetes: EMP % Prevalence: * 2015 = 5.5% (721 of patients) * 2010 = 5.2%	5.8% (897)	6.5% (1,099)	9.6% (1,152)	12.7% (2,878)	Prevalence rates preceding 5 years below SEHCCG 5.6% and England average of 6.4%. Growing rates & numbers as same large proportion of elderly in a growing population.
COPD: EMP % Prevalence: * 2015 = 1.8% (236) * 2010 = 1.5%	2.1% (325)	2.4% (425)	2.7% (506)	3.0% (680)	Prevalence rates preceding 5 years below SEHCCG 2.0% and same as England average of 1.8%. Growing rates & numbers as same large proportion of elderly in a growing population.
Musculo Skeletal Arthritis: EMP % Prevalence: * 2015 = 13.3% (1,742) * 2010 = 13.0%	13.6% (2,102)	13.9% (2,464)	14.2% (2,659)	14.5% (3,286)	Prevalence rates preceding 5 years slightly below SEHCCG 13.9% and equates to England average of 13.2%. Growing rates and numbers as same large proportion of elderly in a growing population.
Stroke: EMP % Prevalence: * 2015 = 2.7% (354) * 2010 = 2.6%	2.8% (433)	2.9% (514)	3.0% (562)	3.1% (703)	Prevalence rates preceding 5 years above SEHCCG 1.9% and England average of 1.7%. Growing rates and numbers as same large proportion of elderly in a growing population.
Mental Health: EMP % Prevalence: * 2015 = 0.6% (786) * 2010 = 0.8%	0.6% (927)	0.6% (1,064)	0.6% (1,124)	0.6% (1,360)	Prevalence rates preceding 5 years were stable but below SEHCCG 0.7% and England average of 0.6%. Same rates, growing numbers as same large proportion of elderly in a growing population.
Dementia: EMP % Prevalence: * 2015 = 1.5% (197) * 2010 = 0.9%	2.1% (325)	2.7% (479)	3.0% (562)	3.3% (748)	Prevalence rates preceding 5 years above SEHCCG 0.7% and England average of 0.7%. Growing rates and numbers as same large proportion of elderly in a growing population.
Alzheimers: EMP % Prevalence: * 2015 = 3.3% (432) * 2010 = NA%	3.3% (510)	3.3% (585)	3.3% (618)	3.3% (748)	Prevalence rates preceding N/ but A 5 years above SEHCCG 1.0% and England average of 1.0%. Significantly growing rates and numbers as same proportion large of elderly in a growing population.



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unknown pace of approval and building may challenge this trajectory and planning needs to be flexible to cope with this.

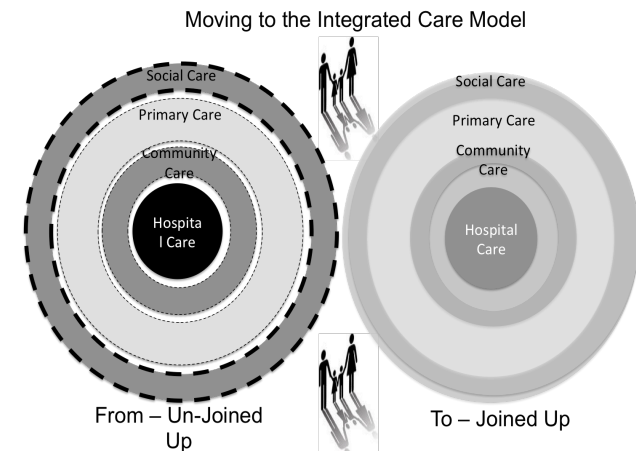
- Demand could therefore rise by the following: Short Term by 18%; Mid Term by 36%; Long Term by 54% and Long / Long term by 73 %.
- Demand will grow because of population increases and growing (disease group) prevalence rates (please see historical trends in Appendix 2).
- Demand will also become more complex and demanding and therefore resource intensive given the high proportion of the Elderly and the prevalence of one or more of the major long term conditions in this age group e.g. cancers, cardio respiratory and neuro-degenerative diseases.
- The 18% to +73% is population driven indigenous demand and would have to be accommodated by EMP or other local GP services (new or existing) or both. Where and how this demand is accommodated and in what timescale will generate different scenarios ranging from increases in EMP demand (based on population growth) of between +9% to +73% depending on whether there are one or two GP Practices (and sites) which are covered in the next section on Options.
- The NHS Policy of substituting up to c30% of hospital patients (bed days) into home / primary care services has not been added to the inexorable population demand growth and would need to be added. Hence the objectives relating to new non core and local specialist and generalist services e.g. GP led Intermediate care services allowed for in the design solutions and illustrative options. The full effect of this 'new demand' is unknown but it will be severe. It therefore must be allowed for as a contingency. Meaning any design solution must have built in flexibility.
- As 1,600 or 64% of the new housing will be in North Emsworth part of the population increase it could orientate to Havant GP's (or not). Hence flexible solutions are required for the development rather than simple replacement of existing EMP services and facilities. What is obvious is that demand, policy and public expectation dictate that there cannot be a simple like for like replacement of the old EMP service and building as this would be completely inadequate in volume and scope of services terms.
- Demand will therefore rise both for hospital care (emergency and elective) as well as primary care.

Conclusions: The Case for Change in Emsworth.

Despite the many uncertainties is certain that demand for primary and community (as well as secondary) care will grow significantly in Emsworth up to 2036.

- Current primary care services (c13,100 list size) are challenged and pressured. This is not an accusation of failure - on the contrary EMPs GP services have consistently risen to the demand pressure – but there are limits. The situation must worsen as the pressures grow over the short, mid and long term.
- The forecasts scenarios of population driven demand growth range from +18% in the short term to +73% (22,663) in the long term. It is open to conjecture what proportion of this increase will be met by one or more GP Practice and sites – therefore options will be modeled which speculate

Table 1: Scenarios (Estimated) Population based Demand Increases. Source: NHS England QOF, SAPF/ONS	2015. SAPF Baseline EMP Registered Patients	Short Term Demand 2016-21. +25% of Population Increase	Mid Term Demand 2021-26. +50% of Population Increase	Long Term Demand 2026-2031. +75% of Population Increase	Long / Long Term Demand 2031-2036. +100% of Population Increase	Comment: Assumptions. All Scenarios assume 'steady state'. Emsworth outflows to other GPs. And. Non Emsworth Ward inflows to EMP remain at same levels.
Total Population Change.	10,339	12,214 +18%	14,089 +36%	15,964 +54%	17,838 +73%	Growth in line with Housing Plans assumes 3 persons per new house +7,500.
Scenario A: 100% of Demand from all New Population to EMP.	13,100	15,458 (+2,358) (+18%)	17,727 (+4,716) (+36%)	18,725 (+7,074) (+54%)	22,663 (+9,563) (+73%)	100% population growth generated demand orientates to EMP.
Scenario B: 70% of Demand from New Population to EMP.	13,100	14,705 (+1,605) (+12.6%)	16,310 (+2,310) (+24.5%)	17,914 (+4,814) (+36.8%)	19,519 (+6,419) (+49%)	Assumes 50% of 1,600 houses at Southleigh Rd generated demand orientate to Havant GPs. Rest to EMP.
Scenario C: 50% of Demand from New Population to EMP.	13,100	14,279 (+1,179) (+9%)	15,458 (+2,358) (+18%)	16,637 (+3,537) (+27%)	17,817 (+4,716) (+36%)	Possible Expansion of other GP services e.g. at Oak Park site & local GPs at Rolands Castle, Southbourne & Havant expand services.
Assumptions: % Population increases applied to EMP total patient numbers generating new patient forecasts which are then modeled for 100%, 70% & 50%.						





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whether 50% or 100% is met by the existing EMP. The important fact is that 100% of the increase will need to be met - somewhere. The lower figure is probably conservative. To ensure resilience we should plan on the basis of peak rather than average demand.

- Current service utilization rates will probably rise at a greater rate than that of population growth. So if anything demand may well rise above population growth rates. This is because growth in healthcare demand will be driven by the very high proportion (c30%) of the elderly in the current and future population. This is due to their longevity and higher prevalence rates of multiple chronic conditions.
- A slight growth in the younger age group (c20% - 23%) though noted will not impact as severely as the elderly as the young are generally well. Health care pressures emanating from this age group are likely to revolve around maternity, family and child development issues and as the area is affluent this impact won't be severe.
- At the same time public expectation for higher performance and quality - better access to more services, better delivered, will impact on all services.
- Further influences which could have a positive impact on demand of: a) Technological innovations – new treatments, ICT apps, etc. And. b) Health education messages as the population take more care of their health and thereby reduce the rates of ill health and ultimately the use of services.
- The much needed and talked about reforms to the structure of healthcare namely the balance between primary and secondary care ('the elephant in the room') could see as much as 30% of current hospital demand (bed days – lesser number of cases) accommodated by primary / community and home care based services in future. The impact on primary care demand is unknown but it will be severe. This would be in addition to the population driven demand forecasts of +18% to +73% it has not been specifically modeled (*but the 100% increase in demand allotted to EMP provides some contingency to cover this*). It is doubtful that the SEHCCG's Five Year Strategy can be delivered without a fundamental redesign of the primary and community care model. This will involve investment – both capital and revenue. Specific action plans with funding commitment are needed.
- Developments in other local GP services could possibly relieve EMP of a proportion of the demand generated by Emsworth's own population growth in the long term. However, this growth will have to be met somewhere and it is unlikely that there is sufficient spare capacity in neighbouring GP practices hence there will still be a need to invest substantially.
- The development of the Oak Park Community Centre concept (between 2012/14) to provide children's, diagnostic and adult out-patients following the closure of EVCH and Havant War Memorial Hospital has not yet fulfilled it's potential as a comprehensive integrated primary and community service and is near but remote for Emsworth residents. Nevertheless further development (including primary care) could form part of the solution for North Emsworth population growth.
- An ideal opportunity presents itself with replacement of the EMP Surgery building to show what an affordable redesigned primary and community care services look like. It could be an exemplar. It could be evolutionary rather than revolutionary and thus more affordable.
- The pressures for change demand a bold response namely a flexible long term plan for an integrated health system of the future – fully 'joined-up' primary - community - secondary care with social care - based on a community / primary care hub (not a replacement GP surgery of the past).
- A leading definition of planning is'the reduction of risk and uncertainty'. Uncertainty - both financial and political – is often cited as reasons not to plan (or at best to do so minimally) and instead to devote effort to managing the short term. Unfortunately this has been common NHS practice and the absence of strategy has done it a great disservice. Arguably it has never been more important than now given the unprecedented pressures on the 'old and outdated NHS model'.



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Where Do We Want To Be?: What Could / Should Good Look Like?

Planning The New EMP Surgery: Or Should We Say Emsworth's Future Primary Care Services:

There is a wise adage used in architectural planning that 'form' (building design) must follow function (i.e. the purpose of the building). NHS capital investment planning rules (or business case methodology) reinforces this. No healthcare organization will get approval for capital expenditure without a clear plan that demonstrates how it will deliver a return on investment – in terms of - future health improvements and benefits, value for money and affordably. In other words service and 'business' strategy must lead building plans and not vice versa. (Put another way - we must get the horse before the cart!).

This may sound obvious but many examples exist of inadequate building led plans leading to expensive suboptimal NHS buildings which don't deliver and are virtually obsolete or outdated by the time they are built. Replacing outdated GP premises should spark a far wider conversation.... *what could or should Emsworth's future primary care services look like?* Unfortunately, neither EMP nor SEHCCG have published any kind of local planning or engaged with their community stakeholders in any form of debate on primary health care futures. So to ENF *The cart indeed appears to be before the horse!*

To fill this vacuum and to stimulate debate EF have put forward its views on 20 objectives and aspirations that we believe any investment in 21 century primary care (both service or building must aspire to). They do not comprise 'wish-lists' or 'special pleading' as they are based on research into what other NHS primary care services (and indeed what other western healthcare systems) are planning for either in piecemeal in the short term or in total in long term. No one organization has all the pieces in place yet – there are many NHS innovations. The following aspirations and objectives are therefore not immutable but debatable as the possibilities generated by the various combinations of services and timing are virtually limitless. They can be changed and new ones added to the mix. What's right will be what's right locally. This can only be decided by engagement between stakeholders.

Constraints:

Modernising primary care services is about rebalancing the local health economy and this will come with a high price tag. ENF are well aware of the public expenditure constraints the NHS is operating under, as indeed it is aware of the investment consequences of the following list of objectives / aspirations.

It would be easy to balk at the scale of change and its price tag however we cannot. The unstoppable pressures of population driven demand plus ambitious NHS policy commitments to revolutionize the health and social care continuum demands a bold response. The type of services described in the following objectives will be essential within the next ten years plus as without major change the currently creaking system will limp on with ever more frequent crises while becoming less and less effective. This will be unacceptable to public opinion.





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The gap between rhetoric and reality has been large over the last ten years, which is why little has happened. However, the conversation about how to find the investment needed to meet public expectation is 'hotting-up'. We must plan services and build for the future not the past delivered - as funding permits whether that is by new or redeployed funding or more likely a combination.

20 Strategic Objectives or Aspirations:

What do we want the future primary care service to be? Answering this requires articulating what stakeholders want into tangible objectives, which are more than statements of 'values' and aspiration (we want to be...). They must be SMART (specific, measureable achievable, realistic and time-scaled) to enable the development of service models, which will:

- Meet the identified deficiencies and challenges facing the current service (See Section 1 the population and disease group challenges). And,
- Deliver the NHS policy agenda to transform the local model of health and social care (including SEHCCG's 5 Year Strategy).

The ambition is to develop a 21st century Primary Care Service (and then design a state of the art building to deliver it). The Strategic Objectives for the type of service required can be split into three categories:

- The improvement of core GP physician services. (Making the existing service better). *Hopefully, achievable in the short to mid term.*
- The development of new (non core) services – uniting primary, community, specialist and social care. (Which will manage demand better and take the pressure off hospitals). *Hopefully, achievable in the mid to long term.*
- The creation of the necessary primary care infrastructure – i.e. Leadership, Building, ICT, Workforce and Organisation & Management. *Hopefully, progressed steadily (in a stepped way) over the short, mid and long term.*

This document breathes life into the conversation of what 21st century primary care should look like. It puts on the table what the key service objectives necessary to meet the performance and demand challenges. Appendix B provides a profile on each objective offering detail.

It is emphasized that these are illustrative presented to stimulate debate on what the service could look like. The objectives have also been phased over the short, mid and long term in line with anticipated population and demand changes examined in Where Are We Now?

The timescale for rebalancing care is a strategic one over a long period of time some 10 to 20 years. The plans to achieve these objectives will need to be



What Emsworth Wants From Primary Care: 20 Strategic Objectives / Aspirations:	Short Term 2016 - 21	Mid Term 2021 - 2026.	Long-Long Term 2026 - 2036.
Improving Existing Core GP Services:			
1. Development of a More Responsive Urgent Care & Same Day Service.	✓	✓	✓
2. Development of a Fully Integrated Local Out of Hours Service (OoHS).		✓	✓
3. Development of Better Access to Personalised Routine Care (Named GP).	✓	✓	✓
4. Development of Case Management Approaches & Targeted Care.		✓	✓
5. Development of Nurse at al Practitioner Led (general & specialist) Services.	✓	✓	✓
6. Development of an Extended Role for Pharmacy and Pharmacist Practitioner.	✓	✓	✓
New Integrated Local Specialist Services (Non - Core):			
7. Development of a Specialist Local Care of the Elderly Services.		✓	✓
8. Development of a Specialist Local Diabetic Service.		✓	✓
9. Development of a Specialist Local Women's' & Children's' Service.		✓	✓
10. Development of a Specialist Local Cardio-Respiratory Service.		✓	✓
11. Development of a Specialist Local (Pro-Active) Cancer Care Services.		✓	✓
12. Development of a Specialist Local Neuro-Degenerative Care Services.		✓	✓
13. Development of Healthy Living / Wellbeing Services.		✓	✓
14. Develop of Local Musculo Skeletal and Rehabilitation Services.		✓	✓
15. Integration of Local Mental Health Services with Primary Care.		✓	✓
New Primary Care Infrastructure in a new future-proofed phased Building:			
16. Development of a local Fast Turnaround Diagnostic Service.		✓	✓
17. Development of Local Minimally Invasive Diagnostic & Treatment Service.		✓	✓
18. Development of Joint Services with Social Care and Nursing Homes.	✓	✓	✓
19. A Makeover of ICT & Business Management Infrastructure.	✓	✓	✓
20. Healthcare Related Practitioners and Retail – Possible joint Ventures.		✓	✓



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prioritization over the short, mid, long and long/long term in a flexible way so that they can respond to challenges which will occur. It therefore requires a strategic planning and management approach (which appears to be currently absent in the NHS).

The key issues to bear in mind when considering the SMART objectives / aspirations are:

1. Large-scale investment is needed in both facilities and workforce over a phased timescale for the Emsworth practice catchment (and other localities also) if SEHCCGs strategy is to be implemented.
2. Priorities would probably see the improvements in performance to core existing GP services take place first and new services developed piece meal thereafter (an evolutionary approach). When considered over a 10-20 year timescale it does not look so daunting financially.
3. Many of the advocated 'specialist services' could only be provided by shared arrangements with specialist hospital based clinicians, nurses and other professional having sessional clinic and home care commitments. These services are currently being provided by acute hospitals, community services and local authority social care. It is not suggested that EMP employ specialist staff – more so – work collaboratively and locally. To do this new facilities and an EPR based ICT infrastructure will be essential. As will developing new forms of shared care organisations clinical governance and budgets.
4. Nursing Practitioner led services covering generic services such as home care teams can be combined with specific areas of interest – 'such as – care of the elderly - women's and child health – and developed as part of the practice or community services.
5. Specific practitioner services could be developed and employed by the practice (assuming the already large practice which could double in population terms can justify it by the increasing scope and economies of scale).
6. The importance of up-front investment in the infrastructure in building; ICT, workforce development and governance terms – cannot be overstated.
7. One should also note that should such a primary care development become widespread that the changing role of the acute hospital will accelerate significantly into becoming high tech centres for complex illness and treatment. This will require its own investment in order to change and meet its own likely increases in demand pressures.
8. The issues of funding are national ones.

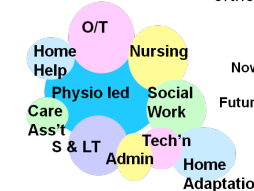


Intermediate Care: Home Care Teams: Specialists & Generalists



◆Early Discharge : Community Rehabilitation Teams

- ☐ Enabling earlier discharge 'step-down' for selected cases
- ☐ Time limited care plan then Community Services
- ☐ GP clinical responsibility shared with Specialist/therapist
- ☐ Intensive Physio Support + other therapists & nursing
- ☐ Social care & Home Help & adaptations - part of the team
- ☐ Activated by central referral / joint assessment
- ☐ Covering: Acquired neurological conditions - mainly stroke & orthopaedic recovery



A) Improving Existing Core Services:

If we go back to the constructive critique of the current service (Context) it is clear that performance is under pressure and improvements are limited by both funding and the deficiencies in the current surgery building.

The leading improvements patients would wish to see include improving access to ones named GP, better out of hours services; extended opening hours (possibly including Saturdays) and better email and phone access. One can add to this the desire to see a range of locally provided specialist, rehabilitation, and healthy living services examined in the following section. Moving to 7 day extended opening hours would be a long/long term ambition. The key objectives focus on fixing these improvements to patient's experiences of the service.

Example: Fractured Femur		Example: Elderly Rehab	
Now	17 days LoS	Now	Home based physical rehabilitation & nursing care for stroke.
Future	2-3 days	Future	Lead clinician; Physio & O.T. 9-5 - 7 days. Minimal service W/Es
	Hosp LoS		6 weeks max duration
	Home Care		



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This group of objectives would be the first priority of a new primary care strategy.

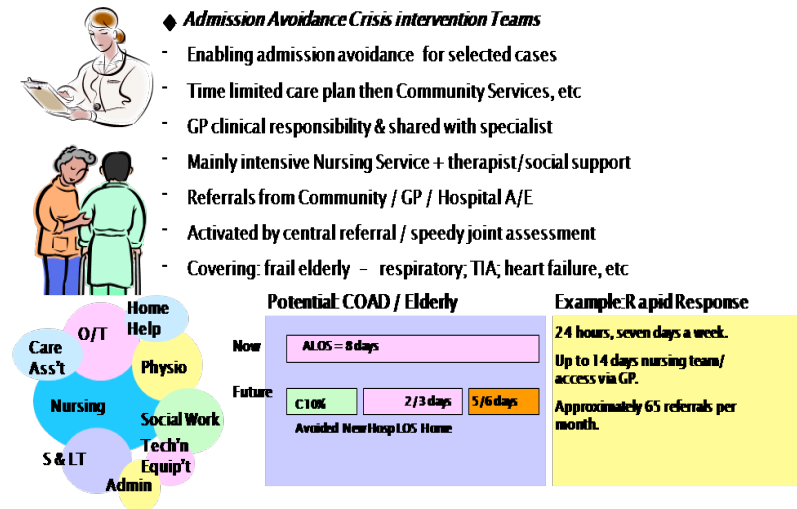
B) New (Non-Core) and Specialist Primary Care Services – (Rebalancing Acute Hospital and Primary Care).

Much has been made of the potential to develop and deliver 'acute' or 'specialist' services in local primary, community and home care settings. The arguments are - that this would be less expensive; that it is healthier to keep patients out of hospital environment; that Hospitals should concentrate on treating trauma and complex illness in high tech environments; and also that patients would prefer this. However, no example exists of a fully comprehensive rebalanced local hospital acute service with its various primary / community / social care partners. There are many initiatives at service levels which are proving to work well and act as exemplars particularly around care of the elderly services and the development of 'intermediate care'. The challenge is to scale these innovations and early adopters up and increase the pace of change. This requires investment funding.

It is open to conjecture as to whether a fundamental rebalancing of care will ever be fully funded and as such affordable and practical - for the following reasons:

1. It is far from certain that the current hospital care identified as susceptible to a change in delivery location – some c30% of bed days (not cases) - due to earlier discharge to home or (institutionalized) care will actually constitute a substitution. It is the case with other innovations such as the 'day case' revelation (80's & 90's) that new demand will occupy the space created.
2. It is therefore highly unlikely to save money, which can be redeployed to primary care, which would then deliver the equivalent care outputs at lesser costs. This is because: (a) new acute hospital demand will occupy the space; (b) one can't just decommission hospital capacity without destabilizing their operating economics; (b) there is little evidence that care in the community will be actually 'cheaper' to provide given the team and time commitments needed.
3. Pump priming would be needed in the form of investment in primary and community care facilities and workforce to set up these services prior to transferring care (earlier discharge) or reap the benefits of hospital admission avoidance (patients treated at home instead). Failure to put new primary / community care services in place first will continue to result in: (a) no significant transfers of care as patients would be GP or self referred anyway (as has been the case over the last +20 years as little rebalancing has taken place); (b) delays in discharge will continue (backing up into acute care beds because of poor access to social care / nursing home placements); and (c) untenable / unsustainable pressure on primary care and family carers not being able to cope (the lessons of closing asylums (80's) without a full community mental health service in place would look tame in comparison).

Nevertheless, the re-balancing of Hospital and community care is 'the only show in town' and is national (and international policy) the failure of the rhetoric so far has been due to no tangible investment backed strategic planning at local levels (witness SEHCCG's published strategy (sans specifics) for rebalancing care by 2020). However this failure maybe what the Sustainability & Transformation Planning (STP) will now address.





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C) New Forms of Organisation, Infrastructure and leadership:

The objectives to develop new services will require a fundamental change to existing healthcare organizational boundaries and management. 'Accountable Care' or 'end to end care' concepts attempt to identify the benefits of joining-up service components, which currently reside in separate organisations with different management and funding priorities and arrangements. They work on the basis of identifying the most effective care pathway. Could services be managed across organizational boundaries by focusing on their core purpose – delivery of a fully joined up service focused on the patient group?

Care of the Elderly is a classic example and would probably be the first candidate. Enabling a joined-up service with one door to knock on and minimal or no organizational 'hand offs' and discontinuities will require a bold initiative to engineer new forms of clinical management and budgetary accountability.

It will also be highly reliant on ICT systems changes and an interoperable electronic patient record available at the point of care.

Teamwork will be essential and this requires a facility that promotes joint working between the various members of the multidisciplinary teams (spanning secondary, primary, community and social care) who need to be physically and 'virtually' co-located – hence the new 'hub' concept.

Finally clinical leadership of this revised model of care will be essential.

Conclusions: Turning Objectives into Implementation:

The final section is titled How Do We Get Their? It offers potential development options. These are derived from the combination of service models (derived from combinations of the 20 objectives), conceptual design solutions, and different timescales (phases). As the number of options one could generate from these variables are limitless we have focused on those that illustrate the major themes and seem most likely to deliver the 20 strategic objectives (to one degree or another).





Chapter 4: How Do We Get There? What Does Good Really Look Like?

Development Options: (Combining - Service Objectives with Design Concepts).

The following (and third main section) 'How Do We Get There?' examines the various possibilities or 'options' for fulfilling the 'specification' of 20 strategic objectives in 'Where Do We Want To Be?' and which in turn addresses the pressures for change set out in 'Where Are We Now, And What's Changing?'

There are many variables, which will determine what the replacement EMP could look like – these include: (Please refer to Figure ? The Planning Variables).

- How and when will the pressures for change will impact?
- Which of the 20 strategic objectives can be delivered in what timescale?
- What future service models can be constructed from the some or all of the objectives?
- Will there should be 1 or 2 or even 3 sites and one or more Practice configurations? And,
- What different conceptual building designs could emerge from the preceding?

Deciding a preferred Strategy therefore requires a consideration of different options. These combine service models (ways of delivering the 20 objectives) with specific building designs, which could best deliver them.

How the options (building and service design) could evolve (over the timescale 2016 to 2036) will depend as much on funding (both capital and revenue) and workforce availability as by demand pressure and public expectation.

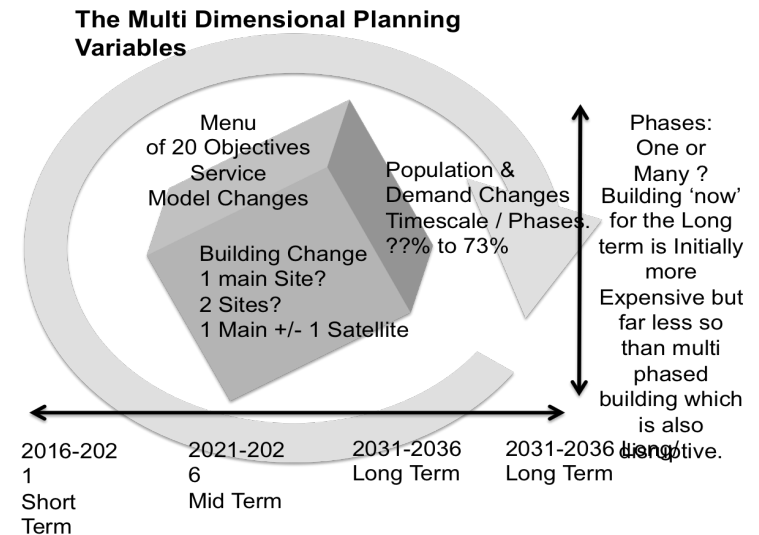
Clearly, the total number of options generated by an equation comprising twenty objectives; ten service model components; four phases (over 20 years); and one or more site locations are vast.

Selecting a preferred option involves making some sensible decisions on how to whittle down these variables in the scenarios into a manageable short list of options, which represents the key themes. They can then be appraised in detail for their costs and benefits.

Constraints & Must Do's:

Each option meets the 'specification' of the 20 objectives in part or total some more quickly or slowly than others. The priorities are that options must:

1. Meet the unfolding population and demand increases in the short, mid, long and long/long term scenarios already outlined.
2. Prioritize the replacement of Core 'updated' GP physician service model in the short term.
3. Next prioritize the development of local specialist (acute, intermediate care and improved diagnostic services and facilities).
4. Next prioritize the range of health and wellbeing service models and required facilities.





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5. Present the best Value for Money profile - Economic sense in terms of capital and running costs related to improved patient outcomes.
6. Present the best Affordability profile – a reasonable capital and running cost expenditure phasing.
7. Be consistent with Workforce availability and supply.
8. Consist of no more than 2 main building phases as the more phases per site as, as a rule – phases are more expensive and disruptive.
9. Consist of no more than 2 sites as more equates to much more expense and fragments the economies of scale of one site.

Four Illustrative Shortlisted Options:

The following profiles outline four representative and illustrative options, which reflect the main planning themes outlined.

1. Do Minimum – modernized core GP service building replacement only and focus on Oak Park for community and diagnostic services.
2. One fully integrated Primary Care Centre – modernized core GP plus non-core specialist local services.
3. One fully Integrated Primary Care Centre plus a satellite core GP service site in North Emsworth / Westbourne.
4. Two fully integrated Primary Care Centres (one at Oak Park).

Components of the Integrated 21st Century Primary & Community Care Services.



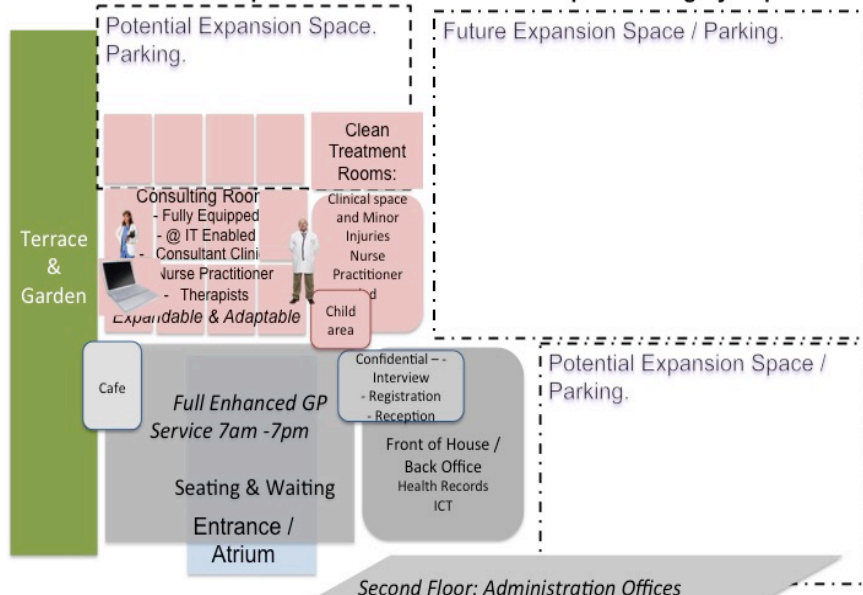


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Illustrative Option 1. 'Do Minimum': One Core Main Site (A) at VCH for a Primary Care Service / Facility.					
Phases → Service Objectives ↓	Short Term 2016-21	Mid Term 2021-2026	Long Term 2026-2036	Long / Long Term 2031-2036	Comment. Meeting Objectives 1 – 20 ✓ ✕
Population % Growth: Based on 100% at EMP.	+18%	+36%	+54%	+73%	✕ All population orientates to VCH EMP Site
Demand % Growth	+18%	+36%	+54%	+73%	✕ 100% of phased future demand.
1) Urgent Care / Minor Injuries.	A Phase 1	→	→	→	✓ Specific facility for Urgent Care - sized for L/T.
2-5) Enhanced Core GP Services.	A Phase 1	→	→	→	✓ Core GP infrastructure sized for the L/T.
6) Extended Role for Pharmacist Practitioners	A Phase 1	→	→	→	✓ Start on Practitioner led services S/T.
7) CoE Intermediate Care GP Led Services.	A Phase 1	→	→	→	✓ Base for Home Care / CoE team.
8-12) Specialist Local Acute Services.		→	→	→	✕ No space allowed. For future phases.
13) Healthy Living, Health Education.	A Phase 1	→	→	→	✓ Base for healthy living / wellbeing services.
14) Rehabilitation Services e.g. Physio, etc.		→	→	→	✕ No space allowed. For future phases.
15) Integrated Mental Health – O/Ps, etc.		→	→	→	✓ Working with Community MH Teams.
16-17) Treatment & Diagnostic Technology.	A Phase 1	→	→	→	✕ No Specialist Imaging & Treatment facilities.
18) Other Social Agencies. One Stop Shop.		→	→	→	✕ Facilities for Social Care / Vol'ary Orgs joint work'g
19) Mgt & ICT infrastructure Makeover.	A Phase 1	→	→	→	✓ Start of Mgt & ICT makeover / Org'al change.
20) Healthcare Related Practitioners & Retail		→	→	→	✕ No Joint Ventures / community Org's, etc

Illustrative Futures: Option 1: Short Term Phase Simple GP Surgery Replacement.



Benefits	Costs
One phase / one site - can be built quickly but delivers only core GP priority services. It is not a long-term solution.	Lesser construction time - c2 years. Adding in later phases more costly.
Adaptable - if a future proofed design - with future phases for new non-core services.	Lower up-front capital cost as limited to core services. A partial solution that will require more cost later.
Improved core GP services delivered quickly plus start made on new services provision. So lower initial running costs	Core services only won't meet most new demand so more running costs pressure / trying to meet new demand.
Initially far less disruptive as basically one main phase (assuming its on the VCH site).	Disruption only deferred. As one-site patients from periphery e.g. North Emsworth have to travel in (Parking?)
Minimal organizational & ICT change as still mainly a core service.	Organizational & ICT change partly funded – the rest deferred.
Service Objectives Met:	
Mostly an updated Core GP service. Objectives 1- 6 delivered in short term. Plus. Objectives 7 & 13 New Services COE and Healthy Living. Plus start is made on Objective 17 better Infrastructure.	
Conclusions: Partially meets future population / demand. Slower benefits delivery / lower cost flow. If built flexibly enables future phases but more expensive overall.	

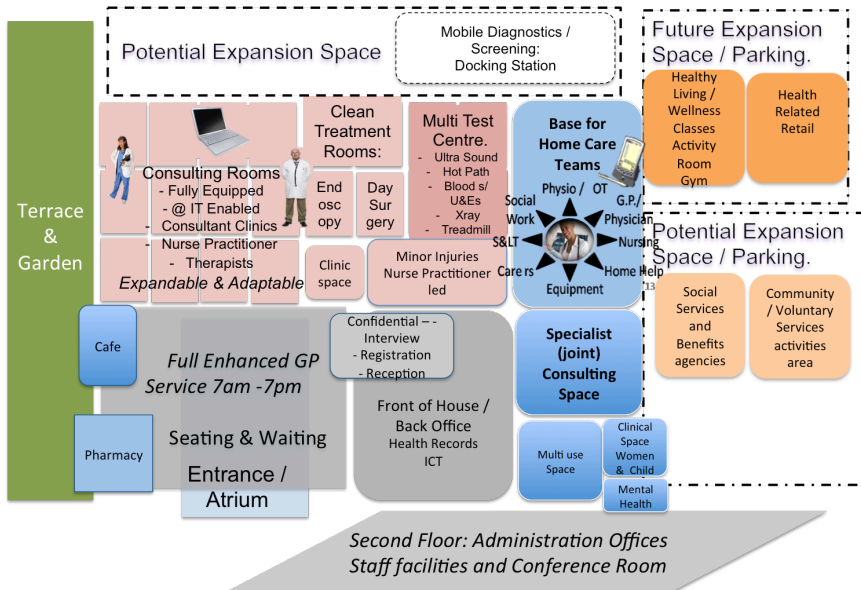


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Illustrative Option 2: One Comprehensive Main Site (A) at VCH a 21st Century Primary Care Service / Facility.					
Phases → Service Objectives ↓	Short Term 2016-21	Mid Term 2021-2026	Long Term 2026-2036	Long / Long Term 2031-2036	Comment. Meeting Objectives 1 – 20 ✓ ✕
Population % Growth: Based on 100% at EMP.	+18%	+36%	+54%	+73%	✓ All population orientates to VCH EMP Site
Demand % Growth	+18%	+36%	+54%	+73%	✓ 100% of phased future demand.
1) Urgent Care / Minor Injuries.	A Phase 1	→	→	→	✓ Specific facility for Urgent Care - sized for L/T.
2-5) Enhanced Core GP Services.	A Phase 1	→	→	→	✓ Core GP infrastructure sized for the L/T.
6) Extended Role for Pharmacist Practitioners	A Phase 1	→	→	→	✓ Practitioner led services S/T.
7) CoE Intermediate Care GP Led Services.	A Phase 1	→	→	→	✓ Base for Home Care / CoE team.
8-12) Specialist Local Acute Services.		A Phase 2	→	→	✓ Space allowed for developing new services.
13) Healthy Living, Health Education.	A Phase 1	→	→	→	✓ Base for healthy living / wellbeing services.
14) Rehabilitation Services e.g. Physio, etc.		A Phase 2	→	→	✓ Space allowed for developing a Rehab service.
15) Integrated Mental Health – O/Ps, etc.		A Phase 2	→	→	✓ Working with Community MH Teams.
16-17) Treatment & Diagnostic Technology.		A Phase 2	→	→	✓ Imaging & Treatment facilities at Phase 2
18) Other Social Agencies. One Stop Shop.		A Phase 2	→	→	✓ Facilities for Social Care / Vol'y Orgs joint work'g
19) Mgt & ICT infrastructure Makeover.	A Phase 1	→	→	→	✓ Start of Mgt & ICT makeover / Org'al change.
20) Healthcare Related Practitioners & Retail		A Phase 2	→	→	✓ Joint Ventures / community Org's, etc

Illustrative Option 2: Core & Non Core Integrated Primary Care Hub & Satellite.



Benefits	Costs
Two phases built reasonably quickly. 1st delivers core GP priority services. 2 nd delivers new services by mid / long term.	Longer construction time - c2 years. And then another 1.5/2 years. But two phases more costly.
Future proofed design – for 1st and 2 nd phases plus future phases for expansion. So could be further 3 or 4 phase solution.	Smoother more affordable capital cost flow over more phases but results in greater overall capital costs.
Improved core GP services delivered quickly plus start made on new services provision. So lower initial running costs	Core services only won't meet most new demand so more running costs pressure / trying to meet new demand.
More disruptive as basically two main phases on the VCH site).	As one site patients from periphery e.g. North Emsworth have to travel in.
Organizational & ICT changes phased over 10 years +	Organizational & ICT change deferred so efficiencies delivered slowly.
Service Objectives Met:	
Mostly an updated Core GP service. Objectives 1- 6 delivered in short term. Plus. Objectives 7 & 15 New Services COE and Healthy Living. Objective 8-15 and objectives 16-20 better Infrastructure met in phase 2.	
Conclusions: Meets 100% future population & demand. Slower benefits delivery, slower (more affordable) cost flow but more expensive overall. Retains > flexibility.	

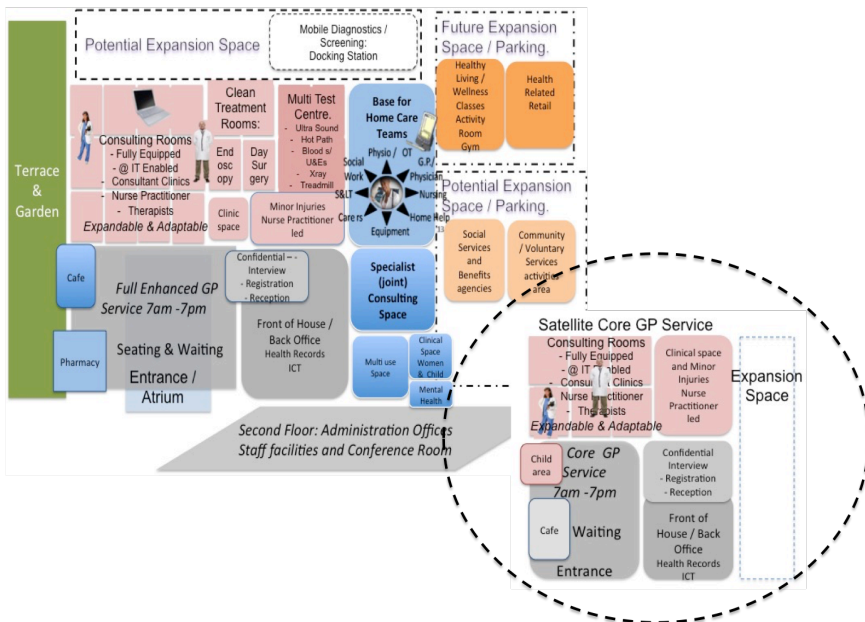


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Illustrative Option 3: One Main Site (A) at VCH 21st Century Primary Care Service + (B) Satellite Core GP site (N.Ems).					
Phases → Service Objectives ↓	Short Term 2016-21	Mid Term 2021-2026	Long Term 2026-2036	Long / Long Term 2031-2036	Comment. Meeting Objectives 1 – 20 ✓ ✕
Population % Growth: Based on 100% at EMP.	+18%	+36%	+54%	+73%	✓ c70% orientates to VCH EMP + 30% to new site
Demand % Growth	+18%	+36%	+54%	+73%	✓ 70/30% split in long-term demand VCH & N Ems.
1) Urgent Care / Minor Injuries.	A Phase 1	→	→	→	✓ Specific facility for Urgent Care - sized for LL/T.
2-5) Enhanced Core GP Services.	A Phase 1	→	B Phase 1	→	✓ Core GP infrastructure sized for 70% of the L/T.
6) Extended Role for Pharmacist Practitioners	A Phase 1	→	→	B Phase 1	✓ Practitioner led services S/T & LL/T both sites.
7) CoE Intermediate Care GP Led Services.	A Phase 1	→	→		✓ Base for Home Care / CoE team VCH site.
8-12) Specialist Local Acute Services.		A Phase 2	→	B Phase 1	✓ Development of new services at VCH site.
13) Healthy Living, Health Education.	A Phase 1	→	→	B Phase 1	✓ Base for healthy living / wellbeing both sites.
14) Rehabilitation Services e.g. Physio, etc.		A Phase 2	→	→	✓ Development of a Rehab service VCH site.
15) Integrated Mental Health – O/Ps, etc.		A Phase 2	→	B Phase 1	✓ Working with Community MH Teams VCH site.
16-17) Treatment & Diagnostic Technology.		A Phase 1	→	→	✓ Specialist Imaging & Treatment facilities VCH site.
18) Other Social Agencies. One Stop Shop.		A Phase 2	→	→	✓ Facilities for Social Care / Vol'y Orgs joint work'g
19) Mgt & ICT infrastructure Makeover.	A Phase 1	→	B Phase 1	→	✓ Mgt & ICT makeover / Org'al change. Both sites.
20) Healthcare Related Practitioners & Retail		A Phase 2	→	→	✓ Joint Ventures / community Org's, etc, VCH site.

Illustrative Option 3: Core & Non Core Integrated Primary Care Hub + Satellite Sites.



Benefits	Costs
2 sites and 4 phases built slowly. Meets all demand. 1st delivers core GP priority services. 2 nd new services by long term.	Longer construction time – Site A c2 years and then Site B another 1.5/2 years. Two sites = higher capital costs.
Future proofed flexible design Site A for 1st and 2 nd plus future expansion. Site B 3 rd or 4th phase solution. Very Flexible.	Smoother capital cost flow over four phases and 2 sites but it will result in higher overall capital costs.
Improved core GP services delivered quickly followed by new services provision. So lower initial running costs	Two sites means running costs. But all costs phased over 10-20 years in line with population growth - flexibly.
More disruptive as two phases on the VCH and satellite site).	As 2 sites patients from periphery do not have to travel far.
Organizational & ICT changes phased over 10 years +	Organizational & ICT change deferred so efficiencies delivered slowly.
Service Objectives Met:	
Mostly an updated Core GP service. Objectives 1- 6 delivered on Site A short term & Site B by long term. Objectives 7-15 delivered Site A mid term & Site B long/long term. Objectives 16-20 Infrastructure met on site A only by mid-long term..	
Conclusions: Meets future population & demand. Unfolds in synch with long-term population / demand changes. Slower benefits delivery, slower (more affordable) cost flow but more expensive overall. Lots of flexibility though.	

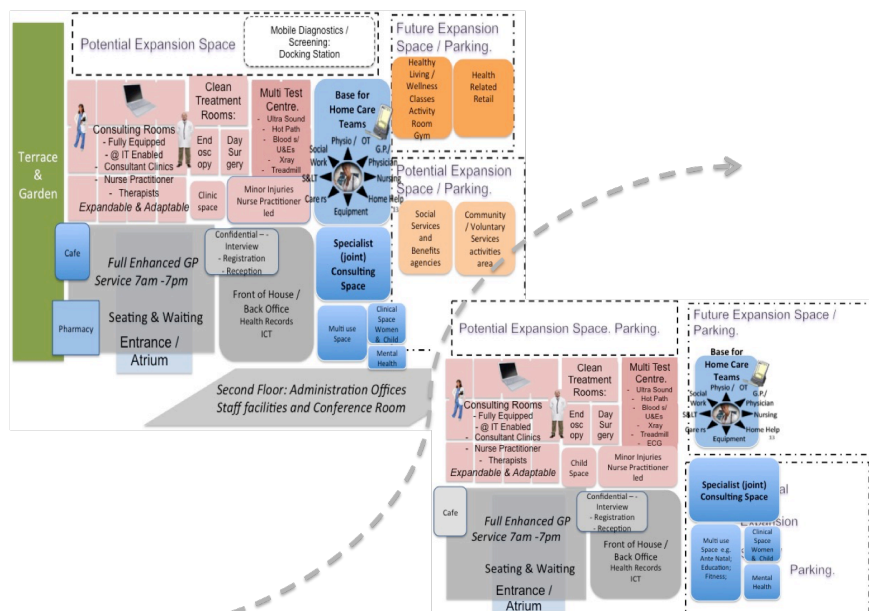


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Illustrative Option 4: Two Equal Main Sites for a 21st Century Primary Care Service. (A) VCH and (B) North Emsworth.					
Phases → Service Objectives ↓	Short Term 2016-21	Mid Term 2021-2026	Long Term 2026-2036	Long / Long Term 2031-2036	Comment. Meeting Objectives 1 – 20 ✓ ✗
Population % Growth: Based on 100% at EMP.	+18%	+36%	+54%	+73%	✓ c50% orientates to VCH EMP + 50% to new site
Demand % Growth	+18%	+36%	+54%	+73%	✓ 50% split in long-term demand VCH & N Ems.
1) Urgent Care / Minor Injuries.	A Phase 1	→	B Phase 1	→	✓ Specific facility for Urgent Care - sized for LL/T.
2-5) Enhanced Core GP Services.	A Phase 1	→	B Phase 1	→	✓ Core GP infrastructure sized for 70% of the L/T.
6) Extended Role for Pharmacist Practitioners	A Phase 1	→	B Phase 1	→	✓ Practitioner led services S/T & LL/T both sites.
7) CoE Intermediate Care GP Led Services.	A Phase 1	→	B Phase 1	→	✓ Base for Home Care / CoE team VCH site.
8-12) Specialist Local Acute Services.		A Phase 2	→	B Phase 1	✓ Development of new services at VCH site.
13) Healthy Living, Health Education.	A Phase 1	→	B Phase 1	→	✓ Base for healthy living / wellbeing both sites.
14) Rehabilitation Services e.g. Physio, etc.		A Phase 2	→	B Phase 1	✓ Development of a Rehab service VCH site.
15) Integrated Mental Health – O/Ps, etc.		A Phase 2	→	B Phase 1	✓ Working with Community MH Teams VCH site.
16-17) Treatment & Diagnostic Technology.		A Phase 1	→	B Phase 1	✓ Specialist Imaging & Treatment facilities VCH site.
18) Other Social Agencies. One Stop Shop.		A Phase 2	→	B Phase 1	✓ Facilities for Social Care / Vol'y Orgs joint work'g
19) Mgt & ICT infrastructure Makeover.	A Phase 1	→	B Phase 1	→	✓ Mgt & ICT makeover / Org'al change. Both sites.
20) Healthcare Related Practitioners & Retail		A Phase 2	→	B Phase 1	✓ Joint Ventures / community Org's, etc, VCH site.

Illustrative Option 4: Duplicated Core & Non Core Primary Care Hubs: Sites a & B.



Benefits	Costs
2 sites and 4 phases built slowly. Meets all demand. 1st delivers core GP priority services. 2 nd new services by long term.	Longer construction time – Site A c2 years and then Site B another 2 years. Two sites = higher capital costs.
Future proofed flexible design Site A for 1st and 2 nd plus future expansion. Site B 3 rd or 4th phase solution. Very Flexible.	Smoother capital cost-flow over four phases and 2 sites but will result in much greater overall capital cost.
Improved core GP services delivered quickly followed by new services provision. So lower initial running costs	Two sites means higher running costs. But all costs phased over 10-20 years as population grows enabling scope.
More disruptive as two phases on the VCH and satellite site).	As 2 sites patients from periphery do not have to travel far.
Organizational & ICT changes phased over 10 years +	Organizational & ICT change deferred so efficiencies delivered slowly.
Service Objectives Met:	
Full updated Core GP service. Objectives 1- 6 delivered on Site A short term & Site B by long term. Objectives 7-15 delivered Site A mid term & Site B long/long term. Objectives 16-20 Infrastructure met on both sites by mid-l/long term flexibly.	
Conclusions: Meets future population & demand. Unfolds in synch with long-term population / demand changes. Slower benefits delivery, slower (more affordable) cost flow but more expensive overall. Lots of flexibility though.	



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Other Local Facilities - Potential to Meet Emsworth Primary and Community Care Needs:

We do not have access to the primary and community care development plans of neighboring GP services at Southbourne, Nutbourne, Rowland's Castle and Havant. We assume that their primary care plans will need to cope with their own growing population changes and challenges.

There maybe spare building capacity now or in the future – but the type of this accommodation is unlikely to meet the objectives defined for a futuristic primary care service. Some sharing of services – e.g. by improved ICT environment for home care teams and local diagnostics may well be possible and would need to be explored by integrating and reconciling individual provider plans over a wider area.



The proximity of the purpose built Community Clinical Centre at Oak Park Havant has been suggested in debate as a reason to plan minimally for a GP surgery replacement in Emsworth. The belief is that Emsworth residents should be prepared to travel the 3-4 miles and 10 -15 minutes journey by private car. However, not all residents (particularly the elderly) drive. Public transport services are not straight forward and involve an indirect bus route (3 per hour) with a change at Havant bus station taking anything up to 45 minutes plus waits for available train / bus. Possibility of a dedicated NHS bus or other transport schemes to and from Emsworth is not seen as desired nor realistic prospect. This requires closer examination and is illustratively allowed for modeled by Options 3 and 4 two-site options.

The substantial housing developments planned for North Emsworth (1,600 in the Denville's / Southleigh Road area by 2036) will be closer to Oak Park. It therefore could be part of the solution to meet primary and community care objectives as it may be possible to use any spare capacity at this facility. If capacity exists at Oak Park it would need to be adapted - at a cost.

Whilst the Forum agrees it is a modern facility and has potential to play a part in any solution it is not a total solution for Emsworth as it is (at present) not a functioning primary care centre capable of providing core and non-core GP services for Emsworth. In the future it might be adaptable and thus ameliorate some of the demand pressure and need for facilities at the proposed new EMP facility.

However, it will not be capable of providing for the future demand generated by all Emsworth residents. Ideally increased demand for primary care should be met in Emsworth wherever possible. Moreover, it opens up the opportunity to develop community-based services co-located with primary care promoting teamwork and innovation envisaged by SEHCCG Strategy. This concept loses cohesion if accommodated separately. Even if a strong ICT virtual environment could be created this will not compensate for the loss of teamwork fostered by co-locating a critical mass of services.

Given the intense pressure on NHS resources and the competing demands – the Forum recognizes the imperative of using all NHS estate facilities / resources to there best advantage. Further specific service level and facility planning is needed to ascertain the level of 'offset' possible at Oak Park and other services and just how intensely the facilities could be used to support Emsworth residents increased demand.

The Costs and Benefits of Different Options:

The four options shortlisted all meet the 20 Policy Objectives. But they do so differently as they have different timing and therefore cost and benefit delivering profiles. The key issues are:

Capital Costs:

- It will be more expensive in capital terms to build the core and non-core long-term capacity in one phase in the short term (in preparation for a future) rather than in phases.



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- But, it is much less expensive 'overall' - in the long term - to build the core and non-core facilities now (but sized for the future) than to adapt and add to them later on. There is little chance of over-building given the future demand / policy pressures.
- Building over a number of phases over the short, mid and long term is much more expensive overall albeit more affordable given the spend rate is less over a longer period.
- A middle route could be taken – that of building core services initially which are sized for the long term and non-core services added in one future phase. This could be enhanced by considering building on one main site and another 'core service satellite site working in a GP confederated organizational model.
- The Forum understands that the capital investment funding is likely to be met by NHS Prop Co under a lease back agreement underwritten by SEHCCG based on a binding agreement with the GP's. Prop co will need to recover its outlay on commercial terms (including interest and depreciation).

Running Costs:

- Building the core and non-core service model facilities in one short term phase - sooner rather than later - would also impact on running costs making them marginally more expensive initially until new services income is funded.
- However, building in phases might be more affordable both from a capital funding and revenue point of view (it will be slightly less expensive in running cost terms because one is not carrying the costs of unoccupied and non revenue attracting capacity).
- Revenue funding the new service and facility will be a major challenge for SEHCCG in the context of the current financial climate in the NHS and the many other competing demands. It is the critical issue, which will determine the scope and the timescale for the development and indeed whether the development happens at all. In particular the funding of the new wider range of non-core specialist plus 'wrap around' community services highlighted in SEHCCG's strategy will be a major issue.
- At this point, the Forum has to ask whether SEHCCG can afford its own Strategy and whether it ever costed it fully before publication. If not, it will need to be revised possibly under the Sustainability and Transformation Planning announced by the NHS to address the alarmingly growing long term NHS deficit and due to be completed during the next few months. At present there is no indication of the funding envelope.
- Once again we warn against a reductionist approach due to financial pressure resulting in underbuilding or creating a cheap inflexible building would effectively frustrate SEHCCG's Strategy implementation.

Disruption and Flexibility:

- It is far less disruptive to clinic operation to build for the long term now in one initial phase rather than to add phase after phase later. The idea of living for years on a building site is not attractive.
- Building in phases introduces a lot of flexibility – which is a key issue – to respond to changing healthcare demand over a 20 year period
- It is known from bitter NHS experience that under-building because of political expediency and a desire to minimize initial funding will be a major mistake and long-term dis-economy (if not a waste of public money). There are many examples in the NHS of 'Phase 1's' only getting built and other phases never being built due to funding being cancelled. This results in the original strategy being distorted over years so that it becomes outdated meaning the initial capital expenditure is at best sub optimal and at worst wasted. This is largely due to very poor 'un-future proofed', inflexible planning and an absence of strategic management. This is compounded under inflexible PFI deals which assume little change in healthcare requirements and facilities over periods of 30 years (unless one is prepared to meet expensive variations costs).
- Under calculating the facility size by not taking account of future demand will result in investing considerable sums in a service and facility, which will not be fit for purpose. Architectural studies confirm that future proofing by enabling maximum flexibility (e.g. providing internal and external expansion space) is not expensive to provide initially. However, fixing this later (e.g. trying to retro-fit for increased demand and new services) is sometimes impossible or at best very expensive and must be avoided.



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Delivery of Patient Benefits (The 20 Objectives):

- From a patients perspective in delivering high performance and high quality services it is preferable to build in less phases and therefore more quickly.

Critical Success Factors:

A viable future strategy for integrated primary care services in Emsworth's will depend on the following critical success factors:

- Leadership and a can do attitude by GPs, Hospital specialists and health and social care stakeholders. Is their ambition and a spirit of innovation.
- Teamwork enabled by co-location of multidisciplinary teams in a suitable facility with access to full back office support.
- Strong commitment from commissioners and providers to a shared strategy for a joined up local health system where services transcend organizational boundaries.
- The creation of a flexible strategic / business planning framework which is focused on action - implementation plans and strategically managed.
- Strong collaborative arrangements between community, secondary and social care organisations at a strategic and operational level.
- Investment in ICT – particularly an interoperable electronic patient record shared with all partners in the local health economy.
- Early adoption of the large number of health 'apps' which are being developed which can monitor patients vital signs, medication and improves communication thus heading off problems.
- A very high degree of flexibility and future proofing in the buildings design solution enabling changing responses to a fast changing healthcare environment.

Conclusions:

What is obvious is that selecting a multi phased option would be more expensive and cause constant building disruption to service provision. However, one has to be realistic about the current public finances and NHS austerity climate. Therefore a middle ground two-phased solution that still delivers the strategic objectives while meeting population driven needs could be pursued.

The four illustrative options consider one or two site solutions with faster or slower implementation 1-4 phases over 5-20 years.

- Option 1: The Do Minimum Option: Almost like for like core GP service replacement Surgery which doesn't meet future demand pressures and only some of the 20 objectives - but is flexible for future phases.
- Option 2: One Main Site: With a one or two phase implementation by the mid term with long term capacity meeting all population driven demand economically (i.e. with economies of scale) as minimally phased and on one site. It also delivers all the benefits (20 objectives) quickly.
- Option 3: Predominantly a One Main Site plus a Satellite Site serving North Emsworth by the mid term - Long term (possibilities for the second site could use Oak Park if capacity exists). A highly flexible option but more expensive (in capital and revenue terms). It delivers the benefits (20 objectives) at a moderate pace. Or?
- Option 4: Two Equal (core and non care) Sites Solution - over four phases, VCH by the mid term (2026) and the other North Emsworth site (possibly Oak Park if capacity exists) over the long / long term (2026 - 2036) It will be overall more expensive both in capital and running cost terms albeit it evens out the capital and running costs over the 20 years of population growth (albeit but it would be overall much more expensive). Benefits (20 objectives) would be delivered at a moderate pace with flexibility.



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Selecting a preferred option depends on a lot more detailed work by the NHS planning team. They will need to complete an objective Business Case comprising an economic appraisal and affordability analysis (a requirement in the NHS for approving capital expenditure). This will identify the exact costs and benefits and return on investment for the NHS. Moving forward will then depend on which options gains support, which depends on:

- What the EMP GP's want – will EMP be willing to develop a much bigger and enhanced service under a new partnership / or NHS model, or two smaller separate GP partnerships, possibly within a form of federated and shared services organization? Or leave new services to Community providers?
- The 'business' arrangements between SEHCCG and the EMP or any new practice(s). (It is not the role of this report to comment on these arrangements as we are not privy to them - unless these arrangements appear to represent a conflict of interests with what EF regard as a the future role and scope of future primary care services).
- What SEHCCG wants and is willing to finance and underwrite.
- The availability of the VCH site at reasonable terms from NHS Prop Co.

And, hopefully.

- What Emsworth stakeholders want as a community.

Chapter 5: Conclusions and Next Steps / Recommendations.

SEHCCG in their published 5 Year Strategy state....

..."We are committed to working with local communities and services, and to supporting people and carers to take control of their own care and wellbeing. Our aim is to ensure that our commissioning decisions flow from the perspectives of local communities and the involvement of people that use services. This will bring a better understanding between all parties of the assets available within local communities and foster a desire to identify and solve problems together....." SEHCCG.

ENF's reason for writing this paper is to respond to this and encourage such discussion between stakeholders on what the future primary and community local service could and should look like. We therefore need the NHS to listen and engage. Unfortunately - to-date - there has been little apparent appetite for this and we hope this will change. Although EMP is held in high regard and there is understanding about the pressures faced by them and SEHCCG a firm commitment and a coherent plan adequately communicated to Emsworth patients is needed now.

From ENFs perspective we see the main issues as:

1. NHS and locally primary care performance is perceived to be under pressure and slipping which it is felt will deteriorate if there is no major structural change - as the inexorable pressures for change bite over the mid to long term.
2. Over the last 10-15 years Emsworth has seen it's community and primary care services diminish (e.g. closure of VCH and the difficulties in getting appointments, etc). there has been no attempt at engagement with stakeholders to communicate a new plan on where these services are going. Instead there has been a series of 'on-off' contradictory statements punctuated by long silences in relation to the replacement of the EMP building.





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3. SEHCCG's published Strategy has the right direction of travel but it is over optimistic for implementation by 2020 as there were never any published action plans on 'how' the required redesign of the service model would be funded and delivered? It therefore remains unclear as to how SEHCCG will address the forecast c73% increase in demand (c3-4% pa) by 2036 as well as a range of new 'out of hospital' services that will most certainly be necessary within the next ten years. Maybe the imminent Sustainability and Transformation Plans may update this.
4. There is a great need for NHS leadership and a commitment to change, which will be delivered. The NHS cannot keep 'kicking the can down the road' because of short-term performance and financial pressures.
5. Most importantly - it is not just about the rebuilding of the EMP Surgery but also about the wider issue of redesigning local primary / community healthcare services. We must not rebuild the past. A rare opportunity exists to build the future service and building. As revolution is unaffordable an evolutionary approach is needed.

ENF Recommend:

1. That a locality healthcare strategy be developed for Emsworth and actively managed which must include specific delivery plans.
2. That any replacement EMP building be futuristic in concept. Preferably, sized for the future strategy for enhanced primary care services in one or two phases on one main site (preferably VCH given the potential of the adjacent sites for a community hub). However, if funding precludes building now for the future (which will be less expensive overall) we strongly recommend a building solution be found which is highly flexible and future proofed to enable minimally disruptive future multiple phases as funding permits.
3. That EMP and SEHCCG engage with Emsworth stakeholders to explore how these deficiencies might be addressed and gain a common view on the diagnosis and the treatment.
4. SEHCCG / EMP agrees an engagement structure and process with stakeholder representation (by ENF) which could comprise:
 - a). An initial short workshop with SEHCCG and EMP followed by regular local engagement forums (possibly two per year);
 - b). A strong Locality Healthcare Plan Steering Group covering the future of the primary / community based services (with specific project teams).
 - c). A EMP Surgery replacement project team. (One of the Steering Groups project delivery teams).
5. A can do attitude and real commitment. Short termism and poverty of ambition being the greatest enemy.

We recognize that this discussion document is not definitive but informative (with limited access to planning data there maybe some omissions or inaccuracies). However, we believe that the analysis and conclusions are robust enough for the purposes of providing a platform for constructive engagement. Overall we believe the illustrative scenarios and options outlined in this discussion document go some way to articulating SEHCCG's Strategy by illustrating what it would take to deliver it.

Community organisations such as the Forum have much to offer. ENF won't indulge in 'special pleading' and we are fully aware of the financial strictures facing the NHS. We will therefore be realistic and supportive contributors. The priority now is to arrive at a factual and deliverable plan and the Forum believes it is better to do this inclusively which is also what SEHCCG has committed to....

"...We will set and meet objective and measurable targets to improve individual and community participation. All engagement models will include a feedback process to keep residents informed of the progress of projects and to describe how their input has been used in the process....."

"...We will develop our range of opportunities for participation with diverse communities and will also continue to develop our Community Engagement Committees."