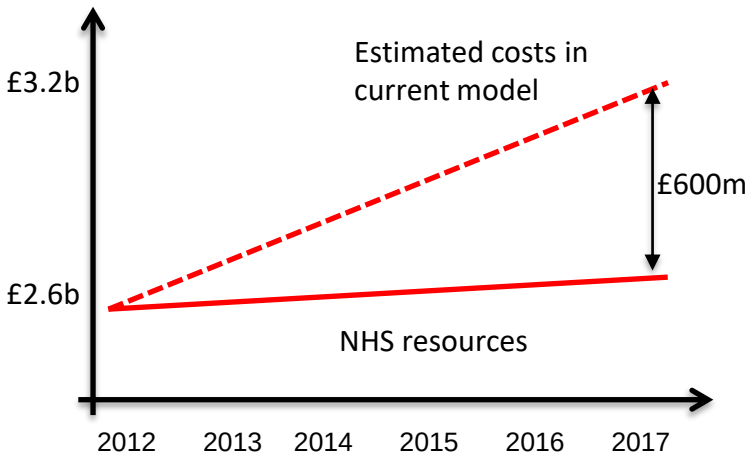
Southern Health NHS
NHS Foundation Trust

Our medium term strategy:
Southern Health in 5 years time

Second draft March 2012

The context in which we work:
Why the health service in Hampshire needs to change

The current model is financially unsustainable



- Demand and costs in the NHS are rising at a rate we can not afford across Hampshire, Portsmouth & Southampton
- Long term care costs are rising exponentially

Patients want, and deserve, a better deal, a better service

Patient experience and customer service

- Patients often experience disjointed, un-coordinated care, and poor customer service

Poor outcomes

- Patients with chronic conditions inadequately supported in the community
- Too many patients admitted to hospital and endure long hospital stays
- High levels of readmission
- Poor care for those ageing with dementia
- Failing to meet both the health and social needs of patients

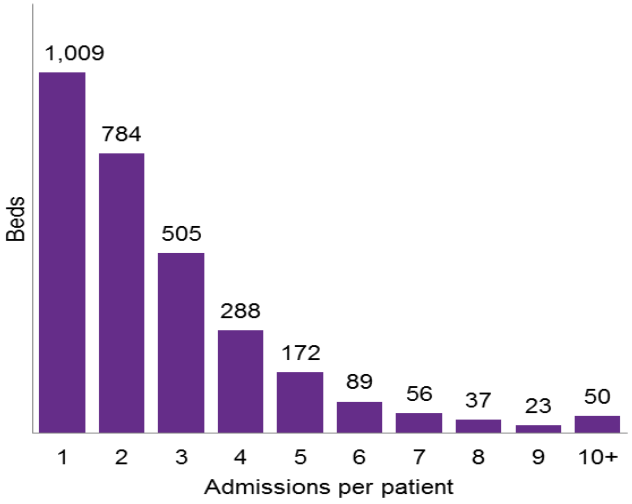
Variation in service across Hampshire

- Unwarranted variation in service quality and performance across Hampshire - including in primary care

190,000 emergency admissions per year
(including Southampton and Portsmouth cities)

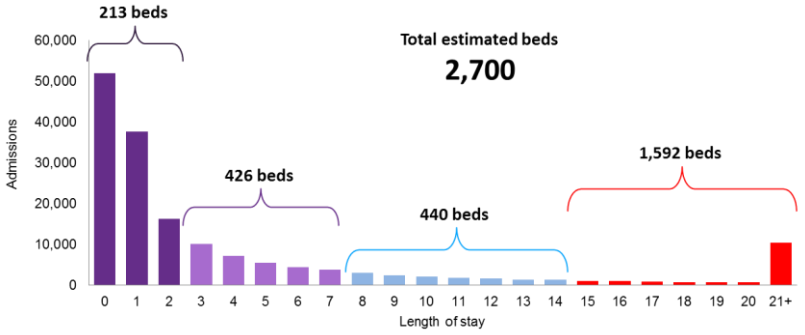
Across Hampshire:

- **2700 beds** used at any one time in Hampshire to support these patients
- 10% of patients stay in hospital more than 2 weeks – but occupy 1600 beds
- **3 in 5 admissions** are for patients who have been in hospital before, within 12 months
- **7500 patients had 4 or more admissions**, and occupy 700 beds at any one time.



We know that:

- Only 1 in 4 of these highest risk patients are known to our community services
- Many patients with extended hospital stays could be better supported elsewhere



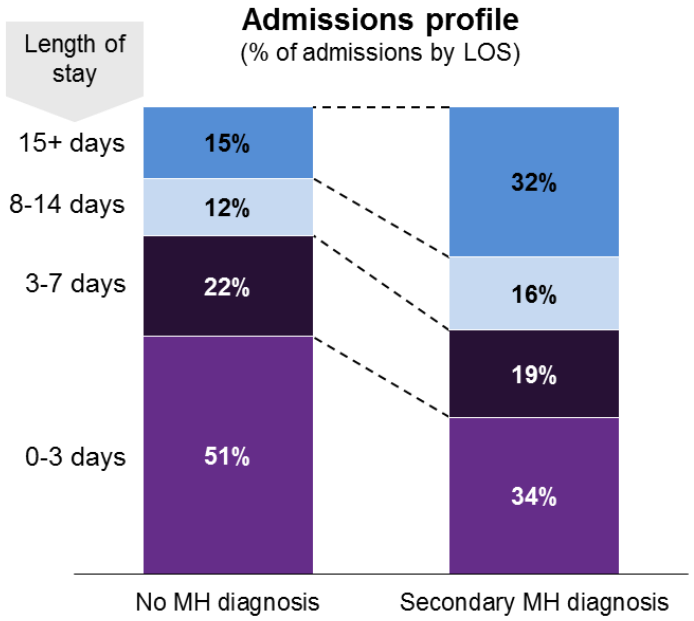
Patients with mental health needs tend to stay in hospital for longer

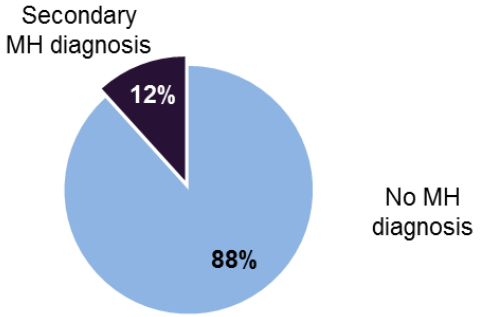
Across Hampshire:

- **1 in 3** patients admitted to hospital with a mental health co-morbidity will have a length of stay of more than 2 weeks
- Patients with mental health needs – and in particular dementia – are **twice as likely** to have a long length of stay
- **1 in 5** of the patients in hospital more than 2 weeks have mental health needs

We know that:

- The overwhelming majority of secondary mental health care is delivered in the community
- Only 8.5% of patients in secondary care mental health services have an admission each year



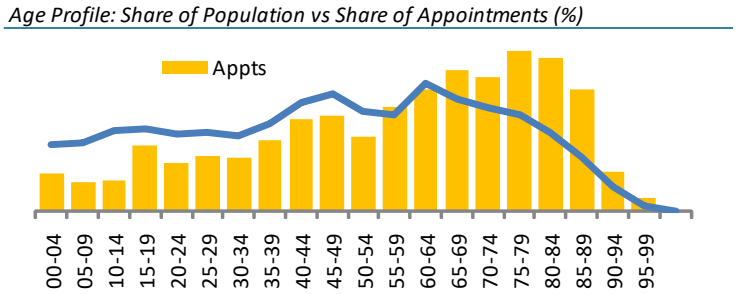


Data relating to emergency admissions to acute hospitals in Hampshire

Opportunity for stronger co-ordination between primary and community care

A two week study in general practice identified that:

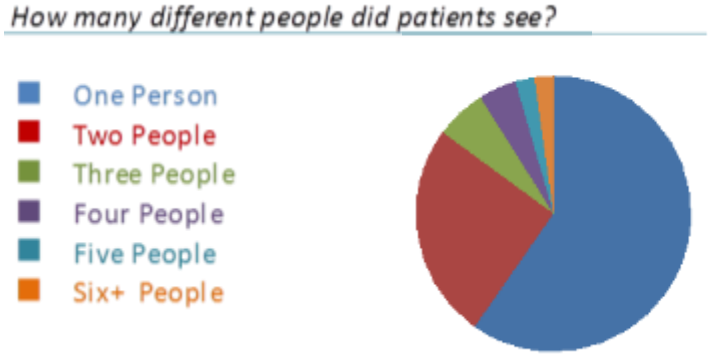
- Patients of all ages visit their practice, but workload tends to focus on the elderly



- GPs see 3 out of 4 of the patients visiting the practice – with the remainder cared for by practice nurses
- 1 in 4 patients had at least 2 appointments
- 1 in 5 of the patients treated by a community nurse were also seen by the practice nurse in that 2 week period

A two week study with community care teams identified that:

- 1 in 6 patients had four or more visits from healthcare professionals during the two week period
- 1 in 10 saw four or more different members of the community care team during that period
- 60% of patients saw more than 1 clinician during that period



CCGs emerging in Hampshire

Our vision for a sustainable health system in Hampshire

An integrated health and social care system

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

Desired outcomes of an integrated care system

A local NHS where more effective out of hospital care leads to:

- Fewer hospital admissions
- Fewer hospital readmissions
- Fewer long term care placements
- Fewer patients with long hospital stays

…and a more affordable service

A local NHS in which patients experience:

- Joined up and co-ordinated care
- Excellent customer service
- Feeling supported to manage their own health and wellbeing
- Reduced NHS duplication and waste
- Feeling, and being, more healthy

What do we mean by 'integrated care'?

Integrated Care seeks to close the historical divisions within health services and between health services and social care. It needs to happen at different levels within the health system:

Individual patient/service user level 'micro integration'

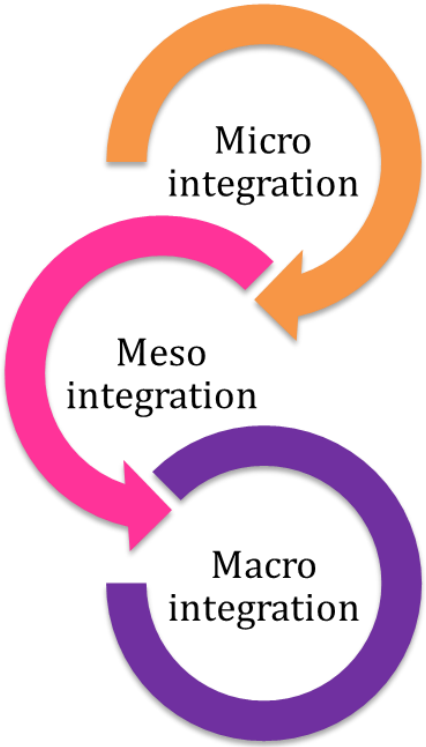
Providers delivering integrated care for individual patients/service users through care coordination and care planning. Responsibility for coordinating care and ensuring patients can access the services they need is assigned to an individual or team. Examples include the Care Programme Approach, and case management. Requires clinicians & managers to work together to meet the needs of individuals

At patient group level 'meso integration'

Providers, either together or with commissioners, delivering integrated care for a group of individuals with the same disease or conditions, for example older people. Responsibility for meeting the needs of the group is given to an individual or team. In Torbay an integrated community health & social care team had responsibility for a pooled budget for the care of a 30,000 population.

At whole population level 'macro integration'

Providers, either together or with commissioners, deliver integrated care across the full spectrum of services to the population they serve. US examples include Kaiser Permanente (9 million pop) & the Veterans Health Administration, which employs professionals at every level in the system, organised into regionally based integrated service networks.



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