South East Clinical Senate

Hampshire Thames Valley

South East

Clinical

senate

South East Clinical Senate (Hampshire Thames Valley)

Review of the

Hampshire Together: Modernising our Hospitals and Health Services

Pre-Consultation Business Case

December 2020

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Foreword

The 12 regional clinical senates were established in England to provide strategic, independent, clinical advice to commissioners and health systems, to help them make the best decisions about health care for the populations they are responsible for. NHS England and Improvement also strongly recommends a clinical senate review of major service change proposals before they go out to public consultation. In that light, the South East Clinical Senate (Hampshire Thames Valley) was asked by the north and mid Hampshire clinical commissioning groups with Hampshire Hospitals Foundation Trust as Hampshire Together to review the draft pre-consultation business case (PCBC), for proposed major changes to where and how sustainable acute hospital care would be delivered in the future, and to provide recommendations.

A multi-disciplinary independent clinical review panel of health and care professionals with a wide range of expertise and experience was brought together to review the draft PCBC and following this have produced a range of recommendations for how the PCBC could be improved and made more fit for purpose prior to public consultation.

We would like to thank the north and mid Hampshire commissioners and clinicians in taking time to present the proposals to the panel and field their questions. I would particularly also like to thank all the members of the clinical senate panel for giving of their own time to participate in this review.

Finally, a thank you to the support team of the clinical senate for coordinating the review and bringing the report together.

Dr Jane Barrett OBE, FRCP FRCR.

Chair, South East Clinical Senate, Hampshire Thames Valley

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1. Executive summary and key recommendations

1.1 Background

The Hampshire Together Modernising our Hospitals & Health Services programme, comprising Hampshire and the Isle of Wight (IOW), (partnership of CCGs), West Hampshire CCG and Hampshire Hospitals Foundation Trust are preparing the Pre-Consultation Business Case (PCBC) for the reconfiguration of acute care across north and mid Hampshire.

The PCBC makes the case for change for significant investment to transform how acute and planned health and care services are delivered across north and mid Hampshire. It also articulates improvements to local care that will enable the acute care transformation. The objective of Hampshire Together is to enable delivery of high quality, sustainable and financially viable clinical services that meet the needs of the north and mid Hampshire population.

The Hampshire and IOW Sustainability and Transformation Partnership (STP) asked the South East Clinical Senate, Hampshire Thames Valley (SECSHTV), to provide an independent clinical review of the draft PCBC prior to its finalisation and release for public consultation in 2021.

The request was to review the clinical aspects of the PCBC, and to focus primarily on urgent and emergency care, maternity, paediatrics and planned care. The remit did not include a review of the process for shortlisting the five options, nor the financial modelling or assumptions.

The SECSHTV assembled a broad panel of independent senior clinicians, other health and care professionals and patient and public engagement representatives. Key lines of enquiry (KLOE) were established, two half day panel meetings were convened using a digital meeting platform via Microsoft TEAMS to review the draft PCBC and supporting appendices that had been provided, and to hear presentations and responses to the panel's questions from a representative Hampshire Together team.

The draft PCBC summarises the case for change, the vision and models of care proposed for north and mid Hampshire both within and outside of the hospital setting, and the process for agreeing a short list of five options for the future configuration of Hampshire Hospitals Foundation Trust (HHFT): Basingstoke and North Hampshire Hospital and Royal Hampshire County Hospital Winchester and two community hospitals Andover War Memorial and Alton, with detail of the nature of these five options.

All options describe variations of a 'hub and spoke' configuration, with a proposed new build centralised acute hospital hub developed on a greenfield site. (NB. All options numbered as per nomenclature within PCBC).

- **Option 2.3** proposes that there will be a centralised acute hospital hub developed on a greenfield site to include; emergency department, complex planned surgery, women and children services and a cancer centre with local 'Spoke' services at Winchester to include a planned surgery centre.
- **Option 2.4** proposes that there will be a centralised acute hospital hub developed on a greenfield site to include; all acute services i.e. emergency department, complex planned surgery, women and children services and a cancer centre with 'Spoke' services at Winchester to include only urgent treatment centre (UTC), community and step down services.
- **Option 2.5** proposes that there will be a centralised acute hospital hub developed on a greenfield site to include; emergency department, complex and planned surgery centres, women and children services, complex outpatient centre and a cancer centre. Local 'Spoke' services at Winchester to include an additional 'local' complex outpatient centre.
- **Option 2.6** proposes that there will be a centralised acute hospital hub developed on a greenfield site to include; emergency department, complex surgery centre, women and children services, complex outpatient centre and a cancer centre with local 'Spoke' services at Winchester to include an additional 'local' planned surgery centre and complex outpatient centre.
- **Option 2.7** proposes that there will be a centralised acute hospital hub developed on a greenfield site to include; emergency department, complex and planned surgery centre, women and children services and a cancer centre with local 'Spoke' services at Winchester to include a complex outpatient centre.

1.2 Summary of key recommendations

We would like to commend the Hampshire Together team for their drive, ambition and initiative in developing innovative population based solutions, that are clinically sustainable to their key challenges to enable delivery of high quality, sustainable and financially viable clinical services, that fully address the challenges of the changing needs of the north and mid Hampshire population.

The establishment of the 'North and mid Hampshire Integrated Care Partnership' where key stakeholders have come together with a shared ambition to collectively fund, develop and implement a model of care which aims to join together and align health and social care to develop a fully integrated service model, is to be praised and will provide the necessary platform to support delivery of the strategic ambition.

Such innovative solutions do require great scrutiny; hence multiple recommendations have been made. Some of them cover similar issues in the different sections. Many of the recommendations are also clarifications and suggestions to improve the case and make it clearer to the reader.

This extensive set of recommendations most of which centre around the following themes should not distract from the significant and excellent work that has been put in, to date to develop sustainable clinical models and patient pathways:

The content and presentation of the PCBC

- Articulate more clearly the changing future health needs and challenges of the north and mid Hampshire population, and how the proposals in the PCBC will address these.
- Re-frame the PCBC to have a clearer, more succinct narrative focused on the options for the hospital reconfiguration as well as the implications for the disposition of services in each of the five options.
- The 'Hub' and 'Spoke' hospitals, urgent treatment centres (UTCs), community and rehabilitation beds and primary and community services are part of a single system: A full understanding of how these all inter-relate with the patient pathways, is required to more fully anticipate capacity and demand in the future models of care.
- Be clearer about the balance that needs to be struck between the patient benefits of centralising the various clinical services, and the increased travel time to those services for elements of the population.

Demand and capacity projections

- Provide population projections through to at least 2035/36 to plan the future capacity required more convincingly.
- The full implications of having UTCs on a different site from the acute hospital, and how any demand and capacity risks will be mitigated, should be described.
- Estimate the projected level of activity in the UTCs that will contribute to the management of emergency department (ED) demand.
- The PCBC should state the current proportion of acute admissions treated as Same day emergency care (SDEC) patients, and the impact of moving to the 33% expectation.
- Given the difficulty in accurately projecting the impact of each of the five configuration options on required future bed capacity, providing a range rather than a fixed number of beds for each 'Hub and Spoke' site would acknowledge the uncertainties and avoid overly ambitious projections.
- It will be important to clearly identify each of the proposed 'Spoke' sites, Andover and Winchester alongside further facilities at Alton and Eastleigh within the narrative. The narrative would be strengthened by describing the proposed role and function of each of the 'Spoke' sites within each of the options.

Clinical standards and improving health

- Better use needs to be made of formal references to clinical standards used to inform the development of the clinical model across the narrative.
- The benefits of centralising acute services taking account of all essential clinical co-dependencies is well described.

Workforce

- Highlight the variation in workforce challenges within each of the proposed options, delivering a range of option specific 'Hub and Spoke' services across two sites.

Clinical, patient and public engagement

- Better use needs to be made of the current examples of public and patient pre engagement. Describe in more detail the level and scope of patient and public pre engagement of the proposed reconfiguration options.
- Describe in more detail the level of clinical engagement about the case for change and the proposed reconfiguration of the Hampshire Hospitals Foundation Trust (HHFT).

Configuration options

- Re consider how to best present the shortlisted options within the PCBC.

Urgent and emergency care pathway

- There is currently insufficient description of urgent and emergency care (UEC) pathways within the PCBC. The UEC system needs to be seen as an integrated whole, with the PCBC detailing the component parts, and how patients would move through the system for each of the five options.
- Urgent Treatment Centres
- Plans for the provision of UTCs and what level of acute care can be provided there, as part of the UEC pathway are not sufficiently stated. A clearer understanding of the proposed model, the implications for patient pathways and the need for transfer to the acute hospital site for those requiring it, should be provided.

Emergency Department

- The current description of ED services does not provide sufficient detail. Specifically, the narrative must define and model the amount of activity including throughput that the ED will be required to deliver in the future for all options.

Acute medicine and surgery 'Hub'

- Insufficient detail has been provided in the PCBC on the proposed clinical models for both acute medicine and surgery. Further detail is required on the proposed consultant workforce needed to run the acute medical and surgical rotas.

'Spoke' hospitals

- The clinical model for 'Spoke' hospitals; the services provided, types of patients and their acuity, patient flow and workforce required is not sufficiently described. As a consequence, it is difficult to assess the validity of any of the options. As such a fundamental component of the reconfiguration plans for all five options, much more detail on services provided and the patient pathways in to and out of these 'Spoke' hospitals is required.

Community services and beds, and inpatient rehabilitation services

- The PCBC needs to detail the planned roles and related capacity of community beds and services, how they will support the proposed clinical models at both of the 'Spoke' sites and the centralised acute hospital.

Inpatient rehabilitation

- The PCBC needs to detail proposals for inpatient rehabilitation across a range of 'Hub and Spoke' settings, detailing proposed clinical pathways.

Liaison psychiatry

- The plans to deliver a 24/7 liaison psychiatry service to the acute hospital is strongly supported. It was not clear to what extent there would be access to liaison psychiatry at the 'Spoke' hospitals.

Critical care

- Estimating the future capacity requirements for ICUs and HDUs in HHFT is essential, including additional COVID ready capacity.

Maternity and neonates

- The PCBC needs to detail proposals for maternity services across the range of 'Hub and Spoke' settings proposed, detailing proposed clinical pathways.

Paediatrics

- The PCBC needs to clearly describe the proposed model for paediatric services. Ideally, the PCBC would take maternity, neonatal care and paediatrics separately.
- Complex planned surgery and outpatient centres

- The PCBC needs to clearly and separately describe the clinical models for complex planned surgery, planned surgery and complex outpatient centres, taking account of the proposed disposition within each of the five options.

Travel

- Travel is important to patients and staff. In the community, more deprived and isolated areas often rely on public transport. The use of patient stories within the narrative would help mitigate the potentially negative views arising from centralising acute services to a single site.

Digital

- It is clear that there is significant ambition to extend digital solutions at scale and pace, acknowledging the lessons learnt in response to the pandemic. But additional detail is required specifically how digital technologies will be used to facilitate the revised new models of care.

COVID-19

- Whilst it was particularly helpful to see the extent to which COVID-19 has impacted on clinical delivery, additional narrative needs to reflect on 'lessons learnt' to date such as the use of digital and the impact on inequalities and how they can address this going forward, especially as COVID will be with us for the foreseeable future.

1.3 Addendum

- Having completed a Clinical Senate Review 1-2 October 2020, the Hampshire Together – Modernising our Hospitals and Health Services (MoHHS) programme was notified by the Department of Health and Social Care (DHSC) on October 2nd, 2020 of conditions necessary to secure Health Infrastructure Plan (HIP) Phase 2 funding.
- As these conditions and additional reconfiguration option were not available for consideration as part of the first Clinical Senate Review it was agreed that a second review, that addressed the three conditions would be undertaken on 2nd December in advance of the formal NHSE&I stage two assurance review scheduled for mid-December 2020 ahead of formal public consultation planned for early 2021.
- The DHSC have required that there are three conditions to be satisfied:
    - *1. Royal Hampshire would receive "significant investment" as part of the scheme*
    - *2. Royal Hampshire's A&E would not be affected*
    - *3. And obstetrics would not be taken out of Royal Hampshire*

Recommendations arising from the clinical senate review of Option 3 are detailed in a formal Addendum to this report, section 23.

1.4 Conclusion

There has been extensive and detailed work undertaken in constructing the draft PCBC, with evidence of good clinical engagement and involvement. There are strong clinical benefits stated for centralising the major acute services on to one site, particularly with respect to maintaining sustainable critical clinical co-dependencies, and a number of trusts across the country have or are in the process of following this course. The ambition to create a sustainable model for acute care, fully integrated with primary and community care and provided locally is identified as a key driver and is well placed.

However, the overall model of having a single acute 'Hub' supported by key 'Spoke' sites raises a number of issues with respect to admission criteria, clinical competencies required, and clinical pathways for more acutely ill patients, at the 'Spoke' sites. This will impact on the five presented options to varying degrees and needs to be considered in more detail to ensure that safety and quality of care would be maintained.

The PCBC was not sufficiently developed for the clinical senate expert panel to come to conclusions about the deliverability and sustainability of each of the five reconfiguration options being proposed. There needs to be a more detailed description of patient pathways, of the role and modus operandi of the 'Spoke' sites, the bed modelling, and a detailed and comprehensive outline of the workforce requirements reflecting an aligned workforce strategy.

There are risks within the current narrative that the five options presented could be interpreted as a single option for the centralisation of acute services onto a greenfield 'Hub' site, supported by a range of nuanced 'sub-options' for the disposition of complex planned surgery and complex outpatient centres. Further consideration should be made to how best to present the options for consultation.

Clinical senate recommendations are not mandatory but reflect the considered opinion of a group of independently acting clinicians and others after reviewing the material shared with them within the timescales required, and it is hoped that the range of recommendations in this report will help the 'Hampshire Together' team to ensure that their proposals are clear, supported by the evidence provided, address quality and safety requirements, and are shown to improve the quality of care for the populations of north and mid Hampshire as they finalise their proposals prior to public consultation.

2. Context, background and scope of the review

The Hampshire and Isle of Wight (IOW) Sustainability and Transformation Partnership (STP) asked the South East Clinical Senate, Hampshire Thames Valley (SECSHTV), to provide independent advice on proposals to modernise and improve future acute services in north and mid Hampshire through undertaking a review of the draft pre-consultation business case (PCBC) prior to its finalisation and release for public consultation in 2021.

The review related primarily to the clinical elements of the PCBC, with a focus on the following key lines of enquiry:

- Meeting the relevant NHS England tests 3 and 5 for service change:
    - There being a clear clinical evidence base for the reconfiguration of acute services for the short-list of options proposed.
    - Ensuring that if any bed closures are considered, that either alternative provision (typically in the community) is in place, that it will be enabled by new treatment pathways, digital solutions or that bed inefficiencies will be credibly addressed[1].
- A clear and convincing clinical case for change.
- Proposals deliver improved and high quality patient outcomes.
- Needs of the population and any health inequalities are addressed.
- Impact of demographic change on the proposals.
- Bed capacity required and proposed.
- Co-dependencies of related clinical services.
- How the hospitals of Hampshire will network services, and deliver seamless clinical information sharing between sites.
- Effective and clinically sound patient pathways.
- Workforce sustainability.
- Impact of increased travel times (ambulance, patient transport and public and private transport).
- The credibility of proposed alternatives to hospital-based care.
- Evidence of meaningful and extensive engagement of the clinical workforce with the proposals.

[1] NHS England 5th test relating to potential bed closures in a service reconfiguration. https://www.england.nhs.uk/2017/03/new-patient-care-test/

The clinical pathways and service models that will be most impacted for the short-list of options under consideration, are:

- ED (A&E) provision
- Acute medical, surgical, paediatric and trauma services
- Critical care
- Diagnostics: primarily radiology, Interventional radiology (IR), pathology and endoscopy.
- Women's Services: Obstetric and midwifery led units; gynaecology inpatient services.
- Planned care centre
- Local neonatal unit.

The Clinical Senate reviewed the PCBC in advance of submission of the final PCBC to NHS England and Improvement (NHSE&I) in accordance with the major service change assurance processes.

The clinical senate review did not consider in full:

- The process by which the shortlisted options for reconfiguration were arrived at.
- Financial modelling.

The report and recommendations focus on the reconfiguration plans proposed for north and mid Hampshire both within and outside of the hospital setting but with a focus on the five shortlisted options for acute care and consequent configuration of Hampshire Hospitals Foundation Trust (HHFT): Basingstoke and North Hampshire Hospital (BNHH) and Royal Hampshire County Hospital Winchester (RHCH) and two community hospitals Andover War Memorial Hospital (AWMH) and Alton Community Hospital (ACH), and detail of the nature of these five options.

All options describe variations of a centralised 'Hub and Spoke' configuration, with all proposing a new build centralised acute hospital 'Hub' developed on a greenfield site. Whilst the community based services are key to supporting and enabling the effectiveness of this new model of hospital based care, out of hospital models of care and patient pathways were not the major focus of this review

The five options are summarised in figure 1 on the following page and the clinical services to be provided in each of the hospitals in options 2.3 to 2.7 (as described in the PCBC) and are detailed in Appendix D.

Figure 1.

Option	Centralised Acute 'Hub'	'Spoke' Hospital
2.3	Emergency Department	UTC
	Complex Emergency Medicine	Locally Delivered Outpatients
	Critical care	Diagnostics
	Emergency Surgery	Step down, elderly care and rehabilitation beds
	Complex Planned Surgery Centre	Midwife led birth unit
	Maternity and Neonatal	Integrated care
	Paediatrics and young people	Hospice
	Cancer centre	Day case/minor surgery
	Complex Outpatient Centre	Planned Surgery Centre
2.4	Emergency Department	UTC
	Complex Emergency Medicine	Locally Delivered Outpatients
	Critical care	Diagnostics
	Emergency Surgery	Step down, elderly care and rehabilitation beds
	Complex Planned Surgery Centre	Midwife led birth unit
	Maternity and Neonatal	Integrated care
	Paediatrics and young people	Hospice
	Cancer centre	Day case/minor surgery
	Complex Outpatient Centre	
	Planned Surgery Centre	
2.5	Emergency Department	UTC
	Complex Emergency Medicine	Locally Delivered Outpatients
	Critical care	Diagnostics
	Emergency Surgery	Step down, elderly care and rehabilitation beds
	Complex planned surgery	Midwife led birth unit
	Maternity and Neonatal	Integrated care
	Paediatrics and young people	Hospice
	Cancer centre	Day case/minor surgery
	Planned Surgery Centre	
	Complex Outpatients centre	
2.6	Emergency Department	UTC
	Complex Emergency Medicine	Locally Delivered Outpatients
	Critical care	Diagnostics
	Emergency Surgery	Step down, elderly care and rehabilitation beds
	Complex Planned Surgery Centre	Midwife led birth unit
	Maternity and Neonatal	Integrated care
	Paediatrics and young people	Hospice
	Cancer centre	Day case/minor surgery
	Complex Outpatients Centre	Planned Surgery Centre
		Complex Outpatient Centre
2.7	Emergency Department	UTC
	Complex Emergency Medicine	Locally Delivered Outpatients
	Critical care	Diagnostics
	Emergency Surgery	Step down, elderly care and rehabilitation beds
	Complex Planned Surgery Centre	Midwife led birth unit
	Maternity and Neonatal	Integrated care
	Paediatrics and young people	Hospice
	Cancer centre	Day case/minor surgery
	Planned Surgery Centre	Complex Outpatient Centre

3. Methodology

The clinical senate assembled a broad based panel of senior clinicians and professionals, who provided their own time and expertise to the review. The panel membership is listed in appendix F1. Great care was taken to avoid conflicts of interest, and all panel members were required to sign a confidentiality agreement (Appendix F2).

The draft PCBC and appendices with supporting information were provided to the clinical senate team on 10th September 2020. The relevant appendices for the clinical senate review were filtered by the clinical senate chair (see appendix E for the list of materials provided), and key lines of enquiry (KLOE) were developed (Appendix C). The PCBC, relevant appendices and key lines of enquiry were shared with the panel, prior to a preparatory meeting (via digital platform, Microsoft TEAMS) of the panel which was conducted one week in advance of the main panel meeting to orientate the members, discuss the KLOEs and address any questions.

Two half-day panel meetings were held on 1st and 2nd October 2020. The first panel day was shared with members of the Modernising our Hospitals and Health Services (MoHHS) programme team and senior clinicians from the CCGs and HHFT, who presented summaries of the PCBC and took detailed questions from the panel. The second panel half day was for the clinical senate panel alone to consider their response and recommendations. The full agendas for the panel days are shown in appendix F4, and the membership of the MoHHS presenting team in appendix G.

The notes from the meeting and comments made were synthesised in to a first draft, which was circulated to the panel for comment. The final draft was then prepared for submission to the MoHHS programme board for matters of accuracy on 23 October 2020, and for review, comment then sign off by the clinical senate council.

4. General themes

4.1 General points relating to the PCBC

R1. Articulate more clearly the changing future health needs and challenges of the north and mid Hampshire population, and how the proposals in the PCBC will address these.

R1.1. The PCBC would benefit from a stronger, clearer statement of the ambition and vision for future healthcare for the defined population.

R1.2. The drivers for change could be more strongly and broadly described, specifically those clinical drivers.

R1.3. Whilst there is reference to the NHS Long Term Plan (LTP) in places in the document, the ways in which the options for reconfiguration in the PCBC will help deliver the relevant priorities of the LTP should be stronger.

R1.4. The PCBC needs to present the clinical case for change and the positive impact it will have overall on outcomes and experience, referencing key national programmes and standards.

R1.5. The context setting of the PCBC as a whole health system working in an integrated way is only partially described. It should more clearly articulate the current and anticipated future health needs and challenges of Hampshire, and specifically, demonstrate how the proposed reconfiguration of acute hospital services will address these challenges [2].

R1.6. There is some description of how the planned reconfigurations will improve health outcomes and quality, but further development would be useful around its impact on inequalities. There is evidence of the building blocks included within the demographic details, with some details about future demand and activity but the PCBC would benefit from further development/modelling, particularly on how this translates into the actions needed to inform the options. This could be captured into a summary describing the "So what impact" of demographic changes.

[2] Hampshire County Council Joint Strategic Needs Assessment https://www.hants.gov.uk/socialcareandhealth/publichealth/jsna#:~:text=Hampshire%27s%20Joint%20Strategic%20Needs%20Assessment%20%28JSNA%29%20looks%20at,and%20social%20care%20within%20the%20local%20authority%20area

R1.7. The ambition to create clinical sustainability is stated predominantly through an acute lens. Focusing on the establishment of a new hospital rather than reflecting the needs of the population and the patient pathways may result in a building that is not fit for purpose or sustainable in the longer term.

R1.8. Other regions and health systems across England have gone through similar reconfiguration programmes, making reference to such examples, and any lessons learnt, will help to demonstrate that the drivers for change are felt similarly across the country, and that the pressures for change within the north and mid Hampshire area under review are not unique.

R2. Re-frame the PCBC to have a clearer, more succinct narrative focused on the options for the hospital reconfiguration as well as the implications for the disposition of services in each of the five options.

R2.1. The ambition to create a sustainable model for acute care, fully integrated with primary and community care and provided locally is identified as a key driver however, it becomes lost in the way the PCBC is written and should be re-cast. It will be essential to highlight succinctly and in a way the public can relate to, the benefits to patient care, outcomes and experience that will result from the reconfiguration proposed. Such benefits as currently described are insufficiently detailed and are somewhat scattered round the PCBC. They should be brought together to demonstrate the benefits to the population of the radical changes being proposed, as well as the implications for the disposition of services in each of the five options.

R2.2. Providing a clear and compelling strategic narrative that sets the case for change in context is more likely to engage clinicians, the public and politicians.

R2.3. The language used to describe the plans for service change, should be understandable by all. The five service configuration options lack clarity in their description. A consistent nomenclature would assist the reader greatly in navigating the options and the PCBC more generally.

R2.4. Terminology of the different hospitals: There is significant potential for the terms 'Hub and Spoke sites' to be equated negatively in the public's mind, with assumptions about the full range of services available at the centralised hub acute site with 'lesser' services provided at the 'Spokes'. It is very important to be explicit about what services are not at a 'Spoke' hospital site as well as what is.

R2.5. For the hospital with the centralised acute services, it would seem more appropriate and sufficient to call it the 'acute hospital' or 'major acute hospital' rather than the term used throughout the PCBC.

R2.6. The PCBC needs to describe any "burning platforms" and the consequences for delivery of healthcare if the PCBC is either delayed or rejected.

R2.7. The PCBC was not sufficiently developed for the clinical senate expert panel to come to conclusions about the deliverability and sustainability of each of the five reconfiguration options being proposed. There needs to be a more detailed description of patient pathways, of the role and modus operandi of the 'Spoke' sites, the bed modelling, and a detailed and comprehensive outline of the workforce requirements reflecting an aligned workforce strategy.

R2.8. There is a risk that the five options proposed could be interpreted as merely nuanced descriptions of a single option - the centralisation of all acute services to a single greenfield site with the subsequent remodelling of services at the 'Spoke' sites of Winchester and Andover. There needs to be consideration made to the number of options finally presented at public consultation.

R2.9. The judicious use of common patient pathways and vignettes would provide an effective tool to meaningfully describe specific pathways, particularly those that realise the model for 'local Spoke care'. This approach would provide significant reassurance to the reader, e.g. the frailty pathway.

R3. The 'Hub' and 'Spoke' hospitals, urgent treatment centres (UTCs), community and rehabilitation beds and primary and community services are part of a single system: A full understanding of how these all inter-relate with the patient pathways, is required to more fully anticipate capacity and demand in the future models of care.

R3.1. There needs to be stronger references to clinical sustainability through a community and primary care lens. The PCBC does not articulate the ambition of sustainable health, that is the PCBC focuses on the establishment of a new hospital rather than reflecting the needs of the population and the patient pathways as drivers for developing a new model for sustainable health care for the population of north and mid Hampshire.

R3.2. The PCBC needs to be clearer about how the proposals will capitalise on the existing primary and community provision to support strategic objectives (enhancing community based care & rehabilitation) and support flow within the north and mid Hampshire System.

R4. Be clearer about the balance that needs to be struck between the patient benefits of centralising the various clinical services, and the increased travel time to those services for elements of the population.

R4.1. The positive potential impact on improved outcomes and quality of hospital based acute care from centralisation (relevant to all options), balanced against the increased travel times to access such care for the residents of certain areas of north and mid Hampshire, should be clear and up front in the presentation of the options. That there is an unavoidable trade-off between these two impacts should be fully acknowledged, and such transparency and honesty is likely to be positively received by the public and their elected representatives.

R4.2. The equality assessment summarising travelling time suggests that there are existing inequalities among Black Asian and minority ethnic (BAME) populations and deprived communities, but this is not developed sufficiently. Patient transport is a key area that needs further development, the Strategic Health Asset Planning and Evaluation (SHAPE) tool [3] is a web enabled, evidence based application that informs and supports the strategic planning of services and assets across a whole health economy. Its analytical and presentation features can help service commissioners to determine the service configuration that provides the best affordable access to care. Application of this tool may be of help in understanding travel better and which communities will be most affected. Once you have this, plans to then mitigate the negative impact of longer travel could then take place.

R4.3. There are no patient pathways described beyond an outline of the scope of services on each site, for each of the five options. More explicit patient pathways for the main clinical services should be presented, particularly for the more geographically isolated populations, to ensure they are demonstrably safe and to provide re-assurance to the population.

R4.4. Make clear how the plans for improved and innovative local services planned for the 'Spoke' hospitals can avoid the need for unnecessary travel to what might be a more distant acute hospital.

R4.5. The PCBC does not articulate the current patient pathways out of area. A description of activity flows into and out of area before and after reconfiguration plus any differences between options would be particularly helpful. It will be important to describe these in sufficient detail; quantify and assess how they may be impacted upon by the centralisation of acute services to a single green field site near Basingstoke.

R4.6. There is insufficient reference to engagement and joint planning with neighbouring acute stakeholders that may be impacted upon by the proposals.

[3] Strategic Health Asset Planning and Evaluation (SHAPE) tool https://shapeatlas.net/

4.2 Changes in population and demand, and bed modelling

4.2.1 Demographic projections

R5. Provide population projections through to at least 2035/36 to plan the future capacity required more convincingly.

R5.1. More detailed analysis of the anticipated demographic changes up to 2036 (reflecting the likely build time for any new hospital) would be helpful, to understand in more detail the future healthcare demand and capacity requirements (including hospital beds), as this will be a major factor in determining the feasibility of the proposed centralised model of acute care. Data should be broken down by age categories (to understand the future demand across a range of services). Not only is there the growth in the more elderly population to anticipate, with their associated co-morbidities and higher use of health and care services, but consideration needs to be given to areas of new housing developments and their populations. Some of this is described in your councils JSNA demography document[4].

R5.2. Population health needs – demographics and future demand is expressed only through the acute services lens. It would be helpful to describe the impact of this data on community and primary care services. The narrative needs to be enhanced around equitable access for all populations. It may be helpful to engage the support of public health colleagues from Hampshire County Council around forecasts and modelling of future demand and how interventions around prevention and demand management may have an impact.

4.2.2 Urgent treatment centres

R6. The full implications of having UTCs on a different site from the acute hospital, and how any demand and capacity risks will be mitigated, should be described.

R6.1. The plans for the future location of UTCs needs to be made explicit within the PCBC and the anticipated scope, opening times, range of services available and alignment with primary and ED services at each proposed UTC should be stated.

[4] https://documents.hants.gov.uk/public-health/JSNA-demography-chapter-2019-12-13.pdf

R7. Estimate the projected level of activity in the UTCs that will contribute to the management of ED demand.

R.7.1. The urgent treatment centres (UTCs) are expected to reduce demand on the planned single consolidated emergency department (ED). This impact is not currently quantified and needs to be separated out from planned demand reduction from any of the other community based initiatives. A clearer outline of the types of cases that would be diverted, and credible methodology provided for such quantification is required. Such information will be essential for planning the required capacity in both planned UTCs and the main ED.

4.2.3 Same day Emergency Care

R8. The PCBC should state the current proportion of acute admissions treated as same day emergency care (SDEC) patients, and the impact of moving to the 33% expectation.

R8.1. Same day emergency care (SDEC, previously known as 'ambulatory emergency care') delivers diagnosis and treatment without admission for acute and sub-acute medical and surgical presentations. The NHS Long Term Plan states that the proportion of acute admissions discharged on the day of attendance will increase from a fifth to a third (nationally), for both medical and surgical patients.

4.2.4 Current bed numbers, demand and capacity modelling

R9. Given the difficulty in accurately projecting the impact of each of the five configuration options on required future bed capacity, providing a range rather than a fixed number of beds for each 'Hub and Spoke' site would acknowledge the uncertainties and avoid overly ambitious projections.

R9.1. The demand and capacity modelling mapped for each of the options is currently incomplete and recognised by north and mid Hampshire as work in progress. This work is essential to complete before the PCBC is taken further, with significantly more detail about the different types of beds across the System, and the assumptions used in modelling is required. There is a risk that reduced length of stay (LoS) and admission avoidance assumptions may be too ambitious, leaving the System with insufficient beds. It is difficult to see how financial costs of the options can be accurately forecast without such work.

R9.2. It would be helpful to include modelling related to plans for admission avoidance and discharge enhancing initiatives. This would provide additional confidence re 'local' pathways of care, demonstrate that this forms part of an integrated approach with primary and community services and would support the validation of acute care assumptions.

R9.3. It is important to separate the bed modelling and assumptions for children from adult services.

4.2.5 'Spoke' Hospital beds and services

R10. It will be important to clearly identify each of the proposed 'Spoke' sites, Andover and Winchester alongside further facilities at Alton and Eastleigh within the narrative. The narrative would be strengthened by describing the proposed role and function of each of the 'Spoke' sites within each of the options.

R10.1. A detailed and clear understanding of the number of beds and what types of patients will use them has not been provided in the PCBC. It is essential that such clarity and modelling is available. The narrative suggests that 'Spoke' sites may admit step down patients and provide a local health network hub, but this is not defined and may not be uniform between each of the sites. If such beds are to be provided at the 'Spoke' site, then it will be important to state the admission criteria to access these beds alongside the proposed medical staffing model.

R10.2. It is essential to make more explicit the anticipated bed numbers at Winchester and Andover as these beds will be part of the overall non-acute bed base. It would be important to understand flow through these beds, and the likely changes in demand resulting from demography (especially the increasing prevalence of the elderly, and those with dementia), and the plans to avoid or minimise acute hospital bed utilisation for patients who don't need such facilities (which will result in patients with greater needs requiring care outside of hospital). A review of length of stay in these beds to understand the potential for more effective utilisation, and for mapping out the future requirements, is advised. The criteria for 'Spoke' hospital and for community bed admission (if separated), for step up and step down patients would benefit from greater clarity when estimating the overall bed requirements.

R10.3. In the options where the Planned Surgery Centre is based at the Winchester 'Spoke' site it is anticipated that low risk surgical patients would also be bedded at Winchester, but the number required was not provided. Inpatients requiring rehabilitation (such as after trauma), would also need access to these beds. Assurance needs to be provided of how patient flow will be managed. Without a very robust pathway these beds may become blocked and down stream flow will halt.

5. Clinical standards, and improving health outcomes

R11. Better use needs to be made of formal references to clinical standards used to inform the development of the clinical model across the narrative. The benefit of centralising acute services taking account of all essential clinical co-dependencies is well described.

R11.1. Whilst it was encouraging to hear the ambition on improving population health outcomes, it was not clear which clinical outcome measures would be used, or how health inequalities would be reduced by the proposals. The PCBC would be much stronger if it focused on considering clinical outcome measures alongside process and staffing metrics. This will be particularly important for populations who are likely to be most impacted by the proposals.

R11.2. The PCBC needs to demonstrate how the proposals will improve outcomes as currently this is not described, especially for maternity, neonatal and paediatric populations.

6. Workforce issues

The PCBC makes clear that detailed workforce plans remain incomplete, but that work was progressing. This significantly constrained the ability of the clinical senate panel to evaluate the deliverability and sustainability of workforce plans for the five options. The panel was therefore restricted to general comments about the workforce issues, identified gaps and highlight areas of concern with regard to how and if the gaps can be addressed. Whilst the panel recognised that this was currently work in progress it is important to note that NHSE&I stage 2 assurance would require the provision of supporting evidence at a level of detail beyond what is currently available.

R12. Highlight the variation in workforce challenges within each of the proposed options, delivering a range of option specific 'Hub and Spoke' services across two sites.

R12.1. Reference is made to the current challenge of maintaining fully staffed rotas across two ED sites with similar staffing challenges in delivering paediatric and maternity services across multiple sites. The workforce requirements and solutions presented in the PCBC predominantly focus on the proposed centralised acute services model, highlighting current areas of consultant staffing 'pressures'. There is insufficient information with respect to proposed staffing models for the 'Spoke' sites, or the maintenance of safe cross site specialty rotas where relevant.

R12.2. The narrative currently focuses on the medical workforce, particularly consultants, with only very limited mention of nursing and therapies staff. There should be more detail provided on the requirements for nursing staff and AHPs (Appendix H) across the range of services and sites including community and rehabilitation. It will be essential that the potential for alternative workforce modelling is maximised to support clinical delivery and sustainability. The workforce strategy will need to be innovative, flexible and use extended roles (such as Physician Associates and Advanced Nurse/ AHP practitioners /Advanced Clinical Practitioners (ACPs)), and the System should continue to work with Heath Education England in developing their plans.

R12.3. The clinical senate heard in the presentation that all the workforce was valued and their wellbeing important, this needs to come through clearly in the PCBC.

R12.4. Insufficient reference is made to ongoing training and education proposals for the existing work force. Consideration should be given to innovative approaches to System wide training and development for all clinical staff, including rotational opportunities between acute and the community. It would be important to state what is innovative about the proposals that would attract the workforce to take up trainee roles in the reconfigured system?

R12.5. There was no mention in the PCBC of recently commenced 'Health and Care Profession' undergraduate programmes at Winchester University or of the potential benefits of building strong alliances with the University. These new programmes provide excellent opportunities for recruiting future clinical staff, as well as generating graduates who will often seek their first roles in the same region as their University. It is possible that postgraduate courses for existing staff will also be available thus increasing opportunities for both recruitment and retention.

R12.6. The workforce requirements of the 'Spoke' sites, particularly for inpatient care, are unknown, as the clinical model and criteria for admission have not been described. The workforce skills and numbers need to align with the acuity and complexity of the patients, and the anticipated workload. This is a serious gap in the current plans and detailed work is required to align a realistic workforce plan with the clinical model.

R12.7. Many community based initiatives working from the 'Spoke' sites, the UTCs, and primary care itself, are highly dependent on the GP workforce. Future plans must take more explicit account of the recruitment challenges posed and describe potential mitigations. It would be helpful to align future PCBC narrative with current primary care strategic plans, developing System wide innovative workforce solutions that are likely to be required to deliver a range of services at the 'Spoke' sites[5].

[5] Hampshire and Isle of Wight Primary Care Strategy June 2019

R12.8. There is a need to take account of the impact of the potential 'split' of complex outpatient centres across two sites (Winchester and Basingstoke), to keep outpatients 'local' on consultant job plans for three of the current options (2.5, 2.6 and 2.7). Any impact assessment would need to include travel time. The panel acknowledges that potential digital solutions will go some way to mitigate this work force challenge, but the PCBC needs to detail the full plans to demonstrate that any proposed rotas are viable and sustainable.

7. Clinical, patient and public engagement

R13. Better use needs to be made of the current examples of public and patient pre engagement. Describe in more detail the level and scope of patient and public pre engagement of the proposed reconfiguration options.

R13.1. Whilst the PCBC reflected some evidence of patient and public pre engagement, there was insufficient illustration of how patients and public could help co-design future services, using 'experts by experience' (formerly 'expert patients') and relevant patient groups. The concept of a population 'Vox Pop' video as shown at the beginning of the clinical senate panel was excellent however, there was some dissonance between the commissioner and provider aspiration for a new acute site with the focus of public comments on the priority to modernise health services sensitive to population needs. If patients and the public have been involved in such co-design, this should be highlighted in the PCBC.

R13.2. Given the potential balance required between the centralisation of acute services sustainability and quality of care on the one hand, and the desire for local access to hospital services on the other, it was not clear if the questions asked of the public addressed this issue. If not, it is likely to prove informative for north and mid Hampshire to understand the public's view of this potential trade off specifically in relation to ED, maternity and paediatric services. This balance applies in different ways to all of the shortlisted options.

R13.3. There is an opportunity to use the centralisation of cardiac services on a single acute site to positively demonstrate the trade-off between improved service delivery and clinical outcomes with a requirement to travel to a centre of excellence.

R13.4. Insufficient reference is made to the 'Listening Document' developed by the System to provide an overview of the plans and encourage patient and public engagement with the planning process. It is recommended that the PCBC narrative reflects the key focus of this strategic overview and that the document should become a formal appendix to the PCBC.

R13.5 The PCBC provides insufficient detail of how patients and the public have been engaged in designing future pathways. A revised narrative should describe the approach taken to involve them in the overall service design programme.

R13.6. Whilst recognising that a patient facing summary document will be available alongside the PCBC it remains essential that the presentation of options must not confuse the reader. It will be essential to revise the PCBC narrative with this in mind.

R13.7. There is no reference to specific maternity or paediatric engagement in the PCBC as written. The clinical case for change ideally needs to be developed and supported by clinicians (medical / nursing / AHP) as this will help overcome resistance from service users and the general public if the focus is on outcomes and experience.

R14. Describe in more detail the level of clinical engagement about the case for change and the proposed reconfiguration of the Hampshire Hospitals Foundation Trust (HHFT).

R14.1. Further clinical and PPE engagement may be facilitated through existing networks including the Maternity Voices Partnership (MVPs), neonatal network and paediatric surgery Operational Delivery Networks (ODNs).

8. The options appraisal process

R15. Re consider how to best present the shortlisted options within the PCBC.

R15.1. Whilst it is not the role of clinical senate to make recommendations on option appraisal process issues, there were concerns expressed about the number of options presented as the short list. Concern was expressed that putting five options forward for consultation was too many, particularly as they could be interpreted as a single option for the centralisation of acute services onto a single site, supported by a range of nuanced sub-options for the disposition of planned surgery and complex outpatient centres.

R15.2. Within this context, concern was expressed that the PCBC narrative currently identified a preferred option and that this may be construed negatively by the broader public during consultation.

9. Urgent and emergency care pathways

R16. There is currently insufficient description of urgent and emergency care (UEC) pathways within the PCBC. The UEC system needs to be seen as an integrated whole, with the PCBC detailing the component parts, and how patients would move through the system.

R16.1. UEC pathways need to be described in greater detail taking account of the main components including ED, SDEC, beds, 111 First, Clinical Assessment Service (CAS), 'Spoke services', UTCs, South Central Ambulance Service (SCAS) and Primary Care etc. Consequently, any future evaluation of reconfiguration options would be able to fully understand the proposed functioning, location, capacity and workforce requirements of each of these component parts.

R16.2. The PCBC should articulate the planned ED pathway/mapping between primary and secondary care. The role of SCAS will be central to the success of the pathway. The development of a robust Directory of Services (DoS) reflecting adult and paediatric services is essential, alongside a (digitally enabled) mechanism that ensures there is a shared understanding of capacity across the System at any time.

R16.3 The PCBC would benefit from a clearer narrative regarding the management of demand. It will be important to describe how an integrated UEC system working alongside community and primary care partners may support demand management, enabling patients to access services appropriately. The use of patient pathway diagrams, or vignettes in the PCBC would significantly benefit the readers' understanding of the proposed UEC clinical model.

R16.4. The PCBC does not evaluate the potential risks or planned mitigation for UEC pathways when ED provision is centralised to a single site that may be geographically distant for some of the population. It is essential that the PCBC acknowledges and quantifies the potential risk that the population in Winchester and the more 'southern and eastern localities of the patch' may choose to access UEC services at Southampton or Frimley as opposed to travelling to the new acute greenfield site. A clear narrative describing the anticipated UEC pathways for Winchester residents would significantly assist understanding of the proposals and allay potential anxieties.

R16.5. Provide details of the increased capacity likely to be required of the ambulance and patient transport services.

10. Urgent treatment centres

R17. Plans for the provision of UTCs and what level of acute care can be provided there, as part of the UEC pathway are not sufficiently stated. A clearer understanding of the proposed model, the implications for patient pathways and the need for transfer to the acute hospital site for those requiring it, should be provided.

R17.1. Whilst the current narrative states that UTCs will be located at both of the 'Spoke' sites, Andover and Winchester, their times of opening are not clear, 24/7 or 12/7? Greater clarity is required on whether there are plans for an alongside UTC on the centralised acute site. The patient pathway for standalone and alongside UTCs will be quite distinct.

R17.2. Whilst full details of each UTC may be excessive for the PCBC, it will be essential to state the workforce plan for the planned UTC provision to include GPs, appropriate nursing, AHP and other staff to reflect opening hours. It is important to note that other providers in England have 'struggled' to staff units according to the UTC specification and are having to use ED staff rather than GPs.

R17.3. The overall impact on reducing demand on the ED at the central acute hospital, and the assumptions made for such modelling, is not apparent. This will be required in planning the future capacity requirements of the ED department. How will you ensure that patients access the UTCs where appropriate rather than coming to the ED?

R17.4 Greater clarity re the scope and range of diagnostics available at all UTC sites is essential to support provision. There are important differences in the appropriateness of an individual UTC for higher acuity, sicker patients, according to the diagnostic and treatment facilities available on site, the range and skills of the workforce available, and the access to acute hospital services.

R17.5. For patients accessing UTCs on the 'Spoke' sites, onward transfer to the centralised acute hospital may introduce delays in diagnosis and treatment, and requires the right triage first time, clear protocols in place, seamless communication with the ED and a range of specialists at the acute hospital, together with sufficient ambulance transfer capacity and agreements with the ambulance service as to which type of patient is conveyed where. For example, acute abdominal pain may be medical, general surgical, vascular, urological or gynaecological in its aetiology. These need to be described within the PCBC.

R17.6. For paediatric UTC provision on a 'Spoke' site there are challenges posed by providing a facility for acute paediatrics without inpatient facilities. There is a need to define what will be provided within or alongside the UTC, defining the imaging / pathology support with access to remote reporting as necessary. This will be especially important for the Winchester population given that they are used to having a paediatric ED available and without this there would be the need to travel to a greenfield (Basingstoke) site to access this or to Southampton or Frimley. It will be important to define how the acutely unwell child presenting to the UTC will be managed. Additional support mechanisms may need to be considered to enable paediatric provision at the UTCs. These may include the need to establish primary care in-reach or consultant-delivered paediatric support to the UTC for defined hours.

R17.7. It is important to note that EDs / UTCs perform a significant primary care function in paediatrics. There may be a need to strengthen PCN-led paediatric care through paediatric hubs adopting a PCN MDT and CHAT model.

11. Emergency Department (ED)

R18. The current description of ED services does not provide sufficient detail. Specifically, the narrative must define and model the amount of activity including throughput that the ED will be required to deliver in the future for all options.

R18.1. There will be impacts relating to demographic change, travel times, the impact of the proposed model for UTCs, and the range of developments planned in primary and community care. Deciding on the overall workforce (primarily medical, nursing and AHPs) for the future ED requires such modelling and should be reflected within the PCBC.

R18.2. The PCBC currently does not provide any detail on proposals for ED medical staffing. Future narrative should detail how the acute medical take is to be provided and by whom (consultants in acute medicine, with or without the participation of consultants from other medical specialties).

R18.3. The narrative should reference any agreed standards and summarise the current and predicted consultant workforce required for each option (if variations are anticipated), factoring in the provision of SDEC on the acute site.

R18.4. The NHS Long Term Plan expects the proportion of acute admissions discharged on the day of attendance to increase from 20% to 33%[6]. We could not locate any data showing the current proportion of overnight admissions avoided, or what the impact of achieving at least the LTP's stated 33% goal would be. This is important to estimate, as it has an impact on manpower, floor space and bed requirements, and on non-elective admissions.

R18.5. It will be important to clarify whether SDEC will be provided at the 'Spoke' sites, if so there is a need for clarity as to who would be delivering this care, and if acute physicians how this would be delivered.

R18.6. Many patients will be identified for SDEC in the planned UTCs. How these UTCs link with the SDEC services, and where they will be located in relation to the UTCs, needs to be established.

[6] NHS Long Term Plan. Page 22. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

12. Acute medicine and surgery at the centralised acute site

R19. Insufficient detail has been provided in the PCBC on the proposed clinical models for both acute medicine and surgery. Further detail is required on the proposed consultant workforce needed to run the acute medical and surgical rotas.

R19.1. The co-location and co-dependencies of acute services should be reflected in more detail as part of the proposed models of care and patient pathways. Currently they are only described as part of the rationale for centralising services on a single acute site. It will be important to consider the impact/influence of the specialist services at the borders of north and mid Hampshire.

R19.2. Clarity is required with respect to major trauma and vascular pathways. It would be helpful to confirm whether current arrangements re diversion to nearest networked centre will remain as they are, managed by network partners.

R19.3. The acute medicine rotas for the centralised acute hospital should take account of the additional sessions required to run the SDEC service, if also provided at the 'Spoke' sites. The SDEC service has not been described in enough detail to fully understand how and where this service is going to be delivered across north and mid Hampshire.

R19.4. Similarly, the provision of an acute surgical SDEC unit will require senior supervision and presence and needs to be taken account of in the general surgeons required workforce.

R19.5 The provision of stroke care (HASU and ASU) within the centralised acute hospital should be made clearer. This would include TIA clinics, and the provision of rehabilitation post-stroke for those unable to return home after acute stroke care (though within the overall inpatient rehabilitation strategy for north and mid Hampshire).

R19.6. The impact of additional stroke mimic patients presenting to the UTCs, on the 'Spoke' sites with transfers to the HASU at the centralised acute site must be considered, and clear pathways should be in place to ensure effective clinical communications (including digital solutions) between the sites providing initial assessment and the stroke team at the HASU, to avoid unnecessary transfers and to ensure the patient gets to the right place for ongoing care within the required timeframe.

13. 'Spoke' Hospitals

R20. The clinical model for 'Spoke' hospitals; the services provided, types of patients and their acuity, patient flow and workforce required is not described. As a consequence, it is difficult to assess the validity of any of the options. As such a fundamental component of the reconfiguration plans for all five options, much more detail on services provided and the patient pathways in to and out of these 'Spoke' hospitals is required.

R20.1. A clearer definition of what types of patients 'step down' into 'Spoke' facilities is required, and the criteria for admission to such beds. Are 'Spoke' beds an integrated element of any frailty pathway?

R20.2. It is assumed that 'Spoke' hospital beds are to be used for patients needing rehabilitation services but who are unable to be cared for in their usual place of residence (such as non-stroke neurorehabilitation, post-trauma, and frailty). These beds would be networked presumably with the current and any planned rehabilitation beds in the community. A summary of the plans for inpatient rehabilitation, (acute and community) in north and mid Hampshire is required to give the full picture.

R20.3. There needs to be more evidence of collaborative working with social services in developing this model, as patients being admitted and discharged are likely to be highly dependent on such local authority services.

R20.4. The workforce required for the inpatient wards at the main 'Spoke' hospital sites, Winchester and Andover has not been described, yet this is critical if such patients are going to be cared for in a safe and high quality clinical environment. There are many similarities between the 'Spoke' hospitals described in the PCBC, and the 'district hospitals' proposed for the Epsom and St Helier NHS trust that was subject to a joint London and South East Clinical Senates review and NHSE&I statutory Stage Two Assurance process in 2019. Much more detail about those district hospital beds were provided to that review than has been made available in the Hampshire Together PCBC. We strongly recommend that section 6 of that review (see footnote for weblink), and recommendations 53-71 therein, is referenced as planning is progressed[7].

[7] Joint Clinical Senate Review of the Improving Healthcare Together 2020-2030 pre-consultation business case, for Surrey Downs, Sutton and Merton CCGs. South East and London Clinical Senates March 2019. https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/06/Joint-clinical-senate-review-of-Improving-Healthcare-Together-2020-2030.pdf

R20.5. Management of public and patient expectations is critical in terms of describing the future configuration of services particularly at the 'Spoke' sites. It will be important to differentiate which aspects of clinical services are to be included within the HIP2 scheme funding and what is outwith current plans and would be subject to additional future bids for funding.

14. Community services and beds, and inpatient rehabilitation services

14.1 Community services

R21. The PCBC needs to detail the planned roles and related capacity of community beds and services, how they will support the proposed clinical models at both of the 'Spoke' sites and the centralised acute hospital.

R21.1. Whilst it is not anticipated that community service developments are part of this scheme, greater clarity re planned community developments and how they will 'dove tail' with plans for acute/'Spoke' services are essential.

R21.2. The anticipated role of community services in supporting admission avoidance as part of the patient pathway needs to be made more explicit. This could include descriptions of a range of community based initiatives that aim to help reduce avoidable acute hospital admissions, and enhance discharge e.g. a frailty or crisis dementia programme. These should be summarised within the PCBC.

R21.3. The PCBC narrative needs to provide confidence that there is sufficient AHP workforce to support the planned capacity in the community for rehabilitation.

R21.4. Using common platforms with primary care to share standardised patient pathways will be essential in order to maximise the benefits of admission avoidance and ensure safe and quality services.[8]

R21.5. The totality of community beds at the 'Spoke' sites alongside home based rehabilitation pathways need to be modelled from a whole system perspective. Pathways in to and out of these beds, and how they relate to patients in the centralised acute hospital as well as all of the 'Spoke' hospitals should be mapped. This will help in understanding the LoS in the various inpatient facilities, and in modelling the bed requirements in Hampshire Hospitals for all options.

[8] https://www.kingsfund.org.uk/sites/default/files/2017-08/Developing_ACSs_final_digital_0.pd

14.2 Inpatient rehabilitation

R22. The PCBC needs to detail proposals for inpatient rehabilitation across a range of 'Hub and Spoke' settings, detailing proposed clinical pathways.

R22.1. Inpatient rehabilitation is provided in a range of settings, depending on the complexity of the patient's needs. Beds are provided in a range of settings, from the acute hospital following surgery, stroke or trauma, through to the proposed 'Spoke' site beds, specialist rehabilitation beds and lower dependency beds in the community. The PCBC does not provide sufficient detail on rehabilitation pathways, and the overall capacity in the community, but will need to in order to understand the demand for the 'Spoke' site bed base for rehabilitation, and how that will be coordinated with other providers, specifically Southern Health NHS Foundation Trust.

R22.2. Inpatient rehabilitation should be provided locally where possible[9]. This depends on the severity and complexity of the patient's needs, and the level of support required. National guidance recommends level 3 (non-specialist rehabilitation) is provided locally, whilst level 2b services should be provided at a district level of 250-500,000 catchment area, with level 1 services provided for catchment populations of 1-3 million[10]. The provision of rehabilitation beds in Hampshire Hospitals within the acute and 'Spoke' sites should be aligned with the overall capacity plans and rehabilitation pathways for Hampshire and IoW in general, and north and mid Hampshire in particular. It will be important to ensure that patients with low complexity needs continue to be able to access 'local' facilities.

R22.3. Adequate capacity of the AHP workforce as it relates to rehabilitation, will be a key enabler of efficient and effective flow through the various inpatient units, and more rapid patient recovery. Workforce and capacity planning for the PCBC and the five options for reconfiguration are unavoidably linked to the AHP workforce capacity and training pipeline, and such links could be made more explicit[11,12].

[9] Manifesto for community rehabilitation. Assorted health-related organisations and charities. December 2019. https://www.csp.org.uk/system/files/publication_files/001669_PUK%20MANIFESTO%202019_MOB%201ST_0.pdf

[10] Specialist neuro-rehabilitation services: providing for patients with complex rehabilitation needs. British Society of Rehabilitation Medicine 2015. https://www.bsrm.org.uk/downloads/specialised-neurorehabilitation-service-standards--7-30-4-2015-forweb.pdf

[11] Allied Health Professions into Action. Using Allied Health Professionals to transform health, care and wellbeing. 2016/17 - 2020/21. NHS 2017. https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf

[12] AHP into Action workforce modelling. https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf and BSRN neuro rehab standards https://www.bsrm.org.uk/downloads/standardsmapping-final.pdf

15. Liaison Psychiatry

R23. The plans to deliver a 24/7 liaison psychiatry service to the acute hospital is strongly supported. It was not clear to what extent there would be access to liaison psychiatry at the 'Spoke' hospitals.

R23.1. An urgent and emergency care system must integrate plans for managing mental health crises, and mental health conditions in those presenting with concurrent acute physical ill health. There is only limited mention of liaison psychiatry services and how they will be provided across the centralised acute hospital and the 'Spoke' hospitals (ED or UTC). Additional detail is required. For context, the NHS Long Term Plan lays out expectations for acute mental health care for both younger people and adults[13,14].

R23.2. Much more detail is also required on their overall approach to mental health, in particular prevention and prevention of suicide.

16. Critical Care

R24. Estimating the future capacity requirements for ICUs and HDUs in HHFT is essential, including additional COVID-19 ready capacity.

There are two key documents that should guide the future critical care service:

- The service specification for critical care of NHS England Specialist Commissioning D05, which should be considered as a requirement now, even for units undertaking minimal specialist commissioning work[15].
- GPICS II[16], which outlines the standards to which Intensive Care Units (ICU) services should be designed to meet.

R24.1. We did not see such modelling in the PCBC or supporting materials, but the assumptions made in such modelling should be verified. It would need to take account of the demographic changes (the aging, increasingly co-morbid population), and the centralisation of services (such as stroke and vascular) that would increase demand for ICU care. The current bed base is across two sites Winchester and Basingstoke.

[13] NHS Long Term Plan: Adult mental health services. https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/adult-mental-health-services/

[14] NHS Long Term Plan: Children and young people's mental health services. https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/children-and-young-peoples-mental-health-services/

[15] Service specification for critical care of NHS England Specialist Commissioning D05. NHS England. https://www.england.nhs.uk/wp-content/uploads/2019/05/Adult-Critical-Care-Service-Specification-FINAL.pdf

[16] Guidelines for the provision of intensive care services. Faculty of Intensive Care Medicine, and the Intensive Care Society. June 2019. https://www.ficm.ac.uk/sites/default/files/gpics-v2.pdf

R24.2. For critical care medical, nursing and AHP staff, it is possible that there is an expectation that large numbers of these staff will transfer from the closing ICU to the site that remains open (Basingstoke in all options). Is there a degree of confidence that this will be the case, illustrated through staff surveys or other assessment?

R24.3. Confidence in the proposed critical care pathways are essential given the fundamental role of critical care in supporting ED, acute medicine and acute surgery. It may be helpful to append any recent reviews by ODNs, providing additional confidence in the proposed models.

R24.4. There is a need to ensure provision in adult critical care for children and young people (CYP) 16-18 years old.

17. Maternity and neonate services

R25. The PCBC needs to detail proposals for maternity services across the range of 'Hub and Spoke' settings proposed, detailing proposed clinical pathways.

R25.1. The trade-offs between the benefits of centralising obstetric inpatient care on to one site, such as greater consultant presence on the obstetric floor across the week, ability to sub-specialise, have separate consultant gynaecology and obstetric rotas, and enhance recruitment and retention potential, with the increased travel times to a more distant obstetric unit, for certain populations in north and mid Hampshire, should be made clearer, with mitigations described for how such women will be able to access a more distant inpatient service. Consideration of the impact on the midwifery workforce should be stated. The challenge of bringing together two workforces/cultures should not be underestimated.

R25.2. The PCBC needs be clear on current provision at Andover, the proposed changes and provide projections on the scope and activity for each site, especially the MLU at Winchester. It is currently unclear on what basis the plan to locate 6 beds in the birthing centre was made.

R25.3. The PCBC needs to be strengthened through user engagement and co-production; the community voice, engagement with the LMS and it should be co-designed with obstetricians and midwives.

R25.4. How does the case for change support and meet the national safety and choice ambitions? The PCBC should state how plans link with the Halve It campaign, around still birth, neonatal death, maternal death and neonatal brain injury and evidence the link to the national standards. What lessons have been learned from Healthcare Safety Investigation Branch (HSIB) reports?

R25.5. The PCBC language should reflect the whole pathway of care and not just maternity led births.

R25.6. There could be more clarity as to how the MLU at Winchester will support home births.

R25.7. It will be important to state whether any change to the referral pathways from Winchester to Basingstoke are envisaged?

R25.8. The narrative does not sufficiently consider perinatal mental health and maternal medicine.

R25.9. There is an opportunity to describe the digital maturity of the IT systems and linkage, specifically the link into the neonatal system.

17.1 Neonates pathway

R25.10. The narrative presents a very strong clinical case for change to convince the public, however, there is some dissonance in the PCBC. If the proposed model is to be fully supported further detail will be required specifically that the standards set out in the Get it Right First Time (GiRFT) recommendations and Care Quality Commission (CQC) actions for neonatology are being met.

R25.11. It will be important to model the neonate activity projections for 80% occupancy, based on the critical care transformation review, but additional capacity needs to be available for future growth. Detailed workforce modelling will be essential in order to mitigate against losing the benefit of a centralised model if duplicate rotas at tier 1 and tier 2 are planned.

R25.12. Neonatal outpatient services are currently provided at Winchester. The PCBC needs to clarify whether the proposed complex outpatient centre will continue to provide these services.

R25.13. Greater clarity is required with respect to the provision of MLUs within the pathway, specifically whether the MLU at Andover will be retained?

18. Paediatrics

R26. The PCBC needs to clearly describe the proposed model for paediatric services. Ideally, the PCBC would take maternity, neonatal care and paediatrics separately.

R26.1. Describe how the population demographic and needs are driving the clinical case for change and how the proposals meet those needs for now and the future.

R26.2. It will be important to provide a clearer explanation of how the service works as an integrated whole and links in to UTCs, assessment units, and community paediatrics. The PCBC should illustrate how patients would move through the system.

R26.3. The scope of paediatric provision at the UTCs is not defined.

R26.4. There is an opportunity to describe the provision of paediatric critical care (level 1) on the hub site.

R26.5. The PCBC needs to clearly describe the proposed model for paediatric outpatients where the strategic model suggests that complex outpatients could be offered at the 'Spoke' sites in options 2.5, 2.6 and 2.7 -There is the opportunity to provide outpatient clinics in neonatology / paediatrics / paediatric surgery if appropriate imaging / pathology services are on-site. There is a strong case for providing outpatient services at the 'Spoke' site, especially Winchester.

R26.6. There is an opportunity to describe provision and pathways for teenage, young adults and transition services which are not sufficiently described currently.

R26.7. The PCBC should consider a separate paediatric ED or dedicated paediatric areas within the main ED on the centralised acute site with activity projections and associated workforce.

R26.8. The PCBC needs to reference all appropriate published clinical standards, ideally demonstrating how current services do not and cannot meet these standards and demonstrating how the proposals will.

R26.9. The PCBC currently does not provide sufficient modelling information for the following:

- The neonatal cot requirement based on 80% occupancy and reflecting neonatal network data.
- Paediatric surgery (day case and IP)
- Paediatric critical care (level 1).

R26.10. Workforce is a driver in neonatology / paediatrics, it is possible that the need to maintain a paediatric service at the UTC (Winchester) and to separate the neonatal and paediatric workforce will not yield the opportunities to improve staffing overall.

R26.11. The workforce plan needs to consider what skill-mix is available at the moment and how this maps to the skill-mix needs in the proposals. Specifically, the consultant workforce skills in neonatology given the need to provide enough consultants with an interest in neonatal medicine to provide a consultant of the week model to the LNU and potentially a dedicated neonatal on-call rota. The plan needs to identify how the RCPCH Facing the Future standards will be met which should be associated with improved patient outcomes and experience. It should be remembered that consultants on-call need to be within 30 mins of the hospital, and this may need the provision of on-site accommodation for any consultants who find themselves living further post reconfiguration.

R26.12. There will be a need for at least one paediatric emergency medicine consultant given activity projections of the ED on the centralised acute site.

R26.13. There is an opportunity to develop a plan on how Emergency Nurse Practitioners, Advanced Nurse/Clinical Practitioner and Physician Associate roles will be integrated given the challenge for medical staffing which is not likely to improve.

R26.14. The proposed model provides the opportunity to develop the integration of CAMHS / IAPT teams into acute care including paediatric mental health liaison teams.

R26.15. There is an opportunity to describe / exploit the benefits of integration with community paediatrics including in safeguarding and meeting the needs of children with disability and chronic conditions

18.1 Paediatric Surgery

R26.16. The PCBC narrative needs to define the provision for paediatric surgery including dedicated paediatric theatre, day-case facilities, surgical beds and outpatient services, ambulatory care, virtual fracture clinics in paediatric orthopaedics and any paediatric surgery OP clinics / theatre sessions provided by network surgeons from a specialised centre.

R26.17. The scope of paediatric provision at the Winchester planned surgery site needs to be defined (if any).

18.2 Interface between acute/UTC/'Spoke' and community primary care

R26.18. There is some description of the scope and integration of PCN / acute / community paediatrics in the PCBC and there is good potential to develop and extend these models further. The use of children's community nursing teams providing acute care and the primary care network MDTs with consultant paediatricians and associated AHPs CHAT / PCN is good. There is a case for developing this model further, especially for populations which will be served by 'Spoke' hospitals. The integration of acute and community paediatrics offers opportunity to deliver good outcomes and experience, especially if IT solutions can be employed between these elements.

19. Planned Surgery and Complex Outpatient Centres

R27. The PCBC needs to clearly and separately describe the clinical models for complex planned surgery, planned surgery and complex outpatient centres, taking account of the proposed disposition within each of the five options.

R27.1. The PCBC narrative needs to detail the proposed day case surgery and inpatient elective surgery patient pathways at the planned surgery centre. The patient case mix, acuity, pathways and essential clinical co dependencies are likely to vary depending on the siting of the planned surgery centre for each option and this must be reflected in the narrative.

R27.2. Understanding the likely proportion of patients who will deteriorate or have complications following their day case or low risk surgery in the planned surgery centre on a 'Spoke' site, and needing transfer to the acute hospital, is important for inter-hospital transfer planning with the ambulance services, and for understanding demand on acute hospital beds and critical care. This should be estimated. The anaesthetic manpower requirements will also need projecting.

R27.3. In options where the planned surgery centre is on a 'Spoke' site it will be important to consider the co-morbidity of patients. There may be greater value in defining the planned surgery centre clinical model by the type of patient not the type of procedure. Population data indicates that many patients may be too old or too unfit to be treated at a 'Spoke' site, a better planning perspective will be to look at types of patients who the 'Spoke' site can cater for.

R27.4. The critical co dependencies for a planned surgery centre with inpatient beds on a 'Spoke' site will require additional services and teams on site. Planned surgery without inpatient beds requires an entirely different service disposition.

R27.5. The PCBC needs to state clearly whether there are plans to protect the bed base for non-emergency inpatient care.

R27.6. The PCBC should explore the opportunities to develop a planned surgery centre at a larger scale. This would require Integrated Care System (ICS) colleagues working collaboratively across a wider geography.

R27.7. It will be important to clarify that for the complex outpatient's centre provided at Winchester (options 2.5, 2.6 and 2.7) whether all the required co-dependent services, specifically diagnostics would be available. The potential impact of 'split' site provision will need to be assessed.

20. Travel Times

R28. Travel is important to patients and staff. In the community, more deprived and isolated areas often rely on public transport. The use of patient stories within the narrative would mitigate the potentially negative views arising from centralising acute services to a single site.

R28.1. The integrated impact assessment within the PCBC provides a brief overview of the baseline travel data, the narrative then progresses to an options impact analysis. Whilst this outline data is helpful it provides insufficient detail of the risks and impact for the ambulance trust. The PCBC narrative should reflect travel times rather than just distance; effective joint working with the ambulance trust will be essential in order to mitigate the risks.

R28.2. It would be helpful to supplement the PCBC with an appendix that documents the travel times by option, site, pathway and proportion of the population able to access services within an acceptable time. There are significant differences to how far a pregnant woman may go to deliver, to someone travelling for an outpatient appointment or in an ambulance.

R28.3. Whilst the PCBC alludes to targeted travel focus groups prior to consultation, the establishment of a dedicated travel group would assist greatly to look at additional public transport needs and routes etc.

21. Digital

R29. It is clear that there is significant ambition to extend digital solutions at scale and pace, acknowledging the lessons learnt in response to the pandemic. But additional detail is required specifically how digital technologies will be used to facilitate the revised new models of care.

R29.1. It is reasonable to assume that there will be an increase use of technology, such as telemedicine, near patient monitoring and use of initiatives such as the Medical Interoperability Gateway (MIG) that will enhance patient record data sharing across sites and enable more local care without transfer. The MIG is an example of how the different health care professionals, sites and organisations can share patient clinical information to ensure coordinated, efficient care[17]. Examples of initiatives such as these will help to give confidence to the public in the future planning of their joined-up patient-centred healthcare.

R29.2. Locally led delivery, using open standards and underpinned by trust in how information is accessed safely and securely will be key to the success of Local Health and Care Records developments. All records should be digital, and they should be available to everybody along the patient pathway, or at least they should be interoperable, maximising the opportunities for 'joined up thinking.'

R29.3. The impact and learning gained through the rapid roll out of COVID-19 related digital solutions needs to be understood by the System, applying an 'honest lessons learnt approach', and then detailed in the PCBC, mapping these changes against the original pre COVID-19 plans.

22. COVID-19

R30. Whilst it was particularly helpful to see the extent to which COVID-19 has impacted on clinical delivery, additional narrative needs to reflect on 'lessons learnt' to date such as the use of digital and the impact on inequalities and how they can address this going forward, especially as COVID will be with us for the foreseeable future.

R30.1. It would be helpful to understand what has been done differently with reference to the proposed clinical models and pathways and to understand what should now continue, what requires further adaptation in order to ensure sustainability and what should be stopped.

R30.2. The panel sought clarification that any new build would reflect revised building requirements in terms of being COVID-19 secure and future proofed.

R30.3. The COVID-19 impact upon critical and major elective surgery could potentially be 'huge'. There is a potential need to model increased volumes of planned care as part of regional and cross regional mutual aid initiatives.

[17] The Medical Interoperability gateway. Nottingham North and East CCG. http://www.nottinghamnortheastccg.nhs.uk/wp-content/uploads/2015/05/What-is-MIG-information-document.pdf

23. ADDENDUM

Second Review of the Pre-Consultation Business Case – Option 3 for Hampshire Together: Modernising our Hospitals and Health Services

23.1 Context and methodology

Having completed a Clinical Senate Review 1-2 October 2020, the Hampshire Together – Modernising our Hospitals and Health Services (MoHHS) programme was notified by the Department of Health and Social Care (DHSC) on October 2nd, 2020 of conditions necessary to secure Health Infrastructure Plan (HIP) Phase 2 funding.

As these conditions and additional reconfiguration option were not available for consideration as part of the first Clinical Senate Review it was agreed that a second review, that addressed the three conditions would be undertaken on 2nd December in advance of the formal NHSE&I stage two assurance review scheduled for mid-December 2020 ahead of formal public consultation planned for early 2021.

The DHSC have required that there are three conditions to be satisfied:

1. *Royal Hampshire would receive "significant investment" as part of the scheme*
2. *Royal Hampshire's A&E would not be affected*
3. *And obstetrics would not be taken out of Royal Hampshire*

This second clinical senate review scrutinised an additional option, Option 3 which reflected the DHSC conditions and has been added to the programme's long list of options to satisfy these conditions.

The Clinical Senate agreed to reconvene the original expert review panel in order to review the additional reconfiguration option (Option 3). The Clinical Senate did not repeat the review of the full PCBC and the options as detailed there in within the second review, focusing solely on Option 3.

The panel membership is listed in Appendix 4. Great care was taken to ensure that all panel member's previous declarations of interest and confidentiality agreements remained valid for the second review.

The review related primarily to the clinical elements of Option 3.

For continuity and consistency, the KLOE previously applied to the clinical senate review of the full PCBC were adjusted where appropriate and similarly applied.

The additional documentation, an *extract* from the *PCBC Version 18* describing Option 3 was provided to the clinical senate team on 23rd November 2020. The document was reviewed and the key lines of enquiry (KLOE) were developed (Appendix 1). The additional narrative detailing Option 3, and key lines of enquiry were shared with the panel,

A half-day panel meeting was held on the 2nd December 2020. Members of the Modernising our Hospitals and Health Services (MoHHS) programme team and senior clinicians from the CCGs and HHFT, presented a summary of Option 3 and took detailed questions from the panel. The second half of the panel meeting was for the clinical senate panel alone to consider their response and recommendations. The full agenda for the panel is shown in Appendix 2.

The notes from the meeting and comments made were synthesised in to a first draft, which was circulated to the panel for comment. The final draft was then prepared for submission to the MoHHS programme board for matters of accuracy on 11 December 2020, and for review, comment then sign off by the clinical senate council.

23.2. General recommendations relating to Option Three

R31. The PCBC needs to present Option 3 in the context of how it may support both the System's strategic ambition and vision for future healthcare for the defined population and the compelling case for change, using a clear unbiased narrative, highlighting challenges and risks where appropriate.

R31.1. Whilst the context and drivers for the development of Option 3 were acknowledged and understood by the Clinical Senate Expert Panel, it is essential that all options put forward within the finalised PCBC are described through adopting a consistent, balanced and unbiased narrative.

R31.2. Alignment and coalescing of options: It has been very helpful to see the response to the previous clinical senate recommendations and feedback with respect to the number of options proposed. The description of Option 2 and its' associated sub options is now much clearer. When developing any final consultation document, it will be essential to ensure that a similar clear and consistent approach is made to the potential options associated with alternative greenfield sites for the 'Centralised Acute Hospital'. Minimising any potential risk for confusion around reconfiguration options will greatly assist the passage through public consultation.

R31.3. Terminology for 'naming' of the different hospitals: The use of a revised nomenclature, adopting 'Centralised Acute Hospital' when referring to reconfiguration options for the current Basingstoke and North Hampshire Hospital and Main Local Hospital when describing the Royal Hampshire County Hospital in Winchester is helpful and removes the potential negative perception of the terms 'Hub and Spoke'.

However, the PCBC extract (v18) reviewed did not adequately refer to or describe the role and function of all other sites that remain part of the acute reconfiguration plans for Option 3. The narrative must also consistently name and describe the full range of services provided at Andover War Memorial Hospital and Alton Community Hospital.

R31.4. You acknowledge that the terminology "Accident & Emergency" is somewhat out-dated but have chosen to maintain the language used by the Department of Health and Social Care (DHSC) rather than retain 'Emergency Department' (ED) for the description of Option 3 as a matter consistency. This approach is very likely to result in confusion to the reader and the broader public at consultation. Further careful thought is required to arrive at the least confusing terminology, supported by clear and consistent descriptions that may be realistically applied across all of the options. It will be important to avoid any potential risk of describing service provision in such a way as to be interpreted as misleading. The operational viability and sustainability of the urgent and emergency care pathways, inclusive of same day emergency care (SDEC) are critical to the overarching success of any future clinical model.

R31.5. The panel recognises that there is a dissonance between the potential 'political' aspiration that 'Local' hospitals can do everything with the realities of clinical sub-specialisation. The narrative would be enhanced through the use of 'local' data describing 'what happens now and what the future needs to look like'. A comparative assessment of how each Option may then achieve this 'future state' would contribute significantly to the cohesive consideration of each option within the final PCBC.

R31.6. The narrative describing the proposed clinical model in Option 3 needs to illustrate transparently the risks and any required mitigations associated with the ambition to create a sustainable model for acute care, fully integrated with primary and community care and provided locally.

R31.7. Whilst there is reference to the NHS LTP in places in the document, the ways in which Option 3 may impact on delivery of relevant priorities of the LTP should be strengthened.

R31.8. At present there is insufficient narrative to describe what the service offer is at each of the sites within Option 3. It will be essential to highlight succinctly, with a clear evidence base and with reference to key national programmes and standards, in a way the public can relate to, any benefits/disbenefits to patient care, outcomes and experience that will result from the reconfiguration proposed.

R31.9. Such risks/benefits as currently described are insufficiently detailed and are somewhat scattered round the document. Clearly tabulating a detailed risk benefits analysis as well as the implications for the disposition of services for all options, that is fully aligned with the impact assessment will be essential to include in the finalised PCBC.

R31.10. The judicious use of patient pathways and vignettes will provide an effective tool to meaningfully describe Option 3 (and all other options). This approach would assist the reader in fully understanding the proposed disposition of services and the clinical corollary of each of the key pathways.

R31.11. The descriptions of the clinical models were not sufficiently developed for the Clinical Senate Expert Panel to come to a final conclusion about the deliverability and sustainability of Option 3. There needs to be a more detailed, evidence based description that is fully aligned to national standards of care, for all patient pathways (but specifically urgent and emergency care, critical care, obstetric, neonate and paediatric pathways).

R31.12. The finalised PCBC must include a clear description of the role and modus operandi of each of the hospital sites across all options including the relevant detailed bed modelling, alongside a comprehensive outline of the workforce requirements reflecting an aligned workforce strategy.

R31.13. The integrated impact assessment presented provides a useful outline assessment. The impact in terms of sustainability of either of the Option 3 variances would benefit from additional analysis and narrative, specifically the summary of travelling times including public transport which is insufficiently developed. Patient transport is a key area that needs further development.

R31.14. Insufficient modelling data is available to illustrate the potential impact on ambulance conveyance for each of the key clinical pathways, specifically for urgent and emergency care inclusive of obstetric emergencies.

R31.15. The potential impact of conveyance of acutely unwell patients on outcomes and quality of hospital based acute care as described within Option 3 should be clear and up front in the presentation of the option. That there is an unavoidable tradeoff between access, quality and outcomes should be fully acknowledged, and such transparency and honesty is likely to be well received by the public and politicians.

R31.16. The Option 3 narrative does not articulate the current patient pathways out of area. It will be important to describe these in more detail, quantify and assess how they may be impacted upon by the provision of urgent and emergency care, obstetric led maternity services and neonatology at the 'Main Local Hospital' site.

R31.17. There is insufficient reference to engagement and joint planning with neighboring acute stakeholders that may be impacted upon by the proposals. This would include specialised and tertiary services.

R31.18. Networked Care: The narrative states that within Option 3 it will be "Less likely to be able to develop a networked care option with HIOW for sustainable services for greater population and benefits to outcomes of services delivered at scale". This is an important risk to outline, but the narrative should also describe plans to mitigate against the threats described.

23.3 Changes in population and demand, and bed modelling

23.3.1 Population health needs

R32. There is only limited description of how Option 3 could impact on health outcomes, quality and currently identified health inequalities. Evidence with respect to demographic details and option specific impact on future demand and activity would benefit from further development/modeling.

R32.1. There is a risk that the current narrative describing Option 3 suggests a downgrading of local services meaning that people are both disadvantaged locally and have to travel to access certain elements of healthcare. The balance suggested is between poorer experience of patients and relatives through travel versus potentially better outcomes from pooling expertise.

R32.2. The presentation at the Clinical Senate review panel described important developments made to address inequalities e.g. Mental Health, Learning Disability (LD) and Autism. It would be helpful to reflect these in the core narrative of the final PCBC.

R32.3. The impact assessment describes Option 3 impact as "marginally beneficial in terms of inequalities". It would be helpful to expand the narrative around potential for positive impacts experienced through the local care model and 'Main Local Hospital' developments.

23.3.2 Urgent treatment centres

R33. Any plans for an enhanced UTC at the 'Main Local Hospital' site within Option 3 needs to be made explicit within the PCBC.

R33.1. The impact of the planned urgent and emergency care model in Option 3 on ED demand (and therefore the size of the proposed future ED, and on non-elective admissions), is not described, and should be included in the final version of the PCBC.

23.3.3 Same day Emergency Care

R34. Same day emergency care (SDEC) delivers diagnosis and treatment without admission for acute and sub-acute medical and surgical presentations. The model for SDEC under Option 3 must be described with robust detail. Activity modelling will need to quantify the anticipated proportion of SDEC patients to be reviewed at the 'Main Local Hospital' Site and the likely projection of patients requiring an admission whom will consequently require a transfer to the 'Centralised Acute Hospital'.

R34.1. It will be important to clarify whether SDEC will be provided at the Main Local and or Local hospital sites, if so, there is a need for clarity as to who would be delivering this care, and if acute physicians how this would be delivered.

R34.2. Many patients will be identified for SDEC in the planned UTCs. How these UTCs link with the SDEC services, and where they will be located in relation to the UTCs, needs to be established.

23.3.4 Current bed numbers, demand and capacity modelling

R35. The demand and capacity bed modelling for Option 3 is currently insufficient. It will be essential to update and progress within any final full PCBC.

R35.1. It would be particularly helpful to draw upon existing data for example the Kings Fund Data Briefing on Emergency Bed use[18] and up to date comparisons from Get It Right First Time (GIRFT) to help describe what your population size needs. This would provide an opportunity to describe how the System as a whole can have access to the right bed at the right time in the right place in a timely fashion. There would be real benefit in including a case study/vignette illustrating how and where a patient (particularly with a chronic disease but subject to acute exacerbation) would move between community and acute care.

R35.2. The provision of a detailed and clear understanding of the number of beds and what types of patients will use them at the 'Main Local Hospital' site within Option 3 is essential. The narrative states that the 'Main Local Hospital' would not receive or admit acute patients, however self-presenting patients may be admitted for stabilisation prior to transfer to the 'Centralised Acute Hospital'.

R35.3. No detail on activity or bed modelling has been provided in Option 3 for neonatology or paediatrics. Inclusion of this data may provide an objective assessment of any clinical inefficiencies inherent in Option 3.

[18] Emergency Bed Use: What the data tells us The Kings Fund https://www.kingsfund.org.uk/sites/default/files/data-briefing-emergency-bed-use-what-the-numbers-tell-us-emmi-poteliakhoff-james-thompson-kings-fund-december-2011.pdf

23.3.5 Main Local Hospital beds and services

R36. It will be important to clearly identify each of the proposed Main Local and Local Hospital sites (Winchester, Andover, Alton and Eastleigh) and services within Option 3. The current narrative describes only the potential service disposition at Winchester.

R36.1. It is not clear within Option 3 whether the Main Local and Local Hospital sites may admit step down patients and thus provide a local health network hub, this may not be uniform between each of the sites. If such beds are to be provided at the Main Local and Local sites, then it will be important to state the admission criteria to access these beds and how they may be differentiated between the sites alongside the proposed medical staffing model.

23.4 Clinical standards, and improving health outcomes

R37. The narrative needs to describe in more detail and evidence that service provision under Option 3 would adhere to all clinical standards that are relevant to delivering high quality care.

R37.1. Option 3 as described is unlikely to deliver the Maternity Transformation Programme and Saving Babies Lives initiative, enabling improved outcomes and experience for families and their babies. It would be helpful to state how Option 3 fails to achieve these standards and what mitigations could be put in place.

R37.2. Similarly, the narrative within Option 3 states that it would not deliver the Royal College of Paediatrics and Child Health (RCPCH) Facing The Future standards, enabling improved outcomes and experience for children. It would also be helpful to define how Option 3 fails to achieve these standards and what mitigations could be put in place.

23.5 Workforce issues

R38. The narrative does not provide adequate evidence that there is a clear and deliverable workforce plan to support sustainable service delivery under Option 3. It is important to give a strong public message that there are clear staffing models in place and to state what the likelihood is of being able to fill those roles.

R38.1. A number of workforce challenges in association with Option 3 are referred to. It would be helpful to describe how/why this option may fail to address this key driver for reconfiguration as stated in the Case for Change. For medical staff this could be through including reference to Royal College data on fill rates for tiers 1, 2 and 3 nationally.

R38.2. Where workforce is mentioned with reference to Option 3 it is described predominantly in terms of being unsustainable. There is only a limited description of gaps in key current roles i.e. it is stated that Option 3 would require an additional 18 obstetricians. The workforce impact of duplicating specified services on two sites must be fully articulated and include references to medical, nursing and AHP roles.

R38.3. The siting of the Planned Care Centre on the 'Main Local Hospital' site could provide an opportunity to evidence potential workforce benefits i.e. that the absence of the 'interruption' of emergency calls can facilitate an excellent learning and development site for trainee anaesthetists, surgeons and other key clinical specialties. (refer to GIRFT Orthopaedic data).

R38.4. It is not clear if there is an intention to implement cross site rotas for staff, it would be helpful to confirm whether this would be mandatory and if not, how it is proposed to make these posts both attractive to recruit to and sustainable. Where different rotas operate for different grades of medical staff it would be important to identify the potential impact on training posts. Confirmation of which sites are designated for training in key specialties, e.g. emergency medicine, obstetrics is also essential. Clear reference to any ongoing work with the deanery and Health Education England (HEE) could support key staffing models within Option 3.

R38.5. Better use could be made of the opportunities afforded by alternative clinical models and supporting 'roles'. Consideration of how best use can be made of Advanced Care Professions and Physician Associates would strengthen the workforce plans significantly.

R38.6. Maternity Workforce: Option 3 does not address current workforce drivers for reconfiguration. There would be the potential to consider Advanced Neonatal Nurse Practitioner (ANNP) - led neonatal services in a standalone neonatal service, but this is not referenced and would require long term planning.

R38.7. Paediatric workforce: The finalised PCBC narrative should articulate the potential paediatric staffing impact. It is likely that Option 3 would require the same tier 1, tier 2 and tier 3 rotas at the 'Main Local Hospital' site as current (unless an ANNP model is proposed). The training opportunities available to trainees on the local hospital site would potentially be diminished in the absence of an inpatient paediatric unit and this would need liaison with HEE as there would be a potential risk of HEE withdrawing trainees in this environment. The narrative does not describe the potential risks and consequent loss of efficiency as these rota tiers would no longer also be supporting inpatient paediatrics on the 'Main Local Hospital' site.

R38.8. Option 3 would require the same tier 1, tier 2 and tier 3 rotas on the 'Centralised Acute Hospital' site as currently provided at the Basingstoke and North Hampshire Hospital. There would be increased activity in the Special Care Unit (SCU) / inpatient paediatric unit which may mean that additional tier 1 and/or 2 support would be required, potentially meaning more medical posts are required than currently. The PCBC narrative needs to highlight the overarching potential sequalae which could be to create a more significant workforce challenge than currently exists.

R38.9. The narrative does not provide any evidence that Option 3 affords an opportunity to augment consultant supervision or consultant-delivered care in accordance with Facing the Future - together for child health Royal College of Paediatrics and Child Health, Royal College of General Practitioners and Royal College of Nursing[19].

R38.10. It is important to demonstrate within the narrative that alternative staffing models have been considered including the use of advanced neonatal nurse practitioners. This would be a forward thinking solution but likely to present sustainability challenges.

23.6 Clinical, patient and public engagement

R39. Given the potential balance required between the centralisation of acute services, sustainability and quality of care on the one hand, and the formal 'conditions' that have defined Option 3 it will be essential to understand the public's view of the proposals specifically in relation to ED, maternity and paediatric service provision. The current narrative does not provide sufficient confidence that patients and the public have been adequately engaged with as this option has been developed.

R39.1 It will be important to develop a strong engagement narrative in advance of consultation making best use of pre engagement opportunities.

R39.2. It may be helpful to identify engagement champions to support and facilitate critical understanding of key aspects of each of the final Options and the reconfiguration plans there in.

23.7 Urgent and emergency care pathways

R40. There is currently insufficient description of urgent and emergency care (UEC) pathways within the Option 3. UEC needs to be seen as an integrated whole, with the PCBC detailing the component parts, and how patients would move through the system.

[19] https://www.rcpch.ac.uk/resources/facing-future-together-child-health

R40.1. The PCBC should articulate the planned ED pathway/mapping between primary and secondary care. The role of SCAS will be central to the success of the pathway. The development of a robust Directory of Services (DoS) reflecting adult and paediatric services is essential, alongside a (digitally enabled) mechanism that ensures there is a shared understanding of capacity across the System at any time.

R40.2. There is currently insufficient description of urgent and emergency care (UEC) pathways within the Option 3 narrative. The current pathways section only lists the services available as opposed to describing clear clinical pathways. It would be helpful to highlight the most common emergency presentations, describe the current pathway and then the future pathway in Option 3. This would provide a clear illustration of what services could 'look like' in Option 3, enabling politicians, patients and the public to visualise provision, wherever they currently are in the geographical area.

R40.3. The detailed descriptions of UEC pathways in Option 3 need to take full account of the main components including ED, SDEC, beds, 111 First, Clinical Assessment Service (CAS), UTCs, SCAS and Primary Care both at the 'Centralised Acute Hospital' and the 'Main Local Hospital'. Descriptions of these component services need to take into full account digital solutions to increase accessibility.

R40.4. It was helpful to hear at the Clinical Senate Panel presentation how SCAS is facilitating support closer to home, with the hope that people will make contact via 111. Acknowledgement that there will be a need for some patient transfers is important and emphasises the challenge of communicating to the public on how services could be different between sites. The PCBC narrative should reflect that SCAS under Option 3 would plan to have mechanisms in place to triage patients to the correct site. Recent changes to the orthopaedic pathway and consequent lessons learnt could be put to considerable benefit in terms of sign posting the patient to the correct site.

R40.5 Option 3 currently states that there will be no increase in turnaround time or any anticipated increased pressure on SCAS. The final PCBC narrative needs to articulate more clearly the rationale that underpins these statements.

R40.6. If implemented, under Option 3 it is highly likely that there would be significant risks that people would inevitably attend 'the wrong place' particularly if faced with a number of U&EC options. The narrative needs to state the risks and mitigation to this challenge and describe the plans in place to change/influence people's behaviour.

23.8 Urgent treatment centres

R41. Plans for the provision of UTCs in Option 3 as part of the UEC pathway are not sufficiently clear. Greater clarity is required of future plans, including access and opening times. It would be helpful to clarify whether in Option 3 there are plans for an alongside UTC on the 'Centralised Acute' site.

R41.1. The patient pathway for standalone and alongside UTCs will be quite distinct, a clearer understanding of the proposed model, specifically where it may differ for Option 3 will be essential. The implications for patient pathways and the need for transfer to the acute hospital site for those requiring it, should be provided. It will be essential to state the workforce plan for the planned UTC provision under Option 3.

R41.2. The overall impact on reducing demand on the ED at the 'Centralised Acute Hospital' and increasing SDEC activity at the 'Main Local Hospital' site alongside the ambition to treat local patients locally needs to be clearly stated. The assumptions made for such modelling, is not apparent but will be required in planning for future capacity requirements.

23.9 Emergency Department (ED)

R42. The current description of ED services does not provide sufficient detail. Specifically, the narrative must define and model the amount of activity, including throughput, that each ED at the 'Centralised Acute' site and at the 'Main Local Hospital' site will be required to deliver in the future in Option 3. There will be impacts relating to demographic change, travel times, the impact of the proposed model for UTCs, and the range of developments planned in primary and community care. Deciding on the overall workforce (primarily medical, nursing and AHPs) for the future ED requires such modelling and should be reflected within the PCBC.

R42.1. The PCBC currently does not provide sufficient detail on proposals for ED medical staffing at either the 'Centralised Acute Hospital' or 'Main Local Hospital'. Future narrative should detail how the acute medical take is to be provided and by whom (consultants in acute medicine, with or without the participation of consultants from other medical specialties). The narrative should reference any agreed standards and summarise the predicted consultant workforce required for Option 3 factoring in the provision of SDEC and the dual provision of ED services on the 'Centralised Acute Hospital' and 'Main Local Hospital' sites.

23.10 Acute medicine and surgery at the Centralised Acute Hospital

R43. Insufficient detail has been provided in Option 3 on the proposed clinical models for both acute medicine and surgery, and how this may be impacted on by the provision of ED services on two sites. This must be addressed in future PCBC iterations. Insufficient detail has been provided on the consultant workforce required to run the acute medical and surgical rotas, and how these may be different for Option 3.

R43.1. The co-location and co-dependencies of acute services should be reflected in more detail as part of the proposed models of care and patient pathways particularly in the context of splitting ED, obstetrics and neonates between two hospital sites.

R43.2. The acute medicine rotas for the 'Centralised Acute Hospital' and the 'Main Local Hospital' sites should take account of the additional sessions required to run the SDEC service.

Similarly, the provision of an acute surgical SDEC unit will require senior supervision and presence and needs to be taken account of in the general surgeons required workforce.

R43.3. The pathway for patients who deteriorate in a 'Main Local Hospital' bed in Option 3 is not sufficiently clear or sound.

R43.4. The patient pathways for 'step down' transfer from the 'Centralised Acute Hospital' to the Main Local or Local Hospitals is not properly described.

R43.5. The impact of Option 3 on the possible distribution of the various key clinical support specialties and services support should be made more explicit. It is very possible that some aspects of scarce AHP and other staffing resources will need to be split across sites. This will have a detrimental impact on access to 7/7 service provision.

R43.6. It will be important to define the scope and range of any admissions at the 'Main Local Hospital' site, specifically admission to the AMU and frailty unit and how this may be impacted on in Option 3.

23.11 Community services and beds, and inpatient rehabilitation services

23.11.1 Community services

R44. The Option 3 narrative needs to be clearer about how the proposals will capitalise on the existing primary and community provision to support strategic objectives (enhancing community based care & rehabilitation) and support flow within the north and mid Hampshire System.

R44.1. There is currently no data available to evidence that the current and planned primary and community based services and initiatives will be of sufficient efficacy and capacity to deliver a new split site U&EC pathway. There are references to community bed capacity within Option 3 however, it will be important to clarify any specific changes within the community to support the flow of patients in and out.

R44.2. It will be important for the final PCBC narrative to fully reflect what was heard on the Panel day with respect to transitional care, i.e. that there are plans for both step up and step down pathways, with a programme to upskill rehabilitation staff in both IV and enteral feeding, and focus on embedding these practices. Bed modelling is being undertaken on reablement and rehabilitation beds.

23.12 Liaison psychiatry

R45. There are no references to liaison psychiatry within the Option 3 PCBC extract. It will be important to ensure that the final PCBC narrative fully reflects what was presented on the Panel day including: liaison psychiatry at the 'Main Local Hospital' site, 111, early intervention primary mental health services looking at pre-crisis care, the development of a new model of care for older persons mental health, working with care homes and the expansion of Improving Access to Psychological Therapies (IAPT) services.

23.13 Maternity and neonatal services

R46. In general, obstetrics, neonatal and inpatient paediatrics are co-dependent and maintaining obstetric and neonatal services in the absence of inpatient paediatrics poses clinical risk and difficulty sustaining workforce models. It also leads to inefficiencies including poor value for money given low volumes of activity and minimum staffing requirements. It would be important to acknowledge these risks within the narrative describing Option 3 more generally and the co dependencies of these specialties specifically.

R46.1. Option 3 as described suggests that current obstetric, neonatal and paediatric activity will be maintained. Thus, it could be inferred that there would be little impact on other neighbouring acute trusts. There needs to be a clearer description, with supporting modelling and data that clarifies the potential impact, if any, of Option 3 on neighbouring trust activity.

R46.2. Option 3 describes the transfer of antenatal care to University Hospitals Southampton (UHS), but it is not clear why this is a change from current configuration. All opportunities to describe the impact of service configuration under Option 3 have not been fully articulated. For example, Option 3 does not realise the potential to avoid the transfer of activity to UHS that would be associated with service configuration under Option 2.

R46.3. Option 3 describes a consultant led birthing unit at both the 'Acute Centralised Hospital' and the 'Main Local Hospital' with 24/7 acute obstetrics Consultant oversight for women who require intervention into antenatal, intrapartum and postnatal pathways. The 'Main Local Hospital' would not have an alongside midwife-led birthing unit. The absence of a midwife led unit at Winchester within this option is important to acknowledge, specifically in terms of 'Choice'.

The users of services and their families are the most important stakeholders in this debate. Their views are of critical importance. A Care Quality Commission survey of women's experiences of maternity care suggests improvements in some areas of care [20]. Some of the notable areas deemed to require improvement – include offering choice and perinatal mental health support.

There are further opportunities within the PCBC to strengthen and make more explicit the current description, across all options of the full scope of choices available to service users and their families about where to have their baby and where post-natal care could be received.

R46.4. The current narrative describing the workforce modelling and staffing requirements for provision of consultant led obstetric care at both sites with 24/7 acute obstetrics consultant oversight for women who require intervention into antenatal, intrapartum and postnatal pathways should be strengthened.

R46.5. A summary of birth rates and the longer term forecast would be essential in subsequent narrative in terms of understanding current and future demand and the consequent long term viability of operating two 'smaller' obstetric led units.

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[20] Care Quality Commission (2020) *2019 Survey of Women's Experiences of Maternity Care*. https://www.bing.com/search?q=Care+Quality+Commission+(2020)+2019+Survey+of+Women%E2%80%99s+Experiences+of+Maternity+Care.&src=IE-SearchBox&FORM=IESR3A

R46.6. There is insufficient exploration of the safety of 'smaller' maternity services within the narrative. This is clearly warranted given the serious concerns that have been raised in recent months about avoidable child and maternal deaths in Shrewsbury and Telford, in East Kent, and earlier at Morecambe Bay. Investigations continue in Shropshire and at East Kent, any future service configuration will need to take into account the outcomes of these investigations and any findings that relate to the size and viability of smaller obstetric led units[21].

R46.7. The viability of any proposed smaller obstetric unit at the 'Main Local Hospital' site is likely to partially depend upon effective local maternity systems (LMSs) network solutions. The current narrative for Option 3 does not explore how the Hampshire and IoW LMS (including challenges, benefits and risks), would need to work to support the proposed unit at Winchester.

Pragmatically, the development of more standardised operating procedures and practices across Hampshire and the IoW would contribute alongside interoperability of information systems. The use of ambulances to support networking requires further examination.

R46.8. Additional detail should be described in Option 3 stating in detail the scope of antenatal care provision, including the provision of specialist antenatal clinics for women with diabetes, cardiac conditions, mental health conditions or other medical illness.

R46.9. Option 3 suggests the scope of preterm deliveries to be limited to 32 weeks or above on both sites, requiring transfer of <32week gestation deliveries to neighbouring Local Neonatal Units (LNUs) or Neonatal Intensive Care Units (NICUs) in the neonatal network[22].

R46.10. Option 3 would require 40-68 labour ward cover by consultants dependent on projected delivery numbers. This option would not provide the opportunity to augment consultant supervision in one obstetric led maternity service. There is no projection in the narrative re the activity on the 'Main Local Hospital' site, this is likely to be influenced by the offer of a co-located MLU on the 'Centralised Acute Hospital' site, especially if this is sited on a proposed greenfield site. A clear narrative that describes the model for HDU obstetric, paediatric and anaesthetist support should be included in the final PCBC.

[21] Ockenden Interim Report https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf
[22] A snapshot of neonatal services and workforce in the UK https://www.rcpch.ac.uk/sites/default/files/2020-09/a_snapshot_of_neonatal_services_and_workforce_in_the_uk_2.4.pdf

R46.11. It will be important to reflect that Option 3 essentially maintains current service provision. It does not provide an opportunity to repatriate deliveries between 28 and 32 week gestation to the 'Centralised Acute Hospital'. There would be value in reflecting the outcome of the neonatal GIRFT review / Neonatal Critical Care Transformation Review for the network or unit to ascertain if this model fails to address any key recommendations.

R46.12. The inclusion of an assessment of the revised neonatal care provision in Option 3 i.e. two level 1 units is essential. There would be a minimum requirement to maintain a level 1 SCU on both sites with no ability to augment one unit to a level 2 unit with the benefits to babies and families that this would bring. This model as described would otherwise meet demand. There is no projection of cot requirement and associated nurse staffing, but as the minimum nurse staffing is nationally defined there are risks that this option may lead to poor efficiency and challenges with workforce sustainability. It will be important to state the proportion of the population who will be affected by only having level 1 neonatal care. The potential impact of not having level 2 neonatal care on neighbouring Trusts should be evaluated.

R46.13. The narrative needs to demonstrate that babies requiring admission to L2 or 3 critical care can be safely managed in the 'Main Local Hospital' pending retrieval as currently.

R46.14. The narrative needs to clarify the pathway for new-born infants requiring assessment or admission following discharge home from the 'Main Local Hospital' site.

R46.15. A full assessment of the risks and mitigation of potentially reducing birth numbers at the 'Main Local Hospital' obstetric Unit should be stated. Any reduction in numbers is likely to have an impact on safety and viability.

23.14 Paediatric services

R47. The narrative needs to include an impact assessment of proposals to maintain an ED on the 'Main Local Hospital' site under Option 3. This would necessitate paediatric support 24/7 to this department and the proposed Short Stay Paediatric Assessment Units (SSPAU).

This support needs defining and should include the requirement to:

- Triage and refer children requiring hospital admission to the acute site with a requirement to avoid ambulance transfers for children to the local hospital site.
- Transfer children requiring overnight hospital admission to the acute site from the SSPAU.
- Ensure a timely transfer to the acute hospital for all children requiring admission.
- Maintain critical co-dependent services on the local hospital site, including anaesthetics.
- Analysis of the projected numbers of children affected.
- Maintain effective safeguarding for children on the 'Main Local Hospital' site 24/7 using registered children's nurses to support.

R47.1. Any planned OP care for children taking place on the Main Local or Centralised Acute site should take place in dedicated paediatric clinics with children's nursing support.

R47.2. Option 3 loses the opportunity to create a dedicated paediatric ED on the 'Centralised Acute Hospital' site, with the benefits to experience and outcome that this would likely bring.

R47.3. The narrative needs to provide assurance that the essential range of support services are available to the ED at both sites, including maintenance of anaesthetic support with experience and skills in paediatrics.

R47.4. The narrative needs to define the arrangements that would be in place to support the 'Main Local Hospital' ED for children requiring surgical review and/or intervention. It is likely that children requiring review may need to be transferred to the acute hospital site, with associated clinical risk.

R47.5. Clearer articulation of the paediatric medical inpatient pathway demonstrating that it is clear and sound is required. There would be a need for effective triage of GP, 111 and self-referrals to the ED to reduce the need for onward transfer to the inpatient paediatric unit. There is inherent clinical risk associated with the transfer of unwell children from the 'Main Local Hospital' ED / SSPAU to the inpatient paediatric unit.

R47.6. The proposed clinical model in Option 3 needs to ensure children of 16y or above can be admitted to the adult intensive care unit at the 'Centralised Acute Hospital'.

23.15 Planned Surgery and Complex Outpatient Centres

R48. Complex outpatients: It has been very helpful to see the response to the previous clinical senate recommendations and feedback with respect to the impact of the models on the planned outpatient facilities. The narrative would be improved by the reflection in the final PCBC narrative of what was heard at the Panel presentation i.e. 'The plan for outpatients has always been to give the right care to the right patients at the right time and as a consequence now plan to have complex outpatient services on both sites.

R48.1. Planned Surgery: Similarly, it has also been helpful to see the response to the previous clinical senate recommendations and feedback with respect to the impact of the proposed model for the Planned Care Centre. The narrative would be improved by the reflection in the final PCBC of what was heard at the Panel presentation i.e.

- That it is planned to triage patients at an earlier point in the care pathway.
- Option 3 will have the greatest impact on unplanned care.
- Whilst there would be ITU/HDU on the 'Centralised Acute Hospital' site 24/7 with outreach it is likely that staff would be stretched to cover an additional site. Consequently, provision at the 'Main Local Hospital' site has been modelled on being geographically remote and classed as a small critical care unit. This will support the work in A&E and maternity at Winchester and have at least an HDU capacity.
- That the main challenges will be with workforce and the recruitment and retention of staff.
- Learning from the COVID pandemic has indicated that there are some additional risks and challenges associated with small units being run as both hot and cold.

23.16 Digital

R49. It remains clear that there is significant ambition to extend digital solutions at scale and pace, acknowledging the lessons learnt in response to the pandemic, insufficient detail has been provided, specifically how digital technologies would be used to facilitate the revised and new models of care in Option 3.

R49.1. There are only limited references to digital solutions to support two site obstetric care e.g. Cardiotocography (CTG) monitoring and Badgernet (patient data management service). This area should be strengthened within the narrative.

23.17 COVID – 19

R50. It would be helpful to reflect on what has been done differently with reference to Option 3 detailing further adaptation in order to ensure ongoing sustainability.

R50.1. None of the clinical models described in Option 3 take into account the need to be 'COVID-19 secure' in the medium to long term.

24. Appendices

Appendix A: Table of Summary Recommendations

Number Ref.	Recommendations
General themes	
General points relating to the PCBC	
R1.	Articulate more clearly the anticipated future health needs and challenges of the north and mid Hampshire population, and how the proposals in the PCBC will address these.
R2.	Re-frame the PCBC to have a clearer, more succinct narrative focused on the options for the hospital reconfiguration as well as the implications for the disposition of services in each of the five options.
R3.	The 'Hub' and 'Spoke' hospitals, urgent treatment centres (UTCs) community and rehabilitation beds and primary and community services are part of a single system: A full understanding of how these all inter-relate with the patient pathways, is required to more fully anticipate capacity and demand in the future, and models of care.
R4.	Be clearer about the balance that needs to be struck between the patient benefits of centralising the various clinical services, and the increased travel time to those services for elements of the population.
Changes in population and demand, and bed modelling	
Demographic projections	
R5.	Provide population projections through to at least 2035/36 to plan the future capacity required more convincingly.
Urgent Treatment Centers	
R6.	The full implications of having UTCs on a different site from the acute hospital, and how any risks will be mitigated, should be described.
R7.	Estimate the projected level of activity in the UTCs that will contribute to the management of ED demand.
Same Day Emergency care	
R8.	The PCBC should state the current proportion of acute admissions treated as SDEC patients, and the impact of moving to the 33% expectation.
Current bed numbers demand and capacity modelling	
R9.	Given the difficulty in accurately projecting the impact of each of the five configuration options on required future bed capacity, providing a range rather than a fixed number of beds for all 'Hub and Spoke' sites would acknowledge the uncertainties and avoid overly ambitious projections.

'Spoke' Hospital beds and services	
R10.	It will be important to clearly identify each of the proposed 'Spoke' sites, Andover and Winchester alongside further facilities at Alton and Eastleigh within the narrative. Additional detail is required to describe the proposed role and function of each of the 'Spoke' sites within each of the options.
Clinical Standards and Improving health outcomes	
R11.	There is insufficient formal reference to clinical standards across the narrative.
Workforce issues	
R12.	Highlight the variation in workforce challenges within each of the proposed options, delivering a range of option specific 'Hub and Spoke' services across two sites.
Clinical, patient and public engagement	
R13.	Describe in more detail the level of patient and public pre engagement about the case for change and the proposed reconfiguration options.
R14.	Describe in more detail the level of clinical engagement about the case for change and the proposed reconfiguration of the HH Trust.
The options appraisal process	
R15.	Re consider how to best present the shortlisted options within the PCBC.
Urgent and emergency care pathways	
R16.	There is currently insufficient description of urgent and emergency care (UEC) pathways within the PCBC. The UEC system needs to be seen as an integrated whole, with the PCBC detailing the component parts, and how patients would move through the system. Currently the PCBC does not present this and needs to do so with reference to the five options.
Urgent treatment centres	
R17.	Plans for the provision of UTCs and what level of acute care can be provided there, as part of the UEC pathway are not sufficiently stated. A clearer understanding of the proposed model, the implications for patient pathways and the need for transfer to the acute hospital site for those requiring it, should be provided.
Emergency Department	
R18.	The current description of ED services does not provide sufficient detail. Specifically, the narrative must define and model the amount of activity including throughput that the ED will be required to deliver in the future for all options.
Acute medicine and surgery at the centralised site	
R19.	Insufficient detail has been provided in the PCBC on the proposed clinical models for both acute medicine and surgery. Further detail is required on the proposed consultant workforce needed to run the acute medical and surgical rotas.

'Spoke' Hospitals	
R20.	The whole clinical model for 'Spoke' hospitals; the services provided, types of patients and their acuity, patient flow and workforce required is not described. As such a fundamental component of the reconfiguration plans in all five options much more detail on services provided and the patient pathways in to and out of these 'Spoke' hospitals is required, to allow a sound judgement of the validity of any of the options.
Community services and beds, and inpatients rehabilitation services	
Community services	
R21.	The PCBC needs to detail the planned roles and related capacity of community services and beds, how they will support the proposed clinical models at both of the 'Spoke' sites and the centralised acute hospital.
Inpatient rehabilitation	
R22.	The PCBC needs to detail proposals for inpatient rehabilitation across a range of 'Hub and Spoke' settings, detailing proposed clinical pathways.
Liaison Psychiatry	
R23.	The plans to deliver a 24/7 liaison psychiatry service to the acute hospital is strongly supported. It was not clear to what extent there would be access to liaison psychiatry at the 'Spoke' hospitals.
Critical Care	
R24.	Estimating the future capacity requirements for ICUs and HDUs in HHFT is essential, including additional COVID-19 ready capacity.
Maternity Services	
R25.	The PCBC needs to detail proposals for maternity services across the range of 'Hub and Spoke' settings proposed, detailing proposed clinical pathways.
Paediatrics and neonates	
R26.	The PCBC needs to clearly describe the proposed model for paediatric services. Ideally, the PCBC would take maternity, neonatal care and paediatrics separately.
Planned Surgery and Complex Outpatient Centers	
R27.	The PCBC needs to clearly describe separately the clinical models for complex planned surgery, planned surgery and complex outpatient centres, taking account of the proposed disposition within each of the five options.
Travel Times	
R28.	Travel is important to patients and staff. In the community, more deprived and isolated areas often rely on public transport. The use of patient stories within the narrative would mitigate the potentially negative views arising from centralising acute services to a single site.
Digital	
R29.	It is clear that there is significant ambition to extend digital solutions at scale and pace, acknowledging the lessons learnt in response to the pandemic. But additional detail is required specifically how digital technologies will be used to facilitate the revised new models of care.

COVID-19	
R30.	Whilst it is particularly helpful to see the extent to which COVID-19 has impacted on clinical delivery, additional narrative needs to reflect on 'lessons learnt' to date such as the use of digital and the impact on inequalities and how they can address this going forward, especially as COVID will be with us for the foreseeable future.
Addendum	
General recommendations relating to Option 3	
R31.	The PCBC needs to present Option 3 in the context of how it may support both the System's strategic ambition and vision for future healthcare for the defined population and the compelling case for change, using a clear unbiased narrative, highlighting challenges and risks where appropriate.
Changes in population and demand, and bed modelling	
Population health needs	
R32.	There is only limited description of how Option 3 could impact on health outcomes, quality and currently identified health inequalities. Evidence with respect to demographic details and option specific impact on future demand and activity would benefit from further development/modelling.
Urgent treatment centers	
R33.	Any plans for the future location of a UTC at the 'Main Local Hospital' site within Option 3 needs to be made explicit within the PCBC.
Same day Emergency Care	
R34.	Same day emergency care (SDEC) delivers diagnosis and treatment without admission for acute and sub-acute medical and surgical presentations. The model for SDEC under Option 3 must be described with robust detail. Activity modelling will need to quantify the anticipated proportion of SDEC patients to be reviewed at the 'Main Local Hospital' Site and the likely projection of patients requiring an admission whom will consequently require a transfer to the 'Centralised Acute Hospital.'
Current bed numbers, demand and capacity modelling	
R35.	The demand and capacity bed modelling for Option 3 is currently insufficient. It will be essential to update and progress within any final full PCBC.
Main Local Hospital beds and services	
R36.	It will be important to clearly identify each of the proposed 'Main Local' and 'Local Hospital' sites (Winchester, Andover, Alton and Eastleigh) and services within Option 3. The current narrative describes only the potential service disposition at Winchester.
Clinical standards and improving health outcomes	
R37.	The narrative needs to describe in more detail and evidence that service provision under Option 3 would adhere to all clinical standards that are relevant to delivering high quality U&EC.
Workforce issues	
R38.	The narrative does not provide adequate evidence that there is a clear and deliverable workforce plan to support sustainable service delivery under Option 3. It is important to give a strong public message that there are clear staffing models in place and to state what the likelihood is of being able to fill those roles.

Clinical, patient and public engagement	
R39.	Given the potential balance required between the centralisation of acute services, sustainability and quality of care on the one hand, and the formal 'conditions' that have defined Option 3 it will be essential to understand the public's view of the proposals specifically in relation to ED, maternity and paediatric service provision. The current narrative does not provide sufficient confidence that patients and the public have been adequately engaged with as this option has been developed.
Urgent and emergency care pathways	
R40.	There is currently insufficient description of urgent and emergency care (UEC) pathways within the Option 3. The UEC system needs to be seen as an integrated whole, with the PCBC detailing the component parts, and how patients would move through the system.
Urgent treatment centers	
R41.	Plans for the provision of UTCs in Option 3 as part of the UEC pathway are not sufficiently clear. Greater clarity is required of future plans, including access, opening times. It would be helpful to clarify whether in Option 3 there are plans for an alongside UTC on the 'Centralised Acute site'.
Emergency Department (ED)	
R42.	The current description of ED services does not provide sufficient detail. Specifically, the narrative must define and model the amount of activity, including throughput, that each ED at the 'Centralised Acute' site and at the 'Main Local Hospital' site will be required to deliver in the future in Option 3. There will be impacts relating to demographic change, travel times, the impact of the proposed model for UTCs, and the range of developments planned in primary and community care. Deciding on the overall workforce (primarily medical, nursing and AHPs) for the future ED requires such modelling and should be reflected within the PCBC.
Acute medicine and surgery at the Centralised Acute Hospital	
R43.	Insufficient detail has been provided in Option 3 on the proposed clinical models for both acute medicine and surgery, and how this may be impacted on by the provision of ED services on two sites. This must be addressed in future PCBC iterations. Insufficient detail has been provided on the consultant workforce required to run the acute medical and surgical rotas, and how these may be different for Option 3.
Community services and beds, and inpatient rehabilitation services	
Community services	
R44.	The Option 3 narrative needs to be clearer about how the proposals will capitalise on the existing primary and community provision to support strategic objectives (enhancing community based care & rehabilitation) and support flow within the north and mid Hampshire System.
Liaison psychiatry	
R45.	There are no references to liaison psychiatry within the Option 3 PCBC extract. It will be important to ensure that the final PCBC narrative fully reflects what was presented on the Panel day including: liaison psychiatry at the main local hospital site, 111, early intervention primary mental health services looking at pre-crisis care, the development of a new model of care for older persons mental health, working with care homes and the expansion of Improving Access to Psychological Therapies (IAPT) services.

Maternity and neonate services	
R46.	In general, obstetrics, neonatal and inpatient paediatrics are co-dependent and maintaining obstetric and neonatal services in the absence of inpatient paediatrics poses clinical risk and difficulty sustaining workforce models. It also leads to inefficiencies including poor value for money given low volumes of activity and minimum staffing requirements. It would be important to acknowledge these risks within the narrative describing Option 3 more generally and the co dependencies of these specialties specifically.
Paediatric services	
R47.	The narrative needs to include an impact assessment of proposals to maintain an ED on the Main Local hospital site under Option 3. This would necessitate paediatric support 24/7 to this department and the proposed Short Stay Paediatric Assessment Units (SSPAU).
Planned surgery and Complex Outpatient Centers	
R48.	Complex outpatients: It has been very helpful to see the response to the previous clinical senate recommendations and feedback with respect to the impact of the models on the planned outpatient facilities. The narrative would be improved by the reflection in the final PCBC narrative of what was heard at the Panel presentation i.e. 'The plan for outpatients has always been to give the right care to the right patients at the right time and as a consequence now plan to have complex outpatient services on both sites.
Digital	
R49.	It remains clear that there is significant ambition to extend digital solutions at scale and pace, acknowledging the lessons learnt in response to the pandemic, insufficient detail has been provided, specifically how digital technologies would be used to facilitate the revised and new models of care in Option 3.
COVID-19	
R50.	It would be helpful to reflect on what has been done differently with reference to Option 3 detailing further adaptation in order to ensure ongoing sustainability.

Appendix B: Glossary

Term	Description/Definition
***Acute Centralised Hospital**	Previously known as a 'hub'
AMU	Acute Medical Unit
AWMH	Andover War Memorial Hospital
BNHH	Basingstoke and North Hampshire Hospital
CCG	Clinical Commissioning Group
CQC	Care quality Commission; The independent regulator of health and social care in England
ED	The Emergency Department, also sometimes known as Accident and Emergency or A&E
GIRFT	Getting It Right First Time
GP	General practice doctor
HCC	Hampshire Country Council
HHFT	Hampshire Hospitals NHS Foundation Trust
HIOW STP	Hampshire and Isle of Wight Sustainability and Transformation Partnership
HIP	Health Infrastructure Plan
ICS	Integrated Care System
JSNA	Joint Strategic Needs Assessment
***Main Local Hospital**	Previously known as 'Spoke/Satellite'
MoHHS	Modernising our Hospitals and Health Services Programme
NHS	National Health Service
NHSE&I	NHS England and Improvement
PCBC	Pre-Consultation Business Case
PCN	Primary Care Network
RHCH	Royal Hampshire Country Hospital
STP	Sustainability and Transformation Partnerships. STPs are a way for the NHS to develop its own, locally appropriate proposals to improve health and care for patients. They are working in partnership with democratically elected local councils, drawing on the expertise of frontline NHS staff and on conversations about priorities with the communities they serve.
UTC	Urgent Treatment Centre

*** Terms added in the addendum.**

Appendix C: KLOEs

A. General KLOE

1. Has the Case for Change, and the health needs of the population been clearly described?
2. Are projections for changes in demand realistic? Taking account of:
    - Factors increasing demand (population ageing, population growth and increasing incidence of acute and chronic conditions)
    - Factors reducing demand (prevention, better long term care, demand management, more proactive primary/community based care, digital solutions.)
3. How will the planned reconfigurations improve health outcomes and impact on inequalities for the populations of North and mid Hampshire?
4. Have clinical standards been identified, and are they sufficiently comprehensive as the framework for delivering high quality care and added value (improved patient outcomes from the available resources)?
5. Is sufficient detail provided on the total beds required (total beds, adult non elective, specialty based, paediatrics, elective surgery and step up/step down beds), based on projected demand and demand management?
6. Are there any major inconsistencies in the proposed reconfiguration of services with the NHS Long Term Plan?
7. Is there a coherent and realistic workforce strategy that takes account of the full range of the clinical workforce and the opportunities provided by new roles and ways of working?
8. Are there plans for the necessary digital clinical information sharing across the multiple care delivery sites across the trust, and alignment of the digital strategies?
9. Do plans take account of 'early lessons learnt' from COVID -19?
10. Has the breadth and depth of clinical engagement been sufficient?
11. Has there been meaningful patient and public involvement in coming to the options being proposed? How has the involvement to date sought to be inclusive of seldom heard, minority and deprived population groups?

B. Service specific KLOE

1. Urgent and emergency care

a) General comments on the patient pathways.

b) Is the patient pathway between the 'spoke' hospitals (including UTC and ambulatory care service,) and the major acute hospital, clear and sound (including the overnight pathways when the UTCs may be closed)?

c) Are there clear and sound criteria for admission to a 'Spoke' Hospital (i.e. Winchester or Andover) vs a centralised acute hospital bed?

d) Does the patient pathway support safe transfer from major acute hospital to spoke site in order to deliver care closer to home?

e) Is there confidence that the ambulance triage and transfer pathways and capacity issues have been sufficiently addressed?

f) Are the benefits and risks (including mitigation) of centralising the various major acute services on to one site clearly articulated?

- A&E (ED)
- Acute medicine pathway (including frailty)
- Emergency surgery pathway
- Critical care
- Liaison psychiatry
- Other major specialties
- Support services including diagnostics, radiology, pharmacy and AHPs.

g) Will the co-location of the various key clinical support specialties and services support the proposed model?

h) How does the proposed model make best use of digital solutions, remote consultation, telemedicine (including learning from the COVID-19 Pandemic)?

i) Do the clinical model proposals take into account the need to be 'COVID-19 secure' in the medium to long term?

j) Is there a clear and deliverable workforce plan? Do the plans take suitable account of the need for clinical teams to work across site between hub and spokes (i.e. cross site rotas)?

k) Is there evidence of adherence to clinical standards that are relevant to delivering high quality U&EC?

l) Will the current and planned primary and community based services and initiatives be of sufficient efficacy and capacity to deliver a new UEC pathway?

2. Planned care (focussing on elective surgery and procedures, not outpatient services)

a) Comments on the distribution of elective surgical services:

- Inpatient (non-orthopaedic) surgery at the major acute hospital
- Day case surgery
- Elective orthopaedics.
- Is there evidence that robust risk assessment processes will be in place to determine the cohort of patients that can safely receive surgical care at a dedicated standalone planned care centre?

b) Are there mechanisms in place in order to determine the most appropriate pathway for post-op patients needing escalation in care/critical care if on different 'spoke' sites from the major acute hospital

c) Are the workforce challenges relating to multiple site surgical services addressed?

d) Will the co-location of the various key clinical support specialties and services support the proposed model?

e) Will the planned capacity for elective surgery (beds, theatres, critical care) be sufficient?

3. 'spoke' hospital services at Winchester and Andover

a) Are the criteria for admission sufficiently described?

b) Is there a clear and sound pathway for patients who deteriorate in a 'spoke' hospital bed?

c) Will there be sufficient capacity in the community to discharge patients and maintain flow?

d) Is there clarity about the bed modelling across the trust for 'spoke' hospital and acute hospital beds

e) How is clinical risk to be managed and owned for these patients not in an acute hospital?

f) Is the staffing model for 'spoke' hospital wards sufficient and appropriate including any new clinical roles, or the availability of 'specialists', and the out of hours cover?

g) Do the plans take suitable account of the need for clinical teams to work across site between hub and spokes (i.e. cross site rotas)?

h) Will there be sufficient on site supporting clinical services at the 'spoke' hospital sited in an alternative hospital from the major acute hospital?

4. Paediatrics

a) General comments on the patient pathways – including outpatient services in the 'spoke' hospitals.

b) Is the patient pathway between any separately sited UTC and the paediatric ED and PAU at the major acute hospital, clear and clinically sound?

c) Will the co-location of the various key clinical support specialties and services support the proposed model?

d) Is the interface and pathways between the acute hospital paediatric service, primary care and the community paediatric service (paediatricians and paediatric nurses) described (so that unnecessary transfers to hospital can be avoided)?

e) Is there a clear and deliverable workforce plan?

f) Are there sufficient published clinical standards referenced in the PCBC?

g) Is the paediatric surgical pathway clear and sound?

h) Is the paediatric medical inpatient pathway clear and sound?

i) Are there any issues in relation to paediatric critical care capacity?

5. Maternity

a) General comments on the configuration of birthing pathways esp. centralisation to single acute site of obstetric led services, and the provision of the MLU and OLU?

- Capacity of proposed

b) Will the co-location of the various key clinical support specialties and services support the proposed model?

c) Is there a clear and deliverable workforce plan?

d) Is the neonatal pathway clear and sound?

- Neonatal Network perspective.
- GIRFT review, findings and next steps.

e) What assessment has been made in respect of the proposed closure of Winchester level 2 unit?

- Is a single level 2 unit on the acute site sufficient to meet demand?

f) Are there sufficient published clinical standards referenced in the PCBC?

g) Are the plans aligned to the Hampshire and Isle of White Local Maternity Systems (LMS) and national strategies including:

- Maternal safety including the standards for perinatal safety (effective Jan 2021)
- Perinatal mental health

C. KLOEs relating to the 5 shortlisted options for future hospital configuration

a) Across the five options for service reconfiguration (new acute major hospital at the preferred site, Winchester and Andover) are there option-specific issues that need highlighting in relation to:

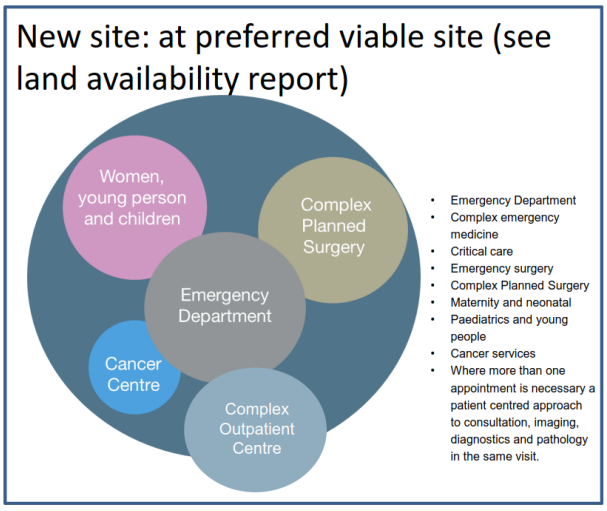
- Impact on quality of care and clinical outcomes
- Equitable access for the population across the CCGs
- Clinical co-dependencies between services
- Impact on specific major inpatient clinical services that may need relocating (e.g. renal, cardiac, emergency surgery)
- Workforce implications
- Capacity (A&E, beds, theatres, critical care)
- Patient flow

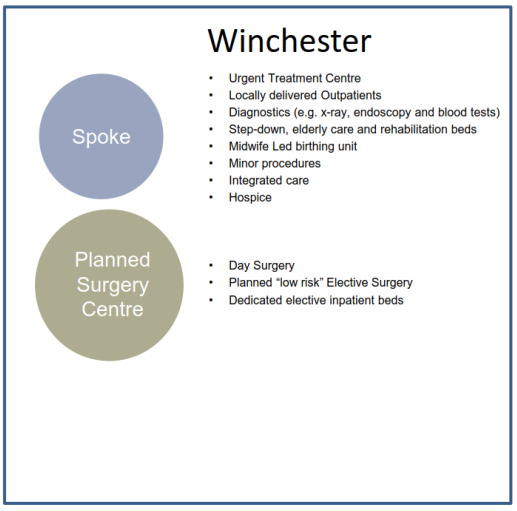
b) Is the impact on neighbouring hospitals clearly described for each option, and are there any associated issues of concern not described in the PCBC?

c) Is the impact on surrounding acute trusts clear for each of the options (including specialist/tertiary services)? Consider UEC, paediatrics and maternity for each.

Appendix D: Options

Option 2.3





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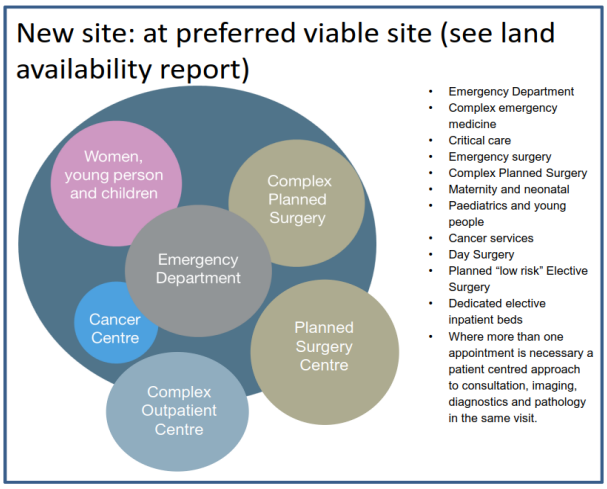

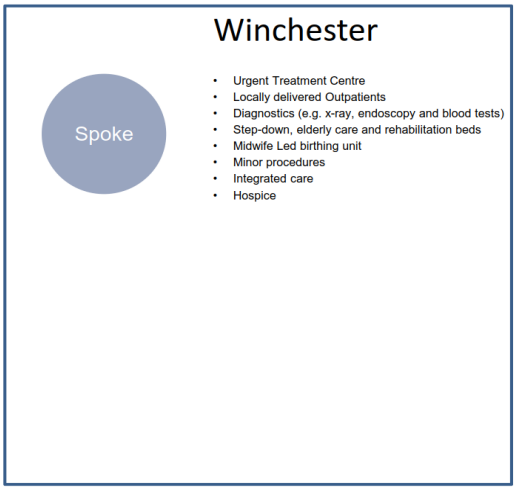

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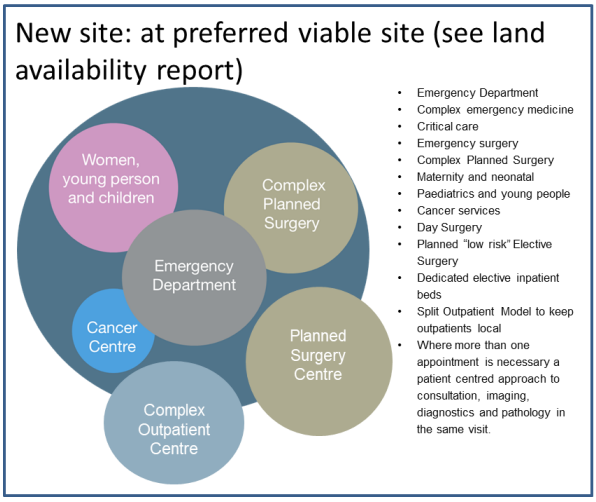

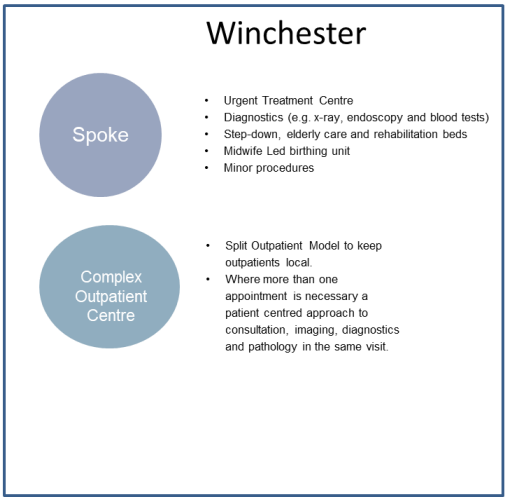

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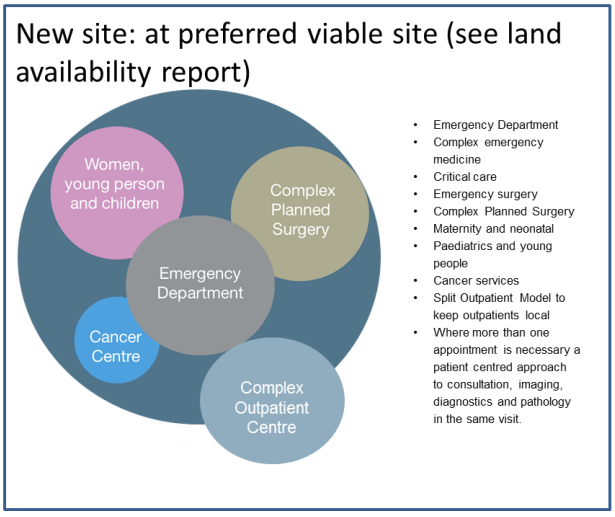

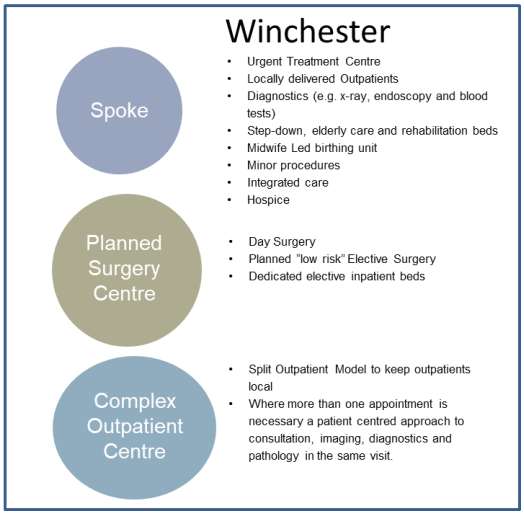

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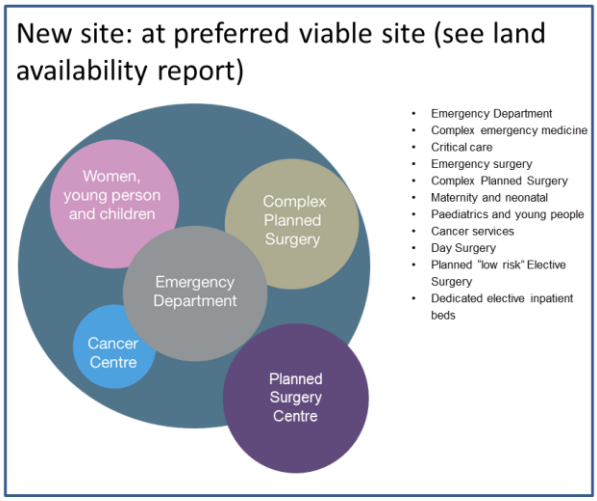
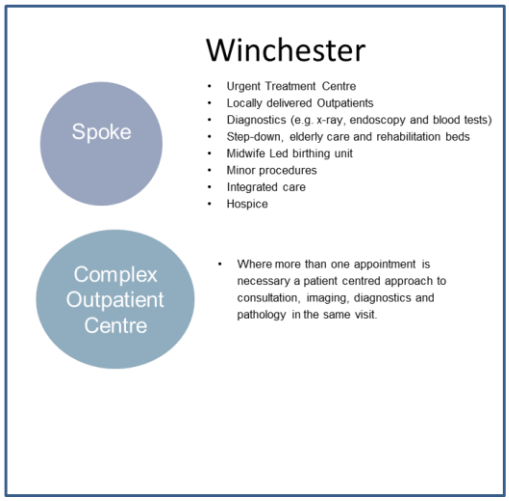

New site: at preferred viable site (see land availability report)
Women, young person and children
Complex Planned Surgery
Emergency Department
Cancer Centre
Planned Surgery Centre
Emergency Department
Complex emergency medicine
Critical care
Emergency surgery
Complex Planned Surgery
Maternity and neonatal
Paediatrics and young people
Cancer services
Day Surgery
Planned "low risk" Elective Surgery
Dedicated elective inpatient beds


Winchester
Spoke
Urgent Treatment Centre
Locally delivered Outpatients
Diagnostics (e.g. x-ray, endoscopy and blood tests)
Step-down, elderly care and rehabilitation beds
Midwife Led birthing unit
Minor procedures
Integrated care
Hospice
Complex Outpatient Centre
Where more than one appointment is necessary a patient centred approach to consultation, imaging, diagnostics and pathology in the same visit.

Appendix E: Resource material provided by Hampshire Together

PCBC and appendices	
1.	Hampshire Hospitals Foundation Trust PCBC 20200921. v0.13
2.	Clinical Senate presentation V0.15 Final
3.	Appendix 2a. Our Vision
4.	Appendix 2b. Full list of services in scope
5.	Appendix 2c. ICP Five pillar programme details
6.	Appendix 2d. HHFT Clinical Strategy 2019 June Final
7.	Appendix 4a. MJM Campus Hospitals Research V1.0
8.	Appendix 4b. 20200903 PSSAG Terms of Reference
9.	Appendix 5a. ToR MoHHS Options Development Group v3
10.	Appendix 5b. Summary of SWOT analysis – service delivery, implementation and funding v2
11.	Appendix 6a. Demand and capacity modelling report_v4.0
12.	Appendix 6b. Clinical Model_v3.0
13.	Appendix 6c. Functional Areas Estimate_options_v5.0
14.	Appendix 6d. Site Selection Study – Vail Williams
15.	Appendix 10a. Legal and policy duties
Supplementary Resources	
14.	Final_-_MOH_listening_document_v3_-_online
15.	Patient Pathways – Paper for clinical senate V0.14
Addendum Resources	
16.	Additional Option Paper for The South East Regional Clinical Senate. Modernising our Hospitals and Health Services (MoHHS) Programme Acute Reconfiguration of Basingstoke and North Hampshire Hospital (BNHH) and Royal Hampshire County Hospital (RHCH) – November 2020

Appendix F: South East Clinical Senate (Hampshire Thames Valley) Review Group membership, declarations of interest and agendas

1. South East Clinical Senate Council Hampshire Thames Valley Review Group Membership

Name	Roles
Jane Barrett	South East Clinical Senate (Hampshire Thames Valley) Chair
Amanda Allen	Clinical Director of Therapies, Maidstone and Tunbridge Wells NHS Trust
Michael Baker	Deputy Director of Healthcare, Public Health England South East Region
Atul Bansal	Consultant, Emergency Medicine, Frimley Health NHS Foundation Trust
Steve Barden	Lead Clinician for Ambulatory and Acute Medicine, Brighton and Sussex University Hospitals Trust
Mike Carraretto	Consultant in Anaesthetics and Intensive Care Medicine, Royal Surrey County Hospital. Medical Lead for Kent, Surrey & Sussex Adult Critical Care Operational Delivery Network
Douglas Findlay	Lay member, South East Clinical Senate (Hampshire Thames Valley)
Mark Hancock	Medical Director, Oxford Health NHS Foundation Trust
Jenny Hughes	Regional Chief Midwife, NHS England and Improvement, South East
Lalitha Iyer	Medical Director, East Berkshire CCG
Tina Kenny	Medical Director, Buckinghamshire Healthcare NHS Trust
Rakesh Kucheria	Orthopaedic Surgeon, Frimley Health Foundation Trust
Jeremy Noble	Consultant Urological Surgeon, Oxford Health Foundation Trust
Ali Parsons	South East Clinical Senate (HTV and KSS) Manager
Karen Owen	Patient Representative, Hampshire Thames Valley Clinical Senate
James Ray	National Clinical lead 111 First, Emergency and Elective Care, Hospitals Team (Same Day Emergency Care) Regional Clinical Lead UEC London, NHS England and NHS Improvement
Jonathan Richenberg	Consultant Radiologist, Royal Sussex County NHS Trust
Guy Rooney	Medical Director, Oxford AHSN
Paul Stevens	South East Clinical Senate (Kent Surrey Sussex) Chair
Isobel Warren	East Sussex Care Homes Place Based Lead, Joint Commissioning, Sussex Clinical Commissioning Groups / East Sussex County Council
Ryan Watkins	Consultant Neonatologist, Brighton and Sussex University Hospitals NHS Trust
Julian Webb	Consultant, Emergency Medicine, Surrey and Sussex Healthcare NHS Trust

2. South East Clinical Senate Council Hampshire Thames Valley Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest	Confidentiality Agreement
Jane Barrett	None	None	None	None	√
Amanda Allen	None	None	None	None	√
Michael Baker	None	None	None	None	√
Atul Bansal	None	None	None	None	√
Steve Barden	None	None	None	None	√
Mike Carraretto	None	None	None	None	√
Douglas Findlay	None	None	None	None	√
Mark Hancock	None	None	None	None	√
Jenny Hughes	None	None	None	None	√
Lalitha Iyer	None	None	Director of private scanning company – Women's Scan Clinic Partner at Farnham Road - renting space in practice for Pyramid Pharmacy Provider of care home services over and above core GP work as per PCN DES. Magna Konserv – director Solutions for Health – Medical Advisor for out of area	Practice rents space out to a community pharmacy, no profit share Globe Management Consultants - secretary	√
Tina Kenny	None	None	None	None	√
Rakesh Kucheria	None	None	None	None	√
Jeremy Noble	None	None	None	None	√

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest	Confidentiality Agreement
Ali Parsons	None	None	None	None	√
Karen Owen	None	None	None	None	√
James Ray	None	None	None	None	√
Jonathan Richenberg	None	None	None	None	√
Guy Rooney	None	None	None	None	√
Paul Stevens	None	None	None	None	√
Isobel Warren	None	None	None	None	√
Ryan Watkins	None	None	None	None	√
Julian Webb	None	None	None	None	√

3. Clinical Senate Council (Hampshire Thames Valley) Review Group Agendas 1st and 2nd October 2020

South East Clinical Senates (HTV) Review Day One, 1st October:
Hampshire Together: Modernising our Hospitals and Health Services
*(Please note: Clinical Senate Panel **only** Pre meet 13.00-13.30pm)*
Via TEAMs link Join Microsoft Teams Meeting

Item	Time	Item	Lead
1.	12.45	**Registration/Join TEAMS**	
2.	13.00	**South East Clinical Senate Expert Review Panel *only* pre-meet.**	**JB**
	13.30	***Hampshire Together: Modernising our Hospitals and Health Services to join the meeting***	
3.	13.30	**Welcome, Introduction, context and approach to the review.**	**JB**
4.	13.35	**Presentation from the Hampshire Together team**, summarising the strategic context, Case for Change, purpose of the proposed reconfiguration, criteria used for options shortlisting and brief overview of options.	**Hampshire Together Panel**
5.	13.55	**Discussion and Q&A** between the clinical senate panel and the Hampshire team, relating to the strategic approach and overarching themes KLOE (Q&A).	**JB**
6.	14.20	**Clinical Models and Pathways presentations and discussion:** **Each model presentation to be followed by Q&A (Part 1.)** Review of the key four proposed clinical models and pathways, including any issues with each of the five shortlisted options: • **Urgent and emergency care, inclusive of critical care, with reference to:** The central acute hospital. The role use of 'spoke services', UTCs, step down/up beds, community rehabilitation beds and the supporting primary and community care services: **(Presentation 10 mins: Q&A 20 mins).** • **Planned care, inclusive of any ICU/HDU**: The central acute hospital, role use of 'spoke services', One Stop Outpatient Centre(s), Planned Surgery Centre. **(Presentation 10 mins: Q&A 20 mins).**	
	15.20	**Comfort break**	
6.	15.30	**Clinical Models and Pathways presentations and discussion** **Each model presentation to be followed by Q&A (Part 2.).** • **Paediatrics**: The central acute hospital, PED, role and use of 'spoke' services, community services **(Presentation 10 mins: Q&A 10 mins).** • **Maternity**: The central acute hospital, obstetric led services, MLU, OLU, Neonates, role and function of 'spoke' services **(Presentation 10 mins: Q&A 10 mins).**	
7.	16.10	**Options presentation followed by Q&A** Review of each of the five options for service reconfiguration (new acute major hospital at the preferred site, with 'spoke' services.) including any option specific issues in relation to delivery of the proposed clinical models and pathways. **(Presentation 20 mins: Q&A 20 mins)**	
8.	16.50	**Summing up, next steps**	**JB**
9.	17.00	**Meeting close**	**JB**

South East Clinical Senates (HTV) Review: - Day Two, 2nd October:
Hampshire Together: Modernising our Hospitals and Health Services
Via TEAMs link Join Microsoft Teams Meeting

Item	Time	Item	Lead
1.	08.45	**Registration/Join TEAMS**	
2.	09.00	**South East Clinical Senate Expert Review Panel** • **Overview of mornings proceedings**	**JB**
3.	09.10	**Strategic KLOE** Discussion: Key findings, evidence base and emerging themes for recommendations. • **Strategic context and ambition.** • **Population health** • **Case for Change, purpose of the proposed reconfiguration** • **Overview of options.**	**All**
5.	10.00	**Clinical models and pathway KLOE** Discussion: Key findings, evidence base and emerging themes for recommendations. • **Urgent and emergency care, inclusive of critical care.** • **Planned care, inclusive of any ICU/HDU**.	
	11.00	**Comfort Break**	
	11.10	**Clinical models and pathway KLOE** Discussion: Key findings, evidence base and emerging themes for recommendations. • **Paediatrics** • **Maternity.**	
6.	12.10	**Options for service reconfiguration KLOE.** Discussion: Key findings, evidence base and emerging themes for recommendations.	
7.	12.50	**Summing up, next steps**	**JB**
8.	13.00	**Meeting close**	**JB**

Appendix G: Hampshire Together Panel (MoHHS) membership

Name	Organisation	Roles
Malcom Ace	Hampshire Hospitals Foundation Trust (HHFT)	Chief Financial Officer
Lara Alloway	HHFT	Chief Medical Officer
Abigail Barkham	Southern Health	Consultant Nurse for Frailty
James Coakes	HHFT	Clinical Director (Critical Care)
Fay Corder	HHFT	Associate Director of Midwifery
Sara Courtney	Southern Health	Deputy Director of Nursing and Clinical Director for Safety and QI
Ben Creswell	HHFT	Consultant Surgeon Associate Medical Director Medical Workforce
Julie Dawes	HHFT	Chief Nurse
Nicola Decker	North Hampshire CCG	Clinical Chair
Ruth Colburn Jackson	North & Mid Hampshire Clinical Commissioning Group	Managing Director
Dominic Kelly	HHFT	Consultant Cardiologist
James Kerr	HHFT	Consultant in Emergency Medicine
Mary Kloer	Southern Health	Consultant Psychiatrist
Lorne McEwan	West Hampshire Clinical Commissioning Group	Board GP
Matt Nisbet	Hampshire and Isle of Wight Partnership of CCGs	GP and Clinical lead, Business and Partnerships
Shirlene Oh	HHFT	Director of Strategy & Partnerships
Simon Struthers	HHFT	Associate Medical Director of Clinical Strategy, Paediatric Consultant
Helen Style	Hampshire County Council	Older Adults Adults' Health and Care
Alex Whitfield	HHFT	Convenor of NM Hants ICP Chief Executive HHFT
Isobel Wroe	South Central Ambulance Service NHSFT	Director of Partnerships and Strategic Development

Appendix H: Allied Health Professionals (AHPs)

Professions
Art Therapist
Drama Therapist
Music Therapist
Chiropodist/Podiatrist
Dieticians
Occupational Therapist (OT)
Operating Department Practitioners (ODP)
Orthoptists
Osteopaths
Paramedics
Physiotherapists
Prosthetists and Orthotists
Radiographers
Speech and Language Therapists (SLT)

25. Addendum Appendices

Appendix 1 KLOEs

A General KLOE

1. How are the health needs of the population addressed through the proposed configuration of services under Option 3?
2. How will the reconfiguration option improve health outcomes and impact on inequalities for the populations of North and Mid Hampshire?
3. Is sufficient detail provided on the total beds required for option 3 (total beds, adult non elective, specialty based, paediatrics, elective surgery and step up/step down beds), based on projected demand and demand management?
4. Are there any major inconsistencies in the proposed reconfiguration of services with the NHS Long Term Plan?
5. Has the breadth and depth of clinical engagement been sufficient?
6. Has there been any additional and meaningful patient and public involvement in coming to the additional option being proposed? How has the involvement to date sought to be inclusive of seldom heard, minority and deprived population groups?

B. Service specific KLOE

1. Urgent and emergency care – Option 3

a) Is the patient pathway between the main local 'spoke' hospitals (including UTC and ambulatory care service,) and the centralised acute hospital, clear and sound (including the overnight pathways when the UTCs may be closed)?

b) Are there clear and sound criteria for admission to a main local 'Spoke' Hospital (i.e. Winchester or Andover) vs a centralised acute hospital bed?

c) Does the patient pathway support safe transfer from centralised acute hospital to spoke (main local) site in order to deliver care closer to home?

d) Is there confidence that the ambulance triage and transfer pathways and capacity issues have been sufficiently addressed?

e) Are the benefits and risks (including mitigation) of providing services at both the centralised acute and the main local (Winchester) clearly articulated?

- A&E (ED)
- Acute medicine pathway (including frailty)
- Emergency surgery pathway

- Critical care
- Support services including diagnostics, radiology, pharmacy and AHPs.

f) Will the co-location of the various key clinical support specialties and services support option 3?

g) How does the proposed option make best use of digital solutions, remote consultation, telemedicine (including learning from the COVID-19 Pandemic)?

h) Do the clinical model proposals take into account the need to be 'COVID-19 secure' in the medium to long term?

i) Is there a clear and deliverable workforce plan? Do the plans take suitable account of the need for clinical teams to work across site between the centralised acute site and spokes (i.e. cross site rotas)?

j) Is there evidence of adherence to clinical standards that are relevant to delivering high quality U&EC?

k) Will the current and planned primary and community based services and initiatives be of sufficient efficacy and capacity to deliver a new UEC pathway?

2. Main local hospital services ('Spoke') at Winchester

a) Is the provision of SDEC and UTC sufficiently described?

b) Is there a clear and sound pathway for patients who deteriorate in a main local 'spoke' hospital bed?

c) Will there be sufficient capacity in the community to discharge patients and maintain flow?

d) Is there clarity about the bed modelling across the trust for the main local hospital 'spoke' i.e. Winchester and centralised acute hospital beds

e) How is clinical risk to be managed and owned for patients in the main local sites?

f) Is the staffing model for main local hospital wards sufficient and appropriate including any new clinical roles, or the availability of 'specialists', and the out of hours cover?

g) Do the plans take suitable account of the need for clinical teams to work across site between the centralised acute and the main local sites (i.e. cross site rotas)?

h) Will there be sufficient on site supporting clinical services at the 'main local' hospital from the centralised acute hospital?

3. Maternity

a) General comments on the configuration of birthing pathways especially:

Consultant led birthing unit at both the 'Acute Centralised Hospital' and Main Local Hospital (The main local hospital, (Winchester)) would not have an alongside midwife-led birthing unit.

Provision of consultant led obstetric care at both sites with 24/7 acute obstetrics Consultant oversight for women who require intervention into antenatal, intrapartum and postnatal pathways.

b) Are the benefits and risks (including mitigation) of providing services at both the centralised acute and the main local (Winchester) clearly articulated?

c) Will the co-location of the various key clinical support specialties and services support the proposed model?

d) Is there a clear and deliverable workforce plan?

e) Is the neonatal pathway clear and sound?

- Neonatal Network perspective.
- GIRFT review, findings and next steps.

f) What assessment has been made in respect of the revised neonate provision, i.e. two level 1 units?

- Is this sufficient to meet demand safely?

g) Are the plans aligned to the Hampshire and Isle of White Local Maternity Systems (LMS) and national strategies including:

- Maternal safety including the standards for perinatal safety (effective Jan 2021)
- Perinatal mental health.

4. Paediatrics: Option 3

a) General comments on the patient pathways – including outpatient services in the 'main local' hospitals, Winchester and Andover.

b) Is the patient pathway between any separately sited UTC and the paediatric ED and PAU at the centralised acute hospital, clear and clinically sound?

c) Will the co-location of the various key clinical support specialties and services support the proposed model?

d) Is the interface and pathways between the acute hospital paediatric service, primary care and the community paediatric service (paediatricians and paediatric nurses) described (so that unnecessary transfers to hospital can be avoided)?

e) Is there a clear and deliverable workforce plan?

f) Is the paediatric surgical pathway clear and sound?

g) Is the paediatric medical inpatient pathway clear and sound?

h) Are there any issues in relation to paediatric critical care capacity?

5. Planned care (focussing on planned care and outpatient centres)

a) Comments on the distribution of planned surgical services in option 3:

- Inpatient (non-orthopaedic) surgery at the major acute hospital
- Day case surgery
- Elective orthopaedics.

b) Is there evidence that robust risk assessment processes will be in place to determine the cohort of patients that can safely receive surgical care at a dedicated standalone planned care centre?

c) Are there mechanisms in place in order to determine the most appropriate pathway for post-op patients needing escalation in care/critical care if on different local 'spoke' sites from the centralised acute hospital

d) Are the workforce challenges relating to multiple site surgical services addressed?

e) Will the co-location of the various key clinical support specialties and services support the proposed model?

f) Will the capacity for planned surgery (beds, theatres, critical care) be sufficient?

C. KLOE relating to option 3 for future hospital configuration

a) Are there option 3 specific issues that need highlighting in relation to:

- Impact on quality of care and clinical outcomes
- Equitable access for the population across the CCGs
- Clinical co-dependencies between services
- Impact on specific major inpatient clinical services that may need relocating
- Workforce implications
- Capacity (A&E, beds, theatres, critical care)
- Patient flow.

b) Is the impact on neighbouring hospitals clearly described for option 3, and are there any associated issues of concern not described?

c) Is the impact on surrounding acute trusts clear for option 3 (including specialist/tertiary services)? Consider UEC, paediatrics and maternity.

Appendix 2 Addendum Review Panel Agenda

South East Clinical Senates (HTV) Second Review, 2nd December:
Hampshire Together: Modernising our Hospitals and Health Services
*(Please note: Clinical Senate Panel **only** Pre meet 12.00 -12.15pm)*
Via TEAMs link Click here to join the meeting

Item	Time	Item	Lead
1.	11.45	**Registration/Join TEAMS**	
2.	12.00	**South East Clinical Senate Expert Review Panel *only* pre-meet.**	**JB**
	12.15	***Hampshire Together: Modernising our Hospitals and Health Services to join the meeting***	
3.	12.15	**Welcome, Introduction, context and approach to the review.**	**JB**
4.	12.20	**Presentation from the Hampshire Together team**, summarising the revised and additional reconfiguration options, including criteria used for further options shortlisting.	**Hampshire Together Panel**
5.	12.25	**Discussion and Q&A** between the clinical senate panel and the Hampshire team, relating to the strategic approach to the revised/additional options and overarching themes KLOE (Q&A).	**JB**
6.	12.30	**Additional Options, Clinical Models and Pathways presentations and discussion:** **Each model presentation to be followed by Q&A** Review of the additional option(s) key proposed clinical models and pathways, including any issues with each of the options presented: • **Urgent and emergency care, inclusive of critical care, with reference to:** The central acute hospital. The role use of the Winchester 'Spoke' site, UTCs, step down/up beds, community rehabilitation beds and the supporting primary and community care services: **(Presentation 10 mins: Q&A 10 mins).** • **Maternity**: The central acute hospital, obstetric led services, MLU, OLU, Neonates, role and function of 'spoke' services **(Presentation 10 mins: Q&A 10 mins).** • **Paediatrics**: The central acute hospital, PED, role and use of 'spoke' services, community services **(Presentation 5 mins: Q&A 5 mins).** • **Planned care, inclusive of any ICU/HDU**: The central acute hospital, role use of 'spoke services', One Stop Outpatient Centre(s), Planned Surgery Centre. **(Presentation 5 mins: Q&A 5 mins).**	
	1.30	***Hampshire Together: Modernising our Hospitals and Health Services to leave the meeting***	
7.	1.30	**Panel Discussion:** Key findings, evidence base and emerging themes for recommendations.	**JB**
8.	14.25	**Summing up, next steps**	**JB**
9.	14.30	**Meeting close**	**JB**

Appendix 3 Hampshire Together (MoHHS) Addendum Panel members

Name	Organisation	Roles
Lara Alloway	Hampshire Hospitals Foundation Trust (HHFT)	Chief Medical Officer
Andrea Burgess	HHFT	Associate Medical Director of Clinical Strategy
James Coakes	HHFT	Clinical Director (Critical Care)
Fay Corder	HHFT	Associate Director of Midwifery
Sara Courtney	Southern Health	Deputy Director of Nursing and Clinical Director for Safety and QI
Ben Creswell	HHFT	Consultant Surgeon Associate Medical Director Medical Workforce
Julie Dawes	HHFT	Chief Nurse
Nicola Decker	North Hampshire CCG	Clinical Chair
Ruth Colburn Jackson	North & Mid Hampshire Clinical Commissioning Group	Managing Director
Dominic Kelly	HHFT	Consultant Cardiologist
James Kerr	HHFT	Consultant in Emergency Medicine
Natasha Kerrigan	HHFT	Programme Director
Lorne McEwan	West Hampshire Clinical Commissioning Group	Board GP
Avideah Nejad	HHFT	Clinical Director, Women's Health
Matt Nisbet	Hampshire and Isle of Wight Partnership of CCGs	GP and Clinical lead, Business and Partnerships
Naomi Ratcliffe	HHFT	Associate Director for Clinical Integration
Shirlene Oh	HHFT	Director of Strategy & Partnerships
Simon Struthers	HHFT	Associate Medical Director of Clinical Strategy, Paediatric Consultant
Alex Whitfield	HHFT	Convenor of NM Hants ICP Chief Executive HHFT
Simon Williams	HHFT	Associate Director of AHP
Isobel Wroe	South Central Ambulance Service NHSFT	Director of Partnerships and Strategic Development

Appendix 4 South East Clinical Senate Council Hampshire Thames Valley Review Group Membership

Name	Roles
Jane Barrett	South East Clinical Senate (Hampshire Thames Valley) Chair
Amanda Allen	Clinical Director of Therapies, Maidstone and Tunbridge Wells NHS Trust
Michael Baker	Deputy Director of Healthcare, Public Health England South East Region
Atul Bansal	Consultant, Emergency Medicine, Frimley Health NHS Foundation Trust
Steve Barden	Lead Clinician for Ambulatory and Acute Medicine, Brighton and Sussex University Hospitals Trust
Mike Carraretto	Consultant in Anaesthetics and Intensive Care Medicine, Royal Surrey County Hospital. *Medical Lead for Kent, Surrey & Sussex Adult Critical Care Operational Delivery Network*
Douglas Findlay	Lay member, South East Clinical Senate (Hampshire Thames Valley)
Mark Hancock	Medical Director, Oxford Health NHS Foundation Trust
Jenny Hughes	Regional Chief Midwife, NHS England and Improvement, South East
Lalitha Iyer	Medical Director, East Berkshire CCG
Tina Kenny	Medical Director, Buckinghamshire Healthcare NHS Trust
Rakesh Kucheria	Orthopaedic Surgeon, Frimley Health Foundation Trust
Jeremy Noble	Consultant Urological Surgeon, Oxford Health Foundation Trust
Ali Parsons	South East Clinical Senate (HTV and KSS) Manager
Karen Owen	Patient Representative, Hampshire Thames Valley Clinical Senate
James Ray	National Clinical lead 111 First, Emergency and Elective Care, Hospitals Team (Same Day Emergency Care) Regional Clinical Lead UEC London, NHS England and NHS Improvement
Jonathan Richenberg	Consultant Radiologist, Royal Sussex County NHS Trust
Guy Rooney	Medical Director, Oxford AHSN
Paul Stevens	South East Clinical Senate (Kent Surrey Sussex) Chair
Isobel Warren	East Sussex Care Homes Place Based Lead, Joint Commissioning, Sussex Clinical Commissioning Groups / East Sussex County Council
Ryan Watkins	Consultant Neonatologist, Brighton and Sussex University Hospitals NHS Trust
Julian Webb	Consultant, Emergency Medicine, Surrey and Sussex Healthcare NHS Trust