Welcome to Southampton
International maritime city

NHS
Southampton City
Clinical Commissioning Group

NHS Southampton City
Clinical Commissioning Strategy 2012 - 2017
A Healthy and Sustainable Future
Summary Document (Consultation Draft)

October 2012

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Please note

The annexes referred to in this document can be found at:

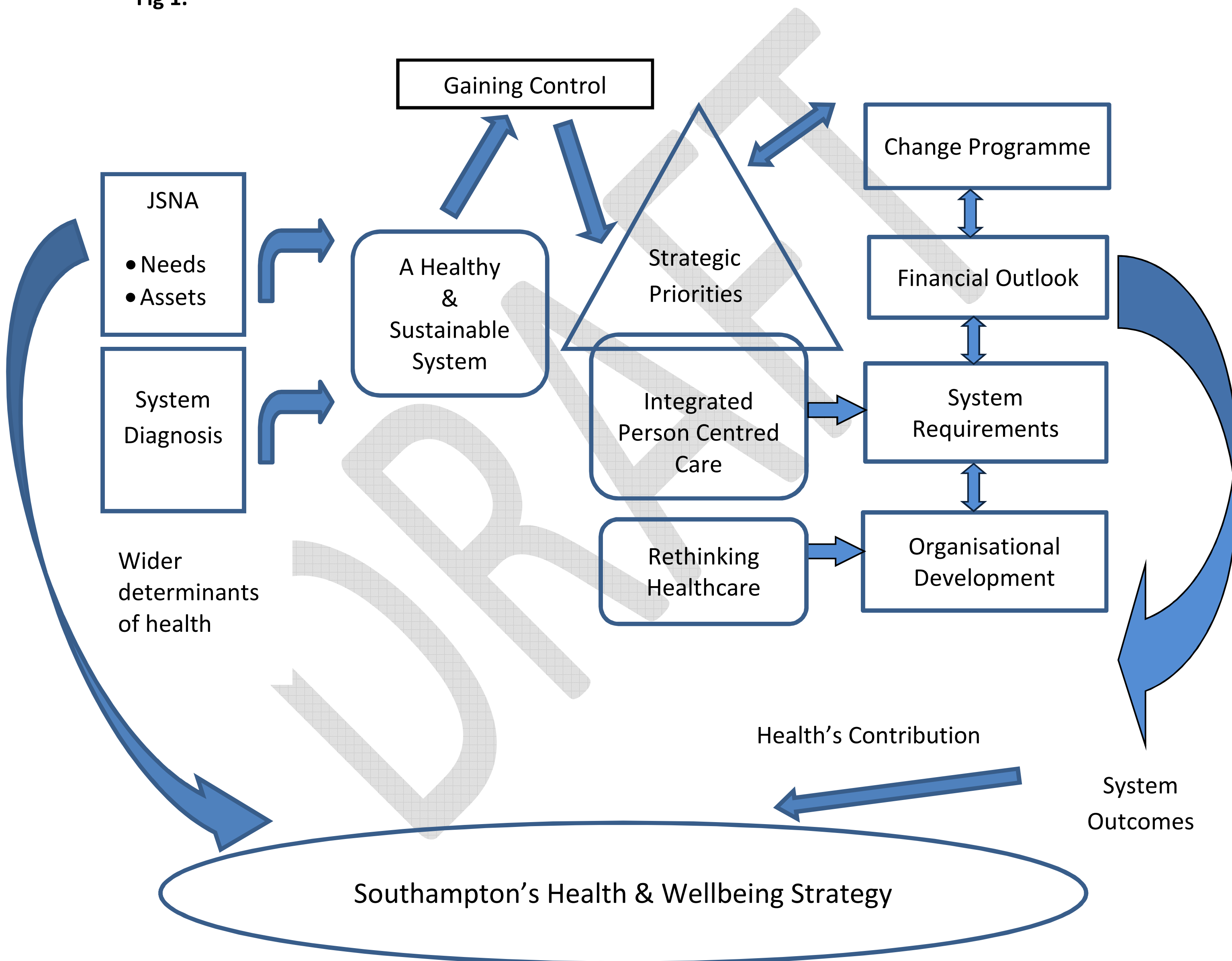
http://www.southamptoncityccg.nhs.uk/have-your-say/consultations-and-engagement

OVERVIEW

1. This document opens with a summary that describes the overall narrative of the CCG's five year strategy (2012-2017): the end to end 'story' of what has driven it, the need for change, the vision of a better future, the main components of its implementation and the plans and change programmes.

The diagram at Figure 1 explains how the story unfolds.

Fig 1.



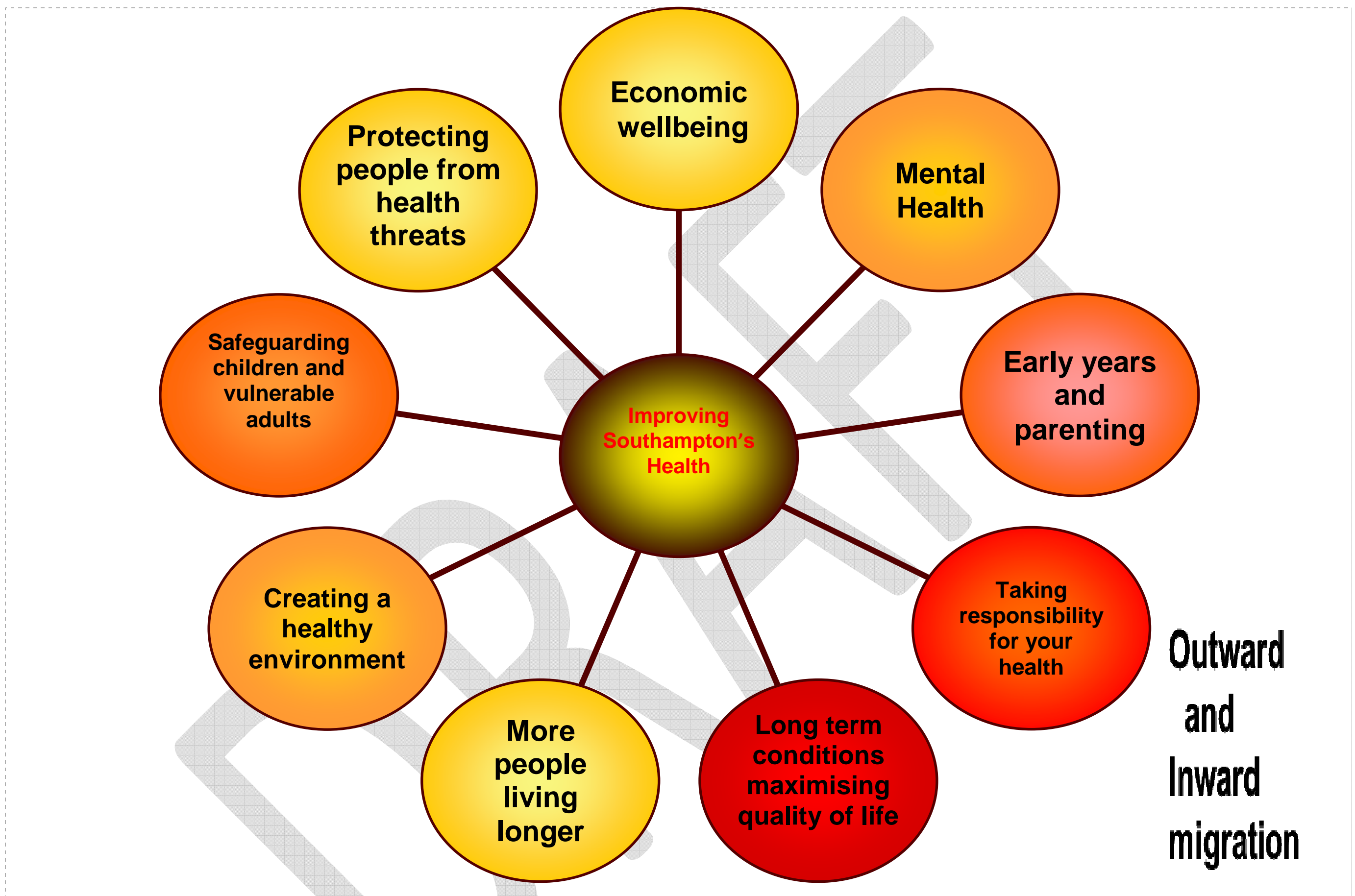
2. Health's contribution to delivering the city's Health and Wellbeing Strategy. Taken together, the outcomes from this strategy will constitute the contribution of the NHS in Southampton to the delivery of the city's Health and Wellbeing Strategy, *Gaining Healthier Lives in a Healthier City*.

DRIVERS FOR OUR STRATEGY

3. Local Drivers: The principal driver for the strategy is the local Joint Strategic Needs Assessment (JSNA) and the resultant joint Health and Wellbeing strategy, *Gaining Healthier Lives in a Healthier City*.

Figures 2 and 3 summarise the key messages of the JSNA.

Figure 2. JSNA KEY THEMES



Southampton is a diverse city with a high level of ethnic backgrounds and significant student population. Whilst the overall health of the population has improved over recent times, the city still faces numerous challenges. Dramatic health inequalities exist within and between communities.

Nationally, Southampton is the 81st most deprived local authority out of 326, and the fifth most deprived in the South East. 23% of residents live in the most deprived Lower Super Output areas (LSOAs) in England. In the next five years people in age groups 5 to 9 years and 70 to 74 years show the largest population increase, with over 20% population increases forecast in both areas. This indicates an ageing population on the one hand and the increase in childbirth on the other, which will mean greater demands on an already pressurised health and social care system.

Figure 3. An Overview of Health in Southampton – key issues

Dramatic health inequalities are still a dominant feature of health.	Levels of teenage pregnancy, GCSE attainment (despite improvement) and tooth decay in children are worse than the England average (2010)
Premature (under 75) deaths are 58.7% higher in priority neighbourhoods and increasing.	Life expectancy is 7.7 years lower for men in the most deprived areas of Southampton than in the least deprived areas.
Life expectancy not significantly different from the national average, but disability-free life expectancy is significantly lower for both males and females.	Priorities in Southampton include violent crime, drug and alcohol misuse and obesity.
Children and young people **Obesity rates in Year R and Year 6 children are similar to national average.**	**Diabetes** Estimated prevalence of diabetes is around 4.2% and growing due to better reporting and early diagnosis.
Older people **Rates of emergency of admissions for fractured neck of femur increase yearly and are slightly higher than national average.**	**Respiratory disease** Estimated prevalence of COPD in Southampton is higher than national average as are mortality rates, and worse in priority neighbourhoods.
Lifestyle **Adult smoking rates are reducing but remain higher than the SE average. Poor diet and lack of physical activity remains and issue.**	**Cardiovascular disease** Early deaths from smoking, heart disease and stroke are higher than the England average.
Cancer **Early deaths from cancer are high especially in priority neighbourhoods. Breast, bowel and cervical cancer screening uptake is challenging.**	**Mental health** Depression crude prevalence rate of 8.9% for the city which is significantly higher than the national figure of 8.5% but about average compared the city's peer authorities

The CCG is working closely with Southampton City Council in the development of a Health and Wellbeing Board to act as strategic decision-making body for all local health and wellbeing services. The draft Health and Wellbeing Strategy has recognised six priorities for the city:

Priority 1: Early years and childhood
Priority 2: Adolescence and young adulthood
Priority 3: Working age adults
Priority 4: Helping people grow old and stay well
Priority 5: Reducing admissions to hospital from preventable causes of both physical and mental ill health
Priority 6: Improving housing options and conditions for people in the city to support healthy lifestyles.

4. National Policy. Our strategy is based on our local vision but is heavily influenced by the government's national reforms and frameworks and the context of economic challenges we face. The reforms also seek to realise efficiency savings through planning and delivering Quality, Innovation, Productivity and Prevention (QIPP).

The NHS national requirements for Clinical Commissioning Groups are set out in the NHS Mandate. The Secretary of State has recently set out his priorities for 2013/14 and 2014/15:

- Quality of care, in particular compassion, patients' experience and essential standards
- Care for people with long term conditions
- Dementia services
- Reducing mortality from the major killer diseases.

SYSTEM DIAGNOSIS

5. The present system is unsustainable. Despite progress in terms of coping with constrained resources so far, there has been little evidence of the kind of transformational change, at scale, that is necessary. The factors driving this challenge are, broadly:

- Demographics – simplistically, people living longer but with more limiting health problems with increasing age; a shrinking population of working people generating less tax, and among the young, a growing problem of lifestyle related morbidity linked to diet and inactivity

- Technology - the increasing capability to do more for people with new technologies

- Public expectations – people are less willing to accept poor access, poor service and poor outcomes

6. Urgent Care Pressures. Hospitals struggling to cope with the demand for unscheduled care from an ageing population are a familiar story. Locally, University Hospital of Southampton Foundation Trust (UHSFT) has been on 'Black Alert' for a substantial proportion of 2012.

7. In summary, therefore there are three key challenges facing the new CCG:

- The bleak financial outlook for public services in general and NHS and social care in particular and the risk of responding to this with crude, ill thought through 'cuts'
- The ownership of the quality of care by those who deliver it
- The pressures caused by the demand for unscheduled care and the current system response.

HOW THE CCG WILL MAKE A REAL DIFFERENCE

8. Improving Quality and Living within Our Means. Focusing first on quality, banishing wasteful processes, and being responsible about using resources.

9. Gain some control. Prioritising work to improve both urgent and planned care, to make them more consistent and systematic.

10. Liberate creative solutions. Creating the right environment for ideas to flourish.

11. Create and empower real clinical ownership of the interlinked nature of the quality and costs of care.

12. Developing a strategic system wide approach.

13. The Southampton system has had a long history of financial challenge, and while the financial position of UHSFT has improved in the last few years, the system as a whole has been relatively slow to change. In performance terms, the system has been a perennial underachiever, with a definitive diagnosis as to why proving elusive.

14. Clinical leadership. Our clinicians must confront these issues, take ownership and do something about it.

STRATEGIC DIRECTION: THE VISION OF A HEALTHY AND SUSTAINABLE SYSTEM

15. In summary, a healthy and sustainable system will entail:

- Developing trustful, open, business like relationships; mutual interdependence
- Designed around the needs of patients, not organisations
- Being sustainable by putting quality improvement first, especially patient safety
- Driving out waste by dealing with failure demand and eliminating wasteful processes
- Affordable costs of infrastructure
- Being clear about the shape, size and skills of the system we want in future

16. Engaging the Wider Community in Setting Priorities. The developing CCG's approach to priority setting has four phases:

- **Forming the Vision and Values.** Annex A shows a summary of how patients and the public were involved in this strategy.

- **Developing Priorities**

- **Testing the Strategy.** An engagement plan is set out at Annex B.

- **Priority Setting Process**

17. A Three Part Strategy. The CCG's clinical strategy will be delivered through three stages: gaining control, focusing on four priorities, and rethinking healthcare.

GAINING CONTROL

18. More systematic arrangements are needed to reduce variation, drive up quality and create an environment where innovation can flourish. This will take broadly two forms, centred on the introduction of the new NHS111 urgent care service and the development of a system for clinical review of referrals in elective care, both of which will start to be put in place during 2012/13. Both of these initiatives will enable a better understanding of what real demand is (not the system's response) so we can use this to redesign services, to give more responsive, tailored services.

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STRATEGIC PRIORITIES 2013/14

19. In the first full year of operation, the CCG will focus on 'Gaining Control' as outlined above and the delivery of the following three strategic priorities:

- Mental health and wellbeing
- A healthy start in life
- Growing older and living with long term conditions.

BRINGING IT ALL TOGETHER: INTEGRATED PERSON-CENTRED CARE

20. We need to 'rethink healthcare' to focus on the individual's needs and look at the whole person not the disease. Many people live with more than one chronic illness and people do not conform to tidy ideas of 'care pathways' but have their own, sometimes complex and often different needs.

Our approach will focus on identifying those most at risk of an acute 'event' and intervening first, as patients with multiple conditions are more likely to be admitted to acute hospital on an urgent care basis.

21. Around 86,000 people in Southampton (32% of the population) are estimated to be living with long term health conditions, such as asthma, diabetes, heart disease, hypertension, epilepsy and severe mental illness. A further 2,395 people are receiving regular case management to co-ordinate their complex treatment and care needs.

22. The programme will focus on the prevention of the need for more specialist services by empowering individuals to manage their own care and achieving efficiencies through improved integrated working between relevant services and wider community-based support.

23. We should aim to treat patients sooner, nearer to home and earlier in the course of disease. To do this we need a combination of:

- Earlier detection of those at risk
- Good control to minimize effects of disease and reduce complications
- More effective medicines management
- Reduction in the number of crises
- Promoting independence, empowering people and allowing them to take control of their lives, and prolonging and extending the quality of life
- Provide the most intensive care in the least intensive setting.

24. Integrated Person-Centred Care Programme. The CCG and Southampton City Council are working together to develop a model of integrated care which will improve outcomes for the people of Southampton and their carers. The focus is primarily on elderly people and those with multiple-morbidities and long term conditions.

25. The aim of the programme is to shift service towards proactive identification and management of patients. The strategy aims to reduce the number of unscheduled care admissions for acute care and reduce residential care admissions by increasing the independence of individuals and carers.

RETHINKING HEALTHCARE

26. Moving beyond the short to medium term priorities set out above, and armed with a better understanding of true demand as a result of the system improvements described above in 'Gaining Control', the CCG and its partners will develop and design new approaches to healthcare that do not rely on traditional service distinctions, organisational or professional boundaries.

27. Failure Demand. We need to eradicate, as far as possible, the 'failure demand' that arrives at the hospital door because something else has gone wrong in responding to the patient's need. This is about putting in place the interventions, further upstream in the patient journey that helps to define the problem more accurately.

28. 'Solution Shops' and Value Added Processes. Further, we need to rethink healthcare completely – to banish the concepts of primary and secondary care and think about how to position our assets (staff and equipment) differently.

- Solution shops seek to answer the question, 'What is wrong with this patient?' and deploy highly skilled diagnosticians and diagnostic kit
- Value added services take a known problem and fix it (e.g. hip replacement) by applying specialised skills in a focused and efficient way.

FINANCIAL OUTLOOK

29. NHS Southampton City CCG's Financial Objectives are

- Generate sustainable financial headroom – by achieving a 1% surplus every year; setting aside 2% recurrent headroom; and holding a contingency
- Deliver our quality, innovation, productivity and prevention (QIPP) challenge – by setting aside 0.7% to invest recurrently in new schemes, and investing in population and service growth of around 1.5%. Also, across five years achieve a gross QIPP saving of an average of 6%.
- Ensure tax payers money is used in the best way.

30. Summarised NHS Southampton City CCG Financial Plan 2013/14 to 2017/18

Table1.

	2013/14	2014/15	2015/16	2016/17	2017/18
NHS Southampton City Clinical Commissioning Group Financial Plan 2013/14 - 2017/18	**Final Opening CCG Budget £'000**	**Final Opening CCG Budget £'000**	**Final Opening CCG Budget £'000**	**Final Opening CCG Budget £'000**	**Final Opening CCG Budget £'000**
Acute Care	156,039	157,359	158,700	159,533	160,375
Community and Mental Health Services	72,609	72,991	73,377	73,770	74,168
Continuing Healthcare	25,708	26,338	26,984	27,647	28,326
Primary Care	40,772	41,555	42,354	43,300	44,271
Support Costs	6,280	6,437	6,566	6,697	6,831
Other	1,296	1,475	1,648	1,822	1,997
Centrally Managed Programmes	4,678	2,825	-586	-5,257	-9,976
Surplus	2,997	3,075	3,091	3,091	3,075
Total	**310,380**	**312,055**	**312,133**	**310,603**	**309,066**
Recurrent Allocation	307,520	309,058	309,058	307,513	305,975
Non Recurrent Prior Year Surplus Return	2,860	2,997	3,075	3,091	3,090
Total	**310,380**	**312,055**	**312,133**	**310,603**	**309,065**

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CHANGE PROGRAMME

31. The aims and objectives outlined in earlier sections must be converted into practicable plans for implementation. Each year, this will be formulated on the Operating Plan that will also have to take account of:

- Current operational pressures in the system
- The priorities emerging from the CCG membership
- The requirements of the NHS Mandate as it develops.

32. Each year, the CCG will prepare its commissioning intentions in the early autumn, which will form the basis of the change programme for the following financial year.

Draft commissioning intentions for 2013/14 are appended at Annex C (and may be subject to development over the weeks ahead until finalised in the Operating Plan). Annex D also provides a cross reference between current year CCG work programmes and the National Outcomes Framework Indicators and the National Operating Framework Priorities.

SYSTEM REQUIREMENTS

33. Having set out its strategic direction and priorities in this strategy, the CCG needs to define the characteristics of the provision system that is needed to deliver it. This will take broadly three forms:

- System capability
- System capacity
- System configuration.

ORGANISATIONAL DEVELOPMENT

34. Creating a Membership Organisation

The CCG is constituted as a membership organisation comprised of its 37 member practices. The CCG will have a General Assembly comprising representatives of every practice and this will delegate functions to a Governing Body (the 'Board') made up of elected clinical representatives, lay members, a Chief Officer, Chief Financial Officer, Executive Nurse, Director of Public Health and a secondary care doctor.

However, giving real meaning to the term 'membership organisation' is about much more than the constitutional arrangements: the organisational development challenge is about developing the roles and behaviours of the members and their management team to create a real sense *of cohesion, ownership and true partnership.*

35. Learning Together: TARGET Days. Regular clinical education and awareness events addressing local clinical issues in a collective learning format.

36. Developing Clinical Leaders. The CCG has developed an organisational development plan that focuses on developing the capability and capacity of the Governing Body in commissioning, governance, development and communications and engagement competencies. However, it further recognises that success depends on the development and support of a much wider group of clinical leaders whose contribution will be made in and around their daily 'operational' clinical roles, not necessarily in dedicated roles that are part of the governance of the Group.

37. Clinical-Managerial Partnership. The CCG will develop a 'contract' for its clinical leaders that sets out what is expected from them and the support they can expect from the wider team.

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38. Working with our providers and co commissioners. The CCG has developed a Compact with West Hampshire CCG that defines how the two CCGs will work together to lead the system in south west Hampshire.

We have also recently commissioned work enabling the leadership community (clinicians and managers, commissioners and providers) to develop a shared common vision and effective governance arrangements to ensure productive joint working. The agreed terms of reference for this initiative are set out at Annex E and the Compact with West Hampshire CCG is presented at Annex F.

39. Joint Working and Commissioning Arrangements with the Local Authority.
In order to adapt and respond to the national and local agenda, the CCG and Southampton City Council are reassessing their current health and social care commissioning arrangements to ensure that both take advantage of the opportunities provided and are able to respond to changing demands. There are a number of joint commissioning appointments in place and the CCG and Council are launching a framework to increase the level of services commissioned together.

We have set out our vision for what we want to achieve by 2015 as:

> *"Working together to make the best use of our resources to commission sustainable, high quality services which meet the needs of local people now and in the future."*

A Joint and Integrated Commissioning Board will be established to ensure effective collaboration, assurance and good governance across the agreed areas of council and health commissioning. The Board will be a sub-board of the Health and Wellbeing Board (HWBB), accountable to the Council's Cabinet and the CCG Governing Body.

SYSTEM OUTCOMES

40. The success of the CCG's strategy will be measured in terms of real improvements in the health of its population. The NHS Outcomes Framework will be used to assess this. Annex G presents an initial baseline in terms of the CCG Quality Profile that has recently been published.

41. The CCG has been closely involved in the development of the city's draft joint health and wellbeing strategy, *Gaining Healthier Lives in a Healthier City*, both through its links with the public health team and the CCG Chair's role as Vice Chair of the Health and Wellbeing Board. Annex H shows the alignment between to the two strategies, and the Commissioning Intentions at Annex Care cross referenced to the relevant sections of both the JSNA and the JHWS.

42. More specifically, the CCG's purpose is "To deliver improved health and wellbeing for **all** in the city" and this includes reduced inequalities in health and in access to services. Annex I sets out how this strategy is aligned to tackling the principal health inequalities in the city's population.

An equality impact assessment (EIA) has been completed for this strategy and is attached at Annex J.

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FEEDBACK

43. We want to hear your views on our planned proposals. You can feedback in a variety of ways

Survey: http://www.southamptoncityccg.nhs.uk/have-your-say/consultations-and-engagement

Email us with your comments at info@southamptoncityccg.nhs.uk

Write to us at: **Southampton City Clinical Commissioning Group, Trust Headquarters, Oakley Road, Southampton, SO16 4GX**

WHAT HAPPENS NEXT

44. Once the consultation has closed we will collate all the feedback received into a report which will be presented to the Clinical Commissioning Group in order that a decision can be made about our plans moving forward. This will be communicated to patients and public.

If you would like any further information, please contact info@southamptoncityccg.nhs.uk

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