NHS
North Hampshire
Clinical Commissioning Group

NHS North Hampshire Clinical Commissioning Group

Strategy 2014 – 2019

(Version 10.1, October 2014)

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NHS North Hampshire Clinical Commissioning Group

Addendum to the CCG Five Year Strategic Plan

The Better Care Fund (BCF) is an important initiative which will support closer integration between Health and Social Care. Since the CCG undertook the planning cycle for 2014/15 and beyond, the Better Care Fund has developed further and the supporting plan including the financial aspects. This addendum provides the key changes as a result of the Better Care Fund plans at the end of September 2014.

- the NHS North Hampshire CCG share of BCF is £11.4m in 2015/16 (building from £3.587m in 2014/15)
- the fund will impact contractually and financially upon Southern Health NHSFT as provider of many of the services which are subject to the changes
- the transformation programme will support the sustainability of our local health system, including our role in managing demand for the acute hospital sector - our main provider is Hampshire Hospitals Foundation Trust - and other associated services including the South Central Ambulance Service and North Hampshire urgent care services (for out of hours and front-door hospital GP care)
- our five year strategic and two year operating plan have not changed materially in terms of activity and initiatives, however the updated BCF now includes new financial risk-sharing arrangements with Hampshire County Council (HCC). Partners to the BCF are committed to minimising the impact of the financial risk and subsequent cost pressures, however, the CCG has agreed to fund a £0.960m one-off contribution to HCC in 2015/16 and has risks of up to an additional £0.960m in 2016/17
- the level of QIPP for the CCG assumed as a result of the BCF has therefore increased to the following:

  2015/16 - £11.1m being 5.1% of revenue allocation

  2016/17 - £10.1m being 4.5% of revenue allocation

1. Foreword by CCG Chair

As we near the end of our first year of operation as a clinical commissioning group (CCG), it is time to reflect on our achievements of the last year and plan for the next five years.

We want to have a new relationship with our population and have begun, in association with Basingstoke and Deane Borough Council, several community partnerships to look at communities holistically. This brings together views on health needs, social needs, housing needs and other facets of daily life in a community. We hope that by building these partnerships we will be able to promote healthy living in a new and exciting way with local people deciding for themselves how this can and should be achieved. We have also had local people involved with our CCG, developing new pathways of care and we look forward to much more engagement in the future.

Caring for more people in the community is high on our list of current projects that are beginning to transform the lives of local families. We have been working closely with the local authority to integrate our services on the ground, identifying people at risk of a serious decline in their health and then working with them to stop that decline before it happens. This is giving people the confidence and proper support to stay healthily and safely at home even with significant frailties. This project has a way to go and later this year will expand to include (when needed) a same day assessment by a consultant and then if possible the patient will return home. We will also have an increasing ability to rehabilitate people who, for whatever reason, begin to lose their independence. This is all designed to keep people independent for as long as safely possible.

Our local hospital, Hampshire Hospitals Foundation Trust is in the middle of a major reconfiguration project. As you would expect we are working closely with them and NHS West Hampshire CCG, to make sure that the new services, whatever they may look like, will provide the safest high quality care in north Hampshire. We are always looking at how we can improve the patient's path through the health system and work with consultants to design new ways of managing their care.

In Primary Care we have started to look at the future and design services that meet the needs of modern life. We have 20 Practices in our CCG and see the future as working more closely together. Currently we are providing primary care input into the Emergency Department at Basingstoke Hospital and this has proved very successful in making sure that urgent cases get dealt with speedily and other cases are directed to the appropriate service.

We appreciate your interest in our five year plan and look forward to hearing your comments and feedback.

Dr Hugh Freeman
Chairman of NHS North Hampshire Clinical Commissioning Group

2. Our Plan-on-a-Page – making the links between our strategy and our ambitions

Our Vision: Making a positive difference to the health and wellbeing of our population…by delivering excellent patient experience and clinical outcomes and to see a better integrated Health and Social Care system for the future

NHS North Hampshire Clinical Commissioning Group

Population 216,000 with pockets of deprivation in parts of South Ham, Popley East, Chineham, and East Brooke wards. The area has a rising population of both young people and the elderly. (Elderly set to rise by 15% by 2018 with numbers of people with dementia increasing by 30% by 2020).	The CCG has £218m to spend on health care. Savings through service redesign will be required to meet the future costs due to people living longer, introduction of new treatments and drugs.	Health improvement possible particularly for those who have Long Term Conditions (Hypothyroidism, Cancer, Depression, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease.	National benchmark data indicates our activity levels are higher than expected (with scope for care pathway redesign) in chronic pain, knee arthroscopies, knee replacements and facet joints.	Hospital admissions for emergency care, higher than expected including the under 19's for asthma, diabetes and epilepsy.	Better Care Fund – pooled resources with Hampshire County Council will support joint commissioning of services. £3.6m in 2015/16 rising to £11.4m in 2019. Early priorities being – older people with dementia and their carers.

CCG Strategic Objectives &	Work Programmes	What will the CCG be doing	The difference we will make
Reduce the gap in life expectancy and health between the most and least deprived wards	**Prevention and Staying Healthy**	Encouraging our population working with other partners, to lead a healthy lifestyle, key initiatives being: to stop smoking, reduce alcohol intake, improve the uptake of screening for breast and cervical cancer immunisation programmes.	Our population will live longer by 2019, with improved health care related quality of life for people who have a long term condition.
Improve access and patient experience	**Quality, Experience and Patient Safety**	Supporting GP's to revolutionise the services which take place in General Practice, working together to innovate different ways of working in support of out of hospital care, and to enable care for the over 75's to be coordinated by a named GP.	Eliminating avoidable deaths in our hospitals and in the community, with less incidents, infections, pressure sores and falls.
Ensure that services are safe, of good quality and have excellent health outcomes		Ensure that our acute hospital care is safe, good quality and clinically sustainable, our work will include involvement in quality improvement, i.e. reducing infections, falls and pressure sores, the proposed Critical Care Centre, 7 day working (A & E, emergency care including diagnostics and coordinated timely discharge from hospital).	Reduce the number of emergency admissions to hospital. By 15% over the next 5 years.
Ensure that planned care services are used effectively	**Planned Care**	Working with providers to reduce clinically unnecessary follow up outpatients appointment and providing increased care in a community setting. Ensure that capacity is jointly planned and that patients are treated in accordance with their right under the NHS Constitution. Projects include a new MSK pathway and extending the use of community based services e.g. Optometrists, paediatrics, and end of life care.	Reducing the amount of avoidable time patients spent in hospital, with joined up services enabling patients to go home safely, with appropriate support to enable patients independence to be retained and carers to feel able to cope.
Provide care and support to children and their families	**Maternity, New born and Children**		
Support those who have long term conditions to maintain a good quality of life	**Long Term Conditions & Integrated Care**	Develop the six GP led Integrated Care Teams, identifying patients who would benefit from case management and patient centered care, working with partners (acute, ambulance, community and social care) to introduce Extended Scope ambulance practitioners (see and treat), extend the remit of the integrated care teams to include Specialist nurses, acute outreach, improving nursing home support , dementia care and continuing care review and co-ordination.	An Increase in the number of people who have received a positive experience of NHS care (in their GP surgery, hospital, community setting, at any time of the week or hour of the 24 hour day.
Redesign services to reduce the need for & use of urgent care, particularly in the acute setting	**Unscheduled Care**		
Adopt a comprehensive approach to mental health and learning disability services	**Mental Health, Learning Disabilities**	Lead GP's working with Clinicians who give care at the sharp end, to redesign care pathways, ensuring care is coordinated across departments and organisations. Priorities being the continuous improvement of the new front door model in A & E, the Integrated Assessment Service, Older people's services and Community Geriatricians.	Patients being able to exercise choice, receiving access to and NHS care at the right time, in the right place with less duplication of questions, tests, gaps in service lessoning the frustration of patients.
Ensure cost effective medicines management to improve patient care and safety	**Medicines Management**	Improving care where there is a gap in provision or where we can do better, projects include extending IAPT, earlier diagnosis of dementia, support to carers, provision of psychiatric liaison, autism and osteoporosis diagnosis and interventions.	Health and Social care services available by a range of providers including the voluntary sector, which are rated to be one of the best in the country and are provided within the resources available.
Making best use of our resources (Finance, workforce, information, technology & estates)	**Essential supporting programmes:** Integrated Governance, Clinical leadership : (GP members and provider clinicians), management leadership and commissioning expertise, Communication & Engagement, Quality, Research and Innovation, Financial Resources and delivery of QIPP, Information Technology including E-booking, and information sharing protocols.		

3. What is a Clinical Commissioning Strategy?

The clinical commissioning strategy sets out our vision and values as an organisation, documents the local needs of our population and details the external influences and demands we face and to which we need to be responsive. The strategy shows what we are aspiring to achieve and guides how we intend to allocate our resources both to commission services for our population and to effectively manage and run our organisation.

The clinical commissioning strategy will form the framework upon which we will review our performance, shape our priorities and service improvement proposals, make strategic decisions, create our annual delivery plans and develop commissioning intentions.

The strategy is influenced not only by the North Hampshire Joint Strategic Needs Assessment and the Hampshire Health and Wellbeing Strategy but also by very local needs that have been identified by GPs working in the area. This is the element that clinical commissioning adds to previous structures within the NHS, the ability to identify and deal with very local issues.

The Hampshire Health and Wellbeing Board provides the key focus for promoting the health and wellbeing of those who live in, work in and visit Hampshire. It brings together leaders from the County Council, NHS and District and Borough Councils to develop a shared understanding of local needs, priorities and service developments.

The Hampshire Health and Wellbeing Board is responsible for ensuring that the Joint Strategic Needs Assessment is developed and for producing a Joint Health and Wellbeing Strategy that explains how healthcare, health improvement and social care services will be changed to improve everyone's health and wellbeing. Member organisations of the Board (of which NHS North Hampshire CCG is one) work closely together to purchase services that will ensure the required improvements take place.

We know that we work within a changing environment. Whilst we have tried to anticipate future challenges we understand that there may be many changes during the next five years which we cannot foresee at this stage. With this in mind we will try to make the final clinical commissioning strategy as flexible as possible and we will be reviewing it regularly to ensure that it remains appropriate.

Involving local people in our five year strategic plan - what you have told us about your priorities over the past year

It is important that our strategic plan reflects not just the vision of the CCG but also that of our local people. Over the last year the NHS North Hampshire CCG has been talking to a variety of local people, finding out what is important to them with regards to health care and what their priorities are for commissioning. All these comments have been carefully considered and will be worked into our strategic plan when it is within our realm to do so.

Consulting on the strategy – what we do with what you tell us

As well as getting local people's views before we write our strategic plan we also think it is very important to consult with them about the final version. We did this in a variety of ways:

- we published the plan on our website and asked for people's views by email, telephone or letter
- copies of the strategy were sent to local patient participation groups for their comments
- we also sent the strategy to a range of local organisations for their comments e.g. local councils, voluntary organisations and community groups
- we held local meetings where we explain the content of the strategic plan and ask for feedback

We were very appreciative of the time that many people took to give us their views on both the way the plan was presented and the vision and priorities that the CCG has for the next five years - a summary of these views can be found at **Appendix B**. Where it has been possible to incorporate specific suggestions for changes to the document we have done so.

Some suggestions were made about how we should involve local communities more in actually carrying out our commissioning strategy. We will be drawing up plans for how we can actually do this.

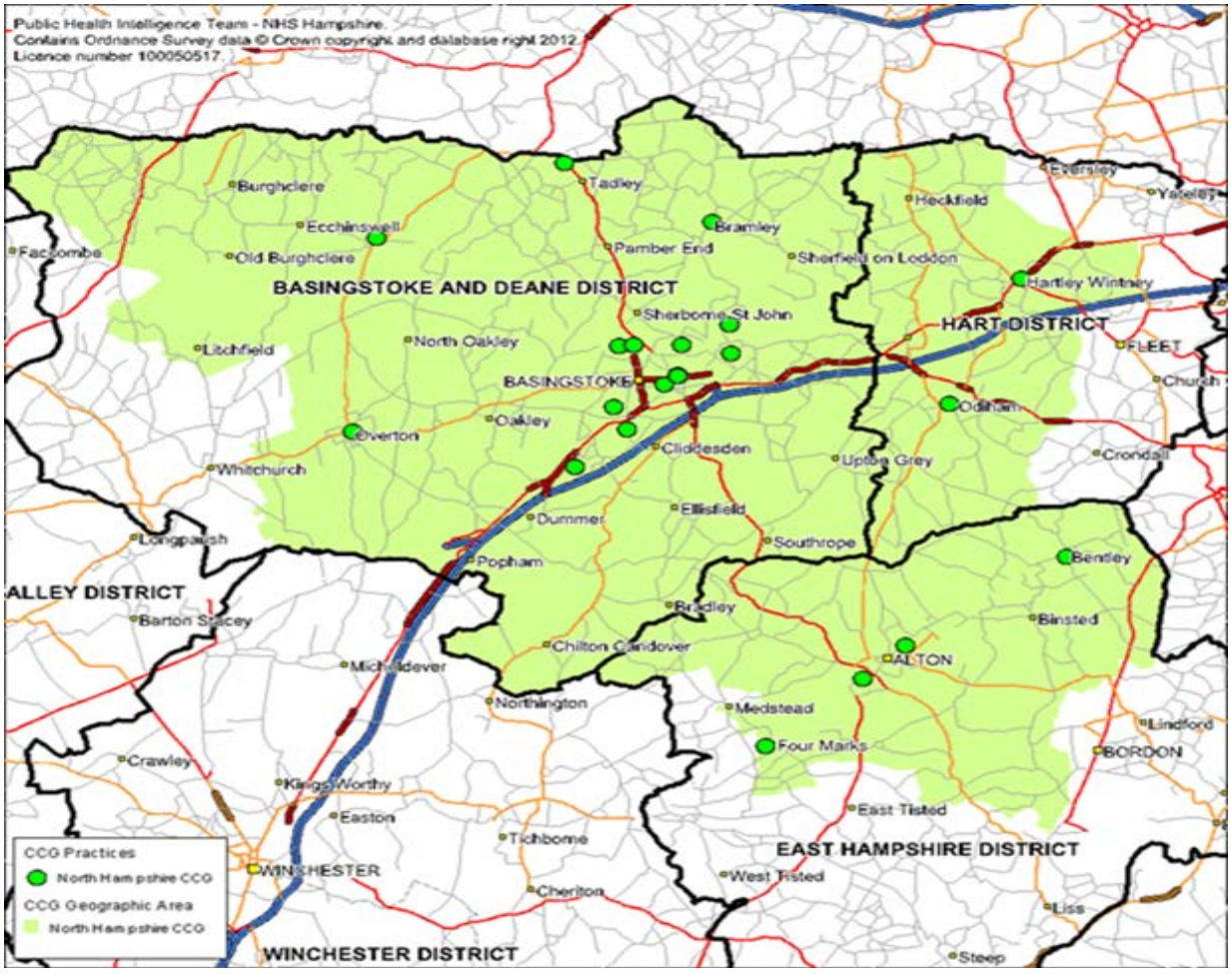
Local people have shown us that they would like to be more involved in their healthcare but we need to give them support to do that. This is the first version of our strategic plan for 2014-19. With the help of our local community we now want to refine both the strategy and the operating plans that emanate from it. This we will be doing over the coming months.

4. Who we are – the facts and basic information about our CCG

Our geography

With a membership of 20 GP practices, NHS North Hampshire CCG is responsible for commissioning for the health needs of a registered population of c.216,000 across a geographical area that covers all of Basingstoke and Deane, some of East Hampshire and West Hart local authority areas and with Hampshire County Council being the authority for countywide services. There is a mix of both urban and rural conurbations with the main populations located in Basingstoke, Alton, Hook, Hartley Wintney, Odiham and Tadley. 76% of our population live in the Basingstoke and Deane District, 13% in the East Hampshire District and 11% in the West Hart District.

The map below shows the location of our practices (green dots) and the geographical boundaries (black lines) of the District Councils.



The context in which we work - national

The Political environment – the NHS reforms and national priorities

The Health and Social Care Act 2012 introduced a wide range of changes to the NHS. The Government's ambition is to make the NHS the most responsive healthcare system in the world. This ambition is rooted in three principles; giving patients more power, focusing on healthcare outcomes and quality standards, and giving frontline clinician's greater freedom and a strong leadership role.

The NHS Constitution 2013 sets out the principles of the NHS and is designed to ensure that future plans are consistent with these values and take into account the rights and responsibilities of patients, the public and staff. The vision of NHS England is to ensure that we commission ***high quality care for all, now and for future generations***.

Our planning guidance **'Everyone Counts: Planning for Patients 2014/15 – 2018/19'**, was published by NHS England in December 2013, and describes the virtues of six new models of care which together will deliver the transformational change needed if the NHS is to deliver improving outcomes in health, namely:

1. A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
2. Wider primary care, provided at scale
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step-change in the productivity of elective care
6. Specialised services concentrated in centres of excellence

From the early results of the national programme '**A Call to Action'**, and building on the principle that citizens must be at the centre of all our planning, NHS England has identified and signalled that any high quality, sustainable health and care system in England will need to design services that have these six characteristics and that they be applied consistently by commissioners and providers across the country.

NHS England are also clear that the initiatives they started to introduce last year should remain central to future planning, and in particular seven day services and delivering the highest possible level of care in the right place and at the right time.

A common theme throughout the planning guidance is a need to create a significant shift in activity, capacity and resource from the hospital sector to the community whereby:

- **patients are informed** enough and supported to manage their own care at home wherever possible
- **primary care provides as many services as possible** that are closer to the patients home
- that **community health care services are integrated** with social care and can call on expert or specialist staff when required
- that **emergency care is responsive**, safe and can access specialist urgent care teams quickly
- that **elective surgery is accessible**, involves the shortest possible stay in hospital and patients receive support upon discharge to live at home

NHS England identified that there are four essential elements to the delivery of high quality services that will need to be maintained in order to drive up successful outcomes, namely:

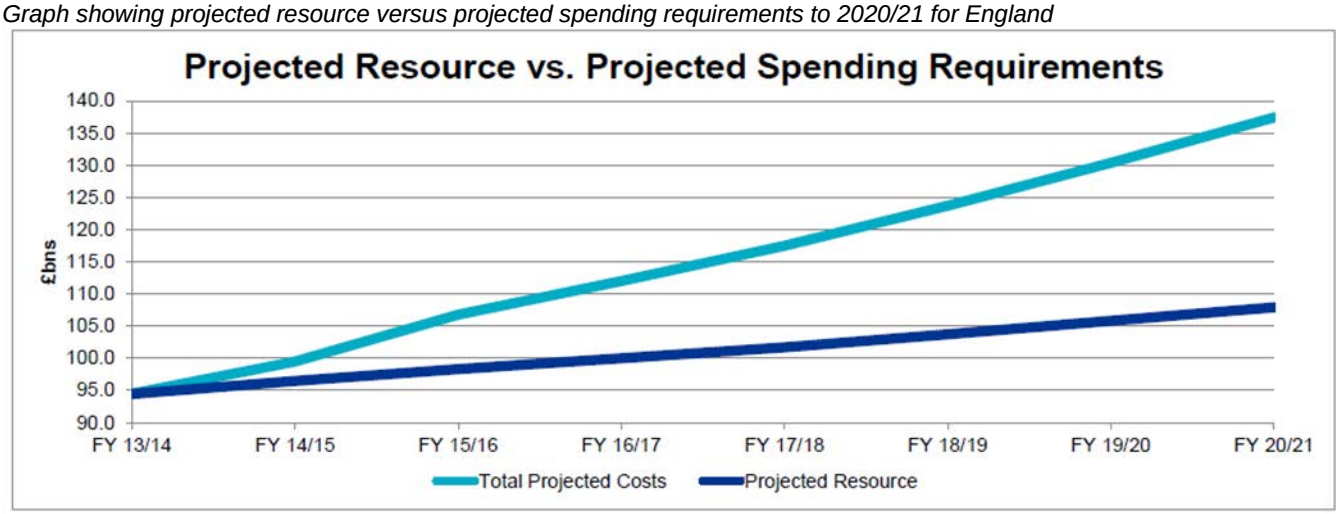
- **Quality** as a central theme – focussing on patient safety, patient experience, compassion in practice, staff satisfaction, seven day services and safeguarding
- **Access** to services – providing services that are convenient and timely
- Driving change through **innovation** – by supporting staff to innovate and evaluate services
- Getting **Value for Money** – and support the implementation of 'Better Procurement, Better Value, Better Care'

The Economic environment

If we continue with the current models of care, it is likely the NHS will face a funding gap between projected health spending requirements and NHS England resource of around £30bn between 2013/14 and 2020/21. Drivers for increasing health spending include:

- increasing demand for healthcare from a growing and aging population
- cost of new technology
- higher patient expectations

Graph showing projected resource versus projected spending requirements to 2020/21 for England

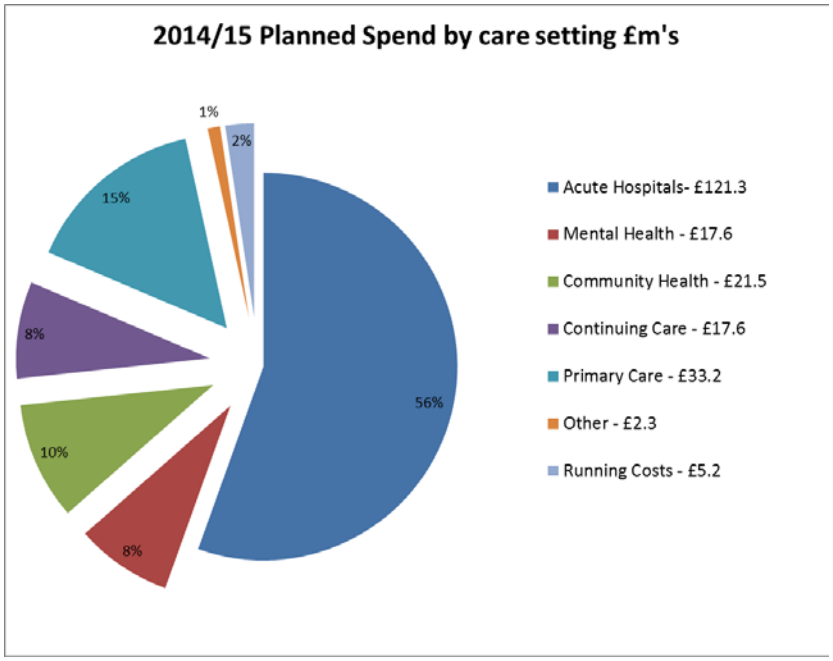


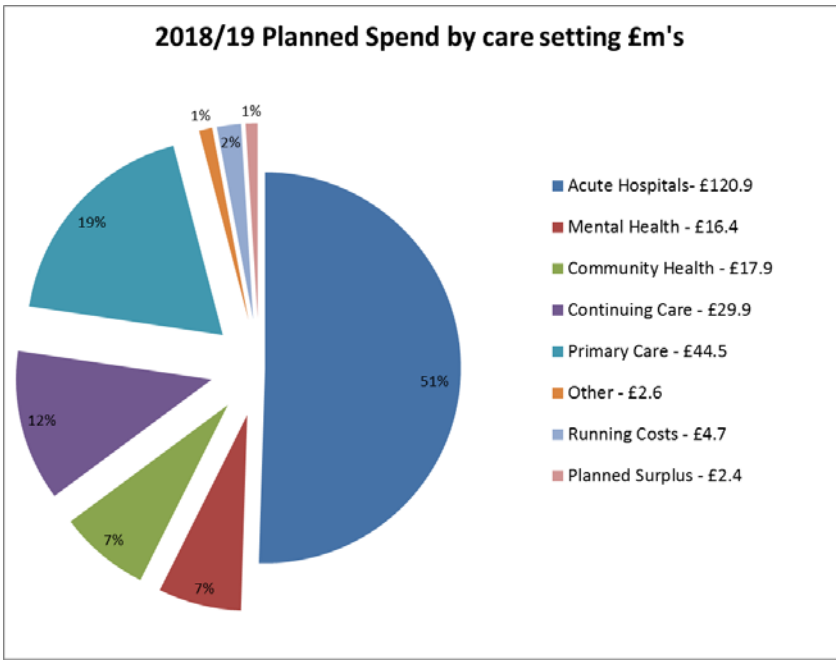
The CCG will have a budget of c£219m in 2014/15 and c£239m in 2015/16, the CCG acknowledges that in there are significant financial challenges currently and in the next few years, and we are clear that pursuit of efficiency is key. There is a need to spend better by influencing the way services are provided and to be open and accountable in our decision making.

Over the period covered by the strategy we expect the way that our resources are spent to change. The two tables below show how we apportioned the budget between the major providers in 2014/15 and how we intend to spend it in 2018/19.

The CCG will be required to manage its business effectively within the resources allocated to it. This will require substantial service transformation. The CCG must drive up quality, improve productivity, prevent illness and be innovative in the delivery of health care. From 2014 - 2015 onwards the CCG will need to make its savings to enable the re-investment into areas that are forecast to experience increased patient needs. This will fund changes in our population, particularly in support of the increasing elderly population, in new treatments and drugs, this will include cancer treatment, care for the vulnerable, frail and elderly. Emergency admissions and the implementation of integrated care will continue to be an area of focus particularly the ability to ensure rapid access to services in the community to avoid unnecessary hospital admissions and to facilitate a timely discharge. There will be changes in the configuration of beds in the acute hospital reflecting specialisation and changes in need and service provision.

Another area of focus will be elective care and outpatient services where there are also opportunities to realise efficiencies by reducing unnecessary follow ups, commissioning more procedures provided on an outpatient basis and the increasing use of technology. There is the potential to improve efficiency, promote one stop care and provide a better patient experience. The CCG has made some progress over the last year in moving towards upper quartile performance in these areas through the implementation of new community based pathways and further development of these will be key to delivering financially sustainable services.





It is through robust strategic planning and understanding of the financial resource available, how it is being spent and the clinical outcomes received from the expenditure incurred that the CCG will be able to assess the value of each service provided to our patients. We are and will continue to use benchmarking as a way of signposting where there is scope to improve quality, access, efficiency, effectiveness and productivity. Use of activity and financial modelling will help to assess the impact of our commissioning plans with regard to:

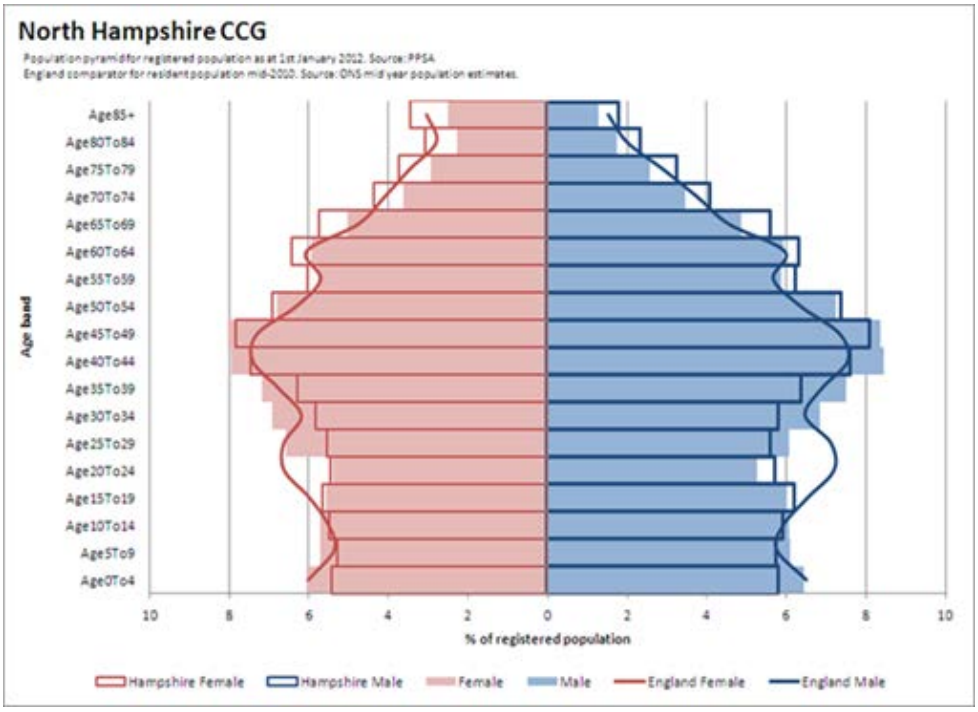
- capacity requirements vs. availability – informing our market management priorities and our commissioning intentions
- informing our commissioning plans and intentions which will be shared with our providers
- identifying opportunities to redesign care pathways and secure savings to invest in areas of need

Where there are significant changes to pathways, perhaps involving a change in provider, it may result in a change in income flows affecting sustainability of services therefore effective planning, involving consultation and impact analysis is essential. Commissioned changes could evolve over a year or more seeing a shift of services from hospital into the community. Actively managing the consequences of these shifts is fundamental. The CGG is committed to making an impact assessment of our plans, testing for unintended consequences and building in exit plans, thus ensuring that funding is spent wisely.

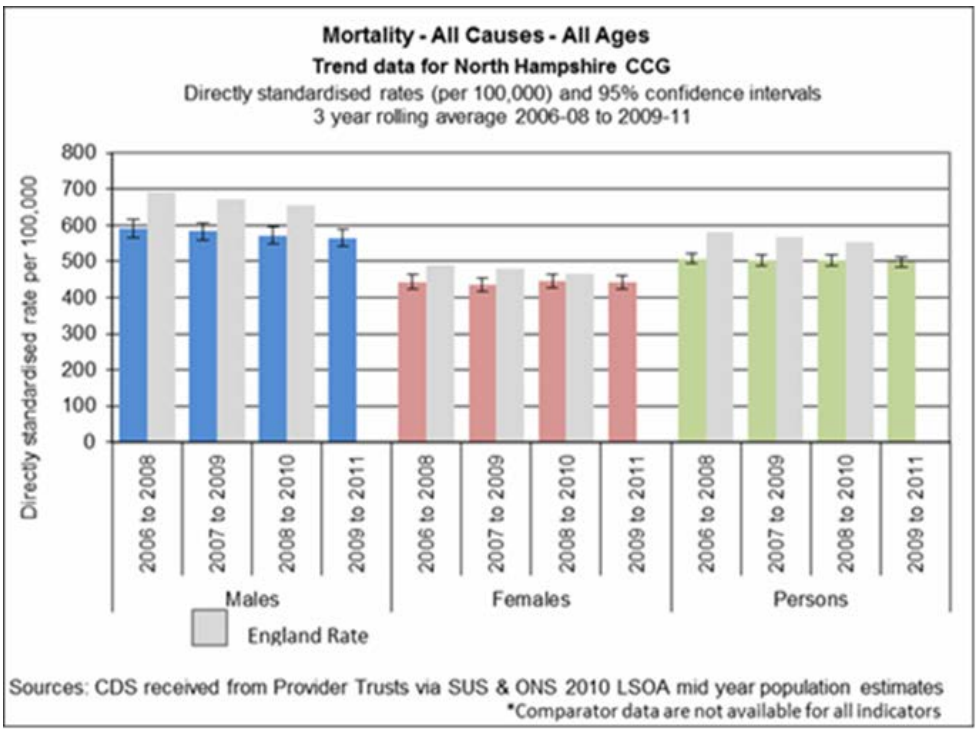
In order to clearly articulate the impact of strategic plans on current health providers, CCGs across Southampton, Hampshire, Isle of Wight and Portsmouth will collaborate with NHS England to agree an explicit roadmap. This roadmap will detail how we will work with health and care providers and other stakeholders to describe the health provider 'end-state' in five years. This will ensure local CCG strategies are cross referenced and local implementation plans are, where necessary, co-ordinated.

Socio / Cultural and environment

Demographic and lifestyle changes will influence our planning. We are expecting growth in our population in the next ten years with the biggest population increase expected to be in the groups of over 45s and over 65s. Our local birth rate is higher than the England average and is increasing. It is anticipated that the economic conditions may put increasing pressure on the need to close the gap in health inequity and life expectancy between the populations who live in wards which that have challenges with regard to social deprivation compared to the areas of greater affluence.



North Hampshire CCG population pyramid for resident population, 2011



All-cause mortality for North Hampshire CCG directly standardised rolling 3 year average 2006-08 to 2009-11

Technology and innovation

The past few years have seen the growing importance of technology in all aspects of healthcare. Our CCG aspires to use information, technology, and innovation to improve the manner with which patients are diagnosed and treated. We believe that technological advances will continue to improve the delivery of healthcare, and will also be a key enabler for sharing of data and clinical information.

The context in which we work – the local health system

Our people

Census figures from 2011 show that the NHCCG **resident population** is a relatively young population with a higher proportion of people under the age of 15 years old than Hampshire or England. The area has a slightly higher proportion of working age people, but a lower proportion people over the age of 65 years old when compared to the rest of Hampshire. There is a projected increase in all population groups except for 15-44 year olds. The greatest projected proportionate increase is for over 75 year olds.

The **life expectancy** at birth in NHCCG is 80.5 years for males and 83.2 years for females, which, for males is similar to the Hampshire average but for females is lower than the Hampshire average but there is variation between the constituent districts.

Whilst NHCCG has a low overall level of **deprivation** when compared to England as a whole, it ranks as one of the worst CCGs (18th out of 212) for geographical barriers sub-domain which measures road distances to key services. Pockets of deprivation exist in South Ham, Popley East and Chineham wards in Basingstoke and parts of Alton East Brooke ward, affecting a substantial number of people who are consequently likely to have poorer health.

Education and employment influence income and there is a well-established link between income and health. Just over half of 16 year olds in Basingstoke and Deane achieve 5 A*- C GCSEs – below the Hampshire average (58.5%) and the England average (59.4%). However, more of the 16-74 year old population in North Hampshire 76.3% (119,012) are economically active than the 73.2% for Hampshire and 69.9% across England. With regard to l**ifestyle choices**, the proportion of people who

smoke is the same as the average for England (21%, or 36,355 people), whilst alcohol-attributable hospital admissions are lower than the national average but have been rising steadily over the last five years.

There are approximately 52,178 **children and young people** aged under 20 in North Hampshire which is around 25% of the total CCG population. North Hampshire has a higher **birth rate** than the county and national averages which reflects the younger population. **Teenage conceptions** have reduced by a third over the last 15 years but the current under 18 conception rate in Basingstoke and Deane is higher than the overall rate in Hampshire. In North Hampshire in 2012/13 67% of mothers were either partially or totally breastfeeding at their primary birth visit (9-14 days) but by the 6-8 week check this is reduced to just over 50%. Around 8% of 4-5 year olds in North Hampshire were obese but this doubles to over 16% amongst 10-11 year olds, which is high for Hampshire.

Roles and responsibilities in the local health care system

Clinical commissioning is the term we use to describe how an organisation (the commissioner) identifies the health needs of a population and then sets about a process to appoint other organisations (providers) to supply services to meet these needs. We have a duty to ensure that the services we commission are high quality, safe, local and accessible and also good value for money.

The table below shows the type of services we commission and the main providers of these services to our population.

Service Type	Main Provider	Commissioner
Planned (elective) hospital care Urgent and Emergency Care (A&E) Maternity Services	Hampshire Hospitals NHS Foundation Trust (Basingstoke and Winchester)	NHS North Hampshire CCG
Ambulance Services '111' Service	South Central Ambulance Service	NHS South East Hampshire CCG NHS Portsmouth CCG (both on behalf of NHS North Hampshire CCG)
Out-of-hours services	North Hampshire Urgent Care	NHS North Hampshire CCG
Community Health Services Mental Health/Learning Disability Services	Southern Health NHS Foundation Trust	NHS North Hampshire CCG
Healthcare Services for Children Healthcare Services for Older People	Hampshire County Council	NHS North East Hampshire & Farnham CCG NHS West Hampshire CCG (both on behalf of NHS North Hampshire CCG)
NHS Funded Continuing Healthcare and Funded Nursing Care	Southern Health NHS FT	NHS West Hampshire CCG (on behalf of NHS North Hampshire CCG)

NHS England is also responsible for commissioning a number of services directly. These include:

- Primary care - GPs (your family doctor), dentists, orthodontists, pharmacists, opticians
- Specialised services (more complex care for rarer conditions)
- Offender healthcare, and
- services for members of the armed forces

Commissioning of public health services is carried out by Public Health England (PHE) and local authorities, although NHS England commissions, on behalf of PHE, many of the public health services delivered by the NHS such as:

- national immunisation programmes
- national screening programmes
- Public health services for offenders in custody
- Sexual health (including sexual assault referral centres)
- Public health services for children aged 0-5 years (including health visiting, family nurse partnerships and much of the healthy child programme)
- child health information systems

5. Our vision for the next five years

Our vision, values and behaviours

Our vision is to place each patient at the centre of their own health. We will deliver the changes required and which are set out in this plan by using the strengths and support of our member practices, and through team working; our approach will be to encourage working together between community and hospital providers, social care and the voluntary sector, maximising their experience and expertise, and breaking down the barriers that hold back transformation.

Our **vision statement** has been developed in partnership with member GP practices and our local communities, and lays the foundation for our business.

Vision

To make a positive difference to the health and wellbeing of our population…by delivering excellent patient experience and clinical outcomes and to see a better integrated health and social care system for the future

Put simply, we aspire to:

- achieve better clinical outcomes
- improve patient experience
- reduce costs
- promote partnership working
- change the system to make it work better

We have developed a **set of values** that NHS North Hampshire CCG stands for, and lives by:

Values

- **We are accountable for what we do**
- **Quality is at the heart of our work**
- **Each patient is at the centre of their own health**
- **Meaningful and open engagement with our population is core to the way we work**
- **We make decisions using evidence, good practice and innovation**
- **We will deliver financial sustainability and value for money**

In everything we do we will:

Behaviours

- **Listen and create a learning environment**
- **Be driven, challenging, resilient and fair**
- **Use the strengths and support of our clinical leadership**
- **Work together with partners to create and deliver a shared vision**
- **Promote positive relationships to achieve the best possible health outcomes**
- **Use cooperation and competition appropriately**

The next 5 years

We very much see the role of CCGs is to play its part in the commissioning of excellent healthcare services along a continuum from birth to death; from preventing or detecting ill-health to recovering quickly from episodes of ill-health; as well as providing interventions and support to those who are suffering from more complex health-related issues, so that the population of North Hampshire can be assured that, whatever their circumstances, they are, wherever possible……

…….“living healthy, happy, fulfilled and productive lives”……

In particular, we envisage a future where:

- **Care starts at home** and people are living happily and healthily whilst taking responsibility for their own health. People have ready access to all the information they need to lead healthy lives and make better lifestyle choices. They take advantage of the all the development, screening and **prevention/staying healthy** programmes made available to them throughout their life and take action to avoid risks to becoming ill whenever possible.

- At times of illness, people have access to all the local resources available to **take care of themselves** and manage their condition at home and to recover as quickly as possible. People will be encouraged to cultivate ‘networks’ of **close family and friends** who can help and provide support at times of illness, or take advantage of carers if they are alone or when life becomes a ‘struggle’. Community groups will be available to join where people can share experiences and issues and perhaps learn how to cope from others who are in similar situations.

- **Primary care** will be the first port of call for most people when they first become ill or require further treatment, be it via the optician, the dentist, pharmacist or General Practitioner (GP). Pharmacists will be able to provide a greater range of services including health screening and testing and social care will work much more closely with doctors.

- GPs and Practice Nurses will provide all the care that people have come to expect, but will also work as part of a wider **integrated community care team** that provides a range of additional services such as community nursing, occupational therapy, mental health/wellbeing counselling and social care – this would be managed by a very senior nurse called a Community Matron.

- If people’s conditions worsen, and the level of care required increases, or people become frail, the community team will develop a care plan that will help guide them through the health system and make sure that they see the right doctors and nurses for their problems and as close to home as possible, if not at home. They will have access to more specialist help for more common conditions such heart disease, COPD and diabetes if required. There will be a menu of services for people to choose from and a computer system that shares medical information so that everyone involved in care can keep up to date and provide people with what is needed at the right time.

- More local clinics will be available for routine consultations and visits to the **local hospital** becomes the exception rather than the norm. If people need to see a more specialist doctor or need an operation, their GP or community team will organise this so that visits to hospital and stays in hospital are event free, as short as is possible and that discharge is safe and back to a place that is either very close to or at people’s homes.

- Our community team will ‘wrap’ their care around people and actively manage them so that they stay at home for as long as possible. People will only have be taken to A&E at the hospital in real life-threatening emergencies. Such emergencies will be dealt with by the **Critical Care Hospital**, as will those people with conditions that are more complex, rarer or involve those who are frail and with multiple conditions that need monitoring more closely.

- At all times, increasing care needs will be met with a smooth progression and flexibility of delivery, whereby only the really necessary professionals can be brought in to help and who have the right information about patients and the right skills to deal with their condition quickly and effectively. The community care team will expand to include different and more specialised members as the needs arise but will contract as people's need diminishes.

The North Hampshire model of person-centred care where integrated community teams 'wrap' around patients at home and different professionals are utilised to give care

Some of the key aspects in more detail

Prevention and staying healthy

"Health promotion and early disease detection is at the heart of what we do to reduce morbidity and mortality, and to increase the years of quality living through targeted prevention"

We will work with partner organisations to jointly tackle health inequalities as identified in the Joint Strategic Needs Assessment (JSNA). This needs to focus on 3 areas, the wider determinants of health, lifestyles and the accessibility and responsiveness of healthcare. Through our understanding of need and strategic aim of reducing the Person Year Life Lost (PYLL) measurement we will work to reduce the gap in life expectancy in comparison to Hampshire and aim for improving the health of all.

We need to work with Local Authorities to facilitate a system-wide approach to improving the wider determinants of health through partnership work of the District Health and Wellbeing Group and the county Health and Wellbeing Partnership Board. We will provide programmes that support the most disadvantaged people in our communities including 'strengthening troubled families'.

In partnership with Public Health England, we will ensure that behaviour change services are accessible for all and that there is a focus on empowering those people who find it harder to make positive lifestyle changes. This includes people who might be from poorer areas, who are unemployed, living with long term conditions and mental illness. It is important to take a life course approach with a focus on promoting actions which will support families to experience a good start in life.

We will work to improve access to health care for vulnerable populations. This will help reduce late diagnosis of the main killer diseases which are more common in disadvantaged communities. We will target approaches to case finding in hypertension, COPD, lung cancer, cardiovascular risk and harmful drinking which will improve outcomes and reduce health inequalities.

Through our public and patient engagement work we will involve people and communities in designing services to meet their health and care needs. We will communicate bold but simple and appropriate messages:

….“Take light exercise regularly”….

….“Reduce your salt intake”….

….“Stop smoking”….

….“Drink sensibly”….

….“It’s better than medication!”….

Caring for yourself and living fulfilled lives with long term conditions

“Self-care is about keeping fit and healthy, as well as how you take medicines, treat minor ailments, and seek help when you need it.”

If prevention is about healthy lifestyles and preventing disease, then self-care is about keeping as fit and as healthy as possible even when people have had a condition for quite some time – so-called ‘long term conditions’ which can be controlled by medication or other therapy but not cured. Around 18 million people in the United Kingdom live with a long term condition such as diabetes, chronic obstructive pulmonary disease or heart disease, and this number is expected to double by 2030. We aim to maximise the potential for a longer quality of life.

“If you have a long term condition it’s about understanding that condition and how to live with it. People have timely access to pharmacists and GPs when they have a health problem that can’t be self-managed”

We know that people with long term conditions can improve their health significantly and have a better quality of life by taking a more active role in their own care – being more self-reliant can also improve people’s chances of getting better more quickly after a stay in hospital. Being more self-reliant means learning how to manage your condition and how to live with it. Importantly, it is also how to seek and get the right help when people need it.

We will work with people to improve their self-management skills so that they become more self-reliant, but at the same time we will:

- promote healthy lifestyles and offer support in helping people improve their diet and exercise regimes
- offer advice and support about managing medicines
- provide easily accessible information about conditions and their treatment - this might be on a computer or in the form of personalised booklets – and access to health records
- look to use tele-care whenever possible to aid self-monitoring
- train people and their family/carers to feel more confident about living with conditions and provide the tools and equipment to make life easier at home
- offer ‘wellbeing’ support
- offer support networks that can help people to share experiences

We would like to see a more person-centred healthcare system where people are supported to make informed decisions about how to successfully manage their own health and care and to choose when to invite others to act on their behalf. It would be a collaborative effort and we would organise for health and social care teams to 'wrap around' the family unit at times of need. A partnership would be formed where decision-making about health interventions are made together and where patients are equal partners in the planning and delivery of their care to make sure it is most appropriate for their needs – it involves putting patients and their families at the heart of all decisions about their care.

"North Hampshire is a place where older people with long term conditions can live healthy fulfilled lives. When they are unwell or need support they are able to access the services they need as locally as possible and in a timely way"

People will have quick access to a named professional who would act to guide them through the care system and to access the most appropriate service. Each patient would have an individual care plan developed so that when they are ill and have to consult a doctor then they will quickly understand people's illnesses and what people have been doing to cope. This may well not a GP but someone who is trained to a high level to treat certain illnesses. It will also not necessarily need a visit to hospital but to a new clinic being run at the local GP Practice, in some instances, where the hospital doctors will hold local consultations.

Primary Care – focussing on those with the greatest need in the community

"Getting the right care, in right place, at the right time. GPs are part of a team of healthcare professionals that deal with everyday healthcare and they promote health and wellbeing. GPs manage long term conditions but they can refer to specialists when appropriate. They can also deal with urgent health needs"

General practice is the cornerstone of NHS care, yet the demands placed upon GPs and their teams have never been greater. General practice is seeing more patients than ever, with more complex needs; it offers a wider range of services; and it is seeking to maintain and improve ever higher standards of care. At the same time, the GP workforce is changing – with significant numbers of experienced GP principals nearing retirement, the GP workforce is increasingly sessional and/or part-time, and many areas are experiencing difficulty with recruitment.

NHS England would like to enable general practice, community pharmacy and other primary care services to play a much stronger role, at the heart of a more integrated system of community-based services where patients can access a broader range of services in their own homes and in their communities, and where general practice co-ordinates care in collaboration with community services and expert clinicians.

The CCG believes that primary medical services need to be fit for the 21st Century so one of our key areas of work will be to focus on those services delivered by general practice to ensure they are responsive to patients needs and deliver a good patient experience and outcome. It is fundamental to the CCG that general practice should be resourced properly to deal with additional workload but also that is should work effectively and efficiently. The CCG has adopted the Productive General Practice scheme from the Institute for Innovation and Improvement as the beginning of this work.

Our vision for primary care services, and general practice in particular, would be to maintain the core components of care that include:

- improving population health, particularly among those at greatest risk of illness or injury (to include things like immunisations)
- managing short-term, non-urgent episodes of minor illness or injury (such as tonsillitis or back strain)
- managing and coordinating the health and care of those with long-term conditions (eg diabetes)
- managing urgent episodes of illness or injury (such as suspected appendicitis)

- medicines management/optimisation
- managing and coordinating care for those who are at the end of their lives

but also to meet the needs of vulnerable population groups such as:

- children and adults with learning or physical disabilities
- the frail elderly
- individuals who are socially marginalised, such as the homeless, gypsies and travellers, sex workers, people suffering from drug and alcohol addiction, recently-arrived asylum seekers, and individuals from communities with little or no experience of using primary care services

General practitioners will look to organise themselves in what are known as a 'federations', so that they come together to form larger-scale organisations or 'networks' to share responsibility for a range of functions, which may include developing and providing services, training and education, back office functions, safety and clinical governance. Federated working will enable practices to work together on a locality basis to plan and deliver new and extended forms of care for patients with long-term conditions or the frail elderly, and in support of public health priorities such as immunisations and vaccinations.

"Care for frail people with multi-morbidities is tailored to the individual needs of patients, in particular people in residential or nursing homes"

GPs will be trained to be 'expert generalists' – their focus will be on the treatment of those patients most at need of careful management; the frail elderly alongside patients with multiple or complex conditions and with poly-pharmacy, or requiring palliative care. They are able to care for patients in their homes and communities, both in and out of hours and be able to develop structured care plans that consider both the patient's conditions whilst placing them at the centre of their own care and life-priorities.

New information technologies that draw on the electronic health record will be accessible during consultations to support effective coordination of care, and teams will use case-finding to identify and target individual patients who may be vulnerable and at the greatest risk of being admitted to hospital unexpectedly and perhaps inappropriately. They will also be able to track patients in the health system, with Rapid Response and Hospital Discharge Teams working together 24/7 in response to immediate need in the community and to provide efficient and joined-up support to patients being discharged from hospital.

GPs will also have access to short-term bed-based services in community settings - to reduce hospital admissions and/or length of stay and provide re-ablement for those at risk of admission to long-term residential care.

Integrated Community Care

" Patients are offered continuity of relationship where this is important, and access to the right services at the right time when it is required"

The emphasis will be to design primary care as part of an integrated, community-based service. Doctors will work alongside colleagues in nursing, hospital and social care, all acting in concert to improve the coordination of care. The GP takes the lead to guide and signpost services alongside a senior Social Worker and a Community Matron. Each Practice will have an associated Integrated Community Team (ICT), either based at the surgery or at a nearby 'hub' – maximising the use of settings such as community hospitals to provide improved information, services previously provide in hospital, treatment and access to more specialist nursing, social care and therapy advice.

There will be sufficient capacity and trained staff to deal with a shift in the work currently undertaken in hospitals into the community - more of the staff normally seen in a hospital setting will have their bases in the community and working in modern surroundings and with simple tests being carried out locally and quickly.

This is all very well in principle but how will this work in practice? – A case study:

A 66-year-old woman with Motor Neurone Disease was declining rapidly. She could only communicate with a pen and board. She was in pain, had difficulty swallowing, difficulty sleeping and difficulty breathing which brought on panic attacks. Both she and her husband were distressed and struggling with her desire to be cared for at home.

The patient could hear and understand everything. Her great wish was to stay in her small bungalow with her husband caring for her, but he was finding it hard and doubted his ability to do what was best for her.

In this case, a combined health and social care team focussed on what mattered most to the patient. Putting her – and her family – at the centre of the decision making and understanding the family's needs, a personalised plan was developed that enabled the patient to be cared for, and to eventually die, at home.

In this case, the ICT included:

- their GP
- Macmillan Nurse
- Motor Neurone Disease visitor
- Community Matron
- Community Nurses
- Therapists
- Social Care Workers
- the Hospice

The patient's medications were put in a "nomad" (a type of monitored medication dosage system) and this was the start of helping her husband to cope. Non-invasive ventilation was provided for overnight and for top ups during the day if she got breathless. She disliked the tight mask and would get upset when using it, but she preferred this to hospitalisation.

A speech therapist worked with her to improve her swallowing and advised a semi-soft diet to avoid choking when swallowing.

To give the husband some respite, hospice day care was organised for twice a week. She attended for a few weeks and was able to become more familiar with the staff so that when she needed admission for advice on pain control she readily accepted.

The joint team built up a relationship with both husband and wife in order to provide the care they wanted. Community nurses visited daily to check her medication syringe driver and home visits were made by Occupational and Physio Therapists.

In the last ten days of her life she remained at home. Adult services organised twice daily visits from carers. The Community Matron visited twice weekly to monitor and support. Night care was provided so the husband could get some sleep. Although the husband found this time very difficult he was pleased afterwards that his wife was able to die at home.

What were the anticipated impacts of this type of care?

Patient benefit:

- Personalised care plans put in place
- Improved patient choice - patients, families and carers are at the centre of decision making.
- Improved dignity and well-being for patients
- Improved support for carers
- Improved rehabilitation and re-ablement services to help people remain at home with reduced packages of on-going support

Organisational benefit from integrated care:

- Six ICTs established covering the whole CCG area
- Improved multi agency/professional working relationships. - ICTs are more personal, more hands on, they make effective use of a joined up system and the patient has benefitted enormously, receiving what she wanted – care at home
- Efficiency savings – the ICT structure allowed the individual organisations to communicate well with each other resulting in saved time and resources
- Improved performance around admission avoidance (hospitals) and supported the continued trend of improvement of reduced admissions to residential and nursing care

This example demonstrates how we have begun to redesign services around the needs of our patients and looking at the whole patient pathway.

Integrated Care and the Better Care Fund

The June 2013 Spending Round announced the creation of a £3.8 billion Better Care Fund – described as a 'pooled' or shared budget for health and social care services to work more closely together in local areas, and based upon a plan agreed between the NHS and local authorities. NHS North Hampshire CCG is actively commissioning an integrated care delivery model between health and social care which cuts across organisational boundaries on order to deliver a better co-ordinated and integrated system of health and social care that is person-centred. Our vision is for a simple "joined-up" health and care journey through the system for people and communities. This approach aims to address three key challenges:

- avoiding unnecessary cost in the system, moving to lower cost solutions
- preventing dependency and demand for longer term publically funded services
- delaying people's dependency on long term health and social care interventions

The CCG has adopted the National Voices definition of integrated care as meaning person-centred, co-ordinated care reflected in the statement:

"I can plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me"

:

Aim	Program Objectives
Provide the right care in the right place at the right time	To increase the proportion of people benefitting from evidence based prevention and early intervention
	To increase the proportion of people with complex and long-term health and social care needs receiving planned and coordinated care in, or close to home
	To ensure people have their health and care needs met seamlessly in the most appropriate setting
Maximise health, wellbeing and quality of life	To improve the health related quality of life and wellbeing of people with long-term conditions
	To maintain or improve independence and recovery for people with long-term health and care needs
	To reduce the difference between those with the best and worst health
Place the person at the centre of care	To empower key population groups to maximise their capabilities and to manage their health and wellbeing
	To increase the proportion of people with health and social care needs that have choice and control of their care. To improve satisfaction with health and care services

Our plan is to approach integration in a phased but interdependent way to avoid destabilising the system of care and to simultaneously use the "**listen, learn and redesign principle**" of working.

The Local Hospital

"The local hospital deals with the majority of elective care and with help from community care teams, acts to maintain people in the community or at home"

Hospital services should only be used when appropriate but when that is the case we expect patients to have an excellent standard of care, infection free and in an environment where they feel empowered to take an active part in their recovery.

We want to instil an ethos in our CCG, which extends to the hospitals we use, that only excellent is good enough. When excellent is not happening we will encourage open and honest dialogue to improve – not punishment and penalise, just a desire to help our hospitals give their best.

In five years' time we would not want to see any frail elderly people in hospital because there is nowhere else for them to go. Equally we would want to see that when a person needs to attend or be admitted to a hospital, the appropriate service and care is available without a lengthy wait.

The Critical Treatment Centre

"Specialises in emergency, critical and critical care and complex surgery"

A critical treatment hospital would be one unit delivering the highest level of emergency consultant led care for all the people of north and mid Hampshire: A centre of excellence for those patients in life threatening situations.

The Public and Patient Voice

A new focus

- Enabling local people to set direction when it comes to service design and change Empowering them to write their own terms of reference in partnership with the CCG
- Patients and Carers treated as equal partners with clinicians
- We will build an informed community who can challenge the CCG in a constructive way

Why?

The NHS North Hampshire CCG has to make difficult decisions about how to spend the money that it receives from the government on NHS services. Local people need to be involved in decisions about commissioning because:

- they are the recipients of the services
- it is their taxes that get distilled to CCGs

Local people should have the opportunity to:

- understand the health needs of our population
- be aware of the financial constraints
- say what is important to then
- identify opportunities for better health care
- feel involved

The CCG also has a responsibility to those who would not normally see their contribution as of any worth to be heard as well.

How?

Our Patient Focus for commissioning services

Identify needs and aspirations, develop priorities, strategies and plans. The CCG will develop campaigns to make local people aware of the commissioning cycle and how they can get involved. We will strengthen existing networks (e.g. Patient Participation Groups, Voluntary Partnerships, and Stakeholder Committees) and build new networks (e.g. Students and Young People, low income families).

Design new and improve old pathways of care. The CCG will support and aid the development of the Community Voice Group. We will encourage new user groups to get established. We will build smooth channels to feedback patient and carer views to the CCG.

Procure Services. We will involve patients and carers in the process of procuring providers for new services, establishing a training programme where necessary.

Monitor and Suggest Improvements. The CCG needs to develop a process whereby local people can monitor and review services e.g. Primary Eye care and Assessment Service (PEARS) and the 'Front Door' service where local GPs work in the Emergency Department at Basingstoke Hospital.

A new focus – promoting transparency

Our aspiration for the next five years:

- starting at Governing Body level we will make papers readable and accessible to local people. We will report key Governing Body decisions in our public newsletter 'Tonic'
- key documents will be written in plain English and tested by our community voice/user groups

- to have local people involved in all service design and change. With our ultimate goal being that local people are instigating pathway re-design. Patient representatives will ‘sign off’ new or re-designed services as having had patient/citizen involvement
- to have local people on procurement panels
- build an environment within the CCG and amongst our partners that encourages and respects challenge
- if mistakes are made – we will tell local people what has happened, why and what we are going to do about it
- we will explain to people what decisions we are making about health services and why, using all forms of media at our disposal

6. Our strategic priorities and aims

NHS North Hampshire CCG with its partners has an opportunity to make a decisive change in the balance of services away from a model based upon treating people whose health is already poor, to a model which is based upon promoting good health, through healthy lifestyles and supporting independence.

Our aim, supported by our collective membership, is about delivery. We believe that we can make a significant improvement in the next 5 years.

Put simply the CCG has 3 key aims which span across all of our business and strategic priorities:

Maximise the opportunity to protect and improve health for all our population within 5 years. With measureable improvements in reducing health problems in our priority areas, concentrating upon improving outcomes.	**Continue to develop integrated care – to achieve this there must be evidence of joint working between commissioners to align direction of travel and in securing effective care pathways across primary, community, acute and social care.**	**To modernise the local NHS system**

Our priorities are further informed by Hampshire's Joint Health and Wellbeing Strategy 2013-2018. The strategy proposes:

- **Starting Well** – supporting every child in Hampshire to thrive and achieve their full potential
- **Living Well** – empowering people to live healthier lives
- **Ageing Well** – supporting people to remain independent, have choice, control and timely access to high quality services
- **Healthier Communities** – helping communities to be strong and support those who may need extra help

Our Priorities and aims

Strategic priorities	Strategic aims
Reducing the gap in life expectancy and health between the most and least deprived wards	**Work with partner organisations to jointly tackle the roots of poor health. Better heath for all is not just about what the NHS does. Significant factors are work, housing, education, leisure and family life. We aim to:** • Increase healthy life expectancy and preventing the development of long term conditions through: – Increased access to information about healthy lifestyles – Supporting communities to adopt healthy behaviours – Improving early diagnosis and management of long term conditions, including cancer and dementia • Ensuring children have the best start in life by improving maternal and child health and wellbeing, with particular emphasis on the most vulnerable. – Build on existing work to further reduce the teenage conception rate in Basingstoke and Deane – Further increase improvements in breast feeding rates – Work with partners to improve childhood immunisation rates

	especially in groups at risk of low vaccination rates eg looked after children and children with disabilities and embed new programmes to prevent vaccine preventable diseases. – Continue to support programmes focusing on the whole Families programme with increased emphasis on health of families • Continue to increase the number of people with healthy lifestyles including healthy weights, smoking and low alcohol intake. – Building on evidence based lifestyle programmes – Changing environments to facilitate positive behaviour change – Changing culture so healthy lifestyles become the norm • Focus health programmes on the most vulnerable to reduce health inequalities by developing a better understanding of how best to support vulnerable groups. • Ensure health and social care services continue to meet the needs of the population and provide quality services
Improving access and patient experience	**Engage with our population to ensure that the CCG understands and is able to take appropriate account of their views in designing services which will meet 21st century requirements:** • Commissioning redesign of service provision so that they are available when and where they are required to enable effective treatment • Improving availability of information relating to services and health issues • Working with our providers and members to ensure that access to Primary Care is responsive • Using feedback from patients and the public to influence quality and service improvements • Working with smaller providers and the Independent Sector to assure quality services are commissioned and delivered to the population • Increasing the number of people who are supported to manage their conditions at home where appropriate • Support Providers to utilise patient and public feedback to improve access to services and overall patient experience
Ensuring that services and safe, good quality and have excellent health outcomes	**Make use of information on the performance of providers and services in terms of safety, quality and clinical outcomes:** • Tackling areas of concern and securing remedial action • Ensuring that clinical governance arrangements are robust in the providers we use and that quality is high on the agenda of the CCG Governing Body • Monitoring providers and promoting reductions in Healthcare Acquired Infections • Supporting providers to eradicate Grade 4 Pressure Ulcers and patient avoidable falls • Commission for clinical outcomes making use of the Outcomes Frameworks • Support the Integrated Care Team approach in the management of patients with complex health needs • Working in partnership with Residential and Care Homes, Provider organisations and GP practices to ensure patients at the End of Life receive care in a place of their choice
Ensure that the population are using planned care services effectively	**Work with our membership to redesign care pathways where there is opportunity to provide more efficient and (or) effective services, with a focus on:** • Continued use of national benchmark measures and undertake capacity planning over a 3-5 year period to use in planning and design of services and using the Better Care Fund to deliver transformational change • Meeting national and Constitutional targets with a focus on delivering 7

	day working across providers over the next 3 years • Right care, right time, right place with a focus on care being delivered closer to home • Referral to treatment initiatives ensuring that waiting times are achieved in accordance with NHS Constitution and national targets • Fully implementing E-referrals, Choose & Book and Map of Medicine to ensure that patients make informed choices within clinically appropriate thresholds which will help reduce unnecessary elective procedures • Developing comprehensive Integrated Community Teams with specialist support to support common conditions so that patients can access care closer to home • Reviewing, designing and delivering new models of care across a number of priority areas to improve patient outcomes: - Cancer & End of Life pathway - Musculoskeletal services and T&O - Integrated diabetes service - Dermatology pathway - Gynaecology pathway - Access to community optometry services - Timely diagnostic services • Embedding a self-management/self-care culture with health professionals and the north Hampshire population • Reduce delayed transfers of care for planned care working with Hampshire County Council, Southern Health FT and Hampshire Hospitals FT to find system solutions using the Better Care Fund • Attaining maximum value from within the existing resources ensuring reduction in clinical variation through the threshold programme • Reducing variation in PROMS data for hips, knees, varicose veins and hernia surgery
Redesign services to reduce the need and use of urgent care particularly in an acute setting	**Use systematic process to identify patients who would benefit from pro-active healthcare support:** • Implement the NH CCG & HCC joint vision for integrated care with HCC and local providers using the Better Care Fund as the lever for transformational change. This will include: - Joint work with the Health & Wellbeing board - Continue to develop the Integrated Care Teams and support use of risk stratification tool - Focus on single point of access to support admission avoidance, supportive discharge and 7 day working - Helping the most vulnerable to stay healthy and stay independent including self-management/self-care approaches - Using innovative and flexible schemes such as personal health budgets - Advanced care planning for all clinicians in a paper and electronic format • Focus on national and Constitutional targets ensuring the 4 hour wait is met working with Clinicians and GP OOHs service in ED • Re-design and plan services to support the frail and elderly care including the 'Front Door' & AAU services provided by GPs • Joint work with SCAS on ambulance waiting times and delivery of the 111 targets • Support GP Practices in supporting the over 75 years and complex patients • Working with the third sector to expand the role that they can play and implement NAVCA bid to commission in a different way with voluntary sector • Joint work with carers to integrate Carers Together on the HHR • Reduce Delayed Transfers of Care for Unscheduled Care working with

	HCC, SHFT and HHFT to find system solutions using the Better Care Fund
Supporting those who have a Long Term Condition to maintain a good quality of life	**Early identification and effective management of patients who have a long term condition:** • Embed a Self-Management/Self-Care culture with health professionals and the North Hampshire population • To prevent premature death and optimise recovery and self-management for patients with: - Cardiovascular disease including stroke cardiac rehab, heart failure, AF & BNP testing - COPD • An Integrated Diabetes Service will be delivered as a Year of Care Model having worked with Diabetes UK and local patients. We will support the attainment of improved survival rates and patient experience for Cancer patients. We will further develop the community based model for diabetic patients, including the prevention of long term complications so that more people can access their care closer to home
Adopting a comprehensive approach to mental health and Learning Disability	**Promoting good mental health provision, promoting recovery with greater use of community and primary care provision:** • Improve effectiveness of services and the general health of those with mental health problems and ensure delivery of Parity of Esteem Programmes in order to focus effort and resources on improving clinical services and health outcomes: - Improving Access to Psychological Therapies (IAPT) to ensure early identification of illness and the timely access to services - Improving diagnosis and support for people with Dementia both in hospital and the community including nursing homes - Improving awareness and focus on the duties within the Mental Capacity Act • Review of out of area mental health placements and opportunities for repatriation in an appropriate service • Review the proportion of people with an adult mental health illness who are on a care programme approach and ensure this is followed up within 7 days of discharge from a psychiatric inpatient facility • Development of primary mental health services to reduce inappropriate admissions and the development of psychiatric liaison within the Emergency Department • Review the physical healthcare of people with a Mental Health illness or learning disability • Focus on primary and hospital prescribing including formulary leading to a reduction in the use of anti-psychotic drugs

Maternity, newborn and children… ***providing care and support to children and their families***	**Provide appropriate support and care to respond to the clinical and social needs of children and their families. This includes working with key partners to:** • Ensure quality community services and planned hospital care for all children and young people, with focus on care for those with disabilities, complex health needs and mental health problems, supporting children to achieve their full potential • Implementation of national guidance relating to peri-natal mental health support for women requesting caesarean sections due to anxiety • Lead responsibility for commissioning Special Educational Needs

	working with education, social care and health partners • Implement Autism Strategy with health and social care partners • Ensure CAMHS services are delivered working with health, education and social care partners • Work jointly with Safeguarding Children Designated Professionals and relevant Local Safeguarding Children Boards work with other agencies to implement the recommendations resulting from the Munro review • Integrated care with improved access to paediatric services including children's therapies in the community and support of specialist when appropriate • Reduce hospital admissions, unnecessary A&E attendances and referrals to PAU • Joint work with Public Health to target strategic priorities within JSNA including antenatal & Newborn screening; immunisation & vaccination programmes; obesity prevention services and sexual health services
Ensure cost effective medicines management to improve patient care and safety	**Optimise cost effective use of medicines management to improve patient care and safety:** • Improve the safety, effectiveness and value of prescribing and medicines use. • Support patients in decisions regarding their medicines. • Support GP's in delivering best practise prescribing • Provided appropriate education, support and resources so that patients have timely access to NICE (National Institute for Health and Care Excellence) recommended medicines • Integration of Medicine Optimisation within patient care pathways and service redesign • Joint approaches to prescribing between providers and independent contractors. - Improved systems for safe and effective transfer of prescribing responsibility between specialists and GPs - Medicines reconciliation to reduce errors across transfer of care - Reducing medicines incidence errors and shared learning - Supporting care pathways and prescribing thresholds and supporting secondary care contract negotiations • Financial and budgetary control of primary care drugs budget within agreed allocation. - Deliver a transformation plan to continuously improve the value for money of medicines used - Prescribing efficiencies as above through savings built to last and sustaining the QIPP prescribing productivity areas embedding these into practice. - Making the most out of patent expiries and disinvesting in medicines that show reduced outcomes or limited efficacy - Continue with reduced growth in unlicensed specials prescribing - Ensuring that prescribing budget requirements meet the needs of the local population • Better use of drugs in prevention. • Identifying long term conditions (LTC) earlier and targeting interventions to identify more patients with LTC to treat to prevent the long term implications of cost pressures and to reduce long term burden of disease and disability • Reducing Clostridium Difficile through antimicrobial prescribing stewardship • Continued reduction in the harm associated with Non Steroidal Anti Inflammatory Drugs • Improvement in the quality and cost effective use of respiratory medicines, diabetes medicines. • Evidence available to demonstrate that people with dementia who are prescribed antipsychotics are regularly reviewed

	• Effective use of Oral Nutritional Supplements (ONS). • Care home medicines processes review and appropriate use of medicines. • IT systems to inform decision making and triangulate disease management e.g. Scriptswitch, Eclipse, risk stratification tools, real time prescribing information. • Risk Stratification where medicines are implicated and therefore reducing associated unplanned admissions • Minimise Medicines Waste collaborative between CCGs, providers and community pharmacies • Support community pharmacy initiatives e.g. use of targeted Medicines Use Reviews (MURs) and the New Medical Services. • Support medicine optimising programmes e.g. Wessex Academic Health Science Network, national programmes.

Our Strategic Non Clinical Priorities

Strategic priorities	Strategic Aims
Stronger partnership working and careful alignment of strategies and programmes	**Ensure that the CCG makes effective use of collaborative arrangements including Health and Wellbeing Boards and joint commissioning opportunities:** • Working with NHS England (Wessex) to: - deliver a joint approach to the development of a primary care strategy supported with robust contracts that are value for money - supporting the role of the accountable GP - helping the development of federated working arrangements - support the implementation of integrated community teams and improve the quality of premises - identify specifications for specialised services and the location of 'centres of excellence', and ensure a smooth interface between CCG and NHSE direct commissioned services - supporting the priority treatment of military servicemen and veterans • Collaborating with sister CCGs in the development of strategic plans and the delivery of firm but fair contracts that able to deliver on all quality and safety outcome criteria as well as delivery on the expected shift in activity that is vital to secure QIPP savings • Careful alignment of the Health and Wellbeing Strategy with the CCG strategy so that all the key aspects and outcomes are delivered with quoted timescales and within budget.
Making best use of our resources (Finance, workforce, Information and technology and estates)	**The CCG is required to meet its statutory financial responsibilities, ensuring its expenditure does not exceed the resources available. To do so the CCG will need to make every £ of its expenditure delivery count**. • Making use of strategic financial planning to enable proactive approach to decision making (including developments and QIPP) • Create financial headroom to support transformation and lever change • Conducting horizon scanning to understand where our resources will be required in the future • Promoting corporate social responsibility • Building a sustainable health care system • Being open and transparent with regard to performance • Securing an efficient CCG (direct workforce and services from the Commissioning Support Unit)

	• Use information and IT to facilitate integration across care settings, and to empower patients and service users • To ensure that services are provided in locations and buildings which are fit for purpose
Effective Market management and contracting	**Actively managing the market to deliver what is required and to drive up quality** • Use of collaboration and competition to improve quality not just and end in itself • Securing effective contract management • Making best use of financial incentives and penalties • Enabling patients to exercise choice • Transparent decision making process • Rich plurality of patient choice in place due to geographical situation with E-referral supporting the choice agenda • Integrated commissioning and procurement of Continuing Healthcare with the Local Authority • Making use of Personal Health Budgets and Direct Payments (e.g. Mental Health Rehab)

Turning the vision into reality

Understanding and identifying the CCG strategic priorities is only part of the challenge ahead. Success will be in delivery – we believe that the CCG will maximise its impact by undertaking a number of initiatives which will completely redesign major care pathways and/or will be a subject of significant focus to deliver the improvement required. Our plans will need to align together and with the plans of others; only by working together will we deliver the changes required. The strategy will not detail all of the work of the CCG, other initiatives can be found in the CCG Commissioning Intentions and our Operating Plan (2014-16) available at:

http://www.northhampshireccg.com/

7. Working collaboratively

Resources and multi-organisational working

As a CCG we fully recognise that the new health and care system is complex and that collaborative working across many different organisations is necessary, for example:

- public health specialists within the Local Authority
- specialist service commissioners within the NHS England Local Area Team (Wessex), along with primary care commissioning and contracting
- Business Intelligence services, performance management and contracting support from NHS South Commissioning Support Unit

We also work with our colleagues in County and District and Borough Councils to look at care services and the wider determinants of health e.g. leisure, housing and adult and children's services.

To ensure effective and joined up care pathways for people we will work hard across this whole spectrum of commissioners and providers to provide the system leadership required. We will support our provider organisations and partner agencies to work in collaboration with shared visions and goals. Our GP clinical leaders will foster a culture of openness and joint working with a drive and determination to ensure that all of our population have a positive experience of care.

We have a clear memorandum of understanding with our CCG partners across Hampshire which details the areas in which we will collectively commission and manage contracts, share key services, co-ordinate approaches to designated service providers, collaborate at a strategic level which includes a coordinated strategy and approach to system-wide transformation and service reconfiguration and improvements.

It is imperative that we work closely with our providers to ensure that there is an understanding of our respective business aspirations. For the CCG we need to influence the direction of travel and speed of implementation of their plans and where there is a lack of alignment the CCG will need to understand the consequences and take appropriate management action, this may be to limit financial exposure or to decommission or set out an exclusion in the contract.

We are aware that some of the building infrastructures in the ownership of NHS providers is in need of replacement. Additionally Hampshire Hospitals NHS FT are, with us and West Hampshire CCG, consulting the public on their clinical vision for their business in the future and one of the options being considered is to develop a Critical Treatment Centre and invest in the Basingstoke and Winchester hospitals. The CCG is cognisant of the importance of their clinical strategy but we are committed to influencing the direction of travel for NHS services in the shorter and longer term. We wish to ensure that as commissioners our major provider's plans are aligned with (where applicable) and will secure delivery of our strategic aims.

8. Keeping track of progress – delivering on our ambitions

Governance arrangements

Setting the strategic direction and assuring delivery

The delivery of the plan is the responsibility of the NHS North Hampshire CCG Governing Body, who is responsible for assessing and planning for future health demands of the population of north Hampshire and in ensuring the local capacity to meet them. It is also responsible for the performance of the service providers contracted to provide services to patients as well as its own performance as a commissioner.

The CCG is accountable for exercising its statutory functions and delivers this by granting authority to act on its behalf to any of its members, its Governing Body, employees (lead officers and teams) and its committees. The extent of the authority to act for each of these is set out in our constitution, and in particular the:

- Scheme of Reservation and Delegation, and the
- Terms of Reference for each of the committees

available on the NHS North Hampshire CCG website at:

http://www.northhampshireccg.com/page1.aspx?p=2&t=1

Although the CCG is a 'membership organisation', whereby the 20 GP Practices in the north Hampshire area have great influence and hold the Governing Body to account, the setting of the **strategic direction** and **stewardship** of the organisation is the responsibility of the Governing Body.

Implementation of the programmes of work is by GP-led programme management groups who are monitored through a robust **integrated governance framework** within the CCG so that those responsible for programme delivery are **held to account** and provide **assurance** to the Governing Body that the right decisions are being made throughout the life of each programme. The most important committee in this respect is the **Clinical Cabinet** – known as the 'engine room' of the CCG – and where all the lead GPs meet and report on progress.

Delivering on our promises

Ultimately, NHS North Hampshire CCG's nine clinically-based strategic objectives will be delivered through the work of the eight key clinical programme areas, and most importantly the ground work of the system reform/commissioning managers of the CCG and the project teams led by each of our lead GPs. These programmes will have a whole system focus, with strong patient and clinical engagement.

The programmes include:

- **Prevention and Staying Healthy**
- **Planned Care** including the **Long Term Conditions** programme for:
  - **Diabetes**
  - **Musculoskeletal Services**
  - **Cardiology**
  - **Stroke and degenerative diseases**
- **Unscheduled** Care programme including:
  - **Integrated Care**
  - **Palliative Care**
- **Mental Health & Learning Difficulties** including:
  - **Dementia and Continuing Healthcare**

- **Children, Newborn and Maternity**
- **Medicines Management**
- **Research, Education and Innovation**

Programme boards and 'steering groups' meet on a monthly basis to discuss progress with the delivery of the individual projects, and the programme of work overall, by looking at the completion of project milestones, the management of risks identified and by closely monitoring the flows of patients into and out of the various services and how much we are paying for them. There is also a strong focus on quality and patient safety throughout our work.

Reports on the delivery of each programme are passed upwards through the organisation and ultimately to the Governing Body via the Clinical Cabinet, with judgements being made at every point as to the success of the programme to deliver the CCG's strategic objectives and ways in which we can improve.

For projects that span across a number of CCGs in the area or rely on the input from other agencies such as the county council, key leaders are recruited into the programmes and joint goals are set to meet the strategic ambitions for the good of the populations of all the CCG areas involved. A number of our programmes, including those for mental health and for maternity/children's services are Hampshire-wide and require collaboration from all parties involved.

Measuring for success

There is strong evidence that illustrates a consequential increase in effectiveness and productivity resulting from quality improvements in the provision of healthcare. We are clear that our primary focus in commissioning is to establish quality at the heart of everything we commission.

We, like NHS England, believe that a key element of measuring the quality and the performance of our service providers and clinical programmes is to identify and measure 'outcomes' of treatment in addition to monitoring where patients go for their treatment. We have mapped out our strategic and clinical programme objectives against the five domains of the National Outcomes Framework 2014/15 and developed a set of specific local ambitions that we believe are critical indicators of success and against which we can track our progress.

9. Where to get more information

NHS Hampshire CCG
Central 40, Lime Tree Way
Chineham Business Park
Basingstoke
RG24 8GU

Telephone: 01256 705507
Email: nhccg.enquiries@nhs.net
Website: http://www.northhampshireccg.com/index.aspx

Hampshire County Council
The Castle
Winchester
Hampshire
SO23 8UJ

Telephone: 01962 841841
Email: info@hants.gov.uk
Website: http://www.hants.gov.uk/

Hampshire Health and Wellbeing Board
http://www3.hants.gov.uk/healthandwellbeing/healthandwellbeing-board-info.htm

NHS England (Wessex)
Oakley Road
Southampton
Hampshire
SO16 4GX

Telephone: 02380 296914

HealthWatch Hampshire
Freepost RTHH-KGST-ZRBC
Westgate Chambers
Staple Gardens
Winchester SO23 8SR

Telephone: 01962 440 262
Email: via http://www.healthwatchhampshire.co.uk/content/contact
Website: http://www.healthwatchhampshire.co.uk/

10. Glossary

NHS	National Health Service
CCG	Clinical Commissioning Group
NHCCG	North Hampshire Clinical Commissioning Group
Health and Wellbeing Boards	Established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health
Primary Medical Services or Primary Care	GP Services, Dental Services, Optometry services and Pharmacy services
Integrated Care	Joining up health care and care provided by social services
Integrated Care Teams	Teams combining primary care, community nurses and social care
Elective or Planned Care	A medical procedure that has been planned for example a hip replacement
Unscheduled or Unplanned Care	When a patient has an urgent medical requirement that was not planned for example acute appendicitis
Elective Admissions	People admitted to hospital for a planned procedure
Palliative Care	Caring for someone at the end of their life when their condition has no cure but they need to be kept comfortable and as pain free as possible
COPD	Chronic Obstructive Pulmonary Disease. Where a person's lungs get blocked up and don't function properly
CHD	Chronic Heart Disease
TIA	Transient Ischaemic Attack (mini stroke)
Hypertension	High Blood Pressure
CKD	Coronary Kidney Disease
MMR Vaccination	Measles, Mumps and Rubella vaccination
Tf/IPV Vaccination	Tetanus, Diptheria and Polio vaccination
WHO	World Health Organisation
Better Care Fund	An amount of money that has been identified to accelerate the integration of health and social care
Joint Strategic Needs Assessment or JSNA	A comprehensive report, produced by Public Health on the health and wellbeing of the population. The JSNA is used to identify inequalities in health and wellbeing

Front Door of the hospital	The Emergency Department
AAU	Acute Assessment Unit at a hospital
NHHFT	North Hampshire Hospitals Foundation Trust (made up of Basingstoke, Winchester and Andover Hospitals)
SHFT	Southern Health Foundation Trust (providing community nursing and mental health services)
Cdiff	Clostridium Difficile – a bowel infection difficult to cure. One of the “superbugs”
MRSA	methicillin-resistant staphylococcus aureusis a type of bacterial infection that is resistant to a number of widely used antibiotics.

11. Appendices

Appendix A NHS North Hampshire CCG Operating Plan 2014 –16

Separate document available at:

http://www.northhampshireccg.com

Appendix B Consultation Exercise with Marginalised Residents of North Hampshire

Hampshire Wellbeing Services (HWS) was commissioned in May 2014 to undertake a consultation exercise with marginalised residents to find their views on the 5 year strategy of the North Hampshire Clinical Commissioning Group (CCG). The task for HWS was to engage with the diverse minority communities in North Hampshire and to seek their views on the principle elements of the strategy and report back to the CCG.

In summary, the consultation process involved 125 people of varying ages, cultures, religions and life experiences. Discussions with them revealed:

a) Strong support for the principles that lie behind the strategy:

- 75.5% Agreement/Strong Agreement for people being responsible for their health
- 68.4% Agreement/Strong Agreement for GPs focussing on the patients with the more complex health needs
- 79.8% Agreement/Strong Agreement for integrated care with GPs working alongside colleagues in nursing, hospital and social care

b) Slightly weaker support for the implementation of the strategy now suggesting residents need some time to prepare for the changes proposed.

- 55.2% Agreement/Strong Agreement for implementing home care now
- 60.2% Agreement/Strong Agreement for implementing primary care elements now
- 68.1% Agreement/Strong Agreement for implementing integrated care

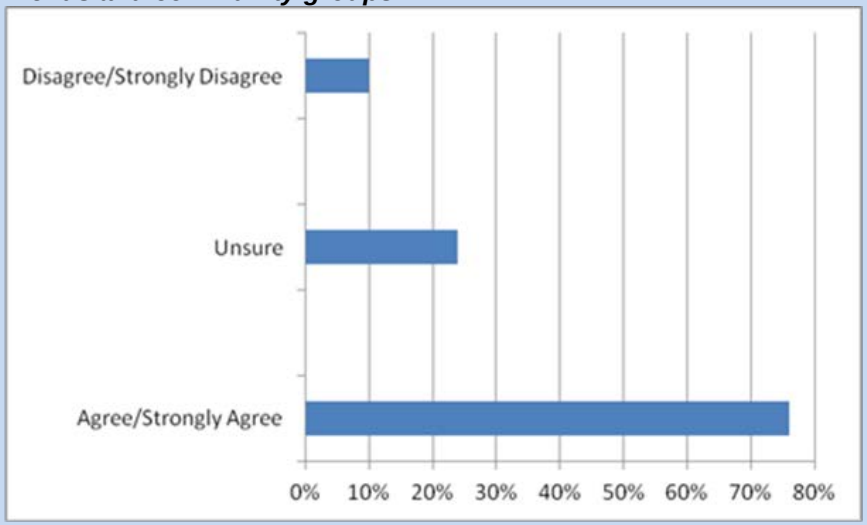
c) Where the participants have reservations, it is with the implementation of the strategy – how will it be undertaken, in what time scale, by whom, how will information be disseminated and how will vulnerable people/groups be protected?

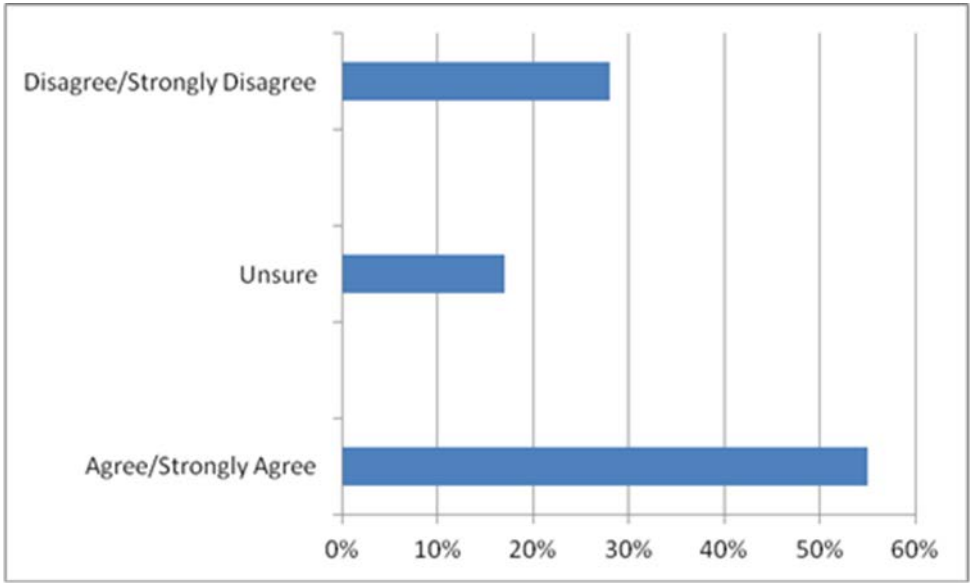
d) The groups who are most vulnerable and with concerns about the impact of the strategy on them appear to be the oldest in our community, those with cognitive impairment, those with mental health issues and young children

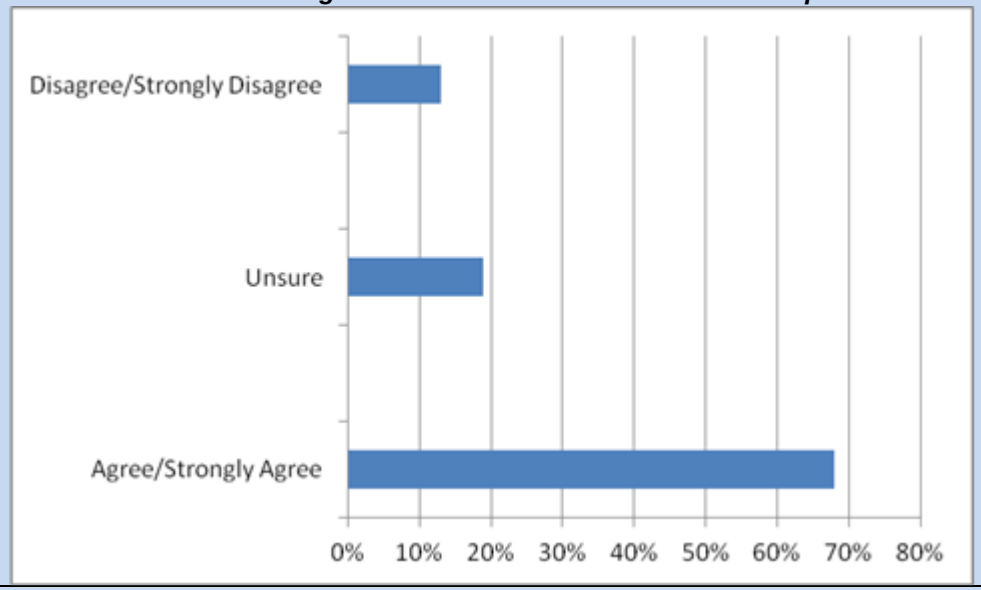
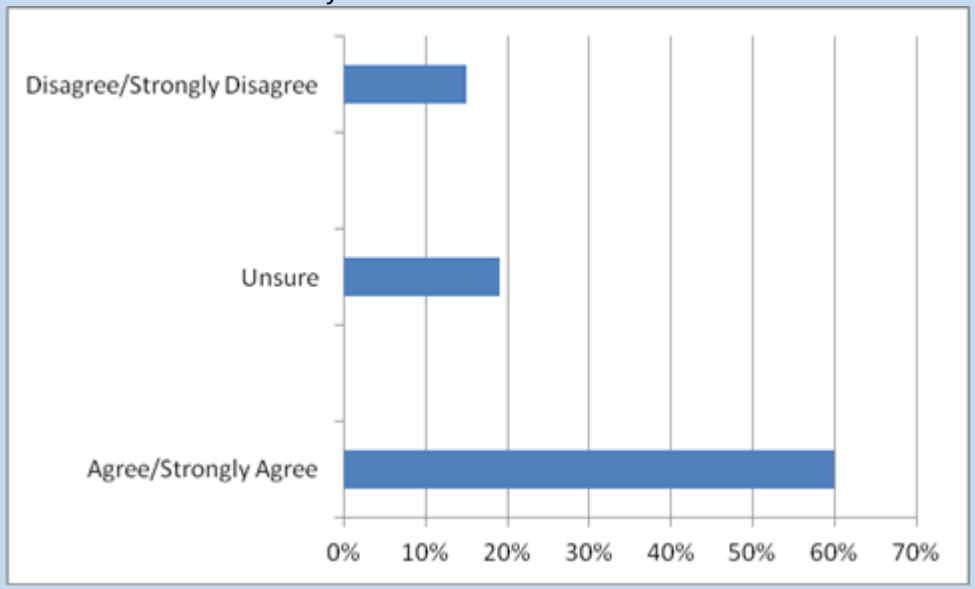
e) There has been a strong positive response to being invited to participate and many have asked to continue to be involved

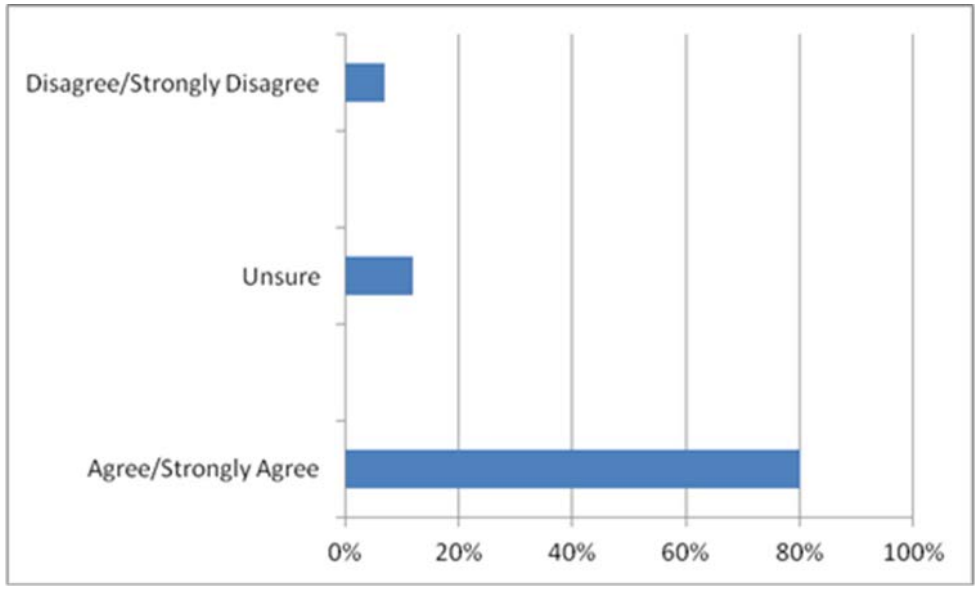
f) Community groups have indicated a desire to support members during times of need but make clear that their capacity is very limited and need additional resources to provide effective and comprehensive long term support.

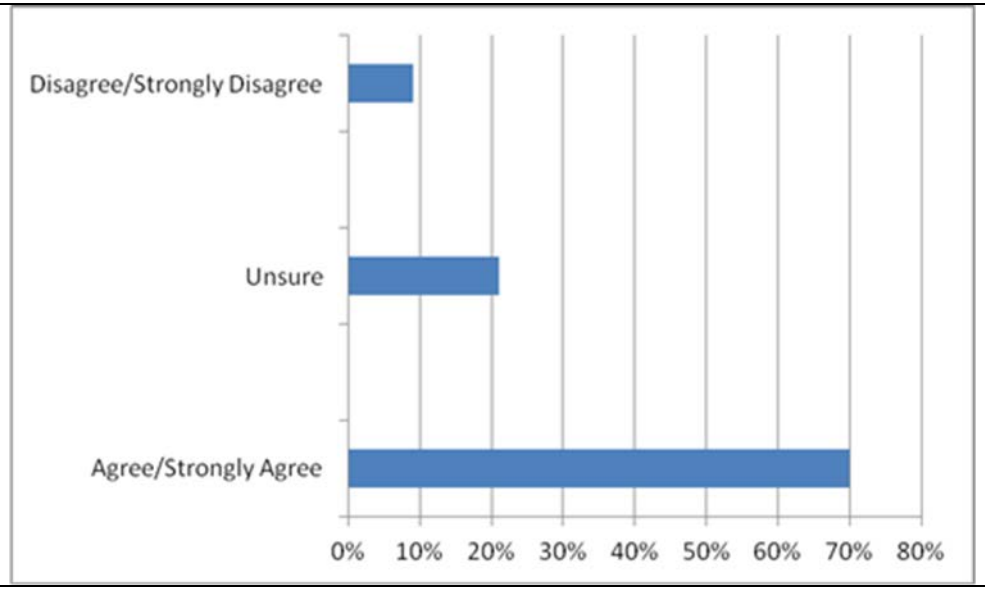
In more detail:

Strategic Aspect	Strategic Theme	Acceptability of Statement	Summarised Commentary
Prevention & Staying Healthy	You would have all the information needed to lead a healthy life and make better lifestyle choices		There was a general agreement that it was good for information to be made available to people and for them to use it. However all groups expressed reservations about access to information. The reservations were both of their own capability access information and that of others whom they felt might struggle with the process. Whatever the information that was provided there was consensus that it should be clear, accessible and in various media supported by public advertising.
	Use screening programmes and take actions to avoid risks to becoming ill		Participants agreed that it was sensible to use screening programmes and take actions to avoid risks to becoming ill but raised practical problems that might arise.
Home Care and support from	Health begins at home, with you. It's your responsibility with your family and friends	***"People should care for themselves with the help of close family, friends and community groups"*** 	Across the participants there was a clear distinction between those people who had the necessary capabilities to take responsibility for themselves and those who might not. The three groups which regularly were referred to were children, the elderly and those with cognitive and/or physical impairment. The participants expressed concerns about self-diagnosis and self-treatment. They are concerned about their lack of expertise, how to go about diagnosis and where the line is to be drawn between those ailments that could/should be dealt with in the home and those that should be drawn to the attention of a health professional.

immediate family, friends and carers			
	People will be encouraged to cultivate 'networks' of close family and friends who can help and provide support at times of illness		Participants had mixed responses to the proposition that family and friends should help. In general terms, it was not the principle that caused concern, rather the practicability of having friends and family help them when ill.
	Community groups will be available to share experiences and help		Those community group leaders who have participated in the consultation have all indicated a desire to support members who are ill or in need of wellbeing support.
Self-Care	At times of illness, people would have access to all the local resources available to take care of themselves and manage their condition at home	***"The CCG vision for Home & Self Care is needed now"*** 	Whilst there is support for people to access information and resources in the community to take care of themselves and manage their condition at home, it is clear reservations exist. These reservations relate to the practical issues of language, mobility and time, the personality needed to interact positively with people and organisations and technical capability to use the internet. The reduction in strength of support [may] reflect people feeling they are not yet ready for the change to finding information for themselves and accessing support and resources in the community. Capacity building seems to be needed at the personal, familial and community group level to meet this element of the strategy.

Primary Care	Primary care will be the first port of call for most people when they first become ill or require further treatment, be it via the optician, the dentist, pharmacist or General Practitioner (GP)	***"Primary Care with GPs focusing on the patients with the more complex health needs and working with other Practices in the area is important"*** 	The evidence from the questionnaire was that, again, most participants felt the aspiration set out in the strategy was the right path. However, their comments in the group discussions made clear that the implementation of such an aspiration was the key to success. It is clear from the comments of participants that their experience of visiting the GP is varied…. comments that suggest pressure on GP time has resulted in delays to getting an appointment and treatment. The aspiration of this element of the strategy should, if successful, reduce that pressure and ease access to appointments and treatment.
	GPs will focus on more complex illness	"The CCG vision for Primary Care is needed now" 	When asked whether the CCG vision for Primary Care is needed now, the strength of support has weakened by 8 percentage points compared with the earlier response to whether the strategy was the right course of action. *This concern was related to the comments made regarding the skills and experience of health professionals in any community services in the sections below.*
		"Integrated Care with GPs working alongside colleagues in nursing, hospital	As with previous strategy sections the

Integrated Community Care	GPs and Practice Nurses will work as part of a wider integrated community care team that will provide support to people when they need it	***and social care, all acting together to improve the coordination of care is important"***  	view of consultation participants was strongly favourable to the principles of this section……. …[however] the participants were very concerned to be reassured about the skills and qualifications of those providing services away from the GP practice. Consequently, the skills and experience of health professionals in any community organised service must not be taken for granted but communicated and explained to potential service users. The participants' experience of community based health care or being referred on to other health professionals has not always been without its problems. What this brings into focus is the range of options that may be open to those who are treated in the community.
	If people's conditions worsen the [integrated] community team will develop a care plan to help them see the right health professional	***"The CCG vision for Integrated Community Care is needed now"***	Whether or not this kind of problem would be solved by a care plan or, indeed, be included in one is to be seen. However, participants were keen for any action that would enable better and more efficient communication between professionals.

			
	Patients will then have access to more specialist services		Participants were keen to ensure the needs of those most vulnerable in the community were protected by appropriate implementation measures. Questions were asked about what counted as a specialist service, who judges it to be so and the range of services that might be on offer. Participants were keen to know that those providing specialist services were professional, had appropriate qualifications and expertise.
	A computer system will share patient details between health professionals		Most participants accepted the need for a computer system which provided details of patients to health professionals. However, questions were raised about who would have access to the information and limits to what they might do with it. Confidentiality and security of data were on the minds of many.
			There was strong agreement for 'wrap around care' and actively manage it so that people stay at home for as long

	The community team will 'wrap' their care around people and actively manage them so that they stay at home for as long as possible		as possible. Participants were strongly in favour of "joined-up" management of health services and could see the potential advantages of using services closer to home.
The Local Hospital	Local clinics will be used rather than attending hospital		
The Critical Treatment Centre	People will only have to be taken to A&E at the hospital in life-threatening emergencies		Participants were supportive of the principle that people should only have to be taken to A&E at the hospital in life-threatening emergencies. However, questions were asked about what counted as 'life-threatening' and who would decide in individual cases.