NHS
Southampton City
Clinical Commissioning Group

A Healthy Southampton for All

Bringing together a Healthy and Sustainable System

Our 5 year strategic plan
(2014-2019)

Contents

Part 1: Bringing it together

Foreword

Our city, our approach, our strategy

NHS Southampton City Clinical Commissioning Group (CCG) exists to plan and buy (commission)[1] health services for local people. We are led by GPs and other clinicians and are one of over200 CCGs across the country, a new type of NHS organisation introduced following the 2012 health reforms.

We have 33 GP member practices who all have a say in how we are run as members of our General Assembly, a formal body which oversees our work. This delegates the running and accountability of the CCG to our Governing Body[2].

We serve a diverse and vibrant population which includes a significantly higher than average number of younger people;[3] greater ethnic diversity than many cities of our size; and a forecast 20% increase in the number of people under 5 years and over 70 years by 2017.

Our vision, *A Healthy Southampton for All,* is about using our new organisation to bring a radically different approach to how we serve our diverse communities. Our city's needs and challenges cannot be addressed by doing the things we have always done: our population is changing; health and care needs are becoming more complex; our care providers are under severe pressure; and the financial outlook for public services is demanding. These are city-wide issues and no one organisation can hope to address them alone – we need to think creatively about what we can to bring the whole health and care system together.

As clinical commissioners, we will play a leading role in making this happen. That is because clinical decision makers commit resources every day and we firmly believe we must take responsibility for both the quality and costs of care. We are taking a **One City** approach to health and care services, working jointly for the common good. We will put the health and care needs of the people of our city first and, make sure that organisational interests never trump those of patients. We will remove barriers to better care and pull together all the key partners to help deliver the services that an individual might need - from home to hospital and back home again.

This is more than just a pledge to work better together; to underscore our commitment we will be pooling a substantial proportion of our budgets with the City Council over the coming years to deliver services in new and better ways. Only through such big thinking can we achieve***A Healthy Southampton for All.***

Our 5 year strategy is firmly rooted in what our public and stakeholders say is important to them and is driven by a need to have healthy and sustainable services. It sets out what we intend to do between now and April 2019 to bring the system together and improve the health and wellbeing of local people. It describes our vision, goals and approach, demonstrating how these have been developed. It also includes detailed action plans which describe how we will achieve this much needed transformation of health and care services.

We hope you find it an interesting read.

Dr. Steve Townsend
Clinical Chair

John Richards
Chief Executive Officer

[1]For more information about Commissioning see Appendix 1 *'What is Commissioning?'*
[2]See Appendix 2 for more information about our Governing Body
[3]Due largely to our two Universities and other further education establishments

About us

We start in this first section with more details aboutwho we are, what we do and our approach along with introducing the key strategic goals that are the guiding force for all our plans and work.

We were established on 1 April 2013 with a clear remit to ensure that family doctors and other clinicians play a leading role in deciding and directing how our local NHS resources should be used. We sit at the heart of the NHS and are set up to listen to and act upon the views and needs of patients, carers and the public as well as working closely with local authorities and other partners. Our role as a CCG is to help meet the health and care needs of our population. We are allocated a budget to achieve this and must use it to plan and buy (or 'commission') health and care services from a number of service providers. We:

- Serve a population of around 269,687, covering 28 square miles
- Have 33 constituent member GP practices
- Have a budget of just over £292 million (in 2014/15) to cover acute hospital services, community services and prescribing
- Share the same boundaries as Southampton City Council

We buy care from the following main providers:

- Care UK (Elective and GP Out of Hours care).
- Solent NHS Trust (for general community and child and adolescent mental health services)
- South Central Ambulance Service NHS Foundation Trust
- Southern Health NHS Foundation Trust (adult mental health services)
- University Hospital Southampton NHS Trust (which incorporates our main acute Hospital)

We also purchase services from a range of private and charitable organisations who provide care on our behalf

Increasingly, as can be seen through this strategy, we are working very closely with Southampton City Council to fully join up our commissioning work for care and community based support across the city, as core members of the Health and Wellbeing Board for the City. Together we have recognised that we will better be able to meet the health and social care needs of our population by working in a more joined up, or integrated way. That is why in November 2013 the CCG and City Council formally established an **Integrated Commissioning Unit** - a single group tasked with using an evidence based approach to commissioning to jointly plan and buy health and social care services. By pooling capabilities and purchasing power in this way, both organisations can exercise much greater control over what we need and buy at affordable prices and with the right level of quality.

For the reasons set out above, the fundamental building block of our strategic planning, or so-called planning footprint, is SouthamptonCity. Nevertheless, we also play a full part in broader strategic themes such as the configuration of providers across Wessex as a whole, both in respect of acute and community services. To do this, we work collaboratively with both neighbouring CCGs and NHS England[4] (Wessex Area Team).

We recognise there are factors[5] driving further centralisation of specialist expertise, and are therefore mindful of the relationship between developments in Southampton and neighbouring centres. We support University Hospital Southampton's (UHS) development as a premier provider of specialised services and recognise the benefits this has brought to local people. We also work particularly closely with West Hampshire CCG because of our shared interest in Southampton

[4] NHS England commission primary care (GP, dental, ophthalmic, and pharmaceutical services) and specialist services for our population and across the wider area.
[5]Evidence shows very specialist or complex procedures need to be concentrated in specialist centres.

General Hospital, and increasingly so with Portsmouth CCG because of a similar shared interest in Solent NHS Trust.

Following recent announcements by NHS England, we are also keen to explore greater involvement in primary care commissioning, (see page 21) especially given the central role we expect to be played by General Practice in delivering integrated local services.

Membership, Clinical Leads andGoverning Body

As with all CCGs we are a membership organisation which means that all GP practices in the City are our 'members'. Our aim is to shift decision-making as close as possible to patients, using membership to ensure local GPs and other clinicians are given power and responsibility for planning healthcare services. Our 33 member practices have all signed up to our constitution and are shaping and influencing the future development of health services.

To further enhance this we have appointed GPs and practice staff to work with us on a number of ad hoc projects such as developing a business case for falls services, developing an urgent care dashboard[6] and GP direct access diagnostics. We have also engaged three GPs as diabetes champions to help drive service improvements in this important area.

In addition, we have six clinical leads – City GPs appointed by the CCG to lead various areas of work and to ensure the experience and views of local doctors is fed into our planning.

The workstreams covered by our GP and clinical leads include:

- Quality
- Planned and urgent care
- Maternity and Child Health
- Sexual health
- Integrated care
- Long Term Conditions
- Safeguarding
- Diabetes
- Community Nursing Review
- Ambulatory Emergency Care projects[7]

To further underscore our approach, our Governing Body is also clinically-led – there are nine clinical leads (including six GPs one of whom is our chair, our Chief Nurse, the City's Director of Public Health, and a secondary care doctor) along with two lay (public) members, the Chief Executive Officer and Chief Finance Officer[8]

Further details about our Governing Body can be found in Appendix 2.

Our vision, mission, values

This document sets out our strategic ambitions and shows how we will lead the bringing together' of the local health and care system so that we can jointly tackle the needs of our population.

[6]A systemthat collates the previous day's urgent care activity data and brings it all together in a user-friendly graphical display, integrated with GP practice data. GP practice staff may access the dashboard via secure login

[7]These are emergency/urgent conditions (for example acute abdominal pain)that have the potential to be managed on an ambulatory basis. The underlying principle is that admission to a hospital bed should only take place if the acute illness that requires inpatient care.

[8]Our Chief Nurse & Chief Quality Officer also serves as Director of Quality & Integration

To guide and drive our work we have set out clear statements of our vision, mission, and values. In developing these, we have worked closely with patients, patient groups and networks, hospitals, commissioners and others to reach a shared understanding of our purpose.

We have discussed with our stakeholders the strategic challenges we face and the work we need to do to overcome them, and we have assessed how we need to allocate resources to meet the care needs of our patients whilst delivering our joined-up programmed of work. The culmination of all this work is set out below:

Our vision

A Healthy Southampton for all

The purpose of our vision is to set out a clear and memorable statement of the desired future state of health in the City. This vision is not solely within our direct control – by setting our vision in the context of the whole system and entire City, we are cementing our commitment to playing a clear leadership role in steering it forward, working through our wider partnerships with the Health and Wellbeing Board and the wider system of healthcare provision. A key part of our role is to helpcreate the right conditions for improvement.

Our vision statement means:

- ✓ **Healthy:** strong and resilient communities that are supported to maximise their potential to live fulfilling and prosperous lives; underpinned by strong, healthy organisations working together in a climate of trust and open, business-like healthy relationships
- ✓ **Southampton:** our City's future is our purpose, firmly shared with our partners
- ✓ **For all:** we are determined to reduce the unacceptable inequalities in health and wellbeing.

Our values:

Our values underpin our vision, drive our behaviour and determine what we do and the way we go about it. We try to live up to these values and they provide a compass to guide us at all times.

- ✓ Patients First, Every Time
- ✓ Relentless about the quality of care
- ✓ Respect for others and their dignity
- ✓ Courage to do what we believe is right
- ✓ Integrity – be honest and decent

Our mission:

Our mission summarises our purpose and the work we are doing right now to set us on the way to delivering our vision:

To ensure that care is coordinated, safe, sustainable and designed to meet the needs of the people of Southampton.

We have set our mission to ensure we take responsibility for providing leadership and co-ordination of the City's health and social care system. We are setting priorities and allocating resources to make sure that it works together in a coordinated, safe and effective way. Through our Better Care Southampton programme (see pages 19 and 56 for more information) we are already putting this ambition into action and working to commission care that is 'joined up' so that it works much more effectively for patients and service users.

Bringing it all together – Our Five Goals

We have established five goals to support the delivery of our Vision and Mission. The five goals are the culmination of our in-depth work to understand and agree with our partners and stakeholders the priority health and care issues, needs and challenges facing our City[9]. Our five goals therefore are more than just a summary of our findings; they are the organising and driving aims for all our work over the next five years.

Our five goals are to:

A. Make Care Safer: We will commission care from safe competent providers**.** We will listen to local people, gather their feedback on their experiences of local services and act upon it.

B. Make it Fairer: We will reduce the inequalities in access to care across our population.

C. Improve Productivity (achieving more with less,more effectively): We will prepare the ground for a transformation in care, doing all we can to bring control to the acute healthcare system.

D. Shift the Balance: We will integrate health and care services to ensure a better more streamlined experience for local people. Together with patients, communities and partners we will co-produce coordinated care through the Better Care Southampton programme.

E. DeliveringSustainable Finances: We will plan strategically for sustainable finances ensuring that we are driven by quality whilst being pragmatic about our resources.

More information on our goals including the guiding principles behind them and the interventions that support them are detailed in Part 3 of our plan.

Our Approach

Playing the leading role in bringing the system together demands that we take a new approach to the way we do business and way we manage our finances.

Principles guiding our approach

We have established some key principles to help guide our work. These principles will underpin all our plans and objectives over the coming years.

We will:

- Lead and coordinate the system, bringing people and organisations together in order to find the best solutions to our challenges.

[9]For more details on the drivers and challenges, see Part 2 'Our City& Our Challenges'

- Adopt a fully integrated approach to commissioning health and social care with our partners in the City Council.
- Create real clinical ownership throughout the system of the quality and costs of care.
- Focus our efforts on the areas where we will make the greatest impact.
- Change our approach to allocating funding to cement our ambitions to bring the system together; by changing the way we buy services we will change the way health and care services are delivered.

Doing things differently: total integration

The requirements of the local health and care system are changing: we are living longer,often with multiple and complex long term conditions.. Alongside this, our hospitals and care providers are under great pressure (more on page 17); and the financial outlook for public services is challenging with funding flat-lining over the coming years.

Currently, we spend around 54% of our total commissioning budget on acute care[10] and demand has been growing. Continuing this trend is unsustainable both financially and clinically –acute services are under immense strain, potentially compromising quality and safety, whilst at the same time better prevention and maintaining independence in community settings needs investment.. However, whilst the benefits of providing more effective and sustainable care in community and primary care settings are well understood, making this shift happen in reality has proved to be very challenging for the NHS.

The introduction of the Better Care Fund (BCF), creating a pooled budget with the City Council to pay for better out of hospital care, marks a step change in approach and a new opportunity to make change happen . This nevertheless comes with its own demands – in order to pay for better out of hospital care we have to deliver a corresponding shift of work and money out of acute services. In all we have to achieve a 15% reduction in non-elective admissions over the next 5 years (3% per year). We must also take into account that the Better Care programme is operating in the context of an austere outlook for social care funding which is set to reduce by a third over the coming years.

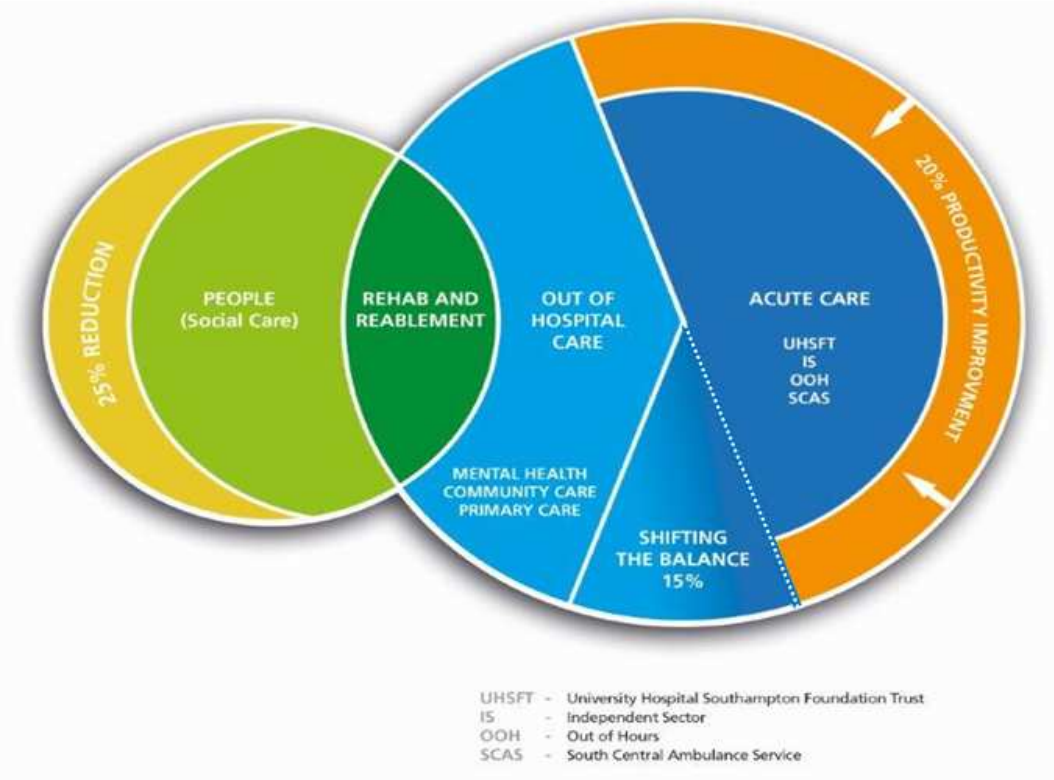
Making such substantial savings means services have to become something quite different – we cannot just provide less of the same. Together with the City Council, we have taken a joint view that neither of us can deliver such huge changes and savings in isolation and that therefore, a more radical and joined up approach is essential. Our joint aspiration is to view the whole of our out of hospital and social care spend as a single resource for Better Care, planned and delivered together. This 'total integration' approach exceeds the minimum requirements of the Better Care Fund policy, but we believe it is the level of ambition we must have in order to succeed.

Our **Better Care Southampton**programme*'Joining up Your Care'*is our joint response to this challenge and brings together our ambitious plans for making this a reality. Achieving success will be a major test but it is by no means impossible. The alternative risks a steady decline and degradation of care and we are not prepared to let that happen

You can find full details about our **Better Care Southampton** programme on pages 19 and 56.

The diagram overleaf illustrates the main areas of activity and the opportunity to shift the balance (15%) of care from acute to out-of-hospital settings whilst making further productivity improvements:

[10]This encompasses contracts with: our main hospital provider (University Hospital Southampton Foundation Trust), local NHS acute and Independent sector hospitals and ambulance services.



UHSFT - University Hospital Southampton Foundation Trust
IS - Independent Sector
OOH - Out of Hours
SCAS - South Central Ambulance Service

Part 2: Our City & Our Challenges

Introduction

In this section we detail the information and data we have used to help us understand the health needs of our City and the challenges we need to address. We have divided this part of our strategy into seven distinct areas each of which represents a key factor driving our work (our 'drivers'). It is the analysis of all these factors that we have used to set our strategic direction, plans and actions which we will be pursuing over the next five years:

- **Population and health trends**- an overview of the City's health needs including public health data (taken from the Joint Strategic Needs Assessment or JSNA) and our commitment to the city's Health and Wellbeing Strategy.
- **Ensuring safe high quality services** – spelling out the rationale behind our organisational commitment to quality, a pivotal factor driving our plans.
- **Hospitals on the edge** – an analysis of our hospital providers, their struggle to meet demand and the role we must play in addressing this.
- **Views and feedback from our member practices** – briefly outlining how the input of local GPs and practice staff has shaped our strategy.
- **National imperatives**– clearly setting out the national drivers for change including standards, initiatives and targets set to ensure high quality care for all.
- **The financial challenge** – setting the financial context for our strategy which is key in shaping the scope of what we can achieve.
- **Your views –** showing how we have taken the views of local people - patients, service users, voluntary groups and other key stakeholders into account when drawing up our plans.

Our City – population and health trends

Baseline data about our population - 2011 Census

Information about population and health trends is always vital when planning health services. The last Census in 2011 told us that the population of Southampton was 236,900[11]. The population has increased by 19,400 since 2001, approximately 8.9%. Most growth since has been in the working age groups, the 16-44s increased by 12.4%. There was also an increase in children aged 0-4 years (27.8%).

Other key facts include:

- 17% of the population is between the ages of 18 and 24 (compared with national average of 9.5%);
- 71% of people are of working age;
- 17% are from non-White British backgrounds (larger than most cities of the size of Southampton)
- We expect to see a 20% increase in the number of people under 10 and over 70 years by 2017.
- 4.2% of 16-74 year olds were unemployed and 18.1% (32,517) were students (compared to 4.4% and 9.2% respectively for England)
- Of all people aged 16 and over, 21% (40,991) have no qualifications (compared to 22.5% nationally)
- 29.5% of households have no car or van (compared to 25.8% nationally)
- 13.6% of households are overcrowded (compared to 8.7% nationally)
- 39.9% of dwellings in the city are flats, maisonettes or apartments and 60% are houses
- 33.8% of households are comprised of people living alone (compared to 30.3% nationally) `

[11] Around 269,687 people are registered with GP practices within the City and this is therefore the population figures used by the CCG for planning purposes (see also footnote [1])

- 7.0% of households are lone parents with dependent children (compared to 7.1% nationally)
- 7.7% of households have no people for whom English is the main language (compared to 4.4% nationally)
- 49.8% of households own their home (or buying with a mortgage) (compared to 63.4% nationally)

Deprivation

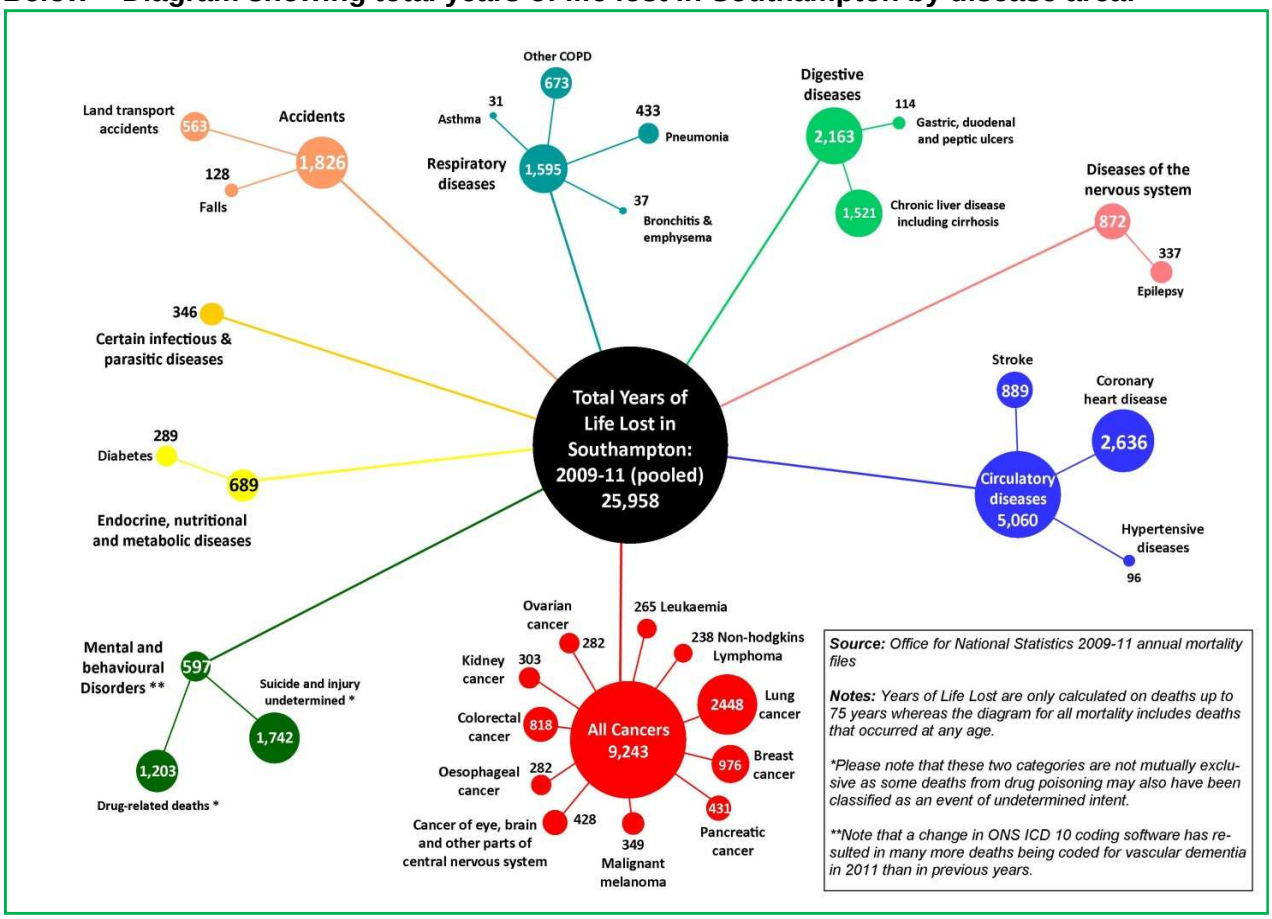
Nationally, Southampton is the 81st most deprived local authority (out of 326), and the 5th most deprived in the South East. 23% of residents live in the most deprived Lower Super Output areas (LSOA's) in England. Deprivation is higher than average for children with 27.5% of Southampton's child population living in poverty compared to 21.3% in England (in some wards this is as high as 42%).The Joint Strategic Needs Assessment (see below for more information) shows that a significant number of people are classified as highly disadvantaged in the city. In addition it shows considerable variation in the level of deprivation experienced by and between communities.

Health Trends

Health inequalities are still a dominant feature of health in Southampton. Levels of teenage pregnancy, GCSE attainment (despite improvement) and tooth decay in children are worse than the England average (2010) as are rates of sexually transmitted infections, road injuries and smoking related deaths. Poor diet and lack of physical activity remains an issue, with 22% of the population classified as obese.

Early deaths from cancer are high especially in priority neighbourhoods and there are considerable risks for those living with mental ill health, learning disabilities or physical disabilities; equally breast, bowel and cervical cancer screening uptake is challenging, resulting in poorer survival rates.

Below – Diagram showing total years of life lost in Southampton by disease area:



Cardiovascular disease, accounts for over 5,000 potential years of life lost in the city. This is a condition that has common risk factors such as raised cholesterol, physical inactivity, obesity and high blood pressure – all these can be addressed through appropriately organised health and care services.

Around 86,000 people in Southampton, 32% of the population, are estimated to be living with a long term condition such as asthma or diabetes. Although many of these are chronic conditions, it is possible to keep people healthy in their own homes local communities and thus prevent acute problems and reduce the need for hospital admission.

Unplanned admissions to hospital for those with chronic Ambulatory Care Sensitive (ACS) conditions are high in Southampton in comparison to other CCGs. We need to do more to improve our performance relative to similar CCGs across the country in areas of emergency hospital admissions and for other acute conditions that should not usually require hospitalisation.

There are also health challenges associated with key population changes that we need to plan for and address. In the next 5 years people in age groups 5 to 9 years and 70 to 74 years will increase by 20% each. The number of people over 85 will have grown to over 6,000 residents by 2017, an increase of over 15%.

For further detailed information on health outcome challenges and deprivation please see Appendix 3 and Appendix 4.

Southampton Joint Health and Wellbeing Strategy *(Including the Joint Strategic Needs Assessment)*

Working together, Southampton City Council, NHS England and our CCG have developed a Joint Health and Wellbeing Strategy for the City. The strategy sets out the approach and plans for addressing the key health and care needs over a three year period (starting in 2013/14).

The content of the strategy, fully adopted by ourselves and the Council, was informed by the Joint Strategic Needs Assessment (JSNA) and through conversations and feedback with stakeholders and the public. The Joint Strategic Needs Assessment is a process undertaken jointly by the City Council and the CCG where data on the health of people living in Southampton, their care needs and a number of the key wider determinants that affect health and wellbeing (including housing and employment) are collated, analysed and published. The JSNA is a web-based resource that is periodically updated as new data become available. It can be viewed at http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/?locale=en

Specific challenges highlighted in the JSNA include:

- Demographic pressures, especially the growth in the city's birth rate (around 35% in seven years).
- The increasing proportion of older people and accompanying increase in dementia
- Deprivation and children in poverty
- The increase in unhealthy lifestyles leading to preventable diseases
- The need to ensure high quality services for specific care groups, including those living with mental ill health, physical disabilities and learning disabilities
- The need to ensure that provider services are joined up and seamless to create robust care pathways for a 'whole person' approach
- The need to support carers to care and the need for volunteering
- Work stresses and worklessness and the impact on mental health
- Recognising the impact on health of wider determinants (education, poor housing, transport and economic regeneration)

From this foundation actions have been identified through the strategy to address the City's health and care needs. These actions are grouped into three themes:

a) **Building resilience and using preventative measures to achieve better health and wellbeing**

b) **Best start in life**

c) **Living and ageing well**

The three themes are intended to secure a life-course approach to improving health and wellbeing and provide a means of reducing health inequalities. Crucially, they also provide scope for improved joint working across health and care systems as they enable a shared ambition and vision of success.

Our five year strategy and associated action plans describe the approach we are taking to play our part in delivering the joint strategy. Our ambitions therefore are not a parallel process – they are part of the integrated and joined-up vision we have for the City.

We have pulled together they key points from the Joint Strategy in Appendix 4. This extract provides more information about the three themes, the key JSNA data we are using and the actions we will be taking with our partners to address the challenges. A copy of the full strategy can also be found here: www.southampton.gov.uk/Images/Joint%20Health%20and%20Wellbeing%202013%20to16_tcm46-348430.pdf

Ensuring safe, high quality services

Putting quality and safety first

Quality and safety has quite rightly been a matter of significant public debate in recent years and as such is a key driver in our strategic planning. The national scandals surrounding Mid Staffordshire Hospitals Trust and Winterbourne View in South Gloucestershire have brought into sharp focus the need for staff at all levels to change behaviours, systems and processes so that safety and quality are the organising principles of health and care services.

The Francis Report into Mid Staffordshire, the Report into Winterbourne View and Don Berwick's report into patient safety were published following the failings in care. All reports have reinforced that quality is about our behaviours and attitudes and the need to address this to ensure high quality care for all.

A common and deeply disconcerting characteristic of all of the failures has been the sense that many health professionals (clinicians and managers) did not seem to take seriously enough their personal responsibility to own the quality of care and to be willing to do something about it.

This is why our very first strategic goal is **Make it Safer**. We see addressing safety and quality as our central purpose. We are committed to ensuring that the recommendations in the Francis, Berwick and Winterbourne View reports are not only delivered but are part of every relationship we have with our partners and patients. In bringing the system together, we will work with all of our providers, partners, GP members and communities to ensure that they are providing competent, safe and effective care whatever the setting - supporting them and challenging them where appropriate to drive standards higher. Our response to the recommendations and requirements coming out of these reviews are central to the strategic ambitions, goals and action plans set out in this document.

As part of our commitment to making care safe we have established a dedicatedQuality Team, working jointly with Southampton City Council, to take a system-wide view on care standards. The team has been working together with commissioners, providers and GP practicesto ensure the very best quality services are being provided to the people of Southampton.

Some of the team's early successes include:

- ✓ Establishing a culture of zero tolerance for dealing with hospital acquired infections
- ✓ Significant reductions in the numbers of people acquiring the *C.difficile* infection both in hospital and in primary care
- ✓ Improvements in the quality of services at our main providers through a reduction in surgical related 'never events' (the kind of mistake that should never happen)
- ✓ A focus on a system-wide approach to quality assurance which has supported a number of Nursing Homes to improve the quality of service provision.

These are the excellent foundations on which we have developed our plans and ambitions for the next five years.

Please see Appendix 5 for more details

Patient Experience

As set out below, our strategy has been developed with the engagement of the public, patients and other key stakeholders. However, it also essential that we have mechanisms in place to continuously capture feedback both in terms of how services are performing and how we are progressing against our plans and ambitions (as experienced by patients through the services they use).

Our strategic approach of bringing the system together will be key in helping us continue to develop patient feedback mechanisms. For example, over the next five years we will work with providers to ensure the full roll-out of the national Friends and Family test across all settings as this gives us a valuable temperature gauge of the public view of services[12].

To ensure we put patients at the centre, making the whole health and care system work on their behalf, we will also continue to develop our patient experience service to gain valuable patient insight. We set up our own in-house service (from April 2014) as a direct result of feedback from patients, carers and families that the complaints system was difficult to navigate and confusing. Our service receives details of patient experiences from across the local healthcare system and co-ordinates responses from the appropriate providers.

Patient and service user experience is one of our key drivers and we will continue to develop our approaches to gathering and acting upon data.

Safeguarding

During 2013 the Government published updated policies and guidance on Safeguarding encompassing all services and agencies that work with or support Adults or Children. These new directions take into account the NHS reforms of 2013 and sets out the responsibilities of both new and reformed public agencies.

[12]Provider performance against the test is monitored via monthly Clinical Quality review meetings that highlight trends and themes. In line with our strategic approach and values, we will support providers develop action plans to address negative feedback.

We have no doubt about our role in making sure every service works to protect the vulnerable adults and children; we also see the opportunity to use our position and approach as key leaders in the local health and care system to ensure we take these responsibilities into all aspects of our strategy and plans.

With the establishment of the integrated commissioning unit (see Appendix 6), we have been able to introduce a new joint Head of Safeguarding post (for commissioned services). The post holder will provide expert advice in both children and adult safeguarding to commissioners in health and social care, be an active participant in local safeguarding boards and ensure the CCG is discharging its safeguarding duties. Key to this process will also be holding all providers – across the full range of health and social care services – to account for their safeguarding work.

Hospitals on the edge

Another important 'driver' for our strategy is the significant challenge facing our hospitals. Demand for care is growing and, as people live longer, this demand is becoming more complex. This changing pattern of use is putting strain on the entire health system, particularly hospitals.

In order to capture and set out the full magnitude of the challenges facing acute care services, the Royal College of Physicians published a report *Hospitals on the Edge? The Time For Action*[13] (September 2012), calling for co-ordinated action to save hospital services from collapse.

As with hospitals up and down the country, the challenges and issues detailed in the report also reflect our experiences in Southampton.

In recent years we had seen a steady rise in the number of emergency admissions to University Hospital Southampton (UHS) and particularly fromthose in older age groups and those with more complex conditions.

In 2012, following sustained difficulty in maintaining the national A&E waiting time standard (of 95% of people being admitted or discharged within four-hours), the Emergency Care Intensive Support Team (ECIST) carried out a review of provision both within UHS and across the wider health and social care system. They concluded that, despite some successes, there had been an over-reliance on schemes to avoid admission and insufficient emphasis on improving discharge planning and onward care. In essence they concluded the whole health and care system needed to change from a culture of trying to 'push' people out of hospital to release capacity, to one where community services intervened to help 'pull' patients through by means of pre-planning effective community or home-based support.

The ECIST findings were recognised as the way forward and comprehensive action plans were developed and implemented. And yet, the pressure on services has continued. Throughout 2013, it became clearer that sustained very high levels of bed occupancy (in excess of 95%) were creating difficulty in admitting patients in urgent need, and creating unacceptable risks to the safety and quality of patient care across the hospital.

In October 2013, following similar concerns nationwide, the National Audit Office published a report, *Emergency Admissions to Hospital: Managing the Demand* which concluded that:

"Many emergency admissions to hospital are avoidable and many patients stay in hospital longer than is necessary…Improving the flow of patients through the system will be critical to the NHS' ability to cope with future winter pressures"

[13]See www.rcplondon.ac.uk/projects/hospitals-edge-time-action

Right now, the pressure on urgent care services continues to be the single most acute concern in Southampton. There have been some positive signs of greater resilience in services with considerable investment in schemes to support complex discharges giving rise to faster discharge from hospital. We are also starting to see a decline in the number of A&E attendances and there is some evidence that the growth in emergency admissions has been stemmed. There is renewed determination across the whole system to build on progress, to sustain efforts to alleviate these problems and to support the hospital in every way possible.

However, performance against the 95% standard remains less than acceptable and this is important because this standard is a key indicator of challenges across the entire system: failure to safely and effectively discharge people leads to significant pressure on elective capacity which in turn means that meeting other crucial national standards (such as referral to treatment times and waiting times for cancer[14]) becomes challenging.

That is why over our 5 year strategic period, the urgent care programme must continue to demand the highest priority from all partners. We need to bring our hospitals back from the edge by creating sustainable longer term solutions and in working with partners to create a whole system response. We are determined to reduce the burden on acute services and are working with provider organisations on a number of urgent care projects to streamline services and remove unnecessary steps which will not only enable patients to move more quickly through the system, but also improve their overall experience.

Alongside this, our transformational Better Care Southampton programme will bring lasting solutions to the challenges. This integrated, joined-up approach to designing and delivering health and care services prioritises prevention, independence and coordinated person centred (out of hospital) care and thus gets to the heart of pre-emptively addressing those needs that currently end up a hospital admissions.

Views and feedback from our member practices

As a Clinical Commissioning Group it is vital that we not only gather feedback from our member practices but also reflect this in our strategic planning. Our elected GP Board members have contributed to this strategy by sharing their thoughts and experiences through a series of strategy development events, meetings and workshops.

Our member practices have also contributed by:

- **Giving feedback via our General Assembly Meetings** – these formal strategic meetings to which each practice is invited have proved an important way for GP and practice members to feed into our strategic planning. Matters discussed and incorporated into our final strategy include: views on the overall strategic direction of the CCG, the scope and impact of clinical leads, the direction of travel for planned and unplanned care, and the development of integrated commissioning.

- **Attending whole system meetings to develop Better Care Southampton** - this key element of the CCG's future strategy has seen GPs from across the city attend workshops, meetings and discovery events designed to gather views on the integrated care agenda. Their feedback on everything from the future shape of integrated services to the development of local 'clusters' of practices has informed our Better Care work, a key part of our five year strategy.

[14]The standards set out in the NHS constitution state that: patients should start consultant-led treatment within a maximum of 18 weeks from referral for nonurgentconditions; and be seen by a cancer specialist within a maximum of two weeks from GP referral for urgentreferrals where cancer is suspected.

- **Locality meetings and direct contact with CCG Chair -** feedback has also been gathered via our locality meetings led by locality lead GPs and attended by GP representatives from each practice. In addition our GPs have an open and honest relationship with our GP Chair. Many feel free to contact him directly by phone or email and the varied insight gathered via lively e-debates as well as feedback about patient stories and experiences have also informed our strategic direction.

In addition to the mechanisms outlined above we have recently launched a GP Portal featuring a discussion forum and giving easy access to direct contact with our commissioning managers. Our GP and practice nurses forums and TARGET (Time for Audit Research Governance and Training) meetings are other opportunities for us hear what our member practices think and to feed views into our service and strategic planning.The process of continually gathering feedback from our GP members is ongoing and will continue to drive our planning.

National policy

As well as the local considerations and needs set out above, some targets and priorities are set nationally. Such targets are intended to help ensure consistency across all services and organisations and to set our minimum standards of care and quality. It is essential we not only meet these standards and priorities but that we strive to exceed them wherever possible.

The Better Care Fund

As outlined in part 1, Better Care will be a central plank of our five year strategy. The Better Care Fund,a national initiative announced by the Government in the June 2013 spending round, is the financial mechanism that makes this possible. The Government's aim is to commit £3.8bn of NHS funding to deliver a transformation in integrated health and social care through the pooling of budgets in local areas.

The Better Care Fund (BCF) offers a unique opportunity to bring resources together to address immediate pressures on services and lay foundations for a much more integrated system of health and care delivered at scale and pace. But it will create risks as well as opportunities. The £3.8bn is not new or additional money - it is funded from national CCG allocations in addition to NHS money already transferred to social care. Every CCG in the country, working with their Health and Wellbeing Board, must therefore have plans in place to realise the benefits of the BCF

Creating *Better Care Southampton*

Throughout this strategy we describe how we believe our commitment to integration will lead to sustainable solutions for our city's most pressing health and care needs. In fact, we had already embarked on a system-wide Integrated Person Centred Care change programme before the BCF was confirmed; it follows therefore that we see the BCF as a great opportunity to go further, faster.

This is why we have we have created the Better Care Southampton programme. It pulls together existing and new strands of work that are necessary to deliver the requirements of the BCF to fully integrate services through transformational change.

Our Better Care Southampton programme is supported by the Integrated Commissioning Unit (ICU)–which has been jointly established and resourced by the CCG and City Council. The ICU have created a vision for integrated care within the city:*"Health and social care working together with you and your community for a healthy Southampton"*

To bring further clarity and focus to our far reaching ambitions we have also established a set of organising principles for all our programmes. These statementshave taken inspiration from the

National Voices' *Principles for Integrated Care*[15] initiative and describe what we aim to achieve and how we aim to do it:

- ✓ **Person Centred** - individuals will have maximum choice and control through person centred care planning and supported self management of their health and wellbeing.
- ✓ **Personal control** –patients and service users can decide how the money allocated for their care should be spent.
- ✓ **You, not your illness** - the approach to care will be holistic and not focussed around diseases or conditions.
- ✓ **Being the best we can be** – we will make the most of the skills and resources available to us, building on the strengths of people, their families, carers and local communities.
- ✓ **Integrated and seamless** - services will be delivered in an integrated way at all levels wherever possible with a focus on local care.
- ✓ **Round the clock** - out of hospital care will be a 7-days-a-week service and will be consistent both in and out of hours.
- ✓ **Community-led** – the vast majority of people's needs will be managed in the community by the local cluster teams. Community services will be the first port of call for people seeking help for themselves or others.
- ✓ **Efficient and consistent** - care planning and assessment may be undertaken by any agency using a common trusted tool.

The BCF is therefore a major driver for us and will play an important part in all that we do over the next five years. You can find out more information about our integration work and Better Care Southampton in Appendix 6 and by visiting our website: www.southamptoncityccg.nhs.uk/have-your-say/better-care-southampton-joining-up-your-care

Compassion in practice

As part of the national commitment to driving up service quality in the NHS, *Compassion in Practice* – the national nursing, midwifery and care strategy – was launched in December 2012. It is a vital national initiative providing a framework and a clarion call to everybody involved in the delivery of care. At its core, the strategy is seeking to ensure we are delivering quality of care as well as quality of treatment.

The framework is organised around six fundamental values – known as the 6Cs – which are: Care, Compassion, Competence, Communication, Courage and Commitment. These 6Cs have been shown to resonate strongly with both staff and people who use services across the full range of health and care settings. Each area of action within the framework has an associated implementation plan with national, local and individual actions.

As part of our strategy, we have made an unequivocal commitment to engaging *all* healthcare professionals, working together with our partners to implement the principles of the framework across the city. This will not just apply to NHS providers but wherever patients and service users access treatment and support - from nursing homes and treatment centres to voluntary organisations and community settings. Where we have direct commissioning responsibility, we will ensure the 6Cs are embedded as part of quality service development.

[15] See: www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/principles_for_integrated_care_final_20111021.pdf

The advent of co-commissioning of primary care

Announced in May 2014, CCGs are soon to get the opportunity to co-commission primary care. Although these plans are still at an early stage, a vibrant and sustainable primary care sector is pivotal to our strategy, especially Better Care Southampton. This development is therefore potentially a very useful enabler and is likely to have a significant impact on strategic planning over the next five years.

NHS England invited those CCGs that are interested in an expanded role in primary care to come forward and show how the new powers would enable them to drive up the quality of care, cut health inequalities in primary care, and help put their local NHS on a sustainable path for the next five years and beyond.

CCGs are required to submit expressions of interest in taking on enhanced powers and responsibilities to co-commission primary care. Applications need to meet a number of tests, including showing they will help advance care integration, raise standards and cut health inequalities in primary care. They will also need to show how they will ensure transparent and fair governance -with a continuing oversight role for NHS England to safeguard against conflicts of interest – all in the context of the CCG's five-year plan for its local NHS services. Each proposal will be discussed by the applicant CCG and the local Area Team of NHS England, which will subsequently make a recommendation for approval by the Board of NHS England.

Anticipating this direction of travel, in 2013, the CCG began developing a vision for a sustainable model of general practice in Southampton. This latest development gives us an opportunity to accelerate progress and we will continue to work with NHS England (Wessex Area Team) as we develop more detailed plans (see our action plan on page 58 for more information).

NHS Constitution – the NHS belongs to us all

The NHS is there for us from the moment we are born. It takes care of us and our family members when we need it most. The NHS Constitution has been created to protect the NHS and make sure it will always do the things it was set up to do in 1948 – to provide high-quality healthcare that's free and for everyone. No government can change the Constitution without the full involvement of staff, patients and the public. The Constitution is a promise that the NHS will always be there for us all.

The Constitution sets out our rights as NHS patients, covering how patients access health services, the quality of care received, the treatments and programmes available, confidentiality, information and the right to complain if things go wrong.

Our entire organisational approach - our vision, values, mission, strategy and plans – have been designed and developed with the principles of the NHS Constitution firmly in mind. We will continue to take account of the Constitution as we review and refine our strategy over the nextfive years.

NHS Outcomes Framework – the Five Domains

The NHS Outcomes Framework has been designed to provide national-level accountability for the outcomes the NHS delivers and to drive transparency, quality improvement and outcome measurement throughout the NHS. Development and delivery against the framework is led by NHS England who work with CCGs to design local delivery plans.

To support this work, a CCG Outcomes Indicator Set has been developed so that performance can be monitored, measured and acted upon at a local level. The CCG Outcomes Indicator Set provides clear, comparative information for CCGs, Health and Wellbeing Boards, local authorities, patients and the public about the quality of health services commissioned by CCGs and the

associated health outcomes. All of the indicators have been chosen on the basis that they contribute to the overarching aims of the five domains in the NHS Outcomes Framework.

Our Outcome Ambitions

To help drive delivery of the domains, NHS England has established a range of Outcome Ambitions that, taken with the Outcome Indicators, enable CCGs to determine their priority actions for delivering against the 5 Domains.

We have carried out a detailed analysis of our current position and have selected the key outcome ambitions we believe will make a real difference to the health and wellbeing of our city (see table overleaf). We have focussed on areas where we will have the greatest impact and where we need to improve our performance comparative to our 'peer' CCG organisations. As with all our main challenges and needs, our analysis clearly demonstrates that successful outcomes against these ambitions depend on bringing together a whole system approach to prevention, treatment and care.

The key actions required to meet or exceed the ambition standards are incorporated throughout our strategic action plans (see section 3). For full details of our Outcomes analysis work, please see Appendix 7

Outcome Ambition	What we will use to measure progress	What is our target performance?	What is our current Performance? (2013/14)	Why did we choose this outcome ambition?
1. Improved Patient Safety and User Experience	1. Reductions in healthcare associated infections 2. Number of never events 3. Friends and Family Test (FFT) 4. Numbers of pressure ulcers	1. No MRSA infections Reductions year on year in C.difficile cases 2. No never events 3. Top quartile performance for FFT 4. 20% reduction on 2014/15 baseline in pressure ulcers	1. MRSA 5 cases C.difficile 58 cases 2. 3 Never Events 3. TBC 4. Using data gathered in 2014/15 as baseline	Patient safety is paramount in all our healthcare services and the measures chosen reflect quality of service provision across all providers. Driving down numbers of healthcare associated infections and pressure ulcers will contribute to improved standards of quality and safety in all settings and FFT provides a measure of patient satisfaction across all services
2. Reduced Inequalities In Life Expectancy	Potential Years of Life Lost = rate per 100,000 population (male & female)	**2083.4** By 2018/19	*2277.7*	At present our performance does not compare well with other CCGs. Our ambition is to move our performance to the middle of next best quintile (based on CCG's 2012 quintile)[16]by 2018/19
3. Reduced Avoidable Emergency Admissions	Rate of admissions per 100,000 population (the emergency admissions composite indicator)-	**2046.2** By 2018/19	*2407.3*	This is central to our goal to shift the balance of care in Southampton. Our target is a 15% reduction by 2018/19 on our current performance.
4. More Older People (over 65) Living Independently - 91 Days After Reablement	Proportion of older people who are still at home 91 days after discharge from hospital into reablement services	**90 % of people discharged into reablement services** By 2015/16	*87.7 %*	This is one of our Better Care national targets and will reflect our success in supporting people to live independently in their own homes, which is a key aim of our local programme. We are already performing well in this area so this target will be challenging but we are determined to continue to improve.
5. Fewer Permanent Admissions To Nursing Homes	Permanent admissions of older people to residential and nursing care homes per 100,000 population	**881.8** By 2015/16	*1005.6*	This is a key area for us as we have a relatively high rate of permanent admissions which we need to address. Our aim is to achieve a 12.3% reduction in all types of admissions in per capita terms.

[16]A quintile is a statistical measure where ordered data is split into 5 equal sized subsets. The 212 CCGs are split into 5 groups best performing to worst performing. We wish to move performance into the next quintile (or section).

Outcome Ambition	What we will use to measure progress	What is our target performance?	What is our current Performance? (2013/14)	Why did we choose this outcome ambition?
(older people over 65)				If we can achieve this it will be a strong indicator that service performance across the board is dramatically improving as a result of our Better Care agenda.
6. Fewer Delayed Transfers Of Care	Number of delayed transfers of care (delayed days) from hospital per 100,000 population = average per month	**441.9** By June 2015	*465.6* *For the period Dec 2012 to Nov 2013*	The numbers of patients in inpatient beds who are clinically ready for discharge on any one day continues to remain too high, in Southampton signifying a failure in our system. It impacts on our ability to respond to patients needs in a timely way and promotes an ethos of dependence rather than one of recovery and independence. Achieving a significant reduction in this area is a key focus of our Better Care agenda and will make a significant difference to both patients and the system as a whole.
7. Reduced Injuries Due To Falls In People Over 65	Standardised rate of emergency admissions for injuries due to falls for people over 65 per 100,000 population	**2334** By 2015/16	*2354*	Our strategy has a significant focus on prevention and supporting people in their own homes and communities. Our aim is to reduce the number of injuries due to falls requiring hospitalisation each week by 12.5%.
8. 20% Productivity Improvement In Elective Care	24% reduction in first face to face outpatient attendances 34% reduction in face to face follow up attendances 4% reduction in outpatient procedures 25% reduction in day case procedures 14% reduction in elective inpatient admissions	To reduce total spend on Acute Elective Care to £33m; reduce number of attendances / interventions to 136,300 Should release £8m saving - based on 49,000 fewer attendances in or interventions.	Total current spend on Acute Elective Care is £41m - based on c. 185,250 attendances / interventions	More informed decision making by users and clinicians Increased support, education and provision in primary and community care Fewer routine follow ups, better use of technology and support for self-management Shift from day cases to outpatient procedures, reduction in procedures of limited clinical value, reductions in length of stay and reduced readmissions or “re-do” operations

Seven-Day Services

Patients need the NHS every day. Although some NHS services like hospitals are open every day, services at weekends are reduced. The limited availability of some services across the health system at weekends can have a detrimental impact on outcomes for patients. Therefore nationally work is underway to secure better access to services seven days a week.

The National Medical Director of NHS England has set up a Seven-Day Services Forum which has looked into the consequences of the non-availability of clinical services across the seven day week – it is also currently exploring proposals for improvements and examining the key issues which affect delivery of a seven day service.[17]

Locally we are committed to seven day services and our contracts for 2014/15 already include an expectation of providers that they will begin scoping work and readiness planning in preparation for the standards and requirements that will emerge from the national Forum work.

Seven day working is also a key principle of our integrated care model (see Better Care on page 19 and Appendix 6) and it is recognised that it is a 'must do' to ensure we can fully achieve our plans to join up care and transfer funds from the acute hospital sector.

The Financial Challenge

Spending on the NHS in the UK as a share of national income has more than doubled since its introduction in 1948, rising by an average of 4.8% in real terms. This period of rapid growth has now come to an end and yet funding pressures on the NHS continue to rise.

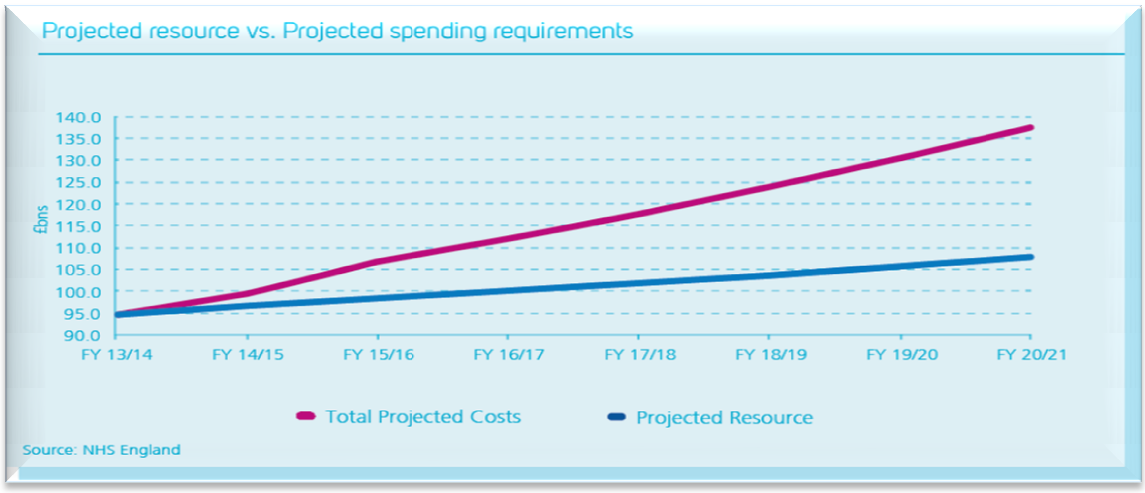
At the same time there has been significant growth in demand, changes in the population make-up (people living longer), increasing costs of new treatments as well as inflationary cost pressures (for example, the cost of drugs, running NHS estate and salaries) all adds up to significant funding gap for the NHS.

The 'QIPP Challenge' first set out in 2009 recognised the need for action to address the funding issues. Focusing on schemes around Quality, Innovation, Productivity and Prevention (QIPP), the aim has been to make efficiency savings of £20bn (4% a year) over 5 years. Crucially, the QIPP approach seeks to drive a fundamentally better approach to delivering financial sustainability by improving quality and avoiding, as tragically illustrated by the Francis's report into the shameful events at Mid Staffordshire Hospitals, the dangers of ruthlessly cutting back.

Recently, the nationalfunding position has been reviewed to take account of initial QIPP progress and further expected changes in funding allocations and demand / inflation. This has led to expectations that the funding gap will increase by a further £30bn by 2020/21 whilst at the same time income will continue to be relatively flat.

This is captured in the chart overleaf:

[17]The Forum is organised into five workstreams covering: clinical standards; commissioning levers; finance and costing; workforce; and provider models. Membership is made up of health commissioners, providers, clinicians and organisations such as: the National Institute for Health and Care Excellence (NICE), NHS Improving Quality and the NHS Confederation.



The QIPP challenge therefore is the means by which all NHS organisations must endeavour to close this gap. By transforming services and improving productivity (doing more for less) and innovating in an effort to reduce costs we can meet the financial challenge:

- **Quality** – Sustain high quality care and continuously improve quality and outcomes for patients, adding years to life, and life to years.
- **Innovation** – Horizon scanning for best practice and transforming patients' pathways with rapid diffusion across the system to meet the population's healthcare demands.
- **Productivity** – Improving efficiency and creating better value for money.
- **Prevention –** Keeping people healthy by promoting healthy lifestyles and delivering healthcare in the right place, at the right time to reduce dependency on health and social care.

Our QIPP challenge

We have modelled our QIPP challenge over the next 7 yearsand have identified that we need to reduce our costs by at least £89m over the period (equating to 31% of our £280m budget for 2013/14)[18]; this will form our contribution to the national £30bn gap.

Our forecast QIPP gap

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
CCG Available Funds	289,322	298,542	303,751	308,718	313,769	318,350	322,997
QIPP Challenge	10,485	17,685	12,462	12,463	12,463	12,463	12,463
QIPP Challenge %	3.62%	5.92%	4.10%	4.04%	3.97%	3.91%	3.86%

Meeting the financial challenge

The expected financial position is clearly a vital determinant of what we can and cannot achieve and what we do and do not prioritise over the next five years. Our strategy is therefore designed to deliver improvements and transformation within our financial limits.

[18] Figures are subject to change as projections around future demand and funding settlements are not fixed.

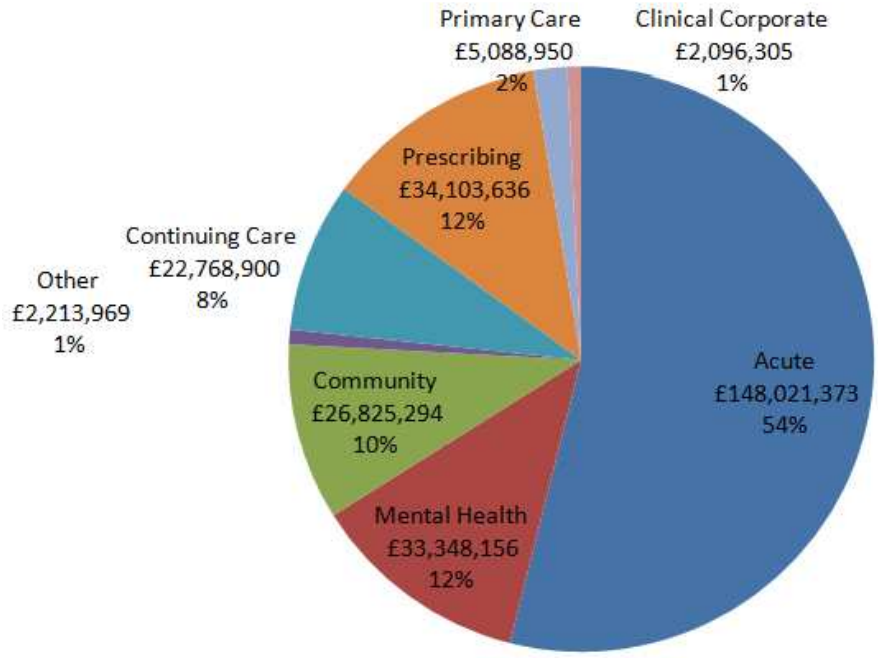
Whilst we received a 2.14% uplift (£5.878m) in funding for 2014/15 the costs of healthcare in the city are increasing at a greater rate. We also face an additional challenge in that we are 'overfunded' – this means we are getting a higher financial allocation than the Government says we need. The reason for this is a change in the basis of CCG funding formulas in 2014/15[19] which will result in us getting a lower uplift than other CCGs in the coming year; put simply we will get less than our anticipated annual allocation year on year until this funding gap is erased.[20]

This affects our five year strategic planning as our anticipated budget will effectively be shrinking in the coming years, increasing our QIPP challenge.

For planning purposes from 2016/17 to 2018/19 CCGs are expected to assume a continuity of the current allocations policy. CCGs have been asked to assume that allocations grow in line with the GDP deflator: for 2016/17 - 1.8%; 2017/18 - 1.7%; and 2018/19 - 1.7%. Whilst this growth is significant in comparison to other providers it fails to grow at the level to meet predicted demand. For example, in 2014/15 our spend per head of registered population will be £1,034.00 (excluding running costs); to give a sense of the size of the financial challenge we face it is worth comparing this £1,034.00 with some typical treatments:

- A hip replacement costs over £6,000
- An outpatient attendance around £200,
- A basic Emergency Department (ED) attendance £57,
- A standard maternity pathway £2,800
- Some complex surgery costing over £30,000
- Continuing healthcare packages may cost over £300,000 per year.

The chart below shows where our 2014/15 commissioning budget will be spent. It is the benchmark for our progress – we aim to see a significant change in future years through the achievement of our goal to shift in the balance of care:



[19]CCG funding formals are largely determined by age – the overfunding challenge in Southampton has been created by a change in the financial weighting for different parts of the population. As a city we have a high student population - generally student age members of the population utilise less healthcare so less funding is received for them. However, the funding formula is not advanced enough to recognise having such a disproportionate student population in a relatively small city may lead to increased healthcare costs.

[20]By the end of 2014/15 we will be 1.4% over funded (£3.923m) and by the end of 2015/16 we will be 1.11 % over funded. There will be decreases each subsequent year with the demands on services likely to increase throughout.

Better Care Fund Finances

As outlined on page 19, in the UK as a whole £3.8 billion has been set aside to support the Better Care Fund initiative. In December 2013 it was confirmed how much each CCG should be putting into the pooled fund as a minimum. Our local minimum requirement is £16.85m in the first year, however, underscoring our strategic approach, we have exceeded this and committed to pooling in excess of £100m over the next 5 years.

Business Rules

NHS England sets CCG a number of financial requirements which they must meet. For example CCGs are expected to deliver a 1% surplus each year. Any surpluses made by CCGs are not lost but returned to the CCG the following year. A CCG may be able to spend some of its surplus however this has to be agreed with NHS England and is driven by agreements by NHS England and HM Treasury.

Meeting the challenges

Making the most of our QIPP opportunities, integrating services though our Better Care Southampton programme and our strategic commitment to bringing the whole system together, we firmly believe we can drive changes that not only mean we can live within our means but which lead to major improvements in outcomes, quality, and patient experience.

For more information on our financial modelling please see Appendix 8.

Your views

In developing our strategy we have taken into account the views, ideas, comments and suggestions of patients, services users, communities, the public, clinicians and a range of other key stakeholders. We have done this through a range of activities including:

- **Southampton Health Conference** – we hosted our first city-wide health conference at St Mary's, the Southampton FC Stadium. The event was attended by almost 150 people from voluntary sector organisations, community and religious groups, health interest groups, the city council and NHS organisations. We were able to share our progress and gain input for our plans for the next five years.

- **Reaching out to our communities** – we organised an event designed for people to have their say about local health services at the Gurdwara Guru TeghBahadur Sahib temple in Southampton. Attended by over 300 local people, the event proved an excellent way for the CCG to work with our local community, and for organisations across Southampton to come together to discuss the future of our health and care services in the city

- We engaging with our **Equality & Diversity Reference group** - members of which represent all nine 'protected characteristics'[21]

[21] It is against the law to discriminate against anyone because of: age; being or becoming a transsexual person; being married or in a civil partnership; being pregnant or having a child; disability; race including colour, nationality, ethnic or national origin; religion, belief or lack of religion/belief; gender; sexual orientation. These are called 'protected characteristics'.

- We engaged with our **Engaging with Communications and Engagement Reference group** - members of which include voluntary groups, carer representatives, charities, co-production groups and pressure groups.

- **Call to Action Consultation –** this nationally-led, locally-delivered engagement programme focussed on how we address the challenges of growing demand, changing needs and reducing funding allocations over the next five years; we used this as an opportunity to discuss the challenges in our city and to help us identify priority areas.

What people told us

The key themes to emerge from this work are captured below; they clearly show the issues of importance to stakeholders and these have been incorporated into our strategic ambitions and planning:

Access
- A desire for more care locally, around the clock
- Better access to GP services was a common theme and need
- There was great support for making better use of the technology –particularly ensuring systems talk to each other (to avoid patients repeating their needs) and making better use of tele-health

Prevention
- People fully supported earlier, better managed discharge from hospital and efforts to avoid readmission / re-enabling people to stay in their own homes
- People are very open to prevention and self management of conditions
- There was a strong feeling that all agencies should support prevention – typical suggestions include addressing community hazards such as broken pavements.

Involving people
- Overwhelming support for involving people in their own care – either supporting self management of long term conditions or through help with making decisions with treatment or care options.
- Strong views that carers needs / role should part of the holistic assessment of health and care need

Involving communities
- Our stakeholders have demonstrated quite clearly that there is a great seam of untapped expertise and energy in the community which needs to be used for the good of all.

Involving other agencies
- There was a recurring theme around the need to take a bigger picture view of health and care needs within communities – we need to do more to bring together housing, education, other Local Authority Services, police and health to address challenges and develop interventions.

You said – We did Framework

Delivering our ambitions relies on open engagement and involvement of our patients, service users, carers, partners and other key stakeholders. As well as activities of the kind described above, we have developed a systematic and embedded approach to insight gathering and engagement and involvement work, via our You Said-We did Framework. Further details can be found in Appendix 9.

Equality Impact Assessment

As part of our commitment to ensuring that all services we commission are fair, equitable, sustainable and of high quality for all people in Southampton, we have carried out an Equality Impact Assessment on this five year strategy. This can be found at Appendix 10.

Part 3: Delivering our Five Goals

Introduction

In this section we detail how we will deliver our strategy. Starting with our **Plan on a Page** (next page), we outline each of our goals in turn explaining what they mean, setting out the guiding principles behind them, and the detailed action plans that support them.

NHS SOUTHAMPTON CITY CCG STRATEGY

THE VISION: *A HEALTHY SOUTHAMPTON FOR ALL*

NHS Southampton City Clinical Commissioning Group

OUR MISSION

To ensure that care is coordinated, safe, sustainable and designed to meet the needs of the people of Southampton.

OUR VALUES

These underpin the vision, drive our behaviour and determine what we do and the way we go about it. We try to live up to these values and they provide a compass to guide us at all times.

Patients First, Every Time | Relentless about the quality of care | Respect for others and their dignity
Courage to do the right thing | Integrity – be honest and decent

GOALS	INTERVENTIONS
A. Make Care Safer	A.1. Nurture a Diverse Range of Safe, Competent Providers A.2. Improved Quality Assurance &Safeguarding A.3. Prioritise Quality Development A.4. Business-like Contract Management of Accountable Providers
B. Make It Fairer	B.1. Reduce Health Inequalities B.2. Promote Equality and Diversity B.3. Uphold the NHS Constitution
C. Improve Productivity *(Achieving more with less, more effectively)*	C.1. Streamline Urgent Care C.2. Efficient & Reliable Planned Care C.3. Prevention, EarlierDetection and Diagnosis
D. Shift the Balance (Better Care Southampton)	D.1. Person-Centred &co-ordinated care closer to home D.2. Better Discharge and Reablement D.3. Engaged & Resilient Communities
E. Delivering sustainable finances	E.1. Strategic Financial Plan Driven by Quality E.2. Plan for the Right Capacity E.3. Deliver Enabling Plans (eg IT, Comms, OD, Estates, Workforce, Research & Innovation)

OUTCOMES

- Improved Patient Safety and User Experience
- Reduced Inequalities In Life Expectancy
- Reduced Avoidable Emergency Admissions
- More Older People Living Independently (91 Days After Reablement)
- Fewer Permanent Admissions To Nursing& Residential Homes
- Fewer Delayed Transfers Of Care
- Reduced Injuries Due To Falls In People Over 65
- 20%Productivity Improvement In Elective Care

Actions Plans – Goal A. Make Care Safer

A.Make Care Safer– this means: we will commission care from safe competent providers**.** We will listen to local people, gather their feedback on their experiences of local services and act upon it:

- Ensuring that we have access to a vibrant, contestable and diverse marketplace and working with providers to drive up the quality of the care they can provide.
- Specifying the quality standards and outcomes that we expect.
- Closely monitoring the quality and safety of services provided and taking decisive action to protect patients when this falls short.
- Cultivating an environment where people learn from mistakes and continuously improve the quality of their services.
- Having effective systems and opportunities for gathering patient feedback.
- Expecting providers to be fully accountable for delivering agreed plans.

Make Care Safer – interventions:

A1. Nurture a Diverse Range of Safe, Competent providers
A2. Improved Quality Assurance & Safeguarding
A3. Prioritise Quality Development
A4. Business Like Contract Management of Accountable providers

A1. **Nurture a Diverse Range of Safe, Competent Providers**

What we plan to do by March 2019 (our aims)	**What we will achieve by 2017 (our expected progress)**	**How we will track our progress**
• The landscape of our locally provided care and support services will be different, with a range of providers and innovative service solutions in place to meet our population's needs. *The aim also links with intervention E2:* Plan for the right Capacity	− We will undertake a thorough analysis of the local care market dynamics to: predict trends in the utilisation of service types across care groups; develop a comprehensive and nuanced picture of service areas where the market is failing to meet demand for local care and support; to empower health and local authority commissioning leads to proactively shape the future landscape of local care and support services. − We will utilise market intelligence to develop a rolling programme of thematically focused and segmented market	✓ A Market Position Statement and forward plan have been developed ✓ Targeted market engagement carried out in advance of any procurement initiation ✓ Expansion in the local supply of tenanted models of care, including those which are suitable for individuals with a low level of nursing need.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	position statements, which will be used to nurture the market for future service providers. − Through our commissioning intentions we will be identifying opportunities, stimulating the expansion of provider capacity, and enabling collaborative work with providers to develop alternative models to traditional care and support. − We will raise the external profile of the Integrated Commissioning Unit as an entity which purchases care and support services on behalf of health and local authorities; this collective influence will enable greater leverage in the development of provision.	
What will change as a result of our plans: ✓ We will have a diverse range of safe, competent providers from whom we can commission quality services for local people.		

A. Make Care Safer

A1. Nurture a Diverse Range of Safe, Competent Providers:
Learning from Francis, Berwick and Winterbourne View

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Francis • All the recommendations from the Francis Report that relate to Southampton will have been fully embedded across all our providers and within our clinical commissioning group **Winterbourne View** • Providers will have a full understanding of the implications and context of what happened at Winterbourne View, and have put in place systems to	− Contracts will include provision for meeting the recommendations and quality and safety requirements. − We will be active participants in the National Patient Safety Collaborative when launched in the autumn of 2014. − Work with providers to ensure key national requirements are implemented including duty of candour, whistleblowing, best practice guidance in determining staffing levels	✓ Ongoing monitoring throughout the year via Clinical Quality Review Meetings. ✓ Visit and assessments reports from the Quality Team

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
ensure safe and effective services **Berwick** • There will be a culture of continuous learning and diffusion of best practice across all commissioners and providers.	− Further strengthen GP involvement in quality assurance of providers − The Core Specification Toolkit all learning disabilities services will be in place, ensuring care of clients with learning disabilities is paramount with a clear focus on reasonable adjustments. − Building on this use, serious incident management will be routinely used to identify themes and trends across the Southampton System and within providers	
What will change as a result of our plans: ✓ The people of Southampton can be confident that they will receive safe, effective, high quality care with a good experience, no matter what health, care or service need they may have.		

A. Make Care Safer

A1. Nurture a Diverse Range of Safe, Competent Providers:

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Infection Prevention and Control • Southampton is recognised as a leader in Infection Prevention and Control, with zero MRSA cases and low numbers of C.diff cases • Achieve high levels of awareness and compliance with the Infection Prevention and Control agenda across Southampton City.	− By 2017 there will be no MRSA bacteraemia cases in Southampton City CCG residents. − The numbers of C.difficile cases will reduce year on year in line with expected national requirements. − The incidence of super resistant bacteria will be monitored and actions taken in line with local and national requirements and recognised best practice to reduce the impact of these infections − Continue work to raise awareness of good hand hygiene and other best practice infection prevention and control standards across the city, supporting reducing the impact of Norovirus and other easily spread infections	✓ MRSA bacteraemia cases will be monitored monthly with Root Cause Analysis conducted in all cases ✓ C.difficile cases will be monitored monthly with trends and themes identified ✓ Super resistant bacterial infections monitored in conjunction with main provider ✓ Audit awareness levels via surveys and focus groups.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	– Work with Public Health on the wider infection prevention agenda including Tuberculosis surveillance, HIV and infection prevention in the Southampton City wider community	✓ Monitoring via regular multi- agency infection prevention quality meetings.
Continuing Health Care (CHC) • Robust and comprehensive management of CHC across all settings to ensure all eligible patients in Southampton City receive • CHC support in a timely and effective manner with high quality service provision balanced with cost effective services. • We will establish an integrated approach to CHC management with Southampton City Council including a shared budget • Establish and embed a children's clinical nurse specialist post for assessment and monitoring of continuing care for children and young people	– The trajectory for the rate of completed CHC review will be o 90% by the end of 2014/15 o 95% by the end of 2015/16 o 98% by 2017 – Elderly mentally infirm reviews completed reaches and maintains 100% compliance – 98% of all self-funding funded nursing care reviews completed by 2017 – Integration of Personal Health Budgets (PHB) into CHC processes so all clients are offered a PHB – Improved range and scope of the CHC liaison post at University Hospital Southampton to encompass additional impact on complex discharge – Establishment of the Continuing Care Children Nurse Specialist post	✓ Reported success against targets ✓ New service / nursing provision in place
What will change as a result of our plans: ✓ Zero MRSA bacteraemia cases in Southampton City CCG patients ✓ Reduction in the number of cases of C.difficile ✓ Raised awareness of super resistant bacteria and minimal or zero cases in Southampton and how to manage / prevent these ✓ Raised awareness in the general population of infection prevention and control ✓ All CHC clients in all care groups, adults and children, will receive timely and effective assessments in line with or better than nationally required timescales. ✓ Assessments and reviews will be high quality and always include the option for personal health budgets for all clients if they wish to take this up. ✓ CHC will facilitate transfers and discharge from hospitals		

A. Make Care Safer

A2. Improved quality assurance and safeguarding:

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Safeguarding adults and children • Southampton will be a safe and health city for vulnerable children and adults.	− Strengthen processes for identifying and monitoring safeguarding standards in all providers − Review contractual standards to ensure they are updated to reflect learning from national and local serious case reviews and policy drivers − Finalise and embed *Integrated Commissioning Unit Domestic Abuse Strategy* and ensure it is put into operation through procurement processes and collaborative working with local partners − Ensure learning from serious case reviews, partnership reviews and single organisation reviews is shared and learning embedded into practice across the city. − Continued active participation in the safeguarding adult and children's multiagency boards in Southampton: multiagency training, audit and promotion of best practice in safeguarding − Continue the quality assurance work with Nursing Residential and Home Care Providers to drive up standards of care and reduce the numbers to zero of those providers being formally managed in safeguarding processes	✓ Audit of safeguarding standards carried out in all providers ✓ Audit and monitoring of the implementation of the Domestic Abuse Strategy ✓ Monthly monitoring of providers being formally managed via safeguarding processes. ✓ Monitor activity via multiagency safeguarding boards for adults and children

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
System wide approach to pressure ulcer prevention • Number of pressure ulcer incidents amongst the lowest in the country making Southampton of the safest places to receive care.	− By 2017 we will expect to see a minimum of a 20% reduction in the development of all grades of pressure ulcers − Ongoing development of a system wider approach to pressure ulcer prevention and management building on the work completed in 2013/14 by CCG's, Providers and NHS England. − This work will include seeking a shared view across Wessex on grading, monitoring and reporting pressure ulcers. A particular focus will ensure the Nursing Home sector is part of the project to support whole system working.	✓ Providers will submit to the CCG monthly data on the numbers of pressure ulcers developed in their care
Serious Incident Management • Serious Incident management processes are embedded in the healthcare system with an open assessment of incidents and diffusion of learning • There will be no never events in the city's provider trusts	− A process of annual deep dives will be in place covering areas identified by the CCG Clinical Governance Committee as areas of concern or focus to address CCG requirements − Work with providers to ensure mechanisms are in place to reduce to zero Never Events with a particular focus on those relating to operative and interventional procedures	✓ Deep dives will be reported to the CCG Clinical Governance Committee on a quarterly basis ✓ Monthly monitoring of Never Events by CCG Quality Report
Primary Care Quality Assurance • Systems will be in place for the monitoring of the quality of services provided within Southampton by GPs. • This will build on the work undertaken by the Primary Care Commissioning Development Manager and team to support CCG Board level assurance on the quality of services.	− First report to be prepared for Q1 completed by 31st July 2014 − We will have clarity and plans for how we how we can further engage primary care practitioners in developing and providing this evidence	✓ GP Quality Report to be presented to CCG Clinical Governance Committee in Quarter 2 2014/15

What will change as a result of our plans:

We will have a safe and effective care across our city:

- ✓ Safe care in all providers
- ✓ Local providers are up to date on national and local learning and this is embedded in practice
- ✓ The Domestic Abuse strategy is in place and being implemented across Southampton
- ✓ No Nursing homes, residential homes or home care providers in Southampton are subject to safeguarding processes and have cautions/suspensions in place
- ✓ System wide sharing of trends, themes and learning from serious incidents to support embedding learning across Southampton
- ✓ No Never Events affecting patients of, or in providers working with, Southampton City CCG
- ✓ To provide the CCG Board with quarterly assurance about the quality of primary care services in Southampton

A. Make Care Safer

A3. Prioritise Quality Development:

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Compassion in practice • All local NHS and non-NHS providers (including the Nursing Home Sector) are implementing Compassion in Practice extending this to all healthcare professionals not just nurses	− Compassion in Compassion in Practice will be embedded across all relevant providers	✓ Monitored via Clinical Quality Review meetings with and via CCG visits to providers
Strengthening clinical leadership • Clinical leadership will be the norm in front line teams with identified clinical champions	− Providers will be actively encouraged to embed robust, high quality clinical leadership in all front line teams − The CCG will have a clear set of clinical champions for all areas of activity	✓ Monitored via contracting and clinical meetings
Best Practice Guidance Implementation • A database supporting the implementation of the range of NICE guidance will be in place. This will include regular horizon scanning for early identification of new guidance	− First version of database will be complete by 30th June 2014 with ongoing development through 2014/15	✓ Monitored via contract performance meetings which include quality, quality assurance visits and other intelligence about providers ✓ Monitored monthly via the CCG Quality Report and Clinical Governance Committee
What will change as a result of our plans: ✓ Patients will receive safe, compassionate services which provide the best care possible, from all healthcare professionals (whatever the setting).		

A. Make Care Safer

A3. Prioritise Quality Development
Prescribing and Medicines Management

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• There will be safe prescribing of items with proven efficacy. • We will be amongst the best performing CCG areas in the country for shared learning through reporting of medication incidents, including Serious Incidents Requiring Investigation (SIRIs).	− We will have more data about performance allowing us to address issues and develop shared learning. This will come through increased reporting by large providers as part of the Quality Premium in during 2004/15 and through GP reporting of incidents to the National Reporting & Learning System (NRLS), as part of the local Quality Improvement Schedule. − GP practices supported to report and keep track of numbers via NRLS − Partnership working with NHS England around community pharmacy NRLS reporting or alternative future options.	✓ Increased rates of reporting by all large providers compared to 2013 baseline levels. ✓ All practices have reported at least one medication incident to the NRLS by July 2015. ✓ Outcome reports and learning points from incidents are reported and shared.
• Electronic Prescribing Systems (EPS) will be embedded in Primary Care GP practices and Community Pharmacies • We will be making the most of Scriptswitch costs as new suppliers and providers enter the market	− EPS will be in place across the whole City by March 2017 (assumes at least one new practice going live every month for 3 years). − At least 10 new or revised pathways involving medicines input each year. − The Eclipse Live pilot (the testing of specialist software for tracking medicines use and compliance) will finish in 5 practices in 2015. If the findings are positive, roll-out across the city will follow.	✓ Quarterly report on number of practices and pharmacies live with EPS, and number of patients receiving repeat prescriptions electronically. ✓ Quarterly report on progress with Eclipse Live, linking with CCG colleagues around medication safety and admission avoidance. ✓ Half yearly report on Scriptswitch costs, savings and acceptance rates by GP practices., followed by full review in March 2016 ✓ Annual review of map of medicine input and planning

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Financial sustainability • Growth in local prescribing costs will be contained to no more than 3% on average every year. • NICE and other good practice guidance will have been fully implemented during the period.	− Annual reviews of patent experiences and new generic savings − Annual reviews of the local impact of national price changes. − Local strategic decision-making on individual medicines and NICE decisions via District Prescribing Committee − Annual reviews of targets within GP Quality Improvement Scheme.	✓ Annual QIPP planning and monitoring of delivery ✓ Half yearly reports to the Clinical Executive Group
What will change as a result of our plans: ✓ Further improved safety, efficacy and financial controls in key areas of prescribing and medicines management		

A. Make Care Safer

A3. Prioritise Quality Development:
Using patient experiences for maximum benefit

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• We will have an understanding of patient experience in every aspect of the services we plan and commission. • Our systems will be comprehensive and focussed on extracting and analysing as much useful data as possible. • Every time a citizen 'touches' the services that we commission, we want to know the nature of the experience. We will then use this feedback to improve services.	− Baseline review of current mechanisms and best practice − Development and delivery of comprehensive programme to create the mechanisms to capture and analyse data. − Demonstrable use of the data in ways the inform and influence services	✓ All current methods of collecting patient experience feedback are mapped and understood. ✓ Regular reports on trends and how they are being used to influence services. ✓ Agreed programme for transforming data collection in place.

Improving Patient and Staff satisfaction • Friends and Family Test (FFT), including the Staff FFT will be embedded across all providers in all health sectors. • Happy, well-motivated staff deliver better care which in turn improves outcomes and patient experiences. We will have in place clear mechanisms which support and encourage providers to help staff to do the best job they can.	− Further roll out of Friends and Family Test (FFT) to services in line with national guidance including outpatients and day services in acute providers and across services in non-acute providers − Support providers in the roll out of the Staff FFT, in line with national requirements − Southampton City CCG providers will be in the top quartile for performance in FFT − The new Patient Experience Service the CCG will be fully embedded to support the collection and analysis of patients and staff feedback.	✓ Monthly reporting via the CCG Quality Report to Clinical Governance Committee
What will change as a result of our plans: ✓ The services that we commission are reflective of patient need. ✓ Feedback is used as a positive way of improving services. ✓ We are collecting patient insight on a scale never before attempted in Southampton ✓ Patients using services commissioned by Southampton City CCG will recommend services to their family and friends and the overall number of negative responses will be significantly reduced. Staff working in providers SCCCG commissions services from will recommend the services to their family and friends.		

A. Make Care Safer

A4. Business-like Contract Management of Accountable Providers

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Contract management • Our contracts are set at a reasonable level, with clear targets, standards and outcomes to be achieved; there will be clear ownership of contracts within the CCG.	− Systematic monitoring of contracts in place − Good, business-like relationships with providers	✓ Monitoring use of contract levers ✓ Monitoring contract compliance and achievement of standards and targets ✓ Contracts agreed on time ✓ Minimal under and over-performance indicating we have contracted the right volumes.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
		✓ Development of remedial / recovery plans where appropriate.
Integrated Commissioning Unit • The Integrated Commissioning Unit will be leading the planning, buying and development of services and for managing contracts across all aspects of health and care that will benefit from joined up approaches.	− We will develop a combined register of contracts held by the CCG and council that are relevant to the objectives of the Integrated Commissioning Unit (ICU), using this as a tool for coordinating a consistent approach to contracts. − We will have developed an operational policy detailing the agreed to contract management including: procurement, mobilisation, performance monitoring, performance/ risk/ quality management, payments, negotiations, variations, and terminations. − All arrangements made for the provision of care and support services (including individual packages of care), will be underpinned by appropriate contractual terms and documentation.	✓ ICU Contracts register developed ✓ Contract management policy developed and adhered to
What will change as a result of our plans: ✓ Enforceable contracts that are used positively to drive achievement, continuous improvement and value for money. ✓ Improved outcomes, patient safety and user experience ✓ Service agreements that deliver demonstrable benefits to patients and value for money		

Actions Plans – Goal B. Make It Fairer

B. Make it Fairer– this means we will reduce the inequalities in access to care across our population through:

- Eliminating variations in the quality of and access to care
- Hearing the voice of disadvantaged people
- Putting people's needs first when commissioning services
- Implementing our equality and diversity policy
- Being accountable for all we do

Our guiding principles/core standards to make care fairer:

1. We will recognise and value the diversity of the local community
2. We will ensure that equality is central to the commissioning of modern, high quality health services.

Make It Fairer – interventions:

B1. Reduce Health Inequalities
B2. Promote Equality and Diversity
B3. Uphold the NHS Constitution

B1. Reduce Health Inequalities

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• We will have reduced health inequalities through targeted approaches and improved access to existing services by protected groups • Better information and advice will be provided about services available in appropriate and accessible formats • People will be able use a Single Integrated Point of	− The expectation of reduced inequalities in health outcomes will be embedded in all our service specifications and contracts − We will have developed and introduced a standardised local system that informs healthcare providers of an individual's learning disability and related health and care needs.	✓ Achievement against the agreed Health and Wellbeing Strategy measures ✓ Achievement against our Outcome Ambitions ✓ Increase in dementia diagnosis rates

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Access to health and social care services, enabling rapid assessment of needs or be directed to the most appropriate service. • We will in particular have reduced health inequalities for people with a learning disability	− Increased dementia diagnosis and improved support following diagnosis	✓ The number of people with learning disabilities and/or mentalhealthissuesaccessing health screening increases year on year.
• We will have addressed health inequalities for people with Mental health conditions by fully implementing the *Parity of Esteem Programme* – a national initiative to reduce the 20 year gap in life expectancy for people with severe mental health illness. This includes working in partnership to tackle areas such as: ▪ Support for young people ▪ Employment ▪ Carer support ▪ Assessing physical and mental health needs holistically ▪ Rapid access to support ▪ More services in local settings ▪ Increasing access to psychological therapies for all sections of our communities • Staff will work with confidence to identify and meet the needs of people mental health conditions across all service areas, ensuring an approach that treats people holistically – addressing both mental health and physical health – through planned programme of training and support.	− Emotional wellbeing is important in minimising the risk of children and young people making poor choices in relation to their long term wellbeing. We will: o Introduce a systematic approach to earlier identification and improved support for young people with mental health problems. o Improve prevention approaches, especially suicide prevention and improved health promotion for those with severe mental illness o Implement an 'Emotional First Aid' programme in schools across the city − Training programme to improve capacity and confidence of frontline staff when addressing both mental health and physical health needs will be running. − Provision for those with dual diagnosis will have improved − People will have early access to "talking therapies" and services which help people retain and return to employment	✓ Annual increase in the number of carers who received health checks. ✓ All mental health providers commissioned by the CCG can evidence assessment of the physical health of inpatients and service users, liaising with their GP's as appropriate. ✓ Increases in number of people appropriately accessing mental health services in Emergency Departments and Inpatient wards. ✓ Tracking the number of older people, BME communities, veterans and children and young people accessing psychological therapies, to ensure improvements. ✓ Take up of places on training courses increases year on year. ✓ Increase in dementia diagnosis and post diagnosis support

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• We will have made improvements in addressing health inequalities by implementing the five most cost-effective high impact interventions (see next column) which have been recommended by the National Audit Office's *Health Inequalities Report* and the Public Accounts Committee Report into *Tackling Inequalities in life expectancy*	− We will have made progress against the five high impact interventions by: o Increasing prescribing of drugs to control blood pressure o Increasing prescribing of drugs to reduce cholesterol o Working with Public health colleagues to increase smoking cessation services, (including focus on people with serious mental health conditions) o Increasing anticoagulant therapy in atrial fibrillation; o Improving blood sugar control in diabetes	✓ Impact on years of life lost from all cardiovascular disease
What will change as a result of our plans: ✓ We will close the gap on health inequalities ✓ Our patients and staff can recognise that the all elements of the Health and Wellbeing Strategy are being implemented locally ✓ People will experience parity of esteem – that is the same access to mainstream services and improved health outcomes if they have mental health needs and or a learning disability		

B. Make It Fairer

B2. Promote Equality & Diversity

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Services will be commissioned in ways that ensure all patients and citizens have the opportunity to take control by adopting a co-production, co-design and co-delivery approach • We will have a truly embedded culture which embraces Equality, Diversity and Human rights, and where staff are confident and feel valued	− Improved equality information and data for commissioning and service planning − Proactive engagement of diverse communities and disadvantaged groups in commissioning decisions − Ensuring all providers collect equalities data and information as part of their contract responsibilities to measure equality and drive improvements	✓ Achieving across all outcomes of the NHS Equality Delivery system (EDS2) ✓ Equality & Diversity Reference group to assess CCG against the 9 patient focused outcomes of the Equality Delivery System ✓ Providers will achieve access rates which more closely reflect the population of Southampton.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	– Embedded approaches to monitoring outcomes and patient, carer and public experiences – Established a representative Citizens Panel in partnership with the City council – Embedded the use of the NHS Equality Delivery system across the CCG and local health system	✓ Increase in numbers of Equality Impact assessments undertaken
What will change as a result of our plans: • People in the most deprived communities and protected groups have access to services and improved health outcomes which more closely reflect the population of Southampton.		

B. Make It Fairer

B3. Uphold the NHS Constitution

The NHS Constitution runs through everything we do and all the actions described in these plans will help us not only fulfill, but exceed our obligations. This intervention is therefore not an end in itself but is intended to ensure we are able to capture our progress in all these different endeavours against the expectations in the Constitution and to ensure that any additional actions are carried out to ensure full compliance.

B3. Uphold the NHS Constitution

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• We will have delivered and upheld the principles, values and pledges concerning provision of care within the NHS constitution, including: • Commissioning sufficient capacity, and creating a vibrant range of provision to ensure equal access, patient choice (as appropriate) and high quality care	– We will have developed strategic modelling tools to test scenarios across health and social care to help refine future commissioning plans to ensure sufficient capacity is available – We will be commissioning efficient and effective emergency care services to provide consistent clinical standards and outcomes seven days a week	✓ Achievement of NHS constitution standards monitored through regular reports to the Governing Body. ✓ Friends and Family test results and patient experience surveys.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• All components relating to urgent and emergency care services consistently throughout the year • Having informed health providers who are able to support patients in making a choice about local health services. • Delivery of safe, effective and patient-centred care across the whole health system • Enable active and influential citizen participation in shaping and developing health and care services	(in line with the 10 national clinical standards for seven day working) – We will have the systems and processes in place to be able to offer Personal Health Budgets to adults, young people and children who would benefit from this. – We will be working closely with NHS England's direct commissioning teams and the Wessex Strategic Clinical Networks to ensure that Specialised Services are safe and sustainable, with is sufficient capacity in the local system.	
• We will have delivered and upheld the principles, values and pledges concerning staff and members: • We will have active leadership from, and engagement with CCG members, using appropriate processes and systems with clear, relevant and timely feedback • We will be a knowledgeable and high performing organisation which attracts motivated people and members • We will be an organisation where people can develop and progress in their careers • Our employees will have access to effective support to improve their own health and wellbeing (see also Organisational Development Plan on p 66)	– We will have made great progress against our Organisational Development (OD) framework, which is aligned to our 5 year strategy and annual business plans, and covers staff and CCG membership development. – We will be running bespoke packages of leadership development opportunities (clinical and managerial) aligned to organisations strategy; there will also be identification of leaders and active succession planning – We will continue to develop apprenticeship opportunities and graduate trainee opportunities – We will have in place a clear method for encouraging, capturing and acting on new ideas and innovations amongst CCG members will be encouraged and acted uponthrough a clear method of capturing and sharing these with the members	✓ GP membership satisfaction ratings regarding to their relationship with the CCG ✓ Use of feedback tools by clinicians ✓ Delivery against the OD action plan ✓ Staff feedback and personal development plan reviews ✓ Successful recruitment of apprentices and graduate trainees ✓ Staff retention rates
What will change as a result of our plans: ✓ Our patients and staff can recognise that the all elements of the NHS constitution are being implemented locally		

Action Plans – Goal C. Improve Productivity

C: Improve Productivity *(achieving more with less, more effectively)*

We will bring control to the acute healthcare system. This means:

- Providing swift access to the right care when people become unwell
- Providing effective alternatives to hospital admission
- Ensuring people receive the most effective and efficient care when they need treatment in hospital
- Supporting people to get the onward care they need as soon as they are ready to move on from hospital

Our guiding principles/core standards for improving productivity:

1. Uphold the NHS Constitution by ensuring that patients receive treatment within the requirements of the NHS constitution by commissioning capacity that is available and accessible to all.
2. Care is high quality and in particular that patients experience is good, with the best possible clinical outcomes.
3. The delivery of care is designed around the needs of the patient, not organisations.

Improve Productivity – interventions:

C1.Streamline Urgent Care
C2. Efficient & Reliable Planned Care
C3. Prevention, Earlier Detection and Diagnosis

C1. Streamline Urgent Care

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• A clearly defined Urgent and Emergency Care System that aligns with the national requirements to be detailed in NHS England Review of Urgent and Emergency Care	– The NHS England review will take place in 2014/15 – will create a full action plan in response to the recommendations and begin implementation. – We will develop our Urgent and Emergency Care system in light of: o The learning that the system has done during the delivery of the Emergency Care Intensive Support Team (ECIST) Whole System Action Plan since it began in 2012/13.;	✓ An agreed joint urgent and emergency care vision in line with national strategy across all localities ✓ Effective joint working and collaboration with key local CCGs, members, providers and stakeholders ✓ An urgent and emergency care system

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	o The progress of our Better Care Southampton programme and its impact on the Urgent and Emergency care work o The needs of Specialist Commissioning working through the Strategic Clinical Networks (especially Major Trauma) to ensure local services are safe and sustainable	map that shows: · patient flows · number and location of emergency and urgent care facilities · services provided · the pressing needs and future needs for our population
Patients will be choosing services appropriate to their urgent care needs: • People are well informed about the services that are available and are able to choose well • NHS 111 is being used as *the* gateway into an Urgent and Emergency Care system that is easy to navigate.	− The NHS 111 Directory of Services will be developed to show the map of Urgent and Emergency Care, to aid decision making. − The early findings from the initial implementation of the Better Care Southampton will be being considered for inclusion in the NHS 111 Directory of Services. − We will have a single set of call taking software being used in 999 and NHS 111 services to eliminate waste and confusion. − Shared decision-making techniques will be being tested in Urgent and Emergency Care − Where clinically appropriate, NHS 111 will be able to book patients into the right place − Ambulance services will be supporting the delivery of urgent and emergency care across the system with a focus on the needs within a non-acute environment	✓ Increased use of 111 ✓ Increased use of the Minor Injuries Unit ✓ Reduced conveyances to hospital ✓ Increased levels of self-management by patients and carers
• There will be demonstrable improvements in clinical decision making	− Ability to 'treat' over the phone will be enhanced − NHS 111 will have piloted access to clinical opinion based on the well-developed concepts for elective clinical decision making (Map of Medicine and Advice and Guidance)	✓ Reduction in frequent 'callers and attendees' ✓ Improved management of patients at risk of falling
• New approaches to dealing with Serious or Life Threatening Emergency Care needs will see: ▪ Consistent levels of senior clinical staffing. ▪ Senior clinical decision making seven days a week in accordance with demand profiles. ▪ Consistent access to rapid diagnostics seven days a	− The right level of Emergency Care capacity will be in place at our main acute service provider (University Hospital Southampton (UHS)) to cater for current and future needs − Core requirements of a Major Emergency Centre have been fully implemented at UHS.	✓ Reduced length of stay for those patients requiring admission ✓ Fewer patients spending time in a Clinical Decision Unit and being discharged having not had a procedure

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
week. • Where patients are admitted, they can expect the following to be in place: ▪ Daily consultant led ward rounds ▪ Early and frequent review. ▪ No delays: patients move through the care pathway with no differences in discharge flow rates because of the day of week.	− Clinical decision support tools are being tested in 50% of specialties − Full provision of support services in place: on site critical care, acute medicine, acute surgery, Trauma &Orthopaedics, Major Trauma. − Real time capacity management in support areas. − Management of patient flow across providers and by providers against a set of jointly commissioned flow metrics − Ambulatory Emergency Care is being used as much as possible to support the wider system capability and response.	✓ Reduced emergency re-admissions within 30 days of discharge from hospital ✓ Improved pathway and patient experience for patients attending hospital with chest pain ✓ Reduced number of Ambulatory Care Sensitive admissions ✓ Reduced number of Delayed Transfer of Care ✓ Ambulatory Emergency Care provision and performance will be benchmarked against national comparators
• There will be improved levels of efficiency and resilience of the Urgent and Emergency care System	− Improved system capacity through more joined up planning and management: o Predictive and resilient planning and management by providers across pre hospital, hospital and community services − Plans for effective management of surges in demand will be developed and implemented	✓ Sustained achievement of performance standards across all urgent and emergency care providers
What will change as a result of our plans: ✓ Patients receive treatment within the requirements of the NHS constitution by commissioning sufficient capacity ✓ Care is of a high quality and in particular the patients experience is good, with the best possible clinical outcomes ✓ Delivery of care is designed around the needs of the patient ✓ 15% reduction in emergency activity ✓ Delivery of Better Care Southampton Outcomes ✓ Value for money is delivered		

C. Improve Productivity (*Achieving more with less, more effectively)*

C2. Efficient & Reliable Planned Care

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Patients and carers will be at the heart of commissioning decisions for elective care	− We will be using large scale patient insight to improve services − There will be significant patient and carer involvement in the development of new service specifications, review of current services and tender evaluations − Shared decision making will be standard practice in all elective clinical decisions − We will also seek to improving patient awareness, access to screening and ways to self-manage conditions	✓ Increase in use of Shared Decision Making. ✓ Patient surveys
Getting people to the right place first time: • All referrals will be through an electronic system which will eliminate duplication and waste. • Decisions to refer will be supported through clinical decision support tool (currently Map of Medicine) and Advice and Guidance from secondary care	− Referrals for routine and urgent care through an electronic system become the norm. − Shared decision making will be standard practice in all elective clinical decisions	✓ Level of utilisation of e-referral by referrer and provider ✓ Monitoring the take up of shared decision making.
Eliminate waste and duplication across all stages of treatment: • Patients will need to attend hospital on fewer occasions to be treated. This means: ▪ Access to diagnostic results on first attendance to assist more rapid clinical decision making ▪ Face to face follow ups with consultants will reduce, with more telephone advice, community based nurse led care, and patients in control using decision support tools.	− GP Direct Access services in place − Development of Rapid Access to diagnostics - one stop models of rapid diagnostics tested and recommendations made − All providers are using the electronic Picture Archiving and Communication System (PACS) to support faster diagnostics − Increased levels of community based consultant and non-consultant led outpatient services	✓ Patient insight into service effectiveness ✓ Reduction in intervals between treatment along pathways ✓ Reduction in face to face follow ups inT&O; ENT; dermatology and ophthalmology

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	− More treatment opportunities closer to the patient in community settings − Targeted reductions in face to face follow ups forTrauma&Orthopaedic (T&O), Ear Nose & Throat (ENT)	
We will re-shape the way Acute Hospital Services are delivered: • Using new techniques and ways of working to deliver more outpatient procedures instead of day cases. • Where there is a requirement for more detailed treatment, more will be carried out as day cases instead of inpatient stays overnight. • In tandem with this, the length of stay for patients will be reduced through the use of Early Supported Discharge, Enhanced Recovery Programmes and 'Hospital at Home' initiatives. • Developments will be supported by a clinically led rolling programme of work to review and re-specify pathways at specialty level.	− Pathways in T&O, ENT , Dermatology and Ophthalmology services will have been redesigned and commissioned to reflect the productivity criteria − Shared decision making will become a standard practice in all elective clinical decisions	✓ 8% productivity improvement ✓ Reduce Acute Length of Stay (occupied bed days)
• 20% Productivity Improvement In Elective Care	− Progress against the following targets: o 24% reduction in first face to face outpatient attendances o 34% reduction in face to face follow up attendances o 4% reduction in outpatient procedures o 25% reduction in day case procedures o 14% reduction in elective inpatient admissions − Progress will be achieved through the Better Care Southampton programme (see Goal D below) and particularly in relation to: o More informed decision making by users and clinicians o Increased support, education and provision in primary and community care o Fewer routine follow ups, better use of technology and support for self-management	✓ Activity and Performance reporting to the Governing Body and Senior Management Team ✓ Progress of the Better Care Southampton programme.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	o Shift from day cases to outpatient procedures, reduction in procedures of limited clinical value, reductions in length of stay and reduced readmissions or "re-do" operations	

What will change as a result of our plans:

- ✓ Patients receive treatment within the requirements of the NHS constitution by commissioning sufficient capacity for example, within 18 weeks from referral to treatment for routine care.
- ✓ Care is of a high quality and patients experience in particular is good, with the best possible clinical outcomes.
- ✓ Delivery of care is designed around the needs of the patient.
- ✓ Value for money is delivered
- ✓ 20% Improvement in productivity in Elective care

C. Improve Productivity (*Achieving more with less, more effectively)*

C3. Prevention, Earlier Detection & Diagnosis

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Ensuring that services that provide early diagnosis and detection are performing in the top 20% nationally. • We will have fast access to diagnostic tests and reports will be shared electronically amongst the relevant health professionals and the patient	− Cancer two-week-wait pathways reviewed and re-specified − Scope of NHS England's direct commissioning screening is understood and correctly deployed to meet our city's needs. − Closer working with the relevant strategic clinical networks to develop and implement solutions − Shared decision will become a standard practice in all elective clinical decisions	✓ Compliance with Cancer Standards

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
What will change as a result of our plans: ✓ Patients are seen more quickly with faster decisions on treatment options ✓ Better outcomes, better experiences ✓ More efficient use of service capacity and capability		

Actions Plans – Goal D. Shift the Balance (Better Care Southampton)

D Shift the Balance: We will work hard to integrate health and social care services to ensure a better more streamlined experience for local people. Together with patients, communities and partners we will co-produce coordinated care through the Better Care Southampton programme. This means:

- Engaging with people and communities to find out what works best for them and building community assets
- Prioritising prevention and early identification of illnesses.
- Creating integrated locally based health and social care teams to provide community based care that is tailored to the needs of individuals; providing more care closer to home.
- Shifting the balance of care from treating acute illness towards prevention and maintaining independence.

Shift the Balance – interventions:

D1. Person-Centred & co-ordinated care closer to home
D2. Better Discharge and Reablement
D3. Engaged & Resilient Communities

D1. Person-Centred &co-ordinated care closer to home

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Health and care services are integrated around local clusters of practices. • Multidisciplinary teams of health staff (community nursing, therapists, geriatrician, MH nurses, and primary care staff), social care staff, housing workers and the voluntary sector are fully operational.	− 6 x cluster teams in operation across the city which bring together health and local authority staff alongside voluntary sector and other community workers to provide joined up care − Common assessment tool in place and fully operational − Shared care plans for 2% of the population with identified accountable professional − 7 day working within teams − Development of a personalised care promoting workforce across all services	✓ Increase in number of integrated person centred care plans in each cluster ✓ Year on year growth in positive feedback from service users and their carers ✓ More staff with the skills to promote person centred care ✓ Increased engagement in community services ✓ Increased uptake of direct payments/ personal health budgets

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	− Greater adoption of Personal Health Budgets, Personal Budgets and uptake of direct payments as the method of arranging care and support to meet individual need − Full integration of mental health into the integrated care model − Increased use of self management approaches − Increased use of technology for delivery of services and support.	✓ More people have self management plans ✓ Increased use of telecare/telehealth
• Single point of access for integrated health and social care will be operational providing easy access city wide to good quality user friendly information that allows people to assess their own needs and choose the best solutions.	− Single point of access tested ready for full roll-out. − Support mechanisms implemented and information needs identified and met.	✓ Positive feedback from service users and their carers ✓ Increased engagement in community services

What will change as a result of our plans:

✓ People will feel more in control and better able to maintain their independence, drawing on their own strengths and resources and those of their community.
✓ People will be able to draw up their own care plan, in partnership with professionals and others where they choose.
✓ If they choose to do so, more people will be able to receive their personal budget as a direct payment and source their own support.
✓ Professionals from different sectors will work together as a single team, trusting each others' assessments, thereby reducing duplication and the need for people to keep repeating their stories.
✓ People's needs will be met earlier and there will be a greater focus on planned care with fewer unplanned attendances and admissions.

D. Shift the Balance (Better Care Southampton)

D1. Person-Centred &co-ordinated care closer to home

Co-commissioning primary care

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Develop a city-wide sustainable model for primary that is able to support and deliver a wider range of integrated services in the community (to help meet the challenge of complex needs and growing demand) • Have in place a model of primary care that is able to respond to major planning developments and to drive and influence collaborative commissioning across pathways to ensure seamless, integrated services • GP practices have also developed "cluster" groups within local neighbourhoods and community nursing has realigned their services around these clusters.	– Develop and agree a clear vision for the provision of hospital services (supported by business cases to deliver new provision where needed) – We will have carried out a significant programme of engagement with local individuals, groups, services and organisations in to discuss and agree fundamental changes – Working strategically with our neighbouring CCG (NHS West Hampshire CCG) we will have assessed the benefits and be implementing the outcomes of co-commissioning primary care with NHS England – Building on our progress already we will have completed the national roll out of a Risk Stratification & Care Planning Directed Enhanced Services (DES)	✓ Partnership approach with NHS England agreed ✓ GP engagement plan agreed and being implemented ✓ Public & Stakeholder plan agreed and being implemented ✓ Regular reports to Governing Body

What will change as a result of our plans:

✓ A modernised, sustainable primary care model for Southampton that is able to effectively manage with 21st century demands on services

✓ Systematic and active CCG engagement in the planning of local primary care and specialist services to address local population need

D. Shift the Balance (Better Care Southampton)

D2. Better Discharge & Reablement

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• An integrated health and social care discharge and reablement service that is available 7 days a week. • Enhanced level of provision to provide more to people with reablement opportunities, supporting effective and timely discharge and reducing the risk of readmission.	− A single enhanced discharge and reablement service and pathway will be in place	✓ Evidence that discharge planning is starting at the point of admission - monitoring of expected discharge dates and plans in inpatient notes ✓ Evidence that assessment of people's community care needs is being undertaken in community setting (as opposed to in hospital) ✓ Reduction in delayed transfers of care ✓ Increased numbers of people accessing reablement services ✓ Fewer people being readmitted within 91 days following discharge into reablement services
• Implementation of a strong reablement culture across wider community provision which promotes independence and supports people to engage with existing support in the community	− Development of a strong reablement focus, through awareness raising, training and clear service specifications within: o The 6 x cluster teams o Domiciliary care o Nursing and residential home providers	✓ Increased engagement in community services ✓ Evidence that providers are building independence-promoting activities into their routine contact with clients ✓ Positive feedback from service users and carers
What will change as a result of our plans: ✓ More people will be supported to maintain their independence for longer or regain independence following a period of illness ✓ There will be reduced demand for nursing/residential care or long term social care input ✓ There will be less demand on acute inpatient care – reduction in admissions/readmissions, shorter lengths of stay, fewer delayed transfers of care		

D. Shift the Balance (Better Care Southampton)

D3. Engaged & Resilient Communities
Building Community capacity

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Provision will be in place that maximise local capacity to support health and well-being of community, including local action to reduce loneliness and social isolation	− Proactive support through voluntary sector partners to attract and maximise alternative funding opportunities (eg. Big Lottery, Trust funds) into local communities of identity (eg. ethnicity, diagnosis, neighbourhoods) − Provision of an integrated health and social care information, advice and guidance service, linked to single point of access − Development of markets and communities to provide an active and vibrant environment for social enterprise, micro enterprises and self-help mechanisms to flourish − A care/support navigator role to act as a single point of contact in each cluster.	✓ Increase number of community groups and activities within each cluster (based on 14/15 baseline) ✓ Greater knowledge of community resources available (more information available) – tested via surveys and usage rates ✓ Increased engagement of local people in community services (based on 14/15 baseline)
• Increased support for carers, underpinned by better information for carers, greater identification within community services and increasing assessments	− Increased range of carer support services − Provision of an integrated health and social care carers' information, advice and guidance service, linked to single point of access − Greater awareness and identification of carers needs amongst frontline services	✓ Increase in numbers of carers identified from baseline of 3,000 in April 2014 ✓ Positive feedback from service users and carers ✓ Greater knowledge of carers support - more information available through range of resources
• Greater encouragement and support for individuals to understand and maximise opportunities for developing social capital through peer support, mentoring, time banking, local networks and community integration	− Implementation of support planning services to empower and enable individuals to plan their own care − Support to those with single diagnosis or low to moderate	✓ Quarterly increases in the number of people involved in planning their own care.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	eligibility for care service support (using the Fairer Access to Care Services methodology).	

What will change as a result of our plans:

- ✓ Engaged and resilient communities and citizens who feel part of their local network
- ✓ Less reliance on public sector services
- ✓ Reduction in admissions to acute sector
- ✓ Reduction in permanent admissions to residential and nursing homes
- ✓ Reduction in readmissions
- ✓ Improvement in numbers of delayed transfers of care from hospital

Actions Plans – Goal E. Deliveringsustainable finances

E. Delivering sustainable finances

We will build a strong and robust foundation to enable us to tackle the challenges we face and effectively deliver our plans. This means:

- Planning sustainable finances - taking a realistic long term view about future resources
- Developing a balanced financial plan
- Developing a contracting plan to deliver the agreed outcomes that is fit for purpose
- Recognising the interdependence of partners in the system and the need for strong viable providers

Delivering sustainable finances – interventions:

E1. Strategic Financial Plan Driven by Quality
E2. Plan for the Right Capacity
E3. Deliver Enabling Plans (Communications, OD, IT, Estates and Workforce)

E1. Strategic Financial Plan Driven by Quality

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Through our Better Care Southampton programme we will have shifted the balance of funding by 15% from acute to community provision: o Our current 54% spend on acute care will reduce to 47% of our annual budget o Our spend on community will rise from 10% to 17% of annual budget.	− By 2017 our spend on community care will have increased to 14% and our acute spend fallen to 50%. This will be achieved through the plans relating to our Better Care Southampton programme.	✓ We will regularly track and report on the allocation of budgets to measure our progress against our aims to shift the balance of funding across our services.
• We will have ensured that national requirement to reduce our running costs by £692,000 over the next 5 years does not lead to gaps in the delivery of our plans.	− A full review of our services / support needs will have taken place to determine the most cost effective ways for delivery – this could be a mixture of efficient in-house provision, services provided in partnership with the commissioning support unit, council or another CCG. − The findings of the review will be implemented	✓ Review progress and outcomes ✓ OD plan as a key enabler

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Our share of the national funding gap (the 'QIPP challenge') will reach as much as £89m by 2020/21. By 2019 we will have delivered 85% of our QIPP target with clear plans in place to achieve the remaining 15% by 2021.	− We will have a transformational change programme which looks forward 3 years (rather than the current 1 year). − Programme management team in place to support the transformation − Our transformational change programme will have a key focus on the quality of services, recognising quality is a key driver of efficient and safe services.	✓ Programme management team progress and exception reports
What will change as a result of our plans: ✓ We will have sustainable finances which gives freedom to invest in services which enhance the quality of care for the patients of Southampton ✓ We will have in place clear longer term (rolling) transformational programmes which support our ambitions		

E. Delivering sustainable finances

E2. Plan for the Right Capacity

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• There will be a broad spectrum of providers delivering capacity to the system and helping to ensure safe and sustainable routine elective capacity for our patients and service users.	− A procurement of routine elective capacity at the Treatment Centre at the Royal South Hants Hospital will take place in 2015. − We will be working with co-commissioners on strategic capacity planning and management, using near real-time information. − We will be working in partnership with NHS England's Specialist Commissioning and Strategic Clinical Networks to ensure safe and sustainable specialised services	✓ No 'on the day' cancellations due to lack of capacity ✓ No medical outliers due to lack of capacity. ✓ Consistent delivery of Referral to Treatment standards by all providers across all specialties ✓ Consistent delivery of the Emergency Department Type 1 Operating Standard at UHS to ensure capacity and outcomes
• We will have a vibrant and contestable provider market within the city covering a range of health and care service	− Working jointly with SCC we will clarify our intentions over a 3	✓ New providers (or new services from existing providers) are commissioned

demand. • Patients and service users will have more choice and greater provision in their communities See also A1'Nurture a diverse range of Safe, Competent providers'	year period through a statement of requirements. – This will be underpinned by regular briefings to potential providers in order that the opportunities can be understood and potential bidders are able to develop provision and become 'business ready'. – Increasing opportunities for self-reliance and community resilience	✓ Increased inward investment in the city ✓ New providers / services create jobs ✓ Waiting times for new services are within agreed targets, expected outcomes are achieved ✓ There is demonstrable development of business start-ups ✓ Equality of provision is achieved across all the city's communities
What will change as a result of our plans: ✓ Patients and service users will have more choice and greater provision in their communities. ✓ Equality of provision willbeachieved across all the city's communities. ✓ Services will be joined up and more responsive to patient, service user and carer needs.		

E. Delivering sustainable finances

E3. Deliver Enabling Plans (eg IT, Communications, OD, Estates and Workforce)

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Information Technology • By 2019 the information technology used by the CCG, its GPs and the local health economy will support innovation and the requirement for IT systems to "talk to each other". • Our IT systems will enable the provision of a comprehensive patient record for clinicians to use in supporting the delivery of joined up health and care services for patients.	– The programme of work should be close to completion by with mobile working in place to support care provided to patients outside of a hospital setting.	✓ An agreed IT strategy and action plan is in place ✓ Development group established to drive and monitor progress against the strategy, ensuring close working with the Better Care Southampton programme. ✓ Roll-out of testing during 2016/17 ✓ Our IT Development Group will monitor the progress.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Business Intelligence • GP members will routinely receive detailed information in relation to their usage of acute capacity, enabling them the nature and pattern of understand referral and how this compares with an indicative budget. • GPs will be able to query patient level data (in relation to their patients) to inform assessment of need the commissioning of the right pathways and services. • Sources of data will be better integrated to provide a single view of activity between the CCG and Providers – this will be providing us with an increased complexity and depth of analysis, improving our ability to easily compare provider performance and benchmark locally.	− We will have fully mapped data sources to support our work across the commissioning cycle. − A significant project to strengthen the ability of the Provider Management Service to scrutinise providers in key areas and to improve provider management reporting to us will be concluded and findings implemented. − Work to enable integration of data sources will be complete.	✓ Our IT Development Group will monitor the progress of this workstream.
Communications & Engagement • People will be involved in planning, developing and monitoring services at all levels. • We will have a strong reputation as an open, responsive, clinically led and successful organisation. • Patients and services users will be able to access information sources about what is going on, about their care and about their choices in a variety of ways and formats – from traditional paper and print to the very latest in mobile accessible information, • Staff and clinical members will feel part of our organisation, our communities and our success.	Through our communications strategy and plan and our engagement plan, we will have: − Created a range of opportunities for people to be involved with our work, making the most of user-led technologies to encourage participation and engagement with protected groups. − Established up easy to use channels to gather patient feedback and ensure this is suitably analysed and used to support decision making − Engaged member GP practices in our work, encouraging and enabling them to become champions and leaders of change and innovation − Developed and implementing plans for: media, campaigns, web/digital & social media, and internal communications (as part of the overarching strategy) as essential enablers for the above achievements. − Established or become members of networks across the public and voluntary sector (living the ethos of integration) to work together in partnership to ensure messages, opportunities, innovations and collaborations are used to maximum effect and impact.	✓ Agreed communications strategy and action plan published during 2014/15 ✓ Year on year improvements in staff, members and patient feedback (/surveys) scores which test how engaged, informed, involved people feel. ✓ Stakeholder reputation survey ✓ To test progress and to ensure findings support decision making.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Organisational Development (OD) • To have further developed the capability and capacity of individuals, teams, departments and members of the governing body • There will be continued dedicated time for all member practices set aside for audit, research, education and training • Our staff, members and partners recognise the vision, mission and values of our CCG, enacting and championing them as appropriate. • Our organisation is recognised as a leader integration and attracts the highest calibre clinical and management talent.	– OD plan in place delivering: o Development of clinical leadership roles o Review of effectiveness each year o Chair to undertake 1-1 sessions to plan for future leadership of the CCG o Facilitated development programme for board members o An embedded performance development framework to enable and support delivery on an individual, team and organisational level o An enhanced appraisal process which reviews performances and aligns staff to our goals; roles and responsibilities are clear and learning and development is identified and supported (supported by PDP's) o An organisation where membership and core CCG business are one and the same; GP members feel involved, valued and recognise opportunities to influence and drive improvements o Clarity across the organisation of our vision, mission, values and objectives – For TARGET to be in place 6 times a year (four main events and two in house events)	✓ Clinical involvement and engagement in projects and service re-design with regular review with the Chair, Clinical Executive Group and Board ✓ Ongoing programme of TARGET days and evaluation ✓ Agreed OD and action plan in place ✓ Staff survey responses ✓ Appraisal completion rates and quality assurance ✓ Membership survey responses ✓ Recruitment & retention performance.
Workforce • We will achieve the standards set out in the 'Mindful Employer' Charter • Staff feel valued, supported and properly organised to deliver our ambition programme	– We will have completed a formal assessment under the Mindful Employer Charter, using outcomes and recommendations to help us achieve the standards set out – Policies and procedures will be fully operational to ensure a safe and healthy work place – Develop channel to effectively work with and support member practices – Clear links with OD and communications are made and maintained	✓ Mindful Employer status ✓ Staff survey results ✓ Turnover, recruitment, retention and sickness rates ✓ Exit interview data
Estates • Health estate will be rationalized as part of a wider City Programme to better manage the public estate and thereby ensure value for money	– Working jointly with the council, partners, patients and the public, we will have developed a plan that rationalizes the Public Estate in Southampton City. – Phase one covering three strategic sites will be underway.	✓ Agreed estates strategy and implementation plan in place ✓ Clear rationale and intended benefits understood

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
		✓ Estates strategy enables joined up working and service integration.

What will change as a result of our plans:

✓ We will be high performing, lean CCG organised in the most effective ways, using highly committed skilled staff and GP members to help drive and deliver our vision of *A Healthy Southampton for All*

E. Delivering sustainable finances

E3. Deliver Enabling Plans

Research & Innovation

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Our commitment to research and innovation will be delivering benefits across our entire strategic programme with a continuous pipeline of activity that stretches beyond the life of our current 5 year strategy	– Report and recommendation from the formal assessment of the integrated care demonstrator site in Woolston and Weston will have produced results for diffusion across the city and beyond. – Demonstrable use and return on investment from our commitment to the University of Southampton's to Whole System Capacity Modelling Tool and use of discipline of "Systems Dynamics", Operational Research Techniques	✓ Demonstrable contributions to priority setting of the Collaboration for Leadership in Applied Health Research and Care ✓ Membership of the Wessex Academic Health Science Network ✓ Active participation in Southampton Connect, an inter-sectoral forum that includes both universities in the City. ✓ Reports from formal research projects, particularly those underway in partnership with University of Southampton ✓ The development of a Whole System Capacity Modelling Tool (in partnership with University of Southampton)

What will change as a result of our plans:

- ✓ Research and Innovation will be central enabler in the way we approach planning and development of service provision
- ✓ Our work will yield local and national benefits
- ✓ Patients will benefit from improved outcomes and a safe and sustainable local healthcare system.

NHS
Southampton City
Clinical Commissioning Group