NHS Southampton City CCG Two Year Operational Plan (2017-19)

Making Southampton a healthy city for all and supporting delivery of the Hampshire & Isle of Wight Sustainability & Transformation Plan (STP)

NHS
Southampton City
Clinical Commissioning Group

Contents

Foreword

In December 2015, NHS England and NHS Improvement set out a series of mandatory national priorities and requirements in the planning guidance. For the first time, every organisation across the health and care system was asked to come together to create a shared plan, called the Sustainability and Transformation Plan (STP), for tackling the three 'gaps' of the Five Year Forward View:

- Health and wellbeing – requiring a radical upgrade in prevention;
- Care and quality – requiring integrated, person-centred care;
- Funding and efficiency – closing the affordability gap.

The local 'footprint' we chose for this STP is Hampshire & Isle of Wight (HIOW) and Southampton City Clinical Commissioning Group (CCG) will play its full part in this, building on the approach we have developed with our partners in the City. Across this system, we face a number of significant shared challenges which means that the way services are provided needs to change:

- Demand for health and care is growing at an unaffordable rate whilst people are living longer, they are increasingly spending longer in poor health;
- Too many people are admitted to hospital and stay in hospital longer than they need to;
- In most sectors we struggle to recruit and retain sufficient numbers of staff;
- As a result, many of our critical health and social care services are under severe pressure.

Throughout 2016, leaders across Hampshire & Isle of Wight health and care organisations have come together to develop a plan of how we will work together to tackle our shared challenges. In October 2016, a delivery plan was produced which outlines the core priorities for the HIOW STP over the next few years. These include:

- Deliver prevention, early intervention and self care at scale and with the support of new technologies;
- Accelerate new models of integrated local care and ensure sustainability of general practice;
- Address the issues that delay patients being discharged from hospital, learning from recent achievements in Southampton;
- Deliver the highest quality, safe and sustainable and efficient acute services to Southern Hampshire and the Isle of Wight, and;
- Improve the quality, capacity and accessibility of specialised mental health services whilst joining up care with other local community services.

The STP enables a proportionate, tiered approach: successful collaboration at scale on the issues that need it, whilst maintaining a focus on local action connected to communities.

The Southampton City CCG Operational Plan is fully aligned with the wider aims of the STP and translates them into practical action. It continues our local journey, working with our partners in Southampton City Council and providers in the City to deliver our Better Care Southampton programme. Our plan details how, over the next two years, together we will achieve reconfiguration of health, social care, housing and other services into integrated teams based around populations (clusters) of 30-50,000 people building on the GP practice registered list that is the backbone of primary care. It shows how, working with the voluntary sector and building strong supportive communities, patients and service users will benefit from easier access to information and have more control and support over their care. GPs will be collaborating with housing, social workers, community nurses and therapists to discuss and understand the whole needs of individuals and their communities. Pooling knowledge and experience means we bring a more joined up and considered approach to care.

Our Operational Plan also meets the requirements of the NHS England planning guidance for 2017-2019, specifically:

- To deliver national standards
- To deliver business rules
- To deliver the Five Year Forward View nine "must do's"
- To demonstrate how our Operational Plan will support the delivery of the HIOW STP

The action plans in this document have been developed by our CCG leads and outline our work programmes over the next two years to deliver significant changes required to achieve both the CCG objectives and the delivery of the HIOW STP.

In particular, our plan demonstrates how we will meet national commitments to invest in mental health and in primary care, whilst also following the principles of the STP in terms of shifting the balance of investment away from hospital services supported by evidence of realistic and quantified actions. The stable platform of control that has been the result of diligent work over the past three years will now be converted into lasting positive change.

We will monitor our plan on a quarterly basis with a half year review at our CCG Governing Body. Overall, our plan will take us much closer towards our vision of making Southampton a healthy city for all.

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Hampshire & Isle of Wight STP priorities

Prevention at Scale
To deliver a radical upgrade in prevention, early intervention and self care

Better Care Southampton
To accelerate new models of integrated local care and ensure sustainability of general practice

Effective Patient Flow & Discharge
To address the issues that delay patients being discharged from hospital

Acute Care System
To ensure the provision of sustainable acute services across Hampshire & Isle of Wight

Mental Health
To improve the quality, capacity and access to mental health services

Enablers: Digital, Estates, Workforce and New Commissioning Models

Southampton City Clinical Commissioning Group (CCG) vision & objectives – "A healthy Southampton for all"

- **Behaviour change:** Improve health outcomes through behaviour change initiatives that support healthy choices.
- **Cancer:** Improve cancer screening uptake, earlier cancer diagnosis, survival rates and deliver NHS constitution standards.
- **Diabetes prevention:** Reduce the risk of patients developing Type 2 diabetes through education, support to lose weight and physical exercise programmes.
- **Falls prevention:** Improve falls prevention services to ensure people who have had a fall or are at risk of a fall have access to effective prevention services.
- **Care technology (telehealth):** Increase the independence and quality of life for vulnerable older people, individuals with a learning disability and others.

- **Integrated health & social care (Better Care Southampton):** Develop integrated health and social care which provides community based person-centred care closer to home and develops integrated provision for 0-19 year olds.
- **Long term conditions:** Develop care pathways in the community for people with long term conditions to improve case finding, management and support.
- **Primary Care:** Develop a strong, effective and sustainable model of primary care which improves access, quality, infrastructure, workforce and collaboration.
- **Learning disabilities:** Deliver actions to transform care for people with learning disabilities.
- **End of life & complex care:** Improve the experience of care in the last year and months of life.

- **Discharge planning:** Ensure that every patient has a discharge plan which is understood by professionals, the patient, their relatives and carers, and includes plans for any future care needs.
- **Effective management of patient flow:** Manage the capacity, demand and utilisation of every bed across the Acute, Community and Mental Health sectors.
- **Complex discharge and hard to place patients:** Identify patients with complex needs and design appropriate support that prevents readmission, long lengths of stay and patient decompensation.
- **Development of onward care services:** Develop and provide cost effective onward health and social care services that maximise patient outcomes.

- **Urgent & emergency care:** Develop NHS 111 to be the gateway to the urgent care system, ensure our population knows what services are available so A&E is no longer the default choice, in a life threatening emergency people will be rapidly transported to hospital and will receive the highest quality of care from expert consultants, and services will meet national standards.
- **Elective care:** Getting people to the right place first time, eliminating waste and duplication across all stages of treatment e.g. eliminating face to face follow ups, and faster access to diagnostics and treatment.
- **7 day standards for urgent care in hospital:** Implementation of the four priority standards that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week.

- **Acute & community mental health:** Review and redesign current acute pathways and community service provision and develop a network of services across the whole age range.
- **Mental health rehab pathway & out of area placements:** Ensure people supported in out of area placements and repatriated and supported in locally provided services.
- **Mental health crisis care:** Develop pathways to ensure people presenting in mental health crisis have access to timely, appropriate care.
- **Dementia:** Improve dementia diagnosis, care and support.

- **Quality:** Ensure people are provided with a safe, high quality, positive experience of care in all providers.
- **Sustainable finances:** Creating a financially sustainable health system for the future.

Our Key Outcomes

- ✓ People are better supported to **stay well and independent**, with greater confidence to manage their own health and wellbeing
- ✓ More people have a **positive experience of care** which is joined up and tailored to meet the needs of individuals
- ✓ Reduced inequalities in **life expectancy**
- ✓ Better **health outcomes** for people with long term conditions and mental health issues
- ✓ Better **access to primary care**, with appointments 7 days a week
- ✓ Reduced **delayed transfers of care** and length of stay following a hospital admission
- ✓ People are able to access **safe, acute services**, 7 days a week
- ✓ Reduced **hospital demand** (elective, A&E and non elective admissions)
- ✓ Consistently **good, coordinated and timely mental health services** experienced by people in a mental health crisis

Prevention at Scale

OVERALL OBJECTIVE

To improve healthy life expectancy and reduce dependency on health and care services through a radical upgrade in prevention, early intervention and self care

Prevention at Scale

Behaviour Change

Objective: Improve health outcomes through behaviour change initiatives that support healthy choices

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

Broad Actions

- Implementation of the newly commissioned Behaviour Change service (in conjunction with Public Health at Southampton City Council)
- Build "stop before the op" into acute contracts and embed the current CQUIN programme around Making Every Contact Count (MECC), to ensure that all patients receive prevention messages about lifestyle choices in all care settings.
- Promote eye health
- Participation in the second wave of the Diabetes Prevention Programme
- Support primary care and Public Health with the NHS Health Check programme

Smoking

- Work with providers to identify and target people who smoke with a long term condition
- Commission mental health services that prioritise reducing the very high prevalence of smoking in this group.

Obesity

- New Tier 2 weight management programme tendered in conjunction with behaviour change programme
- Review the weight management pathway in the city and prioritise weight loss as an intervention to reduce long term conditions and health inequalities.

Alcohol

- Working with Southampton City Council & Public Health to develop an alcohol strategy for the City

Mental Health

- Increase of physical health screening for patients with serious mental illness (SMI) in line with or greater than the population without SMI, offering parity of esteem for all individuals.
- Work with secondary care mental health provider to develop a training programme which enable staff to support behaviour change in clients with regards to their physical health, including smoking cessation, exercise, weight and diet and alcohol consumption.

Our Key Actions in 2018/19

- To monitor progress and work with providers to develop services to achieve the overarching objectives and outcomes for the city
- To further roll-out healthy conversation/motivational interviewing training

Key Outcomes by the end of 2018/19

- ✓ Reduction in the number of residents who smoke (4,900 fewer adults, 115 fewer pregnant women)
- ✓ Increase in the number of residents who are physically active (5,650 fewer being physically inactive)
- ✓ Increase in the number of residents who eat a healthy diet
- ✓ Increase in the number of residents who achieve and maintain a healthy weight (200 fewer adults classified as obese)
- ✓ Reduction in the number of residents drinking alcohol at risky levels (8,500 fewer adults binge drinking)
- ✓ MECC is an adopted and embedded culture for stakeholders
- ✓ Reduction in co-morbidities

Prevention at Scale

Cancer

Objective: Improve cancer screening uptake, earlier cancer diagnosis, improve survival rates and deliver NHS constitution waiting time standards.

Leads: Peter Horne, Lisa Sheron

Our Key Actions in 2017/18

- Ensure our Cancer Plan aligns with the National Cancer Strategy, FYFV and the STP priorities, supports collaborative working with all stakeholders across Wessex, takes a RightCare approach and has prevention and patient experience at its heart.
- Work with University Hospital Southampton to ensure that constitutional standards are delivered through ensuring that pathways are as efficient as possible.
- Carry out audit of lung cancer pathways to understand their pathway and what improvements can be made and to improve the staging of cancer.
- Implement direct access to CT for GPs for the lung pathway. The lung pathway is the primary focus as Southampton has poor outcomes for this tumour site.
- Work with primary care and Public Health England to ensure that screening rates are maximised and promote uptake of cancer screening programmes, particularly in minority ethnic groups and those with learning disabilities and mental health problems.
- Investigate the introduction of a vague symptom pathway as part of the two week wait pathway. This is to prevent patients from being on multiple pathways and help with the early detection of cancer.
- Implement Significant Event Analysis for patients diagnosed with cancer as a result of an emergency admission. This is to understand whether there are any gaps in the provision of services.
- Use the locally developed Cancer Dashboard to target those practices/areas that need particular assistance.
- Review diagnostic capacity (in particular CT) to ensure that the GP 28 days to diagnosis pathway can be delivered by 2020.
- Implement our End of Life Strategy Action Plan.
- Implement an integrated health improvement and behaviour change service for the city that will promote healthy lifestyles and support healthy behaviour change.
- Roll out elements of the Recovery Package.
- Develop and support the roll out of personal health budgets and promoting personalisation for patients/individuals who could benefit from the flexibility of a personal health budget or joint health and social care budget.

Our Key Actions in 2018/19

- Commission all elements of the Recovery Package. Including the holistic needs assessment, a treatment summary sent to the GP at the end of treatment.
- Implementing direct access to CT for GPs for the GI pathway.
- Ensure that stratified pathways are rolled out across all pathways.
- Ensure that sufficient diagnostic capacity is available to implement the 28 days to diagnosis pathway. This will be dependent on the review, carried out in 2017/18.
- Work with providers to ensure all mental health patients have Health Passports and increase take-up of screening with Serious Mental Health Illness.
- Work with providers to progress an End of Life Hospice at Home/Rapid Response service.
- Work with acute providers to map out the cancer pathways (in relation to 28 days to diagnosis pathway).
- Carry out cancer training on new pathways for primary care.
- Ensure that local cancer pathways are embedded into the clinical decision support tool, in advance of the two week wait pathway being phased out.
- Audit cancers diagnosed at Emergency Presentation locally.

Key Outcomes by the end of 2018/19

- ✓ Delivery of the NHS Constitution 62 day cancer standard
- ✓ Improvement in the one year survival rates
- ✓ Diagnosing earlier – improving the proportion of cancers diagnosed at stages one or two
- ✓ Reduce the proportion of cancers diagnosed following an emergency presentation
- ✓ Stratified care pathways introduced

Prevention at Scale

Diabetes Prevention

Objective: Reduce the risk of patients developing Type 2 diabetes through education, support to lose weight and physical exercise programmes.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Work with collaborative partners across the STP footprint to implement wave 2 of the National Diabetes Prevention Programme (NDPP) from April 2017.
- Continue to progress improved Diabetes management in primary care through the Primary Care Local Improvement Scheme in 2017/18 in support of the new model of care for long term conditions including Diabetes.
- Improve the achievement of the three Diabetes treatment targets for HbA1c, Blood Pressure and Cholesterol by reducing variation in the city and ensuring that the city wide average of 41% achievement remains inline with the national average for Type 2 Diabetes.
- By working with primary care, the community diabetes provider and patients, review barriers which impact on the uptake of structured education for all diabetes education programmes provided in Southampton city (Type 1, Type 2 and refresher education).
- Continue to monitor and improve local foot care pathway and increase patient education programme to support patients with a low risk status to help to maintain this status.
- Enhance self-management programmes targeted at people with a LTC to reduce health inequalities.
- Develop and support the roll out of personal health budgets and promote personalisation for patients with a long term condition.

Our Key Actions in 2018/19

- Build on the first year of the NDPP to further improve local take-up to the scheme .
- Review 2017/18 Primary Care local improvement scheme and develop 2018/19 scheme as part of a continuous improvement programme for long term conditions.
- Continue to work to develop an improvement in average achievement of treatment targets in primary care to prevent complications in diabetes.
- Following review and the evaluation of the barriers which impact on the uptake of structured education work with the local community provider, primary care, to improve uptake locally. Following details of transformational bids, our focus will be to enhance Type 1 education.

Key Outcomes by the end of 2018/19

- ✓ By end 2017/18 5,700 referrals made to the NDPP across STP
- ✓ By end 2018/19 additional 6,000 referrals made to the NDPP
- ✓ Improvement performance in the achievement of treatment targets to reduce the complications of diabetes
- ✓ Increase uptake of structured education in Southampton city

Falls Prevention

Objective: Improve falls prevention services to ensure people who have had a fall or are at risk of a fall have access to effective prevention services.

Leads: Stephanie Ramsey, Donna Chapman,

Our Key Actions in 2017/18

- Continue to increase the number of Falls Champions in community settings, including domiciliary, residential and nursing care providers to promote falls prevention and identify risk factors.
- Continue to increase home safety checks in partnership with Hampshire Fire and Rescue Service (HFRS) so that vulnerable individuals can benefit from a multi-faceted home safety check.
- Establishment of a Fracture Liaison service and database, to ensure that patients with poor bone health and falls risk are identified, followed up and supported with treatment plans.
- Continue to commission targeted exercise classes, whilst seeking to develop exercise classes at whole population levels working with leisure services.
- Work with primary care to improve identification of poor bone health risk factors with clear routes into services.
- Pilot the use of telecare solutions to reduce and manage the risk of patients with falls risks.

Our Key Actions in 2018/19

- Embed, evaluate and further improve developments in 2017/18.
- Roll out exercise and falls prevention awareness at whole population level.

Key Outcomes by the end of 2018/19

- ✓ Reduce the number of falls with injury by 3% year on year 17/18 – 20/21 to achieve the current average of our comparator CCGs

Prevention at Scale

Care Technology (Telehealth)

Objective: Increase the independence and quality of life for vulnerable older people, individuals with a learning disability and others

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

- Implement the Care Technology Strategy (Phase 2).
- Connect and embed the implementation of the Care Technology Strategy within the STP developments.
- Increase the use of care technology as a 'first offer' in both social care and health assessment pathways.
- Support the expansion of local initiatives including:
    - Telehealth vital sign monitoring in nursing homes;
    - Use of GPS to support independent living;
    - Use of Video technology to reduce isolation and improve care at home/independent living, and;
    - Reduce the use of 15 minute home care visits through the use of care technology.

Our Key Actions in 2018/19

- Deliver a fully integrated care technology enabling pathway within Better Care Southampton.
- Continue the expansion of local initiatives including:
    - Video consultations in nursing homes; and
    - Telehealth vital sign monitoring in residential care homes.
- Extend the reach of care technology:
    - To connect with patient records;
    - Provide system wide visibility (within confidentiality parameters) to digital information/ vital sign monitoring, and;
    - To support and assist unpaid carers.

Key Outcomes by the end of 2018/19

- ✓ Year on year 20% increase in the number of adult social care clients with care technology embedded into their care package.
- ✓ Year on year 20% increase in the number of health referrals that take up the use of telecare.
- ✓ 9 city based nursing homes use telehealth for vital sign monitoring
- ✓ Integrated provision of care technology service provision (e.g. installation, monitoring and response service)

Better Care Southampton

(New Models of Integrated Local Care)

OVERALL OBJECTIVE

To accelerate new models of integrated care and ensure sustainability of general practice.

Integrated Health & Social Care (Better Care Southampton)

Objective: Develop integrated health and social care which provides community based person-centred care closer to home and develops integrated provision for 0-19 year olds.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

Continue to roll out our vision to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred. This will mean further delivering on our 6 key priorities:

- More rapid expansion of the integration agenda across the full life-course, to include children and families as well as adults and older people.
- A much stronger focus on prevention and early intervention.
- A more radical shift in the balance of care out of hospital and into the community.
- Significant growth in the community and voluntary sector - to achieve the focus on prevention and early intervention required and divert people away from public funded services by building resilience, promoting independence and access to community resources.
- Development of new organisational models which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies.
- New contractual and commissioning models which enable and incentivise the new ways of working described above.

Our key actions for 2017/18 will be:

- Developing place based commissioning focussed around our 6 clusters, principles of integrated person centred care and strong cluster based leadership and accountability.
- Exploring new contractual and payment structures to better support our vision of integrated local care.
- Developing primary care in line with the city's primary care strategy as the bed rock to our vision.
- Embed delivery of 7 day services.
- Roll out discharge pathways and processes, underpinned by discharge to assess and trusted assessment principles.
- Develop community services to support the management of higher levels of acuity in the community.
- Formally integrate prevention and early help services for children 0-19 and their families to deliver a more streamlined pathway of support that enables more families to manage independently, thereby increasing family resilience, promoting the protective factors for children and young people and reducing the need to resort to expensive specialist or statutory intervention.
- Support to develop the community and voluntary sector as equal partners in achieving our vision. To include specific developments such as roll out of care navigation, development of our "older person's offer" and development of advice, information and guidance.
- Continue to develop delivery of care and support centred around integrated care planning through integrated systems and governance.
- People being in control of their care or support – through user led delivery, development of one plan and formalisation of coordination and key worker roles.
- Further development of the proactive approach to identification of those most at risk, expanding the focus from 2 – 5% and across the whole life course.
- Support to carers – work with Southampton City Council to ensure increased identification and signposting of carers.

Our Key Actions in 2018/19

To continue to implement our vision for integrated person centred care, delivered as locally as possible and our 6 priorities.

Our key actions for 18/19 will be:

- To commission at a place based level, centred around the city's 6 clusters, devolving greater responsibility for resources and delivery of city wide targets. This will involve in working closely with providers to embed new forms of delivery which have been tested in 2017/18 to be extended and formalised.
- Implementation of new contractual and payment mechanisms to support this.
- Further strengthening and modernising primary care.
- Seek to formalise the shift the balance of care from acute to community where this is appropriate – through integrated models of delivery.
- Ongoing development of links with health and social care, promoting alignment in commissioning and provision where this is appropriate.

Key Outcomes by the end of 2018/19

- ✓ Reduction in NEL admissions
- ✓ Reduction in delayed discharges and transfers of care (to achieve and maintain the national DTOC target)
- ✓ Reduction in permanent admissions to residential and nursing homes
- ✓ Improved patient experience as measured against the National Voices 'I' Statements

Long Term Conditions

Objective: Develop care pathways in the community for people with long term conditions (Diabetes, Respiratory and Cardiovascular) to improve case finding, management and support.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Continue to progress improved management of long term conditions in primary care through the Primary Care Local Improvement Scheme in 2017/18. This approach supports our new models of care for long term conditions by promoting improved knowledge and skills through training and education, improved practice processes and management of care through audit, implementation of learning and sharing of good practice and the utilisation of specialist community teams in the practice setting.
- Implementation of the 'learning to listen' strategy to improve outcomes for those with more than one long term condition.
- Building upon the work to date, develop integrated models which places care and expertise in the most appropriate setting. Where possible to support collaboration between this pathway and other long term condition areas. Specific focus will be on Cardiology which will include Heart Failure. The other two most common long term conditions this approach will impact on is for those with Diabetes and COPD.
- Continue to review and make recommendation to reduce NEL admissions for those with long term conditions, particularly where resource use is high, including COPD and other respiratory conditions, and those with Diabetes complications.
- Continue to review best practice and emerging new models of care across the STP to help promote improved outcomes within the city, such as Mission ABC and include review of new technologies.
- Work with Mental Health Commissioners to continue to review and develop plans to improve psychological support for those with a long term condition.
- Basing delivery on the key principles of better care and those within the learning to listen guidance.
- Enhance self-management programmes targeted at people with a long term condition to reduce health inequalities, through Collaborative Care and Support Planning.
- Develop and support the roll out of personal health budgets and promote personalisation for patients with a long term condition.
- Prevention - Deliver early detection and management of cardiovascular disease programmes including promoting the NHS Health Check programme and delivery of regular Know Your Blood Pressure events at community events and corporate workplaces and the atrial fibrillation pilot.

Our Key Actions in 2018/19

- Review 2017/18 Primary Care local improvement scheme and develop 2018/19 scheme as part of a continuous improvement programme for long term conditions.
- Improve access rates for psychological support for those with a long term condition in line with the national targets.
- Building upon the work with all commonly occurring long term conditions support primary care to develop integrated person centred approaches to collaborative care and support planning as standard.
- Continue to review and make recommendation to reduce NEL admissions for those with long term conditions, particularly where resource use is high, including COPD and other respiratory conditions, and those with Diabetes complications.
- Continue to review best practice and emerging new models of care across the STP to help promote improved outcomes within the city, such as Mission ABC and include review of new technologies.

Key Outcomes by the end of 2018/19

- ✓ By end 2018/19 improve access target to 19%
- ✓ Promoting person centred delivery – evidenced through qualitative evaluation approaches.
- ✓ Promoting person centred delivery - evidenced through specialist advisory role promoting individuals single care plan.
- ✓ Increase the number of people with long term conditions who access Psychological Support in line with agreed trajectory.

Primary Care (Access)

Objective: People are provided with access to the level of care that they need at the appropriate time, with same day access and services available in the evenings, 7 days a week.

Leads: Stephanie Ramsey, Sue Robinson, Ali Howett

Our Key Actions in 2017/18

- Continue to commission (following handover of contract from NHS England) an Enhanced Access Service to deliver improved access coverage for same day and pre-booked appointments, Monday to Friday 8am to at least 8pm and, Saturdays and Sundays to meet local population needs, against a clear service specification which includes the national core requirements, building on the learning from the Prime Minister's Challenge Fund (PMCF) pilot and feedback from patients, the public and other key stakeholders. Ensure this service is well publicised to maximise uptake/coverage and address inequalities in access.
- Ensure the Enhanced Access Service is providing a minimum additional 30 minutes consultation capacity per 1,000 population, making use of the national new capacity monitoring tool to match capacity to demand, both in-hours and in extended hours.
- Develop and implement commissioning plans for the Enhanced Access Service into 2018/19 and beyond, following appropriate procurement processes.
- The existing Enhanced Access Service already delivers improved access to primary care services. Our plans ensure that we will continue to build on that success.
- Develop the use of digital approaches to support new models of care in general practice, e.g. e-consultations, online assessment (funding for online general practice consultation software systems). E-consultations will be piloted in Q4 2016/17 in collaboration with Southampton Primary Care Limited with a view to full coverage by 1st April 2018.
- Work with current Out of Hours provider to identify and implement opportunities for providing additional capacity for same day appointments within the Enhanced Access Service hubs to relieve pressure on OOH and emergency services and deliver a more coordinated and integrated pathway of support 24 hours a day, 7 days a week, removing duplication.
- Explore, test and develop the roles of other professionals as part of the primary care team, using learning from the PMCF and other pilots, including advanced nurse practitioners (ANPs), clinical pharmacists addressing polypharmacy in elderly people and helping management of long term conditions, mental health therapists, physiotherapists as well as voluntary and community support groups.
- Further develop the model of care and support planning, improving patient activation and education, linking this to the extension of the Local Improvement Scheme (LIS) and work with community and voluntary sector partners e.g. roll out of community navigation and other community solutions (see Collaboration section) and enhanced use of technology, to educate and support patients to manage their own health.
- Develop a self-referral model for patients presenting with Musculoskeletal (MSK) problems who can directly self refer to physiotherapy. Looking at MSK triage in primary care and booking with the appropriate service.
- Continue to develop the scope and reach of the minor ailment scheme in community pharmacies.

Our Key Actions in 2018/19

- Secure future delivery of the Enhanced Access Service, following appropriate procurement processes ensuring continued programme of patient engagement informs the future model of delivery.
- Ensure the Enhanced Access Service is providing a minimum of 45 mins consultation capacity per 1,000 population.
- Continue to develop the use of innovative technological solutions to improve access and self management as part of core primary care.
- Develop programme to promote new ways of accessing primary care.
- Embed new contracts for OOH Service and NHS 111, ensuring strong alignment and collaboration with the Enhanced Access Service and core primary care service delivery to deliver seamless, fully integrated primary care pathways 24 hours a day, 7 days a week.
- Continue to develop the role of other professionals as part of the primary care team, based on the learning from 2017/18 e.g. ANP and clinical pharmacist (one per 30,000 population) available to all surgeries, roll out of mental health therapists, physiotherapists.
- Trained facilitators to support roll out of care and support planning to cover 4% of the population (5% by 2019/20).
- Continue to work with system partners to streamline access to services, ensuring people get to the most appropriate service first time, through development of mechanisms like single point of access.
- Explore self-referral models for other service areas.

Key Outcomes by the end of 2021/22

- ✓ People can telephone or visit their surgery any time between 8am and 6.30pm, Monday to Friday.
- ✓ Pre-booked and same day appointments are structured across 7-days per week to meet peoples' needs.
- ✓ Providers of primary and secondary care services work together to co-ordinate a fully integrated community based primary care pathway for urgent care 24 hours and 7 days a week.
- ✓ Patients are encouraged, educated and empowered to manage their own health and understand when clinical intervention is needed.
- ✓ Innovative and technological solutions to support access, for example e-consultations, apps, home monitoring and telemedicine, are embedded as part of core primary care service delivery.

Primary Care (Quality)

Objective: People are provided with high quality care which is safe and effective, meeting their needs. People have a positive experience, which is person-centred, dignified and compassionate.

Leads: Stephanie Ramsey, Sue Robinson, Ali Howett

Our Key Actions in 2017/18

- Implementation of a Quality Framework for Primary Care (medical) by working closely with general practice and identifying local health care needs.
- Patients and general practice work together to support patient engagement, empowerment, self care and self management; through the use of collaborative working, care planning and the development of new consultation types with all healthcare professionals.
- Development of the multi-disciplinary approach to support physical and mental health working with a range of healthcare professionals including community pharmacists, district nurses, dentists, opticians, etc.
- Work to reduce the variation in quality through the development of key skills and knowledge across the healthcare system, to deliver both public health and healthcare support; providing a single view of the patient's health across the health and social care system.
- Meet patient needs by working with existing partners and developing new partnerships with health and social care providers within the cluster model.
- Support general practice to further develop a learning culture through the review of incidents and event reporting. Engraining in the sharing of information and outcomes to enhance the safety environment.
- Establish a standardised approach to mortality review in primary medical care, building on the work already underway in Solent NHS Trust primary medical care practice.
- Review the TARGET meetings structure to support quality improvement.
- Review inequalities in primary medical care with a particular focus on accessing general practice based on local evidence and agree actions to resolve any inequalities identified.
- The cluster resource centres currently in development will ensure equity of access to primary care in areas of high need.
- We will further strengthen the support available to practices with a poor CQC outcome in collaboration with the GP Federation.
- Building on the work already completed in 2016/17, we will work to identify practices who would benefit from the GP resilience programme and support them to access this.
- Develop plans with Public Health England to increase the uptake of screening and immunisations for identified target groups, inclusive of local resilience planning.

Our Key Actions in 2018/19

- Extend a Quality Framework for Primary Care (medical) through working closely with general practice, the clusters and new models of care to agree and deliver on quality standards.
- Establish a comprehensive support programme for patients who are engaged in self care and self management. To include education and peer support, working closely with voluntary and charity providers.
- Extend the multi-disciplinary approach to involve both out-reach and in-reach services to support the principle of the right time, right place, right professional. Supported by access to a single view of the patient record.
- Work with general practice and other providers of health and social care to deliver a comprehensive learning and development programme for healthcare professionals; learning together to share knowledge and skills and develop professional networks and relationships.

Key Outcomes by the end of 2021/22

- ✓ The quality framework shows evidence of reduced variation in the quality of care delivered across all practices
- ✓ Expected standards for screening and immunisations are achieved across the whole population, using the principle of making every contact count
- ✓ Patient reported outcome measures such as the GP Patient Survey and Friends and Family Test demonstrate improved satisfaction and experience
- ✓ Health professionals have all the clinical knowledge and skills required to deliver safe and effective care to meet the needs of the population
- ✓ There is evidence that providers are engaged in incident/event reporting and peer review to support a culture of ongoing learning and development
- ✓ Practices throughout the city are rated good/outstanding by the CQC

Primary Care (Workforce)

Objective: Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers.

Leads: Stephanie Ramsey, Sue Robinson, Ali Howett

Our Key Actions in 2017/18

- Focus workforce activities on supporting the CCG's future model of primary care with the patient at the centre.
- Update our baseline survey of current workforce in general practice, workload demands and identifying practices that are in greatest need of support; including the development of a "safe working day" in general practice.
- Create a CCG wide workforce development plan which sets out future ways of working, including the development of multi-disciplinary teams, support for practice nursing and establishing primary care at scale; including new roles such as clinical support officers, physicians assistants, visiting practitioners and other healthcare professionals working in primary care.
- Support the development and implementation of initiatives to attract, recruit and retain GPs and other clinical staff, taking advantage of locally designed and nationally available schemes. Consider the development of general practice nurse consultant roles who have even broader expertise than advanced nurse practitioners.
- Build on the new model of primary care in the city to ensure GPs are operating at the top of their license, for example through use of clinical pharmacists and upskilling other healthcare professionals to manage less complex health problems.
- Commitment to develop, fund and implement local workforce plans in line with the GPFV and support delivery of the STP.
- Support practices to access the GP resilience programme to support the development of a sustainable and resilient workforce in the city.
- Build on existing support networks for practice staff such as the practice nurse forum and practice managers forum by developing a menu of support and development for all practice staff including mentorship and coaching.
- Support the development of cluster based practice management including sharing best practice across clusters and across the city.
- Develop relationships with Health Education England (Wessex) to support workforce development and planning in Southampton.
- Explore options with wider CCG partners to support new ways of working / new models of care for primary care in line with the STP.
- Develop extended community navigators (Social Prescribers) someone who is a highly emotionally intelligent fixer with motivational skills, with a close working relationship with the GPs and practice staff.
- Develop multidisciplinary working to support nursing and care homes.

Our Key Actions in 2018/19

- Facilitate an expanded multi-disciplinary team and greater integration across community services to optimise out of hospital care for patients including access to premises, diagnostics, technology and community assets.
- Establish the viability of a city wide "chambers" (staff bank) for flexible working, with a focus on development of roles including clinical leadership, special interests. Apply beyond GPs and include all practice staff.
- Development of new roles and extension of those already in place to practices.
- Development of career pathways for GPs and other practice staff to support recruitment and retention, including supporting staff to work in different practices where possible to gain boarder experience. Including the development of special interests – linking to moving work into primary care.
- Establishment of city wide protocols / charters to support reducing the burden of document and data transfer for GPs, including robust systems for clinical support officer / physicians assistant type roles.

Key Outcomes by the end of 2021/22

- ✓ Practice teams are motivated and engaged, incorporating a range of skilled professionals delivering the appropriate level of care to meet patients' needs.
- ✓ Professional development and succession planning are embedded principles for all providers.
- ✓ GPs and other health and care professionals working in the city are supported to achieve their preferred career pathway and develop special interests, so facilitating recruitment.

Primary Care (Infrastructure)

Objective: Fit for purpose premises which enable access to clinical services out of hospital, 7 days a week. Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care.

Leads: Peter Horne, Paul Benson

Our Key Actions in 2017/18

Primary Care Estates

- Building on work already undertaken during 2016/17, obtain approval for and deliver a comprehensive survey/inventory of the primary care estate across Southampton.
- Identify high-priority issues from the inventory that require rectification insofar as they are obstacles to the delivery of the Primary Care Strategy and/or Better Care Southampton Plan. Develop a costed rectification plan which will take the form of the "modernisation programme".
- Complete a business case development for the establishment of six Cluster Resource Centres (CRCs) across the city. Subject to successful due diligence, one of these – Shirley Health Centre - will be part-funded (66%) via the Estates and Technology Transformation Fund (ETTF) and the procurement process is expected to be completed in the early months of 2017/18 to ensure that this development is completed by the end of 2018/19.
- In respect of the other five CRCs, and assuming the business cases receive necessary approvals and consents, initiate the procurement of the CRCs and commence building works where feasible.
- Work closely with CCG colleagues and members to understand the estate implications of the Primary Care Strategy and specifically the emerging solutions within each cluster.
- Monitor the development of new capital funding options, such as those being developed currently (Autumn 2016) by NHS Property Services/Community Health Partnerships (e.g. "Project Phoenix").
- More information on primary care estates can be found on page 37.

Primary Care Technology

Please refer to the Digital section on pages 35-36

Our Key Actions in 2018/19

Primary Care Estates

- Continue the implementation of the primary care estate modernisation programme.
- Complete the development of the ETTF-funded Cluster Resource Centre at Shirley Health Centre.
- Continue the work on fulfilling our long term aspiration for a Cluster Resource Centre in each of the six clusters. Engagement with partner organisations is a critical part of this development.

Primary Care Technology

Please refer to the Digital section on pages 35-36

Key Outcomes by the end of 2021/22

- ✓ Completion of a modernisation programme ensuring that primary care premises are fit for purpose, provide increased capacity and enable services to be delivered 7 days per week.
- ✓ Flexible, multi-use space is available which is adaptable to service needs and can accommodate innovative and collaborative projects for health and social care provision in partnership with other agencies.
- ✓ A resource centre is located in each of the six clusters across the city providing; a multi-occupancy base for the integrated team supporting all practices in the cluster; multi-use space for training, outreach services and other local initiatives; and information and tools to support people to manage their own health.
- ✓ Premises and technology developments support a culture of learning and education for both staff and patients.
- ✓ Clinical computer systems are interoperable, facilitating communication and information sharing between all parts of the health and care system.
- ✓ Creative and innovative digital solutions which support and empower people to manage their own health are embedded.

Primary Care (Collaboration)

Objective: Sustainable and resilient GP services support delivery of integrated care in the city.

Leads: Stephanie Ramsey, Sue Robinson, Ali Howett

Our Key Actions in 2017/18

- Develop and test collaborative initiatives which support practices working at scale e.g. acute home visiting service, acute same day appointments, online consultations.
- Develop and pilot workforce development initiatives, such as expanding the roles of community pharmacists, introducing medical assistants and signposters into expanded practice teams.
- Maintain the pace for MCP/new model of care development including a structure that is acceptable to the CCG, practices and Southampton City Council. Take first steps in 2017/18 to the establishment of a voluntary shadow MCP/new model of care contract.
- Further develop the leadership of the clusters and strengthen the integration into decision making of the CCG.
- Through clusters, further develop the role of care/community navigators and third sector to support people develop their own plans. Care navigators or third sector supporting GP practices to develop care and support plans for at least 1% (one third of the new Local Improvement Scheme LIS) using an agreed delivery model.
- Develop the LIS to 3% of the population in 2017/18 and 4% in 2018/19 (5% in 2019/20). 80-90% of care plans to be undertaken at surgery level by the core team focused on the registered list but supported by cluster development. Wider cluster development to ensure care plans are supported by police, housing and social services.
- Develop the model for care and support planning as mainstream work and develop operating processes via the primary care development centre. 50% of practices in holding regular MDT's with community and surgery nurses in quality time within the LIS.
- Establish a plan for facilitated learning to implement person centred care.
- Establish clarity of services delivered within clusters laying the foundation for place based commissioning under MCP or equivalent.
- Formally hand over accountability of cluster leadership to clinical and managerial leadership from within each group.
- Establish simple metrics for measuring patient experience and test in shadow form in 2017/18.
- Through the cluster dashboard generate mirror responsibility for performance against key system metrics.

Our Key Actions in 2018/19

- Shadow MCP/new model of care contract to become real with at least 33% of practices volunteering.
- Implement devolved responsibility for key system performance metrics.
- Formally hand over accountability of cluster leadership to MCP.
- 2% of care and support plans (50% of LIS) begin undertaken with care/community navigators .
- 100% of practices holding regular MDT in core quality time.
- Implement patient experience metrics into the LIS contract.

Key Outcomes by the end of 2021/22

- ✓ GP practices operating within a business framework that ensures sustainable primary care.
- ✓ Practices are working together to build a resilient service in the future which operates at scale but remains focused on the registered population.
- ✓ Primary care is fully engaged with the local integrated provider group to deliver true person centred, integrated care.
- ✓ The operating model delivers improvements to health outcomes, patient experience, access and workforce development.

Two documents are available separately to the Operational Plan which provide more detail on our strategic primary care plan:

- The Transforming Primary Medical Care in Southampton Five Year Strategy sets out our long term vision and objectives to ensure that the people of the city have access to high quality, consistent, sustainable primary care that meets their needs, whilst being attractive to support recruitment and retention of GPs and their allied staff, e.g. nurses or therapists.
- The Delivery Plan looks at the key actions for years one and two of the Transforming Primary Medical Care Five Year Strategy that will need to be implemented to take us a step closer towards achieving our vision of "building a model of general practice in our city that will be the strong, effective and sustainable foundation of our integrated health and social care system".

People with Learning Disabilities

Objective: Deliver actions to transform care for people with learning disabilities.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

The overarching action over the next two years will be implementation of the Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) Transforming Care Plan for people with learning disabilities, including those with autism. The plan includes all CCGs and local authorities in the SHIP area as well as NHS England specialist commissioning for the region.

The work areas and action arising from the SHIP Transforming Care Plan and related Southampton specific plans are:

- Roll out of a community forensic service across Hampshire and Southampton to support individuals at risk of becoming inpatients and those who are being discharged.
- Roll out of Learning Disability Friendly GP Practices.
- Increase offer and uptake of annual health checks. This will focus in particular on the quality of health checks, ensuring that there are tangible outcomes written down in a health action plan. The processes involved in organising health checks, GP recording and payments will also be improved. The right to a health check will be promoted to individuals as well as to care/support providers so they can facilitate attendance and active involvement in the health check as well as implementing the actions from the resultant health action plan.
- Review annual health checks pilot work from 2016/17 and develop options appraisal for future service model and commissioning arrangements.
- Working with commissioners and providers of mainstream prevention services such as weight management, cancer screening, sexual health and others to ensure that reasonable adjustments are made so individuals with learning disabilities can access them.
- Continued involvement in the Learning Disability Mortality review 'LeDeR' programme so that premature deaths of individuals with learning disabilities can be learnt from and findings used to directly inform future commissioning practice and service delivery.
- Ensuring the LD workforce, including care providers are equipped to deliver Positive Behavioural Support.
- Identify the full range of housing options for individuals and provide clear easy to read guidance for them and their families.
- Work with local housing departments to expand the portfolio of high quality housing options for individuals including supported living.
- Implementation of an 'At Risk' register to identify individuals at risk of becoming inpatients and mitigating actions. A common criteria for inclusion is to be developed as well as appropriate data protection and information governance processes.
- Initial development of an integrated health and social care Learning Disability team which will support more effective joint working including holistic and person centred assessments, reviews and support plans.

Our Key Actions in 2018/19

Key actions in 2018/19 will primarily be to build on the progress made in 2017/18 towards implementing the SHIP Transforming Care plan. In particular there will be further work on:

- Increasing the availability and quality of annual health checks, including alternative commissioning arrangements (dependent on options appraisal completed in 2017/18).
- Continuing to develop the range of housing options for individuals. Many of the housing development projects will be multi-year so there will likely be ongoing work in this area, particularly in the creation of highly bespoke supported living properties.
- Continuing integration of health and social care Learning Disability teams, including options for colocation.

Key Outcomes by the end of 2018/19

- ✓ By the end of 2019, the SHIP region will have reduced the number of LD inpatients from 68 to 44.
- ✓ 75% of people with learning disabilities on GP registers receive an annual health check
- ✓ The number of people with learning disabilities on the 'At Risk' register decreases

End of Life & Complex Care

Objective: Improve the experience of care in the last year and months of life.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

The model of End of Life care across community and acute provision will provide:

- Equitable access to end of life/palliative care regardless of diagnosis.
- Consistent overnight and out of hours advice and support to allow patients to achieve their preferred place of care (where practicable).
- End of life/palliative care provided through integrated working, aligned with cluster teams with practitioners collaborating to ensure seamless 24/7care.
- Current domiciliary care arrangement for EOL provision managed differently.
- Workforce integration to provide a seamless integrated service where patients can transfer between levels as needs escalate/de-escalate.
- Support to develop End of Life knowledge and skills in the wider Integrated Care workforce.
- Progression of Six Steps EOL training in the wider care home sector.

Our Key Actions in 2018/19

- Build on and embed progress of 2017/18.
- Progress organisational culture to dispel myths and taboos around end of life.
- Progress with developments to establish a Hospice at Home Model
- Re-procurement of hospice function.
- Develop and support the roll out of personal health budgets and promoting personalisation for patients/individuals who could benefit from the flexibility of a personal health budget or joint health and social care budget.

Key Outcomes by the end of 2018/19

- ✓ Reduction in DTOC
- ✓ Increase in number of people achieving preferred place of care (PPC)
- ✓ Reduction in unnecessary admissions
- ✓ Reduction in SCAS call-out
- ✓ Increased capacity in domiciliary care market

Wheelchair Access

Objective: Reduce waiting times for wheelchairs

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Wheelchair service review to be undertaken Jan to March 2017, findings from review to inform service improvements in 2017/18.
- Review data definition with Commissioning Collaborative & Providers to accurately reflect new referrals and clock stops.
- Monthly service review meetings to continue in 2017/18 – commissioning representative from the across the collaborative partnership will continue to review performance of the service against service criteria ensuring that quality indicators are being achieved.
- Develop and support the roll out of personal health budgets as an option instead of the current voucher scheme and promote personalisation for wheel chair service users.

Our Key Actions in 2018/19

- Continue to performance monitor service provision.

Key Outcomes by the end of 2018/19

- ✓ Deliver the National Standard of no children waits over 18 weeks for wheelchairs

Effective Patient Flow & Discharge

OVERALL OBJECTIVE

To address the issues that delay patients being discharged from hospital

Effective Patient Flow & Discharge

Discharge Planning

Objective: Ensure that every patient has a discharge plan which is understood by professionals, the patient, their relatives and carers and includes plans for any future care needs.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

To continue to implement the 8 high impact change model of managing transfers of care. Specifically, we will:

- Implement the 3 standardised pathways that have been designed locally for discharge: 1) simple, 2) supported and 3) enhanced with clear operating procedures and a strong focus on discharge to assess using home first principles and trusted assessment .
- Tighten up the use of EDDs, to ensure that all patients have an expected discharge date and clinical criteria for discharge along with a discharge plan within 14 hours of admission.
- Strengthen the role of the community clusters in discharge planning, underpinned by good communication and sharing of information.
- Remodel the hospital discharge team to focus on more complex discharges.
- Develop the urgent Response Team (Rehabilitation and Reablement) to manage pathway 2, supported discharge, building on the 16/17 discharge to assess pilot.
- Develop the trusted assessment role within the hospital and community teams to support all pathways.

Our Key Actions in 2018/19

- Continue to embed and build on the actions undertaken in 2017/18, evaluating their impact.
- Strengthen communication and sharing of information through developments in the interoperability agenda.

Key Outcomes by the end of 2018/19

- ✓ Reduction in DTOC, working with WHCCG and providers to bring Southampton in line with the 3.5% national target
- ✓ Improved patient satisfaction of the discharge process

Effective Management of Patient Flow

Objective: Manage the capacity, demand, utilisation and efficacy of every bed based care space across the Acute, Community and Mental Health sectors.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Work with the hospital to implement the SAFER effective flow management bundle, to remove internal delay, working together to measure improvements in flow.
- Implement ambulatory care front door turnaround teams.
- Continue development of 7 day standards for urgent care in hospital.
- Continue to work with the market to develop onward care capacity to support timely discharge and flow, in particular domiciliary care.
- Continue to work with care homes to improve communication, encourage greater responsiveness to discharge and implement a model of enhanced healthcare support to care homes based on the NHS England publication and learning from the Vanguards.

Our Key Actions in 2018/19

- Continue to embed and build on the actions undertaken in 2017/18, evaluating their impact.
- Work with Southampton City Council to implement further improvements in onward care to support timely discharge, capitalising on opportunities linked to:
  - Recommissioning of the domiciliary care framework.
  - Commissioning of a nursing and residential care home framework.
  - Development of the Housing with Care Market.

Key Outcomes by the end of 2018/19

- ✓ Improvements in length of stay for patients staying 7-30 days
- ✓ Improvements in length of stay for episodes of 2-7 days
- ✓ Improvements in length of stay for episodes of 0-2 days

Effective Patient Flow & Discharge

Complex Discharge & Hard to Place Patients

Objective: Identify patients with complex needs early in their journey and design appropriate support that prevents readmission, eliminates long lengths of stay and minimises patient decompensation.

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Continue to identify patients with complex needs early in their journey through the Integrated Discharge Bureau and take collective action to eliminate elongated acute spells and minimise patient decompensation.
- Implement a clear pathway for complex discharge (pathway 3 – enhanced – see previous section) and remodel the hospital discharge team to specifically focus on this pathway.
- Explore provision and potential for pooled funding arrangements to specifically support discharge to assess for complex patients whilst their health/social care needs are more clearly defined.
- Work across the system to identify key gaps in capacity and provision for particular client groups, e.g. those with dementia related challenging behaviour, non weight bearing, bariatric, and identify joint solutions.

Our Key Actions in 2018/19

- Continue to embed and build on the actions undertaken in 2017/18, evaluating their impact .

Key Outcomes by the end of 2018/19

- ✓ Patients supported in the setting most appropriate to their health and care needs leading to improvements in LOS for patients currently residing in acute and community hospital beds (DTOC)
- ✓ no patient, however complex, should spend more than 14 days in an acute or community care setting, if they are clinically stable for discharge, unless it is deemed by the MDT that hospital is the appropriate care environment

Development of Onward Care Services

Objective: Develop and provide cost effective onward health and social care services that maximise patient outcomes.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

- Improve and maintain quality gains within the sector, including the launch of Home Care Manager Leadership Programme.
- Build greater intelligence of workforce availability and the changing demand – building upon the work of 1617.
- Workforce development features as a key deliverable in the Home Care capacity building plan.
- Promote partnership working between Home Care agencies and employment or education providers.
- Building capacity through innovations and improvements e.g. care technology and dedicated delivery for those at the end of life.
- Work with Southampton City Council to design the new tender for Home Care – building upon the lessons learnt through the implementation of the Framework in 15/16 and 16/17.
- Work with Southampton City Council to expand roles of Home Care providers, building on the lessons learnt from Lot 5 implementation and other initiatives in 16/17.
- Work with Southampton City Council to address blockages at key points in the pathway.

Our Key Actions in 2018/19

- Building upon workforce development lessons in 17/18, including opportunities through partnership with health and other care providers.
- Promote partnerships to embed and sustain. Aiming to build a career pathway which supports.
- Tender the service – through a contracting method which builds upon the lessons learnt.
- Addressing blockages at key point in the pathway.

Key Outcomes by the end of 2018/19

- ✓ Development of a sustainable Home Care Market
- ✓ Home care reputation changed – being seen as a member of the core delivery in the city i.e. as a member of Multidisciplinary Team
- ✓ Change the offer to promote quality and change in provision to meet the changing pattern of demand
- ✓ Care technology seen as a standard enabler for delivering home care.

Acute Care System

OVERALL OBJECTIVE

To ensure the provision of sustainable acute services across Hampshire and Isle of Wight

Acute Care System

Urgent & Emergency Care

Objective: Develop NHS 111 to be the gateway to the urgent care system, ensure our population knows what services are available so A&E is no longer the default choice, in a life threatening emergency people will be rapidly transported to hospital and will receive the highest quality of care from expert consultants, and services will meet national standards.

Leads: Peter Horne, Lisa Sheron

Our Key Actions in 2017/18

Our Urgent and Emergency Care priorities in 2017/18 and 2018/19 will focus on delivery of the four hour A&E constitutional standard, and standards for ambulance response times, through implementing the five elements of the A&E Improvement Plan, as well as the other 'Must Dos' to support sustained improvement in Urgent and Emergency Care. This work will be aligned to delivery of the HIOW STP commitments, particularly Southampton City Better Care and the GPFV, and informed by RightCare benchmarking.

Our Top Ten Actions for 2017/18 are:

- Continue to implement the Local A&E Delivery Board Improvement Plan, which includes streamlining at the front door to ambulatory and primary care, increasing the number of 111 calls transferred for clinical advice rather than referred to ambulance or A&E, increasing ambulance 'hear and treat' and see and treat' to reduce conveyances to hospital, improving patient flow through the hospital and embedding 'Discharge to Assess' and 'trusted assessor' models of discharge.
- Support UHS to implement and deliver a new contractual Emergency Pathway RAP to ensure delivery of the agreed 2017/18 A&E performance trajectory and delivery the 4 hour standard by March 2018.
- Continue to work with UHS to ensure focus on improved bed management and flow earlier in the day, simple discharges, 'home before lunch' initiative and 7-day services.
- Ensure that providers have met and sustain the four priority standards for 7-day hospital services.
- Continue to implement the Urgent and Emergency Care Review, working towards a 24/7 integrated care service for physical and mental health.
- Continue to develop a system-wide approach for improving waiting times for urgent care for those in a mental health crisis.
- Further improve and streamline access to local urgent primary care through aligned procurements of a new NHS111 service, enhanced GP access service, out of hours service and home visiting service.
- Further increase capacity in primary and community care for patients with minor conditions to self-manage and/or have care close-to-home, with easy access to advice, support and treatment from Pharmacies, Optical Practices, General Practice and Community Services to reduce demand on A&E.
- Continue to enhance the Directory of Skills and Services to ensure all appropriate dispositions are available for patients.
- Continue the ongoing communication and engagement campaigns to further increase public awareness of alternatives to A&E.

Our Key Actions in 2018/19

Continuing from 2017/18, develop further integration for 24/7 physical and mental healthcare, further streamline services working towards a true single point of access , and increase "out of hospital" access for urgent care.

Our Top Ten Actions for 2018/19 are:

- Sustain the improvements delivered through the five elements of the A&E Improvement Plan.
- Support UHS to sustain delivery of the four hour standard.
- Support the ambulance service to sustain a reduction in hospital conveyances and further improve response time.
- Build on the delivery of 7-day services across the system to further improve patient flow through and out of hospital.
- Ensure forthcoming waiting time standard for urgent care for those with mental health crisis are met.
- Fully implement an improved and streamlined urgent primary care service through mobilisation of the new NHS111 service, enhanced access GP service, out of hours service and home visiting service.
- Maximise use of technology to support delivery of the right care in the right place and the right time first time.
- Continue to implement the Urgent and Emergency Care Review, working towards a 24/7 integrated care service for physical and mental health by March 2020.
- Continue to enhance the Directory of Skills and Services to ensure all appropriate dispositions are available for patients.
- Continue the ongoing communication and engagement campaigns to further increase public awareness of alternatives to A&E.

Key Outcomes by the end of 2018/19

- ✓ Sustained delivery of A&E 4 hour standard (95%)
- ✓ Sustained delivery of ambulance response times
- ✓ Increased access to out of hospital services for urgent care
- ✓ Control over activity in line with STP trajectories
- ✓ Increased use of digital solutions to support self care and signposting to the most appropriate care setting
- ✓ Preparedness to deliver 24/7 integrated care service for physical and mental health by March 2020
- ✓ Single point of access into an urgent and emergency care system with sufficient capacity and without duplication
- ✓ Measurable improvement in clinical outcomes and patient experience

Acute Care System

Elective Care & RTT

Objective: Getting people to the right place first time, eliminating waste and duplication across all stages of treatment e.g. eliminating face to face follow ups, and faster access to diagnostics and treatment.

Leads: Peter Horne & Lisa Sheron

Our Key Actions in 2017/18

Our Elective Care priorities in 2017/18 and 2018/19 reflect continuing delivery of the national RTT constitutional standard, choice and electronic booking for all first routine and urgent outpatient appointments and delivery of the HIOW STP commitments through service redesign and efficiencies, including RightCare

Our Top Ten Actions for 2017/18 are:

- Commission sufficient activity across a range of local providers and redesigned clinical pathways to meet demand and waiting time standards.
- Ensure contracts reflect STP activity shifts and efficiencies, e.g. reduced follow ups, Acute Alliance, increasing GPSI activity.
- Continue to promote local Choices and e-referrals to patients and GPs;
- Develop and support the roll out of personal health budgets and promoting personalisation for patients/individuals who could benefit from the flexibility of a personal health budget or joint health and social care budget.
- Support providers to develop sub-contracting arrangements for maximising use of all local capacity to manage seasonal flows.
- Commission more GP and Community direct access diagnostics capacity; reduce duplication between providers through best use of technology.
- Clarify and standardise service specifications to ensure fair competition and best practice delivery, including shared decision making, application of agreed referral criteria, clinical thresholds, management in primary and secondary care, enhanced recovery principles, PROMS and discharge planning.
- Continue to work with UHS to eradicate Appointment Slot Issues (ASIs) on E-referrals so 100% of urgent and routine appointments are electronically-bookable (supported by CQUIN).
- Continue to work with all providers to increase access to, and speed-up response times for, Advice and Guidance on E-referrals; increase opportunities for day to day communication between GPs and Specialists to help manage referral demand.
- Switch to DXS from 1st April as the new GP clinical decision support system of choice, decommissioning Map of Medicine. Monitor referrals with GP practices and resolve outlier issues.

Our Key Actions in 2018/19

Continuing from 2018/19, seek greater integration across clinical pathways by testing prime contractor models, reflect our STP Digital and Prevention programmes in commissioned activity and contracts, and increase "out of hospital" access for routine care.

Our Top Ten Actions for 2018/19 are:

- Implement programmes for prevention and self-care at scale to improve health and reduce referrals for specialist intervention, including stronger links and engagement with voluntary organisations.
- Increase primary care and community specialist services to manage common conditions outside hospital, linked to above.
- Review 17/18 diagnostic access and commission additional if required including potential for self-referral; similar for therapies where low-cost early intervention may benefit.
- Update and promote local pathways and Choices; clarify changes to clinical thresholds including Priorities Committee decisions to stop specific investigations or interventions where these have no proven benefit. Utilise clinical audit as routine to test compliance.
- Reflect the introduction of e-consultation in contracts (STP Channel Shift); test the full potential for 19/20 contracts, activity and access times. Engage with the pilot stage of the Patient Portal.
- Clarify pathways between the extended primary care/community services for common conditions (e.g. GPSIs City-Wide) and the Integrated H&SC teams for chronic conditions and care of the elderly (Clusters) – clear Multi-Specialty Community Provider Model for routine and urgent care in place.
- Reflect STP efficiencies and activity shifts in contracts; ensure capacity matches anticipated demand at the right point the pathway.
- Implement agreed STP Acute Alliance clinical pathway changes, including relevant community services to support these, e.g. single point of access. Monitor reduced clinical variation and improved outcomes.
- Review RightCare benchmarking and progress against 16/17 position; inform further pathway or contractual changes where an outlier on price and/or activity.
- Test prime contractor models for agreed clinical pathways.

Key Outcomes by the end of 2018/19

- ✓ Sustained delivery of RTT standard (92%)
- ✓ Continued provision and use of appropriate local Choices, all via E-Referral
- ✓ Increased access to out of hospital services for common conditions and routine care
- ✓ Control over hospital referrals and activity in line with STP trajectories
- ✓ Increasing use of digital solutions to support self care and self referral
- ✓ Engaged public and voluntary sector
- ✓ Integrated primary and community teams for planned care, linked to urgent response
- ✓ Sufficient diagnostic capacity, without duplication
- ✓ Efficient providers with clear service specifications and pathways,
- ✓ Increased communication between GPs and consultants
- ✓ Clinical audit as routine measure of threshold compliance.
- ✓ Improved position against 16/17 Right Care benchmarking
- ✓ New contractual models going forward.
- ✓ Measurable improvement in clinical and patient reported outcomes

7 Day Standards for Urgent Care in Hospital

Objective: Implementation of the four priority standards that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week.

Leads: Peter Horne, Lisa Sheron

Our Key Actions in 2017/18

- In 2017/18, UHSFT will build on improvements in 2016/17 which aimed to deliver the 4 priority clinical standards, including the 5 urgent specialist services:
  - Time to first consultant review;
  - Twice daily consultant review in critical care areas;
  - Seven day access to emergency investigations; and
  - Seven day access to consultant directed interventions.
- Initial priorities are:
  - Pharmacy
  - Therapies
  - Admin and Clerical support on the wards
  - Elderly care
  - Mental Health in ED
  - Stroke Thrombolysis
  - Women and Children's
- Continue key focus on workforce recruitment, retention and skill mix improvements, as well as hospital processes and supporting IT such as the bed management system.
- Continue to review Hospital Standardised Mortality Ratios at Trust Board, with all safety metrics (SIRIS and Never Events) identified in and out of hours.
- Agree further care group priorities with UHSFT to extend to at least a further 25% of hospital patients.

Our Key Actions in 2018/19

- Building on work during 2017/18, in 2018/19 ensure the majority (75%) of hospital patients can receive safe and consistent care across 7 days ahead of full implementation during 2019/20.
- Close working with all partners working to deliver other priority programmes within the HIOW STP, particularly integrated health and social care teams in the community (Southampton Better Care), enhanced access to primary care, 7 day services across all urgent response areas, including access to residential care and domiciliary care.
- Continue to redesign workforce, in tandem with new ways of working to deliver more effective clinical care and better outcomes; aligned to the core commitments in the STP Acute Alliance programme to maximise resources across Solent hospitals, stop ineffective practices such as routine follow ups and ensure scarce skilled staff are best utilised to deliver professional care to those who need it across 7 days.
- Ensure monitoring processes are in place to include detailed UHS plans.

Key Outcomes by the end of 2018/19

- ✓ Reduced length of stay of NEL admissions in outlying areas (Medicine, Elderly Care and Surgery)
- ✓ Improved weekend discharge rates
- ✓ Fewer internal delays – operational standards – no Black alerts during the Winter period.
- ✓ At least maintain Hospital Standardised Mortality Ratio below 100 and aim to show improvement across both weekends and weekdays.

Mental Health

OVERALL OBJECTIVE

To improve the quality, capacity and access to mental health services

Acute & Community Mental Health

Objective: Review and redesign current acute pathways and community service provision and develop a network of services.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18

- Increase number of children and young people (CYP) with a diagnosable mental health (MH) condition receiving treatment from an NHS-funded community mental health service to 30% from 2016/17 baseline by developing early intervention mental health team.
- Develop CYP IAPT services (Increasing Access to Psychological Interventions.
- Increase amount of CYP accessing evidence-based community eating disorder services within 4 weeks for a routine appointment and 1 week for an urgent appointment.
- Develop services and support to access early intervention and prevention services for all ages – to include the development of community solutions and navigation roles.
- Reduce waiting times for child and adolescent mental health services (CAMHS) from 18 weeks to 16 weeks, with the aim to reduce to 7 weeks by 2020/21.
- Begin to develop 0-25 years transition service for mental health.
- Continue to meet the early intervention in psychosis (EIP) target for 50% receiving treatment within 2 weeks.
- Increase the number of people accessing individual placement support (IPS) from a baseline of 2016/17.
- Increase the number of people with severe mental illness (SMI) who have received NICE-recommended screening and access to physical care interventions to 30%.
- Increase access to psychological therapies (IAPT) for adults to 17% with a particular focus on long term conditions.
- Eliminate the inappropriate use of acute out of area (OOA) placements by 2020/21.
- Support a reduction of suicides from a 2016/17 baseline by 10% by 2020/21through the development and implementation of a suicide prevention strategy.
- Develop coherent developmental disorders pathway for CYP and adults with ADHD, autism and Asperger's.
- Reporting will continue via Main CQRM, to include evidence of learning.
- Establish Implementation Board & Steering Group to monitor transformation, including risk assessment of projects on a monthly basis. Priority areas to include workforce , recruitment & retention.

Our Key Actions in 2018/19

- Increase number of children and young people (CYP) with a diagnosable mental health condition receiving treatment from an NHS-funded community mental health service to 32% from 2016/17 baseline by continuing to develop the early intervention mental health team.
- Continue to develop CYP IAPT services.
- Continue to increase amount of CYP accessing evidence-based community eating disorder services within 4 weeks for a routine appointment and 1 week for an urgent appointment.
- Develop services and support to access early intervention and prevention services for all ages – to include the development of community solutions and navigation roles.
- Reduce waiting times for CAMHS to 12 weeks, with the aim to reduce to 7 weeks by 2020/21.
- Continue to develop 0-25 years transition service for mental health.
- Continue to meet the early intervention in psychosis (EIP) target for 50% receiving treatment within 2 weeks and to reach Grade 2 specialist provision in line with NICE recommendations.
- Continue to increase the number of people accessing IPS by 25% from 2015/16 baseline.
- Increase the number of people with severe mental illness (SMI) who have received NICE-recommended screening and access to physical care interventions to 60%.
- Increase access to psychological therapies (IAPT) for adults to 19% with a particular focus on long term conditions.
- Eliminate the inappropriate use of acute out of area placements by 2020/21.
- Support a reduction of suicides from a 2016/17 baseline by 10% by 2020/21through the development and implementation of a suicide prevention strategy.
- Develop coherent developmental disorders pathway for CYP and adults with ADHD, autism and Asperger's.

Key Outcomes by the end of 2018/19

- ✓ 32% of CYP with diagnosable MH condition receiving treatment
- ✓ CYP IAPT service available
- ✓ Eating disorder target within 4 and 1 week to be set following 2016/17 baseline – 95% compliance by 2020/21
- ✓ Commissioned early intervention and prevention services
- ✓ CAMHS waiting times – 95% seen within 12 weeks
- ✓ 0-25 transition service in place
- ✓ Meet EIP Nice recommendations and access target
- ✓ Increased access to IPS form 2015/16 baseline by 25%
- ✓ 60% of people with SMI have screening and access to physical care interventions
- ✓ Increase access to IAPT to 19%
- ✓ Reduced OOA placements for acute inpatients
- ✓ Suicide prevention strategy
- ✓ Developmental disorders pathway developed

Mental Health

Mental Health Rehab Pathway & Out of Area Placements

Objective: Ensure people supported in out of area placements and repatriated and supported in locally provided services.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
• Redesign rehabilitation pathway and reduce out of area rehabilitation placements.	• Continue to redesign rehabilitation pathway and reduce out of area rehabilitation placements.	✓ Reduced number of out of area rehabilitation placements

Mental Health Crisis Care

Objective: Develop pathways to ensure people presenting in mental health crisis have access to timely, appropriate care.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
• Continue to develop crisis resolution and home treatment teams to be effective and properly resourced delivering best practice standards as described in the CORE fidelity criteria. • Develop appropriate crisis provision out of hours including s136 provision and support to patients experiencing a crisis as an alternative to acute inpatient admission, use of s136 or admission to emergency departments. • Continue to develop all-age acute hospital mental health liaison to achieve 'Core 24' service standard.	• Continue to develop crisis resolution and home treatment teams to be effective and properly resourced delivering best practice standards as described in the CORE fidelity criteria. • Develop appropriate crisis provision out of hours including s136 provision and support to patients experiencing a crisis as an alternative to acute inpatient admission, use of s136 or admission to emergency departments. • Continue to develop all-age acute hospital mental health liaison to achieve 'Core 24' service standard.	✓ Crisis team meets CORE fidelity ✓ Alternative crisis provision in place ✓ 24/7 all-age psychiatric liaison services

Dementia

Objective: Improve dementia diagnosis, care and support.

Leads: Stephanie Ramsey, Carole Binns

Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
• Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support to include the development of Dementia Friendly Southampton.	• Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support to include the development of Dementia Friendly Southampton.	✓ Dementia diagnosis rate of 66.7%

Supporting Enablers

- Quality
- Digital
- Estates
- Workforce
- New Commissioning Models

Improving Quality in Organisations

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Further review quality indicators for Providers to ensure they are fit for purpose and will deliver quality improvement.
- Roll out of serious incident (SI) assurance panels across all Providers to ensure the CCG receives relevant and appropriate assurance around actions being taken and learning and improvement in patient safety.
- Improve reporting to include better focus on outcomes to provide evidence of improvements for patients.
- Working in partnership with the other Clinical Commissioning Groups to revise quality reporting requirements to remove the non added value elements and reduce the burden on Providers.
- Support Providers in developing new staffing models to address current recruitment problems.
- Continued quality monitoring through Clinical Quality Review meetings to obtain assurance on the quality of services we commission and to share learning and good practice.
- Enhance quality visits to Providers to test improvements in service provision are being embedded and to provide support in addressing any issues identified or sharing of good practice.
- Support Providers in ensuring there are appropriate governance arrangements in place to ensure patients are safe and services are delivered in line with local and national requirements.
- Review Provider Cost Improvement Plans (CIP) plans to ensure they do not negatively impact on the quality of services to patients.
- Maintain quality and safety of clinical care, including interdependencies in promoting joint working across providers where relevant.
- Work with Providers in relation to discharge processes to ensure patients are provided with quality care as close to home as possible and are supported to live independently.
- Further development and implementation of a Quality Framework for Primary Care to provide assurance to the CCG Board about the quality of primary care.
- Continue to develop an effective process for the monitoring and management of general medical practices in special measures to support practices to make required improvements.
- Maintain continued quality improvement within Nursing Homes to identify areas for improvement and support them to meet required standards.
- Maintain continued quality improvement within health providers ensuring compliance with CQC standards and supporting providers who are rated as requires improvement or inadequate.
- Continue to use complaints, concerns, comments and compliments to provide learning for supporting commissioning decision making and quality review of services.

Our Key Actions in 2018/19

- Embed SI assurance panels across all Providers and continuous evidence of learning to drive quality improvement where needed.
- Evidence outcomes from new staffing models to ensure that they are effective or to support Provider to further review new ways of working.
- Review quality elements of the new 2 year contracts to ensure required outcomes are being delivered.
- Improvement in and embedding quality monitoring across Primary Care.
- Sharing lessons learned from incidents reported onto NRLS by Primary Care.
- Embed any changes made to the Primary Care Framework, to ensure potentially vulnerable practices are highlighted.
- Further work with Nursing Homes to ensure they are able to provide support to enable patient/client flow across the system.
- Working in partnership with the other Clinical Commissioning Groups to continue to review and further revise quality reporting requirements to ensure reporting is meaningful and reflects improvements being made across all Providers.
- Review Provider Cost Improvement Plans (CIP) plans to ensure they do not negatively impact on the quality of services to patients.
- Continued quality monitoring through Clinical Quality Review meetings to obtain assurance on the quality of services we commission and to share learning and good practice.
- Further enhance and where required, change format of quality visits to Providers to test improvements in service provision are being embedded and to provide support in addressing any issues identified or sharing of good practice.
- Embed, as required the process for the monitoring and management of practices in special measures.

Key Outcomes by the end of 2018/19

- ✓ Improved and embedded SI assurance process
- ✓ Improvement in patient safety
- ✓ Delivery of key quality indicators / targets
- ✓ Effective implementation of new staffing roles / reduced vacancy factor
- ✓ Reduction in burden of reporting on Providers / improved assurance
- ✓ Improved quality and performance targets
- ✓ Quality visits provide improved assurance on the quality of services commissioned

Avoidable Deaths

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Support Providers in appropriate learning from serious incidents where avoidable deaths are recorded (SI's).
- Quality Team members to attend provider Mortality meetings.
- Support delivery of the new quality indicator for Southern Health NHS FT to embed outcomes from the Mazars report and the continued improvement of investigation of deaths.
- Support Providers to identify key themes from investigations into patient death and ensure appropriate actions are taken.
- Work with Providers to ensure joint investigations are undertaken where required.
- Review of avoidable deaths in primary care – building on work started in Solent NHS Trust GP practices, explore how this model can be rolled out to other GP practices in Southampton.
- Establish methods of sharing learning across the Southampton system and the wider STP patch.

Our Key Actions in 2018/19

- Support Providers in further embedding a continuous learning culture.
- Embed SI assurance process in relation to patient death investigations.
- Test improved partnership working across Providers through review of investigations.
- Embed across primary care review of avoidable deaths.

Key Outcomes by the end of 2018/19

- ✓ Evidence of learning and improvements from serious incidents
- ✓ Improved and embedded SI assurance process in relation to patient deaths
- ✓ Reduction in number of patients deaths with the same root cause / contributory factors

Safeguarding

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Continue to improve GP engagement with the safeguarding process e.g. embed GP supervision, establish a GP safeguarding leads network.
- Contribute to Local Safeguarding Board strategies and ensure commissioned health services have systems in place to recognise and respond appropriately to safeguarding concerns e.g. childhood neglect/self-neglect, MCA/DoLS and domestic abuse.
- Work collaboratively to support unaccompanied asylum seeker children and looked after children to meet their health needs in appropriate timescales.

Our Key Actions in 2018/19

- Continue to improve GP engagement with safeguarding process e.g. support development of Safeguarding "champions" within Primary Care.
- Continue to support greater system-wide learning, review and actions and evaluate outcomes of all domestic homicide reviews, serious case reviews action plans and Significant Incident Learning Process (SILP) of both single and inter-agency action to receive assurance that plans have been implemented and in turn improves outcomes for children and adults with care and support needs.

Key Outcomes by the end of 2018/19

- ✓ High standards of safeguarding practice across the health system
- ✓ Improvements in the quality and safeguarding practice of Primary Care
- ✓ Ensure the effectiveness of multiagency arrangements to safeguard and promote the wellbeing of children and adults at risk from abuse or neglect.
- ✓ Continue to commission services which promote quality safeguarding practice and protect individuals at risk.
- ✓ Ensure collaboration of multi-agency partners to support delivery of NHS England safeguarding work streams

Sepsis & Clostridium Difficile (CDI)

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- In line with Government targets work to establish a robust reporting metric a wider range of infections in line with reducing the impact of serious infections, specifically within our acute providers.
- Work closely with our providers at reducing the number of HCAI's; focussing on those identified within the NHS Quality Premium 2017-19 as well as the current mandated HCAIs.
- In line with the Quality Premium Indicator 17/18 &18/19 for Blood Stream Infections (part A) work toward a 50% reduction of Gram Negative blood stream infections.
- Work to establish a sepsis pathway within the social care sector, as well as the primary care sector, which would provide assurance around care delivery to the deteriorating resident or patient.
- Continue to monitor all cases of CDI, whether within the Acute or Community sector to establish that no trends are developing.
- Continue to drive a reduction in high-risk antimicrobial prescribing and PPI's, specifically within the primary care sector, which are known triggers for CDI.
- Continue to contribute to the collegiate approach to CDI appeals to ensure that lapse of care was not a factor in the CDI.

Our Key Actions in 2018/19

- Utilising the metrics identified and created in 2017-18, work with our providers to drive the reductions required.
- Work closely with our providers at reducing the number of HCAI's; in particular around those identified within the NHS Quality Premium 2017-19.
- In line with the Quality Premium Indicator 17/18 & 18/19 for Blood Stream Infections part A work toward the aims of the O'Neill review for a 50% reduction of Gram Negative blood stream infections.
- Monitor the embedding of the sepsis pathway within the social care sector.
- Continue to drive a reduction in high-risk antimicrobial prescribing and proton pump inhibitors (PPI's), specifically within the primary care sector, which are known triggers for CDI.
- Continue to monitor all cases of CDI, whether within the Acute or Community sector to establish that no trends are developing .

Key Outcomes by the end of 2018/19

Sepsis:

- ✓ 90% of cases of Sepsis accurately identified on admission to ED
- ✓ 100% of identified patients with sepsis receiving the 1st course of appropriate antibiotics within 60 minutes of admission to the acute setting.
- ✓ A reduction in the number of deaths where sepsis is identified on the death certificate as a key cause of death.

C-Difficile:

- ✓ All CDI cases within both the Acute and Community settings are identified and a RCA completed.
- ✓ Continue to drive down the number of CDI incidences in line with national initiatives.
- ✓ All decisions around CDI's that are not as a result of lapse in care are agreed by consensus.

Personal Health Budgets

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Review existing Continuing Health Care (CHC) PHB policies and processes ensuring learning from the first PHB's has been incorporated into these.
- Review, refine and further strengthen a comprehensive CHC PHB offer including a menu of brokerage, support , training and insurance options for individuals interested in PHB's to chose from.
- Ensure the CHC PHB offer is published and readily available for CHC clients and their families to view.
- Support further development PHB offer beyond CHC.
- Evaluate options for offering PHB within fast track and end of life care.

Our Key Actions in 2018/19

- Establish reasons for non-uptake of PHB's when offered and develop approaches to address these barriers to PHB take-up.
- Work with local providers and community representatives to support wider take-up of PHB's.
- Investigate development of the PHB offer for use within nursing and residential homes.

Key Outcomes by the end of 2018/19

- ✓ Reasons for non-take up of all PHB's offered to CHC clients to be clearly documented.
- ✓ For there to be evidenced creative approaches to overcoming barriers to PHB take-up and the effectiveness of these approaches to have been evaluated.
- ✓ Evidence of continued increase in take up of PHB's within CHC.

Antimicrobial Prescribing

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

The Quality Premium Indicator 17/18 &18/19 for Blood Stream Infections requires:

- Part b) reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care
- Part c) sustained reduction of inappropriate antibiotic prescribing in primary

We will:

- Publicise key antibiotic messages in our GP / prescriber bulletin 'Antidote' to highlight antimicrobial prescribing.
- Monitor ongoing surgery level data for both volume (Antibiotic STAR-PU) and quality UTI prescribing.
- Monitoring of antimicrobial prescribing via the CQRM process for OOH's.
- Support the government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates using.

Our Key Actions in 2018/19

- Support GP practices through the use and application of the Antibiotic Prescribing Guidelines (2014) available electronically, in paper format and as a phone App, both for In-Hours and Out of Hours prescribing.
- Provide Medicines Management team input into GP TARGET training days throughout the year to ensure wider circulation and support for prescribers.
- Provide Medicines Management lead GP Task Group meetings (5 per year) to inform prescribing leads who will disseminate information within their GP practices.
- Include targets in our prescribing work programmes with GP surgeries with incentives.
- Give support and feedback to GPs at GP surgery specific meetings (at least 2 per year) as part of this work programme where we challenge inappropriate prescribing in UTIs and high antibiotic prescribing (Antibiotic STAR-PU).

Key Outcomes by the end of 2018/19

- ✓ Reach the required targets of
- ✓ A 10% reduction (or greater) in the Trimethoprim: Nitrofurantoin prescribing ratio based on CCG baseline data (June 2015-May 2016)
- ✓ a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June 2015-May 2016)
- ✓ Demonstrate a sustained reduction of inappropriate antibiotic prescribing in primary care - items per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR-PU) must be equal to or below England 2013/14 mean performance value of
- ✓ 1.161 items per STAR-PU

Maternity

Leads: Stephanie Ramsey, Donna Chapman

Our Key Actions in 2017/18

- Work with maternity services in relation to local delivery of the local maternity review and delivery and service development and improvement plan.
- In first year implementation: Work with local maternity service and neighbouring commissioners to deliver progress on key elements of the national Better Births review for full roll out to 2020.
- Development of our national maternity pioneer personalisation and choice proposals.
- Work with local maternity service and neighbouring providers and commissioners to improve the consistency of care in relation to the maternity service specification in line with the STP plan for the SHIP8 area.
- Commission maternity services that promote breastfeeding and prioritise reducing smoking in pregnancy.

Our Key Actions in 2018/19

- Work with maternity service to evaluate the effectiveness of new locality working arrangements and their impact on patient experience and workforce stability, especially in relation to unplanned abstraction from community midwifery functions to birthing unit.
- Continue to work with local maternity service and neighbouring commissioners to deliver on key elements of the national Better Births review.
- 2nd year implementation – continued development of our national maternity pioneer personalisation and choice proposals.
- Continue work with local maternity service and neighbouring providers and commissioners to improve the consistency of care in relation to the maternity service specification in line with the STP plan for the SHIP8 area.

Key Outcomes by the end of 2018/19

- ✓ Improved workforce stability and lower vacancies
- ✓ Reduced levels of smoking in maternity
- ✓ Improved breastfeeding rates
- ✓ Improved normal birth rate
- ✓ Further improved Family and Friends ratings
- ✓ Area wide service consistency through shared specification

Digital

Digital Workstreams

Lead: Mark Kelsey

Southampton City CCG is part of the Southampton local delivery system for the STP and key projects will be delivered through this delivery system. We have set up a Southampton and South West Hampshire system technology delivery group, comprising of local commissioners from Southampton and West Hampshire and local providers through which local projects will be managed. Within Southampton City CCG, we also have a commissioner's ICT group to focus more on primary care technology projects. The six technology projects within the Southampton City CCG Operational Plan align directly with the equivalent STP projects, as below. Southampton City CCG is also well represented at the HIOW Digital Programme board and associated groups.

Area	Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
Integrated Digital Health & Care Record	• Our local solution, the Hampshire Health Record, will be upgraded to a new version, improving accessibility and visibility of data from multiple organisations. The new version is being tested in Southampton Q4 16-17 with wider roll out in 17/18. • Hampshire Health Record data sharing agreements reviewed and agreed by all data controllers across Hampshire. • Conduct full assessment of the current state against the universal digital capabilities and a plan for addressing these over period of plan.	• A new integration engine will be developed to improve linkage between local systems and share more data. • New data flows from mental health provider (Southern Health) will be developed to improve information shared for mental health patients.	✓ Upgrade to the HHR will enable support for mobile working and customisable dataset interfaces for clinical staff. ✓ An integration engine and master patient index will provide the backbone of integration across care settings ✓ Integrated care plans functionality will provide a single source for care plans to be created, stored and accessed ✓ Wider data sharing models will build on the success and experience of the data sharing through the HHR.
Patient Portal & Channel Shift	• A digital participation strategy will be developed jointly across Hampshire. In Southampton, we will explore linking existing UHS MyHealthRecord users into their Hampshire health record data, once the new HHR version is working. • We will continue to increase uptake of patient online services through GP practices, for repeat prescription and record viewing.	• A unified patient portal will be developed within Hampshire and we will ensure local systems are linked into this. • Further development of the portal as above will support increasing patient use of online services. • We will link with public health digital front door to allow access to self-help lifestyle interventions. • Through the work across Hampshire on apps we will promote use of health management apps in long term conditions such as diabetes, and mental health.	✓ There will be a single patient portal that is accessible by patients of all Southampton care services on multiple devices and is their main route in to the Southampton health and care system. ✓ The portal will allow patients to view their records, access self-help information, manage appointments, order repeat prescriptions and ultimately contribute to their care management alongside health and care professionals.
Mobile Working for Integrated Teams & Digital Comms across Providers	• Wifi access will be enabled across all primary care sites so that any health and care provider can securely access their own business systems from any health setting.	• Wifi access will be developed uniformly across remaining secondary, community and social care sites.	✓ Integrated health and social care teams will be able to work seamlessly across sites and organisations

Digital Workstreams

Lead: Mark Kelsey

Area	Our Key Actions in 2017/18	Our Key Actions in 2018/19	Key Outcomes by the end of 2018/19
E-Prescribing	• We will continue to promote uptake of EPS within primary care settings, initially for repeat prescriptions, and repeat dispensing, and then increasingly for acute prescriptions.	• Audio and video calling will be available to NHSMail users. We will work with our integrated care teams to enable them to use Skype for business for team communication and patient consultations. • Working with hospital providers we will ensure systems are available which better support medicines reconciliation across care settings.	✓ Improved medicines safety ✓ Increased use of electronic prescriptions, streamlining systems for surgeries and patients.
Care Coordination Infrastructure	• Integrating with work across Hampshire to reprocure 111 and OOH services, we will link our local enhanced access and home visiting services into the HIOW care coordination centre infrastructure.		✓ Simpler access to care, with arrangements in place to refer citizens quickly to the most appropriate service, advice or website ✓ Earlier and streamlined assessment of need, with better use of information and by securing a wider range of specialist input ✓ Improved decision support, directly influencing the effectiveness and efficiency of resource deployment across the system ✓ Support more people in their own home or community (shifting care from acute), by remote monitoring and/or by linking citizens to the relevant specialist by video (rather than having to travel)
Optimising Intelligence Capability	• We will identify areas where improved intelligence capability can help tackle our challenges within Southampton. • We will streamline and simplify access to existing intelligence tools to increase usage and uptake.		✓ Data-driven insights will support clinicians to increase efficiency, and improve the performance of local service delivery ✓ Unlocking data connections and building our analytical capabilities will empower us to create reliable and actionable insights ✓ The adoption of population health management will improve health outcomes and achieve behaviour change at the same time as lowering costs. ✓ The programme will deliver insight and intelligence to inform future strategies and transformation plans.

Estates

Leads: Peter Horne, Paul Benson

Our Key Actions in 2017/18

2017/18 will see continuing focus on the implementation of the Southampton Strategic Estates Plan which itself provides an important contribution to the estates workstream of the Hampshire & Isle of Wight STP. Central to this will be the project to deliver improved utilisation of the two community hospitals in Southampton – the Royal South Hampshire Hospital and the Western Community Hospital. An Outline Business Case to identify a preferred reconfiguration option is presently in development and is expected to be approved by relevant stakeholder statutory bodies by March 2017. Thus during the period 2017/18-18/19 the project will move to the next phase – the development, approval, and implementation of a Full Business Case. Work will also continue on the estate improvement elements of the Southampton City Primary Care Strategy which includes the establishment of a six Cluster Resource Centres ("hubs") across the city. Through the forum of the Southampton One Public Estate Group, the CCG will continue to examine estate rationalisation/ improvement opportunities with other public sector bodies in the city – in particular the City Council.

Royal South Hampshire Hospital & Western Community Hospital estate optimisation project

- Consequent upon approval of the OBC by all relevant stakeholders, develop and secure approval of a Full Business Case to deliver the preferred option. The complete FBC is expected no later than March 2018 and will include all necessary consents.
- Assist Comms and Engagement colleagues in engagement with public and staff stakeholders (already in progress).
- Work with colleagues in Southampton City Council and NHS Property Services to deliver a c80 unit Extra Care facility on surplus land (up to 25% of the site) at the RSH. This will provide a vital contribution in the delivery of Southampton City Council's strategy to significantly expand Extra Care capacity at key sites across Southampton which will in turn support the delivery of the Better Care Southampton Plan.

Primary Care Estate

- Finalise the business case for the development of an ETTF-funded (66%) Cluster Resource Centre (CRC) on the Shirley Health Centre site (Cluster 1).
- If the business case is approved, and if the local funding is secured, initiate the delivery programme.
- Develop a programme for the delivery of CRCs for the other five clusters (including the proposed One Public Estate development for Bitterne).
- Develop a practice infrastructure modernisation programme to support CCG Primary Care Strategy.

Our Key Actions in 2018/19

2018/19 will see implementation of the first phases of the **Royal South Hampshire Hospital & Western Community Hospital estate optimisation project.** Key actions will include:

- Rationalisation of the current usage of the RSH (in particular the Mary Seacole block) to ensure that it is used only for services that need to be in a community hospital location for operational reasons - alternative, and less costly "office" accommodation will be arranged.
- Following-on from this, adaptation/construction of a new location for Lower Brambles (OP rehabilitation ward) and the demolition of the current building. The site will be used for a Cluster Resource Centre for the Nicholstown/Newtown neighbourhood.
- If the business case is agreed, building works to establish a Cluster Resource Centre at Shirley Health Centre will be completed.
- Again subject to an approved business case, demolition of the redundant Dept of Psychiatry building at the Royal South Hants Hospital and the construction of a c80 unit Extra Care facility in a project led by Southampton City Council.
- Work will continue on implementation of the Primary Care Estate Strategy which will include the establishment of a network of five further Cluster Resource Centres and also an infrastructure modernisation programme to ensure that all primary care premises are fit for their purpose.

Key Outcomes by the end of 2018/19

- ✓ Completion of the ETTF-funded (66%) Cluster Resource Centre at Shirley Health Centre.
- ✓ Implementation of a programme, including capital funding arrangements (eg LIFT or Project Phoenix) to provide five (non-ETTF) CRCs in key locations across the city.
- ✓ An approved Full Business Case for the optimisation of the Royal South Hants Hospital and the Western Community Hospital: this will include the replacement of accommodation that is no longer fit for inpatients (Kite Unit/Lower Brambles Ward).
- ✓ Following on from the above, the release of surplus NHS land for Extra Care accommodation and key worker/affordable housing. Specifically, we expect to see a c80 unit Extra Care facility adjacent to the RSH.
- ✓ An agreed site master plan for both the Royal South Hants Hospital and the Western Community Hospital which will map out how the sites are to be developed across the next 10 years

Workforce

Leads: CCG Managers and Providers

Our Key Actions in 2017/18

- Continue to work with providers to support the development of a flexible workforce: new roles, changes to skill mix and support recruitment and retention initiatives.
- Ensure reviews of CIP and QIPP schemes to determine impact on the workforce.
- Support providers with their recruitment and retention, and staffing redesign plans including the introduction of new roles in relation to Adult Mental Health services and particularly ensuring safe staffing at Antelope House.
- Review CCG engagement with Health Education England to ensure appropriate representation is in place to support providers in the development of the workforce to deliver the 2017-19 plans.
- Ensure the continuation of CCG engagement methods with providers in relation to workforce, including a focus on safer staffing at CQRMs and via contracting processes to ensure appropriately trained and skilled staff are available to support services.

Our Key Actions in 2018/19

- Continue to make further progress with key actions from 2017/18.
- Work as one system to develop the right people, skills and capabilities to support the transformed health and care system.
- Continue to work with providers for a flexible workforce shared across geographical and organisational boundaries, working in new ways with extended skills to deliver the workforce transformation.
- Increase the time our staff spend making the best use of their skills/experience.
- Explore the potential of new technology and reduce unnecessary competition for limited staffing resources.

Key Outcomes by the end of 2018/19

- ✓ No overall growth in the workforce over the next five years
- ✓ Improved recruitment and retention
- ✓ Reduction in use of temporary and agency workers
- ✓ QIPP delivery

Continuing Healthcare (CHC)

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Refine and develop normal business process to embed existing and emerging best practice in NHS Continuing Healthcare and Continuing care for children. This will include but not be limited to - NHS England operating model for Continuing Healthcare, Continuing Healthcare Assessment tool, emerging best practice in local and national CHC networks.
- Refine and develop normal business process to embed the 6c's (care, compassion, competent, communication, courage and commitment) in every interaction or transaction that the team has.
- Refine and develop existing successful normal business process to maximise delivery of cost efficiencies alongside care and patient/family experience that is safe, effective and timely.
- Refine and develop educational and other support for system partners and stakeholders, supporting delivery of increased number, quality and timeliness of assessments for patients.
- Support commissioning colleagues and systems partners in reviewing service specifications/contracts across a range of areas (particularly primary care and community nursing) to embed appropriate levers/incentives that support increased engagement and involvement in CHC.
- Collaborate with system partners to develop, agree and implement new system wide approaches to reducing the number of CHC assessments completed in acute settings.
- Collaborate with systems partners to deliver integrated services for Adults with learning disabilities (LD) in Southampton.
- Support commissioning colleagues in refining, further developing and improving existing community end of life services and care pathways in Southampton.

Our Key Actions in 2018/19

- Continuous review, refinement and where appropriate further development of all 2017-18 actions/areas.
- Refine and develop use of technology to improve efficiency, transition between services and patient/family experience.
- Refine and develop links with community groups and third sector colleagues in supporting policy and process development (for example – expanding scope of independent panel chairs, increased involvement in policy development and stakeholder groups).
- Collaborate with system partners and care providers in Southampton to deliver earlier identification and assessment of potential CHC eligibility in care settings.
- Further refine, progress and develop integrated working and commissioning to maximise opportunities to share best practice, maximise cost efficiencies and deliver safe, appropriate and timely care.
- Support work across STP area to maximise best practice and cost efficiency in CHC.

Key Outcomes by the end of 2018/19

- ✓ Normal CHC business incorporates local, regional and national best practice in both NHS Continuing Healthcare and Continuing care for children.
- ✓ Feedback from clients, families and system partners clearly evidences embedding of the 6c's in normal CHC business.
- ✓ Integrated whole system approach to CHC assessment and applications.
- ✓ Increased number, quality and timeliness of CHC assessment and applications.
- ✓ Increased number of CHC applications that originate from outside of the acute hospital setting, delivering or surpassing nationally mandated metric.
- ✓ Improved quality and patient/family experience in Adult LD services and end of life services to population of Southampton.
- ✓ Continued robust delivery of cost efficiencies alongside safe, effective and timely care – leading and contributing to wider delivery across STP area.

Prescribing & Medicines Management

Leads: Stephanie Ramsey, Carol Alstrom

Our Key Actions in 2017/18

- Cost–effective use of generic medicines, from new and existing patent expiry savings. Requires year on year work.
- Continuing to support cost–effective prescribing by promoting tools at the point of prescribing in GP surgeries: OptimiseRx.
- Reducing the use of Items less suitable for prescribing.

Other Practice Based Interventions

- Antidepressant Work: Examining the pathway and use of Antidepressants: We are an outlier in Right Care for antidepressant prescribing as spend per ASTRO-PU (weighted population). This requires a system wide review of all available support for depression rather than an isolated look at prescribing. We will need Clinical Leadership and patient engagement. We will develop a work plan across two years.
- Care Home medicines waste reduction (ordering systems): Ordering systems are complex and prone to create waste through poor communication. We have a pilot tested project plan which will require robust NHSBSA data (due Jan 2017) to spread further and give meaningful results.
- Reducing Repeats within Community Pharmacy Systems: These systems can lead to errors and medicines waste and remove control of prescribing from the patients and GP. We need to support the transfer of prescription ordering to Electronic Repeat Dispensing. This will require specific patient engagement. By doing this we anticipate we can reduce prescription items by 1%.
- Ensuring Appropriate Infant Feed Prescribing: Drug Usage Review (a pre audit review) vs. Hampshire Infant Feeding Guidelines to ensure appropriate use of these specialist feeds.
- Pharmacy support for multidisciplinary medication review of patients within the care home environment: Use of the STOPP START tool.
- Benchmarking of PbR excluded high cost medicines across HIOW providers including maximising the use of Biosimilars. Southampton are the national leaders in this area by way of operating a gain share system.

Our Key Actions in 2018/19

- Cost–effective use of generic medicines, from new and existing patent expiry savings. Requires year on year work.
- Continuing to support cost – effective prescribing by promoting tools at the point of prescribing in GP surgeries: OptimiseRx.
- Maintenance of savings made: by reducing Items less suitable for prescribing Cost avoidance in these areas.

Other Practice Based Interventions

- Antidepressant Work Continued: We plan to release savings from prescribing but may need to invest elsewhere in the pathway to ensure we can offer the best outcome for our patients.
- Care Home medicines waste reduction (ordering systems): This will take up to 18 months to spread depending on start time. By improving relationships between 3 key partners: GPs, Pharmacies & Care homes we aim to reduce medicines waste and ensure cost effective & safer use of medicines leading to better patient care.
- Reducing Repeats within Community Pharmacy Systems: Continuing this project roll out across remaining GP practices. Outcomes: Returning to Patient & GP control of medicine ordering which is safer and more cost effective.
- Ensuring Appropriate Infant Feed Prescribing: Safer & cost effective prescribing .Maintenance of savings – cost avoidance. Better patient care in early years.
- Review of current up take of primary care rebates on specific medicines which are offered by the pharma industry – evaluation at scale across the HIOW system to share effort and savings.
- Transfer of care initiatives to refer patients to community pharmacy following an in patient stay. Following on from the Newcastle experience.

Key Outcomes by the end of 2018/19

- ✓ Safer and cost effective prescribing
- ✓ Safer ordering, reduction in medicines waste
- ✓ Better patient care

Southampton System Delivery of the Sustainability and Transformation Plan (STP)

Strategic Oversight and Governance	At a local level, the Southampton Health and Wellbeing Board will be the vehicle for maintaining oversight of local system delivery, ensuring alignment of CCG plans with the priorities of the revised Southampton Health and Wellbeing Strategy; This will also provide the means by which to ensure alignment between local planning and implementation and the wider HIOW STP via participation in the new Joint Committee of the four HWBs.
HIOW Executive Delivery Group	The CCG will participate fully in the EDG through its Accountable Officer and expect to be held to account to deliver its Operating Plan in full alignment with the STP.
Local Delivery System	Southampton System Chiefs is an established group comprising CEOs of the CCG, City Council, UHSFT, Solent NHS Trust and Southern Health FT. This group will oversee the development of: • Integrated commissioning for the City (currently undertaking an option appraisal which will build on the establishment of the integrated commissioning unit) based on the 'one city' with a single budget and a single vision approach. • Integrated provision for the City based on an MCP model through the Better Care Southampton programme, joined up health and social care, physical and emotional health and primary and community services, built around six clusters of 30-50,000 people. • Links to wider new care models (eg PACS) via the Solent Acute Alliance. • Improved mental health services through implementation of the 'Mental Health Matters' programme. The System Chiefs Group will agree new terms of reference, programme management and resourcing arrangements and is likely to expand its membership to include other key delivery partners including the independent, voluntary and primary care sector providers.
HIOW Commissioning Board	• The CCG will work collaboratively with CCGs in HIOW and specialised commissioners to set out a coherent and cohesive view of future requirements (including robust capacity and demand planning) and develop new and simplified approaches to contracting that support the aims of the STP, share and mitigate risk and enable new models of care.

Finance, Activity, RightCare & QIPP

Sustainable Finances

Objective: Creating a financially sustainable health system for the future.

Leads: James Rimmer, Kay Rothwell

Our Key Actions in 2017/18

- Contribute to the STP wide financial savings requirements of £577m by 2020/21. For Southampton City CCG in 2017/18, this is £10.55m or 2.9% of turnover.
- Continue to support the meetings of the Directors of Finance of all the health and social care organisations within the STP footprint, for 2017/18 this will be focusing upon delivery of the indicative system control total through monthly monitoring or the finances reporting to the STP Board where corrective action is required.
- The CCG's main providers within the STP footprint of Solent, Southern and UHS see their control totals improve by £12m in 2017/18 compared to 2016/17. The CCG will need to be conscious of this as it concludes its contract negotiations.
- Within the £577m savings requirement is £63m of savings yet to be identified, the FDs need to update the financial of the STP reflecting of some non allocation changes and impacts of the 2017/18 contract round, with any yet to be identified gap closed during 2017/18.
- Following agreement of 2 year contracts for 2017/18 and 2018/19, the CCG will need to carefully monitor its monthly activity performance against plan taking any corrective actions as required to deliver its share of the STP.
- Southampton City CCG to achieve in year breakeven in 2017/18, as in line with the business rules we have a 1% cumulative surplus.
- Ensure the IR transfer of responsibility for commissioning certain activity between the CCG and specialised commissioner flows as expected in the contract for 2017/18 and where this is not the case seek tripartite agreement for allocations adjustments to correct.
- Ensure the NHS Property Services move to market rent is cost neutral in line with any funding from NHS England and any voids the CCG funds are minimised.
- Continue to support the RightCare pathway review approach, embedding the changes identified from the two pathway reviews undertaken in 2016/17 and complete the work in 2017/18 ready for delivery. See page 47 for more information on RightCare.

Our Key Actions in 2018/19

- Contribute to the STP wide financial savings requirements of £577m by 2020/21. for NHS Southampton City CCG in 2018/19 this is £10.77m or 2.9% of turnover.
- Continue to support the meetings of the Directors of Finance of all the health and social care organisations within the STP footprint, in 2018/19 this will likely be focusing upon delivery of a formal system control total through monthly monitoring or the finances reporting to the STP Board where corrective action is required.
- The CCG's main providers within the STP footprint of Solent, Southern and UHS see their control totals improve by £7.1m in 2018/19 compared to 2016/17. The CCG will need to be conscious of this as it concludes its contract negotiations.
- Look towards 2019/20-2020/21 contracts and prepare 2 year contract offers with finance and activity plans inline with the STP.
- Southampton City CCG to achieve in year breakeven in 2018/19, as in line with the business rules we have a 1% cumulative surplus.
- Continue to support the RightCare pathway review approach, embedding the changes identified to the pathway reviews undertaken in 2017/18 and complete the work in 2018/19 ready for delivery in 2019/20.
- Commence work on identification of 2 year QIPP schemes ready for delivery from 2019/20.

Key Outcomes by the end of 2018/19

- ✓ Deliver £21.32m of QIPP.
- ✓ Maintain 1% cumulative surplus.
- ✓ System to achieve its control totals in both 2017/18 and 2018/19.

Finance (cont.)

Sustainable Finances (cont.)

Objective: Creating a financially sustainable health system for the future.

Leads: James Rimmer, Kay Rothwell

Our Key Actions in 2017/18

- Invest £662k in New Care Models at Solent NHS Trust in line with the STP model in order to reduce demand in the acute sector. This new investment is in addition to tariff and population growth funding of £172k in Solent NHS Trust.
- Invest £419k in mental health services in line with the MH FYFV and the STP model in order to partly reduce demand in the acute sector and support improvements to mental health services. This new investment is in addition to tariff and population growth funding of £177k in Southern Health NHS Foundation Trust.
- Invest £366k in children's mental health services in line with the MH FYFV and the STP model in order to support improvements to mental health services. This new investment is in addition to tariff and population growth funding of £26k in Solent NHS Trust.
- Other investments in children's and adults MH services will be made in line with the MH 5YFV with providers outside of the STP footprint / NHS family of £252k.
- All acute contract growth for NHS providers within the STP footprint is in line with the IHAM growth model adjusted then downward to reflect the STP solutions for reducing acute demand, in Southampton much of this will relate to the investment in new care models and RightCare.
- Growth in the CCG's primary care allocation is £2.1m, whilst some of this will be required to fund list size growth and inflationary pressures the balance will be used to drive new investments in primary care in the City. The CCG ends 2017/18 5.1% underfunded in its primary care allocation.
- Growth of the CCG's programme allocation per capita is 1.4% in 2017/18, this level of growth is significantly challenging when meeting all the required pressures and investments required, hence the STP overall challenge and the CCG QIPP gap. The CCG ends 2017/18 4.7% underfunded on its programme allocation.
- The CCG's use of specialised services see it being over using its indicative allocation by £11.6m in 2017/18 seeing its closing overfunding at 17.2%.
- CCGs are required to hold 1% headroom, which is £3.57m in 2017/18. 50% of this can be committed upfront, of which £415k will be deployed with the local practices to support delivery of the high impact changes as per the GPFV the balance of £1.374m will be used to further bring forward transformation schemes to speed up delivery. The remaining £1.789m is held and cannot be spent without NHS England's permission.

Our Key Actions in 2018/19

- Invest £713k in New Care Models at Solent NHS Trust in line with the STP model in order to reduce demand in the acute sector. This new investment is in addition to tariff and population growth funding of £185k in Solent NHS Trust.
- Invest £431k in mental health services in line with the MH FYFV and the STP model in order to partly reduce demand in the acute sector and support improvements to mental health services. This new investment is in addition to tariff and population growth funding of £181k in Southern Health NHS Foundation Trust.
- Invest £78k in children mental health services in line with the MH FYFV and the STP model in order to support improvements to mental health services. This new investment is in addition to tariff and population growth funding of £29k and Solent NHS Trust.
- Other investments in children's and adults MH services will be made in line with the MH FYFV with providers outside of the STP footprint / NHS family of £755k.
- All acute contract growth for NHS providers within the STP footprint is in line with the IHAM growth model adjusted then downward to reflect the STP solutions for reducing acute demand, in Southampton much of this will relate to the investment in new care models and RightCare.
- Growth in the CCG's primary care allocation is £1.1m, whilst some of this will be required to fund list size growth and inflationary pressures the balance will be used to drive new investments in primary care in the City. The CCG ends 2018/19 4.9% underfunded in its primary care allocation.
- Growth of the CCG's programme allocation per capita is 1.4% in 2018/19, this level of growth is significantly challenging when meeting all the required pressures and investments required, hence the STP overall challenge and the CCG QIPP gap. The CCG ends 2018/19 4.7% underfunded on its programme allocation.
- The CCG's use of specialised services see it being over using its indicative allocation by £12.1m in 2017/18 seeing its closing overfunding at 17.2%.
- CCGs are required to hold 1% headroom, which is £3.7m in 2018/19. 50% of this can be committed upfront, of which £417k will be deployed with the local practices to support delivery of the high impact changes as per the GPFV the balance of £1.456m will be used to further bring forward transformation schemes to speed up delivery. The remaining £1.873m is held and cannot be spend without NHS England's permission.

Key Outcomes by the end of 2018/19

- ✓ Ensure the investment of over £1.7m in community services delivers the changes required to stem acute activity demand.
- ✓ Ensure the investment of over £800k in children's mental health services delivers the improvements as outlined in the mental health section of this plan.
- ✓ Ensure investment of over £1.9m in adult mental health services delivers the changes required in line with the MH FYFV and the improvements set out in this operational plan.

Activity, Constitution Standards & IAF

Activity & NHS Constitution Standards

Objective: Develop robust, deliverable plans

Leads: CCG Managers

Our Key Actions for 2017/18 plans

Activity Plans

- Submit activity plans that reflect NHS England's view of 2016/17 forecast outturn.
- Develop activity plans to ensure alignment to NHS England's view of forecast outturn.
- Fully understand issues relating to coding by providers of activity defined nationally as NHS England direct commissioning activity; monitor the impact of these in 2017/18
- Apply the IHAM model growth assumptions as per the STP with explanation of any different growth used.
- Continue to agree the impact of the Identification Rules to reflect activity commissioning responsibility movements between the CCG and Specialised Commissioning.
- Identify our Southampton City CCG share of the overall HIOW transformational changes from the STP "Impacts on Activity" table within STP. Include adjustments to reflect changes that CCG has clear transformational implementation plans to support the activity changes.
- Include QIPP reductions aligned to the STP or reflective of our local plans towards achieving the STP transformation agenda.
- Agree reductions and include in provider contracts.
- Ensure Mental Health & Community Contract discussions have included workforce implications of new significant investment, including risks & mitigating actions.
- Include rebasing of referrals plan agreed in October 2016 with local NHS England team.
- Continue detailed internal reporting and monitoring of referrals and activity.
- Continue to have robust performance management processes in place to implement mitigation where and when necessary in a timely manner.

NHS Constitutional Standards

- Ensure all standards and trajectories have been agreed with providers to meet the National Standards.
- Ensure the UHS A&E trajectory is challenging, improves on previous years' performance, agreed and deliverable.
- Set trajectories using previous years' performance, seasonality, growth and efficiency reductions.
- Ensure monthly reporting is in place to monitor performance data for current and new standards, with appropriate mitigation when required.

Our Key Actions for 2018/19 plans

- Ensure any adjustments resulting from 2017/18 are bought forward into 2018/19 Plans.
- Continue with alignment of STP transformational change reductions are reflected in plans and implemented within QIPP Programmes.
- Agree plans with providers, and include in contracts.
- Ensure appropriate reporting and monitoring processes are in place.
- Continue to have robust performance management processes in place to implement mitigation where and when necessary in a timely manner.

Key Outcomes by the end of 2018/19

- ✓ Delivery of the NHS Constitution Standards
- ✓ Delivery of the activity plans
- ✓ Monitoring and reporting processes in place

Improvement & Assessment Framework

Objective: Develop the CCG Improvement and Assessment Framework

Leads: CCG Managers

Our Key Actions for 2017/18 plans

- As part of the new CCG Improvement & Assessment Framework (CCG IAF), an initial baseline rating for six clinical priority areas was published by NHS England in September 2016. The CCG will ensure validation and actions to improve are in place for Southampton CCG ratings:
  - Cancer – Needs Improvement
  - Dementia – Performing Well
  - Diabetes – Performing Well
  - Learning Disabilities – Needs Improvement
  - Maternity – Performing Well
- Develop the ratings derived from the indicators in the new framework looking at the CCG's current baseline performance using the most recent data available as at the end of June 2016. These provide a starting point for future assessments.
- Continue to review, validate and communicate the CCG IAF dashboard published by NHS England.
- Continue to ensure lead CCG managers are aware of performance and actions required for improvement.

Our Key Actions for 2018/19 plans

- Continue to develop the CCG IAF ratings and actions to continuously improve the CCG's position/ratings.
- Continue to review the CCG's position in its peer group to ensure satisfactory performance and ranking.

Key Outcomes by the end of 2018/19

- ✓ Accurate and reliable data for ratings
- ✓ Improvement actions in place
- ✓ Continuous improvement

RightCare

Lead: James Rimmer, Clare Young

Our Key Actions in 2017/18

RightCare is a national programme, rolled out by NHS England in 2016/17, to equip CCGs with benchmarking resources that enable them to be able to identify areas of unwarranted variation, across both spend and quality. During 2016/17, the benchmarking resources from RightCare helped us to identify that we are a significant outlier for spend on Neurology and Gastrointestinal. We subsequently agreed to carry out deep-dive reviews of these pathways to identify improvements and efficiencies. Some improvements in Neurology and Gastrointestinal were implemented in 2016/17, the below sets out the key deliverables for 2017/18:

Neurology

- Increase GP confidence to manage and diagnose headache in primary care: GP education on different types of headache and migraine, including updated Maps of Medicine and GP tutorial. A UHS Consultant Neurologist will also run a session at TARGET in March 2017.
- Investigate reducing unnecessary emergency CT scans: Work with UHS clinicians to implement a protocol in ED for instances where a CT scan is appropriate for patients presenting with headache – this would assist juniors with decision making.
- Improve community services for Neurological long term conditions: Work with Solent to establish an improved model of community neurology services, including community nursing provision.
- Reduce Epilepsy NEL Admissions: Review of the Epilepsy pathway to look for improvement opportunities.

Gastrointestinal

- Reduce NEL abdominal pain admissions: GP education on abdominal pain, including launch of a new Map of Medicine and GP tutorial.
- Reduce unnecessary endoscopies: Launch of a new referral form for endoscopies with strengthened referral criteria.
- Reduce low complexity activity in secondary care: Implement a Community Gastrointestinal Service to shift low complexity conditions out of secondary care, into the community. This will cover IBS, Dyspepsia and Constipation.

Cardiovascular

- In addition to the 2 major pathway reviews above, we also carried out a 'mini' review of Cardiovascular which identified atrial fibrillation as an area to improve. In 2017/18, we will complete the pilot and commence full rollout of NICE-recommended AF detection devices, called WatchBP, in GP practices in Southampton.

New RightCare projects planned for 2017/18:

- MSK & Pain: The rationale for reviewing this pathway is that we spend £3m more than our similar CCGs on elective MSK activity, and £2m more on NEL pain admissions.

Our Key Actions in 2018/19

Implementation of recommendations from the MSK & Pain pathway review carried out in 2017/18.

Actions for 2018/19 will be determined following completion of these reviews.

Key Outcomes by the end of 2018/19

FINANCIAL OUTCOMES

- ✓ Reduction in NEL short stay Headache Admissions
- ✓ Reduction in NEL Epilepsy admissions
- ✓ Reduction in emergency CT scans
- ✓ Reduction in Outpatient Appointments for Headaches
- ✓ Reduction in NEL short stay Abdominal Pain Admissions
- ✓ Reduction in elective endoscopies
- ✓ Reduction in Stroke admissions (AF)
- ✓ Other financial outcomes from MSK & Pain to be determined in 2017/18

QUALITY OUTCOMES

- ✓ Patients only admitted as an emergency when necessary
- ✓ More appropriate GP referrals
- ✓ Patients not receiving unnecessary tests
- ✓ Reduction in NEL admissions rate for children <18yrs with epilepsy
- ✓ Reduction in mortality from Gastrointestinal disease, under 75s
- ✓ Improved GP knowledge of abdominal pain and headaches
- ✓ Reduction in strokes – increased detection of AF and anticoagulation
- ✓ Improved management of conditions in the community – care closer to home
- ✓ Other quality outcomes from MSK & Pain to be determined

QIPP Programmes (Quality Innovation Productivity & Prevention)

Programme	Scheme	Short Description of Scheme	Leads	Alignment to STP Programmes
1 Continuing Healthcare (CHC)	1.1 CHC	• Delivering assurance across entire CHC client group that every element of our spend is clinically justified, delivering high quality and cost effective care. • Areas: mental health, children, normal CHC (plus others being investigated)	Stephanie Ramsey & Carol Alstrom	• New Commissioning Models
	1.2 Learning Disabilities CHC	• Integrating timely review activity, robust financial management (including high cost review) and LD complex housing. • Proposal being developed on integration of Southampton City Council's LD team with the CCG's CHC team to pool resources and use a holistic approach.	Stephanie Ramsey, Carol Alstrom & Carole Binns	
2 Medicines Management	2.1 Patent Expiries	• Ensuring continued cost effective use of generic medicines: maintain existing patent expiry savings and to realise further savings by ensuring that new generic savings are realised at a level of at least 95%	Stephanie Ramsey & Carol Alstrom	• New Commissioning Models
	2.2 OptimizeRx	• Ensuring continued cost effective prescribing through use of these valuable prompting tools at the point of prescribing in GP surgeries		
	2.3 Practice Based Interventions	• GP practice based interventions in specific therapeutic areas with the use of audit, PrescQIPP where available and other tools as appropriate. • Antidepressant prescribing • Reducing repeats within Community Pharmacy Systems • Reducing paracetamol prescribing • Infant feeds • Care home work • Rosuvastatin prescribing		

3 Planned Care	3.1 MSK	Further reduction in activity and cost in:
		• Referrals (A&G, SDM, MoM, thresholds) and first attendances
		• Outpatient follow up activity
		  • only when required – patient triggered
		  • increase telephone/on-line – reduce face-to-face
		  • shift to community services where appropriate
		• Inpatient activity
		  • further day case to OPPROC opportunities
		  • further inpatient to day case opportunities
		  • pathways (SDM, thresholds)
		  • shift to community/primary services where appropriate
		• One-stop clinic (OP/IP) opportunities
			Peter Horne & Lisa Sheron	• Acute Alliance & Configuration

	3.2 Gynaecology			
	3.3 Urology			
	3.4 Ophthalmology			
	3.5 Sleep Studies			
	3.6 ENT			
	3.7 Dermatology			
	3.8 General Medicine			
	3.9 General Surgery			

QIPP Programmes (cont.)

Programme	Scheme	Short Description of Scheme	Leads	Alignment to STP Programmes
4 Urgent Care	4.1 Urgent Care Activity Shift	• Signposting and shift of ED presentations to least intensive and most appropriate care setting (e.g. SCAS conveyance to MIU rather than ED) • Shift of interventions to most appropriate care setting	Peter & Lisa	• New Models of Integrated Care • Acute Alliance & Configuration
	4.2 Working Age Adults Short Stay NEL Admissions (Better Care)	• Continued identification of frequent/complex users – implementation of cluster working, key worker role and personalised care and support planning • New Pathology screen approach to low risk chest pain pathway • Development of psychological approaches – focusing upon psychological support for individuals who have multiple long term conditions. • Implementation of new screen within primary care (hubs) for Atrial Fibrillation detection.	Stephanie & Donna	• New Models of Integrated Care • Prevention at Scale
	4.3 Older People Falls & ACS NEL Admissions (Better Care)	• Delivery of the falls prevention plan • Roll out of community navigation city wide, with a stronger focus on targeting those at risk. • A stronger focus in clusters of reducing NEL admissions • Development of support to residential and nursing homes to develop their skills and confidence in preventing avoidable admissions • Development of the community nursing offer • Supporting end of life patients to die in preferred place	Stephanie & Donna	• New Models of Integrated Care • Prevention at Scale • Effective Patient Flow & Discharge
	4.4 Reducing NEL Excess Bed Days (Better Care)	• Continuation of an accelerated discharge pathway (using discharge to assess principles) through the integrated rehab and reablement service to reduce the number of delayed transfers of care and XBDs associated with patients who have complex needs requiring a supported discharge package.	Stephanie & Donna	• Effective Patient Flow & Discharge
	4.5 Paediatric Ambulatory Care	• Taking learning from frequent users for working age adults and applying to children • Embed Wessex Healthier Together • Develop Connecting Care for Children Locality GP hubs • Embed paediatrics within Primary Care enhanced access hours service specification • New model for community acute nursing (COAST)	Stephanie & Donna	• New Models of Integrated Care

QIPP Programmes (cont.)

Programme	Scheme	Short Description of Scheme	Leads	Alignment to STP Programmes
4 Urgent Care	4.6 Respiratory NEL Admissions	• Reach those who haven't yet got a COPD diagnosis and ensure they are supported to self manage • Have a stronger push on supporting self management in the overall COPD population – through further strengthening the work with practices, medication compliance, smoking cessation, use of care technology • Develop plans for other respiratory conditions (which we so far have not significantly focussed on e.g. asthma)	Stephanie & Donna	• Prevention at Scale • New Models of Integrated Care
	4.7 Diabetes NEL Admissions	• Year 3 of savings from the Diabetes foot care pathway improvement business case – reduction in NEL admissions and NEL amputations	Stephanie & Donna	• Prevention at Scale • New Models of Integrated Care
	4.8 Deep Vein Thrombosis (DVT) NEL Admissions	• Full year effect of the improvements made to the pathway in 2016/17	Peter Horne & Lisa Sheron	• New Models of Integrated Care • Acute Alliance & Configuration
	4.9 Eye ED Attendances	• Increasing telephone triage to divert patients to the right place first time, confident re-direction of walk-in patients who can be managed in community/primary care, booking patients who require secondary care assessment and management to into 'hot clinics' at sub-specialty level and reducing follow up rates.	Peter & Lisa	• New Models of Integrated Care • Acute Alliance & Configuration
5 RightCare	5.1 Gastrointestinal	• Endoscopies - strengthen endoscopy referral form & criteria to reduce inappropriate referrals • Abdominal Pain - Improved primary care enablers (Map of Medicine & GP Tutorial), senior decision making earlier for emergency abdo pain patients and a hotline in ASU for GPs to call for urgent advice • Community Gastrointestinal Service for low complex conditions (IBS, dyspepsia and constipation)	Peter Horne & Lisa Sheron	• New Models of Integrated Care • Acute Alliance & Configuration
	5.2 Neurology	• Headache & Migraines – protocol in ED for when a CT scan is appropriate, clinical audit into NEL admissions, improved primary care enablers (map of medicine, GP tutorial and HEADMAT), improved referral criteria. • Epilepsy & Neuro Rehab – epilepsy pathway review, redesign of community neuro rehab services.	Peter Horne & Lisa Sheron Stephanie & Donna	• New Models of Integrated Care • Acute Alliance & Configuration
6 Mental Health	6.1 Mental Health Matters	• Implementing improvements following the Mental Health Matters consultation in 2016/17 – all efficiency savings will be reinvested into mental health services.	Stephanie Ramsey & Carole Binns	• Mental Health Alliance

Key Risks & Challenges

Key Risks & Challenges

Risk Title	Risk Description	Key Mitigation Controls
Mental Health	• Failure to respond to improvements required in implementing mental health matters.	• Exploring alternative provision if collaboration is ineffective • Regular CQRM and Contract review meetings in place. • Southern Health action plan and quality improvement plan being implemented. • Implementation of change through Mental Health Matters.
Primary Care	• Pressures on sustainability of Primary Care, failure to recruit, practices in special measures and others facing significant quality challenges.	• Process in place to support practices in special measures agreed at Clinical Governance Committee • Delegated commissioning framework - NHS England framework to support practices in crisis which there is a local provider • Locally commissioned services have specific quality requirements built in • Primary Care strategy and delivery plan in place (GPFV)
Provider Workforce	• Pressures on recruitment and retention of qualified healthcare staff such as reregistered nurses, specialist practitioners including mental health staff and non-registered support staff.	• All Health providers required to produce monthly safer staffing data which is monitored via CQRMs and Quality Managers (nursing focused). Exception reporting is in place in all CQRMs where staffing concerns may be impacting on the quality of care. • Monthly workforce data from CSU • Monitoring wider staffing concerns/intelligence e.g. Solent staff issues in Portsmouth • Nursing Homes supported via leadership training and peer support network which promotes access to training and wider support
Local Authority Funding Shortfall	• Reductions in public health grant carried through into front line service reductions, with direct impact on NHS providers and sustainability of key services to vulnerable people. • Failure of service redesign to mitigate impact of social care funding pressures for adults and children, resulting in loss of capacity in areas such as domiciliary care that are critical to successful delivery of STP priorities (e.g. delayed transfers of care reduction).	• Service efficiencies and prioritisation to maintain the most critical services; collaborative agreement to manage pace of change • Collaborative work to accelerate integration and achieve service efficiencies; alternative forms of provision; targeted CCG investment to support maintenance of priority services.
Performance	• Failure of the standard for 95% or more patients to wait no longer than 4 hours in A&E (NHS Constitution requirement).	• Weekly scrutiny of system patient flow. • Monthly oversight from the contract performance panel. • CCG scrutiny of actions and plans at monthly business meeting. • Monthly ED RAP progress monitoring meetings between UHS and commissioners
Engagement	• Engagement of members and localities may not be sufficiently robust to enable the CCG to achieve its objectives and carry out its functions and responsibilities.	• TARGET (Time for Audit, Research, Governance Education and Training) • Local improvement schemes • Dedicated Clinical Leads
Out of Hours Contract	• The ability of the provider to respond to developing requirements, including GP access and integrated 111/OOH.	• Monthly contractual meeting. • Weekly exception reports on operational issues are being provided to Commissioners from PHL.
Financial Sustainability & Savings	• Failure to achieve our CCG planned surplus. Non-delivery of our savings plans.	• All budgets delegated to directors and authorisation limits of all staff reviewed. • Monthly financial reporting and forecasting is used to identify risk areas. • Bi-monthly Board Finance and Performance report and CFO internal monthly review of year end forecasts. • Monthly Senior Business Team Meeting in place to monitor QIPP delivery and milestones. • Primary Medical Committee will give additional focus to the primary care delegated budgets.

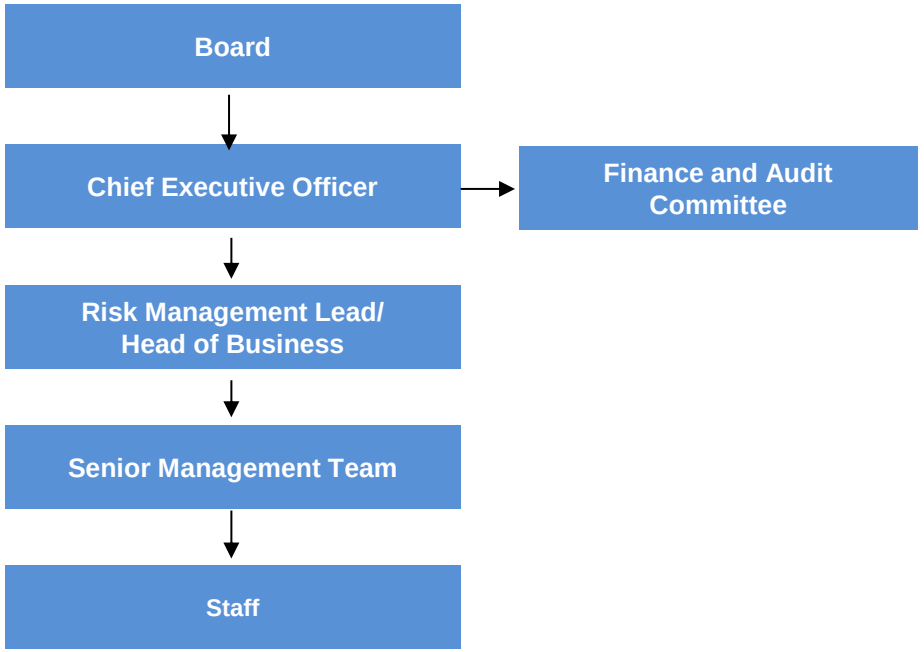
CCG Risk Management Policy & Process

The CCG has a robust Risk Management Policy and process in place. The aim of the policy is to enable a common approach to the identification and management of risk, to include:

- Outline Southampton City CCG's approach to Risk management;
- Ensure there are internal systems and processes to provide assurance that Southampton City CCG is able to discharge its responsibilities;
- Set out the accountability arrangements for Southampton City CCG.

Responsibilities for Risk Management

- **The CCG Board** is ultimately and collectively responsible for effective risk management within the CCG.
- The **Finance and Audit Committee** is responsible for reviewing the establishment and maintenance of an effective system of risk management and internal control across the whole of the CCG's activities that support the achievement of its objectives.
- The **Accountable Officer** will have executive responsibility for Risk management in the CCG.
- The **Risk Management Lead** (Head of Business) is a central point for risk management issues within the CCG and facilitates the risk management process. The Risk Management Lead is responsible for the maintenance of the Board Assurance Framework and CCG Risk Register, ensuring that there is sufficient and timely engagement from CCG staff.
- The **Senior Management Team (SMT)** is responsible for reviewing an effective system of risk management across the whole of the CCG's activities that support the achievement of its objectives. The role of SMT is to also provide challenge to the risk score if necessary.
- **Leadership and Management Teams –** All managers and clinical leads within the CCG are accountable for the day-to-day management of risks of all types within their area of responsibility.
- **Internal and External Audit -** The auditors are responsible for agreeing (with the Finance and Audit Committee) a programme of audits which assess the exposure and adequacy of mitigation of the principal risks affecting the organisation.



Southampton City CCG will operate an assurance framework where strategic objectives will be defined on a yearly basis and strategic risks outlined against each objective. The CCG Board then reviews this in public, bi monthly. The Board Assurance Framework is informed by the CCG Risk Register and will contain all risks graded 10 and above.