NHS
West Hampshire
Clinical Commissioning Group

Operating Plan

2017/18 – 2018/19

Quality services, better health

Contents

Executive Summary

Our Operating Plan supports our vision of commissioning and enabling the delivery of high quality patient centred healthcare, which is innovative, equitable, efficient, effective and, where possible, prevention based, contributing to the healthiest population in England.

The plan (in part 1) describes who we are and our challenges faced over to coming year. It sets out (in part 2) in more detail, how we will deliver the strategic priorities for 2017/18 to 2018/19. Appendix 1 of the plan sets out our work plan for the next two years.

In December 2015, the NHS shared planning guidance 2016/17 - 2020/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England produced a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

West Hampshire CCG is a member of the Hampshire and Isle of Wight Health and Care System. To deliver our shared priorities we are working with our partners across H&IOW in ten delivery programmes: six core programmes focused on transforming the way health and care is delivered, and four enabling programmes to create the infrastructure, environment and capabilities to deliver successfully.

Our care strategy 'Changing the Shape of Care Delivery' will help us deliver the STP priorities and has helped shape the priorities within our Operating Plan. This care strategy builds upon strategic plans already in place and enables us to change focus and to move from a reactive to a proactive care model, to be less dependent on hospital services and to improve community and GP services to enable people to help themselves maintain their health. People will have greater levels of support to manage their own condition, with their goals recorded and care increasingly being available in the community until the end of life. Everyone within our community will have the opportunity to maintain a healthy lifestyle.

We have a reputation as a listening, proactive and responsive CCG, which uses feedback from the public, patients and GP members to make patient focused changes to local healthcare. GPs support patient choice and offer realistic options to patients enabling appropriate use of healthcare services.

People will have the same access to mainstream services and improved health outcomes whether or not they have mental health needs and or a learning disability. Families feel safe and supported in the health and wellbeing of their children, and have choice and access within in the community.

There is a clinical focus threaded through everything we do. Patients will be clear about which urgent and emergency services to access, which will be of higher quality, many of which will be available seven days a week. All patients have the same information so they can make informed decisions about their care and experience seamless care delivered in a timely manner. Patients experience an improvement in their quality of life through the effective use of medicines to enable them to manage their conditions. Patients understand how to take their medicines and are involved in decisions including the benefits and risks of choices available. We have developed patient focused services with all partners who have a range of inputs to ensure any decisions consider a wide range of views.

We also want improved access for patients to primary care services with greater choice and co-ordinated care so patients receive services, which meet their individual needs and enable them to manage their own conditions. There is active CCG engagement in the planning of local primary care and specialist services to address local population needs working with our GP practices to adopt new models of primary care.

We have started to deliver our vision of commissioning and enabling the delivery of high quality patient centred healthcare, which is innovative, equitable, efficient, effective and, where possible, prevention based, contributing to the healthiest population in England.

People in the organisation are clear about what we need to deliver along with a sense of strategic direction and collective ownership. People understand the organisation's culture and are able to demonstrate their contribution. People support each other and work well as partners with other health and social care organisations to serve public, patients and carers. We have knowledgeable and motivated staff with skills and abilities to contribute to the development of the organisation.

The financial plan for 2017/18 delivers the required planning surplus (0.7%), includes a 0.5% contingency and 0.5% non-committed headroom reserve as required under NHS England planning requirements. The financial challenge has reduced from £41.2m, at the time of the original STP submission on 5th October 2016, to £29.7m as at 23rd December 2016. Of the current £29.7m challenge, QIPP schemes have been identified totalling £22.8m and work continues to identify schemes to deliver the required balance, of £6.9m. Key financial risks include conclusion of the detail within contract agreements, in-year activity and QIPP delivery, Continuing Healthcare and medicines management.

We commission healthcare within available resources and maintain financial stability, whilst improving healthcare quality, innovation, prevention and productivity. We work within a robust governance structure. We will make sure that we continue to be responsive to local needs through an ongoing dialogue with our communities about local health services and provide easy ways for people to let us know how we are performing.

Dr Sarah Schofield, Clinical Chairman and Heather Hauschild, Chief Officer

NHS West Hampshire Clinical Commissioning Group

Plan on a page

Our Vision is to be consistently recognised for commissioning and enabling the delivery of high quality patient centred healthcare, which is innovative, equitable, efficient, effective and, where possible, prevention based, contributing to the healthiest population in England.

Our Values - In everything we do we aim to be compassionate, honest, ambitious, fair and inclusive

Strategic Objectives	Key strategic priorities	Work Programmes	Outcomes
1**. Ensure system financial sustainability;** to ensure compliance with business rules	• Deliver STP system control total • Financial Recovery Plan and QIPP • Development of new forms of contract	• Financial Management • QIPP projects • Contracts • Procurement	• High quality, safe services delivered consistently • Reduction in smoking, obesity and alcohol related health conditions by promoting healthy lifestyles • People with long term conditions and multiple chronic physical and mental health issues experience better health outcomes • People are better supported to stay well and independent, with greater confidence to manage their own health and wellbeing • National access targets will be delivered • Delayed transfers of care rate will be reduced to and maintained at 3.5% • More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs • Earlier diagnosis of physical and mental health conditions leading to improved outcomes and survival rates and more healthy years of life • Bed capacity will be used more effectively to generate a reduction in the acute bed stock • Activity growth in the acute sector will reduced and patients treated in the best setting to improve outcomes • A&E attendances and emergency admissions will not increase and ideally be reduced • Estate footprint and costs will be reduced • Everyone is able to access appropriate primary care, 7 days a week, in their locality out of hours and at weekends • Everyone is able to access safe acute services offering the best possible outcomes, 7 days a week • Patients receive more of their care at home and in their community, and following acute care in hospital are transferred home without delay • Consistently good, co-ordinated, timely response experienced by people in a mental health crisis, and consistently high quality mental health services • Create a sustainable workforce with a decreased reliance on agency workers and greater flex of staff resources
2. **Ensure safe and sustainable high quality services;** to provide the best possible care for patients	• Commission for improvement of Patient experience / outcomes in line with national guidelines • Achieve constitutional standards • Contracts / spec delivery – significant areas of non-delivery	• Quality – including primary care • Medicines Management • Urgent and Emergency care • Patient Experience • Personal health budgets • Safeguarding • Continuing Healthcare • Performance • Contract Monitoring	

3. **Work in partnership to commission health and social care collaboratively;** to commission services at the appropriate tier to achieve the best possible outcomes for patients	• Deliver the aims and objectives if the STP
	• Develop and optimise collaborative contracting and commissioning
	• Future of commissioning - strategy
	• Integrated commissioning with HCC
	• Workforce - right people, skills and capabilities
	• Achieve digital interoperability
		• Maternity and family health
		• Mental health
		• Learning disabilities
		• H&IOW level STP programmes
		  ◦ Acute Alliance
		  ◦ Workforce
		  ◦ Flow and discharge
		  ◦ Mental health alliance
		  ◦ Commissioning
		  ◦ Digital	

4. **Establish local delivery systems;** to deliver patient centred care closer to home which is integrated, prevention based, equitable and high quality	• Deliver WHCCG GP Forward View (Locality plans and projects)
	• Develop population outcome focussed contracting for new models of care in response to 5YFV
	• Develop clinical services in line with national guidance lines and innovation
	• Local Delivery Systems to operationalise objectives from STP
		• Prevention, health and wellbeing
		• Primary care
		• Planned care
		• Service Development work
		  ◦ Long term conditions, frailty and end of life care
		  ◦ Diabetes, respiratory, cardiology and neurology
		• Locality Plans
		• Estates strategy
		• WHCCG Digital work plan
		• Patient/population/ carer engagement plan	

5. **Develop the CCG workforce;** to meet the future commissioning needs of the population	• Develop skills for future commissioning • Maintain high quality engaged workforce	• Organisational development and workforce	

PART ONE - WHO WE ARE AND OUR CHALLENGES

1. INTRODUCTION

West Hampshire CCG's operating plan, sets out our contribution to Years 2 and 3 of the Hampshire and Isle of Wight (H&IOW) Sustainability and Transformation Plan (STP), and sets out:

- Local drivers for change
- Vision and values
- Strategic objectives, key strategic priorities, work programmes and outcomes
- Commissioning strategy to change the shape of care delivery

We are a clinical commissioning organisation which plans the health services for a GP registered population of over 550,000 people, a geographical area of 2,242.4 square kms (865.8 square miles). There are 50 GP practices within the area, each being a core member of the commissioning group. We have 4 GP Federations in west Hampshire. These practices are split into six localities, managed within three commissioning directorates (mid, south and west), in order to ensure local population needs are represented in plans and local delivery reflects partnership with local communities and councils.

Mid directorate

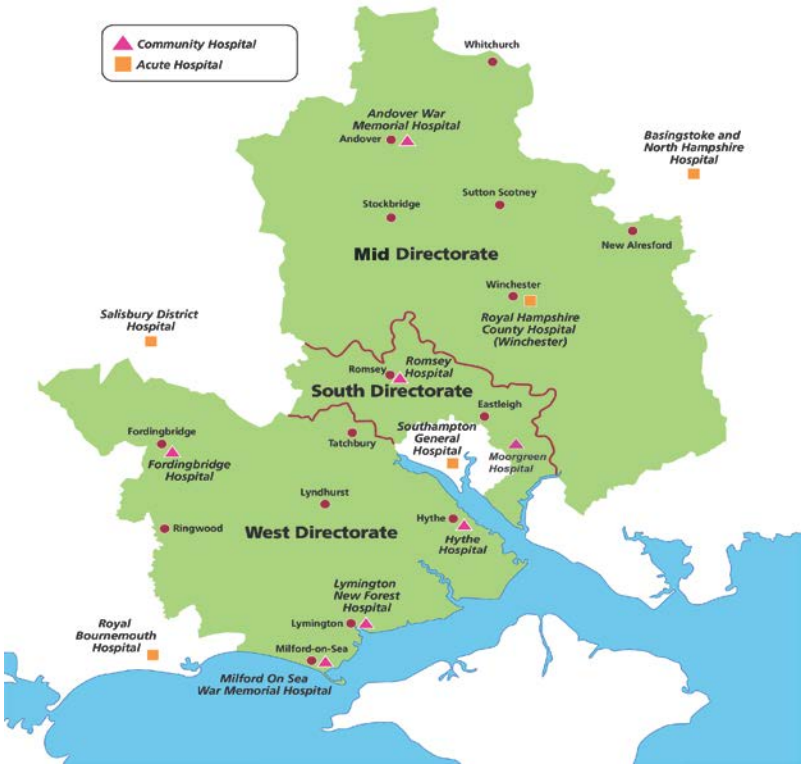
- Winchester
- Andover

South directorate

- Eastleigh North and Test Valley South
- Eastleigh Southern Parishes

West directorate

- Totton and Waterside
- West New Forest



2. LOCAL POPULATION NEEDS AND CHALLENGES

Addressing health inequalities

Reducing health inequalities is core to the NHS constitution and values and is a national commissioning priority. We have a number of duties under the Health and Social Care Act (2012) regarding health inequalities in the way it commissions and ensures the provision of healthcare. By taking action with Local Authorities to reduce health inequalities the CCG will realise substantial population health gains, reduced healthcare spend and improved health outcomes.

Social and economic determinants of health such as income, employment, education and environment lead to inequalities in health. We will be working collaboratively across all sectors, particularly with Local Authorities, to develop systems to reduce health inequalities. Increased interaction and information sharing between partners will help establish effective initiatives and maximise optimal utilisation of various healthcare.

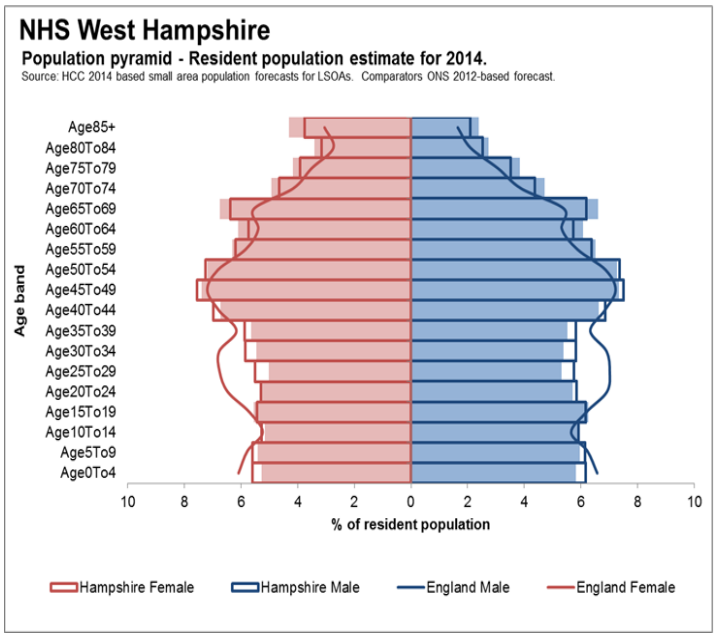
West Hampshire's rural geography affects accessibility to services. We are aware that we need to create greater access to alternative community, domiciliary or peripatetic services where social networks may be poorly developed. We are exploring the current utilisation of services in these settings to help ascertain if commissioning primary care services, including public health services from these providers can help reduce inequalities in health.

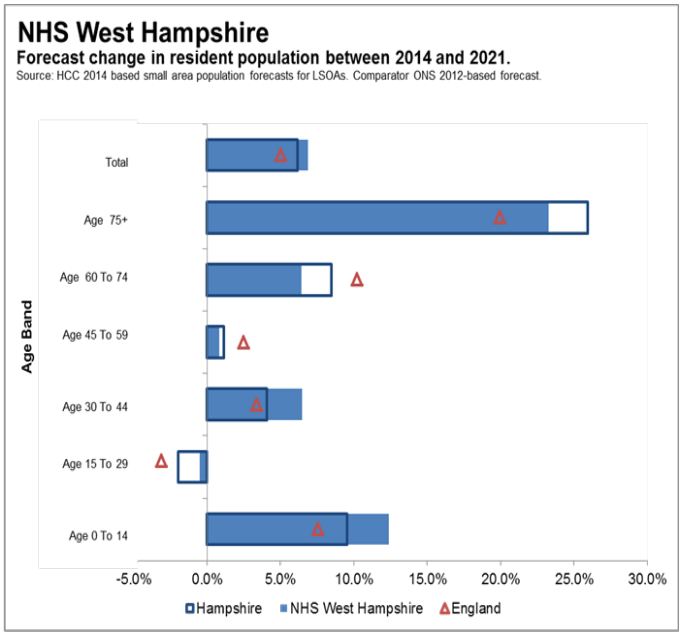
Local population

The population of West Hampshire is an aging population, over the next 5 years the percentage of over 85's in West Hampshire is expected to increase by over 30% which will be twice the national average. The proportion of under 18s in our population is expected to decline. This population change is key to commissioning future services that address the increased frailty of our population and the likelihood of more people with more than one long term condition.

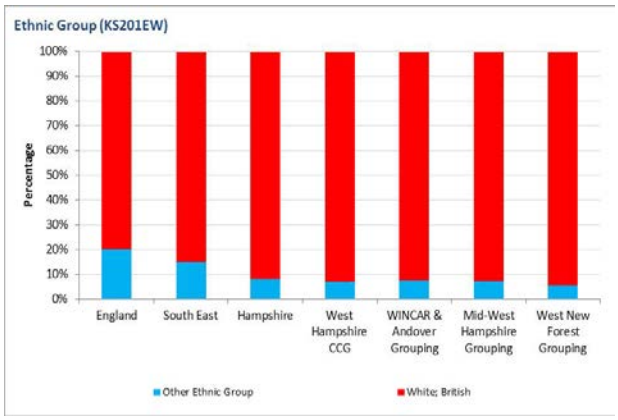
The ratio of people of state pension age is increasing compared to working age population. By 2025 for every 2 people of working age there will be 1 person of pensionable age in Test Valley and Winchester; in New Forest the ratio will be less than 2:1; in Eastleigh the ratio will be closer to 4:1.

Population Change 2014 to 2021						
Age band	**NHS West Hampshire**				**Hampshire**	**England**
	2014	2021	Difference	% Change	% Change	% Change
Age 0 To 19	124,315	134,627	10,312	8%	6%	5%
Age 20 To 39	118,968	128,162	9,194	8%	6%	3%
Age 45 To 59	115,419	116,412	993	1%	1%	2%
Age 60 To 74	96,628	102,837	6,209	6%	8%	10%
Age 85+	18,557	24,398	5,841	31%	26%	20%
Total	549,591	587,415	37,824	7%	6%	5%





Estimates of the ethnicity of the CCG's practice population drawn from Public Health England's National General Practice Profiles show that the percentage of people who are of a non-White ethnic group, ranges from 0 to 2.5%. Other non-White ethnic groups range from 0 to 1.7%. Mixed race population groups and Asian ethnic groups have the highest representation, whereas other broad ethnic groups have a lesser representation, with only one practice recording 1.2% of its list size as being Black. Eastleigh North and Test Valley South is the most ethnically diverse locality in West Hampshire and the majority of the CCG's Asian population are registered in this locality.



Source: 2013 West Hampshire CCG JSNA

Areas of deprivation

Although we have generally very good health outcomes compared to England, there are health inequalities that arise from inequalities in social and environmental factors that affect health. Small pockets of deprivation affecting relatively small numbers of people tend to be obscured, and thus difficult to identify and address in an otherwise wealthy community. For instance:

- People are more likely to live alone

- 136,000 people live in rural communities
- There is very localised deprivation

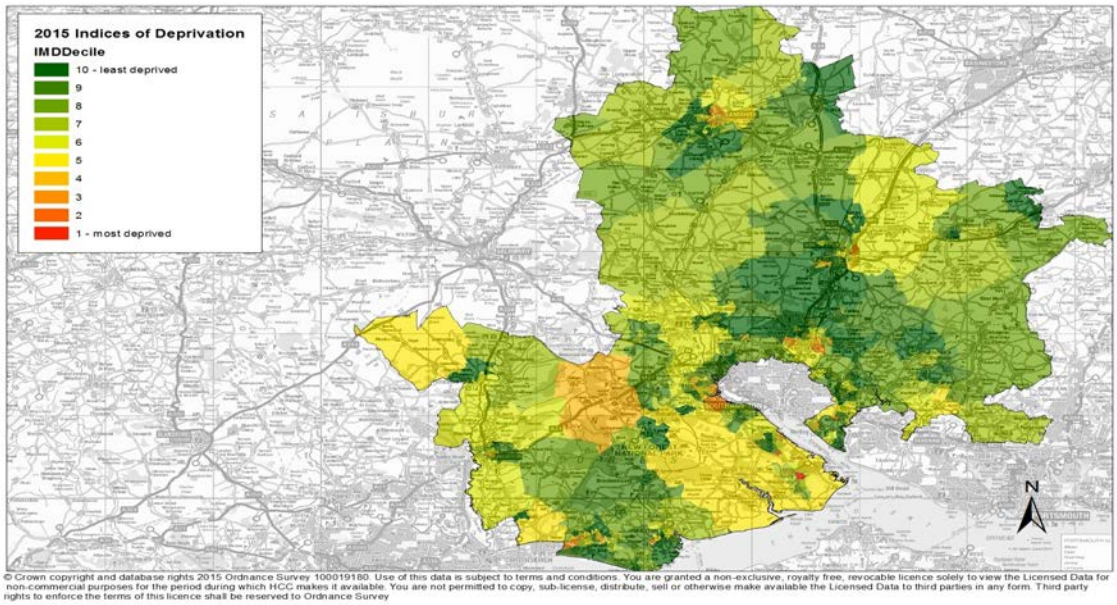
West Hampshire CCG ranking by type of deprivation domain (where 1 is the most deprived out of 209)

Income	Employment	Health Deprivation and Disability	Education, Skills and Training	Barriers to Housing and Services	Crime	Living Environment	Income deprivation affecting Children	Income deprivation affecting older people
196	190	194	176	87	188	177	193	202

Source: DCLG 2015 and Hampshire County Council

We have high levels of deprivation with regard to the index of 'Barriers to Housing and Services' domain compared to the England average with a rank of 87 out of 209 CCGs, indicating that physical and financial accessibility of housing and local services is an issue for our population and we have a pivotal role in recognising this aspect when commissioning and siting services.

Index of multiple deprivation



Relative to England, we have lower levels of deprivation affecting children (10.4%); it is the 16th least deprived CCG in the country as regards income deprivation among children. There are deprivation pockets in Eastleigh (Bursledon and Old Netley and Eastleigh Central), New Forest (Butts Ash and Dibden Purlieu, Fernhill, Holbury and North Blackfield, Milton, Pennington and Totton West), Test Valley (Alamein), and Winchester (St John and All Saints and St Luke).

At 9%, we have lower levels of deprivation affecting older people compared to the England average making it the 7th least deprived CCG in the country with regard to income deprivation among older people. However, there do exist large numbers of the population suffering deprivation especially in Andover town, central and south Eastleigh, Winnall and Highcliffe in Winchester, and Holbury, North Blackfield (Waterside), New Milton, Fordingbridge, Lymington, Totton and Wickham in the New Forest.

Health of our population

We have an increasing number of patients with long term conditions with:

- Higher than average prevalence of dementia of 0.74%, higher than the rest of Hampshire (0.65%) and England (0.53%) with 4,295 patients
- 22,982 patients with diabetes
- 8,224 patients with chronic obstructive pulmonary disease
- 18,073 patients with chronic heart disease
- 11,005 patients who have had a stroke or mini stroke
- 32,990 patients with asthma

Areas where we can improve the health of our population

We intend to adopt a more proactive population based collaborative approach to preventing ill health in West Hampshire to combat health inequalities. Opportunities exist to maximise lifestyle advice, early detection and treatment to minimise inequalities by addressing unwarranted variation.

Whilst there has been a decrease in the proportion of people affected by public health issues such as smoking or alcohol abuse in recent years, this decline has taken place at a much slower rate amongst the most deprived members of the population. Interventions that focus on reducing levels of smoking can make a real difference to health inequalities. Gender related alcohol inequalities are concerning as women are at greater risk than men of negative alcohol-related health effects.

There are significant opportunities to focus on reducing the risk of people becoming ill or having increasing need; focusing on prevention, particularly working with the mid aged (40-64 years) adult population to promote healthy ageing; to keep people active and eating healthily to reduce future risk of disease or to support active management of health conditions to improve outcomes and help people retain independence for longer.

Changing the way vulnerable groups live, to eat more healthily and be more active now, will ensure that they remain independent, living at home in the future but it also reduces the risk of developing complications and comorbidities which lead to frailty and disability later in life. Promoting healthy lifestyles across all ages to ensure people have and continue to have good health outcomes and remain independent.

Good mental health is also important for continuing good health. Focussed work is needed with different groups of people with poorer mental health to understand better the lack of access to current services, particularly primary care, and to co-design these services to improve accessibility. People with poorer mental health are also at significant risk of social isolation; initiatives that develop social networks for this group of people are important in helping to improve their mental and physical health.

Encouraging women with complex social factors and from disadvantaged backgrounds to access maternity services early will reduce health inequalities and improve birth outcomes and maternal health.

Providing support for children and families during the early years of their children's lives can help break the cycle of deprivation and poor health. It will also address low child immunisation rates and elevated rates of measles, whooping cough and other infections.

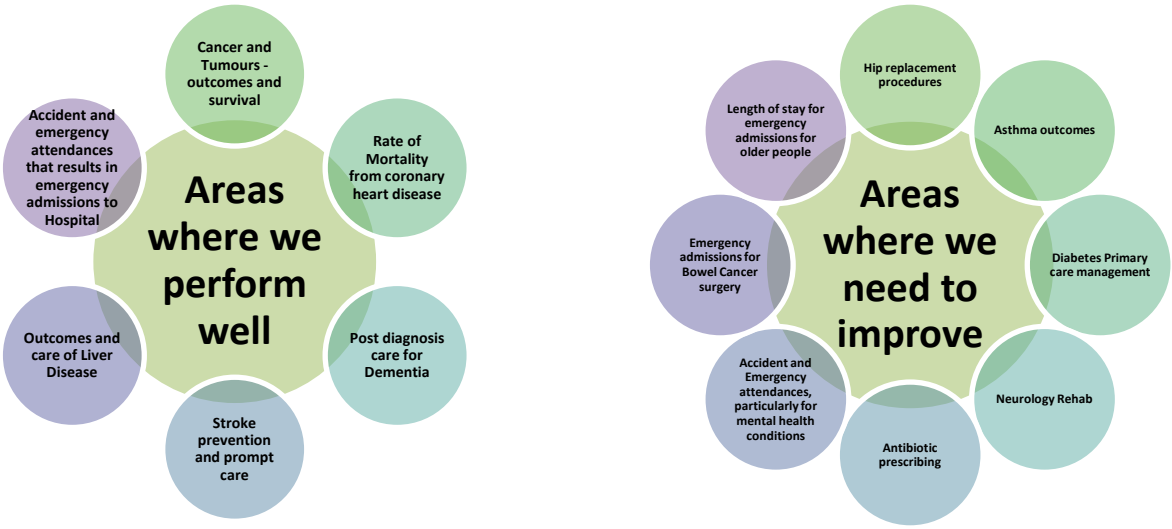
NHS England estimates that 15-20% of the life expectancy gap can be directly influenced by healthcare interventions.

How we benchmark against comparable CCGs

Using the NHS Rightcare data packs we can benchmark ourselves against each other and national requirements to understand the clinical areas where patients receive good treatment and highlighting areas for improvement. NHS RightCare package uses data and evidence to highlight unwarranted variation to support an improvement in quality.

For west Hampshire CCG we consistently rank it the top quartile for the majority of services but we know we have areas for improvement.

The latest intelligence drawn from the Rightcare data packs shows the following areas where we perform well and areas where we need to improve.



Data Source: NHS Right Care

For example in the long term conditions data pack, the CCG was measured against the 10 CCGs, most similar to West Hampshire CCG which showed the following results which reflect the challenge of having an aging population with higher:

- Incidence for breast cancer
- Incidence for bowel cancer
- Than average for prevalence of dementia, atrial fibrillation and chronic kidney disease
- Rate of emergency admission of over 75s with stay of less than 24 hours
- Rate of patients with delayed transfers of care
- Number of admissions in the last year of life and long length of stay

Hampshire's health and wellbeing priorities

Our operating plan is designed to support the delivery of the priorities of the Hampshire's Joint Health and Wellbeing Board.

Starting well	**So every child can thrive.**
Living well	**Empowering people to live healthier lives.**
Ageing well	**Supporting people to remain independent, have choice, control and timely access to high quality services.**
Healthier Communities	**Helping communities to be strong and support those who may need extra help.**

National priorities

Five Year Forward View

Our plans help deliver the NHS England's Five Year Forward View (5YFW) to:

- Drive improvements in health and care
- Restore and maintain financial balance
- Drive up access and quality standards

In delivering this, we will improve preventative, primary and community based care, through building relationships with patients and communities, seeing the totality of health and care in identifying solutions and using social care and wider services to support improved productivity and quality as well as people's wellbeing.

The national priorities that we are working to deliver are:

- **Preventing ill health and moderate demand for healthcare** such as reducing childhood obesity, enrolling people at risk in the diabetes prevention programme, doing more to tackle smoking, alcohol and physical inactivity and **to reduce avoidable admissions**

- Engaging patients, communities and self-care in a **step change in patients managing their own health**, expand the use of personal health budgets and patient choice, and improve the health of NHS employees

- Improving the **resilience of general practice** by supporting primary care redesign, improved access and more shared working across practices

- **Implementing new care models** that break down the boundaries between different types of provider, and foster stronger collaboration across services – drawing on, and strengthening, joint work with partners, including local government

- Achievement and maintenance of **performance against NHS constitution standards**

- NHS England's **2020 key clinical ambitions** on cancer, mental health, learning disabilities, maternity services, dementia

- **Improving quality and safety** by achieving significant reduction in avoidable deaths, ensuring most providers are rated as outstanding in good and improving antimicrobial prescribing and resistance rates

- **Utilising technology** to accelerate change

- **Developing the workforce** needed to deliver these services and change

- Maintaining **financial balance**

Mental Health 5 Year Forward View

To compliment the 5YFW NHS England published a mental health 5YFW setting out their ambition to deliver rapid improvements in outcomes by 2020//21 through ensuring that 1 million more people with mental health problems are accessing high quality care.

There are three overarching priorities:

- A 7 day NHS – right care, right time, right quality
- An integrated mental and physical health approach
- Promoting good mental health and preventing poor mental health - helping people lead better lives as equal citizens

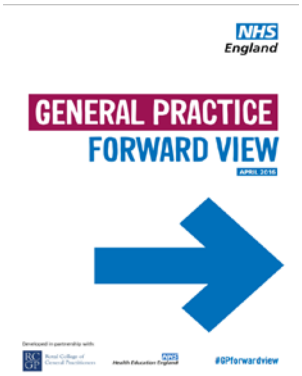
These are underpinned by eight principles:

- Decisions must be locally led
- Care must be based on the best available evidence
- Services must be designed in partnership with people who have mental health problems and with carers
- Inequalities must be reduced to ensure all needs are met, across all ages
- Care must be integrated - spanning people's physical, mental and social needs
- Prevention and early intervention must be prioritised
- Care must be safe, effective and personal, and delivered in the least restrictive setting
- The right data must be collected and used to drive and evaluate progress

These principles have been reflected in the H&IOW STP and we are committed to working towards their delivery.

General Practice 5 Year Forward View

Alongside the Operating Plan we are required to respond to the General Practice 5 year Forward View published in April 2016, a separate plan is being developed. The GP Forward view contains specific, practical and funded steps - on investment, workforce, workload, infrastructure and care redesign these are detailed below:



- **Investment**: by 2020/21 recurrent funding to increase by an estimated £2.4 billion a year, decisively growing the share of spend on general practice services, and coupled with a 'turnaround' package of a further £500 million. Investments in staff, technology and premises, and action on indemnity and red tape

- **Workforce**: pulling out all the stops to try to double the growth rate in GPs, through new incentives for training, recruitment, retention and return to practice. Having taken the past 10 years to achieve a net increase of around 5,000 full time equivalent GPs, aiming to add a further 5,000 net in just the next five years. Plus 3,000 new fully funded practices based mental health therapists, an extra 1,500 co-funded practice clinical pharmacists, and nationally funded support for practice nurses, physician associates, practice managers and receptionists

- **Workload**: a new practice resilience programme to support struggling practices, changes to streamline the Care Quality Commission inspection regime, support for GPs suffering from burnout and stress, cuts in red tape, legal limits on administrative burdens at the hospital/GP interface, and action to cut demand on general practice

- **Infrastructure**: new rules to allow up to 100% reimbursement of premises developments, direct practice investment tech to support better online tools and appointment, consultation and workload management systems, better record sharing to support team work across practices

- **Care redesign**: support for individual practices and for federations and super partnerships; direct funding for improved in hours and out of hours access, including clinical hubs and reformed urgent care; and a new voluntary contract supporting integrated primary and community health services

3. SUSTAINABILITY AND TRANSFORMATION PLAN

In December 2015, the NHS shared planning guidance 16/17 - 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England produced a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency. West Hampshire CCG is a member of the Hampshire and Isle of Wight Health and Care System.

H&IOW is a diverse region with a population of 2 million people. Health and social care services for this population face a number of significant challenges which mean that the way services are provided needs to change. These challenges are summarised below:

- **Demand** for health and care is growing at an unsustainable 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
- There is a gap between the funding available to the NHS and the cost of delivering services
- As a result, many of our critical health and social care services are under **severe pressure**

Delivering the STP

To deliver our shared priorities we are working with our partners across H&IOW in ten delivery programmes: six core programmes focused on transforming the way health and care is delivered, and four enabling programmes to create the infrastructure, environment and capabilities to deliver successfully. This portfolio of programmes is the shared system delivery plan for the STP.

The six core programmes are:

- New models of integrated care
- Solent acute alliance
- Mental health alliance
- Effective patient flow and discharge
- Prevention at scale
- North and mid Hampshire configuration

The four enabling programmes are:

- Digital infrastructure
- Estate infrastructure rationalisation
- Workforce
- New commissioning models

Delivering the STP plan will result in tangible benefits and improvements for local people and communities by:

Investing in prevention and supporting people to look after their own health	We are implementing a series of evidence based solutions focused on primary and secondary prevention and behaviour change, supported by technology. This will improve healthy life expectancy, improve cancer survival rates, and reduce dependency on health and care services. Tackling obesity in childhood and improving life choices will deliver long term benefits
Strengthening and investing in primary and community care	We are implementing the GP Forward View in H&IOW. GP practices collaborating and working at scale to deliver access for urgent needs across an extended 7 day period. Services operating within the currently fragmented out of hospital system are coming together to deliver a single, coordinated extended primary care team for local populations. More specialist care is being delivered in primary care settings. New models of integrated care for children are being delivered across our system

Simplifying the urgent and emergency care system	We are simplifying the urgent and emergency care system, making it more accessible to patients. As a result we will consistently deliver the A&E and ambulance standards. We are improving patient flow, ensuring that best practice is implemented in every locality without delay, and investing in home based care capacity. This will mean that delayed transfers of care are lower than the national 3.5% requirement
Improving the quality of hospital services	Acute hospital providers are working as an alliance to reconfigure unsustainable acute services and to consolidate clinical support services for the population in southern Hampshire and on the Isle of Wight. We will determine the best option for a sustainable configuration of acute services in North and mid Hampshire and work together to deliver the agreed option. We are implementing the national recommendations in maternity services to improve outcomes and reduce variations in practice
Making tangible improvements to mental health services	We are making tangible improvements to mental health services for children and adults, and services for people with learning disabilities. The three H&IOW Trusts providing mental health services (SHFT, Solent NHST and IoW NHST), commissioners, local authorities, third sector organisations and people, who use services, are working together in an alliance to deliver a shared model of care with standardised pathways and enact the Five Year Forward View for Mental Health
Creating a financially sustainable health system for the future	As we transform services to improve patient experience and outcomes, we are also reducing overall system costs and avoiding future cost pressures from unmitigated growth in demand. We are striving for top quartile efficiency and productivity in all sectors. We are adapting financial flows and contracting and payment mechanisms to align outcomes, metrics and financial incentives to support optimum patient outcomes, improved decision making and financial stability. Through a combination of efficiency savings and transformation, and using £60m of the STP fund, we will deliver at least a breakeven position by 2020/21

4. LOCAL IMPLEMENTATION OF SUSTAINABILITY AND TRANSFORMATION PLAN

In west Hampshire we will be taking forward the STP by:

- Delivering of our ambition for **new care models**
- **Shared and stronger approach** to commissioning and contracting
- Delivering the North and mid Hampshire **service reconfiguration**
- Improving the **health and wellbeing** of the population through prevention
- Service improvements within **mental health**; particularly around crisis care and Children's and Adolescents Mental Health service
- Healthcare **estate reconfiguration** and improved utilisation
- Transformation delivered through adoption of **digital technologies**
- Enhancing and supporting **GP sustainability**

Local delivery systems within the STP

Intensively over the last few months we have been developing in partnership the STP for the region. Within the STP there are a number of key programmes which span H&IOW, including strategic workforce development, acute physical and mental health development, digital transformation and strategic investment models. However, it is recognised that the Local Delivery Systems will be the engine rooms for change, and the route to secure clinical, patient and public engagement.

We have arguably the most complex geography in H&IOW for describing a local delivery system. We recognise this and took positive steps to work and plan in geographically aligned Directorates as a key step towards local system planning and implementation. However, we recognise that the local delivery system boundaries for WHCCG extend beyond the borders of the CCG catchment population. Therefore we have embarked on a journey of engagement with our stakeholders to agree the Local Delivery Systems for our populations and to develop a collectively owned preference for the future form for our Accountable Care System(s).

Local Delivery System (LDS) Boards will be established from January with membership from CCG's, acute providers, community and mental health providers, general practice, local authorities and, as they develop, patient and public representation. The LDS Board will be responsible for:

- The delivery of the single system control total, aiming to align activity, finance and workforce assumptions with an underpinning agreed change plan regarding QIPP

- The resolution of local priority programmes, for our North and Mid Hampshire LDS with includes the resolution of the acute services review

- Building a 5 year strategic plan for the LDS, aligned to the STP, and including a strategy for the development of and contracting for new care models

Planning guidance indicates a move to system planning and new ways of working'
The local delivery systems will provide the platform for new ways of commissioning services within the principles of the 5YFV and the operating plan guidance. The key principles for new ways of contracting are highlighted:

- STPs are more than just plans. They represent a different way of working, with partnership behaviours becoming the new norm
- What makes most sense for patients, communities and the taxpayer should always trump the narrower interests of individual organisation
- Even good organisations working in silos cannot implement the Five Year Forward View and deliver the required productivity savings and care redesign required
- We need new care models that break down the boundaries between different types of provider, and foster stronger collaboration across services – drawing on, and strengthening, joint work with partners, including local government
- NHS organisations want to spend less of their time locked in adversarial and transactional relationships
- Commissioners will still have the ability to let new longer-term contracts, based on new care models and whole population budgets, revising existing contracts accordingly
- To ensure that organisational boundaries and perverse financial incentives do not get in the way of transformation, from April 2017 each STP (or agreed population/geographical area) will have a financial control total that is also the summation of the individual organisational control totals

- All organisations will be held accountable for delivering both their individual control total and the overall system control

- It will be possible to flex individual organisational control totals within that system control total, by application and with the agreement of NHS England and NHS Improvement

We wish to explore future contracting options which ultimately include the following elements:

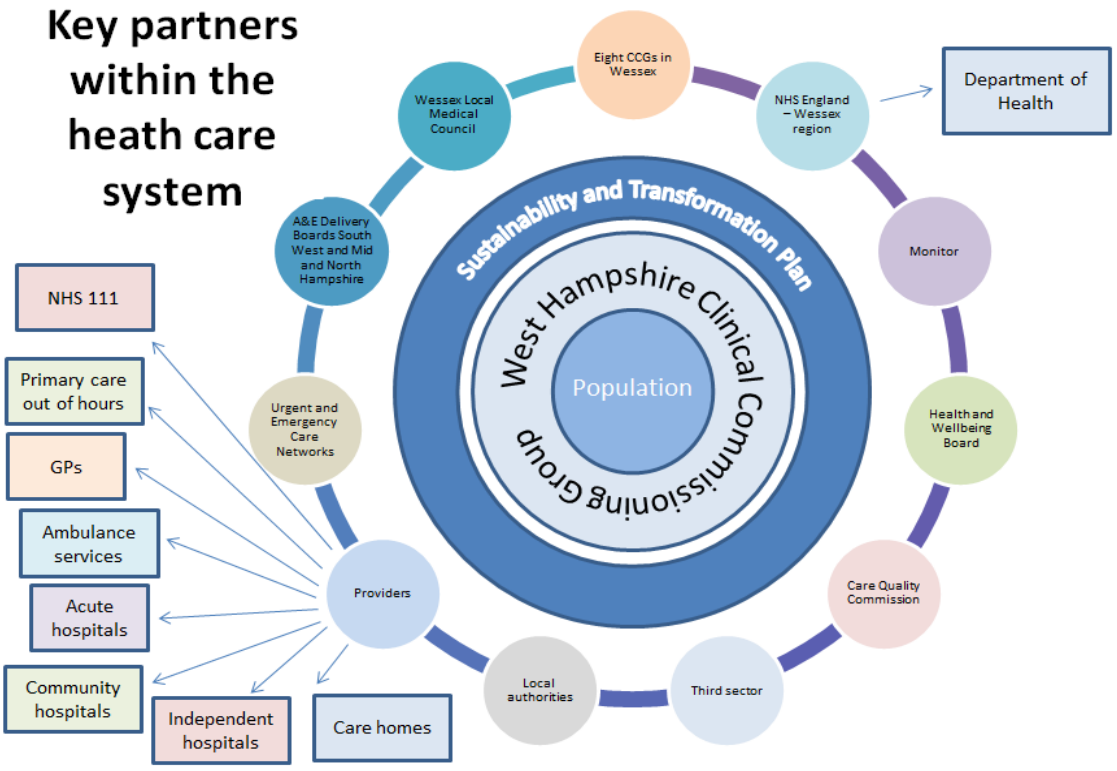
- Whole population budget for the range of services covered

- Performance element linked to patient outcomes

- Gain/risk share for delivering the system financial targets

Delivering in partnership

The development of the local delivery systems will build on our existing partnerships; these include a number of public, private and third sector organisations to help deliver CCG and STP objectives to ensure effective healthcare commissioning.



For example we currently work:

- **With Sustainability and Transformation Plan Partners** - the eight CCGs in Hampshire and Isle of Wight, NHS England Specialised Commissioning, Isle of Wight NHS Trust, Portsmouth Hospitals NHS Trust, University Hospitals Southampton NHS Foundation Trust (UHS), Hampshire Hospitals NHS Foundation Trust (HHFT), South Central Ambulance Service NHS Trust (SCAS), Solent NHS Trust, Southern Health NHS Foundation Trust (SHFT), Hampshire County Council (HCC), Isle of Wight Council, Portsmouth City Council and Southampton City Council to ensure that strategies align in a holistic way and maximise the value for money for the population to deliver the priorities within the STP

- **To align strategic and operating plans** with the plans of other key stakeholders such as NHS England and Hampshire Health and Wellbeing Board

- In partnership with neighbouring CCGs, local authority colleagues and voluntary sector organisations the CCG will work to **join up services and deliver more services in the community**

- Alongside the Clinical Senate for Southampton, Isle of Wight, Portsmouth, Dorset, Bournemouth and Poole to **strengthen collective clinical leadership** along with promoting major service change

- With our population, for example through patient participation groups to ensure that we are **a listening, proactive and responsive organisation**, using insight and feedback from the public and patients to make changes to local health services

- In partnership with local authorities to **help shape and understand housing, planning, and licensing needs**, as well as the county trading standards, to help reduce health inequalities

- With the **Academic Health Science Network** through AHSN Wessex Board representation, for example, through board member sponsorship of the nutrition programme

- With **our Public Health colleagues** to protect and improve the nation's health and wellbeing, and reduce health inequalities

Commissioning strategy to change the shape of care delivery

Implementing the STP is consistent with our vision, values and strategic objectives for the organisation:

- **Our vision** is to be consistently recognised for commissioning and enabling the delivery of high quality patient centred healthcare, which is innovative, equitable, efficient, effective and, where possible, prevention based, contributing to the healthiest population in England

- **Our values** - we have set ourselves the following values so that in everything we do we aim to be:

- **Our strategic objectives** are to:

    1. Ensure **system financial sustainability**; to ensure compliance with business rules

    2. Ensure **safe and sustainable high quality services**; to provide the best possible care for patients

    3. Work in **partnership to commission health and social care collaboratively**; to commission services at the appropriate tier to achieve the best possible outcomes for patients

    4. Establish **local delivery systems to deliver patient centred care closer to home** which is integrated, prevention based, equitable and high quality

    5. **Develop the CCG workforce** to meet the future commissioning needs of the population

Our care strategy 'Changing the Shape of Care Delivery' will help us deliver the STP priorities and has helped shape the priorities within our Operating Plan. This care strategy builds upon strategic plans already in place and enables us to change focus and to move from a reactive to a proactive care model, to be less dependent on hospital services and to improve community and GP services to enable people to help themselves maintain their health.

The care strategy will enable us to:

- Ensure the **best possible start in life** with maternity services centred around mothers and their babies

- Support the **health and wellbeing of children and young people** through access to earlier interventions

- Ensure if a person's health deteriorates, they will know **what to do and who to contact**; the ability to quickly respond and intervene to support people in the community is a critical

- Intervene early to identify **vulnerable people, or those with complex needs**, in the community who could benefit from a proactive and personalised programme of care, tailored to patient needs and views, to help patients and carers lead as independent and fulfilling lives as possible

- Ensure people with more serious or life threatening emergency care needs receive **treatment in centres with the right facilities** and expertise to maximise chances of survival and a good recovery

- Have a greater focus on **prevention, empowerment and self-care** as people are living longer but are experiencing more years of ill health and high need for social care

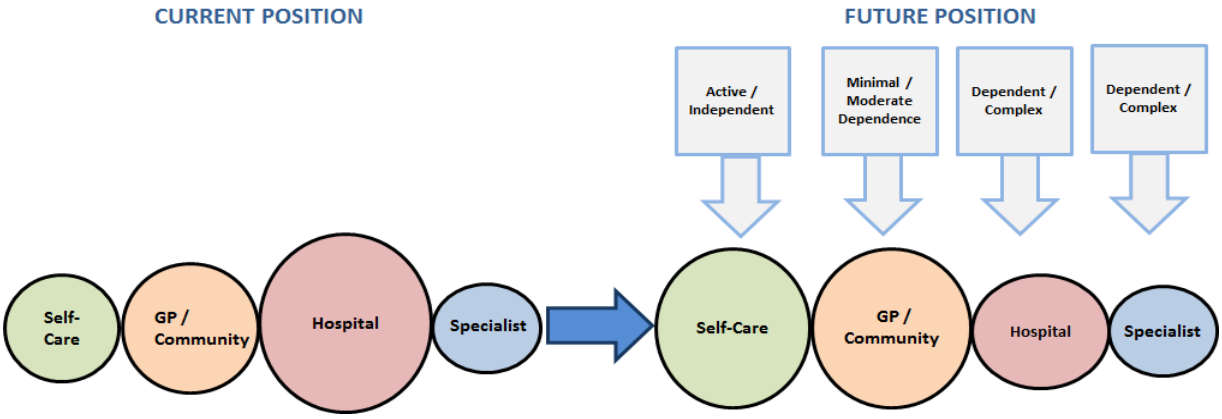
- Ensure people are supported to **make informed decisions** about their care and to access the right care, in the right place and at the right time

- Support people to take greater control of their health and well-being and to make **healthy lifestyle choices**

- Maintain equal focus on physical and mental health, as well as social and environmental factors, including the **wider determinants of health**

- Ensure if admission to hospital is required, patients only remain for the acute phase of their illness or injury, with **timely transfer or discharge**; care at home will always be the default for care delivery, with people supported to recover and regain maximum function and independence

- Manage **end of life care** in line with jointly agreed advanced care plans and more people will be supported to die in their place of choice



Research, innovation and growth

In delivering the STP we recognise the important role that research and innovation will play in allowing us to develop better care. We support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research.

As active partners at Board level in the Wessex Academic Health Science Network we are committed to increasing the uptake of technologies to support self-management. We are engaged in Collaboration for Leadership in Applied Health Research and Care funded respiratory research projects in primary care across west Hampshire.

MyHealth technologies to support patient triggered outpatient follow up is a key project that we are promoting through the STP.

We will facilitate the informing, motivating and supporting of primary care colleagues across the CCG through the Wessex Academic Health Sciences Network/ Southampton University clinical meetings.

Particular focus areas relating to innovation for the improvement of patient outcomes are:

- Endoscopy service improvement
- Dementia
- Genomics
- Medicines optimisation
- Nutrition
- Mental health
- Digital health
- Respiratory
- Orthopaedics
- Reducing harm from alcohol
- Life science

Outcomes

Our plans aim to improve the outcomes for our patients through, joined up integrated care delivery with a focus on prevention. We are committed to achieving on improvement of outcomes, particularly as follows:

Deliver locality plans

- **High quality, safe services** delivered consistently
- **Reduction in smoking, obesity and alcohol related health conditions** by promoting healthy lifestyles
- People with long term conditions and multiple chronic physical and mental health issues experience **better health outcomes**
- People are better supported to **stay well and independent**, with greater confidence to manage their own health and wellbeing

Develop integrated care around local delivery systems

- National **access targets** will be delivered
- **Delayed transfers of care** rate will be reduced to and maintained at 3.5%
- More people will have a **positive experience of care,** which is joined up and is tailored to meet personal and holistic needs
- Everyone is able to **access appropriate primary care** in their locality out of hours and at weekends
- Everyone is able to **access safe acute service** offering the best possible outcomes, 7 days a week

- Patient receive more of their care at home and in their community, and following acute care in hospital are **transferred home without delay**

- Consistently good, co-ordinated, timely response experienced by people in a **mental health crisis**, and consistently high quality mental health services

- Earlier diagnosis of physical and mental health conditions leading to **improved outcomes and survival rates and more healthy years of life**

Financial Sustainability

- **Bed capacity will be used more effectively to generate a reduction in the acute bed stock**

- **Activity growth** in the acute sector will reduced and patients treated in the best setting to improve outcomes

- **A&E attendances and emergency admissions** will not increase and ideally be reduced

- **Create a sustainable workforce** with a decreased reliance on agency workers and greater flex of staff resources

- **Estate** footprint and costs will be reduced

Our work plan for 2017/18 to 2018/19 can be found at **Appendix 1**. The work plan pulls together all priorities, set out within part two of the plan, into a single document which enables the delivery of the operating plan to be performance managed. Further information on our performance management arrangements are set out in section 5.

5. FINANCIAL SUSTAINABILITY

We are planning to return to a cumulative underspend over the two year period to 2018/19 by delivering a 1% surplus by the end of 2018/19, i.e. a cumulative underspend of £4.8m in 2017/18 (0.7%) and £6.8m in 2018/19 (1.0%), therefore, ensuring compliance with business rules. This is in line with the H&IOW STP control total surplus expectation for the CCG.

The table below presents a summary of the key financial information submitted to NHS England on 23rd December 2016.

Revenue Resource Limit			
£ 000	**2016/17**	**2017/18**	**2018/19**
Recurrent	723,573	737,721	752,108
Non-Recurrent	1,077	2,984	2,782
Total In-Year allocation	724,650	740,705	754,890
Income and Expenditure			
Acute	351,983	358,712	361,137
Mental Health	42,800	43,717	44,594
Community	65,909	68,053	68,254
Continuing Care	77,187	78,762	84,605
Primary Care	95,124	97,400	103,068
Other Programme	13,260	10,230	6,606
Primary Care Co-Commissioning	66,974	68,221	70,949
Total Programme Costs	**713,238**	**725,094**	**739,214**
Running Costs	11,412	11,907	11,902
Contingency	-	3,704	3,774
Total Costs	**724,650**	**740,705**	**754,890**

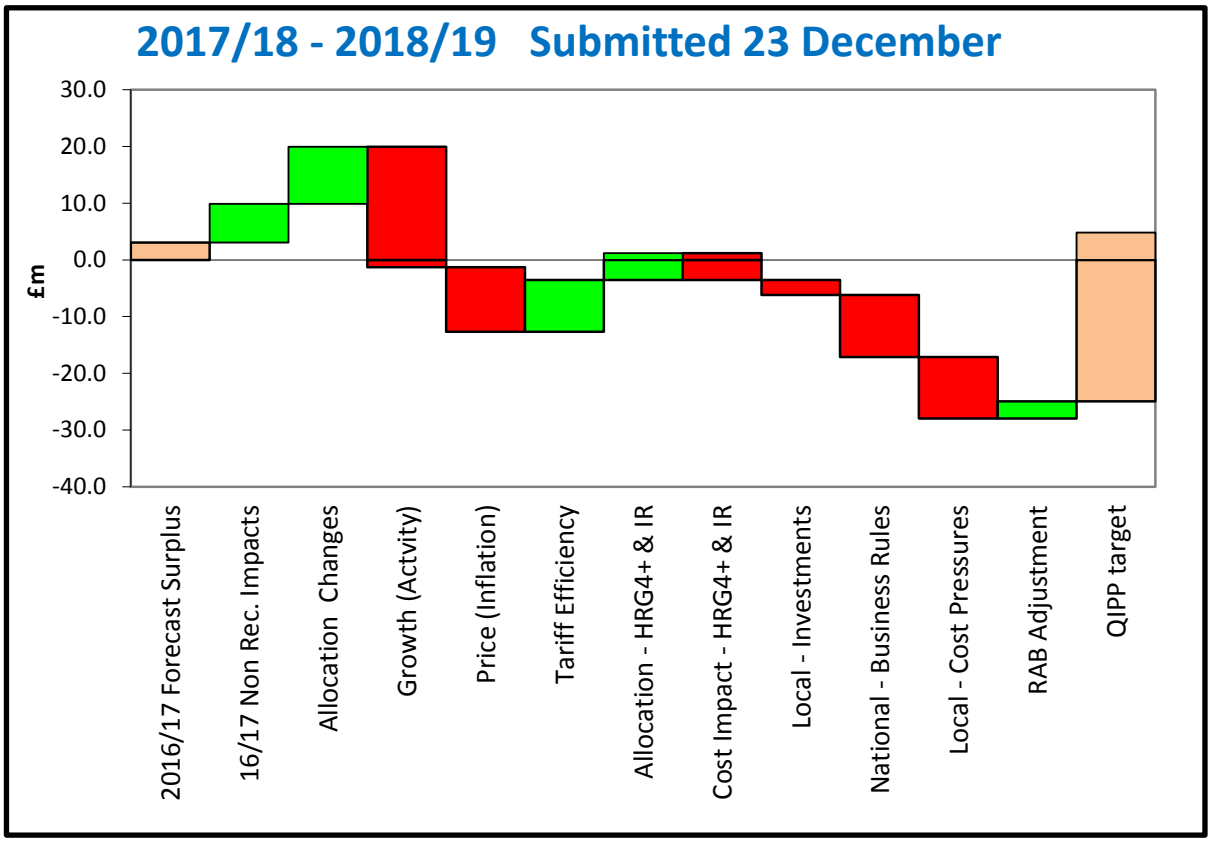
BALANCE SHEET memorandum - Movement on historic underspend/(deficit)	**2016/17**	**2017/18**	**2018/19**
Brought forward underspend/(deficit)	45	3,045	4,805
Adjusted for in-year (drawdown)/draw-up	3,000	1,760	2,038
In-year change from plan/In-year deficit	0	-	-
Balance carried forward	**3,045**	**4,805**	**6,843**
Underspend/(Deficit) %	0.5%	0.7%	1.0%
Underspend (RAG)	**AMBER**	**AMBER**	**GREEN**

We forecast to deliver a surplus of £3.0m in 2016/17 in line with the approved financial plan for the year. However, a number of on-going financial pressures will require further mitigation in order to remain on this trajectory, for example over-performance within acute contracts, continuing healthcare spend and delivery of the 2016/17 QIPP programme, where we are currently forecasting 89% delivery.

It is anticipated that the 0.5% contingency will not now be spent in full. However, in order to ensure delivery of the surplus and achieve all business rules, the financial recovery plan will continue through 2016/17 until recurrent expenditure is affordable within the recurrent allocation.

Financial Planning Assumptions

The bridge below shows the impact of the 2017/18 financial planning assumptions.



The key planning assumptions underlying the 2017/18 to 2018/19 financial plan as submitted on the 23 December 2016 are as follows:

- We will hold a 0.5% contingency and retain a 1% non-recurrent (headroom) requirement, of which 0.5% will remain uncommitted

- The tariff uplift of 2.1% has been applied to contracts less the 2% efficiency requirement as per the planning guidance. A further 0.7% uplift to fund the Clinical Negligence Scheme for Trusts CNST has also been applied to acute contracts

- Growth has been applied to contracts at STP levels (as per the Indicative Hospital Activity Model (IHAMs model) adjusted for historical trend and future anticipated activity, taking into account QIPP expectations to achieve an overall affordability envelope

We have modelled our activity to reflect years 2 and 3 of the STP, using IHAMs as the starting point for growth in the ‘do nothing’ scenarios for 2017/18 and 2018/19.

The capacity in the NHS and existing independent sector contracts is considered sufficient to meet demand and additional capacity has not been sourced.

The table below provides a summary of these assumptions.

Key Planning Assumptions

	2017/18	2018/19
Notified Allocation Change (£'000)	12,887	13,040
Notified Allocation Change (%)	2.0%	2.0%
Tariff Change - Acute (%)	0.6%	0.8%
Tariff Change - Non Acute (%)	0.0%	0.0%
Demographic Growth (%)	1.1%	1.4%
Non Demographic Growth - Acute (%)	2.1%	1.9%
Non Demographic Growth - Cont.Care(%)	0.7%	1.4%
Non Demographic Growth - Prescribing (%)	4.1%	6.2%
Non Demographic Growth - Other Non Acute (%)	1.0%	1.4%
Mental Health Investment Standard	Y	Y

Finance and activity plans are clearly linked; the levels of growth in the STP, financial planning, contract envelopes, and activity plans are fully aligned, although the metrics and baselines may differ due to different sources (e.g. activity plans based on NHS England tNr data; contracts based on Service Level Agreement Monitoring data). The resulting financial model means that we must deliver 4% QIPP across our programme budgets to deliver our control total and required business rules. This is a challenging target for savings which is higher than the level of savings delivered by most organisations. At the time of submitting our draft plan £22.8m, or 77%, of the £29.7m required savings has been identified.

At the time of submitting our plan, we are in the process of agreeing trajectories with providers for emergency departments, standards which meet NHS Improvement's requirements for the STF; and have agreed fully complaint trajectories for referral to treatment and cancer 62 day standards. For other cancer standards and diagnostics, we expect performance to be maintained at or above constitutional standards, and will agree this with providers.

We are in the process of ensuring that we have the necessary performance data to monitor current and new standards, recognising the challenge of the new areas of collection, specifically in relation to the range of new mental health indicators.

Capacity in the independent sector will be maintained at current contractual levels adjusted for growth and the impact of relevant QIPP programmes, and we are confident that this capacity exists with our local providers.

We consider our Improvement and Assessment Framework (IAF) position on a regular basis and expect a financial plan which is compliant with business rules and our control total to improve our position in 2017/18.

Financial Risks

There are a number of risks to this plan, the most significant of which is the identification and delivery of QIPP schemes across the period. The QIPP target of £29.7m (inclusive of the full year effect of 2016/17 QIPP) or 4.0% of total allocation is extremely challenging and higher than most CCGs would expect to deliver. The QIPP target has reduced from £42m

as per our contribution to the H&IOW STP submission on 5th October 2016, which reflects the progress made during the planning cycle.

At this point in time, £6.9m remains unidentified, which is 23% of the total target. Work is underway to close the gap, both as part of the CCG's financial recovery plan and as part of it's planning for 2017/18 and beyond.

QIPP schemes will cover demand reduction measures including implementing RightCare, elective care redesign, urgent and emergency care reform, supporting self-care and prevention (ACSC), medicines optimisation and improving the management of continuing healthcare processes.

We will work with STP partners to help to deliver provider efficiency measures including implementing pathology service and back office rationalisation, implementing procurement, hospital pharmacy and estates transformation plans, improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity, implementing the 'Getting It Right First Time' programme and implementing new models of acute service collaboration and more integrated primary and community services.

Our QIPP programme for transformational change reduces activity from the 'do nothing' scenario. The programme aligns with the joint commissioning intentions for the STP and takes account of other initiatives such as Better Local Care. Each QIPP project within the programme clearly describes the impact on activity as well as finance where appropriate, contract by contract. This has then been built into the activity modelling, aligning both financial planning and contract envelopes with the activity modelling.

The table below shows a breakdown of the CCG's QIPP Schemes for 2017/18:

Transactional / Transformational	Description of Scheme	Recurrent Saving FYE 16/17 £000s	Recurrent Investment FYE 16/17 £000s	Recurrent Saving 17/18 £000s	Recurrent Investment 17/18 £000s	Non Recurrent Saving 17/18 £000s	Unidentified Recurrent Saving 17/18 £000s	Grand Total 17/18 £000s
Transactional	AEC	0	0	1,566	0	0	0	1,566
	Contract challenges	0	0	1,500	0	0	0	1,500
	Discharge from CDU	0	0	1,010	0	0	0	1,010
	Elective Excess Bed Days	0	0	684	0	0	0	684
	HQ Spend	0	0	200	0	0	0	200
	Non Elective Bed Days	0	0	1,939	0	0	0	1,939
	Paediatric Phlebotomy	0	0	23	0	0	0	23
	Paediatric pricing	0	0	86	0	0	0	86
	Short Stay Admissions	0	0	1,415	0	0	0	1,415
	Tongue tie (Frenulotomy)	0	0	13	0	0	0	13
	Well Babies	0	0	500	0	0	0	500
	Investment slippage	0	0	0	0	1,000	0	1,000
	External Audit Contract	0	0	25	0	0	0	25
	Contract Management	0	0	2,081	0	0	0	2,081
	Reserve Management	0	0	0	0	3,000	0	3,000
Transactional Total		**0**	**0**	**11,041**	**0**	**4,000**	**0**	**15,041**
Transformational	CHC	0	0	1,500	0	0	0	1,500
	Diabetic Footcare MDT	0	0	20	-35	0	0	-15
	Enteral Feeding (South Lot)	307	-160	0	0	0	0	147
	EOL CMH/Oakhaven	0	0	246	-220	0	0	26
	Funded nursing care	0	0	292	-340	0	0	-48
	GP Prescribing	0	0	1,900	0	0	0	1,900
	Mid ACSC COPD	0	0	83	0	0	0	83
	Mid ACSC Flu	0	0	210	0	0	0	210
	Mid ACSC UTI	0	0	7	0	0	0	7
	Minor Eye Conditions	0	0	77	-49	0	0	28
	MIU West Directorate	0	0	711	-345	0	0	366
	New DVT Pathway	73	0	0	0	0	0	73
	Outpatient Transformation	0	0	3,000	0	0	0	3,000
	PLCV Arthroscopies	906	0	0	0	0	0	906
	PTS	0	0	900	0	0	0	900
	Rightcare Gastroenterology	77	0	14	0	0	0	90
	Rightcare Tier 2 MSK Model	738	0	0	0	0	0	738
	Rightcare Trauma & Injury	189	0	0	0	0	0	189
	RTAP Shoulder	2	0	80	0	0	0	83
	South ACSC Asthma	0	0	8	0	0	0	8
	South ACSC COPD	0	0	56	0	0	0	56
	South ACSC Diabetes	0	0	11	0	0	0	11
	South ACSC Flu	0	0	125	0	0	0	125
	South ACSC UTI	0	0	28	0	0	0	28
	Tier 2 (GP Led) Cardiology Serv	54	-42	0	0	0	0	13
	High Cost Medicines (Biosim)	0	0	480	0	0	0	480
	OPMH Comm Nurse Assessor	0	0	30	0	0	0	30
	Schemes at risk of delivery	0	0	-3,099	0	0	0	-3,099
Transformational Total		**2,347**	**-202**	**6,678**	**-989**	**0**	**0**	**7,835**
Unidentified	Unidentified	0	0	0	0	0	3,771	3,771
	Schemes at risk of delivery	0	0	0	0	0	3,099	3,099
Unidentified Total		**0**	**0**	**0**	**0**	**0**	**6,870**	**6,870**
Grand Total		**2,347**	**-202**	**20,819**	**-989**	**4,000**	**6,870**	**29,746**

Other Risks

The other key risks which continue to be quantified, along with management plans, are as follows:

- Finalisation of HRG4+ and specialist transfers on provider contract values, along with in-year risks (e.g. from specialist transfers not reflecting activity costs in 2017/18)

- The impact on Resource Accounting and Budgeting in 2017/18 if 0.5% planned surplus is not delivered in 2016/17. At this stage of the planning cycle we continue to assume full delivery of 2016/17 plan

- Activity above planned and contracted growth in 2017/18. Risks of deviating from the activity plan will be mitigated through implementing the QIPP programme described above and through the application of contractual measures in year

- In addition, other risks include those relating to Continuing Health Care and medicines management and delivery of the QIPP programme, including closure of unidentified QIPP

In the financial plan submitted on 23rd December 2016, £10m of net risks were identified as follows:

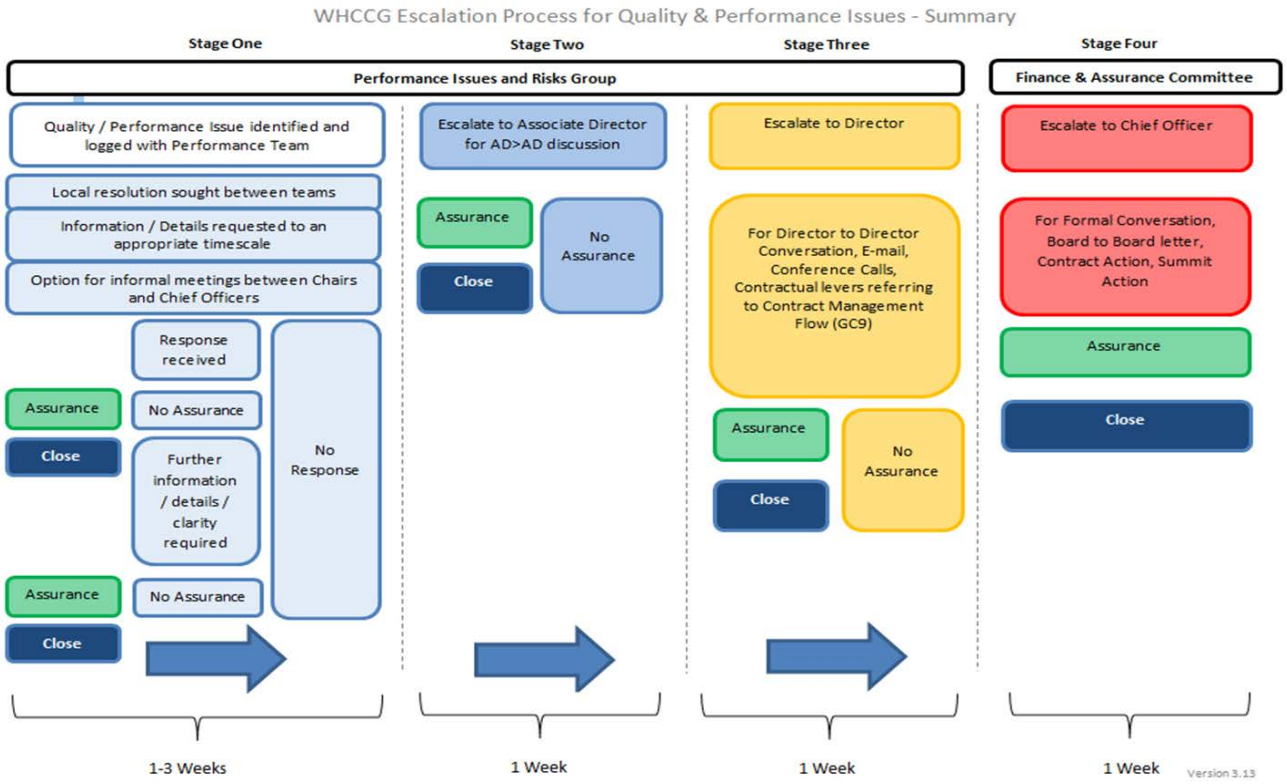
RISKS & MITIGATIONS	Gross £'m	Likelihood £'m	Net £'m
Risk:			
Delivery of Identified Contract Stretch QIPP	(2.6)	100%	(2.6)
Delivery of Unidentified QIPP	(6.9)	100%	(6.9)
Delivery of Identifed QIPP (excluding contract stretch QIPP)	(19.1)	10%	(1.9)
CHC Risk (including Risk Pool)	(0.9)	50%	(0.5)
RAB Risk (re 2016/17)	(3.0)	0%	-
HRG4+	(1.4)	25%	(0.4)
Specialist Transfers	(1.5)	25%	(0.4)
Market rent above £585k	(0.6)	100%	(0.6)
2017/18 In-Year Activity Pressures	(5.0)	50%	(2.5)
Risk	**(41.0)**	38%	**(15.7)**
Mitigations:			
Headroom (Balance re 0.5% re transformation)	0.6	100%	0.6
General Reserves	3.3	24%	0.8
Market rent allocation	0.6	100%	0.6
Contingency	3.7	100%	3.7
Mitigations	**8.3**	69%	**5.7**
Unmitigated Risk	**(32.8)**	30%	**(10.0)**

These risks continue to be developed and refined.

Performance management

We aim to deliver high quality and consistent services on behalf of our population. To help assure ourselves that this is achieved, we have an established performance management regime to review the performance of both ourselves and our providers. The Performance Management Framework has been reviewed and approved by the Finance and Assurance Committee. The review included establishing clearer processes for escalation for emerging issues at an earlier stage (see table below), and a protocol for investigating performance in detail when required.

The framework will be further developed by a new internal Performance Issues and Risks Group, reporting to Finance and Assurance Committee.



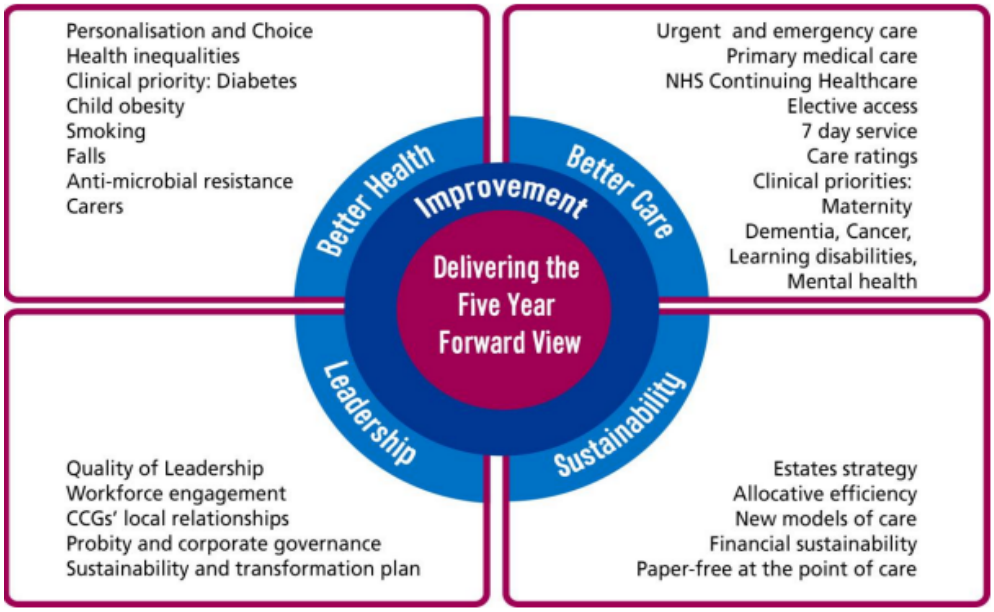
We are confident that in establishing more robust performance management arrangements internally, we will be able to improve our ability to triangulate performance concerns with quality issues more effectively.

The CCG recognises that there are a range of new constitutional standards in place this year, and therefore a need to collect and review a range of new performance data. This is particularly in relation to new targets for children and young people with mental health conditions, and eating disorders. Currently, the availability of robust and reliable datasets is not guaranteed for all these measures but we are working with colleagues in CSU and NHS England, as well as directly with our providers and lead commissioners, to resolve this.

CCG assurance

NHS England has set an assurance framework to measure the performance of CCG's against. CCG Improvement and Assessment Framework is the basis on which CCGs' performance is formally assessed and rated by NHS England. It is structured around the Five Year Forward View and developed to fit with STPs. It draws together in one place NHS Constitution and other core performance and finance indicators, outcome goals and transformational challenges. The actions within this Operating Plan are designed to meet the following requirements. The new framework covers indicators in four domains:

- Better Health: looks at how we are contributing towards improving the health and wellbeing of its population, and bending the demand curve
- Better Care: focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas
- Sustainability: looks at how we are remaining in financial balance, and are securing good value for patients and the public from the money it spends
- Leadership: assesses the quality of our leadership, the quality of its plans, how we work with partners, and the governance arrangements that we have in place to ensure we act with probity, for example in managing conflicts of interest



Risks

We recognise that commissioning healthcare services and the activities associated with caring for patients, such as employing people, providing premises and managing finances, all involve a degree of risk.

The CCG Board is committed to combining the management of non-clinical and clinical risk and integrating risk management into the objectives, plans and management systems. It will

strive to promote and achieve excellence while seeking to identify and manage risks to ensure, as far as is reasonably practicable, the safety of patients, people and visitors. Our approach to risk management focuses upon experiences and learning to improve the quality of care and clinical outcomes and improve the working environment. We aim to anticipate, assess and, where possible, reduce risk.

The risk appetite statement of the CCG Board outlines the fundamental principles we will adopt in relation to our approach to risk management. The CCG Board recognises that we must take risks. Indeed, only by taking risks can we achieve the objectives of the Operating Plan, and deliver beneficial outcomes to patients. However, risks must be taken in a controlled manner, reducing the exposure to a level deemed acceptable by the CCG Board and patients.

Methods of controlling risks must be balanced in order to support innovation and the imaginative use of resources, especially when seeking to achieve substantial benefit. In addition, we may accept some high risks because of the prohibitive costs of controlling them. As a general principle, we will seek to control all highly probable risks which have the potential to:

- Cause significant harm to patients, staff, visitors and other stakeholders
- Compromise severely the reputation of the organisation or the wider NHS
- Have financial consequences that could endanger viability
- Jeopardise significantly our ability to carry out our core purpose
- Threaten our compliance with law and regulation
- Compromise the delivery of our responsibility for constitutional standards.

Quality and equality impact assessment

We have a standard procedure which outlines the process for completion of the quality and equality impact assessment as an integral part of the QIPP plans, before the projects are approved and ratified. The following principles have been adapted from National Quality Board guidance and underpin the CCG's quality and equality impact assessment process:

- The patient comes first, not the needs of any organisation or professional group
- Quality and Equality is everybody's business
- If we have concerns, we speak out and raise questions without hesitation
- We listen to what patients and staff tell us about the quality of care and services
- If concerns are raised, we listen and 'go and look'
- If we are not sure what to decide or do, then we seek advice from others

- Our behaviours and values will be consistent with the NHS Constitution

The process aims to:

- Ensure that the CCG's QIPP plans have a neutral or positive impact on quality as well as reducing costs
- Ensure that the outcomes and objectives of our QIPP plans ensure equality for all patients
- Ensure that plans do not bring quality below essential CQC standards
- Assess all plans by their potential impact on equality, quality and safety
- Undertake more in-depth reviews on those plans which are deemed to have a significant impact on equality and quality
- Provide governing board assurance on the outcomes of assessing the equality and quality impact of plans
- Ensure there is an ongoing process for assessing the equality and quality impact of plans

At the same time, QIPP plans undergo a Privacy Impact Assessment & Equalities Impact Assessment to ensure the implication on patient privacy have been fully considered and addressed, including personal data, and that they will not have a negative impact on protected characteristics.

PART TWO – STRATEGIC PRIORITIES FOR 2017/18 - 2018/19

6. IMPROVING QUALITY

Quality

The quality teams in all H&IOW CCGs work collaboratively to share ideas and best practice, and will continue to do so to take forward the STP level system quality aims.

Alongside our partners we are committed to improving the quality of care for our population. To achieve this we monitor provider performance and put in place action plans in response to nationally published reports, inspections by regulators, and our own commissioner led inspections and local intelligence.

Working with partners we will:

- Identify organisational **quality priorities** through contract reporting. For 2017/19 the contract reporting requirements will include provider identification of service level priorities following triangulation of complaints, incidents, concerns, serious incidents, Never Events, patient, carer and staff feedback

- Identify action plans to **address areas for improvement**. Part of this work is to raise the standard of transfers and discharge from acute, community, mental health and learning disabilities and independent hospital providers through the revised transfer and discharge from care schedule which we have placed in the 2017/19 contract

- **Facilitate multi-agency/provider learning** using incidents to focus improvement work

- Ensure provider benchmarking reviews and reports are shared across providers to **drive service improvement**

For primary care, we are embedding significant event reporting and management processes to enhance wider sharing and promote a culture of system learning, through continuation of work started in 2016/17 Quality Progression Scheme.

If we have a provider placed in special measures, we will work with the relevant provider through 1:1 targeted support, oversight meetings and through contractual meetings to support identification and delivery of improvement actions.

Providers receive support from us to learn from innovation and good practice in the system through newsletters and learning events which is very important to us. We use deep dives and pathway reviews to identify innovation and new ways of working to support improvement. Safe staffing levels are important to ensuring patient safety and we are committed to monitoring staff numbers and skills mix in accordance with the safer staffing guidance and working with providers to put any actions in place to address any concerns. We provide the CCG Board with exception reports if we consider patient safety, experience or outcomes is at risk.

We continue to work with our partners to achieve reduction in avoidable deaths. To do this we will:

- Actively participate in, the **Learning Disabilities Mortality Review** programme to help identify potentially avoidable contributory factors to the deaths of people with learning disabilities

- Look for differences in health and social care delivery across England and ways of improving services to **prevent early deaths of people with learning disabilities** and to develop plans of action to make any necessary changes to health and social care services for people with learning disabilities

- Support providers' development of **internal mortality review processes** and receive mortality reports which allow us to measure and monitor deaths and improve the quality and safety of services

- Support work to develop an **inter-provider mortality review process**. We will be adding the need for providers to participate in the national work to annually report deaths, including unexpected/avoidable deaths and publish avoidable death rates into our 2017/19 contract

- Promote the use of standardised **early warning** scores across providers to ensure early recognition and appropriate escalation of the physically deteriorating person to reduce morbidity and mortality

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
General Practice		
• Implement the quality development programme, including quality visits, CQC support and service improvement as part of the quality framework to support **quality in General Practice**	Apr 2017	Quality of service improved in GP practices
• Support a **sustainable nursing workforce** by working with Health Education England (Wessex) to enable student and return to practice placements within primary care	Sep 2017	Increase number of students choosing General Practice as a career pathway
• Enhance **safety and quality within general practice and access** to primary care services to improve patient experience, as measured via Friends and Family Test and GP National Survey	Mar 2018	Improved services leading to better results in the Friend and Family Test and GP National Survey
• Implement development programme based around leadership, locality based forums and specialist subject groups with a focus on **essential skills and training for General Practice Nursing**	Mar 2018	Practice nurses have improved skills leading to better levels of service for patients
• Deliver the overarching **Primary Care Quality Strategy** through collaborative working with primary care teams, CCG commissioning and quality team	Mar 2019	Quality of service improved in GP practices

• Develop and submit **bids for improvement grants** for funding to improve the quality of GP practice premises and improve infection control	Mar 2019	GP practices are fit for purpose and able to reduce risk of infection in their buildings
Quality Progression Scheme		
• Establish sharing of significant events through the Datix system within General Practice to **support a culture of learning and safety**	Sep 2017	Increased and faster reporting of significant events
• Improve significant event recognition, reporting, and investigation with a culture of systems-based sharing and learning following implementation of the **Quality Progression Scheme**	Mar 2019	Standardised reporting of significant events with greater system learning to improve quality and safety
Patient Experience		
• **Maintain patient safety and experience** when constitutional targets are breached and escalated through assurances processes including; clinical assurance visits; reporting and discussion at clinical quality review meetings, investigations of specific cases, or cluster analysis of themes emerging	Mar 2018	Reduction in breaches of constitutional targets
Shared Learning		
• Review of **Clinical Quality Review** Meeting processes, including Quality Team visits to providers to review services or pathways, focussed in relation to incidents/SIRIs, concerns, national guidance, patient feedback, CCG priorities, aligned to reporting information to test provider plans and delivery at patient level; for example reviewing the fractured neck of femur pathway and achievement of the best practice tariff	Sep 2018	Quality incidents and concerns are dealt with effectively to reduce reoccurrence
• **Work with providers to share learning** from organisations where others have had greater success, and support with assisting the provider to understand their issue and identify potential solutions/actions to deliver improvement	Mar 2019	Better trained staff to reduce occurrence of incidents
• Continue to use '**Qwest 4 Improvement' newsletter** to improve learning from innovation, system-wide serious incidents requiring investigation (SIRIs), provider SIRIs and never events, sharing with providers and other CCGs	Mar 2019	Improved shared learning to reduce incidents occurring

Link to strategic outcomes

- High quality, safe services delivered consistently

Medicines management

We support the development of safer and more effective prescribing through a fully integrated, end to end medicines management which allows automated supply, decision support and real time monitoring as set out in the STP. The STP's acute alliance work stream includes a programme on pharmacy with the objective to improve the cost efficiency and maximise income generation through collaboration. We are a key partner within this work stream and our priorities set out within the operating plan are aligned to this.

We promote messages to the public supporting the appropriate use of medicines including antibiotics and encouraging self-care including seeking advice from 111 and community pharmacists. We will continue to work with all our providers to improve the appropriate prescribing of antimicrobial agents. This will include providing GPs with comparative prescribing data, educational tools and support to undertake audits. In addition, we will investigate the adoption of innovative new patient testing diagnostics to support GPs in their prescribing decisions.

The medicines optimisation team has a range of levers to support prescribing interventions including:

- Medicines optimisation incentive schemes
- Practice based pharmacists and technicians, who can support practices to undertake audits of prescribing
- Comparative prescribing data and benchmarking to support discussion and change through peer support and peer pressure
- Educational events, for example, through existing GP medicines management groups and Time for Audit, Research, Governance, Education and Training (TARGET) events
- Clinical decision support tools within GP clinical systems

Priorities 2017-18 – 2018/19	Delivery Date	Outcomes
General Practice		
• Support GP practices to improve the treatment of **atrial fibrillation**	Mar 2018	People with atrial fibrillation are prescribed the most effective medicines to reduce their risk of stroke
• Support GP practices to audit their prescribing of asthma medicines in line with the findings of the **National Review of Asthma Deaths**	Mar 2018	People with asthma have regular reviews of their medication to ensure they receive the most effective treatment in an inhaler they can use
• Support GP practices to reduce the inappropriate prescribing of **antimicrobial agents**	Mar 2018	Reduced prescribing of antibiotics overall, whilst ensuring that patients who require an antibiotic receive the appropriate medicine
• Continue to support GPs to review **frail patients receiving multiple medicines**, particularly problematic medicines	Mar 2019	Patients only receive the medicine they need
• Support GP practices to review patients with learning disability who are prescribed **antipsychotic medicines**	Mar 2019	People with learning disabilities have regular reviews of their medication with their GP
• Increase prescribing to address **hypertension** by focussing on primary care management of hypertension in those under 85 and in people with long term conditions, especially diabetes	Mar 2019	Patients with high blood pressure are regularly reviewed and are prescribed the appropriate medicines
Prevention		
• Increase prescribing to reduce cholesterol through the promotion of the '**How Healthy am I**' publicity campaign in pharmacies, job centres and smoking cessations clinics	Mar 2019	Reduction in patients with high cholesterol

Link to strategic outcomes

- High quality, safe services delivered consistently

Patient experience

Improving patient experience and choice is at the heart of our work.

We are committed to delivering the STP aims which enable patients to say:

- I am able to proactively **manage my own health**
- I receive easy to access and tailored **support in the community**
- I find it easy to access **specialist care** in the community
- I have the best **quality and most innovative care** available to me

To ensure we get consistent feedback we gain information from a series of surveys conducted on a mixture of month, quarterly and annual basis. This involves:

- Friends and Family Test
- Service User Survey
- Staff Survey – for the CCG and providers
- Carer Feedback – feedback is sought form adult and child patients
- CCG Annual Survey
- Patients waiting longer than 4 hours in the Emergency Department – the providers gather information of patient experience in the emergency department
- Improving patient and carer experience of discharge from hospital by measuring patient/carer experience of the discharge process
- Complainant Survey – feedback as to complainant satisfaction of the complaints process through the use of a local complaint satisfaction survey

The results of the surveys are reviewed and analysed with written reports going to the Clinical Quality Review meetings for discussion and with actions plans put in place where needed. Oversight of these reviews is undertaken at CCG Board level.

We want to significantly improve patient choice, for example in maternity, end-of-life care and for people with long-term conditions, ensuring an increase in the number of people able to die in the place of their choice, including at home.

Further information on how we engage our population in developing the local healthcare services can be found in Section 14 of this plan.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Patient Experience		
• Feed **patient experience information** into the development of commissioned services	Mar 2019	More people responding positively that their care is co-ordinated and achieves their goals and outcomes

Links to strategic outcomes

- High quality, safe services delivered consistently
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs

Personal health budgets

We have committed to 1273 people having a personal budget as part of the Hampshire Integrated Personalised Commissioning Pilot site. Adults who receive continuing healthcare or are in receipt of aftercare under section 117 of the Mental Health Act, and children with care packages in place are being offered personal budgets. Personalised support is a key work stream of our Transforming Care Partnership (TCP). To ensure this happens it has been built into contracts and will be monitored on a quarterly basis with actions being taken to maximise response levels.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Personal health budgets		
• Continue to deliver **personal budgets** under the Hampshire Integrated Personalised Commissioning Pilot	Mar 2019	Number of patients with personal budgets increased and aim to achieve the performance trajectory

Links to strategic outcomes

- High quality, safe services delivered consistently
- People are better supported to stay well and independent, with greater confidence to manage their own health and wellbeing
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs

Safeguarding

We are part of the NHS England National Safeguarding Wessex Steering Group consists of eight subgroups, providing specialised support for affected individuals. The overarching aim of this programme is to facilitate high quality practice. The sub-groups include:

- Adult Safeguarding Network
- Adult Sexual Exploitation
- Child Protection – Information Sharing
- Child Sexual Exploitation
- Children Safeguarding Network
- Female Genital Mutilation
- Looked After children
- Mental Capacity Act
- PREVENT

The programme objectives include:

- Safeguarding leaders across Wessex will **agree shared priorities and objectives** to develop an improvement plan for Wessex safeguarding
- Developing **practical guidance and tools** for frontline practitioners across all providers in Wessex
- Developing a **shared vision** with key stakeholders, partner agencies and the public
- Leading a programme of activities in line with **shared priorities**
- Developing performance indicators to measure **improved outcomes**

- Contributing to the development of a **learning culture**
- Building upon and developing networks across the system through **collective discussion forums** such as the Wessex Designated Safeguarding Forum and safeguarding boards
- Developing a repository of **best practice and lessons learned**
- Provision of support to provider organisations, capturing key messages (The Care Act 2014) **making safeguarding personal**

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Safeguarding		
• Deliver the **Wessex Safeguarding programme**	Mar 2019	Vulnerable adults and children receive a better service and practitioners upskilled

Links to strategic outcomes

- High quality, safe services delivered consistently
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs

Continuing healthcare

In line with STP we are transforming the CHC function to share learning and where appropriate develop a system wide approach for CHC which ensures the delivery of financial savings whilst maintaining the quality of care and compliance with the national framework.

The continuing healthcare function in Hampshire is hosted by us; we provide the service for our CCG as well as for South East Hampshire CCG, Fareham and Gosport CCG, North Hampshire CCG and North East Hampshire CCG. In recent years, the context in which the Continuing Healthcare (CHC) and NHS-funded Nursing Care (FNC) service is operating has become very challenging. The model for delivery and funding arrangements for CHC across the 5 CCGs in Hampshire has not met the requirements of the National Framework for NHS CHC and FNC nor the NHS Assurance Framework for CHC.

The CHC team is being restructured to put them in a position to address the local and national needs. There has been an increase in demand for CHC care especially in Fast Track (FT) applications and appeals, which has led to the need for more resources. Ongoing demand for CHC increases by approximately 10% per annum and the service needs to be fit for the future and to process an increase in applications and reviews. High levels of complaints indicate that the interface with CHC services is challenging for patients and can be a very poor experience with long delays and poor communications.

The new working model will enables us to support the 5 CCGs aspiration for locality based working and a drive towards integrated locality teams. The new model will enable closer integrated working with the Local Authority and community based services.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Service improvement		
• **Refine the KPI schedule for CHC delivery** that meets the requirement of the Business Cases	Jul 2017	Quantifiable quality measures introduced to ensure the CHC service meets NHS England Assurance Framework quality standards
• **Consolidate brokerage arrangements** to enable feedback on quality of care with providers and explore options for a joint brokerage arrangement with HCC	Sept 2017	A joint brokerage arrangement with HCC agreed leading to swifter placement for patients
• **Review the backlogged cases** of people in receipt of CHC and FT funding in a timely manner that ensuring clinical needs are reviewed, ongoing entitlement established and if necessary care packages are right sized to reflect ongoing need	Oct 2017	Backlog of cases reduced and care packages reflect ongoing need
• Prioritise activity to **take forward innovative commissioning** activity to deliver new types of services	Jul 2018	Improved outcomes and patient experiences e.g. care for fast track patients linked to hospice services
• **Implement the two business cases** that have been approved by the Hampshire 5.	Dec 2018	Improved CHC service that meets current and

Business case I - is being implemented and will be operating fully by July 2018. Business case II - has a longer lead in time and will be concluded by December 2018		anticipated future demand
• Ensure service development takes account of messages received via the **complaints process and independent audit of users experiences of CHC**	Dec 2018	Business processes aligned to meet customer expectations resulting in reduced complaints
Personal health budgets		
• Promote **better integration of personal health budgets** into continuing healthcare process by aligning personal health budget activity closer to the day to day work of the CHC team	Oct 2017	Increased use of personal health budgets
Financial sustainability		
• Have in place **framework agreements for over 80% of the care** purchased for CHC eligible patients	Dec 2017	Commissioned care meets the quality and price expectations
Workforce		
• Push ahead proactively to **recruit to all the new Business Case posts**	Mar 2018	Staff are properly inducted and fully trained to meet the demands of the service and the changes that will be happening
• **Develop guidance and training for acute providers** to ensure compliance with the National Framework guidance	Mar 2018	Acute providers better equipped to comply with the national framework guidance to provide a seamless service for patients
• Enable delivery of **a new workforce model** and organisational structure to enable delivery of CHC to a necessary standard that meets the requirement of the National Framework. Develop and implement the new workforce model, taking forward the hub and locality model for the service and closer working with CCGs on all aspects of the business	Apr 2018	New workforce model meets the national framework standard and leading to a better service for patients

Links to strategic outcomes

- High quality, safe services delivered consistently
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs
- Create a sustainable workforce along with a decreased reliance on agency workers and greater flex of staff resources

7. PRIMARY CARE

Responding to the General Practice Forward View 2017-2019

Our vision is for improved access to general practice and wider primary and community services that offer people convenience and choice, with fast, responsive and high quality care tailored to individual needs - helping people to make informed lifestyle choices and maintain their health and well-being to live as fulfilling life as possible, for as long as possible.

We want all local people to have the best primary care services - services that are safe, clinically effective and offer a good patient experience.

In line with our Primary Care Strategy, over the next two years we will further develop general practice at the centre of integrated health and social care, with a greater focus on prevention, early intervention and increasingly care delivered locally. To succeed, we need to transform local services – redesigning the way in which care is delivered and developing the necessary workforce and infrastructure to ensure the sustainability of general practice now and in the future.

We will work across the STP footprint to deliver core elements, whilst ensuring local ownership through co-production and delivery at a local level. Central to this, is the further development and delivery of the Locality Plans developed with primary care and local stakeholders. The plans set out local priorities for action based on local demographic need for each of the six localities across West Hampshire, together with the future vision of care – with practices increasingly working together, with greater integration and a strong community focus. The plans are a single, joint plan with the local Vanguard - Better Local Care, with collaborative working to ensure delivery at pace.

Care Redesign

Our Primary Care Strategy sets out our four ambitions for the type of primary care that local people should receive:

1. Health promoting care
2. Fast, responsive access to care
3. Holistic, person centred, co-ordinated care
4. Consistently high quality care

These form our four key work streams, together with three key enablers – workforce, infrastructure and transformational support.

Health Promoting Care - Prevention, Health and Well-being

We want people to have the best possible start in life and to stay as active and independent as possible for as long as possible throughout their lives. People will be supported to take greater control of their health and well-being and to make healthy lifestyle choices. A holistic approach will be adopted, with equal focus on physical and mental health, as well as social and environmental factors; the wider determinants of health. People will be supported to make informed decisions about their care and to access the right care, in the right place and at the right time.

Our CCG is committed to the STP aims of:

- Supporting more people to be in good health for longer (improving healthy life expectancy) and reducing variations in outcomes (improving equality)
- Targeting interventions to improve self-management for people with key long term conditions (diabetes, respiratory, cancer, mental health) to improve outcomes and reduce variation
- Developing our infrastructure, using technological (including digital) solutions to reduce demand for and dependency on health and care services
- Developing our workforce to be health champions; having 'healthy conversations' at every contact
- Improving the health of local people and our workforce

We are committed to working in collaboration with public health to improve health and wellbeing and reduce health inequalities. We are actively working with practices to increase the annual uptake of immunisations and vaccinations, particularly in relation to influenza and the ongoing PPV (pneumonia) vaccination schemes.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Prevention		
• Roll-out and promote the use of **on-line consultation systems** providing access to self-help information (see Access to Care)		
• Support **'Stop before the Op'** and '**Quit4life**' initiatives (particularly in areas of deprivation)	Apr 2017	Patients supported to give up smoking with resulting in improved

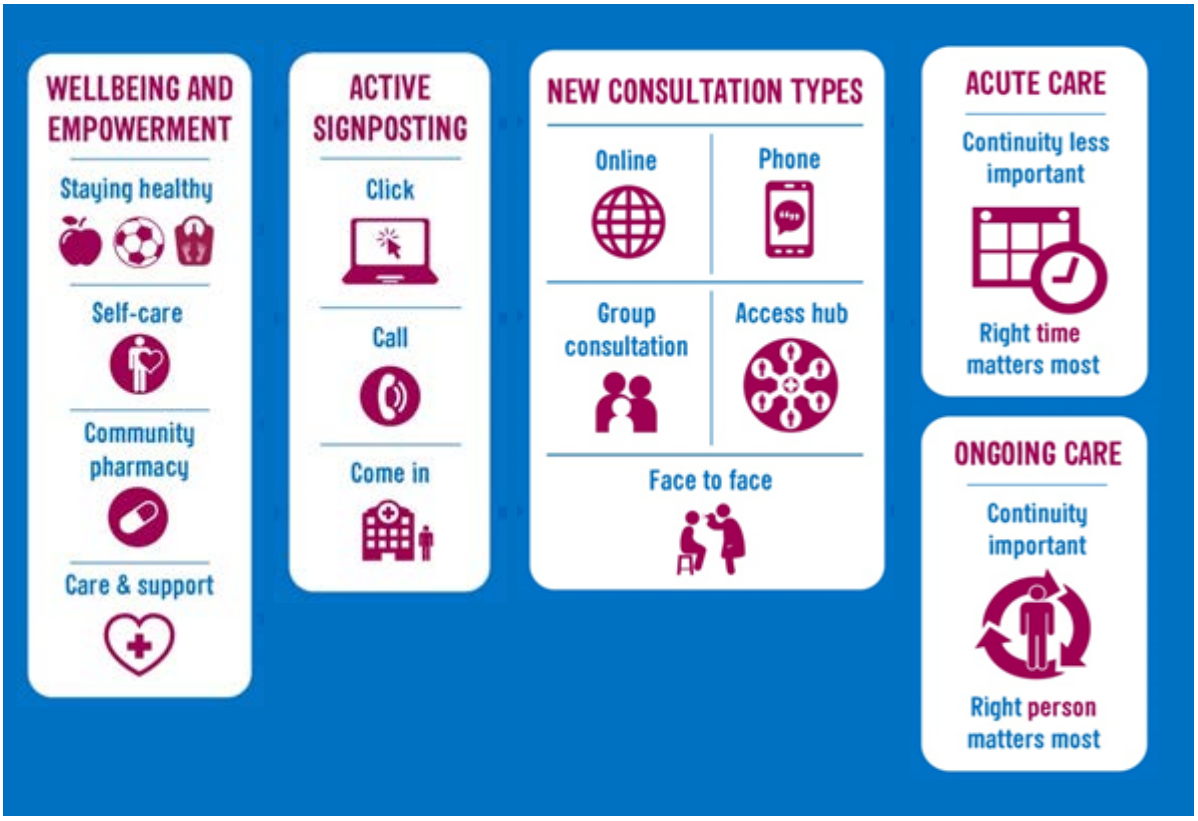
		health benefits
• Hold a workshop in April 2017 for practice nurses who run the LTC clinics, primary care health care assistants, community specialist nurses, allied health professionals and community mental health nurses on 'behaviour change' covering smoking cessation, alcohol brief advice, psychological therapies and weight management	Apr 2017	Staff trained in behaviour management skills
• Support GP Practices, through our quality Progression Scheme to implement a major campaign 'Get Hampshire Walking'	Jul 2017	Health benefits of walking are reflected in the wider health of the population
• Facilitate support through primary care for the new Tier 2 weight management service to target men and pregnant women	Sept 2017	Patients supported to manage their weight resulting in improved health benefits
• Facilitate a collaborative programme to follow up people that do not attend screening with a particular focus on people with mental illness and learning disability	Dec 2017	Increased number of people with mental illness and learning disabilities attend screening programmes
• Increase **social prescribing** in particular to combat social isolation and loneliness. Roll-out of Hampshire County Council 'Connect to Support' PC tablets within general practices giving touchscreen access to a range of voluntary services and community groups. Increased signposting by Receptionists and Care Navigators (see workforce section)	Mar 2018	Decreased social isolation; stronger community networks
• Support brief interventions training and the sustainability of **alcohol** care teams with public health partners	Mar 2018	People supported to manage their alcohol intake with resulting health benefits
• Implement new Tier 3 weight management specification with partners across wider Hampshire and take on delegated responsibility for Tier 4 **weight management** form specialised commissioning	Mar 2018	Patients supported to manage their weight resulting in improved health benefits
• Incorporate NHS Right Care falls prevention project on focussed on care homes into locality teams wider programmes on frailty with the aim of reducing falls in all people over the age of 75	Mar 2018	Less people in care homes have falls
• Encourage local people to live well through the continued implementation of a three year **'Get Hampshire Walking campaign'** launched in 2016. Work will focus on engaging specific target groups identified through 'market segmentation' of our population and what motivates them using a tool developed by Sport England. The campaign has the support and	Mar 2019	Health benefits of walking are reflected in the wider health of the population

sign-up of all West Hampshire GP Practices and is a key element of social prescribing. The campaign is being delivered with the District Councils and utilises existing resources within the community to encourage people to take regular exercise		
• Work with local partners to tackle **health inequalities** in areas of deprivation through the development of joint local action plans (as a key element of our Locality Plans). This will focus on lifestyle factors, as well as the wider determinants of health and will be informed by public health information. Patient Activation has been shown to be a powerful mechanism for tackling health inequalities and will be utilised to improve patient engagement and outcomes and to target interventions	Mar 2019	Reduction in health inequalities – targets to be agreed in each Locality
• Target people with long term conditions for **Tier 2 Weight management** by ensuring referral through LTC community specialist services	Mar 2019	Patients supported to manage their weight resulting in improved health benefits
• Address **smoking levels in people** with serious mental illness	Mar 2019	Patients supported to give up smoking with resulting in improved health benefits
Cancer		
• Reduce the rate of first detection of cancer through emergency presentations to 15%	Mar 2019	Fewer cases of cancer detected through emergency presentation
• Increase the cancers detected in stages one and two to 70%	Mar 2019	More cancers detected early in stages one and two, than in more serious stages
Diabetes		
• Implement plans to extract data from primary care systems to refer to the chosen provider from the framework and **identify referral routes from primary care** to support the programme	Apr 2017	People at risk of developing Type 2 diabetes are supported in managing behavioural change and lifestyles to minimise and/or delay risk
• Implementation of the STP wide programme of the **national diabetes prevention programme**	Apr 2017	People at risk of developing Type 2 diabetes are supported in managing behavioural change and lifestyles to minimise and/or delay risk
• Implementation of the H&IOW national d**iabetes prevention programme**	Apr 2017	People at risk of developing Type 2

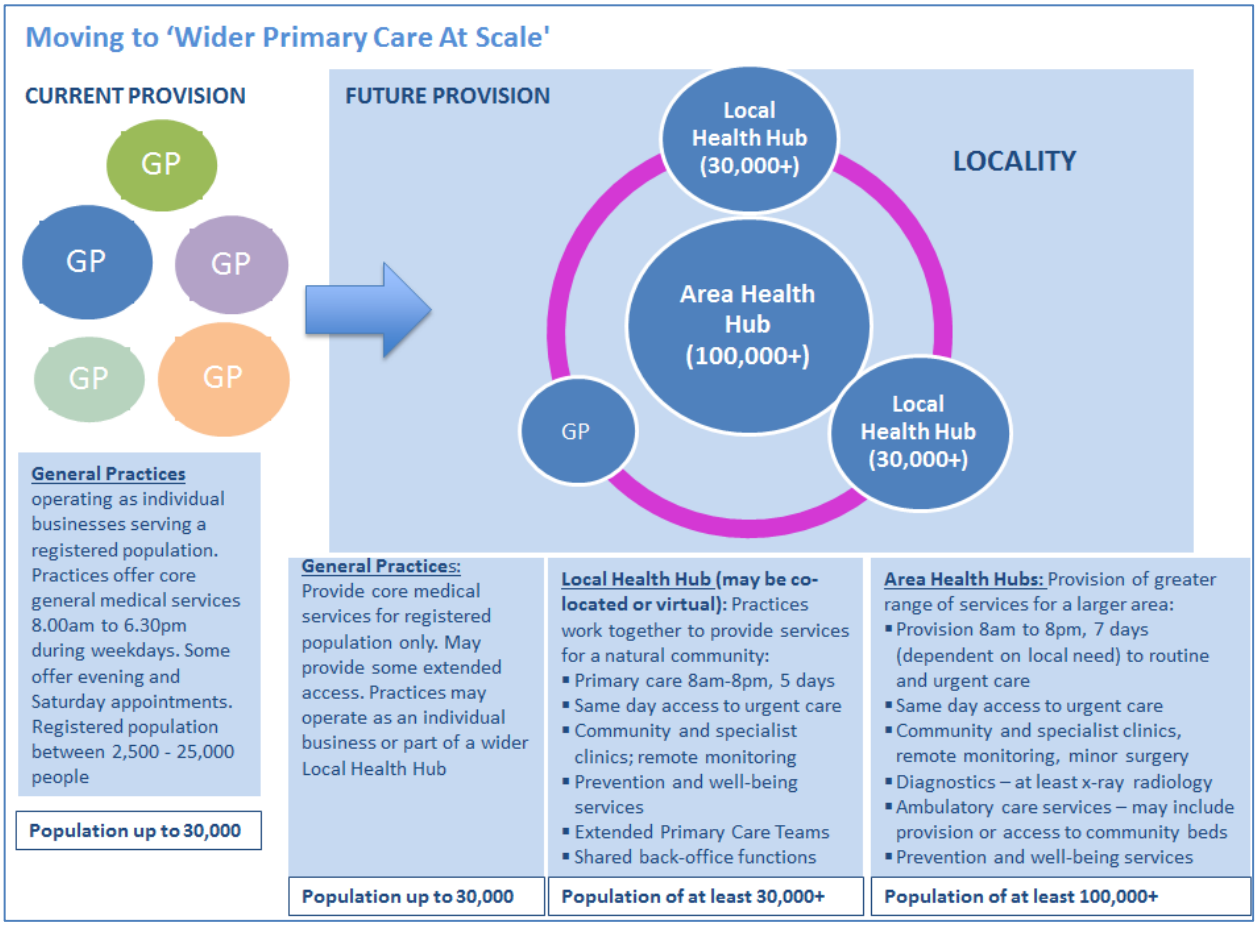
Communication & Engagement Plan (from April 2017)		diabetes are supported in managing behavioural change and lifestyles to minimise and/or delay risk

Fast, Responsive Access to Care

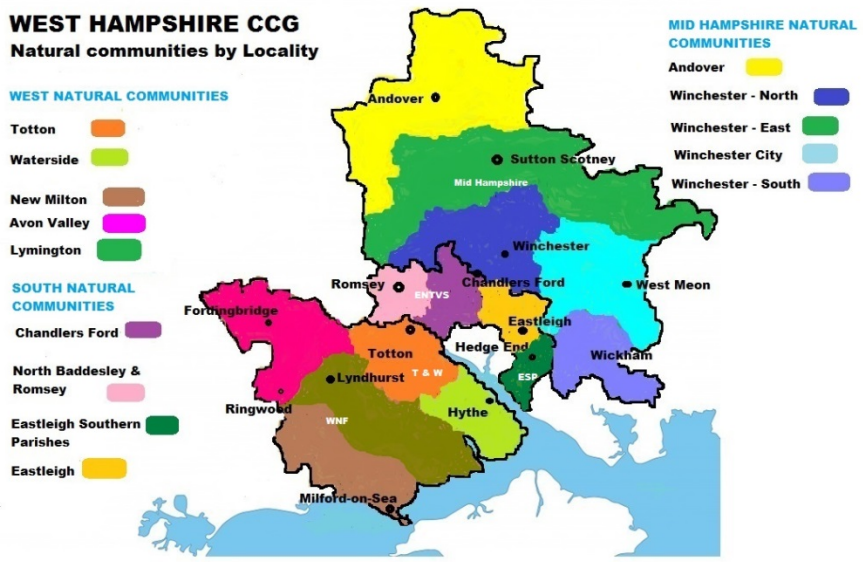
In response to growing demand and workforce challenges, the way in which general practice services are delivered will fundamentally change. Technology will increasingly be utilised enabling on-line access to self-help information, healthy living apps and decision support tools to help people proactively manage their own condition and rapidly access advice and support when needed. Information regarding local services and community groups will be readily accessible through the Hampshire County Council on-line tool 'Connect to Support' with tablets available in general practices and public places for people to use. Practice Receptionists trained in signposting will help people to access the right services at the right time, with Care Navigators providing additional support and co-ordination of care for vulnerable people and those with complex need.



General Practices will increasingly work together in collaboration with other providers to deliver services. This is known as 'primary care at scale.' The changing shape of care delivery is shown in the diagram below:



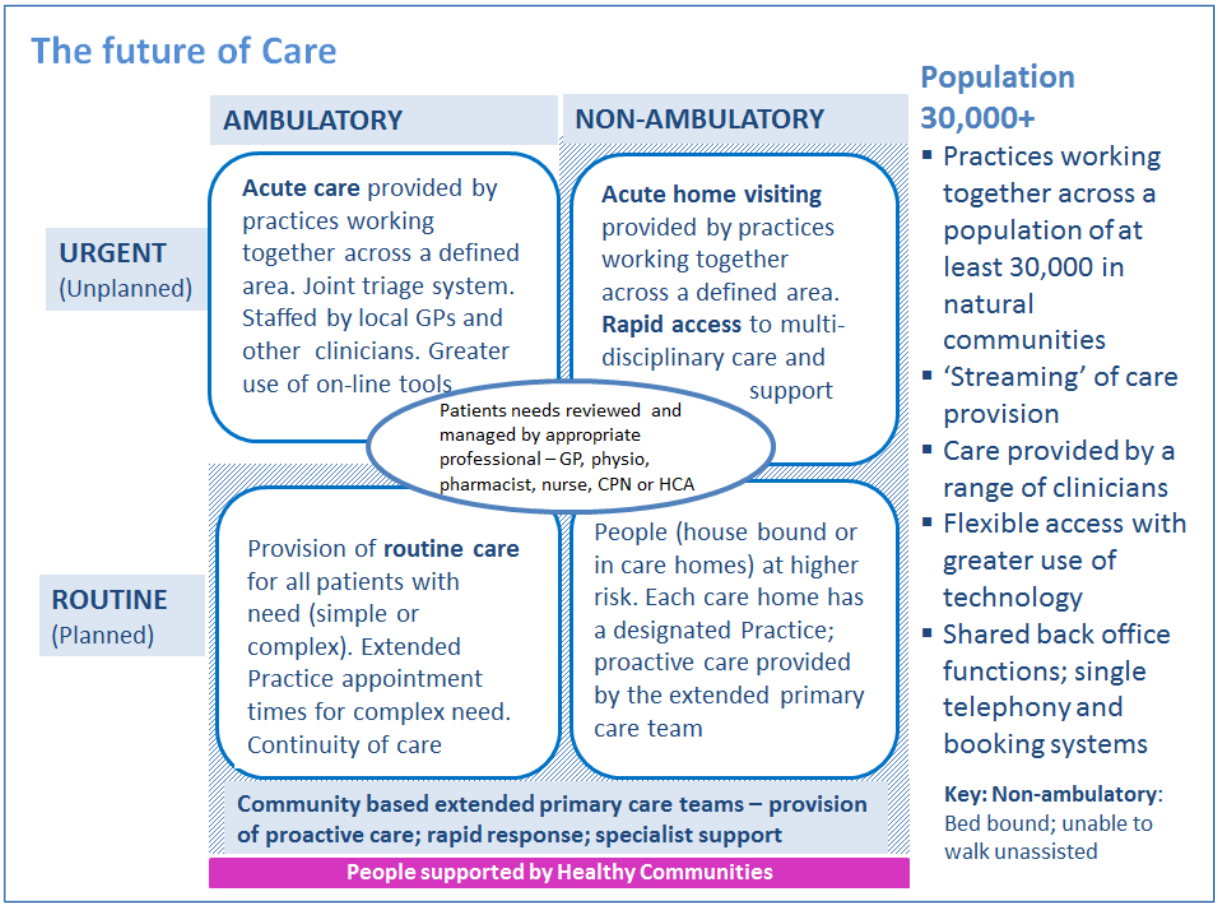
Practices will work together to provide back office functions and to 'stream' the provision of care to a population within a defined local geographic area covering a population of at least 30,000 within a natural community. This is known as a '**Local Health Hub'** which can be located on a single site or virtual. The map below shows the proposed distribution of Local Health Hubs across West Hampshire based on natural communities. These may be co-located or virtual.



Within natural communities, same day access to urgent care will be collectively provided, with a single triage and shared booking system. This may mean that (ambulatory) patients may need to attend the local health hub or another practice within the natural community to receive urgent care. Practices may also choose to work together to provide (not exhaustive) urgent home visiting, routine care such as long term conditions, minor surgery, screening and immunisation clinics, and to utilise available expertise within the community to give their patients' greater access to local specialist advice and support. Services will increasingly be co-located enabling 'one stop' visits and integrated (joined-up) care.

General Practice will continue to focus on the routine provision of care to vulnerable people and those with complex need, where continuity of care is particularly important. This will include people who are ambulatory and non-ambulatory (housebound), including those in care homes. Care will be proactive and take a person centred, care co-ordinated approach to address a person's holistic needs. Extended appointment times will be available.

The diagram below shows how care will be delivered



A greater range of community services serving a wider population of 100,000+ will be provided from our six **Area Health Hubs** across West Hampshire (see map below) to enable local people to get most of the care they need closer to where they live. This will include (not exhaustive):

- Extended primary care (urgent and routine) in the evenings and at weekends offering greater convenience and choice with directly bookable appointments by NHS 111

- Health and well-being services, together with voluntary services to provide advice and support

- Diagnostics enabling rapid assessment, diagnosis and treatment

- Ambulatory care services (which may include community hospital beds)

- Community and specialist clinics (traditionally accessed through attendance at a hospital)

- Training provision (including the development of Community Education Network Providers in collaboration with Health Education Wessex) to support the recruitment and retention of staff

The map below shows the location of the six ‘Area Health Hubs’ serving populations of 100,000+

Care will increasingly be provided by a range of professionals and people will be seen by the person most appropriate for their individual need. This will include the development of new roles and career portfolios to support the changing shape of care delivery and the recruitment and retention of staff.

The pace of change and model of care delivery may vary across geographic area depending on local demographic need and available supporting infrastructure. Any proposed changes to care delivery will be subject to public and stakeholder engagement and consultation.

We will:

- Work in collaboration with other CCGs in the STP footprint to test the market and procure an **on-line consultation system** in 2017. This will be informed by the eConsult pilot implemented through Better Local Care across West Hampshire in 2016-17. Implementation will be supported by a Practice training programme and public engagement and media campaign to raise awareness and promote usage. Through on-line consultation systems patients can use a symptom checker, self-manage, signpost to other services or complete an on-line consultation for one of 100 common General Practice conditions with a GP at a time convenient to them. Studies have shown a significant reduction in GP appointments, with 60% of patients using on-line consultation systems able to resolve their health concerns without visiting their practice. Phased investment will be £144k in 2017-18, increasing to £192k in 2918-19

- Commission and fund **additional capacity to improve access to GP services at evenings and weekends** to meet locally determined demand, alongside effective access to other primary care and general practice services (such as urgent care). Additional capacity will be procured across West Hampshire in line with national criteria for extended access. This will include weekday provision of access to pre-bookable and same day appointments to general practice services in the evenings 6.30-8.00pm and on Saturdays and Sundays to meet local population needs. This will support the development of primary care working at scale. West Hampshire will receive recurrent funding of £6 per head of weighted population in 2017-18 as one of a number of designated Transformation Areas identified nationally to accelerate delivery of improving GP access

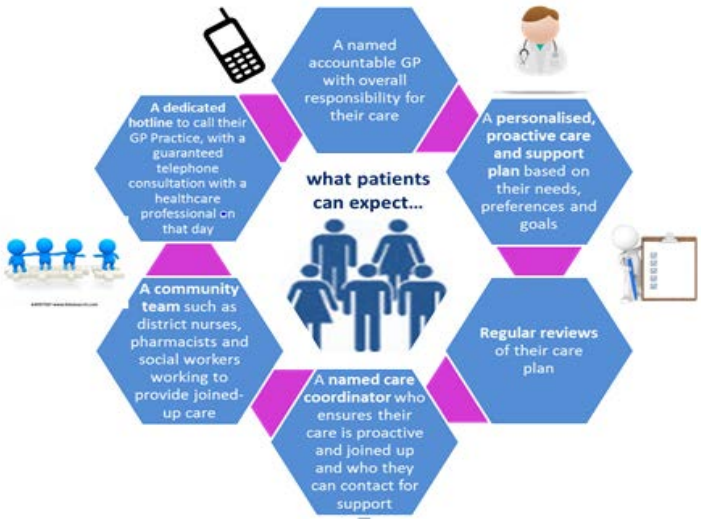
Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
• Develop and implement practice, public and **stakeholder engagement plans** to inform the development of a service specification for extended access in line with national criteria (ensuring alignment with plans for the re-procurement of NHS 111 and GP Out of Hours Service)	Apr 2017	April 2017: 12% population coverage
• Secure the continued provision of **the primary care access centre, The Practice**, located in the Area Health Hub at Lymington New Forest Hospital. The Practice covers a population of 68,000 across South West New Forest and was originally established through a successful national Prime Ministers Challenge Fund bid	Apr 2017	Improved access to care; improved patient experience (measured by GP national survey); sustainability of general practice
• **Procure extended access services** in the evenings and at weekends across West Hampshire CCG in line with an agreed service specification. This will include the phased integration of urgent care services	Sep 2017	Sept 2017: 100% population coverage

• Market test and procure an **on-line consultation system and roll-out across West Hampshire Practices.** Implementation of Practice training package and public media campaign. Evaluate impact. Planned population coverage: 2017-18: 50% 2018-19: 100%	Mar 2019	Improved access to care; improved patient experience (measured by GP national survey)
• **Support Practices to develop** and work together within Local Health Hubs to provide care across a natural community. Ensure shared learning across West Hampshire and the wider STP footprint	Mar 2019	

Vulnerable people and those with complex need

We will continue to take a proactive, person centred and co-ordinated approach to the provision of care for vulnerable people and those with complex need. Care will be delivered through extended primary care teams covering populations of around 30,000. Extended primary care teams will consist of health and social care professionals, with access to specialist support and advice.

The diagram below describes personalised, proactive care.



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

Care Navigators will be an integral part of the extended primary care teams and will actively support older people and those with complex needs to deliver the following outcomes:

- Improved person centred care planning and care co-ordination with patients and carers as active participants
- Increased self-care and supported self-management, including utilisation of community support and the voluntary sector; (social prescribing)
- Assisting patients to navigate their way through the health and care systems so that they access the right services at the right time
- Reduction in emergency department attendances and acute hospital admissions

A key focus in 2017-18 will be the development of comprehensive frailty services across West Hampshire. This will support the proactive management of people to improve outcomes and reduce acute hospital admissions, with a particular focus on ambulatory care sensitive conditions. These conditions, such as pneumonia and cellulitis, can be managed in the community with the right support.

Key Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
• Fully evaluate pilot schemes and invest in proactive care and **Care Navigator** roles across WHCCG	Mar 2019	Patient Reported Outcome Measures: Improved health related quality of life, health confidence, personal wellbeing and patient experience. Reduction in ED attendances and NEL admissions

Consistently high quality care

See Quality Section

Workload

General Practice is experiencing a significant increase in demand and resulting pressure as a result of an ageing population, increase in long term conditions, and rising costs and public expectations.

We are committed to supporting our Practices to manage their workload differently, reducing pressure and freeing up time to see patients. This will help our Practices to be sustainable now and provide the foundations for the development of new models of integrated care in line with our STP.

We will:

- Continue to proactively identify vulnerable Practices who could benefit from the **national GP Resilience Programme** which offers an individual programme of tailored support. West Hampshire CCG currently has a number of Practices receiving support from the programme

- Continue to support our **Primary Care Federations** to facilitate practices working at scale and the development of **super-partnerships** with practices working collaboratively to provide care and back office functions across a natural community (see Care Redesign)

- Ensure the capture of real time general practice **demand and capacity information** to inform system planning

- Continue to ensure providers implement the new legal requirements in the NHS standard contract for hospitals in relation to hospital / general practice interface

- Implement the 5 core elements (based on proven innovations) of the national **General Practice Development Programme** across West Hampshire. West Hampshire CCG signed up to be a 'fast implementer' in 2016 and has offered all Practices the opportunity to take part in the core elements of the programme which will be delivered over the next 12 months. Non-recurrent funding has been made available to support GP backfill costs to take part in Actionable Learning and to train as Improvement Leaders. Where there is sufficient interest, programmes will be delivered locally by the national team. Further details are provided below

No	General Practice Development Programme: Description
1.	**General Practice Improvement Leaders – building capability for improvement**
	Skills development training for individuals in leading and facilitating change projects locally. The programme is open to any member of the Practice team. Time commitment: 6 days over 3 – 6 months
2.	**Releasing Time for Care - Actionable Learning**
	Group learning activities bringing together enthusiasts from General Practices to implement the **10 High Impact Actions (see below)**. Individuals will be supported to learn new skills, test them out and share their experiences. Time commitment: 9 learning events and time in practice over 6 – 9 months. Each Locality will initially focus on 2 High Impact Actions in 2017-18 aligned with identified priorities within Locality Plans. Practice focused actions to release time based on key daily practice activities from the original **Productive General Practice programme**. The programme is led by trained facilitators who provide hands-on support within Practices, together with group learning sessions. Time commitment: 4 group learning sessions and time in practice.

	
3.	**Training for Reception and Clerical Staff**
	Training for receptionists to play a greater role in active signposting and for clerical staff to manage more incoming correspondence: **Active signposting:** Reception staff will receive training and access to a directory of information about services to help direct patients to the most appropriate source of help or advice. This may include services in the community as well as within the practice. Benefit: Releases about 5% of demand for GP consultations in most Practices **Correspondence management:** Clerical staff will receive additional training and relevant protocols to support the GP in clinical administration tasks. All incoming correspondence about patients from hospitals is processed by a member of the clerical team. Benefit: 80-90% of letters can be processed without the involvement of a GP, freeing up approximately 40 minutes per day per GP. West Hampshire CCG in consultation with Practices (and in collaboration with local CCGs) will procure training from the NHSE directory of services commencing in early 2017.
4.	**Practice Manager Training**
	We will continue to support the sharing of good ideas, action learning and peer support through our local Practice Manager Forums. Where additional mentoring or support is required, we will work with the Wessex LMC to support this. We will actively encourage Practice Managers to attend the free regional workshops commencing in Dec-16.
5.	**On-line consultation systems**
	Designed to free up GP time to focus on only what they can do. See Care Redesign Section

Key Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
• Secure the capture of '**real-time' general practice demand and capacity information**	Sept 2017	Improved system resilience planning
• Development of a **super-partnership toolkit** encapsulating a step-by-step guide to the creation of a super-partnership to facilitate collaborative working between practices within natural communities. Ensure shared learning and expertise across WHCCG	Mar 2018	Greater collaborative working at scale to provide new models; increased sustainability
• Implement the five core elements of the **national GP Development Programme** across West Hampshire	Mar 2019	Release of approximately 10% of time to care
• Continue to identify Practices who could benefit from the national **GP Resilience Programme**	Mar 2019	Reduced number of 'vulnerable' Practices

Workforce

There has been national recognition of the workforce issues that we face and the need to look at innovative solutions to recruit and retain staff.

We have 426 General Practitioners (365 whole time equivalents), 223 Practice Nurses (138 whole time equivalents) and 93 other healthcare professionals; (National General Practice Workforce return Mar-16). 22% of our GP's and 37.5% of our practice nurses are over the age of 55 years, with small numbers entering these professions.

We need to encourage those within the professions to remain or to return to work by offering flexible working and new opportunities for different areas of work within portfolio careers.

We have educational opportunities within West Hampshire and the wider STP to create innovative training opportunities. Working with HEE Wessex, we plan to develop our main Area Health Hubs into Community Education Providers Network (CEPN), offering new training opportunities in primary and ambulatory care within a community setting to enhance recruitment into new roles. Joint working has already commenced with HEE to develop Lymington New Forest Hospital as a CEPN.

We will undertake a Primary Care Clinical Skills Assessment of our primary care workforce, allowing us to develop a local training plan to support our current workforce and to develop new roles and ways of working to deliver new models of care. This will include (not exhaustive):

- **Care Navigators**: Care navigators delivering direct signposting and support to help vulnerable people and those with complex need access the right services, at the right time, in collaboration with the voluntary sector. We will commission Care Navigators across West Hampshire following the successful evaluation of the Primary Care Transformation Fund pilots, ensuring expansion to seven day provision

- **Clinical Pharmacists**: Expansion of our current pilot for the Integration of Clinical Pharmacists into general practice to provide direct support for medication reviews (of people using multiple medications) and those in residential settings. Optimisation of clinical prescribing will improve quality, allow cascade learning of best practice and address prescribing inequalities more consistently

- **Associate Mental Health Practitioners**: Development of Associate Mental Health Practitioners within primary care to provide proactive support.

- **Frailty Practitioners**: The development of Frailty Practitioners with expert knowledge in the diagnosis and management of the condition of frailty to improve the provision of both routine and urgent care, enabling more people to receive support either within their own home or as close to home as possible

- **Reception/clerical staff**: Receptionists will be trained to support signposting to ensure people access the right services at the right time; clerical staff will be supported and trained in work flow optimisation, together with a potential to develop Medical Assistants who directly support GPs with all administrative tasks

In addition, we will also explore the opportunity with partner organisations to develop Physician Associates, Nurse Associates and Emergency Care Practitioners/ paramedic roles to support the sustainability of general practice and to transform care delivery.

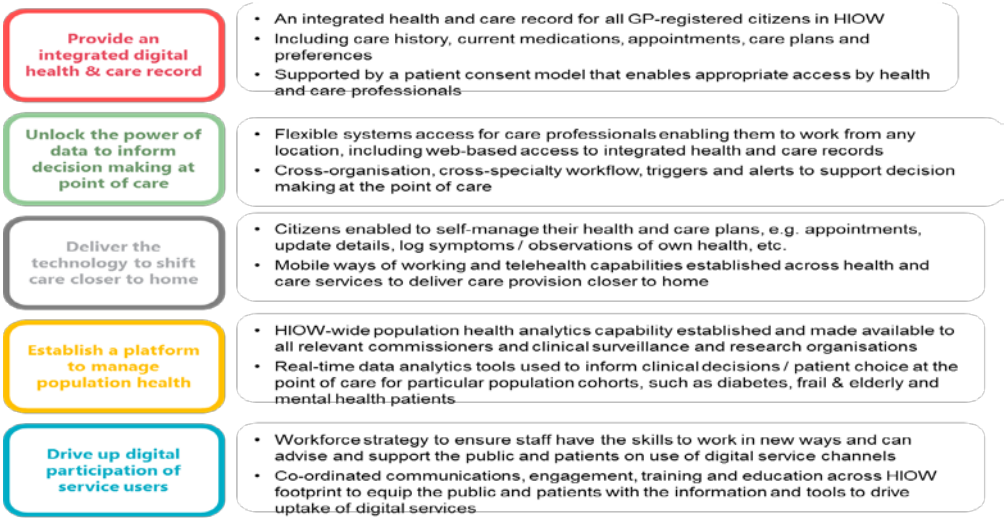
Key Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
• Evaluate the **integrated medicines optimisation** service to inform future commissioning	Dec 2017	De-prescribing of problematic polypharmacy using the STOPIT tool; reduced wastage
• Develop LNFH as a **Community Education Provider Network (CEPN)** in collaboration with Health Education (Wessex)	Mar 2018	Increased training posts; improved recruitment and retention
• **Commission training for receptionists and clerical staff** in signposting and work flow optimisation	Mar 2018	See Workload
• Commission **Care Navigator service** across West Hampshire CCG	Mar 2019	See Care Redesign
• Explore the **further development of CEPN** within the remaining five Area Health Hubs across West Hampshire	Mar 2019	Increased training posts; improved recruitment and retention

Primary Care Infrastructure

Information Management and Technology

We are working as a key partner within the STP digital work stream which has developed the Local Digital Roadmap. Our aim is to give people control of their information and how it is used, enabling them to proactively manage their condition and to have more flexible access to information and advice at a time and in a way that suits them.

The five digital transformation priorities over the next five years are shown below:



The five digital priorities will be delivered through 8 core critical projects:

- **Patient Data Sharing Initiative**

  - A shared record would enable all health and social providers to access a single source of patient information which would reduce the need for patients to repeat information, save professionals time and reduce duplication of diagnostics

  - Integrated complex care plans allow multi-disciplinary teams to develop and deliver plans for identified groups of patients, by providing a single up-to-date record which can be shared and updated across a whole health community

  - Digital care plans that includes social care information and patients' personal circumstances provide the admitting hospital with the information they need to assess. As a result preparations for complex discharges can begin much earlier in the process

  - Help clinicians to identify those at risk using intelligent analytics to target brief intervention

  - Link patients directly to their results and advice on treatment, if needed

- **Patient Portal**

  - A patient portal will allow patients to co-manage their healthcare online reducing the need for hospital visits. It will offer 24/7 support and information, allow patients to cancel and re-book appointments online, view their record and facilitate online consultations

  - Helping to keep relatives/carers informed and engaged

  - Provide patient access to self-help interventions for smoking, alcohol interventions, weight self-management and increasing activity levels. Linking to health portal can help personalise information

- **E-Prescribing and Medicine Reconciliation**

  - Safer and more effective prescribing through a fully integrated, end to end medicines management which allows automated supply, decision support and real time monitoring. This will comprise e-prescribing and medicine reconciliation in hospitals including closed loop prescribing for safety, medicines reconciliation and standards for coding

  - Ensuring that ‘to take out’ (medicines given to patient on discharge from hospital stay) are ready and available immediately the patient is discharged from Hospital

- **Digital Communications**

  - Instant messaging and telepresence enables professionals in different care settings to interact easily with group video calls enabling multi-disciplinary teams to meet online

- **Wi-Fi for H&IOW and Cyber Security**

  - Ability for staff to access and update patient records, and for patients to access online resources at all health and social care sites

  - Broadly available Wi-Fi will allow community teams that are either co-located or working in the community to get access to their line of business of systems and the HHR

- **Channel Shift (phase 1-e-consultations)**

  - Provides access online resources 24/7. Reduces need for face-to-face consultations, leading to practice efficiency savings. Provides opportunity to collect comprehensive history and early identification of symptoms leading to more productive consultations

- **Care co-ordination centre Infrastructure**

- A H&IOW level ‘flight deck’ for co-ordinating health and care service delivery, building upon the infrastructure for 999 and 111 calls, providing routing for primary care appointments, referring to clinical hubs, and improving maintaining a live directory of services

- Improved decision support directly influencing the effectiveness and efficiency of resource deployment

- **Optimising intelligence capability**

  - Unlocking the power of information we have is central to our digital roadmap. The analytics capability will drive improvements in service outcomes at a population health commissioning level as well as at a clinical decision making level

The Digital work stream will deliver the following outcomes and benefits:

- By 2016/17 we will have developed a robust technical strategy, commenced a major upgrade to the integrated care record and rolled out e-consultations

- By 2017/18 made Wi-Fi available across all care settings, rolled out e-consultations, deployed the infrastructure to support the care coordination centre and completed the SCAS live link pilot

- Enabled an integrated care record for all GP registered patients

- Created flexible IT systems enabling care professionals to work from any location, with access to patients health and care records

- Supported people to self-manage their health and care plans – e.g. managing appointments, updating details, logging symptoms

- Facilitated real time information to support clinical decision making

Delivery will be supported through funding allocated through the Estates and Technology Transformation Fund (subject to due diligence) across the STP footprint for:

- Wi-Fi access across primary care, for patients and staff (approximately £750,000 over 3 years)

- Digital health and care record upgrade, included upgrade to version 3 and automated care plans (approximately £750,000 over 3 years)

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Clinical information		
• Phase 2 of the improving the transmission of electronic discharge summaries complete	Mar 2018	Patient treatment safer and more accurate
• Hampshire Health Record programme complete	Mar 2019	Integrated care
General Practice		
• Clinical system migrations completed at Hedge End Medical Centre and Brownhill Surgery	Apr 2017	Improved functionality for GP Practices
• GP IT equipment, including PCs/monitors upgraded	Apr 2017	Improved functionality for GP Practices
• HEADMAT™ tool introduced and operational	Apr 2017	Better patient experience
• Comprehensive utilisation of DXS complete	Apr 2017	Better patient experience
• Patient online services programme complete	Mar 2019	Better patient experience
• Improve e-Referral utilisation programme complete	Mar 2019	Better patient experience

Estates

We will invest in modern, fit for purpose estate in line with our Strategic Estates Plan and the STP to support the delivery of new models of care. This will enable the provision of primary care at scale and the integration of services through colocation (see Care Redesign).

Capital funding has been secured (subject to due diligence) through the Estates and Technology Transformation Fund (ETTF) to support the development of Local Health Hub's in Andover and Eastleigh, together with the extension of Shepherd's Spring Practice in Andover to meet population growth due to planned housing developments.

Revenue consequences have been planned and are affordable. Where developments have not been supported through the ETTF, advice has been sought from NHS Property Services regarding potential alternative solutions. These will be explored with Localities.

Priorities 2017/18 - 2018/19	Delivery Date	Outcomes
West New Forest, Totton and Waterside		
• Redevelopment of Hythe and Dibden War Memorial Hospital (**Area Health Hub**)	Dec 2018	Extended access; Care closer to home
• Increased utilisation of Lymington New Forest Hospital (**Area Health Hub**)	Mar 2019	Improved access; Care closer to home
• Explore the redevelopment of Ashurst Hospital as a **Children's Centre**	Mar 2019	Care closer to home
• Explore the redevelopment of Milford-on-Sea War Memorial Hospital	Mar 2019	Care closer to home
• Explore potential opportunities to support the provision of modern, **fit for purpose premises** in New Milton and Totton	Mar 2019	Care closer to home
Eastleigh Southern Parishes and Eastleigh North and Test Valley South		
• ETTF Bid: **Development of Local Health Hub** within Eastleigh (subject to due diligence and public consultation)	Mar 2019	Extended access Care closer to home
• Explore the development of Moorgreen and **Romsey Hospitals** as Area Health Hubs	Mar 2019	Extended access Care closer to home
Winchester and Andover		
• ETTF Bid: **Extension of Shepherd's Spring Medical Practice**, Andover to provide an additional four consultation rooms	Apr 2017	Sufficient capacity to meet population growth
• ETTF Bid: **Development of Local Health Hub within Andover** (subject to due diligence and public consultation)	Mar 2019	Extended access Care closer to home
• Explore the **development of Andover War Memorial Hospital and Royal Hampshire County Hospital** as Area Health Hubs	Mar 2019	Extended access Care closer to home
• **Re-provision of the St Clement Practice** within Winchester City Centre	Apr 2019	Sufficient capacity to meet population need
West Hampshire wide		
• Continue to apply for improvement grants	Ongoing	

Transformational Support

We are committed to the development of primary care. Non-recurrent funding (equating to at least £3 per head of population) will be invested annually in the West Hampshire Quality Progression and Medicines Management Optimisation Schemes. The aims of the schemes are to:

- Support General Practices to be active participants in their Locality to improve the quality of care and health of a local population, with a particular focus on the reduction in health inequalities
- Support locality practices to implement new ways of working, including the proactive use of on-line consultation systems
- Deliver bespoke education which improves quality of care
- Provide the opportunity to improve the health of a local population by involvement in initiatives to support patients to take greater responsibility for their own lifestyles
- Improve the safe, high quality and cost effective use of medicines
- Support the development of shared learning and collaborative working between practices

The investment facilitates the implementation of the ten high impact actions, the implementation of new ways of working and care delivery models and helps secure the sustainability of general practice.

Planned phasing of spend equating to at least £1,673k will be over two years:

2017-18: £834k
2018-19: £839k

Key Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
• Development of the **2017-18 Quality Progression and Medicine Management Optimisation Schemes**	Apr 2017	Quality improvement
• **Implementation, monitoring and evaluation**. Quarterly reports to Primary Care Committee	Mar 2018	Delivery of key priorities within Locality Plans; reduction in health inequalities
• **Implementation, monitoring and evaluation.** Quarterly reports to Primary Care Committee	Mar 2019	Delivery of key priorities within Locality Plans; reduction in health inequalities

8. MENTAL HEALTH AND LEARNING DISABILITIES

Mental health

We are committed to valuing mental and physical health equally to ensure that support for mental health is embedded holistically across the system and not seen in isolation in order to achieve parity of esteem. We will ensure that people experience a seamless coherent pathway that incorporates the key principles of prevention, risk reduction, early intervention and treatment through to end of life care. The Five Year Forward View for Mental Health, Dementia Implementation Plan and the Wessex Clinical Network Strategic Vision provide us with a blueprint for realising improvements and investment by 2020 /21 and the mechanism for mobilising the system. We will achieve this by working at scale to review and transform:

- acute and community mental health care pathways
- rehabilitation and out of area placements
- mental health crisis care pathways

We recognise a growing need to support people with severe mental illness and to support people in a mental health crisis. Across adult and older people's mental health there has been a reported increase in the acuity of need that is further stretching resources in mental health services. We have been working with our provider of secondary care services to develop a pathway for people with psychosis and borderline personality disorder and are committed to build on previous CQUINs in joint working groups. These groups will aim to improve mental and physical health for people with lived experience.

For people experiencing a mental health crisis we have funded a psychiatric liaison service and we are working to improve the performance and delivery of this service jointly with acute care and mental health care. We are also seeking to help people avoid a crisis by placing further support earlier in the pathway in primary care. As an outcome from our working groups on psychosis we will be looking to remove the cut-off age of 65 for the service.

We are passionate about co-producing system reform and service redesign and see people with lived experience of mental illness and their family carers as key partners. We will continue to run co-production strategy groups for adult mental health and older people's mental health. These groups have helped us to increase access to psychological therapies by examining the needs of groups in details and developing a bespoke response.

We will use experience based co-design to help us develop our offering in primary care, working alongside and taking decisions with people with lived experience. We will support the Recovery College to grow, helping new staff to train alongside individuals on their recovery journey, sharing valuable insights that feed into service redesign. We will harness the experience of people with mental health illness, their families and staff across secondary care and in the third sector to help us deal with priorities in peri-natal mental health, suicide prevention and substance mis-use.

We will be looking to improve data quality and transparency to ensure the foundations of our plans are stable, ensuring our provider reports through Mental Health Services Data Set, improving access to psychological therapies minimum data set and UNIFY in line with national expectations. We will also continue to use incident reporting as learning for improvement through the well establish quality review process already in place. Transformation of mental health services for children and young people will be aligned to the Mental Health Alliance and the STP. This transformation programme will be underpinned by integrated approaches to commissioning mental health services on an alliance wide basis. We are committed to more being done to prevent the development of mental illness and promoting earlier intervention not only in primary care but by making every contact count. By 2020 the STP will achieve this by:

- Improving the response to mental illness in primary care
- Expanded access to evidence based psychological therapies to 25% of adults with anxiety and depression each year, including those with a long term conditions, veterans and a serious mental illness, using innovative technologies to improve access and recovery
- Increase the number of people with serious mental illness who have a health check and follow-up intervention
- Reduce suicide by 10% through co-ordinated efforts and delivery of the suicide prevention plans
- Increase access to Recovery Colleges
- Perinatal Mental Health Services - improving identification of those at risk
- Dual diagnosis - joint project between the prevention and mental health work stream

We will develop the workforce to deliver holistic and integrated services for people.

We are working with the Sussex Partnership to introduce community eating disorder teams so that 95% of children and young people receive treatment within 4 weeks of referral for routine cases, and one week for urgent cases. The service specification for the teams has been written taking account of feedback from parents and carers.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Mental Health		
• Addressing mild illness with expanding **access to psychological therapie**s to limit the progression in some people, to the moderate or severe illness	Mar 2018	Limit progression to moderate or severe illness
• Offer more **psychological support** to people and their carers with long term conditions, which includes digital solutions where	Mar 2018	Better provision of psychological support

appropriate		to people and their carers
• **A single point of contact** for anyone seeking help with a mental health crisis is established, with access to a range of immediate support	Mar 2018	Patients know how to make contact when seeking help
• Commissioning of **early crisis support** to for West Hampshire residents to prevent deteriorating mental health leading inevitably to a full mental health crisis,	Mar 2018	Early crisis support service in place
• A local west Hampshire recovery based solution **replacing high cost out of area residential long term rehabilitation** will be in place as part of the review and redesign of the Mental Health Rehabilitation Pathway across the STP including a new out of area Placement Protocol	Mar 2018	Improved mental health services for patients
• **Acute and community mental health pathway review** and redesign, Including psychosis, borderline personality disorder, dementia and psychological therapies	Mar 2018	Patients experience a seamless service
• A sustainable solution for **in patient, PICU and community provision** will be agreed	Mar 2018	Patients have equity of service if they require mental health rehabilitation
• **Joint commissioning arrangements and pooled budgets** in place for H&IOW co-ordinated mental health rehab pathway and OAP protocol and process	Mar 2018	Patients know how to make contact when seeking help
• We will be expanding the capacity of **early invention psychosis** support pathways – with 40% growth applied between 2016/17 Q1 and 2017/18 and a further growth of 7.1% between 2017/18 and 2018/19	Mar 2019	Early crisis support service in place
• **Mental health support** available in primary care settings, as part of the extended primary care team, so that an integrated service is provided for patients	Mar 2019	More long term residential rehabilitation beds available

Links to strategic outcomes

- High quality, safe services delivered consistently
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs
- National access targets will be delivered

- Consistently good, co-ordinated, timely response experienced by people in a mental health crisis, and consistently high quality mental health services

- Earlier diagnosis of physical and mental health conditions leading to improved outcomes and survival rates and more healthy years of life

Learning disabilities

We are leading on delivery of the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Transforming Care Partnership (TCP). We have developed a system wide plan.

SHIP TCP wants to prevent the 'revolving door syndrome' trying to fit people into a traditional solution that does not meet the person's needs that results in regular placement breakdown and more restrictive regimes being put in place. This plan aims to build on the person's unique strengths and abilities, not seeing them as a problem and get it right for the person first time. Complex people and those in crisis are often managed through reactive strategies rather having proactive strategies agreed and in place in the event of requiring intensive support, avoiding a hospital admission.

This plan focuses on children, young people and adults with a learning disability and/or autism and includes:

- Young people in transition to adults
- Individuals at risk of admission to hospital
- Patients already in specialist learning disability hospitals
- People requiring adapted behaviour treatment programmes
- Those who are currently living in long 'unsettled' accommodation e.g. Residential Care, 38/52 week Education based placements
- People wanting to have a personal budget (blended from health, social care and education)

The SHIP TCP Plan identifies key areas of work required to meet the needs of Children, Young People and Adults with a learning disability and/or autism, the future model will focus on;

Early Intervention and Prevention

- Developing an Early Intervention and Prevention Charter to avoid people being admitted to hospital, this includes supporting good physical health as well as mental health

- Having robust care planning with relapse prevention strategies agreed with pre-agreed funding in place either directly funded or via personal budgets to help keep people well

- Developing an 'at risk register' for those people who are at risk of admission, this will include:

    - Early intervention and prevention – knowing individuals and ensuring that a crisis plan is in place, that people are aware of this and ensuring planning of clinical work to support the person (this may include clinical work or issues such as accommodation/environmental factors, provider support etc.)

    - Reviewing/monitoring of support packages and the use of suitable standards to achieve this e.g. periodic service reviews, framework contracts etc.

    - Analysis – identifying service gaps

    - Planning and developing resources e.g. training for support staff

    - To develop the 'at risk' template three key criteria will be included; systems, individual and behaviour

Reducing the number of inpatients in specialist Learning Disability units

- The SHIP TCP will reduce the reliance on in-patient services between now and the end of 2019 from 68 beds to 58 beds:

    - 5 Less by end March 2017

    - 2 less by end March 2018

    - 3 less by end March 2019

- Reducing the length of stay for those individuals requiring assessment, diagnosis and treatment

Developing Community Services

- Developing a community forensic rehabilitation / relapse prevention service

- Existing Community Learning Disability Health and Social Care Teams to be reviewed and reconfigured to support early intervention and prevention of people with investment aligned to support the function

- Developing and implementing Learning Disability Friendly GP Practices across SHIP

- Increasing the number of Annual Health Checks to 75% in line with the national target and working with GP Practices who haven't signed up to delivering Annual

Health Checks. We are also exploring if the GP Federation can carry out the Annual Health Checks on behalf of those GP Practices who are not signed up.

- Reviewing the epilepsy pathway and identifying the gaps
- Developing our Learning Disabilities Liaison Services to enhance provision for people with learning disabilities and/or autism in acute hospitals
- Developing a community rehabilitation services for people with autism and provide intensive support at an earlier age (14+)
- Developing the pathway for those aged 65+ with a learning disability

Developing the Workforce

- Developing a training and development structure for support staff
- Increasing the number of Personal Assistants in Care available in the TCP region
- Working with providers in the use of positive behavioural support

Increasing the offer and uptake of Personal Budgets

- The number of people with a 'personal budget' with a health component will increase to 1,276 people
- Developing a SHIP wide personal budgets share and learn group to support each area with increasing the uptake of personal budgets
    - Sharing the learning and experiences from the two demonstrator Integrated Personal Commissioning (IPC) sites within SHIP (Hampshire and Portsmouth)

Hampshire's IPC Programme, 'My Life, My Way' will build upon the work undertaken to date, sharing of the lessons learnt across the Transforming Care Partnership and aims to:

- Remove the 'cliff edge' for young people and their families going through transition to adulthood
- Shift power to people with a learning disability and their families by offering personal budgets to more people with a learning disability
- Reduce the number of crises leading to placement breakdown and hospital admission
- Reduce length of stay in learning disability inpatient units
- Reduce the use of institutional care and increase the use of supported living through joint housing strategies across health and social care

The Hampshire IPC project focuses on people with a learning disability and or autism aged 14 years and older who are:

- In receipt of health and/or social care services
- Registered with a disability with a Hampshire GP
- People who are inpatients in either Assessment and Treatment Units or Forensic Rehabilitation Units

- Working with national leads to unblock barriers to the delivering personal budgets

Developing a regional approach to housing development

- Identifying the current housing options and through co-production collate information and map what type and where people want accommodation in the SHIP region
- Holding a housing workshop involving service users to understand the current situation and the need
- Developing a portfolio of sufficiently high quality housing options for individuals, working with local housing departments
- Establishing a programme of de-registration of residential care settings to supported living models of care and support

- Providing clear easy read guidance for individuals and their families/carers that outlines the local options available, how to access this accommodation and what ongoing support will be provided e.g. tenancy advice etc…

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Learning Disabilities		
• Development and deployment of an **'at risk of admission' register** across the SHIP area	Apr 2017	Register kept of people with learning disabilities at risk of admission to hospital to improve the treatment they receive
• Commission and mobilise a community **forensic rehabilitation service**	Jul 2017	Community Forensic Service in place to provide mental health assessment and advice to Police custody areas and magistrates courts
• Capital project funded by NHS England to provide **transitional and supported living accommodation**	Sept 2017	People with learning disabilities supported enabling them to live independently in their own homes or in supported living accommodation
• Commission Health Facilitators to work with GP Practices to deliver on the ambition that 75% of people on GP registers are receiving an **annual health check**	Mar 2019	Health Facilitators assisting people with learning disabilities to achieve and maintain good health
• Aim for the number of people in Hampshire with a **'personal budget'** with a Health component to increase to 1276 individuals	Mar 2019	Increased people accessing personal health budgets
• We will work to **reduce inpatient bed capacity** by March 2019 to 10-15 in CCG-commissioned beds per million of population and 20-25 in NHS England-commissioned beds per million of population	Mar 2019	More people receive treatment in the community rather than a hospital setting

Links to strategic outcomes

- High quality, safe services delivered consistently
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs
- National access targets will be delivered

- Earlier diagnosis of physical and mental health conditions leading to improved outcomes and survival rates and more healthy years of life

9. MATERNITY AND FAMILY HEALTH

The STP includes specific work relating to maternity and family health and we are working with partners to delivered shared objectives on the following areas:

- **Transformation of mental health services** for children and young people including access to tier four beds for young people will be aligned to the Mental Health Alliance and the STP delivery plan

- Young people will have improved access to emotional wellbeing services through the **Future in Mind** Transformation Plans

- Joint work stream with **children's commissioning** with the potential to reduce the current spend on infant formulae whilst improving patient outcomes

- The **Better Birth Maternity Pioneer** programme to be implemented

North East Hampshire and Farnham CCG is the host for the Children and Maternity collaborative for the Hampshire five CCGs including WHCCG. They have a strong partnership with evidence of gaining economies of scale and efficiencies through Hampshire wide commissioning activity. The vision for this service is that children, young people and families will be healthier, happier and reaching their full potential, through improved integrated service delivery models.

This work is broken down into 5 themes:

Avoidable Hospital Admissions and Attendances

We will implement the 'Facing the Future' recommendations to help avoid admissions and/or attendances at hospital. We will promote accident avoidance and support parents to manage illnesses at home through improved pathways of care in the community.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Avoidable Hospital Admissions and Attendances		
• Develop options for community children's nursing teams to **deliver acute and ambulatory care in the community**	Mar 2018	Reduction in acute admissions with more children treated in the community
• Agree **new specification for children accessing children's ED and Paediatric Assessment Unit** incorporating a new urgent care pathway agreed across our systems	Mar 2018	New urgent care pathway introduced to provide better quality assessments for children
• **Evaluate the patient flow improvement** measures introduced in 2016/17, measure performance and outcomes and revise the new service as appropriate according to need	Mar 2018	Better patient flow resulting in improved use of resources and patient outcomes
• Evaluate the benefits of improved pathways to **support babies under 12 months with complex feeding needs** and revise the new service as appropriate according to need	Mar 2019	Improved support for mothers and babies with complex feeding needs
• **Evaluate the Wessex Clinical Network acute clinical pathways** introduced in 2016/17, measure performance and outcomes and revise the new service as appropriate according to need	Mar 2019	Acute clinical pathway revised to ensure most appropriate service provision for patients
• Review any **Facing the Future recommendations implemented** and ensure any changes are having a positive impact on service user satisfaction rates	Mar 2019	User satisfaction rates increased

Links to strategic outcomes

- High quality, safe services delivered consistently
- People with long term conditions and multiple chronic physical and mental health issues experience better health outcomes

- People are better supported to stay well and independent, with greater confidence to manage their own health and wellbeing
- Everyone is able to access safe acute services offering the best possible outcomes, 7 days a week
- Bed capacity will be used more effectively to generate a reduction in the acute bed stock

Maternity

We will respond to the national maternity review recommendations and ensure all women have access to personalised health care, choice and good quality antenatal and postnatal support.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Maternity		
• A plan to respond to recommendations of **still birth bundles**, advice from managing diabetes in pregnancy guidance and results of the Perinatal Mental Health services review and will monitor the outcomes improvements in quality	Mar 2018	Quality of prenatal care increased
• Evaluate the **improved breastfeeding support services** in partnership with Public Health and the voluntary sector with the aim of increasing initiation and continuation of breastfeeding and revise the new services as appropriate according to need	Mar 2018	Mothers receive improved support with breastfeeding
• We will also develop and agree a **single maternity specification** across all acute providers, including agreed Public Health measures	Mar 2019	Equity of access for all women to maternity services
• Design and deliver at pace the recommendations of the **Better Births review**	Mar 2019	Better Births recommendations implemented

Links to strategic outcomes

- High quality, safe services delivered consistently
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs

- Everyone is able to access safe acute services offering the best possible outcomes, 7 days a week

Children and Young People with Additional Health Needs

We will improve access to services specifically supporting the roll out of Personal Health Budgets and integrated working models, ensuring services are co-produced with children and families at the heart of the design.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Children and Young People with Additional Health Needs		
• Learn from the **new models of integrated care for children with disabilities or complex health needs** pilot sites and identify methods of created the integrated model in other areas	Mar 2018	New models of integrated care piloted and plans in place to extend to other areas
• Commission and implement revised **continence services** and **special school nursing services** and review current integrated therapies services and re-procure	Aug 2018	Improved continence and special school nursing services introduced
• Roll out, at scale, **Integrated Personal Commissioning** and personal health budgets, to promote choice and flexibility in the way in which people access healthcare	Mar 2019	Increased uptake of personal health budgets

Links to strategic outcomes

- High quality, safe services delivered consistently
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs
- Consistently good, co-ordinated, timely response experienced by people in a mental health crisis, and consistently high quality mental health services
- Earlier diagnosis of physical and mental health conditions leading to improved outcomes and survival rates and more healthy years of life

Emotional Wellbeing and Mental Health

We will deliver the priorities of the ‘Make it Worthwhile’ emotional wellbeing and mental health strategy, improve timely access to services through earlier intervention and prevention and work in partnership with the third sector organisations.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Emotional Wellbeing and Mental Health		
• Evaluate the **provision of psychiatric liaison within hospital emergency departments** and the benefits of any new provision and make adjustments in the provision as necessary	Mar 2018	Improved psychiatric liaison services within hospital emergency departments
• Implement and evaluate the agreed priorities within the **Transforming Care Partnership Plan**	Mar 2018	Care transformed for children and young people with mental health illnesses
• Implement an action plan to improve access to services and redesign pathways to improve **access to timely intervention**	Mar 2018	More timely intervention for children and young people with mental health illnesses
• We will monitor and improve the **third sector** specifications and outcomes and seek feedback	Mar 2019	Increased quality of service provided by the third sector
• Evaluate the impact of the **Future in Mind Plan** and service specifications and continue to build upon our Transformation plans	Mar 2019	Children and young people are able to access emotional wellbeing services where they need them, at a time they need them

Links to strategic outcomes

- High quality, safe services delivered consistently
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs
- Consistently good, co-ordinated, timely response experienced by people in a mental health crisis, and consistently high quality mental health services
- Earlier diagnosis of physical and mental health conditions leading to improved outcomes and survival rates and more healthy years of life

Participation and Life Choices

We will develop and implement a youth engagement strategy including encouraging healthy life choices to reduce obesity and support the development of seamless services between childhood and adults or end of life care.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Participation and Life Choices		
• Contribute to the Hampshire childhood obesity strategy and evaluate the impact of the '**Better Me'** programme	Mar 2018	Reduced childhood obesity levels
• Begin to monitor trusts to ensure improvement of **transition services** against the service specification	Mar 2018	Better transition services to help young people move into the adult care system
• Improve the **youth engagement and participation strategy**, we will include various methodologies for engagement incorporating digital technology	Mar 2019	Young people have more input into services designed for them
• **Review End of Life and Palliative care for children** developing/amending contracts as necessary to ensure consideration of end of life and palliative care needs is embedded in everyday practice	Mar 2019	Improved end of life and palliative care for children and young people

Links to strategic outcomes

- High quality, safe services delivered consistently
- People are better supported to stay well and independent, with greater confidence to manage their own health and wellbeing
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs

10. LONG TERM CONDITIONS, FRAILTY AND END OF LIFE CARE

For the last two years we have been working through a strategy to improve the out of hospital offer to people with enduring conditions and frailty. This has centred on earlier intervention, self-management support and providing rapid coordinated care when needed. Integrated care teams have begun to deliver expanded out of hospital care.

For the next two years we will transform services to implement a new frailty model and provide joined up, enhanced, multi-professional, primary care teams and extended access care hubs in localities. Through Better Local Care, specialist community professionals in long term conditions and mental health will join these teams and upskill other team members, thereby delayering specialist support. The aim is to provide prompt access for all care, generic and specialist, seven days a week. Care navigators and social prescribing will enhance the offer building skills & capacity to support people with voluntary sector opportunities to reduce social isolation and improve wellbeing.

We will support the STP work stream in Diabetes and Respiratory care, rolling out existing projects with the local National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLARHC) into our localities. These projects focus on case finding and case management of complex cases. Psychological support is specified in our community respiratory service and we will aim to embed psychological support in all community integrated care services.

At end of life, we are working towards supporting people to be able to die in their place of choice with dignity and respect through taking a collaborative approach, involving generic, specialist and third sector organisations in delivering an integrated end of life care service.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Long term conditions		
• Expand **access to existing structured education** for chronic pain, diabetes, cardiac and respiratory conditions to include digital and psychological support	Mar 2018	Patients access better information on long term conditions in the format they wish
• Improve uptake of **e-consult and social prescribing**	Mar 2018	Better e-consult and social prescribing to provide an improved service to patients
• Expand current initiatives to **support people with multiple long term conditions**: more pharmacist support to GPs in localities, care home reviews, longer GP appointments structured education that is not disease specific	Mar 2018	Reduce polypharmacy and person centred coordinated care

• Introduce **health coaching training** for the health care workforce	Mar 2018	Patients supported to make behavioural change and improve their health
Frailty		
• Develop and implement a comprehensive **frailty model** focused on the reduction in ambulatory care sensitive conditions	Mar 2018	New pathway introduced to provide a seamless service to patients
• Conduct a publicity campaign to raise **frailty awareness and reduce social isolation**	Mar 2018	Public more aware of frailty and social isolation issues
Complex/End of life		
• Deliver quick **seven days a week** access for specialist services	Mar 2019	Patient access to specialist service improved
End of life		
• Negotiate into contracts and deliver a new **end of life care** specification	Mar 2018	Patients and family see an improvement in end of life care

Links to strategic outcomes

- High quality, safe services delivered consistently
- People with long term conditions and multiple chronic physical and mental health issues experience better health outcomes
- People are better supported to stay well and independent, with greater confidence to manage their own health and wellbeing
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs
- Everyone is able to access appropriate primary care in their locality out of hours and at weekends
- Patients receive more of their care at home and in their community, and following acute care in hospital are transferred home without delay

Diabetes, respiratory, cardiology and neurology

We will support the STP work stream in Diabetes, Respiratory and Cardiology, rolling out existing projects with the Academic Health Sciences Network and NIHR CLAHRC Wessex into our localities. These projects focus on case finding and case management of complex

cases. Psychological support is specified in our community respiratory service and we will aim to embed psychological support in all community integrated care services.

Diabetes

Tackling diabetes is a key programme of work, with our aging population being at significant risk. There are approximately 24,000 people with diabetes in west Hampshire.

We are committed to delivering the NHS England Diabetes Prevention Programme. As part of H&IOW CCGs' compact we have been successful in our submitted bid to NHS England to host the Diabetes Prevention Programme from April 2017 and are the lead organisation in the H&IOW National Diabetes Prevention Programme with Public Health England and Diabetes UK. The programme involves supporting pre-diabetic people with non-diabetic hyperglycaemia with behavioural and lifestyle initiatives and interventions to support weight loss and increased exercise.

The programme is supported by all of the diabetes clinical leads and commissioners in the STP area. It is envisaged that the partnership could generate a total of 5,700 referrals to the National Diabetes Prevention Programme the first year (3,900 from GP records and 1,800 from Health Checks). A programme board for the partnership has been established for joint oversight and monitoring of implementation of the initiative.

To increase the number of patients recorded on disease registers with diabetes we are encouraging GPs to participate in the National Diabetes Audit (NDA) 2016/17. The participation rate for the 2015/16 audit was 96% and we want to improve on this rate. We will undertake a review of 2016/17 NDA findings to determine variation between practices regarding the nine diabetes care processes and are seeking support from the New Improvement Fund for Diabetes in a joint bid with our providers.

We have recently received a 'first look' report from NHS Digital National Diabetes Audit for the 2016/17 year. This showed a relatively similar position compared with the 2015/16 year, but with a drop in achievement of all treatment targets from 39.6% to 36.8%. This is largely due to blood pressure achievement of ≤ 140/80, and the CCG are looking to utilise the national transformation funds for diabetes treatment and care to minimise variation in outcomes, particularly focusing on BP. This will entail a detailed action plan for focused improvement, particularly since the range of BP achievement is between 50% to 89% in GP practices, despite the BP care process being achieved at >90% in all practices.

We recognise the need to improve uptake rates for policy, systems, environment (PSE) education for newly diagnosed type 2 diabetes mellitus patients (T2DM). As such, the CCG are looking to recruit a Project Manager to support the practices and SHFT (who provide T2DM education) with a jointly developed action plan to improve uptake. Furthermore, the CCG are looking to implement the national guidance on recording of attendance and completion of T2DM patient structured education which will improve the rate.

To improve performance in primary care each practice will have a Diabetes Action Plan in 2017/18. The west Hampshire community diabetes service has been commissioned to develop these with practices and so far 60% have draft plans.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Diabetes		
• Increase **awareness of diabetes**, improve screening, care and quality of care for residents with or developing diabetes	Apr 2017	Slow the rate of increasing prevalence of diabetes. Earlier structured education to self-manage Diabetes. Better glycaemic control in primary care
• Develop a **diabetic foot care** multi-disciplinary team at UHSFT to provide equity across West Hampshire and actively manage foot ulcers.	Apr 2017	Reduction in major amputations and minor amputations
• Identify cohort of people with **comorbidities of diabetes and CVD**	Jul 2017	Reduction in angina, heart attack and stroke in people with Diabetes
• Establish **engagement with patient cohort** to inform views on a proposed pathway for people with comorbidities of diabetes and hypertension	Sept 2017	Reduction in angina, heart attack and stroke in people with Diabetes
• **Develop a renal pathway** to help to manage patients with renal complications as a result of diabetes	Mar 2018	Reduction in those going on to need dialysis
• **Review pre-conception care** (for people with diabetes) at HHFT	Mar 2018	Reduction in birth complications/still births associated with poor glycaemic control
• **Identify and implement pathway** for people with comorbidities of diabetes and hypertension	Mar 2019	Reduction in angina, heart attack and stroke in people with Diabetes

Links to strategic outcomes

- High quality, safe services delivered consistently
- People with long term conditions and multiple chronic physical and mental health issues experience better health outcomes

Respiratory

We have a programme of service and pathway improvements for patients with respiratory conditions (notably, COPD and asthma) that move away from largely reactive episodic care based in hospitals, to pro-active and patient centred services, delivered via multi-disciplinary teams and partnership working in the community.

Providers are held to account for delivery against the service outcomes for: proactively preventing hospital admission / attendance, rehabilitation (including withdrawal or reduction in prescribed oxygen and medications) and supporting people upon discharge from hospital.

Further opportunities we will exploit to improve outcomes include: joint work with ambulance service, technology to assist self-management and continued partnership working with NIHR CLAHRC Wessex.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Respiratory		
• Ensure provider compliance with **end of life service** specification	Ongoing	Improved quality of life for patients at end stage of disease
• Identify further pathway **improvements for people with comorbidities of COPD / asthma** to optimise care	Apr 2017	Increased capacity and avoidance delays minimised in providing care achieved through pathway efficiencies
• Agreement and implementation of **joint clinical protocols** between Community Integrated Respiratory Service, Primary care and Ambulance Service	Jun 2017	Reduction in conveyances
• Agreement and implementation of **joint clinical protocols** between Emergency Departments and Community Respiratory Services	Jun 2017	Reduced and prevented re-attendance
• Embed **smoking cessation** within service specifications	Mar 2018	Reduced incidence of respiratory non elective admissions

• Appraise technologies that support **self-management of long-term respiratory conditions**, taking forward proposal to Clinical Cabinet	Jun 2018	People supported to self-manage their disease

Links to strategic outcomes

- High quality, safe services delivered consistently
- People with long term conditions and multiple chronic physical and mental health issues experience better health outcomes

Neurology

Building on extensive stakeholder consultation we will progress the development for an optimum model for community neurological rehabilitation.

We will progress pathway improvements to create capacity that improves access to expert care for those who need it. This will ensure adequate expert community provision of rehabilitation and support, including psychological support, for people with a long term neurological condition and those who care for them.

Recent NHS Right Care benchmarked data (October 2016) suggest opportunities to improve the outcomes and value of money from neurological services commissioned.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Neurology		
• Support primary care to **improve the timeliness of diagnosing neurology pathology** and imaging	Apr 2017	Increased patient and GP satisfaction
• Progress commissioning of **new community neurological rehabilitation service** (subject to approval)	Mar 2018	Improved coordination of services and resources with reduced variation and increased equity of provision
• Review **comorbidities associated with neurological condition** and ensure pathways deliver best outcomes and value for money	Sept 2018	Efficient management and reduction in unplanned admissions / attendances in secondary care
• Ensure adequate **rehabilitation support services** are commissioned to support those with long term neurological condition	Mar 2019	Improved function and independence and the quality of life along with less non elective admissions

Links to strategic outcomes

- High quality, safe services delivered consistently
- People with long term conditions and multiple chronic physical and mental health issues experience better health outcomes

Cardiovascular Disease

We are addressing the core risk factors which put people at risk of developing cardiovascular disease(s), including stroke and transient ischaemic attack 'mini stroke'.

A new hypertension intervention strategy is being launched which focuses on identifying and optimising digital enablers such as Primis and Blood Pressure monitoring digital apps to measure a quantifiable reduction of people with blood pressure higher than 150/90.

We will continue with our broad stroke prevention strategy and work plan to deliver improvements in providers' stroke treatment targets.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Cardiology		
• Collaborating with providers to deliver stroke service improvements **- Review of Sentinel Stroke National Audit Programme** working alongside Wessex Cardio Vascular Network for good practice	Ongoing	Continued improvement in all-provider achievement of stroke targets
• Launch new **hypertension intervention strategy** focusing on identification/optimising management utilising enablers such as PRIMIS and Blood Pressure apps	Jun 2017	Reduced number of patients with blood pressure in excess of 150/90
• Twelve month evaluation of pilot for new Community Cardiology Service	Dec 2017	Reduced acute outpatient /diagnostic appointments with shorter waits times and improved patient GP experience
• Potential procurement for full rollout of T2 Community Cardiology Service	Mar 2018	Reduced acute outpatient /diagnostic appointments with shorter waits times and improved patient GP experience
• Collaborating with providers to deliver stroke service improvements - **implement intra-arterial therapy (IAT)** within acute trusts	Mar 2018	Continued improvement in all-provider achievement of stroke targets

• **Collaborating with providers to deliver stroke service improvements -** commission six month reviews across the breadth of the CCG	Mar 2018	Continued improvement in all-provider achievement of stroke targets

Links to strategic outcomes

- High quality, safe services delivered consistently
- People with long term conditions and multiple chronic physical and mental health issues experience better health outcomes

11. URGENT AND EMERGENCY CARE

For our patients we are committed to transforming urgent and emergency care services.

As part of the STP we will work in collaboration with UHS, Portsmouth Hospital NHS Trust, IoW NHS Trust and Lymington Hospital to improve outcomes, reduce clinical variation and lower cost, of acute services. To provide equity of access to the highest quality, safe services for the population. We will continue working with HHFT and SCAS to improve outcomes, reduce variation and lower the cost of acute services.

Across our acute providers we will work in partnership to adopt standard approaches, reduce variation and implement evidenced based best practice. Good examples include NHS England's 'Safer, Faster, Better' guidelines for delivering urgent and emergency care and ensuring patient can leave hospital early in the morning creating 'flow' for others awaiting admission in emergency departments or acute medical assessment units. We are committed to working with partners to implement five initiatives designed to improve urgent and emergency care performance:

- Introduce **primary and ambulatory care screening** in the emergency departments
- Increase the proportion of **NHS 111 calls handled by clinicians**
- Implement the **Ambulance Response Programme** - dispatch on disposition and improved clinical coding
- Implement SAFER and other measures to improve **in-hospital flow**
- Implement **discharge best practice** to reduce Delayed Transfers of Care (DToCs) - for example, discharge to assess, trusted assessor etc...

To assist with this, Local Accident and Emergency Delivery Boards have been established to manage this new workload and working with system partners to achieve their delivery. These boards are designed to evidence change, measure urgent and emergency care activity and performance and plan for periods of high demand including winter, bank holidays, Christmas and Easter.

The key challenge for our hospitals is to achieve the delivery of the four hour A&E standard. Likewise for our ambulance services, challenges remain the delivery of constitutional ambulance response times. We continue to work together with both sectors to improve and maintain performance.

All of our main acute hospital providers have Emergency Pathways Recovery Action Plans in place including a number of actions to assist in delivering these standards. Whilst the performance at all hospitals has been generally improving there is recognition that more can be done and plans are in place for achievement and maintenance of key standards.

We are committed to working with our providers to meet by November 2017 the four priority standards for seven-day hospital services for all urgent network specialist services. The five priority standards are incorporated, reviewed and monitored as part of the work programme of the A&E Delivery Board. One of our providers, UHS is an early implementer site for the seven-day hospital services.

Under the auspices of the Local A&E Delivery Board, we will be introducing a new integrated NHS 111 service in early 2018 ensuring a 24/7 integrated care service for physical and mental health is available, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.

Utilising the rapid implementation guidance for local systems milestones the progress toward full implementation of the Urgent and Emergency Care review by 2020 will be shared and overseen by the local A&E Delivery Board.

We are working with the SCAS to deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transformation to an emergency department. SCAS is actively involved in the National Ambulance Response Programme. Whilst not one of the three pilot trusts, they have moved to 240 seconds dispatch on disposition.

There is a clear focus on reducing conveyance to hospital and SCAS have worked to increase Hear and Treat along with See and Treat levels as a result. Local opportunities to increase See and Treat rates by making use of suitably trained ambulance clinicians responding to 999 calls to assess patients, complete management at scene, discharge and/or refer into alternative care pathways are underway with a pilot - specialist paramedic hubs (based outside the control rooms) to offer extended clinical telephone advice / support to 999 operational staff whilst on scene with patients, to enable further discharges at scene and/or refer into alternative care pathways. Increasing Hear and Treat and See and Treat is also being monitored and reviewed as part of the A&E Delivery Board work programme.

Mental health crisis care remains a key issue for us and we are working across Southampton and west Hampshire to put in place an updated Crisis Care Concordat Plan. An options paper around models for crisis care/crisis avoidance for west Hampshire has been presented to the CCG executive. They will consider and agree which option they wish the CCG to progress.

Working with our partners at HHFT and North Hampshire CCG, we will be taking forward the STP core work programme to provide a sustainable, quality configuration of acute services for the population of North and Mid Hampshire.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Urgent and Emergency Care		
• Work with partners to adopt the **Safer, Faster, Better** good practice detailed in the A&E Improvement in 2016/17 Rapid Implementation Guidance for local systems	Apr 2017	*Safer, Faster, Better* key principles and safer care bundles adopted by appropriate providers as standard practice
• To monitor and have oversight of **seven-day hospital services** for all urgent network specialist services through contract Service Development and Improvement Plans which are agreed with each provider and will include mandated references to seven-day service implementation	Nov 2017	Seven day hospital serviced delivered
• Initiate a cross-system approach to prepare for the forthcoming **waiting time standard for urgent care for those in a mental health crisis** by agreeing workforce development plans along with developing joint performance reporting between SHFT and HHFT/UHS and escalation procedures	Mar 2018	Access to mental health services at time of crisis sustained across all providers
• Support delivery of the **constitutional standards** for four hour A&E and for ambulance response times, through continued monitoring of remedial action plans	Mar 2018	Consistent achievement of constitutional standards
• Implement local plans to reflect the STP work stream - **Effective Flow and Complex Discharge** – and achieve reduced delayed discharges from the acute sector to other care settings	Mar 2018	Achieve system target reduction of DTOC rate to 6.5% by March 2017 and 3.5% by March 2018
• With partners hold public consultation on and agree the preferred option for **configuration of acute services in North and Mid Hants**	Mar 2018	Sustainable access to 24/7 consultant delivered acute care for the North and Mid Hampshire population and improved outcomes through care closer to home
• Introduction of a **new integrated NHS 111 service** ensuring a 24/7 integrated care service for physical and mental health is available, including a clinical hub that supports NHS 111, 999 and out-of-hours calls	Jun 2018	Consistent and sustained integrated 111 service providing access to appropriate support
• Work with partners to adopt all of the NHS	Mar 2019	*Safer, Faster, Better*

England **Safer, Faster, Better** good practice in delivering urgent and emergency care		key principles and safer care bundles adopted by appropriate providers as standard practice

Links to strategic outcomes

- High quality, safe services delivered consistently
- Everyone is able to access safe acute services offering the best possible outcomes, 7 days a week
- Bed capacity will be used more effectively to generate a reduction in the acute bed stock
- A&E attendances and emergency admissions will not increase and ideally be reduced
- Create a sustainable workforce along with a decreased reliance on agency workers and greater flex of staff resources

12. PLANNED, SPECIALIST AND CANCER CARE

Planned

In line with our STP objectives we are committed to designing system pathways to ensure effective and efficient planned care pathways, which are based on population needs, optimise available resources and; resulting in delivery of accessible services which can respond to demand and support shared decision making.

To ensure delivery we will meet our improvement targets for:

- **Reducing cancelled operations**, cancelled operations as percentage of all relevant operations. Patients offered another binding date within 28 days, no urgent operation to be cancelled for a second time

- Improving reported **patient satisfaction** of outpatient care

- Local providers achieve a 20% **productivity improvement** within 5 years, so that existing activity levels can be delivered with better outcomes and 20% less resource

- NHS constitution **waiting time targets**

- Meeting **CCG national measures** including 92% of all patients on incomplete pathways being treated within 18 weeks

To deliver patient choice of first outpatient appointment, and achieve 80% of use of e-referrals by September 2017 and 100% by September 2018, we are working with providers to ensure there are sufficient clinic slots available to E-Referrals to ensure there are no appointment slot issues which will eliminate the faxing or emailing of referrals. All referrals must remain within the e-Referrals system and not be 'Booked outside of ERS'.

We will be streamlining elective care pathways, by re-designing work streams in the following areas:

- **Demand management and referral support**. Providers to employ substantive advice and guidance with education for GPs (SAGE) covering common conditions which enables the management of the patient in the community and supports 'right place, right time' considerations

- **Outpatient's efficiencies**. Financial recovery plans are in place to work with providers to re-organise outpatients ensuring maximum efficiency and expediency to patient discharge. These incorporate patient initiated follow-up, non-face to face initiatives and empowerment of patients to share responsibility for their own care needs. To enable this it is the intention of commissioners to finance this activity as a

block using national best practice new to follow-up ratios. It is expected that governance processes are introduced to ensure patient safety

- **Repatriation of activity into appropriate services**. All appropriate patients to be routed through west Hampshire Community Tier 2 service where they exist i.e. dermatology, ear nose and throat, musculoskeletal /orthopaedics, vasectomy, diabetes and cardiology. Providers are expected where agreed to route all GP referrals through these intermediate hubs regardless of acuity and to help in communications projects with primary care to forge single point of access for services as standard

- **Streamlining outpatient pathways including diagnostics**. Providers are to organise outpatients in such a way that all feasible consultations, investigations and assessments will occur in one visit or in advance of the first outpatient appointment to facilitate early diagnosis and management planning. This will improve patient satisfaction, reduce the need for return visits, decrease patient transport costs and lower did not attend rates

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Planned Care		
• All **routine follow-up appointments** to be initiated by the patient as required and in conjunction with advice from clinicians empowering patients to take responsibility for their own care needs; this includes new models of conducting patient follow-up appointments including the up-skilling of lower banded staff, telephone and non-face to face consultations are to be inherent in delivering patient initiated follow-ups to make best use of clinical and financial resource	Apr 2017	Patients experience more integrated services offered in different but more appropriate settings
• Develop Communication and Engagement Plan to support the 2017/18 commissioning intention that all patients to be routed through the appropriate Tier 2 service where they exist	Mar 2018	Tier 2 services that are capable and resourced to triage all primary and consultant to consultant referrals
• Increase the proportion of patients routed through the **Community Tier 2 services** where they exist (i.e. Dermatology, ENT, MSK/Orthopaedics, vasectomy, diabetes and cardiology) and work with providers to improve integration and communication	Mar 2018	Patients supported in shared decision making and self-management within all planned care services
• **Redesign outpatient care** in such a way that all feasible consultations, investigations and assessments will occur in one visit which will facilitate early diagnosis and management planning whilst reducing the need for return visits, excessive patient transport costs and	Mar 2018	Earlier diagnosis and better patient satisfaction

lower rates of DNAs with alternatives offered to ensure that consultations by telephone or other media are considered if appropriate		
• Consolidate services, work through outstanding mobilisation issues and embed intermediate care services as a permanent fixture in our healthcare environment. **Utilise the Carter Review and RightCare Commissioning for Value Pack** to support the identification of opportunities to provide a more comprehensive Intermediate care offer	Mar 2019	Established cost effective intermediate services delivered locally through a network of GP practices and community care settings
• Work with providers to undertake **care redesign** and identify additional services or pathways suitable for inclusion in new models whilst continuing to work with community providers to ensure best value for money and reduction in secondary care hospital based activity	Mar 2019	Patients access their care services nearer to home
• Engage with our hospital providers to identify further alternative ways or opportunities to deliver outpatient appointments in a different or more local way	Mar 2019	Further efficiencies

Links to strategic outcomes

- High quality, safe services delivered consistently
- National access targets will be delivered
- Delayed transfers of care rate will be reduced to and maintained at 3.5%
- Bed capacity will be used more effectively to generate a reduction in the acute bed stock
- Activity growth in the acute sector will reduced and patients treated in the best setting to improve outcomes

Specialist

We will work with NHS England specialist commissioning in the region to:

- **Take on delegated authority** as we have done for bariatric, neurological and wheelchair services
- **Implement specialised commissioning with the acute alliance** across the STP footprint
- Work on pathways where **earlier and prompt intervention** may limit demand for specialist services e.g. vascular services, Tier 4 Children and Adolescent Mental Health Service and secure hospital services for people with learning disability

- Commission **wheelchair services** on behalf of: West Hampshire CCG, Southampton City CCG, Portsmouth City CCG, Fareham and Gosport CCG and South Eastern CCG

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Specialist		
• Information for patients which will be accessible, accurate and current so that they can participate in, and be supported to make **informed choices** and decisions about their care	Mar 2019	Patients have the right information to help them make informed choices

Links to strategic outcomes

- High quality, safe services delivered consistently
- People are better supported to stay well and independent, with greater confidence to manage their own health and wellbeing
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs

Cancer care

In 2016 we have engaged with stakeholders on our cancer strategy which is closely aligned to the Wessex Clinical Network Cancer Strategy. We have established links with a range of partners and have included patients and their representative organisations as regular co-producers of our plans and actions.

We have taken action to address early detection with several initiatives by:

- Revising the **cancer referral patient letter** and promoting this to practices
- Improving the **accessibility of electronic information** to GPs
- Promoting **healthy lifestyles**
- Improving public **knowledge of symptoms** and **promoting training** for practice nurses

The following success criteria will measure improvements to prevention, treatment and care:

- **Direct patient involvement** in co-design of service redesign and improvements
- National **Cancer patient experience survey**
- National **cancer diagnosis audit**
- Significant events analysis included within **Primary Care Quality Progression Scheme**
- Providers attain and exceed all **mandated access standards**
- Improvements to **one year survival rates**
- **Reduce cancer diagnosis** via emergency routes
- **Earlier diagnosis** and staging

In 2016 we have engaged with stakeholders on our strategy which is closely aligned to the Wessex Clinical Network Cancer Strategy. We have established links with a range of partners and have included patients and their representative organisations as regular co-producers of our plans and actions.

The Cancer Engagement Event in October 2016 brought together the Clinical Network (WCN), patients, neighbouring CCGs, providers, GPs and 3rd sector organisations to agree the actions below:

Short term – by March 2017	Medium term – by March 2019	Longer term
2 week wait patient leaflet reviewed and publicised to	WCN connecting screening hubs with GP lists of people	Work with care homes commissioner on cancer

practices and DXS	with Learning disabilities	detection and individual care plans
Partners and CCG sourcing Easy Read leaflets on screening. CCG to publicise and DXS	Prevention project manager and 3rd sector organisations to plan smoking cessation development	Scoping for development of patient held records
Sourced Easy Read translation of 2 week wait patient letter. CCG to publicise and DXS	Promote direct access imaging – work with local directorates	WCN developing patient website re local services and further digital innovations including online data resources for CCGs
Promoted explanation and use of 2 week wait patient letter in practices – to reinforce and monitor	Care plan for people with learning disabilities - accessible - in contract and monitor implementation incl. user feedback	WCN developing web-based education for primary care: support and promote
Physical activity for recovery – local directorates promoting Healthworks – continue to publicise and increase referrals to cancer programme	Emotional support at diagnosis and post treatment – scope and plan use of community and 3rd sector resources including provision for carers and families (children)	Continuity of clinical support and care planning/navigators – liaise with clinicians
Equalities lead liaising with occupational health departments of provider organisations for baseline information	Actions to spread good practice in Occupational Health depending on baselines	

We have taken action to address early detection with several initiatives: by revising the cancer referral patient letter and promoting this to practices, improving the accessibility of electronic information to GPs, promoting healthy lifestyles and public knowledge of symptoms and promoting training for practice nurses.

The following success criteria will measure improvements to prevention, treatment and care:

- Direct patient involvement in co-design of service redesign and improvements
- National Cancer patient experience survey
- National cancer diagnosis audit
- Significant events analysis included within Primary Care Quality Progression Scheme
- Providers attain and exceed all mandated access standards
- Improvements to one year survival rates
- Reduce cancer diagnosis via emergency routes

- Earlier diagnosis and staging

Evidence will be collated via national programmes and reporting, and locally generated intelligence from health and social care system and monitored monthly and quarterly.

Early detection work

The proportion of patients presenting as an emergency with a new cancer diagnosis will be below the England average across all nine CCGs in Wessex, aiming for an aggregate figure of 15% by 2020. Following the WCN report on emergency presentations the following recommendations are made for commissioners:

Recommendation	WHCCG position
1. Commission cancer of unknown primary clinics across Wessex in line with NICE guidance	Currently scoping with RightCare
2. Work with Public Health to implement local public awareness campaigns focussing on the signs and symptoms suggestive of cancer	In progress
3. Implement the new NICE guidance 2 week wait referral recommendations	2ww guidance on DXS and being used – monitoring and liaising with providers re impact
4. Support symptom specific based referral pathways; monitor the findings of vague symptom pathway pilots within the Accelerate, Co-ordinate, Evaluate (ACE) programme	Monitoring. Colorectal pilot outcome being used in GI QIPP
5. The use of Low Dose CT scans are being piloted in several sites nationally for patients with high risk of lung cancer, we recommend attention should be payed to the outcome of these evaluations when they are reported	Pilot found this to be cost effective, UHS funded for new radiotherapy treatment machines
6. Monitor the proportion of cancers diagnosed following emergency presentation	Have asked for this to go in information schedules in order to monitor - will use to identify targeted actions needed
7. Ensure providers have robust tools to ensure their diagnostic capacity is able to meet rising demand	WCN offering capacity and demand. QIPP and locality projects re diagnostics. Ongoing monitoring of delays to identify capacity issues to ensure 85% of patients continue to meet the 62 day standard – cystoscopy identified and currently scoping
8. Improve timely access to diagnostics for primary care	Glycaemic index (GI) QIPP project started to return results and to increase over 17/18
9. Consider levers to improve/increase screening uptake	

Have asked for stage reporting to be in information schedules in order to monitor more currently and relate to actions being taken to address.

Recovery package work

Within 5 years all Wessex patients with a new cancer diagnosis will be offered a holistic needs assessment, a primary care cancer review and a detailed treatment summary, as a consequence of the implementation of the Recovery Package. Holistic needs assessments and detailed treatment summaries were in the Service Development and Improvement Plan 2015-16, and have asked for them to be in information schedule. Evidence will be collated via national programmes and reporting, and locally generated intelligence from health and social care system and monitored monthly and quarterly.

Priorities 2017-18 - 2018/19	Delivery Date	Outcomes
Prevention		
• Introduce opportunities to **promote smoking cessation** and other brief interventions to reduce known risk factors in line with reducing smoking prevalence to below 13% nationally by 2020 – this includes working with 3rd sector organisations	Mar 2018	Patients supported to give up smoking with resulting health benefits
• Support the **Wessex Cancer Network's presentations to schools**	Mar 2018	To improve the lifestyle of children to reduce the incidence of cancer in the longer term
• Support Wessex Cancer Network's **training for primary care staff** to support them in difficult conversations with patients around lifestyle	Mar 2018	To improve the lifestyle of patients to reduce the incidence of cancer in the longer term
Screening, awareness and early detection		
• We will be continuing to **implement the following improvements for 2 week wait patients** - 2ww patient information letter has been re-written to improve attendance, is on DXS and is being translated into easy read version. Wessex wide 2ww referral forms have been put on DXS and promoted to practices, including NICE referral guidelines. Screening information leaflets in Easy Read versions to be promoted with practices, and gaps filled	Apr 2017	Patients experience improved seamless service
• Creation of a **register of practice cancer leads** in order to cascade information and to receive issues raised by practices such as learning needs	Apr 2017	Patients experience improved seamless service
• Work is ongoing to **monitor the effectiveness of diagnostic pathways** and highlight issues to locality directorates. Upper and Lower GI project underway, bringing together GPs, acute and community providers to maximise	April 2017	Robust diagnostic services in place meeting expected demand

efficiency of pathways and improve communication between different parts of the system		
• Detailed collation and analysis of various data sources in order to **prioritise cancer pathways for improvement** and highlight to locality directorates being reviewed monthly	April 2017	Patients experience improved seamless service
• Facilitate engagement with **training and resources for professionals** to increase early detection – MacMillan lead GP visiting practices and targeting visits to practices with low screening rates including reminding them to conduct 6 month review	Mar 2018	More clinicians trained in early detection techniques
• Take **targeted actions to increase screening rates** in areas of low uptake and reduce inequalities: a) connecting screening hubs to partners working with people with learning disabilities and mental illness b) developing communications aimed at these groups c) enabling care plans to be on patient record for improved continuity, working with our partners	Mar 2019	Screening rates increased, particularly amongst targeted groups
• Reduce the **number of cancers diagnosed in A&E departments** through improved screening, diagnostics pathways, and facilitation of communication between referrers and providers, public awareness of risk factors, electronic availability of information for referrers	Mar 2019	Fewer cases of cancer detected through emergency presentation
• Promote **national awareness campaigns** at a local level in relation to early signs of cancer, through messaging and support for early/direct access to diagnostics	Mar 2019	More people attending GP practices reporting suspected early signs of cancer
Access to services		
• Hold **providers to account for attainment** (and ideally exceed) national cancer waiting time standards	Continuous	National waiting time standards consistently achieved
• Ensure that **routes to diagnostics are clear**, effective and have sufficient capacity to accommodate demand, engaging with partners	Mar 2019	Robust diagnostic services in place meeting expected demand
• Identify **pathway improvements and develop direct access and one-stop clinics**, patient activated follow up appointments, remote surveillance and scope new developments such as patient held records and care navigators, using technology and engaging with a variety of partners for system-side improvements	Mar 2019	Patients experience improved seamless service
Patient experience and survivorship		
• **Co-ordinate multi-stakeholder actions** to	Mar 2018	Carers and families

provide elements of the recovery packages including physical activity, emotional and social support		receive improved support
• **Improve support to carers and families** using our contacts in NHS England and charity organisations	Mar 2018	Patients receive appropriate support to help them recover from cancer
• **Encourage and support GP practices** and providers to implement elements of the National Survivorship initiative (Recovery packages/strategic pathways) and cancer reviews in Primary Care and link with work in care homes	Mar 2019	Seamless recovery packages in place
Patient Experience		
• Regularly use the **National Cancer Patient Experience Survey**, organisations representing patients and carers, and direct involvement with patients to inform our actions	Ongoing	Patients report better experience of using the service and their views taken into account in service development

Links to strategic outcomes

- High quality, safe services delivered consistently
- People are better supported to stay well and independent, with greater confidence to manage their own health and wellbeing
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs
- National access targets will be delivered

13. ORGANISATIONAL DEVELOPMENT AND WORKFORCE

The CCG is committed to the ongoing development and support of its, and the wider NHS, workforce. There are a number of workforce challenges within the NHS such as an ageing workforce, difficulties in recruitment, particularly for our clinical workforce, and the need to retain skilled and effective staff. The CCG is an active partner in the STP work and the work to support and develop the workforce. Much of the work of the STP is designed to address these issues.

We are fully supportive of the plans within the STP workforce programme to ensure the system has the right people, skills and capabilities to support the transformed health and care system. Wider organisational development sits with the Board and the Chief Officer and Chair and will be managed in conjunction with CCG partners as part of the STP programme. The CCG will continue to be an active partner in the workforce work stream of the STP to contribute to the wider discussions about the future development of clinical and support staff for the local area to ensure sustainability and support for this key resource.

The priorities within the STP support the opportunity to realise the benefits of working together across the system to:

- Develop a **flexible workforce** shared across geographical and organisational boundaries, delivering the needs of the local health and social care system
- Create health and care roles which are more attractive to local people, enabling the **development of a stronger community based workforce**
- **Reduce significantly** the use of **temporary and agency workers**
- Increase the time staff spend making the **best use of their skills and experience**
- Understand how to maximise resources within the context of **no overall growth in the workforce** over the next five years across the STP footprint

With a view to

- Reducing **temporary staff costs** within the wider system by **10%**
- Reducing **corporate costs** by **15%** through a system-wide rather than an organisational approach

The CCG will align its key work streams to those identified within the STP, and support the priorities identified within the workforce section of the plan. We will share learning and ensure that developments and activities support the wider STP actions.

This alignment can be seen below:

STP WORK STREAM PRIORITIES	CCG TWO YEAR OPERATIONAL PRIORITIES
Workforce planning and information	
Develop a workforce plan supported by relevant and up to date workforce data and information to understand the workforce needs of the wider system and plan effectively for the future	Develop a people plan which outlines the activities to be undertaken by the CCG to support and develop its workforce. Develop and deliver the skills development programme to identify the development needs of the organisation to produce a learning and development plan. Investigate the opportunities for apprenticeships within the CCG and how these can add value to the workforce
Recruitment and retention	
Develop an approach across the wider system to improve the recruitment and retention of staffing groups historically difficult to resource and retain	Further embed the work on values based recruitment within the CCG to attract people to the CCG and local area, recruiting people on both competencies and values to align with the culture of the CCG. Implement work to ensure effective retention of staff, including work to ensure effective performance development reviews, staff development, engagement, health and wellbeing and staff rewards. Support staff to develop a clear career framework to ensure a well-trained and highly valued workforce using the talent management programme being implemented early in 2017
System-wide use of resources	
Ensure that we have a flexible and efficient workforce across the STP area and the right workforce to meet the local demands over the next five years for both clinical and back office requirements	Implement a CCG-wide approach to flexible working with support and development to ensure that it works for the organisation as well as the individuals. Support staff to work differently, in partnership and across organisational boundaries to deliver agreed priorities
Technology	

Link closely with the digital work stream to ensure that staff have access to available technology for both clinical and developmental purposes	Ensure staff contribute to the digital work plan which outlines the digital requirements of the CCG, including how technology can support teams and individuals to work effectively, efficiently and flexibly
Education and development	
Ensuring there is an education and development process which meets local needs and better support staff to undertake training through the effective use of technology	Use the learning and development plan to align education and development across the system and identify common themes which can be delivered effectively across the system and further use the ConsultOD platform, TVWLA and other existing resources to support staff education and training
Engagement and organisational change	
Developing a shared workforce change process underpinned by a workforce engagement plan	Implement the CCG staff engagement plan and further embed effective staff engagement across the organisation

Support and development of the clinical workforce

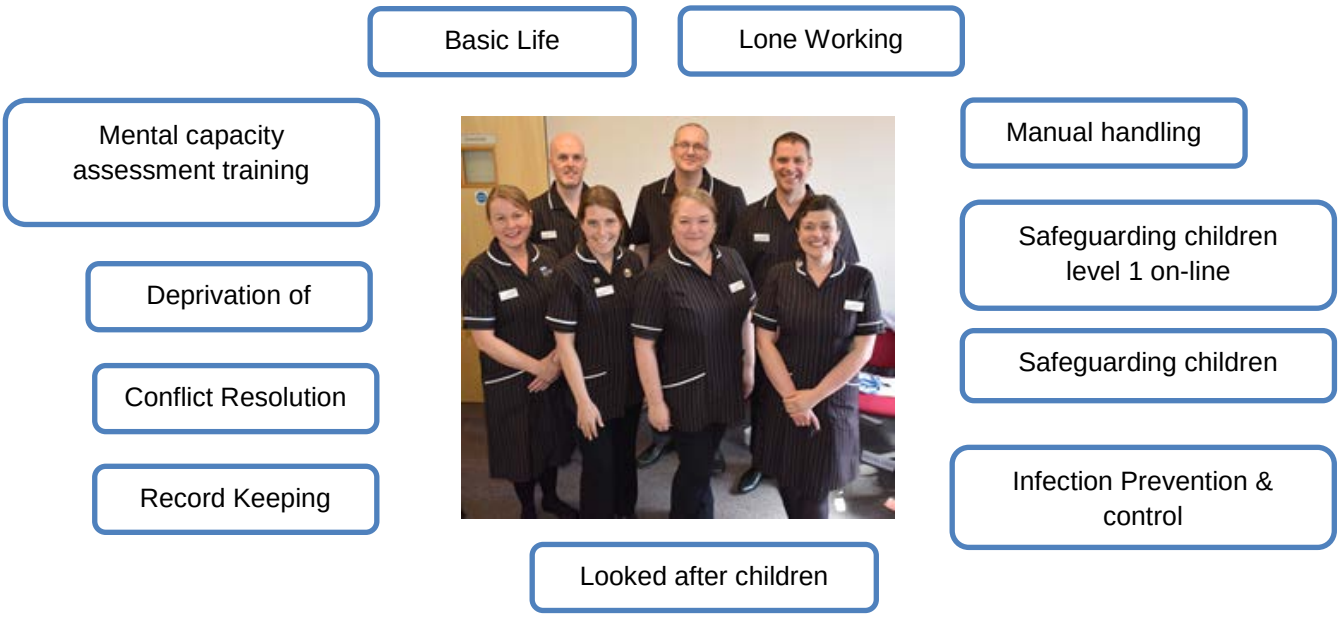
Within west Hampshire we are committed to support the training of our colleagues in GP practices. Through TARGET meetings we have been and will continue to support GPs and other practice staff to keep up to date with latest clinical developments and local service development. This will be supported through the work with localities under the direction of the CCGs clinical cabinet.

We will continue to support care home nurses and carers within west Hampshire and currently have a pilot of the early warning sepsis scoring within a care home, with a view to extending the sepsis scoring to other care homes, working with the local authority and independent homes. Support for carers will feature as a priority over the next two years to ensure they are identified and engaged to ensure they have a voice to develop support and services relevant to them.

We will continue to support and develop the pharmacists and pharmacy technicians in the medicines optimisation team to enable them to deliver new roles in practices which will be more patient facing and clinical. We will utilise the national training programmes being provided by the Centre for Pharmacy Postgraduate Education as well as locally delivered education. In addition, we are working with local community pharmacists to support their changing roles.

We will work with our acute and community providers to identify opportunities for shared learning and development across the wider system and work through the STP workforce group to identify wider opportunities to support this key part of the NHS workforce.

We will maintain and review our annual mandatory training programme for our clinical front line staff as shown below.



Supporting and retaining CCG staff

The support for our staff over the coming years is central to ensuring the effective delivery of the STP priorities.

In early 2017 we will be completing a staff skills self-assessment to enable staff to identify their strengths and weaknesses. This will then allow us to understand areas where we need to grow and develop skills and encourage staff to make the best use of their skills and experience.

We are also embarking on a talent management development programme in conjunction with the Thames Valley and Wessex Leadership Academy to support staff to develop within the CCG and further within the system. This programme will also be considering the retention of staff, succession planning and rewards systems.

The ongoing engagement of staff remains a priority for us. The staff engagement plan will continue to be delivered and further support on the 'our staff first approach' will ensure that staff are fully engaged with the work of the CCG and the wider system.

We have an active staff forum which supports the health and wellbeing agenda for the CCG, actively champions improvements and developments within the CCG and has taken on a role as a consultative group. This will be further developed over the coming years. In September 2016 we supplemented this with a with a staff forum for the CHC team who are based outside the main headquarters building to give them a place to raise and discuss issues unique to their working environment. Further work will take place in 2017 to support and develop the CHC staff forum, alongside the main forum to ensure it is empowered and representative.

We have recognised the importance that good health and wellbeing has on our staff and we will be looking to achieve the Workforce Wellbeing Charter in 2018 following our self-assessment in 2015. We have a lead director and a draft wellbeing strategy which will be fully implemented in the first year of this operating plan. One priority for this work will be the implementation of the Dignity and Respect Policy. This has been has been drawn up

following responses from the 2015 staff survey. It will be introduced alongside training for all staff on how to recognise report and deal with bullying, harassment and abuse, which will start in early 2017. We want to further develop behaviours that support a positive work climate, build trust and promote open communication. This strategy will also be considering the retention of staff, succession planning, rewards systems and increasing diversity at all levels of the organisation.

Listening to and engaging staff

As a CCG we listen to the feedback that our staff give us and work with them to introduce solutions to issues they raise. We are committed to ensuring effective engagement of staff and will be further reviewing our staff engagement plan and seeking to increase our staff engagement scores over the coming two years. We will continue to undertake and be part of the national staff survey to ensure that we gather staff feedback both formally and informally. We aim to increase our response rates for the survey and to show improvements based on this feedback year on year. We will further develop our newly launched staff suggestion scheme and celebrate the achievement of our staff with our recognition scheme, hearing the issues raised by our staff and recognising what they highlight as being important.

Priorities 2017/18 - 2018/19	Delivery Date	Outcomes
Support and development of the clinical workforce		
• Extend the pilot of the **early warning sepsis** scoring within a care home, to other care homes in west Hampshire	Mar 2018	Cases of sepsis will reduce amongst care home population
• Promote **sepsis recognition** and promote the sepsis guidelines in primary care	Mar 2019	Lead to early identification of sepsis cases which will promote better outcomes for patients
• Continue to support TARGET events to deliver up to date and relevant **training and development for GPs**	Mar 2019	The GP workforce is supported and able to maintain their development
Supporting and retaining CCG staff		
• Train all staff in **dignity and respect** and increase awareness of the approach the CCG is taking	Apr 2017	Staff Survey results 2017 will show cases of bullying and harassment have reduced and staff are confident where these occur that they are dealt with effectively
• **Complete skills assessment for all staff** and implement the results to ensure there is a	Apr 2017	Staff have the opportunity to increase

comprehensive skills development programme for CCG staff		their skills base and we target resources to address organisational training needs
• **Support and develop the staff forum** for the organisation and identify training and development to enable them to effectively represent staff	Jun 2017	Staff feel valued with a place to raise issues unique to their workplace
• Implement a **management development programme for new managers** to support their transition into their new role	Sept 2017	Staff have the skills to ensure effective management of staff and feel supported to undertake this
• **Embed values into the recruitment process** to deliver a robust values based recruitment plan. Ensure values are included in personal development reviews	Nov 2017	The CCG retains staff through an effective recruitment process and embeds values throughout the organisation
• **Review the health and wellbeing plan** and seek to achieve the Health and Wellbeing Charter	Jan 2018	Staff are supported in their own health and wellbeing to reduce absenteeism and increase retention
• Continue to provide opportunities **for staff to come together both formally and informally** through networking events, all staff events and briefings and social events	May 2018	The event will foster engagement and participation across the organisation
• Develop and implement the **talent management programme** across the CCG and within the primary care workforce	Sept 2018	CCG has a clear succession programme and talent management pipeline
Listening to and engaging staff		
• Review and further implement the **CCG staff engagement plan** identifying robust measurement and outcomes	Mar 2018	Staff feel engaged and supported within the CCG
• Develop an approach to **co-production with staff** and empower them to make the changes needed within their service area and the CCG as a whole	Mar 2018	Staff feel engagement and empowered within the organisation and the CCG has a reputation as a good place to work
• Continue to utilise the result of the **staff survey** to make improvements to the CCG	Mar 2019	CCG is seen as responsive to staff views and a better place to work

Links to strategic outcomes

- High quality, safe services delivered consistently

- Create a sustainable workforce with a decreased reliance on agency workers and greater flex of staff resources

14. ENGAGEMENT

As part of the communication and engagement support within the STP, we will support the programme of communication and engagement agreed through the programme office. As part of the communication and engagement steering group the CCG will ensure that key local audiences are engaged appropriately. The CCG will support the development of an engagement calendar for the Hampshire and the Isle of Wight STP to have a footprint-wide map of where engagement is planned to take place over the next 12 months. This will help with the wider STP communications as material can be shared where appropriate and opportunities to coordinate engagement across boundaries, where appropriate, can be identified.

We are committed to the ongoing engagement and involvement of local residents to help shape local health services and increase local understanding of our work.

There are two aims of our engagement activities, to:

- **Increase public and stakeholder understanding** of the CCG and positively influence their opinions of our services

- **Communicate with and involve** our patients, carers, the public, health and social care organisations, local authorities and the voluntary and community sector in our work to help us shape and improve future services

We are also fully supportive of local developments around STP, Better Local Care and locality plans and recognise that often its engagement needs to be wider than just the CCG. The engagement cycle, is used, as the process for undertaking effective engagement across the CCG.

Our engagement activity will support specific priorities identified in this Operating Plan. The Communication and Engagement Team will work closely with directorates to ensure effective and meaningful engagement on these priority areas to ensure the patient voice is heard.

The operational engagement priorities for the coming two years are as follows and are designed to develop and improve our skills, approach and capability.

Priorities 2017/18 - 2018/19	Delivery Date	Outcomes
Digital		
• Develop and agree a **digital communication engagement plan** to ensure that different channels and resources are being used to engage with local people	Sept 2017	Better engagement with local people using the media platforms they wish to be contacted on
Mental health and learning disability		
• Build relationships with **mental health and learning disability groups** to gain input from their members to understand how we can engage better with these groups	Oct 2017	Better engagement with mental health and learning disability groups contributing to providing services which best address their needs
General Practice		
• Develop and support further initiatives to **engage member practices** in our work, including work with practice managers, locality directors and clinical leads	Nov 2017	Better engagement with GP member practices

Workforce		
• To build on the **staff engagement plan** to enhance the overall staff experience and support wider engagement and involvement in the development of the CCG	Jan 2018	Staff feel supported and engaged with the strategic direction of the CCG
Carers		
• Develop a **proactive approach to carer engagement** making links with support groups and carers cafes to ensure their voices are heard and develop a specific work plan to engage young carers	Mar 2018	Services reflect the needs of our population
Young People		
• Work with local colleges to **engage with young people** to ensure they have a voice in local service development	Mar 2018	Better engagement with young people contributing to providing services which best address their needs
Patient involvement		
• Develop the **health involvement network** to ensure it is representative of the local community and is able to effectively engage with the CCG on service development and change	Mar 2018	The health involvement network numbers grow so it is representative of the local community and can help to contribute to providing services which best address the community needs
• Continue to work with **Patient Participation Groups** to develop them as an effective resource for GP practices	May 2018	Patient Participation Groups feel empowered to support their GP practices
• Develop the **Involvement Steering Group** to extend its membership to include underrepresented groups and ensure it is an effective resource	Mar 2019	Increased representation of all patient groups to allow it to best contribute to the development of services

Links to strategic outcomes

- High quality, safe services delivered consistently
- More people will have a positive experience of care, which is joined up and is tailored to meet personal and holistic needs

15. FURTHER INFORMATION

For further information, please contact:

Heather Mitchell

Director of Strategy and Service Development

heather.mitchell@westhampshireccg.nhs.uk

NHS West Hampshire Clinical Commissioning Group

Omega House, 112 Southampton Road, Eastleigh, Hampshire SO50 5PB

Tel: 02380 627240

www.westhampshireccg.nhs.uk

APPENDIX 1 - WEST HAMPSHIRE CCG WORK PLAN 2017/18 – 2018/19

Strategic Priorities	Actions		Delivery date	Link to the Sustainability and Transformation Plan programme
Improving Quality	Quality	Implement the quality development programme, including quality visits, CQC support and service improvement as part of the quality framework to support quality in General Practice	Apr 2017	New Models of Integrated Care
		Support a sustainable nursing workforce by working with Health Education England (Wessex) to enable student and return to practice placements within primary care	Sep 2017	Workforce
		Establish sharing of significant events through the Datix system within General Practice to support a culture of learning and safety	Sep 2017	Workforce
		Enhance safety and quality within general practice and access to primary care services to improve patient experience, as measured via Friends and Family Test and GP National Survey	Mar 2018	New Models of Integrated Care
		Implement development programme based around leadership, locality based forums and specialist subject groups with a focus on essential skills and training for General Practice Nursing	Mar 2018	Workforce
		Maintain patient safety and experience when constitutional targets are breached and escalated through assurances processes including; clinical assurance visits; reporting and discussion at clinical quality review meetings, investigations of specific cases, or cluster analysis of themes emerging	Mar 2018	Prevention at Scale
		Review of Clinical Quality Review Meeting processes, including Quality Team visits to providers to review services or pathways, focussed in relation to	Sep 2018	Prevention at

		incidents/SIRIs, concerns, national guidance, patient feedback, CCG priorities, aligned to reporting information to test provider plans and delivery at patient level; for example reviewing the fractured neck of femur pathway and achievement of the best practice tariff		Scale
		Deliver the overarching Primary Care Quality Strategy through collaborative working with primary care teams, CCG commissioning and quality team	Mar 2019	New Models of Integrated Care
		Develop and submit bids for improvement grants for funding to improve the quality of GP practice premises and improve infection control – move to Primary Care Commissioning	Mar 2019	Estates
		Work with providers to share learning from organisations where others have had greater success, and support with assisting the provider to understand their issue and identify potential solutions/actions to deliver improvement	Mar 2019	Prevention at Scale
		Improve significant event recognition, reporting, and investigation with a culture of systems-based sharing and learning following implementation of the Quality Progression Scheme	Mar 2019	Prevention at Scale
		Continue to use 'Qwest 4 Improvement' newsletter to improve learning from innovation, system-wide serious incidents requiring investigation (SIRIs), provider SIRIs and never events, sharing with providers and other CCGs	Mar 2019	Prevention at Scale
	Medicines management	Support GP practices to improve the treatment of atrial fibrillation	Mar 2018	New Commissioning Models
		Support GP practices to audit their prescribing of asthma medicines in line with the findings of the National Review of Asthma Deaths	Mar 2018	New Commissioning Models
		Support GP practices to reduce the inappropriate prescribing of antimicrobial agents	Mar 2018	New Commissioning Models
		Continue to support GPs to review frail patients receiving multiple medicines, particularly problematic medicines	Mar 2019	New Commissioning

				Models
		Support GP practices to review patients with learning disability who are prescribed antipsychotic medicines	Mar 2019	New Commissioning Models
		Increase prescribing to address hypertension by focussing on primary care management of hypertension in those under 85 and in people with long term conditions, especially diabetes	Mar 2019	New Commissioning Models
		Increase prescribing to reduce cholesterol through the promotion of the 'How Healthy am I' publicity campaign in pharmacies, job centres and smoking cessations clinics	Mar 2019	Prevention at Scale
	Patient experience	Feed patient experience information into the development of commissioned services	Mar 2019	New Commissioning Models
	Personal health budgets	Continue to deliver personal budgets under the Hampshire Integrated Personalised Commissioning Pilot	Mar 2019	New Models of Integrated Care
	Safeguarding	Deliver the Wessex Safeguarding programme	Mar 2019	Prevention at Scale
	Continuing healthcare	Refine the KPI schedule for CHC delivery that meets the requirement of the Business Cases	Jul 2017	New Commissioning Models
		Consolidate brokerage arrangements to enable feedback on quality of care with providers and explore options for a joint brokerage arrangement with HCC	Sept 2017	New Commissioning Models
		Review the backlogged cases of people in receipt of CHC and FT funding in a timely manner that ensuring clinical needs are reviewed, ongoing entitlement established and if necessary care packages are right sized to reflect ongoing need	Oct 2017	New Commissioning Models

Promote better integration of personal health budgets into continuing healthcare process by aligning personal health budget activity closer to the day to day work of the CHC team	Oct 2017	New Commissioning Models
Have in place framework agreements for over 80% of the care purchased for CHC eligible patients	Dec 2017	New Commissioning Models
Push ahead proactively to recruit to all the new Business Case posts	Mar 2018	New Commissioning Models
Develop guidance and training for acute providers to ensure compliance with the National Framework guidance	Mar 2018	New Commissioning Models
Enable delivery of a new workforce model and organisational structure to enable delivery of CHC to a necessary standard that meets the requirement of the National Framework. Develop and implement the new workforce model, taking forward the hub and locality model for the service and closer working with CCGs on all aspects of the business	Apr 2018	New Commissioning Models
Business case 1 approved by the Hampshire is being implemented and will be operating fully	July 2018	New Commissioning Models
Prioritise activity to take forward innovative commissioning activity to deliver new types of services	Jul 2018	New Commissioning Models
Business case 2 approved by the Hampshire will be concluded	Dec 2018	New Commissioning Models
Ensure service development takes account of messages received via the complaints process and independent audit of users experiences of CHC	Dec 2018	New Commissioning

				Models
Primary Care	Health promoting care - Prevention, health and wellbeing	Roll-out and promote the use of on-line consultation systems providing access to self-help information (see Access to Care)		Digital
		Support ‘Stop before the Op’ and ‘Quit4life’ initiatives (particularly in areas of deprivation)	Apr 2017	Prevention at Scale
		Hold a workshop in April 2017 for practice nurses who run the LTC clinics, primary care health care assistants, community specialist nurses, allied health professionals and community mental health nurses on ‘behaviour change’ covering smoking cessation, alcohol brief advice, psychological therapies and weight management	Apr 2017	Prevention at Scale
		Implement plans to extract data from primary care systems to refer to the chosen provider from the framework and identify referral routes from primary care to support the programme	Apr 2017	New Models of Integrated Care
		Implementation of the STP wide programme of the national diabetes prevention programme	Apr 2017	New Models of Integrated Care
		Implementation of the H&IOW national diabetes prevention programme Communication & Engagement Plan (from April 2017)	Apr 2017	New Models of Integrated Care
		Support GP Practices, through our quality Progression Scheme to implement a major campaign ‘Get Hampshire Walking’	Jul 2017	New Models of Integrated Care
		Facilitate support through primary care for the new Tier 2 weight management service to target men and pregnant women	Sept 2017	Prevention at Scale
		Facilitate a collaborative programme to follow up people that do not attend screening with a particular focus on people with mental illness and learning disability	Dec 2017	New Models of Integrated Care
		Increase social prescribing in particular to combat social isolation and loneliness. Roll-out of Hampshire County Council ‘Connect to Support’ PC tablets within general practices giving touchscreen access to a range of voluntary services and community groups. Increased signposting by Receptionists and Care Navigators	Mar 2018	Prevention at Scale

(see workforce section)		
Implement new Tier 3 weight management specification with partners across wider Hampshire and take on delegated responsibility for Tier 4 weight management form specialised commissioning	Mar 2018	Prevention at Scale
Incorporate NHS Right Care falls prevention project on focussed on care homes into locality teams wider programmes on frailty with the aim of reducing falls in all people over the age of 75	Mar 2018	Prevention at Scale
Encourage local people to live well through the continued implementation of a three year 'Get Hampshire Walking campaign' launched in 2016. Work will focus on engaging specific target groups identified through 'market segmentation' of our population and what motivates them using a tool developed by Sport England. The campaign has the support and sign-up of all West Hampshire GP Practices and is a key element of social prescribing. The campaign is being delivered with the District Councils and utilises existing resources within the community to encourage people to take regular exercise	Mar 2019	Prevention at Scale
Work with local partners to tackle health inequalities in areas of deprivation through the development of joint local action plans (as a key element of our Locality Plans). This will focus on lifestyle factors, as well as the wider determinants of health and will be informed by public health information. Patient Activation has been shown to be a powerful mechanism for tackling health inequalities and will be utilised to improve patient engagement and outcomes and to target interventions	Mar 2019	New Models of Integrated Care
Target people with long term conditions for Tier 2 Weight management by ensuring referral through LTC community specialist services	Mar 2019	Prevention at Scale
Address smoking levels in people with serious mental illness	Mar 2019	Prevention at Scale
Reduce the rate of first detection of cancer through emergency presentations to 15%	Mar 2019	Prevention at Scale
Increase the cancers detected in stages one and two to 70%	Mar 2019	Prevention at

				Scale
	Primary care	Develop and implement practice, public and stakeholder engagement plans to inform the development of a service specification for extended access in line with national criteria (ensuring alignment with plans for the re-procurement of NHS 111 and GP Out of Hours Service)	Apr 2017	New Models of Integrated Care
		Development of the 2017-18 Quality Progression and Medicine Management Optimisation Schemes	Apr 2017	New Models of Integrated Care
		Secure the continued provision of the primary care access centre, The Practice, located in the Area Health Hub at Lymington New Forest Hospital. The Practice covers a population of 68,000 across South West New Forest and was originally established through a successful national Prime Ministers Challenge Fund bid	Apr 2017	New Models of Integrated Care
		Procure extended access services in the evenings and at weekends across West Hampshire CCG in line with an agreed service specification. This will include the phased integration of urgent care services	Sep 2017	New Models of Integrated Care
		Secure the capture of 'real-time' general practice demand and capacity information	Sept 2017	Digital
		Evaluate the integrated medicines optimisation service to inform future commissioning	Dec 2017	New Models of Integrated Care
		Development of a super-partnership toolkit encapsulating a step-by-step guide to the creation of a super-partnership to facilitate collaborative working between practices within natural communities. Ensure shared learning and expertise across WHCCG	Mar 2018	New Models of Integrated Care
		Develop LNFH as a Community Education Provider Network (CEPN) in collaboration with Health Education (Wessex)	Mar 2018	Workforce
		Commission training for receptionists and clerical staff in signposting and work flow optimisation	Mar 2018	New Models of Integrated Care

		Implementation, monitoring and evaluation. Quarterly reports to Primary Care Committee	Mar 2018	New Models of Integrated Care
		Market test and procure an on-line consultation system and roll-out across West Hampshire Practices. Implementation of Practice training package and public media campaign. Evaluate impact Planned population coverage: 2017-18: 50% 2018-19: 100%	Mar 2019	Digital
		Support Practices to develop and work together within Local Health Hubs to provide care across a natural community. Ensure shared learning across West Hampshire and the wider STP footprint	Mar 2019	Workforce
		Fully evaluate pilot schemes and invest in proactive care and Care Navigator roles across WHCCG	Mar 2019	Workforce
		Implement the five core elements of the national GP Development Programme across West Hampshire	Mar 2019	Workforce
		Continue to identify Practices who could benefit from the national GP Resilience Programme	Mar 2019	Workforce
		Commission Care Navigator service across West Hampshire CCG	Mar 2019	Workforce
		Implementation, monitoring and evaluation. Quarterly reports to Primary Care Committee	Mar 2019	New Models of Integrated Care
		Explore the further development of CEPN within the remaining five Area Health Hubs across West Hampshire	Mar 2019	Workforce
	Primary Care Infrastructure	Continue to apply for improvement grants	Ongoing	Estates
		ETTF Bid: Extension of Shepherd's Spring Medical Practice, Andover to provide an additional four consultation rooms	Apr 2017	Estates

Clinical system migrations completed at Hedge End Medical Centre and Brownhill Surgery	Apr 2017	Digital
GP IT equipment, including PCs/monitors upgraded	Apr 2017	Digital
HEADMAT™ tool introduced and operational	Apr 2017	Digital
Comprehensive utilisation of DXS complete	Apr 2017	Digital
Phase 2 of the improving the transmission of electronic discharge summaries complete	Mar 2018	Digital
Redevelopment of Hythe and Dibden War Memorial Hospital (Area Health Hub)	Dec 2018	Estates
Hampshire Health Record programme complete	Mar 2019	Digital
Patient online services programme complete	Mar 2019	Digital
Improve e-Referral utilisation programme complete	Mar 2019	Digital
Increased utilisation of Lymington New Forest Hospital (Area Health Hub)	Mar 2019	Estates
Explore the redevelopment of Ashurst Hospital as a Children's Centre	Mar 2019	Estates
Explore the redevelopment of Milford-on-Sea War Memorial Hospital	Mar 2019	Estates
Explore potential opportunities to support the provision of modern, fit for purpose premises in New Milton and Totton	Mar 2019	Estates
ETTF Bid: Development of Local Health Hub within Eastleigh (subject to due diligence and public consultation)	Mar 2019	Estates
Explore the development of Moorgreen and Romsey Hospitals as Area Health Hubs	Mar 2019	Estates
ETTF Bid: Development of Local Health Hub within Andover (subject to due diligence and public consultation)	Mar 2019	Estates

		Explore the development of Andover War Memorial Hospital and Royal Hampshire County Hospital as Area Health Hubs	Mar 2019	Estates
		Re-provision of the St Clement Practice within Winchester City Centre	Apr 2019	Estates
Mental Health and learning disabilities	Mental health	Addressing mild illness with expanding access to psychological therapies to limit the progression in some people, to the moderate or severe illness	Mar 2018	Mental Health Alliance
		Offer more psychological support to people and their carers with long term conditions, which includes digital solutions where appropriate	Mar 2018	Mental Health Alliance
		A single point of contact for anyone seeking help with a mental health crisis is established, with access to a range of immediate support	Mar 2018	Mental Health Alliance
		Commissioning of early crisis support to for West Hampshire residents to prevent deteriorating mental health leading inevitably to a full mental health crisis	Mar 2018	Mental Health Alliance
		A local west Hampshire recovery based solution replacing high cost out of area residential long term rehabilitation will be in place as part of the review and redesign of the Mental Health Rehabilitation Pathway across the STP including a new out of area Placement Protocol	Mar 2018	Mental Health Alliance
		Acute and community mental health pathway review and redesign, Including psychosis, borderline personality disorder, dementia and psychological therapies	Mar 2018	Mental Health Alliance
		A sustainable solution for in patient, PICU and community provision will be agreed	Mar 2018	Mental Health Alliance
		Joint commissioning arrangements and pooled budgets in place for H&IOW co-ordinated mental health rehab pathway and OAP protocol and process	Mar 2018	Mental Health Alliance
		We will be expanding the capacity of early invention psychosis support pathways – with 40% growth applied between 2016/17 Q1 and 2017/18 and a further growth of 7.1% between 2017/18 and 2018/19	Mar 2019	Mental Health Alliance
		Mental health support available in primary care settings, as part of the extended primary care team, so that an integrated service is provided for patients	Mar 2019	Mental Health Alliance

	Learning disabilities	Development and deployment of an 'at risk of admission' register across the SHIP area	Apr 2017	Prevention at Scale
		Commission and mobilise a community forensic rehabilitation service	Jul 2017	Prevention at Scale
		Capital project funded by NHS England to provide transitional and supported living accommodation	Sept 2017	New Models of Integrated Care
		Commission Health Facilitators to work with GP Practices to deliver on the ambition that 75% of people on GP registers are receiving an annual health check	Mar 2019	Prevention at Scale
		Aim for the number of people in Hampshire with a 'Personal Budget' with a Health component to increase to 1276 individuals	Mar 2019	New Models of Integrated Care
		We will work to reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million of population and 20-25 in NHS England-commissioned beds per million of population	Mar 2019	New Models of Integrated Care
Maternity and Family Health	Avoidable hospital admissions and attendances	Develop options for community children's nursing teams to deliver acute and ambulatory care in the community	Mar 2018	Effective Patient Flow & Discharge
		Agree new specification for children accessing children's ED and Paediatric Assessment Unit incorporating a new urgent care pathway agreed across our systems	Mar 2018	Effective Patient Flow & Discharge
		Evaluate the patient flow improvement measures introduced in 2016/17, measure performance and outcomes and revise the new service as appropriate according to need	Mar 2018	Effective Patient Flow & Discharge
		Evaluate the benefits of improved pathways to support babies under 12 months with complex feeding needs and revise the new service as appropriate according to need	Mar 2019	Effective Patient Flow & Discharge
		Evaluate the Wessex Clinical Network acute clinical pathways introduced in 2016/17, measure performance and outcomes and revise the new service as appropriate according to need	Mar 2019	Effective Patient Flow & Discharge

		Review any Facing the Future recommendations implemented and ensure any changes are having a positive impact on service user satisfaction rates	Mar 2019	Effective Patient Flow & Discharge
	Maternity	A plan to respond to recommendations of still birth bundles, advice from managing diabetes in pregnancy guidance and results of the Perinatal Mental Health services review and will monitor the outcomes improvements in quality	Mar 2018	Prevention at Scale
		Evaluate the improved breastfeeding support services in partnership with Public Health and the voluntary sector with the aim of increasing initiation and continuation of breastfeeding and revise the new services as appropriate according to need	Mar 2018	Prevention at Scale
		We will also develop and agree a single maternity specification across all acute providers, including agreed Public Health measures	Mar 2019	Effective Patient Flow & Discharge
		Design and deliver at pace the recommendations of the Better Births review	Mar 2019	Effective Patient Flow & Discharge
	Children and young people with additional health needs	Learn from the new models of integrated care for children with disabilities or complex health needs pilot sites and identify methods of created the integrated model in other areas	Mar 2018	New Models of Integrated Care
		Commission and implement revised continence services and special school nursing services and review current integrated therapies services and re-procure	Aug 2018	New Models of Integrated Care
		Roll out, at scale, Integrated Personal Commissioning and personal health budgets, to promote choice and flexibility in the way in which people access healthcare	Mar 2019	New Models of Integrated Care
	Emotional wellbeing and mental health	Evaluate the provision of psychiatric liaison within hospital emergency departments and the benefits of any new provision and make adjustments in the provision as necessary	Mar 2018	Mental Health Alliance
		Implement and evaluate the agreed priorities within the Transforming Care Partnership Plan	Mar 2018	Mental Health Alliance
		Implement an action plan to improve access to services and redesign pathways to improve access to timely intervention	Mar 2018	Mental Health Alliance

		We will monitor and improve the third sector specifications and outcomes and seek feedback	Mar 2019	Mental Health Alliance
		Evaluate the impact of the Future in Mind Plan and service specifications and continue to build upon our Transformation plans	Mar 2019	Mental Health Alliance
	Participation and life choices	Contribute to the Hampshire childhood obesity strategy and evaluate the impact of the 'Better Me' programme	Mar 2018	Prevention at Scale
		Begin to monitor trusts to ensure improvement of transition services against the service specification	Mar 2018	New Models of Integrated Care
		Improve the youth engagement and participation strategy, we will include various methodologies for engagement incorporating digital technology	Mar 2019	Digital/Prevention at Scale
		Review End of Life and Palliative care for children developing/amending contracts as necessary to ensure consideration of end of life and palliative care needs is embedded in everyday practice	Mar 2019	New Models of Integrated Care
Long term conditions, frailty and end of life care		Ensure provider compliance with end of life service specification	Ongoing	New Models of Integrated Care
		Collaborating with providers to deliver stroke service improvements - Review of Sentinel Stroke National Audit Programme working alongside Wessex Cardio Vascular Network for good practice	Ongoing	New Models of Integrated Care
		Increase awareness of diabetes, improve screening, care and quality of care for residents with or developing diabetes	Apr 2017	New Models of Integrated Care
		Develop a diabetic foot care multi-disciplinary team at UHSFT to provide equity across West Hampshire and actively manage foot ulcers	Apr 2017	New Models of Integrated Care
		Support primary care to improve the timeliness of diagnosing neurology pathology and imaging	Apr 2017	New Models of Integrated Care
		Identify further pathway improvements for people with comorbidities of COPD / asthma to optimise care	Apr 2017	New Models of Integrated Care

Agreement and implementation of joint clinical protocols between Community Integrated Respiratory Service, Primary care and Ambulance Service	Jun 2017	New Models of Integrated Care
Agreement and implementation of joint clinical protocols between Emergency Departments and Community Respiratory Services	Jun 2017	New Models of Integrated Care
Launch new hypertension intervention strategy focusing on identification/optimising management utilising enablers such as PRIMIS and Blood Pressure apps	Jun 2017	New Models of Integrated Care
Identify cohort of people with comorbidities of diabetes and CVD	Jul 2017	New Models of Integrated Care
Establish engagement with patient cohort to inform views on a proposed pathway for people with comorbidities of diabetes and hypertension	Sept 2017	New Models of Integrated Care
Twelve month evaluation of pilot for new Community Cardiology Service	Dec 2017	New Models of Integrated Care
Expand access to existing structured education for chronic pain, diabetes, cardiac and respiratory conditions to include digital and psychological support	Mar 2018	New Models of Integrated Care
Improve uptake of e-consult and social prescribing	Mar 2018	Digital/ New Models of Integrated Care
Expand current initiatives to support people with multiple long term conditions: more pharmacist support to GPs in localities, care home reviews, longer GP appointments structured education that is not disease specific	Mar 2018	New Models of Integrated Care
Introduce health coaching training for the health care workforce	Mar 2018	Workforce
Develop and implement a comprehensive frailty model focused on the reduction in ambulatory care sensitive conditions	Mar 2018	New Models of Integrated Care
Conduct a publicity campaign to raise frailty awareness and reduce social isolation	Mar 2018	New Models of Integrated Care

Negotiate into contracts and deliver a new end of life care specification	Mar 2018	New Models of Integrated Care
Develop a renal pathway to help to manage patients with renal complications as a result of diabetes	Mar 2018	New Models of Integrated Care
Review pre-conception care (for people with diabetes) at HHFT	Mar 2018	New Models of Integrated Care
Embed smoking cessation within service specifications	Mar 2018	Prevention at Scale
Progress commissioning of new community neurological rehabilitation service (subject to approval)	Mar 2018	New Models of Integrated Care
Potential procurement for full rollout of T2 Community Cardiology Service	Mar 2018	New Models of Integrated Care
Collaborating with providers to deliver stroke service improvements - implement intra-arterial therapy (IAT) within acute trusts	Mar 2018	New Models of Integrated Care
Collaborating with providers to deliver stroke service improvements - commission six month reviews across the breadth of the CCG	Mar 2018	New Models of Integrated Care
Appraise technologies that support self- management of long-term respiratory conditions, taking forward proposal to Clinical Cabinet	Jun 2018	New Models of Integrated Care
Review comorbidities associated with neurological condition and ensure pathways deliver best outcomes and value for money	Sept 2018	New Models of Integrated Care
Deliver quick seven days a week access for specialist services	Mar 2019	New Models of Integrated Care
Identify and implement pathway for people with comorbidities of diabetes and hypertension	Mar 2019	New Models of Integrated Care
Ensure adequate rehabilitation support services are commissioned to support those with long term neurological condition	Mar 2019	New Models of Integrated Care

Urgent and Emergency care	Urgent and emergency care	Work with partners to adopt the Safer, Faster, Better good practice detailed in the A&E Improvement in 2016/17 Rapid Implementation Guidance for local systems	Apr 2017	New Commissioning Models/ Solent Acute Alliance
		To monitor and have oversight of seven-day hospital services for all urgent network specialist services through contract Service Development and Improvement Plans which are agreed with each provider and will include mandated references to seven-day service implementation	Nov 2017	New Commissioning Models/ Solent Acute Alliance
		Initiate a cross-system approach to prepare for the forthcoming waiting time standard for urgent care for those in a mental health crisis by agreeing workforce development plans along with developing joint performance reporting between SHFT and HHFT/UHS and escalation procedures	Mar 2018	New Commissioning Models/ Solent Acute Alliance/Prevention at Scale
		Support delivery of the constitutional standards for four hour A&E and for ambulance response times, through continued monitoring of remedial action plans	Mar 2018	New Commissioning Models
		Implement local plans to reflect the STP work stream - Effective Flow and Complex Discharge – and achieve reduced delayed discharges from the acute sector to other care settings	Mar 2018	Effective Patient Flow and Discharge
		With partners hold public consultation on and agree the preferred option for configuration of acute services in North and Mid Hants	Mar 2018	North & Mid Hampshire
		Introduction of a new integrated NHS 111 service ensuring a 24/7 integrated care service for physical and mental health is available, including a clinical hub that supports NHS 111, 999 and out-of-hours calls	Jun 2018	New Commissioning Models
		Work with partners to adopt all of the NHS England Safer, Faster, Better good practice in delivering urgent and emergency care	Mar 2019	Effective Patient Flow and Discharge
Planned, Specialist and	Planned care	All routine follow-up appointments to be initiated by the patient as required and in conjunction with advice from clinicians empowering patients to take responsibility	Apr 2017	Effective Patient Flow and

Cancer Care		for their own care needs; this includes new models of conducting patient follow-up appointments including the up-skilling of lower banded staff, telephone and non-face to face consultations are to be inherent in delivering patient initiated follow-ups to make best use of clinical and financial resource		Discharge
		Develop Communication and Engagement Plan to support the 17/18 Commissioning Intention 3.6. 'Outpatients': All patients to be routed through the appropriate Tier 2 service where they exist	Mar 2018	Effective Patient Flow and Discharge
		Increase the proportion of patients routed through the Community Tier 2 services where they exist (i.e. Dermatology, ENT, MSK/Orthopaedics, vasectomy, diabetes and cardiology) and work with providers to improve integration and communication	Mar 2018	Effective Patient Flow and Discharge
		Redesign outpatient care in such a way that all feasible consultations, investigations and assessments will occur in one visit which will facilitate early diagnosis and management planning whilst reducing the need for return visits, excessive patient transport costs and lower rates of DNAs. Alternatives will be offered to ensure that consultations by telephone or other media are considered if appropriate	Mar 2018	New Models of Integrated Care
		Consolidate services, work through outstanding mobilisation issues and embed intermediate care services as a permanent fixture in our healthcare environment. Utilise the Carter Review and RightCare Commissioning for Value Pack to support the identification of opportunities to provide a more comprehensive Intermediate care offer	Mar 2019	New Models of Integrated Care
		Work with providers to undertake care redesign and identify additional services or pathways suitable for inclusion in new models whilst continuing to work with community providers to ensure best value for money and reduction in secondary care hospital based activity	Mar 2019	Effective Patient Flow and Discharge
		Engage with our hospital providers to identify further alternative ways or opportunities to deliver outpatient appointments in a different or more local way	Mar 2019	New Models of Integrated Care
	Specialist care	Information for patients which will be accessible, accurate and current so that they can participate in, and be supported to make informed choices and decisions about their care	Mar 2019	New Models of Integrated Care

	Cancer care	Hold providers to account for attainment (and ideally exceed) national cancer waiting time standards	Continuous	Prevention at Scale
		Regularly use the National Cancer Patient Experience Survey, organisations representing patients and carers, and direct involvement with patients to inform our actions	Ongoing	Prevention at Scale
		We will be continuing to implement the following improvements for 2 week wait patients - 2ww patient information letter has been re-written to improve attendance, is on DXS and is being translated into easy read version. Wessex wide 2ww referral forms have been put on DXS and promoted to practices, including NICE referral guidelines. Screening information leaflets in Easy Read versions to be promoted with practices, and gaps filled	Apr 2017	Prevention at Scale
		Creation of a register of practice cancer leads in order to cascade information and to receive issues raised by practices such as learning needs	Apr 2017	Prevention at Scale
		Work is ongoing to monitor the effectiveness of diagnostic pathways and highlight issues to locality directorates. Upper and Lower GI project underway, bringing together GPs, acute and community providers to maximise efficiency of pathways and improve communication between different parts of the system	April 2017	Prevention at Scale
		Detailed collation and analysis of various data sources in order to prioritise cancer pathways for improvement and highlight to locality directorates being reviewed monthly	April 2017	Prevention at Scale
		Introduce opportunities to promote smoking cessation and other brief interventions to reduce known risk factors in line with reducing smoking prevalence to below 13% nationally by 2020 – this includes working with 3rd sector organisations	Mar 2018	Prevention at Scale
		Facilitate engagement with training and resources for professionals to increase early detection – MacMillan lead GP visiting practices and targeting visits to practices with low screening rates including reminding them to conduct 6 month review	Mar 2018	Prevention at Scale
		Co-ordinate multi-stakeholder actions to provide elements of the recovery packages including physical activity, emotional and social support	Mar 2018	Prevention at Scale

		Improve support to carers and families using our contacts in NHS England and charity organisations	Mar 2018	Prevention at Scale
		Support the Wessex Cancer Network's presentations to schools	Mar 2018	Prevention at Scale
		Support Wessex Cancer Network's training for primary care staff to support them in difficult conversations with patients around lifestyle	Mar 2018	Prevention at Scale
		Take targeted actions to increase screening rates in areas of low uptake and reduce inequalities: a) connecting screening hubs to partners working with people with learning disabilities and mental illness b) developing communications aimed at these groups c) enabling care plans to be on patient record for improved continuity, working with our partners	Mar 2019	Prevention at Scale
		Reduce the number of cancers diagnosed in A&E departments through improved screening, diagnostics pathways, and facilitation of communication between referrers and providers, public awareness of risk factors, electronic availability of information for referrers	Mar 2019	Prevention at Scale
		Promote national awareness campaigns at a local level in relation to early signs of cancer, through messaging and support for early/direct access to diagnostics	Mar 2019	Prevention at Scale
		Ensure that routes to diagnostics are clear, effective and have sufficient capacity to accommodate demand, engaging with partners	Mar 2019	Prevention at Scale
		Identify pathway improvements and develop direct access and one-stop clinics, patient activated follow up appointments, remote surveillance and scope new developments such as patient held records and care navigators, using technology and engaging with a variety of partners for system-side improvements	Mar 2019	Prevention at Scale
		Encourage and support GP practices and providers to implement elements of the National Survivorship initiative (Recovery packages/strategic pathways) and cancer reviews in Primary Care and link with work in care homes	Mar 2019	Prevention at Scale
Organisational development	Development of wider	Extend the pilot of the early warning sepsis scoring within a care home, to other care homes in west Hampshire	Mar 2018	Workforce

and workforce	workforce	Promote sepsis recognition and promote the sepsis guidelines in primary care	Mar 2019	Workforce
		Continue to support TARGET events to deliver up to date and relevant training and development for GPs	Mar 2019	Workforce
	CCG staff	Train all staff in dignity and respect and increase awareness of the approach the CCG is taking	Apr 2017	Workforce
		Complete skills assessment for all staff and implement the results to ensure there is a comprehensive skills development programme for CCG staff	Apr 2017	Workforce
		Support and develop the staff forum for the organisation and identify training and development to enable them to effectively represent staff	Jun 2017	Workforce
		Implement a management development programme for new managers to support their transition into their new role	Sept 2017	Workforce
		Embed values into the recruitment process to deliver a robust values based recruitment plan. Ensure values are included in personal development reviews	Nov 2017	Workforce
		Review the health and wellbeing plan and seek to achieve the Health and Wellbeing Charter	Jan 2018	Workforce
		Review and further implement the CCG staff engagement plan identifying robust measurement and outcomes	Mar 2018	Workforce
		Develop an approach to co-production with staff and empower them to make the changes needed within their service area and the CCG as a whole	Mar 2018	Workforce
		Continue to provide opportunities for staff to come together both formally and informally through networking events, all staff events and briefings and social events	May 2018	Workforce
		Develop and implement the talent management programme across the CCG and within the primary care workforce	Sept 2018	Workforce
		Continue to utilise the result of the staff survey to make improvements to the CCG	Mar 2019	Workforce

Engagement	Engagement	Develop and agree a digital communication engagement plan to ensure that different channels and resources are being used to engage with local people	Sept 2017	Workforce
		Build relationships with mental health and learning disability groups to gain input from their members to understand how we can engage better with these groups	Oct 2017	Workforce
		Develop and support further initiatives to engage member practices in our work, including work with practice managers, locality directors and clinical leads	Nov 2017	Workforce
		To build on the staff engagement plan to enhance the overall staff experience and support wider engagement and involvement in the development of the CCG	Jan 2018	Workforce
		Develop a proactive approach to carer engagement making links with support groups and carers cafes to ensure their voices are heard and develop a specific work plan to engage young carers	Mar 2018	Workforce
		Work with local colleges to engage with young people to ensure they have a voice in local service development	Mar 2018	Workforce
	Patient involvement	Develop the health involvement network to ensure it is representative of the local community and is able to effectively engage with the CCG on service development and change	Mar 2018	Workforce
		Continue to work with Patient Participation Groups to develop them as an effective resource for GP practices	May 2018	Workforce
		Develop the Involvement Steering Group to extend its membership to include underrepresented groups and ensure it is an effective resource	Mar 2019	Workforce