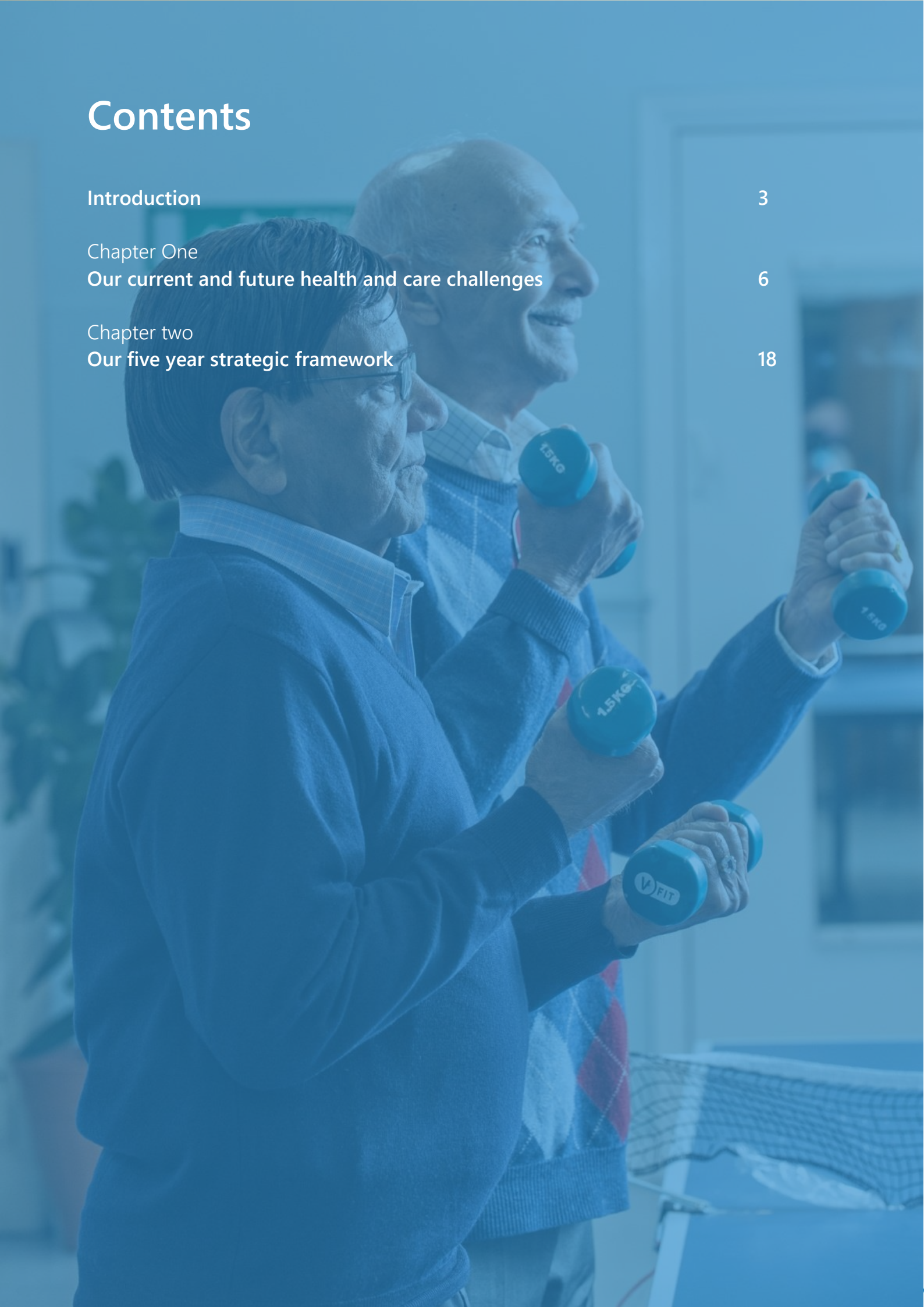
Transforming health and care outcomes for the people of Southampton

Our five year strategic plan
2019–2023

Contents



Introducing our five year strategic plan

Work started during the summer of 2018 on the preparation of a new five year strategy for health and care in the City. This involved detailed analysis into the health and wellbeing of the population, linked to deprivation and service use. In discussion with partners, it was agreed to develop a response to these needs that goes beyond the NHS into social care and wider, which can be owned by all of our partners in the City. It remains, nonetheless, a subset of the wider ten year strategy for health and wellbeing led by the Health and Wellbeing Board.

In early 2019, the NHS Long Term Plan (LTP) was published and it has been agreed that Southampton's strategic plan should also be the City's contribution to the wider Hampshire and Isle of Wight five year response to the LTP which is due later in Autumn.

Our strategic plan sets out a high level view of the challenges we face and proposes a framework to guide the activities of all partners over the next five years.

The strategic framework is summarised on page 20, including our proposed vision, goals, mission, programmes and enablers, and principles of working together. These have been widely supported and developed by partners.

The framework incorporates feedback from various system-wide bodies including:

- Health and Wellbeing Board
- Joint Commissioning Board (JCB)
- Southampton System Chiefs Group
- Southampton Connect
- Better Care Steering Board
- Health Overview and Scrutiny Panel (HOSP)

We have held two partnership conferences on the theme of the emerging strategy, on 29 March and 8 May 2019.

A community engagement event was held on 20 November 2018 to support increased public participation in the development of the strategy. Alongside this, opportunities have been taken to share information and invite discussion of the emerging plans with Healthwatch, the CCG Patients' Forum, Southampton Voluntary Services (SVS) and a wide variety of other community groups. Public involvement will be an ongoing feature of the way we work.

Looking back

2018/19 was the final year of the CCG's five year strategy and, similarly, of our two year operational plan. Since summer 2018, we have been undertaking a stocktake of our position and reviewing the outcomes and prospects for our population.

First, we reviewed the outcomes of our CCG strategy published in 2014. There were eight outcome indicators we set:

- Improved patient safety and user experience
- Reduced inequalities in life expectancy
- Reduced avoidable emergency admissions*
- More older people living independently (91 days after reablement)*
- Fewer permanent admissions to nursing and residential homes*
- Fewer delayed transfers of care*
- Reduced injuries dues to falls in people aged over 65*
- 20% productivity improvement in elective care

*Outcomes marked with an asterisk were also outcomes we specified in the Better Care Plan

The results of our stocktake were mostly positive. We considered whether we had done what we said we were going to do, if not why not, and what had we learned in the process.

Whilst we have done relatively well on our own terms as a CCG, we wanted to focus on our challenges as a City.

We looked at what had happened to our population over the last few years. We were able to review how deprivation across the city has affected health, such as disease prevalence, and utilisation of healthcare services in the city (for example, emergency hospital admissions). This revealed a stark picture of growing inequalities across the city and gaps in life expectancy.

We also reconfirmed that the City performs poorly by comparison with our statistical neighbours and nationally. For example, Southampton is ranked second worst of our 10 comparator CCGs and 35th worst out of all 201 CCGs in terms of inequalities in the rates of emergency admissions for certain urgent care sensitive conditions. This gives us a powerful indicator of where we need to focus over the next few years.

The analysis into rates of emergency admissions is particularly useful as an indicator of need (assuming people are only admitted to hospital as emergencies if they are seriously unwell) as opposed to demand (which may be influenced by the convenience of access, for example, to A&E). We found that the most deprived areas of the city were also the places with the highest rates of emergency admissions. These admissions are probably a good indicator of where we are failing to prevent ill health or to provide planned care interventions that could have avoided an emergency admission.

Thus, if we can target what we do to focus on improving access to prevention and earlier, planned intervention in these areas of the city, we may reduce the inequalities gap and improve health outcomes overall.

Our analysis also enabled us to see at a detailed population level how varied health and healthcare usage is across the City. We were able to break down admissions by age, gender and ethnicity for different health conditions (e.g. cardiac, respiratory, diabetes and mental health). This analysis provides each of the six health and care clusters with rich data about the particular challenges for their local populations.

We have also been able to look at population and long term conditions projections for the period ahead to help predict future healthcare demand, and demand for social care.

Broadening the scope

It has become apparent that to understand what is happening to our population in the city, we need to look wider than just health. The picture of increased deprivation and its palpable impact on health, and of widening inequalities between different communities, raises challenges about the resilience of the population as a whole. It also means we have to take a system-wide perspective in our plan for the next five years.

First, this plan has to be a plan for social care too. It is true that the quality and capacity of social care provision has an important impact on the health service. It is also argued that whilst initiatives to fund directly, or transfer funding

from the NHS to social care, have tended to be focussed on initiatives to get people home from hospital, this may have skewed social care priorities. This means that the years of reductions to local government funding of social care have cut even deeper into the provision of 'core' social care which helps to keep people healthy and independent.

But social care is not just there to support the NHS. It has a huge value in its own right as part of the fabric, the social solidarity, of society as a whole.

Evidence suggests there has been a serious deterioration in the mental and emotional wellbeing of people living in the City, whereby mental wellbeing is now increasingly a factor in people's presenting needs across every aspect of healthcare. So, the plan has to be a plan for health and wellbeing.

Furthermore, we know that communities themselves, and wider civil society (including police, fire and rescue, probation, education, employment support, housing and so on) have a huge role to play in the determinants of health and wellbeing. The plan has to be relevant to and owned by communities and partners right across the City as a whole.

The NHS often struggles to comprehend the meaning of 'place', assuming instead our health planning is all about hospitals and healthcare institutions. This would be to miss the point on so many levels. This is why we are passionate about our One City approach: the importance of engaging, mobilising and galvanising a wide range of partners including citizens themselves, to develop and be part of implementing the plan for the next five years and beyond.

Looking Forward

This has generated some constructive discussions with our health and care partners and a shared intention to develop a new five year strategy for health and care in the city as a whole. At the end of March 2019, we held a partnership conference to take stock of our emerging city strategy and to invite partners to own and commit to its development.

In January 2019, we received the new Long Term Plan from NHS England which has been prepared in response to the Prime Minister's announcement in May 2018 of a five year funding settlement of £20 billion in return for which it is clear that the Government expects to see NHS provider finances restored to balance, NHS Constitution standards performance recovered, and other improvements.

Alongside the development of the new five year strategy for the city as whole, we agreed that 2019/20 would be the right time to also review the CCG's primary care strategy. With the recent publication of the new GP contract, including ambitious plans for investing in new workforce and the development of primary care networks (PCNs), primary care development will be a major focus this year.

The October 2018 Planning Letter sets out the expectation that local areas will prepare their five year plans during the first half of 2019, due in Autumn.

2019/20 begins the new period in our work to improve health and wellbeing in the city.

Chapter One

Our Current and Future Health and Care Challenges

Deprivation & Health Inequalities in Southampton

Deprivation

The Index of Multiple Deprivation (IMD) measures deprivation for small areas at a neighbourhood level. In Southampton, there are 148 small neighbourhoods, of which each has a deprivation ranking.

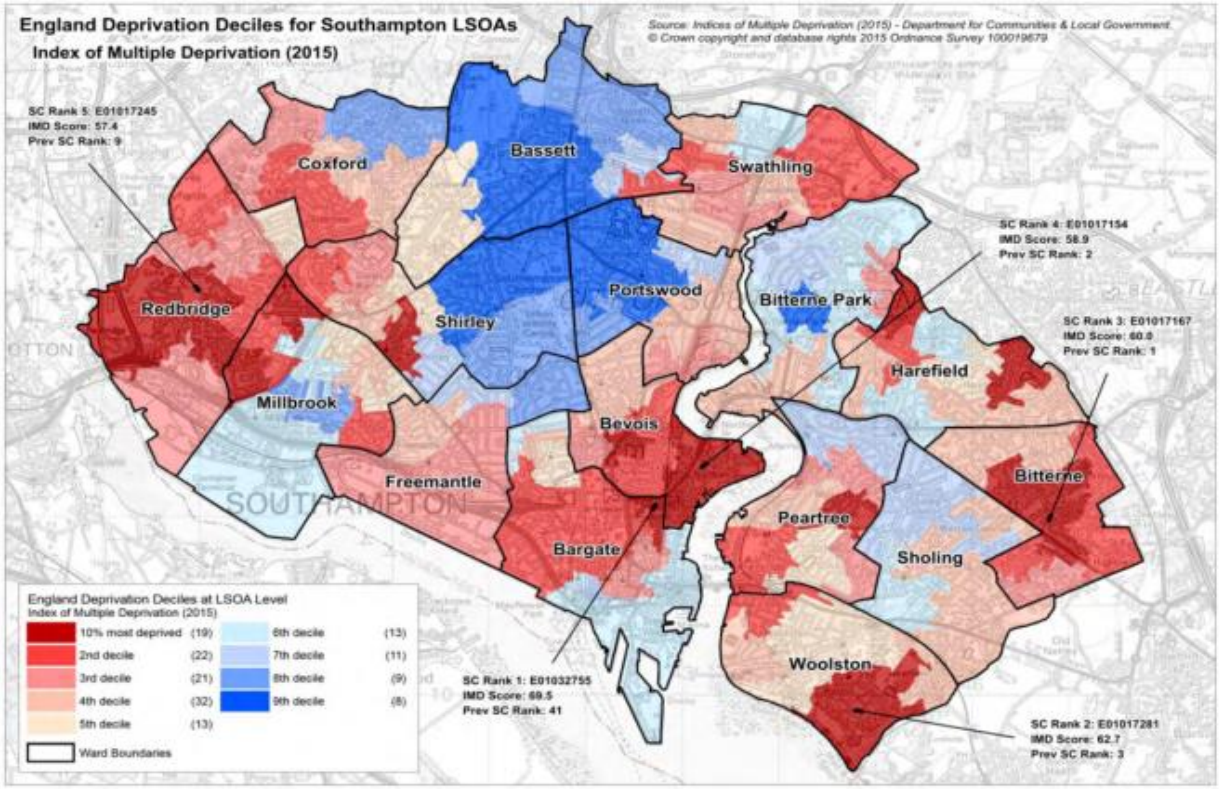
The map below show levels of deprivation across the city. The darker shades of red indicate areas in Southampton which fall into the 10 per cent most deprived neighbourhoods nationally. The darker shades of blue indicate areas in Southampton which fall into the least deprived neighbourhoods nationally.

In Southampton, 19 of the 148 neighbourhoods fall into the 10 per cent most deprived neighbourhoods nationally.

Overall, Southampton is ranked the 54th most deprived local authority out of 326 local authorities in England.

There is a common misconception that deprivation means how affluent an area is. To some extent this is true, however the IMD measures seven domains which contribute to deprivation (weightings in percentages):

- Income (22.5 per cent)
- Employment (22.5 per cent)
- Education (13.5 per cent)
- Health (13.5 per cent)
- Crime (9.3 per cent)
- Barriers to housing and services (9.3 per cent)
- Living environment (9.3 per cent)



Health Inequalities

"Inequalities are a matter of life and death, of health and sickness, of wellbeing and misery. The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health. Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age."
The Marmot Review, 2010

In Southampton, deprivation and health inequalities are inextricably linked – inequalities in health result from inequalities in society. In a fair society, health outcomes would be equal for people living in the most and least deprived areas of the city. However, there is a social gradient in health – the lower a person's social position, the worse his or her health. The existence of health inequalities in Southampton means that the right of our residents to the highest attainable standard of physical and mental health is not being enjoyed equally across the population.

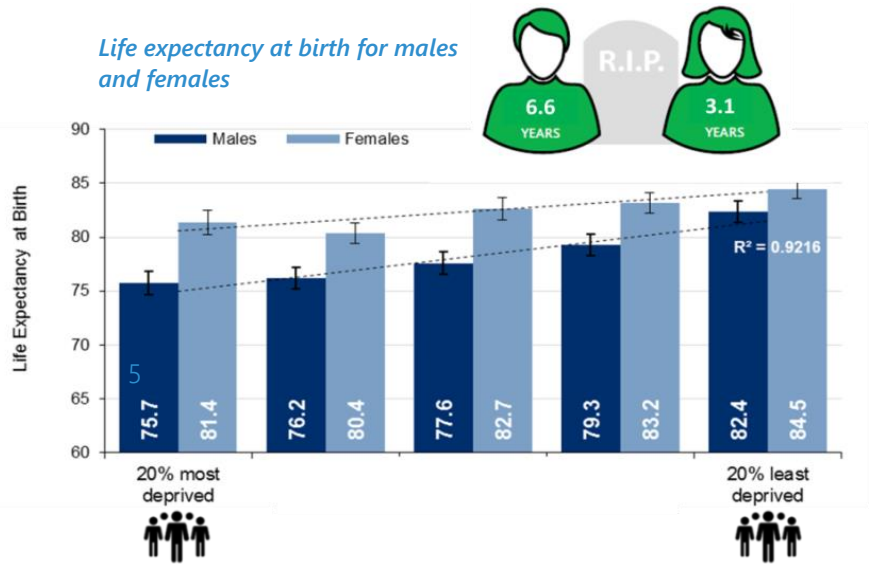
The social gradient in heath in Southampton is demonstrated in the following graphs which show that inequalities in health are related to inequalities in social status.

Inequalities in Life Expectancy

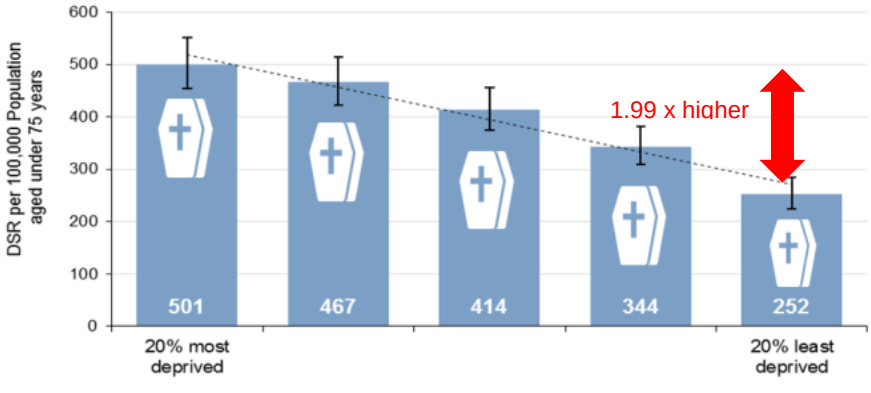
In Southampton, people living in the most deprived areas of the city **die earlier** than those living in the least deprived areas. Males living in the most deprived areas of the city are likely to die 6.5 years earlier than males living in the less deprived areas of the city. Females living in the most deprived areas of the city are likely to die 3.1 years earlier than females living in the less deprived areas of the city.

Premature deaths (defined as deaths under the age of 75 years) from all causes are twice as high in the most deprived areas of the city than the least deprived areas of the city.

Life expectancy at birth for males and females



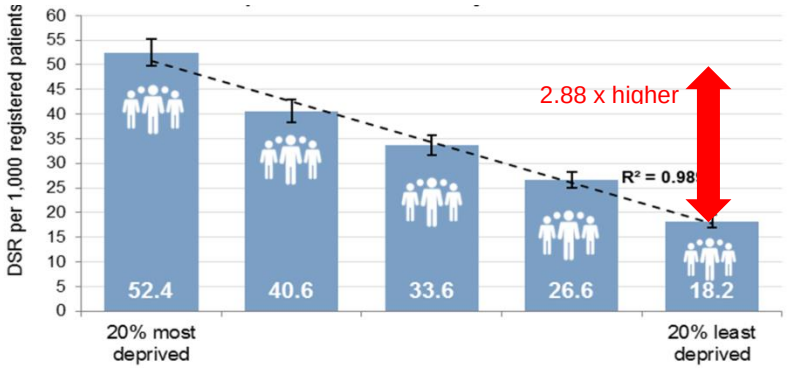
Premature deaths from all causes



Inequalities in Long Term Conditions

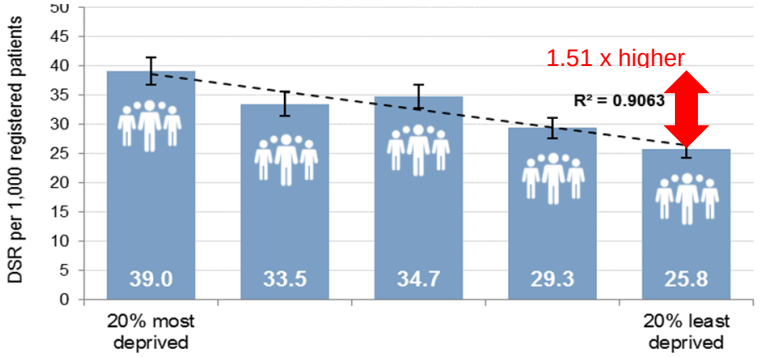
Prevalence of Chronic Obstructive Pulmonary Disease (COPD) is nearly three times higher in the most deprived areas of the city compared to the least deprived areas.

Chronic Obstructive Pulmonary Disease (COPD) Prevalence



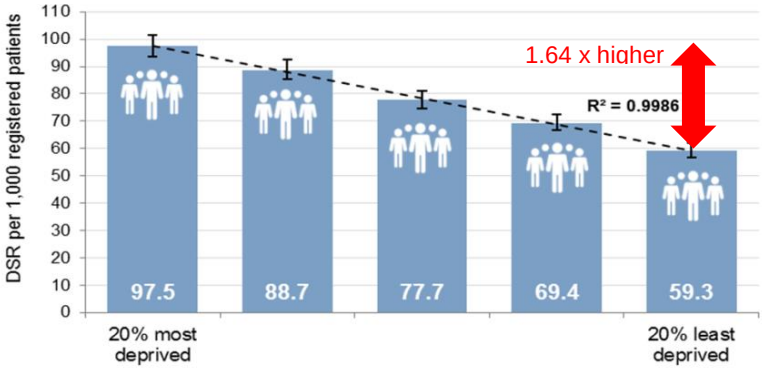
Prevalence of Coronary Heart Disease (CHD) is one and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Coronary Heart Disease (CHD) Prevalence



Prevalence of Diabetes is over one and a half times higher in the most deprived areas of the city compared to the least deprived areas.

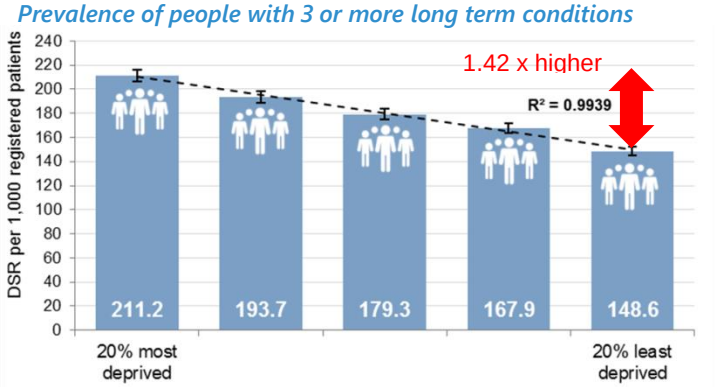
Diabetes Prevalence



Inequalities in Multi-morbidity

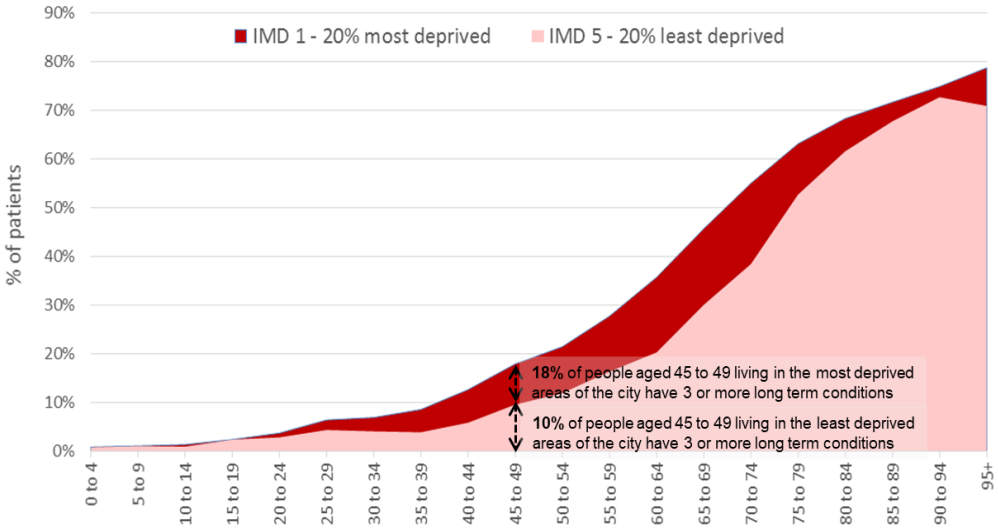
The prevalence of people living with multiple long term conditions (multi-morbidity) is higher in the most deprived areas of the city compared to the least deprived areas. For example, prevalence of people with three or more long term conditions is nearly one and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Prevalence of people with 3 or more long term conditions



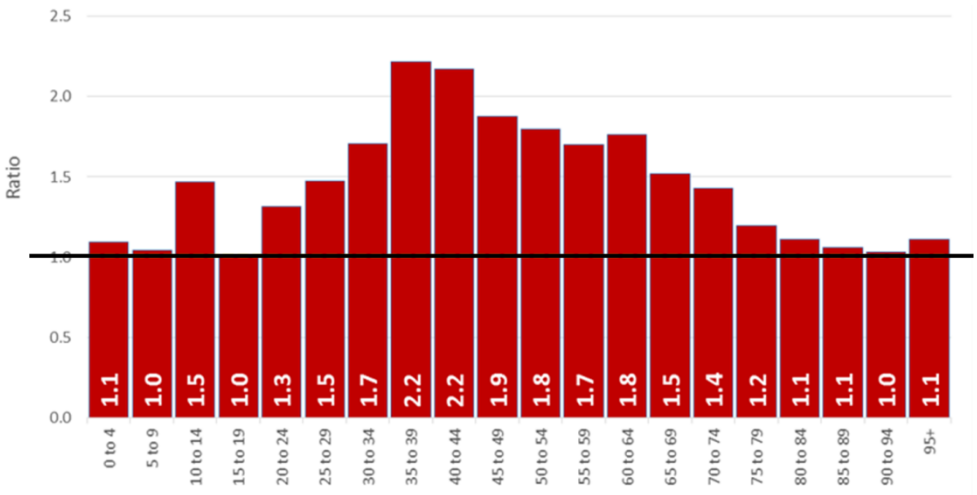
This graph shows the proportion of people in Southampton with three or more long term conditions, by age group. Importantly, it shows the proportions by deprivation group. For example, 10% of people aged 45 to 49 living in the least deprived areas of the city have three or more long term conditions, compared to 18% in the most deprived areas.

Proportion of people with 3 or more long term conditions, by age group



This graph demonstrates a similar trend. It shows how many times higher the prevalence is for people living in Southampton with three or more long term conditions in the most deprived compared to the least deprived areas. For example, it shows that for the 35 to 39 year old age group, prevalence of multi-morbidity is more than two times (x2.2) higher in the most deprived areas of the city compared to the least deprived areas.

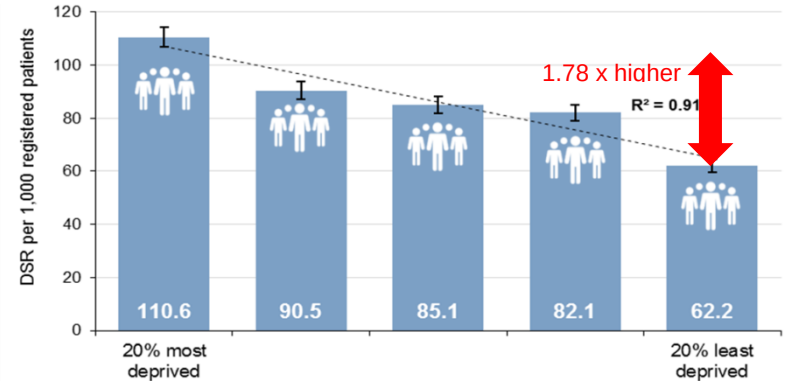
Proportion of people with 3 or more long term conditions, by age group: how many times higher in the most deprived areas of the city



Inequalities in Mental Health

Prevalence of Depression is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Depression Prevalence



Prevalence of Schizophrenia is nearly three times higher in the most deprived areas of the city compared to the least deprived areas.

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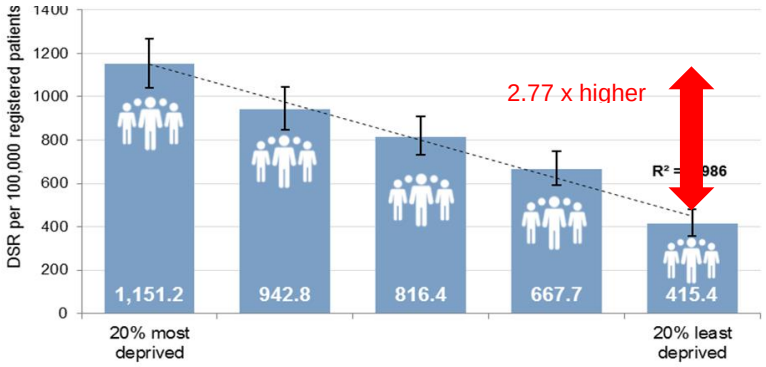
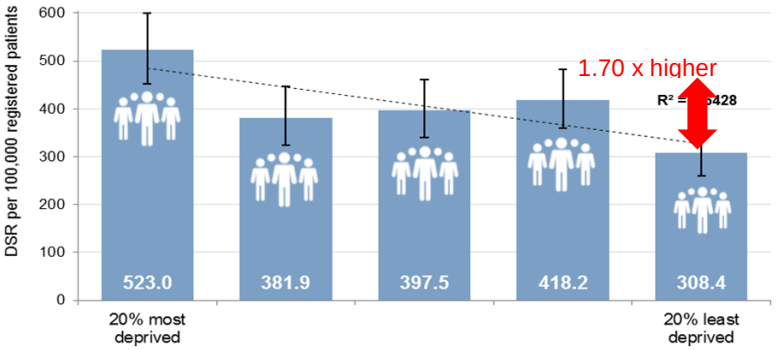
Schizophrenia Prevalence



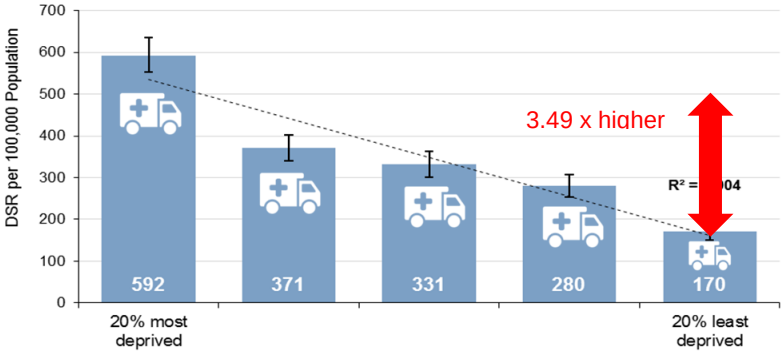
Prevalence of Bipolar Disorder is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Bipolar Prevalence



Emergency admissions as a result of intentional self-harm are three and a half times higher in the most deprived areas of the city compared to the least deprived areas.

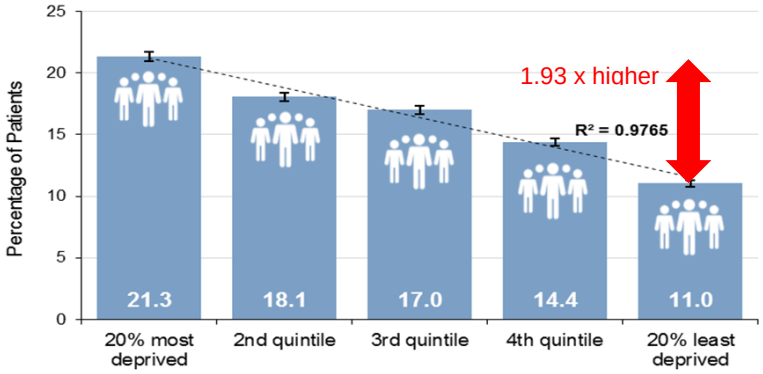
Intentional self-harm emergency admissions



Inequalities in Health Behaviours

Prevalence of Smoking is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Smoking Prevalence



Prevalence of inactivity is over two and a half times higher in the most deprived areas of the city compared to the least deprived areas.

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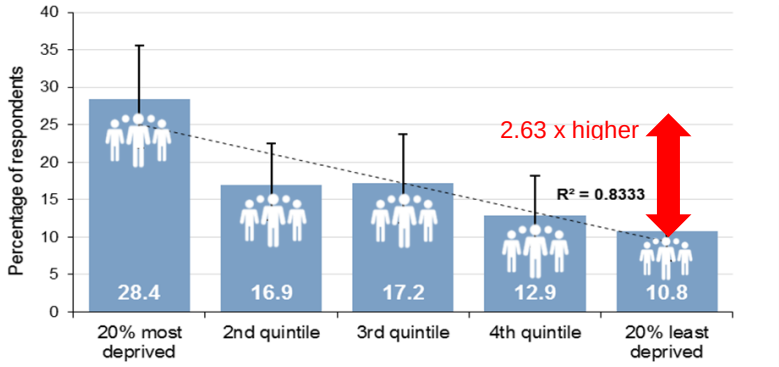
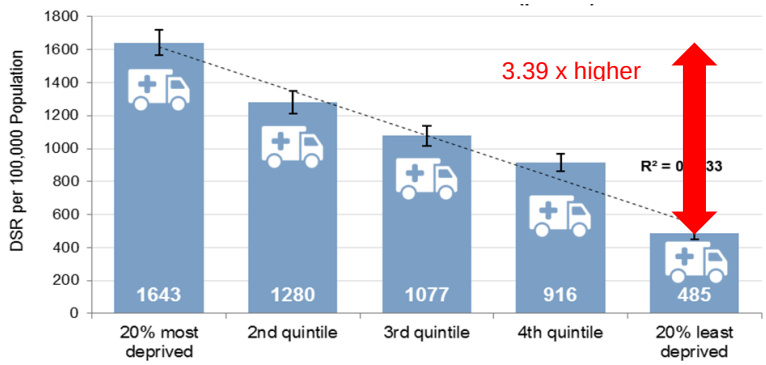
Inactivity Prevalence



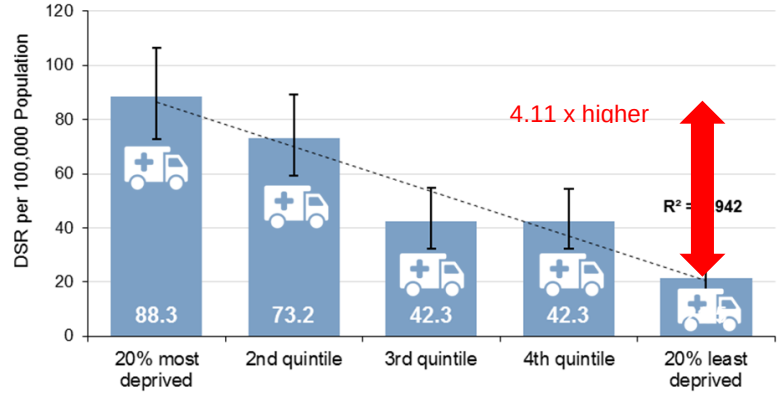
Emergency admissions from alcohol-specific conditions is nearly three and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Emergency admissions from alcohol-specific conditions



Emergency admissions as a result of poisoning from illicit drugs are over four times higher in the most deprived areas of the city compared to the least deprived areas.

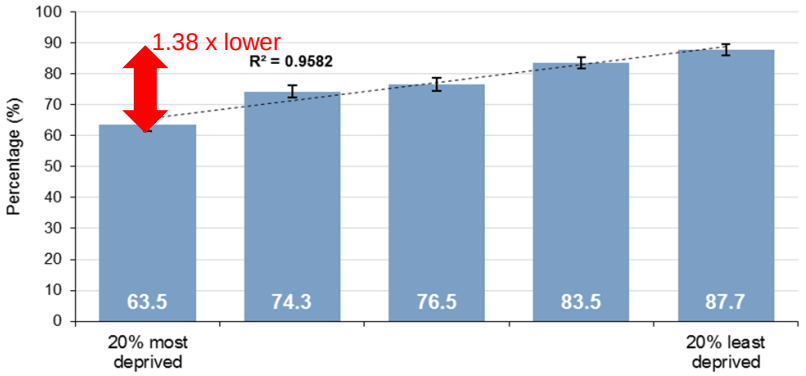
Emergency admissions from poisoning of illicit drugs



Inequalities in Healthy Start in Life

Prevalence of mothers breastfeeding is almost one and a half times lower in the most deprived areas of the city compared to the least deprived areas.

Breastfeeding Prevalence



Prevalence of mothers smoking during pregnancy is over four times higher in the most deprived areas of the city compared to the least deprived areas.

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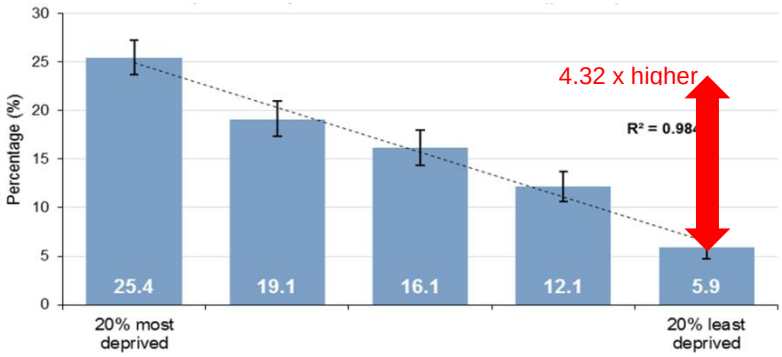
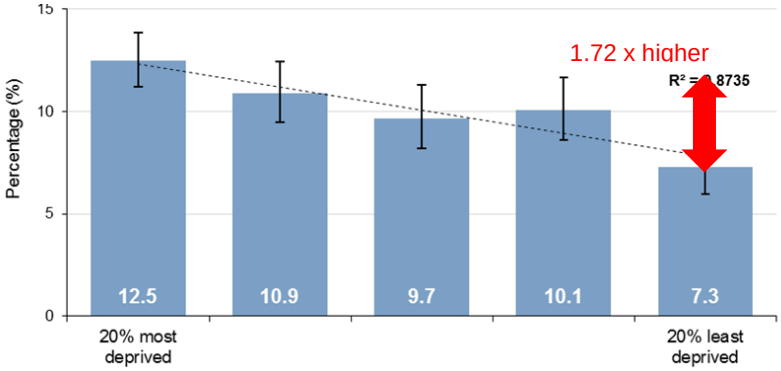
Smoking during Pregnancy Prevalence



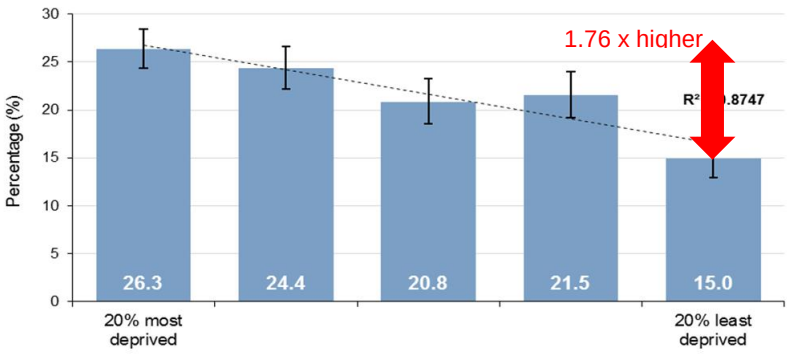
Prevalence of children considered to be obese in Year R is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Year R Obesity Prevalence



Prevalence of children considered to be obese in Year 6 is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

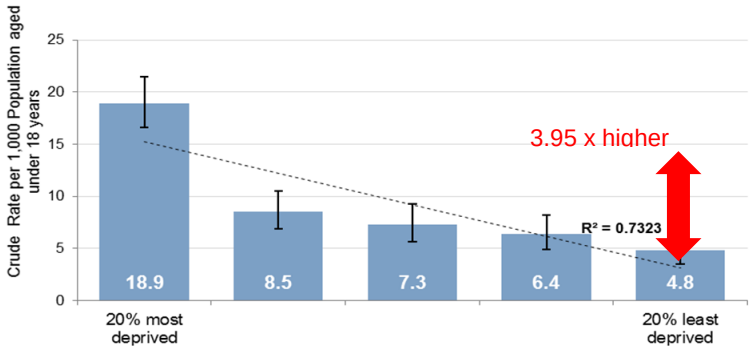
Year 6 Obesity Prevalence



Inequalities in Wider Determinants of Health

The rate of looked after children (children in care) is nearly four times higher in the most deprived areas of the city compared to the least deprived areas.

Rate of looked after children



Prevalence of children living in poverty is nearly five times higher in the most deprived areas of the city compared to the least deprived areas.

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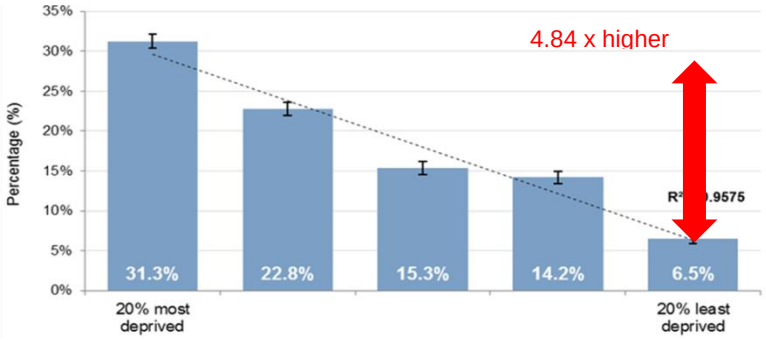
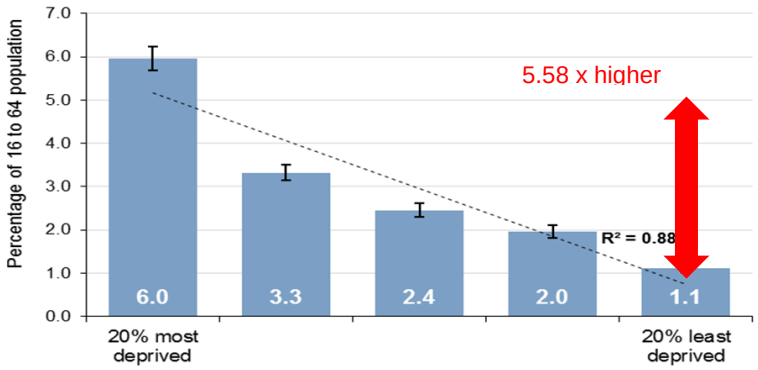
Children living in poverty



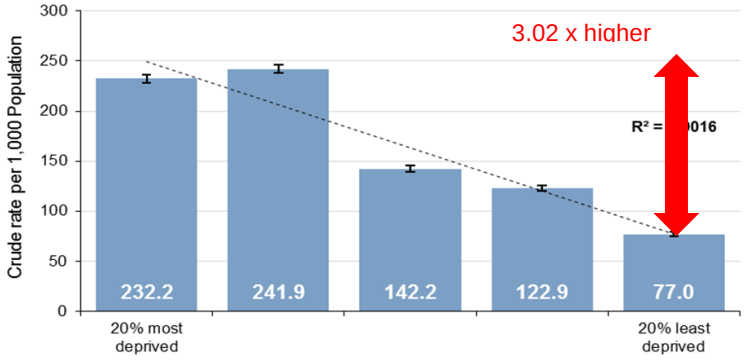
Prevalence of people claiming out of work benefits is five and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Claimants of out of work benefits (aged 16 to 64)

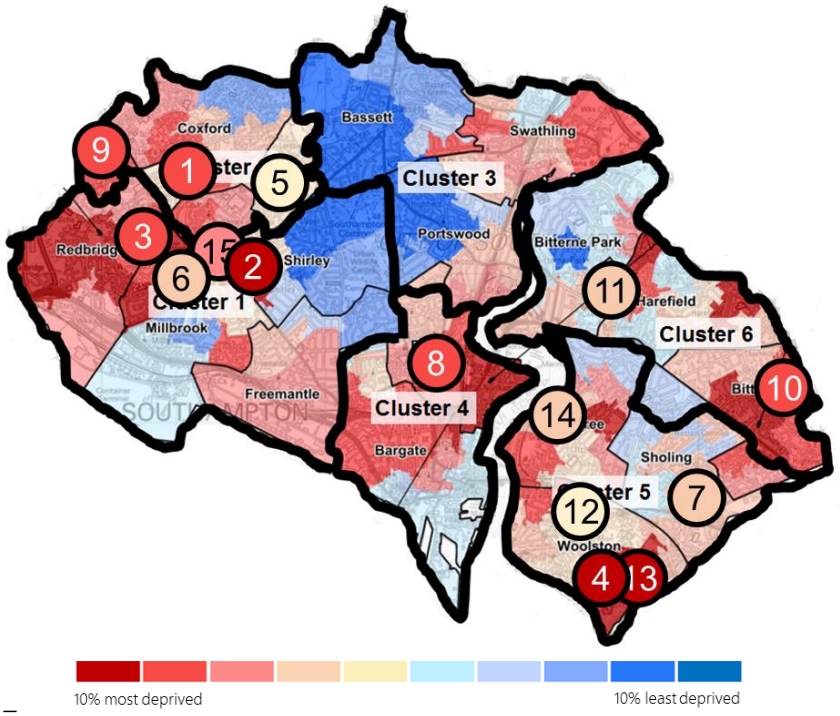


Prevalence of police recorded crime is three times higher in the most deprived areas of the city compared to the least deprived areas.

Police recorded crime



How is deprivation affecting healthcare usage?



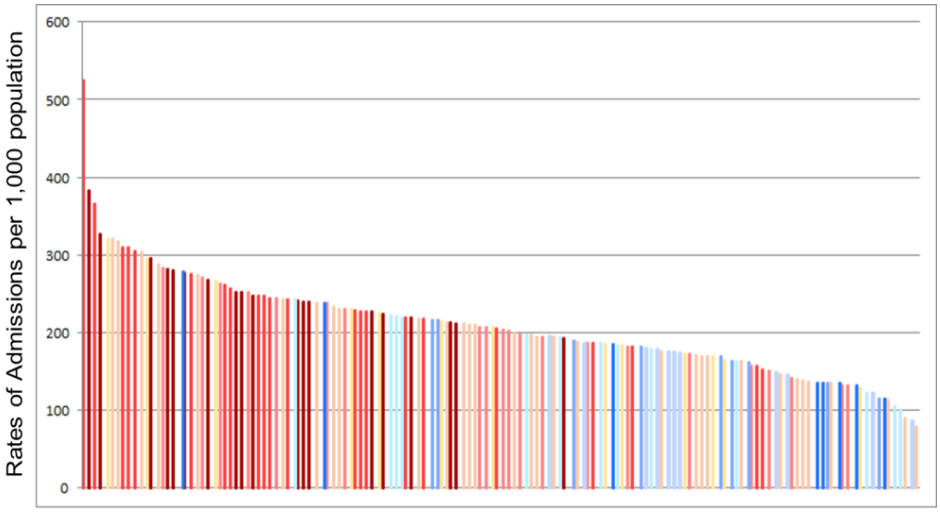
In Southampton, there is a strong link between deprivation and rates of urgent healthcare usage. We have found that areas of the highest deprivation are also the places with the highest rates of emergency admissions.

The map on this page shows the 15 neighbourhoods in the city with the highest rates of emergency admissions per 1,000 population. The graph then shows the rates of emergency admissions for all 148 neighbourhoods in Southampton – this shows that the more deprived areas of the city have (red shades) have higher rates of emergency admissions than the less deprived areas of the city (blue shades).

The analysis is particularly useful as an indicator of need (assuming people are only admitted to hospital as emergencies if they are seriously unwell) as opposed to demand (which may be influenced by the convenience of living close to the hospital).

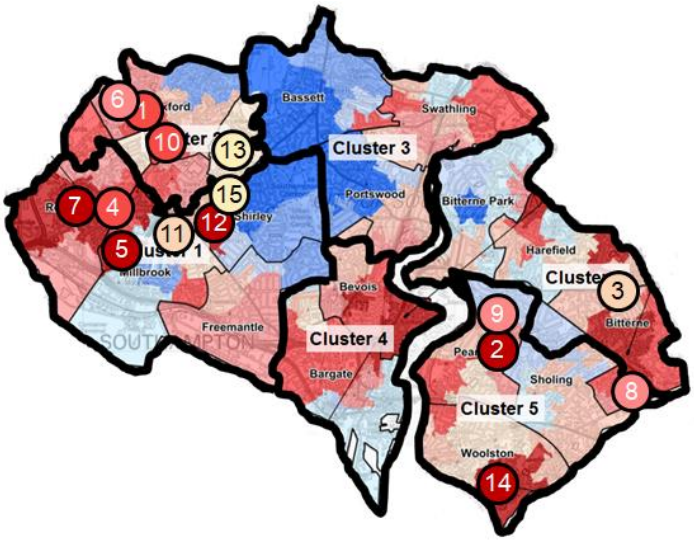
This analysis is also a good indicator of where we our local health and care system is failing to prevent ill health or to provide planned care interventions that could have avoided an emergency admission.

Thus, if we can target what we do to focus on improving access to prevention and earlier, planned intervention in these places, we may reduce the inequalities gap and improve health outcomes overall.

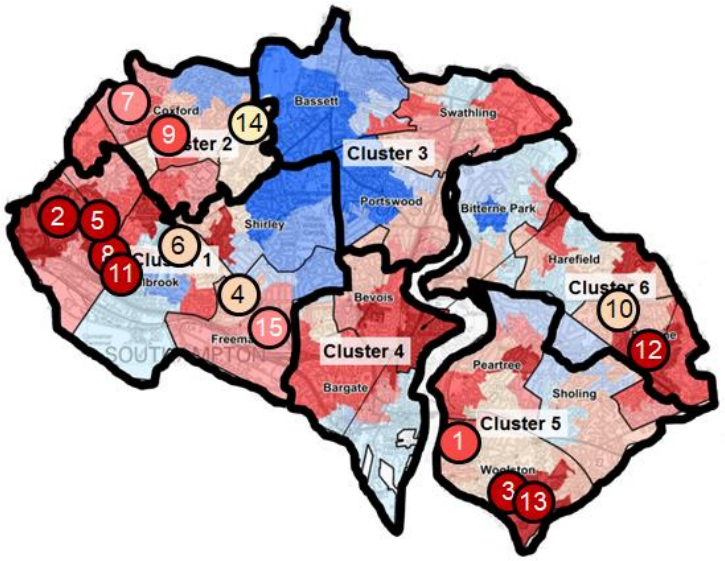


Our analysis has also enabled us see which areas of the city have the highest rates of emergency admission for certain conditions. A few examples are shown below and show a similar trend that the highest rates of emergency admissions are from more deprived areas of the city.

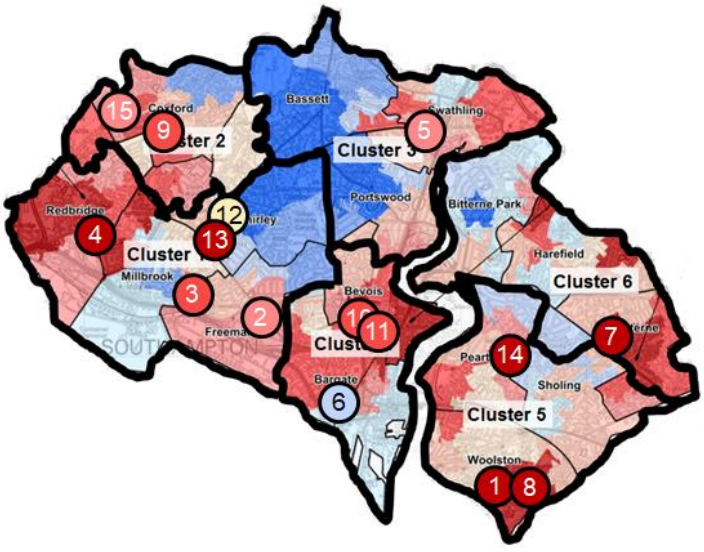
Emergency Admissions for Chronic Obstructive Pulmonary Disease (COPD)



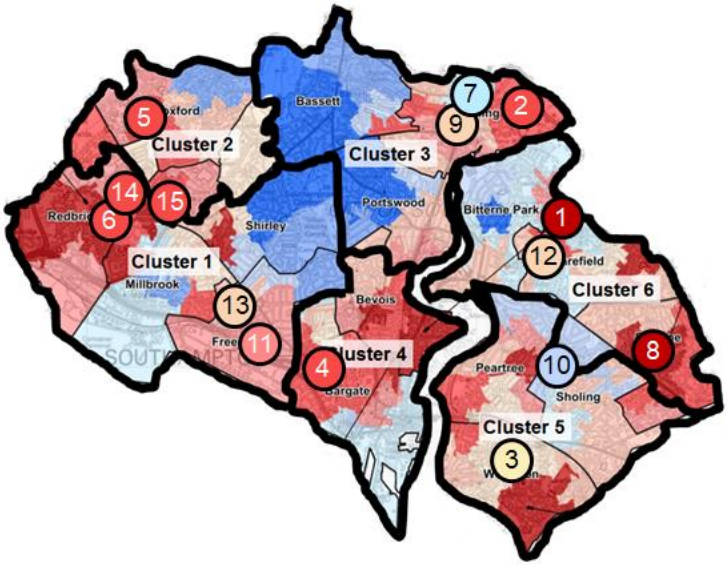
Emergency Admissions for Abdominal Pain



Emergency Admissions for Acute Mental Health Crisis



Emergency Admissions for Cellulitis



Future Health and Care Challenges

Population growth

In Southampton, it is estimated that between 2018 and 2024, the city could have 12,300 more residents. This is equivalent to a 4.8 per cent increase.

By age group:

2,730 more children and young people (5.5 per cent increase)

4,530 more working age adults aged between 18 and 64 (2.7 per cent increase)

5,030 more older people aged over 65 (14.5% increase)

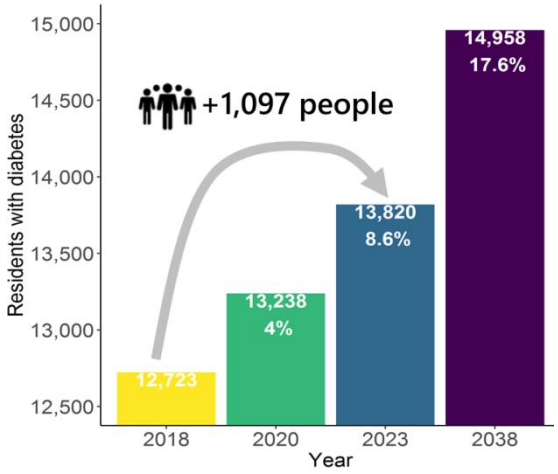
The age group with the biggest percentage increase will be the older population, and we know that a growing and ageing population will add more pressure onto the city's health and care services.

Long term conditions

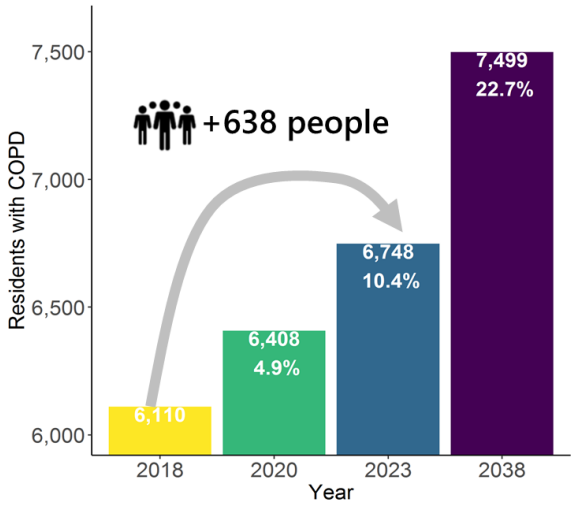
By combining population estimates with current trends in long term conditions, we have been able to forecast increases in long term conditions for our population.

The graphs show the forecast increases in the number of residents with long term conditions, against a baseline of 2018.

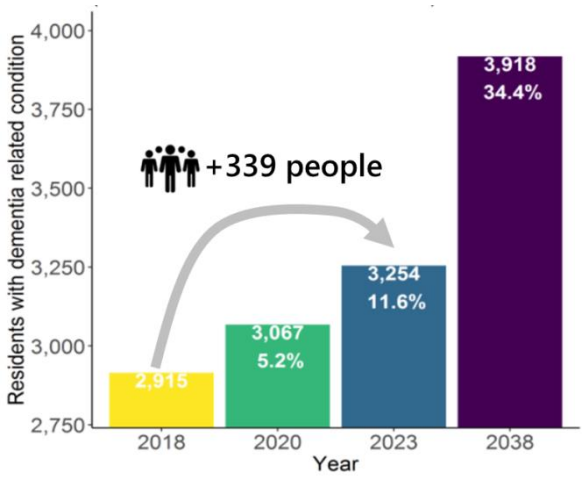
1,097 more people with diabetes



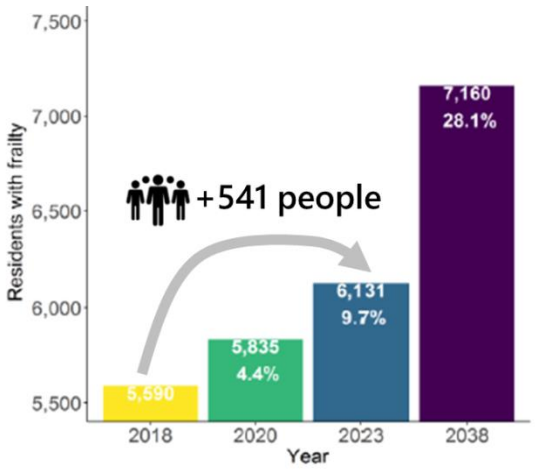
638 more people with COPD



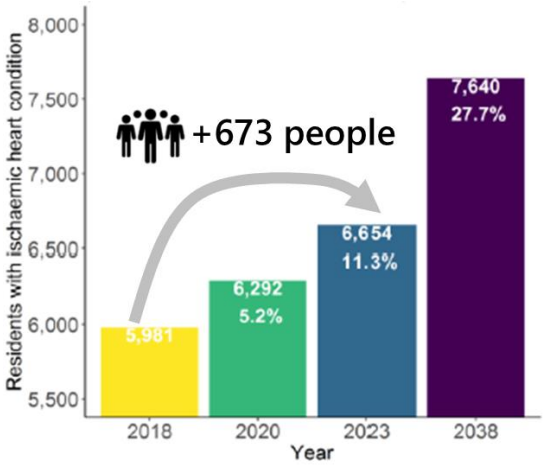
339 more people with dementia



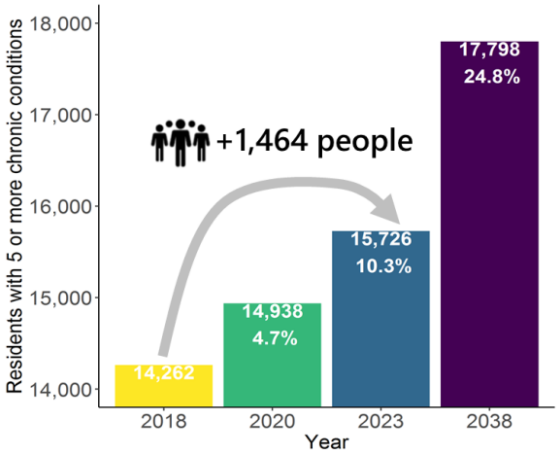
541 more people with frailty



673 more people with coronary heart disease



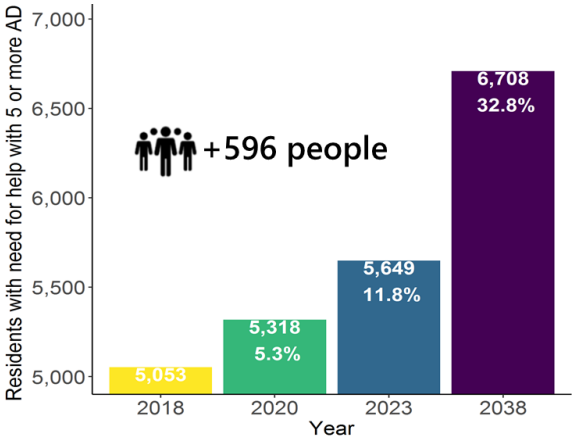
1,464 more people with five of more long term conditions



Adult social care

By combining population estimates with current trends in adult social care demand, we have been able to forecast increases in people needing adult social care support.

The number of people needing home care support with five or more activities of daily living (such as bathing, using the stairs, getting dressed) is estimated to increase by 596 people between 2018 and 2023.



Chapter Two

Our five year strategic framework

Transforming health and care outcomes for the people of Southampton

Our five year strategic framework (2019-2023)

Our Vision

One city, our city, a healthy Southampton where everyone thrives

Our Goals

- **Reduce health inequalities and confront deprivation**
- **A strong start in life for children and young people**
- **Tackle the city's three 'big killers': Cancer, Circulatory diseases and Respiratory diseases**
- **Improve whole-person care**
- **Improve mental and emotional wellbeing**
- **Build resourceful communities**
- **Reduce variation in quality and productivity**

Our Mission

Effective system partnerships delivering safe, sustainable, coordinated care with the people of Southampton

Our Goals

Reduce health inequalities and confront deprivation. Whilst most of the wider determinants of health are beyond the scope of health and care services, the data we now have about the distribution and characteristics of social deprivation across the City means we can get much more scientific about the way we target our limited resources to where they can have the maximum benefit.

A strong start in life for children and young people. Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. We want Southampton to be a city where children and young people get a strong start in life, are able to fulfil their potential and become successful adults who are engaged in their communities.

Tackle the city's three 'big killers'. In Southampton, the three big killers – cancer, circulatory diseases and respiratory diseases – account for most deaths. The Department of Health estimates that two thirds of premature deaths among under-75s in England are preventable. We want to take stronger action on improving prevention and encouraging healthy lifestyle changes to reduce smoking, obesity and alcohol consumption.

Improve whole-person care. In Southampton, by age 45-49 a quarter of our population have two or more long term conditions. Multi-morbidity is higher in the most deprived areas of the city. This means that our services need to fundamentally change, from treating single illnesses, towards supporting people in a more joined up way to live with their long term conditions.

Improve mental and emotional wellbeing. This is summed up well by the phrase, 'No Health Without Mental Health'. Mental health services are a high priority. Beyond this. mental and emotional wellbeing is demonstrably now such an all pervasive issue that our approach has to be about recognising the mental health dimension of everything we do and seeing it as an indispensable part of every interaction that health and care professionals, and citizens have with each other.

Build Resourceful Communities. This is about 'Getting Behind People'. Individuals and communities have 'agency' and are willing and able to help themselves; the job of public services might be more about 'standing behind. For example, in 2014/15, the residents of Newtown mobilised themselves to stop 'Immigration Street', but the support of every part of the public sector and business community (Southampton Connect) made them feel strong enough to make it happen.

Reduce variation in quality and productivity. Tackling unwarranted variation to improve outcomes and achieving excellence in quality of care.

Better Care Southampton

Our aim is to further enable the delivery of the One City vision: specifically a place-based approach that is fully inclusive of City partners, not just the NHS. This is about partnership, not structure. It is also easy to overlook the obvious and to assume the existence of an implicit consensus means that improvement and change will happen. Just because 'Better Care' is the bedrock of our established approach, we need to be realistic about how much remains to be done to achieve its aims.

Integration is one of those terms so overused that we are at risk of losing its meaning. We also need to recognise that integration is only a means to an end, not an end in itself.

The Southampton integration vision has evolved and is well established locally, characterised by strong and inclusive partnerships built painstakingly over several years. It is essentially very simple, based on Better Care, which has given us a strong sense of united purpose around care that is joined up and co-produced with people.

The original 2014 Better Care Southampton plan was based on the notion of integrated person centred care, with outcomes for people derived from the national 'I statements' and structured around a 'three legged stool' concept:

- cluster based teams, embedded in communities, of integrated primary, community, social and mental health care
- integrated discharge, rehabilitation and reablement (realised in 2016 by the creation of the Urgent Response Service)
- building community capacity

This has shaped our work programme ever since.

The compelling case for integration hinges in the fact that the City has 123,000 people (46%) living with a long term condition. Whilst multi-morbidity increases substantially with age, this is not just a problem of old age. By the age of 45, half the population has at least one long term condition. This means that our services need to fundamentally change, from treating single illnesses towards prevention and early intervention outside of hospital, but also towards supporting people in a more joined up way to live with their long term conditions.

We see integration as a means to improve people's outcomes, not an end in itself. No-one has to participate, but neither do they have a veto. Our approach is about working together effectively rather than pursuit of organisational goals. Similarly we do not feel constrained by any particular contractual tools and inter-organisational arrangements may be facilitated by both informal and formal arrangements to manage risk and express accountability in the interests of the people of the city

Integration is not the same thing as collaboration, neither does it equate to the absence of competition or an end to procurement. Some legal changes to competition requirements might be helpful but even the Health and Social Care Act 2012 already places on all parties a duty to provide services 'in an integrated way'.

Better Care Southampton

Better Care has evolved since 2014 from a programme into an all-pervading approach. Thus, at the heart of our strategy is the Better Care Southampton Programme, which has three main areas of focus:

- **Promoting independence and wellbeing**
- **Timely and appropriate access to care and support**
- **Proactively joining up care across health and social care, physical and mental health and primary and secondary care.**

Workstreams:

- Maternity
- Sexual Health and Teenage Pregnancy
- Improving outcomes for children with SEND
- Prevention & early help for children & families
- Addressing the needs of high intensity users (HIUs)
- Transforming Care for people with Learning Disabilities
- Community Solutions
- Housing related support and homelessness
- Personal health budgets
- Implementing the city's frailty model
- Enhanced Health Support in Care Homes (EHCH)
- Supporting appropriate timely discharge & out of hospital model
- Home Care
- Housing with Care
- End of Life and Complex Care

Start Well

Children and young people get the best start in life, providing the foundation to ensure they are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives.

Live Well

Individuals and communities thrive and are resilient with access to health and care services, good jobs, affordable housing, leisure activities, lifelong training, education and learning.

Age Well

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks.

Die Well

Supporting people to have the best opportunities in their last years of life, by reconceptualising death and dying to be part of the norm by discussing and capturing end of life wishes.

Our Programmes & Enablers

A key next step in evolving the strategic plan will be the development of high level plans for each programme. Currently, the programme descriptors and workstreams below are draft.

Behaviour Change & Prevention

Encourage people to make healthier lifestyle choices and drive reductions in demand on health and care services caused by smoking, alcohol and obesity

- Smoking
- Alcohol
- Obesity

Primary Care

Build a model of general practice that will be the strong, effective and sustainable foundation of our integrated health and social care system

- Access
- High quality and sustainable services
- Collaboration

Social Care

Work with individuals, their carers and wider communities in a more inclusive way to promote independence, focussing on strengths as opposed to a deficit model

- TBC

Mental Health

Improve mental wellbeing and provide support at the right time to avoid people getting into crisis

- Adult mental health
- Child and adolescent mental health
- Crisis care
- Dementia
- Suicide

Cancer & Long Term Conditions

Increase earlier detection and treatment of cancer, and transform clinical pathways to improve productivity and provide care closer to home

- Cancer prevention & earlier diagnosis
- Long term conditions pathways

Urgent & Emergency Care

Redesign and strengthen the urgent and emergency care system to ensure that patients receive the right care in the right place, first time

- NHS 111 development
- Urgent treatment centre
- Emergency response (999)
- Same Day Emergency Care (SDEC)
- Eye A&E & minor eye conditions service (MECS)

People & Workforce

Training health and care staff together so that they develop common approaches, and focusing on behaviours and attitudes just as much as skills. Thus enabling Healthy Conversations, both with people and between professionals.

Digital

Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care

- People powered
- Connected systems, shared information
- Digital-first access

Estates

Ensure we have the right type of buildings (size, configuration, flexibility, cost) in the right locations across Southampton

- TBC

Working together to transform outcomes

Our mission

Effective system partnerships delivering safe, sustainable, coordinated care with the people of Southampton.

Health and care organisations in the city have committed to work together to deliver the strategy. The vision we share for health and care in the city has evolved out of strong and inclusive partnerships between commissioners, providers, communities and citizens, built painstakingly over a number of years.

How we'll work

- **Promoting independence.** Supporting self-care and strengths-based approaches.
- **Co-production.** Communicating and engaging with residents and encouraging participation.
- **Population health management.** Understanding our population and planning for the future.
- **Simplifying processes.** In other words, a complete reversal of a 'gatekeeping' approach to services, instead stripping out the steps that add no value to the 'patient/client'. Thus, 'right place, right contact, first time', enabling better productivity and efficiency in service provision.
- **Moving from urgent care, to planned care.** By putting better anticipatory care in place, we spend less time reacting to a problem and more time preventing it.
- **Tackling unwarranted variation.** Actively using benchmarking tools like Public Health Fingertips, Dr Foster, RightCare and Getting it Right First Time (GIRFT) to improve outcomes.
- **Getting the basics right.** Working in partnership is not a substitute for successful, efficient, well run organisations.
- **Financial Strategy, based on the following principles:**
  - Good planning, not heroic assumptions.
  - Risk reduction, not risk transfer. Reducing system cost, not cost shunting. Also, improving payment mechanisms but recognising they are not the answer.
  - Investment in change: recognising that change costs money and has to be funded.

Our values