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Health and Wellbeing Board

Wednesday, 23rd October, 2013
at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Shields (Chair)
Councillor Bogle
Councillor Baillie
Councillor Lewzey
Councillor McEwing

Rob Kurn – Health Watch
Alison Elliott – Director of People
Dr A Mortimore – Director of Public Health
Dr S Townsend – Clinical Commissioning Group (Vice Chair)
Dr S Ward – NHS England Wessex Local Area Team

Contacts
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Democratic Support Officer
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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board
The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities.
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

Southampton City Council's Priorities:

- **Economic**: Promoting Southampton and attracting investment; raising ambitions and improving outcomes for children and young people.
- **Social**: Improving health and keeping people safe; helping individuals and communities to work together and help themselves.
- **Environmental**: Encouraging new house building and improving existing homes; making the city more attractive and sustainable.
- **One Council:** Developing an engaged, skilled and motivated workforce; implementing better ways of working to manage reduced budgets and increased demand.

Responsibilities
The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular:

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
  - Health care
  - Social care
  - Public health services
  - Ensuring safety in improving health and wellbeing outcomes

Smoking policy – The Council operates a no-smoking policy in all civic buildings.
Mobile Telephones – Please turn off your mobile telephone whilst in the meeting.

Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take
Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.
Proposed Municipal Year Dates

2013	2014
23 October	29 January
27 November	26 March

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED

Only those items listed on the attached agenda may be considered at this meeting.

RULES OF PROCEDURE

The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

QUORUM

The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "personal" or "prejudicial" interests they may have in relation to matters for consideration on this Agenda.

DISCLOSURE OF INTEREST

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Personal Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PERSONAL INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value fo the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or

if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having a, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the Council's Website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Board made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 STATEMENT FROM THE CHAIR

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 14 August 2013 and to deal with any matters arising, attached.

5 THE NHS COMMISSIONING LANDSCAPE

To consider the report of the Medical Director, NHS England, Wessex Local Area Team outlining the major elements in the NHS commissioning landscape, attached.

6 SEASONAL PLAN 2013/14

To consider the report of the Director of System Delivery, Southampton City Clinical Commissioning Board, detailing key aspects of the 2013-14 Seasonal Plan, attached.

7 UPDATE ON USE OF FUNDING TRANSFER FROM NHS TO SOCIAL CARE IN 2013/14

To consider the joint report of the Chief Executive, Southampton City Clinical Commissioning Group and Director of People, Southampton City Council updating the Board on the funding transfer from NHS to Social Care in 2013/14, attached.

8 UPDATE ON INTEGRATION TRANSFORMATION FUND IMPLEMENTATION

To consider the joint report of the Chief Executive, Southampton City Clinical Commissioning Group and Director of People, Southampton City Council, seeking approval of the timetable and procedures outlined in the report for developing pooled budgets, attached.

9 PROPOSAL TO JOIN THE SMOKEFREE ACTION COALITION

To consider the report of the Director of Health, seeking approval to join the Smoke Free Action Coalition, attached.

10 UPDATE FROM THE CHAIR, HEALTH AND WELLBEING BOARD

To consider the report of the Chair of the Health and Wellbeing Board providing an update to the Board, attached.

Tuesday, 15 October 2013 Head of Legal, HR and Democratic Services

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 14 AUGUST 2013

Present: Councillors Baillie, Bogle, Lewzey, McEwing and Shields
Alison Elliott, Andrew Mortimore, Dr Steve Townsend and Rob Kurn

Apologies: Dr S Ward

8. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the Minutes of the meeting held on 29th May 2013 be approved and signed as a correct record.

9. **HEALTH AND SOCIAL CARE INTEGRATION PIONEER BID**

The Board received and noted the report of the Director Quality and Integration Southampton City CCG/Head of Integrated Strategic Commissioning Southampton City Council detailing the Health and Social Care Integration Pioneer Bid.

The Board noted that the Government had published a document "Integrated care and support: our shared commitment" in May 2013 and invited expressions of interest for Health and Social Care Integration Pioneers. Southampton City Council and Southampton City Clinical Commissioning Group (CCG) submitted an expression of interest, with support from a range of partners. This report highlighted the key objectives behind the proposals and enabled the Health and Wellbeing Board to see the ambitions and intentions in the Southampton expression of interest.

It was noted at the meeting that whilst the bid had not been successful in the short listing process the focus the bid had provided for the City would align future work priorities to key national objectives for change particularly the Integrated Person Centred Care Programme. It was also noted that there would be opportunities to bid in later tranches of the process and feedback was being sought on the initial bid.

Reference was made to the Health and Social Care Integration Transformation Fund which would provide great opportunities albeit there would be some risks. It was noted that this was not new money; the NHS would see a 3% reduction in its budget which would be transferred to the Local Authority to fund and deliver the integrated model at local level.

10. **IMPLICATIONS OF THE WINTERBOURNE VIEW REVIEW – LOCAL AUDIT**

The Board received and noted the report of the Director Quality and Integration Southampton City CCG/Head of Integrated Strategic Commissioning Southampton City Council informing the Health and Wellbeing Board of a stock take of progress that had been undertaken in response to the Winterbourne View Joint Improvement Programme, a national framework intended to enable local areas to assess their progress and identify what help they needed from a Joint Improvement Programme.

A draft joint strategic plan to address the local impacts had been developed and identified a number of priorities and recommendations for 2013/14 which would be finalised in October and be overseen by the Local Adult Safeguarding Board.

11. **UPDATE FROM THE CHAIR OF THE HEALTH AND WELLBEING BOARD**

The Board received and noted the report of the Chair of the Health and Wellbeing Board detailing actions taken and correspondence to the Chair since the May meeting of the H&WBB.

12. **OPERATIONS PROTOCOL BETWEEN HEALTH AND WELLBEING BOARD, HEALTH OVERVIEW AND SCRUTINY PANEL AND HEALTHWATCH SOUTHAMPTON**

The Board considered the report of the Director of Public Health detailing a proposed operating protocol between Health and Wellbeing Board, Health Overview and Scrutiny Panel and Healthwatch Southampton. The Health and Social Care Act set out the roles and responsibilities of Health and Wellbeing Boards and local Healthwatch. It also modified the responsibilities of Health Overview and Scrutiny Committees. The proposed protocol set out the respective roles and responsibilities of these bodies and a framework for handling key issues.

The Board noted that the protocol was a helpful document which set out the principles for separate and joint working, would remain a work in progress document taking account of any developments across health and care systems and would not outrank the Council's Constitution. It was also noted that the protocol would be reviewed annually at the start of each Municipal Year.

The Board made reference to paragraph 8 of the protocol, Commissioning and Decommissioning Services and indicated that NHS England should be included and the specific reference to Social Care Services deleted.

RESOLVED:

i. that the draft protocol as detailed in Appendix 1 of the report be approved subject to the inclusion of NHS England and deletion of reference to Social Care Services in Paragraph 8 titled Commissioning and Decommissioning Services;
ii. that the draft protocol be referred to the Health Overview and Scrutiny Committee and Healthwatch Southampton for consideration and approval; and
iii. that authority be delegated to the Director of Public Health following consultation with the Chair to make any drafting or other amendment required following consideration by the Health Overview and Scrutiny Committee and Healthwatch Southampton that did not affect the spirit of the intentions of the protocol.

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		THE NHS COMMISSIONING LANDSCAPE		
DATE OF DECISION:		23RD OCTOBER 2013		
REPORT OF:		MEDICAL DIRECTOR, NHS ENGLAND, WESSEX LAT		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dr Stuart Ward**	**Tel:**	**023 80296032**
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Director	**Name:**	**Dr Stuart Ward**	**Tel:**	**023 80296032**
	E-mail:	**stuart.ward@nhs.net**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The Health and Social Care Act 2012 resulted in a major re-organisation of the NHS. The new structures came into effect fully on 1st April 2013. This report outlines the major elements in the NHS commissioning landscape. In addition, a presentation will be made to the Health and Wellbeing Board outlining the national role of NHS England and the Wessex Area Team.

RECOMMENDATIONS:

(i) That the report be noted.

REASONS FOR REPORT RECOMMENDATIONS

1. To provide the members of the Health and Wellbeing Board with an understanding of the wider landscape for NHS commissioning.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. It was considered important to provide this information to the Health and Wellbeing Board and to enable members to ask questions to develop their understanding of the new bodies in the system.

DETAIL (Including consultation carried out)

3. The Health and Social Care Act 2012 resulted in the largest re-structuring of the NHS since it formation in 1948. This report outlines some of the major elements of the new commissioning landscape and details the new organisations that have been established to deliver commissioning functions since April 2013.
4. The following organisations are taking over some of the functions (and in some cases receiving staff) from the six Primary Care Trusts (PCTs) that have been operating in the area, along with some of the functions of the former Strategic Health Authorities, which ceased to exist at the end of March 2013.

NHS England

5. NHS England has approximately 5,500 employees. It is based in Leeds, with the majority of its staff being based in 4 regional and 27 area teams. It aims to work with NHS staff, patients, stakeholders and the public to improve the health outcomes for people in England. NHS England has developed an eight component operating model to ensure that the commissioning system is in the best possible place:

- Supporting, developing and assuring the commissioning system
- Direct Commissioning: NHS England directly commissions specialist services, primary care, public health services, dental services, armed forces health services and offender health services
- Emergency Preparedness
- Partnership for quality
- Strategy, research and innovation for outcomes and growth
- Clinical and professional leadership
- World class customer service: Information, Transparency and Participation
- Developing Commissioning Support

NHS England (Wessex) – "Wessex Area Team"

6. This is the local arm of NHS England and is responsible for:
- CCG Assurance and Development;
- Directly commissioning primary care services (those provided by GPs, dentists, optometrists and pharmacists);
- Directly commissioning specialist health services (this is for relatively rare and specialist treatments that need to be commissioned across higher population numbers);
- Directly commissioning public health screening services (such as bowel screening, cancer screening, vaccinations and immunisation services);
- Emergency preparedness, resilience and response;
- System oversight - including quality and safety, partnerships and service reconfiguration.

7. Given the lead arrangements in place within NHS England, the Wessex Area team will be commissioning Specialist health services on behalf of the Thames Valley Area (which covers Buckinghamshire, Oxfordshire and Berkshire). The Thames Valley Area team will be commissioning Offender Health Services provided within our patch, on our behalf. Meanwhile, the Bath, Gloucestershire, Swindon and Wiltshire Area team will be commissioning Military Health services on behalf of all Area teams in the south of England, including Wessex.

Clinical Commissioning Groups (CCGs)

8. CCGs are commissioning organisations formed from general practices. All practices are required to join a CCG. Practices will shape commissioning decisions and hold the CCG to account for decisions made on their behalf. Many CCGs cover a smaller area than the previous PCTs. They are intended to ensure a closer relationship between local people, GPs and commissioning decisions. There are nine CCGs in Wessex, including one, North East Hampshire and Farnham CCG, which straddles the border with Surrey.

9. Clinical leaders, usually the Chair but sometimes the Accountable Officer, provide clinical leadership for each CCG. They represent the clinical voice of members; oversee governance and relationships with partners. Each CCG has an Accountable Officer, usually a senior manager, but sometimes a clinician, nominated by the CCG and appointed by NHS England, who is charged with ensuring that the CCG fulfils its duties and exercises its functions effectively, efficiently and economically.

Commissioning Support Units (CSUs)

10. Commissioning Support Units (CSUs) provide CCGs with many of the commissioning support functions and services that were previously carried out by PCTs, such as business intelligence and procurement. Some CCGs also call upon Commissioning Support Units to provide other functions, such as transactional HR and finance.

11. CSUs are currently hosted at “arm’s length” by NHS England. The majority of CCGs within Wessex have identified NHS Commissioning Support South based in Eastleigh as the CSU they would like to buy functions and services from for 2013/14.

Quality Surveillance Groups

12. A network of Quality Surveillance Groups (QSGs) have been established across the country to bring together different parts of health and care economies locally and in each region in England to routinely share information and intelligence to protect the quality of care patients receive. QSGs are supported and facilitated by the NHS England’s Commissioning Board’s 27 Area and 4 Regional Teams.

13. QSGs are not intended to add another level of bureaucracy, but instead provide a forum for local partners to realise the cultures and values of open and honest cooperation which should be in place already. They seek to reduce the burden of performance management and regulation on providers of services, by ensuring that supervisory, commissioning and regulatory bodies work in a more coordinated way.

14. The Wessex Area Team has developed a QSG which brings together commissioners, the Local Authority, the Care Quality Commission (CQC), Healthwatch and other organisations to share information about the quality of local NHS services. In this way and in line with the recommendations

following the public inquiry into the failings at Mid Staffs Hospital, we will be better placed to spot the early warning signs of problems with quality and take swift action to ensure patients are safe and receive the best care possible.

Public Health

15. A large part of the public health function transferred from PCTs to local authorities, with some responsibilities moving to Public Health England (PHE), which will promote health protection and prevention. NHS England (Wessex) is responsible for commissioning public health screening services. The regional team from Public Health England met a number of members of the Health and Wellbeing Board at an event at Chilworth in September 2013.

Clinical Senates

16. Across the country, 12 clinical senates provide advice and leadership to help CCGs, Health and Wellbeing Boards and the NHS England make the best decisions about healthcare for local populations. The senates are made up of clinicians and health professionals including public health and social care, alongside patients, the public and others. NHS England Wessex will host the **Wessex Clinical Senate**, which covers the same geographical area as the Local Area Team.

Strategic Clinical Networks

17. Strategic Clinical Networks (SCNs) are hosted and funded by the NHS England, and cover conditions or patient groups where improvements can be made through an integrated, whole system approach. These networks help local commissioners to reduce unwarranted variation in services and encourage innovation in the following areas:
    - Cancer
    - Cardiovascular disease (including cardiac, stroke, diabetes and renal disease)
    - Maternity and children's services
    - Mental health, dementia and neurological conditions.

    Strategic Clinical Networks cover the same 12 areas as the clinical senates, and as such, this will be another responsibility of the Wessex Area team.

Wessex Local Education and Training Board (LETB)

18. The Wessex LETB is a sub-committee of Health Education England, which has responsibility for the education, training and development of the healthcare and public health workforce across the whole of the Wessex Area and southwest Wiltshire.

19. The Executive Board has representation from the Deanery, local healthcare training universities, providers and commissioners (including CCGs and the Wessex Area Team). The Board is in the process of developing a strategy to align with the needs of these groups, and aims to work with the social care sector to enhance partnership working and synchronise training where appropriate.

Wessex Academic Health Science Network (AHSN)

20. Based at the University of Southampton, the Wessex AHSN covers the whole of the Wessex Area plus southwest Wiltshire, in the same way as the LETB. Its membership will include representation from a wide range of organisations.

21. The role of the AHSN is to promote research and innovation in healthcare and to work in partnership with both the academic sector and the local business sector to achieve them. It will measure its success by the development of innovative care, by new pathways, new techniques or new equipment. It is anticipated that a major, positive outcome of the new AHSNs will be an improvement in local business development for the area and ultimately, for the country. The AHSN will also ensure systematic roll-out and adoption of good practice across a much wider area.

NHS Trust Development Authority (NTDA)

22. The NTDA provides governance and oversight of NHS provider trusts that are not yet foundation trusts. The functions of the NTDA have previously been carried out mainly by strategic health authorities and the Department of Health. There is a strong expectation that the majority of trusts will achieve foundation status by April 2014.

NHS Property Services Ltd

23. The majority of the PCT estate transferred to this new national organisation which maintains, manages and develop facilities ranging from GP practices to administrative buildings. It is a limited company but will remain wholly owned by the Secretary for State for Health. PCT estates staff transferred directly to this organisation.

RESOURCE IMPLICATIONS

Capital/Revenue

24. None.

Property/Other

25. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

26. The Health and Social Care Act 2012 sets out the legal framework for the operation of Health and Wellbeing Board.

Other Legal Implications:

27. None

POLICY FRAMEWORK IMPLICATIONS

28. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None.

Documents In Members' Rooms

1.	None.

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Report Tracking

VERSION NUMBER:	2
DATE LAST AMENDED:	14/10/13
AMENDED BY:	Claire Heather

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		SEASONAL PLAN 13/14		
DATE OF DECISION:		23RD OCTOBER 2013		
REPORT OF:		DIRECTOR OF SYSTEM DELIVERY, SOUTHAMPTON CITY CLINICAL COMMISSIONING BOARD		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Peter Horne**	**Tel:**	**023 80725506**
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Director	**Name:**	**John Richards**	**Tel:**	**023 80725637**
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STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

Every year organisations are required to develop seasonal plans, particularly for winter, to ensure business continuity and contingencies are in place for times of exceptionally high demand for local services. This paper summarises the key aspects of the 2013-14 Seasonal Plan.

RECOMMENDATIONS:

(i) It is recommended that the plans for winter readiness, summarised in the report, be noted.

REASONS FOR REPORT RECOMMENDATIONS

1. The Southampton City Health and Well Being Board requested an overview of arrangements in Health and Social Care for Winter 2013/14.
2. CCG's have produced required plans in collaboration with partners and taking lessons learnt from previous winters; all provider plans are incorporated within the overarching plan.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None.

DETAIL (Including consultation carried out)

Introduction

4. Winter 2012-13 proved challenging – here and nationally - but locally our System Chiefs met to review the lessons learnt, supported a programme of transformational change and agreed to create additional, targeted capacity across all providers to support services over winter.

5. Last year the system experienced backlogs of patients occupying acute beds or downstream community beds because processes were not working effectively to help move them through. This in turn created queues in the Emergency Department (ED), sometimes preventing admissions and many times resulting in cancelled elective operations. The available capacity was not being used to best effect.

6. With the help of the national Emergency Care Intensive Support Team (ECIST) and the production of a Whole System Action Plan, our Unscheduled Care Programme has delivered many operational changes over the last six months to create more responsive, efficient and collaborative services aimed at keeping patients flowing smoothly through the system by having better channels of daily communication and shared working practices across organisations. Intense focus has been directed at improving operational practices at the "back door" of the hospital for complex patients who need support to facilitate their discharge. The aim has been to ensure that:
    - all patients who require an acute emergency bed can access an emergency bed when they need it;
    - patients who do not need an acute hospital bed are supported appropriately in the community;
    - patients who have made arrangements for an elective procedure are not cancelled on the day.

7. The 2013-14 Seasonal Plan is the operational blueprint for providers and commissioners that draws on all the system changes that have been implemented, pulls them together in an agreed escalation framework, with identified contingencies and business continuity plans, to ensure patient services are maintained safely and effectively. This year the CCG has worked in partnership with our colleagues in West and North Hampshire CCG's and all providers across the patch to create a mutually-supportive approach to delivering a resilient, flexible and responsive plan and escalation framework. Importantly this year it includes the additional flex capacity agreed by System Chiefs which is already being put in place. The System Chiefs comprise NHS Chief Executives and local authority directors of adult social care.

8. The approach to the plan is underpinned by a joint approach to co-ordinating system resilience activities across the patch. The plan is due to be tested with a table top exercise to be run in the week commencing 7th October 2013. Adjustments will then be incorporated into the plan if required.

9. All providers have incorporated their individual organisational plans into one overarching plan, and contributed to the development of the agreed escalation framework and contingencies. Following positive early feedback in September, the finalised plan covering Southampton, Winchester and Basingstoke systems was submitted to the Wessex Area Team on the 30th September 2013.

Purpose

10. The purpose of the Seasonal Plan is to set out the Southampton, Winchester and Basingstoke health and social care systems' shared plan to manage periods of high demand both day to day and during seasonal peaks of pressure. This will ensure that the appropriate arrangements are in place to provide co-ordinated, high quality and responsive services over the 13/14 period and beyond. The plan provides a particular focus on the winter 13/14 period, but also provides assurance for:
    - Day to day capacity management
    - System-wide capacity and situation reporting
    - Surge and escalation processes and tools
    - Seasonal and pandemic flu preparedness
    - Individual organisational plans and joint working
    - Communications and co-ordination

11. The Seasonal Plan is intended to be used by all organisations within the local health economy as a guide to the various systems and processes put in place to manage periods of high pressure, both day to day and associated with seasonality.

Day to Day Management and Surge and Escalation

12. One of the main themes from both the shared learning event in June and feedback at system resilience meetings was around the need for consistency of escalation in the system. The challenge was twofold:

    - A need to improve the practice of sharing and communicating information relating to capacity in a consistent manner.
    - A need to clearly define the process of escalation, including triggers and contingency actions

13 These challenges have been addressed as follows:

Daily System Dashboard

A daily Systems Dashboard was created in mid-July 2013. The format is pictured in Appendix 1. All providers feed in their daily capacity figures and statuses to a central inbox; the information is put into this dashboard and shared widely within the system usually before midday every day. The aim of this is to provide an "at a glance" picture of how the system is functioning each day, and to encourage proactive action and conversation between organisations around how they may act to support each other, especially at times when pressure is increasing.

14. *Daily Complex Discharge Meetings*

University Hospitals Southampton NHS Foundation Trust now runs a daily complex discharge meeting out of the Integrated Discharge Bureau (IDB), with representation from acute, local authority and community partners. The purpose of this meeting is to provide a platform and structure for information relating to patients requiring a complex discharge, who might be requiring

multiple services, to be shared and recorded on a daily basis. The aim is to maximise the flow of patients through services and reduce delays, and to ensure that patients who are cared for in the right place at the right time.

15. *Escalation Framework*

Using the NHS England (South) Escalation Framework as a basis, a bespoke escalation framework has been developed for use within our local health economy. This has been developed with input from all organisations across our local health economy including the acute and community trusts, the ambulance service, the local authorities and 111 and out of hour's services.

The framework features two major components:

- •Trigger points for escalation
- •Contingency actions to be taken by each organisation once an escalation level has been reach

16. In order to encourage ownership of the framework, both the trigger points and contingency actions were provided by and developed in consultation with the system resilience leads of each organisation. By using this approach, it is expected that all organisations will be well prepared in the event of escalation, and that escalation will become more consistent across the system.

System Resilience Conference Calls

17. It was recognised that conference calls in the past have been lengthy and added little value to the situation at hand.

18. In response to this we have refreshed the conference call contact lists to ensure the correct people are contacted in the event of escalation. In addition a standard conference call agenda is available to ensure that participants have the correct information to make a difference to the system. The standard agenda, coupled with some swift chairmanship should ensure the conference calls are focussed and efficient.

On Call

19. To further support the joint approach endorsed by system resilience and seasonal planning, and to support the new joint on call arrangements, the on-call pack has been refreshed to cover both the Southampton and Mid Hampshire systems. This will be distributed during October 2013.

Seasonal Preparedness

20. This section of the plan describes the extra processes and arrangements put in place to assist in the management of the pressured winter period and beyond. It has been largely informed by the lessons identified in the joint winter learning event that was held in June.

Forward Planning and Coordination Conference Calls

21. It was felt that the system would benefit from a bi-weekly conference call during the peak of winter pressure. These would take the form of a post-weekend check-in to debrief and escalate any blocks encountered over the weekend for resolution, and a pre-weekend check in to ensure the system is prepared for the weekend and any specific requests for support can be made. The aim is to ensure that the system is looking about 10 days ahead to anticipate and deal with pressure.
In response to the feedback, this has been extended to include primary care out of hours and 111 as important partners in the system.

Extra winter capacity in the South West System

22 Learning identified in the joint workshop was formulated into specific Winter Pressures Projects, and submitted to System Chiefs to apply for funding in August 2013. System Chiefs approved several projects which included:

- Access to quick response taxi provision for people who are ready for discharge and provided with all practical discharge arrangements
- Two full time Continuing Healthcare (CHC) nurse assessors, working Monday to Friday to be based within the acute hospital's Integrated Discharge Bureau, to enhance robust discharge processes.
- Increase the staffing levels of the Children's Outreach Assessment & Support team (COAST) from November 2013 to March 2014, to take referrals directly from GP's and reduce acute hospital admissions.
- One off purchase of additional equipment to support care and support plans for people in the community
- Training and support for suspended nursing homes, helping to re-open them in the city and provide management training and leadership skills to avoid further suspensions
- SCAS to operate an additional discharge vehicle during core hours to support the Acute Trusts and the pull of discharges and transfers back into the community.
- A modular build adjacent to the existing ED to facilitate the provision of a Geriatric Assessment space to support rapid assessment of frail elderly patients who attend ED or Acute Medical Unit (AMU)
- Enhancement of Mental Health intervention in ED at weekends (psychiatry liaison), to promote prompt and effective decision making for patients whose mental health requires assessment is deemed to be urgent
- Spot purchasing of additional capacity for non-weight bearing patients, when required, to allow for an improvement in the discharge process. This will allow patients' non weight bearing and rehabilitation needs to be managed in a nursing home environment more suitable to their needs, rather than in the acute Trust.
- Commissioning of three residential reablement placements from a specialist dementia care home to provide care for people with dementia who have some potential to return home but who are unable to achieve that potential in an acute or community hospital.
- To staff 8 additional rehab beds at Lymington Hospital (Wilverley 1) and an additional 5 beds in Lymington' s Medical Assessment Unit (MAU).

Flu Planning

23. Every provider has its own Infection Prevention and Control Policies, and Outbreak Plans which will be used to manage localised outbreaks. Public Health colleagues are leading local campaigns and have a robust plan for the uptake of vaccinations across the community. In addition, uptake of flu vaccinations within providers will be monitored.

The flu vaccine targets have been altered this year to encourage greater uptake with the target for over 65's, at risk groups and pregnant women increasing to 75% Pharmacies are being encourage to support GP practices in administering the vaccine. This will also be the first year of the Childrens Flu Programme covering children aged 2-3.

The flu surveillance that was previously completed by the Health Protection Agency has transferred to Public Health England. Their reports are now received directly into our systems resilience inbox and will be cascaded through the daily dashboard.

Provider Business Continuity and Seasonal Plans

24 As part of the planning exercise, all provider Trusts have shared their individual business continuity and/or seasonal plans, which have been incorporated into the overarching Seasonal Plan document.

Communications

25. The NHS England (South Region) communications team are working on behalf of CCGs to ensure a coordinated and consistent approach to communications at times of peak demand. This will include using a range of channels such as NHS and council websites, materials such as leaflets, partners' newsletters and publications, local community groups, the local media and social media to communicate key messages around how the public should access services and where to access information and advice, this will often be based on the Choose Well concept. During winter we will ensure that messages are consistent with these developed nationally through the 'Get Ready for Winter' campaign led by the Cabinet Office.

Southampton City CCG, West Hampshire CCG and North Hampshire CCG are currently discussing a joint communications campaign for this winter. Further meetings are occurring to progress this into early October.

Conclusion

26. The CCG believes the local South West System has made significant improvements to partnership working since last winter, that additional flex capacity agreed by System Chiefs will provide earlier access to contingencies, that a clear media campaign will help people identify where they need to go to seek the care they need, and that new daily processes and shared information will help deliver proactive and responsive services to meet fluctuations in demand. This does not mean there is any complacency as the winter is expected to be tough, given pressure on resources in all provider organisations; however it does signal that partners are prepared and supported to work together in the best interests of our patients.

RESOURCE IMPLICATIONS

Capital/Revenue

24. None.

Property/Other

25. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

26. N/A

Other Legal Implications:

27. None.

POLICY FRAMEWORK IMPLICATIONS

28. None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Daily System Blackboard

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Report Tracking

VERSION NUMBER:	2
DATE LAST AMENDED:	04/10/2013
AMENDED BY:	Martin Day

Appendix 1

Daily system blackboard

Daily System Dashboard Friday 27/09/13 11:30

System Status - Southampton, Winchester and Basingstoke

G/A/R/B	
Weather	No weather alerts have been issued

Acute

UHS	Status		Breaches this week	147		Y'day complex caseload (active section 5)	137
UHS	Y'day attendances	?	Handover Compliance	84%	Excess Turnaround 06:11	Notes	
RHCH	Status		Breaches this week			Y'day complex caseload (active section 5)	
RHCH	Y'day attendances	99	Notes				
BNHFT	Status		Breaches this week			Y'day complex caseload (active section 5)	
BNHFT	Y'day attendances	132	Notes				

Community

Solent	Rapid Response		8-12 slots	16	12.-14	5	14.-18	15	18.-22	7
Solent	Community Nursing		Virtual Ward Use		Notes	RRT have no capacity for evening calls. Community Nursing has reduced staffing and high pt dependency				
Solent	RSH		Beds	9	Delays	0	Notes	2 discharges today		
Solent	Western (SNRU)		Beds	0	Delays	3	Notes	0		
Solent	Brownhill		Beds	3	Delays	0	Notes	0		
Southern	Community Care Teams (inc RR)				Notes					
Southern	Lymington		Beds		Delays		Notes			
Southern	Romsey		Beds		Delays		Notes	CLOSED FOR REFURBISHMENT		
Southern	Fordingbridge		Beds		Delays		Notes			
Southern	Abbey		Beds		Delays		Notes			
Southern	Brendoncare		Beds		Delays		Notes	0		
Southern	Alton		Beds	0	Delays		Notes			

Ambulance

SCAS (REAP)	3	Notes	

Social Services

Hants	Staffing		Notes					
Hants	Reablement Beds	1	Notes	1xFlemming House				
City	Community Team Staffing	77%	HDT Staffing	72%	CCFS Staffing	70%	Sourcing Care Packages	Within 72 hrs
City	Social Services Beds	?	Brownhill beds	Avail	SiPs	11	Notes	

OOH's - Weekend Only

Out of Hours	Fri	Triage	89%	PCC	100%	HV	100%	Notes	
	Sat	Triage	96%	PCC	96%	HV	100%	Notes	
	Sun	Triage	94%	PCC	98%	HV	100%	Notes	

111 - Weekend Only

111	Sat	Handler	110%	Clinician	102%	Notes	
111	Sun	Handler	119%	Clinician	107%	Notes	

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		UPDATE ON USE OF FUNDING TRANSFER FROM NHS TO SOCIAL CARE IN 2013/14		
DATE OF DECISION:		23RD OCTOBER 2013		
REPORT OF:		CHIEF EXECUTIVE, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP AND DIRECTOR OF PEOPLE, SOUTHAMPTON CITY COUNCIL		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
NONE.

BRIEF SUMMARY

Since 2010/11 the Department of Health has allocated funding to Primary Care Trusts, and subsequently the NHS Commissioning Board, to transfer to local authorities to support health and social care joint working. This has been a time limited investment to act as a catalyst for change to increase sustainability in the system and improve the quality of patient outcomes. This is in addition to the funding for reablement services. . The funding must be used to support adult social care services in each local authority, which also has a health benefit. For 2013/14 the amount for Southampton is £3,970,677.

The Health and Wellbeing Board agreed in March 2013 that the proposed priorities for the use of the funding transfer from NHS to Social care (NHS Transfer) were based on priorities within the Joint Strategic Needs Assessment and existing commissioning plans for both health and social care and these were used to inform the allocation of the funding.

A proportion of the initiatives were a continuation of schemes with contractual agreements in place from the previous year's Transfer monies and some new investments. This report is a resume of interim progress and outcomes of the work supported via the Social Care Transfer Funding from NHS for 2013/14.

RECOMMENDATIONS:

(i) That the expenditure plans for the Social Care Transfer Fund 2013/14 be noted.

REASONS FOR REPORT RECOMMENDATIONS

1. The proposed use of the NHS Transfer monies is based on priorities identified in the Joint health and Wellbeing Strategy to meet key social care and health priorities within the City.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. All initiatives were assessed against agreed priorities.

DETAIL (Including consultation carried out

3. Since 2010/11 the Department of Health has allocated funding to Primary Care Trusts to transfer to local authorities to support health and social care joint working. This has been a time limited investment to act as a catalyst for change to increase sustainability in the system and improve the quality of patient outcomes. From 2013/14, the funding transfer to local authorities has been carried out by the NHS Commissioning Board with close involvement of the CCG. The funding requirement is that it must be used to support adult social care services in each local authority, which also has a health benefit.

4. The guidance states that the NHS Commissioning Board must make it a condition of the transfer that the local authority and health partners agree how the funding is best used within social care and the outcomes expected from this investment. It was agreed that this should be done via the Health and Wellbeing board.

5. Proposals for the criteria and priorities for the use of the 2013/14 spend were developed by SCC Adult Health and Social Care and the Clinical Commissioning group.

Requirements for the use of 2013/14 funding

6. The funding must :
   - support adult social care services in each local authority, which also has a health benefit.
   - meet priorities identified within the Joint Strategic Needs Assessment and existing commissioning plans for both health and social care
   - demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

7. The funding transfer can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. In addition it can support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

8. The Caring for our future White Paper also set out that the transfer of funding can be used to cover the small revenue costs to local authorities of the White Paper commitments in 2013/14 (excluding the Guaranteed Income Payments disregard, which is being funded through a grant from the Department of Health).

9. **Proposals for use of 2013/14 NHS transfer**

The criteria identified by SCC and the CCG and agreed by the Health and Wellbeing Board to identify the 2013/14 spend were that the initiatives must:

- Support achievement of a priority within the Joint Health and Wellbeing Strategy: Theme 1 – Building resilience and prevention to achieve better health and wellbeing and Theme 3 – Ageing and Living Well
- Support reablement and prevention
- Support appropriate discharge and recover
- Reduce demand on residential placements
- Support implementation of personalised approaches
- Build on initiatives already shown to be effective
- Improve, or maintain, Joint NHS and SCC outcomes

10. The aim is to pilot models to inform longer term planning and investment as well as supporting work to improve the efficiency of current systems and processes that would then be self-sustaining. The main focus of the initiatives supported were:

11. **Agreed Priorities**

Priority	
Continuation of schemes with contractual agreements in place	
Peer support and development of Timebanking – to develop focus on self management and reduce incidence of relapse	75,000
Further increasing access to psychological therapies to support those with long term conditions	170,000
Alcohol prevention and early treatment	95.200
Initiatives to support increase uptake and use of direct payments	37,400
Vulnerable Adult team in Emergency Department	55,000

Minimise assessment waits and targeted reviews	130,600
Social workers/care managers hospital discharge team to further improve assessments and planning from when date of discharge set	346,100
Newly identified schemes that meet the criteria	
Reablement – specific initiatives to support speedier implementation including medicines management Increase access to equipment, including further development of telecare and telehealth and specialist advisory service to Joint Equipment store to ensure effective use of equipment	61,500
Prevention/raising quality in residential and nursing homes	351,700
Support to carers, including respite, and focus on self-management	87,900
Improving hospital discharge	198,300
Development of extra care services for those with dementia and complex health needs	89,000
IT infrastructure (PARIS)	48,600
Project management	14,000
Schemes to support maintaining eligibility criteria (funding to support existing adult social care services)	
	2,380,000

12. Outcomes achieved with the investment

Details of the outcomes are shown in Appendix 1. These have included some areas of system change as well as specific measurable outcomes such as:

- Ongoing system transformation to support admission avoidance and maximise independence through investment in re-ablement services, to help people regain their independence and reduce the need for ongoing care.
- Increase pace of roll out of personalisation and direct payments – including market management and peer support development
- Improved efficiency and effectiveness through increased capacity of social workers/care managers in Hospital discharge team ,community hospitals and complex case teams to facilitate discharge and prevent avoidable readmissions
- Social care packages that are the right size to support individuals to be as independent as possible
- Improved use of re-ablement and equipment services to support appropriate discharge and admission avoidance
- Increase in numbers accessing telecare/telehealth
- Widening of peer and community/voluntary sector support availability
- Increased number of carers assessed & supported.
- Increase in percentage of people who reduce their alcohol consumption to recommended levels

Examples of specific initiatives

13. Time Banking is detailed in Appendix 2.

14. **Future use of funding**

    The schemes are all due to cease from end of March 2014. The Social care Transfer funds will be incorporated into the recently announced Integration transformation Fund. Ongoing evaluation of the schemes outlined above will be used to consider their effectiveness to be included in any future integration work.

RESOURCE IMPLICATIONS

Capital/Revenue

15. There is some minimal carry forward of underspend from 2012/13 in addition to the £3,970,677.

Property/Other

16. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

17. Payments will be made via an agreement under Section 256 of the 2006 NHS Act.

Other Legal Implications:

18. None.

POLICY FRAMEWORK IMPLICATIONS

21. The Operating Framework for the NHS in England specifies the requirement for this funding to support adult social care.
22. Requirements for 2013/14 have been outlined in a letter from the Director General, Social care, Local government and care partnerships Gateway reference 18568.

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Priority Outcomes
2.	Specific Initiatives – Time Banking

Documents In Members' Rooms

1.	None.

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None.	

Report Tracking

VERSION NUMBER:	2
DATE LAST AMENDED:	14/10/13
AMENDED BY:	KW

Progress against priority outcomes

Priority	Actions	Anticipated Outcomes	Investment £	Progress September 2013
Continuation of schemes with contractual agreements in place				
Peer support – to develop focus on self management and reduce incidence of relapse	Peer Support services commissioned Timebanking development	Decreased risk of relapse Decreased symptoms Increased self esteem Reduced stigma Increased control over their future Increased community involvement Improved quality of life Increased social support and networks Increased independence Feeling safe in the community	50,000 15,000	Peer support has led to an increase in an individual's wellbeing and independence, reducing their need for support and input from other services. As at June 2013 there were 200 Timebanking members who had exchanged more than 1800 hours activity with each other
Increasing access to psychological therapies	Additional investment within current IAPT contract to widen focus to support people with Long term conditions The future plan	Increase in people feeling supported to manage their condition Improving functional ability in people with long term conditions - employment of people with long terms conditions Reducing time spent in hospital by people with long	170,000	The project has limited outcomes to date; this is not unexpected due to the stage the project is currently at. There is an evolving research base to support the inclusion of psychological support in the treatment of patients with Long term health conditions (LTHC) Outcomes that have been demonstrated in

	is to focus on a particular LTHC, diabetes, as this has demonstrated best outcomes in the national pilots in reducing cost to health and social acre and reducing need for intensive treatments/ encouraging adherence to treatment. Fits with IPCC Meets following strategic criteria - Helping individuals and communities to work together and help themselves", Theme 1 of the H& WB	term conditions - unplanned hospitalisation for chronic ambulatory care sensitive conditions Enhance quality of life for carers - health related quality of life for carers Increased quality of life, ability to self care, compliance with treatment and satisfaction with services received Decreased service utilisation, resulting in potential cost saving		other pilots include: Significant improvement in general psychological measures; PHQ, GAD and WSAS. Significant improvement in diabetes specific psychological measures; self-caring activities, general diet, specific diet and foot care. Significant improvement in blood markers from pre-intervention to 3 month post intervention. Reduction in healthcare cost, Primary Care and Secondary Care utilisation. There is some evidence of outcome in - Staff changes in knowledge, skills, confidence and understanding – through training evaluation Increase in detection of common mental health problems Additional audit for end of scheme includes - Patient changes including; physical health outcomes, mental health outcomes, quality of life indicators, patient's satisfaction, patient confidence in managing self-care and feedback from carers. Qualitative and quantitative information will be included.

	Strategy, "Building resilience and using preventative measures to achieve better health and wellbeing.". Supports roll out of self-care.			Audit of changes to referral rates to the Steps to Wellbeing IAPT service and the outcome of patients involved with this service.
Alcohol prevention and early treatment	Tender for Tier 1 and 2 service provision	Tier 1 and Tier 2 - Individual outcomes (via accredited monitoring tool outcome we or star) Tier 1 and Tier 2 - Service outcomes (via accredited monitoring tool outcome we or star) Increase in number of screening and BI undertaken, based on agreed penetration, and year on year improved rate across drinking population Achievement of standard of 1 in 8 people reducing alcohol consumption as a result of BI Increase in % of people who	95,200	Increase in number of screening and Brief Interventions I undertaken, In Quarter 1 of 2013/14 the provider is achieving well above the target rate for initial screening and Brief Interventions in telephone, face to face and BIT contacts. Currently approximately 1 in 10 people in contact with the service reduce their alcohol consumption to recommended levels Increase in % of people who reduce their alcohol consumption to recommended levels - The first year's activity indicates that 10% of people in contact with the service reduce their alcohol consumption. This will become the benchmark for

		reduce their alcohol consumption to recommended levels Improved efficiency , reduction in DNA, increased volume at Tier 1 Service take-up reflects population profile of Southampton and demonstrates equality of access (including age, gender, ethnicity, city ward, GP practice)		improvement in the next 12 months.
Initiatives to support increase uptake and use of direct payments	The Pilot is targeted to support the City Plan social priority of “increasing take up of clients receiving self-directed support” and contribute to the One Council priority of transformation.	Increase in direct payments The purpose of the ISF Pilot is to help identify:- (i) the specific benefits(or dis-benefits) of an ISF for customers, carers, providers and the Council; (ii) Customer demand for an ISF; (iii) the costs of delivering an ISF An Evaluation Report is scheduled for April 2014, and will include the impact of ISF on:- • Customer choice and control	37,400	The Pilot is at the mid-stage now and an interim evaluation has been completed by each Provider. Findings include:- i) A positive customer demand for ISF. E.g. the Pilot is not only exploring how customers on an SCC “managed account” can transfer to an ISF, but also attracting customers in the Shared Lives service, and a customer who’s “suitable person” is no longer able to mange the DP on their behalf; (ii) An increase in customer and carer satisfaction. E.g. “Carers have been willing to be involved and have viewed ISF as a way of their relative having more control and choice over services”;

		over services; • Customer and carers satisfaction; • The Transition process • Culture change in relationships between customers, provider and the LA; • Service costs; • Progression to a Personal Budget being taken as a Direct Payment (DP). The two Providers will produce a joint "How to - ISF" Guide at the end of the Pilot to inform other providers.		(iii) An emerging interest in considering taking a DP at the end of the Pilot. (iv) An innovative change in PARIS to record the ISF, which also has SCC savings potential on all DP accounts and is a step-change from "time and task" support plans. (v) New and effective partnership working relationships which have improved parent engagement e.g. between Spectrum, SEND Inspector and parent. (vi)The negative impact on stakeholders of the complex records/finance processes and systems within SCC, and inefficiencies.
Vulnerable Adult team in ED		Safeguarding vulnerable children, young people and adults. Improving people's health by helping them to make better lifestyle choices Creating easy referral pathways from secondary to community care Increasing opportunities for self-resilience. Reducing health inequalities	55,000	On average, the Vulnerable Adult Support Workers intervene in the care of 110 patients per month. They are a key referring team to a multitude of community agencies, often identifying and referring patients who are not being identified through other pathways Data provided by key partners suggest the following engagement rates for Southampton City patients (post codes SO14-19): • 80% engagement with the

		amongst those who come from the most deprived populations within the City Promoting better access to services, particularly for those who find it difficult to engage Working in productive partnerships with patients and other health and social care providers Care that is integrated with community services and designed around individual need Review of weekly assault data and multi-agency risk assessment conference (MARAC) lists demonstrate that the VAST are significantly reducing individual patient and organisational risk relating to domestic homicide, due to their comprehensive interventions. VAST plays an important role for the Safe City Partnership by providing weekly data on assaults, as well as impact data about large drinking events.		Independent Domestic Violence Advocacy Service for high risk domestic abuse cases (n = 8/10) from mid July-Dec 12. 75% engagement for standard / medium risk cases referred to Southampton Women's Aid (n=4/6) from mid July-Dec 12. • 54% of referrals to the Quitters service were interested in smoking cessation when contacted post ED attendance ie, booked to clinic, given telephone support or referred to local service (18% not interested; 28% uncontactable). With a UHS average quit rate of 65%, it is estimated that 53 patients referred by ED from May-Dec 12 will have given up smoking for four weeks or more. • Of 81 patients referred to Options/CRI, 35% (n= 28/81) engaged with assessment and 9 patients (11% of total) were referred on to New Road for alcohol treatment. • Of 61 patients referred to the New Road Frequent Attendee Service by VAST and/or the UHS Alcohol Specialist Nurse Service, 83% have engaged with the New Road team. • 58% of referrals to the Drug

				Outreach Team (n = 7/12) from Jul-Dec 12 accessed drug treatment at The Bridge or New Road. The team are playing a major role in meeting the requirements of CQUIN 2013/14 for high intensity users. Evaluation of the alcohol related frequent attendee programme, of which the Vulnerable Adult Support Service plays a major role (through identification and referral of frequent attendees) has demonstrated an average saving per quarter per client of just over £1000. Over a 35-day period, the Vulnerable Adult Support Workers spent 60% (155 out of 262.5 hours) of their time in face-to-face, and other direct clinical activity. If the Vulnerable Adult Support Workers were not available much of this work would either be undertaken by clinical staff or would not be undertaken at all.
Minimise assessment waits and targeted reviews	Increased care management capacity x3		130,600	
Social workers/care managers hospital discharge team to further			346,100	

improve assessments and planning from when date of discharge set				
Newly identified schemes that meet the criteria				
Reablement – specific initiatives to support speedier implementation including medicines management Increase access to equipment, including further development of telecare	0.5wte Telecare technician Telecare project manager OT specialist support	Increase widely held professional awareness of the use of telecare Reduction in care packages due to use of telecare Reduce delayed transfer of care from hospital, attributable to equipment shortage/availability Increase proportion of people who were offered telecare services following discharge Increased number of clients enabled to stay in their place of choice Reduction in admissions to residential and nursing care homes Increased proportion of community to bed based funded packages of care Reduce emergency readmissions within 30 days of discharge	61,500	Increased uptake of telecare opportunities
Prevention/ raising quality in	Quality assessor team	Appropriately skilled workforce across commissioned sector	351,700	Implementation of quality reviews of provider organisations

residential and nursing homes	x 4.5wte	Improved quality standards across commissioned sector Evidence of more personalised care within care homes More choice being exercised by residents Improved activity programmes within residential homes Fewer medication related incidents Reduce avoidable and/or inappropriate ambulance conveyances. Reduce avoidable and/or inappropriate A&E activity Reduce avoidable and/or inappropriate acute admissions		Programme of care funding calculator reviews
Support to carers and focus on self-management	Advocacy support to parents with a Learning disability i therapy for LD clients Independent visitors	Reduced loneliness and isolation Improving health and wellbeing Improving education skills Increasing community spirit	87,900	

Improving hospital discharge	3 x Care manager posts Hospital Discharge admin officer Hospital Discharge weekend worker	Implementation of 7 day discharge service from acute hospital (unsure if this has been achieved) Increased proportion of older people who were offered rehabilitation services following discharge from acute or community hospital Increased proportion of older people 65+ who were still at home 91 days after discharge from hospital into reablement/rehabilitation services Reduce delayed transfer of care from hospital Reduce emergency readmissions within 30 days of discharge	198,300	Contribution to overall reduction 40% of complex patients now being discharged within 2 days, lower in comparison to neighbouring LA's Support available over weekend
Development of extra care services for those with dementia and complex health needs	Specialist adaptations to Graylings to ensure accommodation suitable for those with dementia	Improved levels of independence Admission avoidance improved Reduced isolation Reduction in emergency admissions for acute conditions that should not usually require hospital	89,000	Complete and Graylings about to start providing accommodation for individuals with dementia

		admissions		
It infrastructure			48,600	
Project management			14,000	
Schemes to support maintaining eligibility criteria (funding to support existing adult social care services)			2,380,000	
Outturn 2012/13			**3,495,167**	

2013/14 SCT Allocation	3,970,700
2012/13 Carry forward	147,100
2013/14 less funding for Maintaining Eligibility	-2,380,000
2013/14 Funding Available	1,737,800
2013/14 SCT Funding Requirement / Spending Plan	1,737,100
Surplus / (Deficit)	**700**

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Appendix 2

Example of specific initiative

Timebanking

As of June 2013, there were 200 Time Bank Members, who had exchanged more than1800 hours of activity with each other. A formal Evaluation has been completed on both Woolston and Freemantle Time Banks. It is clear that the impact is positive for both the individuals involved and their communities. The evaluation findings mirror national research which is that Time Banks help their members reduce reliance on paid support, improve their physical / mental health and increase their employment prospects, as well as bringing wider economic benefits to the community as a whole. National research has indicated the average cost of running a Time Bank is £450 per member per year, but the economic returns are of the value of £1300 per member per year. (LSE/ Nef 2011)

Time Banking specifically supports the delivery of SCC priority, “Helping individuals and communities to work together and help themselves”, and Theme 1 of the Health and Wellbeing Strategy, “Building resilience and using preventative measures to achieve better health and wellbeing.”

The plan is to develop a further Time Bank in Redbridge, within existing staff resources and budget. Evidence from national research demonstrates that enabling people to build and maintain social networks and make a positive contribution to their community does promote better health and wellbeing and reduces illness, death rates and emergency bed days with the associated significant savings. Redbridge is a target area for the benefits of Time Banking as it is an area where high numbers of people have been identified as at risk of loneliness and isolation. (Mosaic)

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		UPDATE ON INTEGRATION TRANSFORMATION FUND IMPLEMENTATION		
DATE OF DECISION:		23RD OCTOBER 2013		
REPORT OF:		CHIEF EXECUTIVE, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP AND DIRECTOR OF PEOPLE, SOUTHAMPTON CITY COUNCIL		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

In August 2013 the Government announced £3.8 billion of funding to ensure closer integration between Health and Social Care. This funding has been described as "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities".

To access the ITF there is a requirement to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related elements will be met. This plan will also set out how the additional Social Care transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum. This paper outlines the process for developing the plan.

RECOMMENDATIONS:

(i) That the timetable and procedures outlined in the report for developing pooled budgets be approved.

REASONS FOR REPORT RECOMMENDATIONS

1. Plans for the use of the pooled monies will need to be developed jointly by the Clinical Commissioning Group and local authority and signed off by each of these parties and the local Health and Well Being Board by March 2014.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Options for use of the ITF will be developed as part of the planning process. The options will identify how the funding streams already coming into the CCG and SCC, that are badged under the ITF, can be redesigned to achieve integration priorities

DETAIL (Including consultation carried out)

3. **Expectations of the Integration Transformation Fund**

   The aim of the ITF is to provide an opportunity to transform care so that people are provided with better integrated care and support. The main focus being on development of high quality, co-ordinated care for frail older people and those with long term conditions.

4. The NHS England statement on the ITF states that: The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The ITF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. We see the ITF as a significant catalyst for change.

5. The ITF will be subject to the following national conditions which will need to be addressed in the plans:
   - Plans to be jointly agreed
   - Protection for social care services (not spending)
   - As part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
   - Better data sharing between health and social care, based on the NHS number
   - Ensure a joint approach to assessments and care planning
   - Ensure that, where funding is used for integrated packages of care, there will be an accountable professional
   - Risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached/outcomes not delivered
   - Agreement on the consequential impact of changes in the acute sector, hospital activity will have to change to support new models of care

6. The ITF is identified as a way to achieve integration as defined in 'Integrated care and support: our shared commitment'. This is described from the perspective of the individual – as being able to "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".

7. The features of the models include concepts such as:

- Personalisation approach, strong investment in preventative services and towards self management of care
- Risk stratification to identify those who will benefit most from integrated acre
- Care co-ordination, including co-ordination that starts as soon as person enters hospital
- Well managed transitions
- Single electronic care records
- Multi disciplinary teams working around primary care practices
- Holistic approach, including integration between physical and mental health

8. The elements described above, including the definition of integration, are all key features of the Integrated Person Centred Care strategic priorities identified locally. This is an opportunity to achieve significant transformational change and a lever to drive up the quality and effectiveness of services.

9. **Approval process**

Plans for the use of the pooled monies will need to be developed jointly by the Clinical Commissioning Group and local authority and signed off by each of these parties and the local Health and Well Being Board by March 2014. The plan will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

10. Ministers have agreed that they will oversee and sign off the plans. As part of achieving the right balance between national and local inputs the LGA and NHS England will work together to develop proposals for how this could be done in an efficient and proportionate way.

11. The funding will be released based on the agreement of a joint local plan, At this stage it is not confirmed if the money will be released from NHS England or via local CCGs. The intention is that this is a pooled budget not just a transfer from health to social care.

12. Local areas can add to the fund or pool more budgets. This may want to be considered, including discussions with NHS England Local area team.

13. **Funding detail**

The £3.8billion is made up of the existing amount (£859m) that transfers from NHS to Local Authorities and around £2billion of 'new' funding which is being allocated from CCG budgets and other sources.

14. £1billion (locally approximately - £4.6m) of the ITF in 2015/16 will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014/15 as the first half of the £1bn, paid on 1st April 2015, is likely to be based on performance in the previous year. NHS England will be working with central Government on the details of this scheme, but they anticipate that it will consist of a combination of national and locally chosen measures.

15. The potential implications of this for Southampton are:

- Social Care Transfer funding of £3,971,000 that currently flows from NHS England Local Area Team to SCC
- Additional Social Care Transfer £925,000 for 14/15. Funding source currently unknown
- Re-ablement funding of £1,387,000. This is held by the CCG and the majority is invested in SCC reablement services
- CCG Carers Breaks funding

16.

Description	National	Southampton impact (estimate)	Comment
	£'000	£'000	
National £859m	859,000	3,971	Already exists. Funding flows: DH>LAT>LA
Additional funding 14/15	200,000	925	Funding flows unknown
Capital	350,000	1,618	Held nationally
Re-ablement	300,000	1,387	Already in CCG budget
Carers Breaks	130,000	601	
CCG Additional Funding	1,900,000	8,783	
Total	3,739,000	17,285	

17. How the funding is to be allocated to each area is still to be confirmed. The figures outlined above are locally developed estimates based on currently available information. There will a shift from CCG baseline budgets and will impact on currently commissioned services. All of the funding outlined above is already currently committed within budgets. The aim of the ITF development is how locally we will work together to define how the funding will be spent differently

18. **Timescale for the funding**

The Integration Transfer Fund (ITF) does not come into full effect until 2015/16 but it is expected that Clinical Commissioning groups (CCGs) and Local Authorities build momentum in 2014/15, using the additional £200m due to be transferred to LAs to support transformation. This is assumed to be transferring from CCG baselines but this is still to be confirmed. In effect there will need to be two-year plans for 2014/15 and 2015/16, which must be in place by March 2014.

19. 2014/15 will be a lead in and planning year. 2015/16 full level of funding will be released.

20. **Process to develop plan**

Task and Finish group will be established, co-ordinated by the Integrated Commissioning Unit. This outputs of this group will include:

- Mapping and scoping
- Principles and outcomes
- Option appraisal, including plans for financial risk sharing
- Communications plan and user/carer engagement

21. Vulnerable People Board will function as stakeholder group with monthly meetings.

22. Initial draft proposals will be presented to the Health and Well Being Board 27/11/13, with more refined recommendations 29/01/14 and final sign off at the March 2014 meeting. This will allow for work with key stakeholders and allow time for effective scrutiny.

RESOURCE IMPLICATIONS

Capital/Revenue

23.

£1.9 billion existing funding continued from 14/15 this money will already have been allocated across the NHS and social care to support integration	
£130 million Carers' Breaks funding	£350 million capital grant funding (including £220m of Disabled Facilities Grant).
£300 million CCG reablement funding.	£1.1 billion existing transfer from health to social care.
Additional £1.9 billion from NHS allocations Includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. Includes £1 billion that will be performance related, with half paid on 1 April 2015 (which we anticipate will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in year	

performance).

Property/Other

24. To be determined as part of the planning work

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

25. NHS England Publications Gateway Ref 00314 outlines the initial details of the Integration Transformation Fund.

    Detailed guidance will be included in the NHS Planning Framework once issued. NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:
    - Allocation of Funds
    - Conditions, including definitions, metrics and application
    - Risk-sharing arrangements
    - Assurance arrangements for plans
    - Analytical support e.g. shared financial planning tools and benchmarking data packs.

Other Legal Implications:

26. None

POLICY FRAMEWORK IMPLICATIONS

27. This will impact on SCC and CCG Commissioning intentions

KEY DECISION Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Project Initiation Document

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes – will be developed as part of the planning process

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
None	

Report Tracking

VERSION NUMBER:	2
DATE LAST AMENDED:	14/10/13
AMENDED BY:	Claire Heather

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NHS
Southampton City
Clinical Commissioning Group

Appendix 1

DRAFT Project Brief
Integrated Commissioning Unit
Integration Transformation Fund

Overall Aim:	To produce a local delivery plan for the Integration Transformation Fund which is a national requirement for submission by 31 March 2014. The plan will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related elements will be met. The plan needs to be signed off by the local Health and Wellbeing Board and the final draft is due to be presented to the Board for sign off on 29 January 2014.
Main Objective(s):	To ensure the development of a robust jointly agreed local delivery plan capable of: a) achieving the national and local targets for the performance related elements of the fund and managing any associated risks and b) driving the scale of system and cultural change required to improve outcomes for vulnerable adults living in Southampton.
Project Title:	Development of Local Delivery Plan for Integration Transformation Fund.
Project Director:	Stephanie Ramsey
Project Lead:	Donna Chapman
Project Manager:	Jamie Schofield
Start date:	1 October 2013
End date:	31 March 2014

Version	Date Issued	Brief Summary of Change	Owner's Name
1	8 October 2013	Initial draft	DC
2			
3			

1. Project Description / Purpose

The purpose of this document is to set out how the CCG and City Council will work together to develop the local plan for the Integrated Transformation Fund (ITF) which will need to be submitted to DH by 31 March 2014. It sets out the key principles for use of the ITF, what the plan will cover, the key tasks required and timeline to develop the plan, how key stakeholders will be involved and how the plan will be signed off locally.

It should be noted that detailed guidance on the use and make up of the ITF is not due til December and so this PID and the drafts of the local plan that are developed before 31 December 2013 have been based on the limited guidance available to date and are subject to change.

The PID will be presented to and signed off by the Health and Wellbeing Board.

2. Background

In August 2013 the Government announced £3.8 billion of funding to ensure closer integration between Health and Social Care. This funding has been described as "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities".

To access the ITF there is a requirement to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related elements (£1bn) will be met. This plan will also set out how the additional £200m Social Care transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum. In effect there will need to be two-year plans for 2014/15 and 2015/16, which must be in place by March 2014.

Ministers have agreed that they will oversee and sign off the plans. As part of achieving the right balance between national and local inputs the LGA and NHS England will work together to develop proposals for how this could be done in an efficient and proportionate way.

The funding will be released based on the agreement of the joint local plan. At this stage it is not confirmed if the money will be released from NHS England or via local CCGs. The intention is that this is a pooled budget not just a transfer from health to social care.

Funding detail

The £3.8billion is made up of the existing amount (£859m) that transfers from NHS to Local Authorities and circa £2 billion of funding which is being allocated from CCG budgets and other sources.

£1billion (locally approximately £4.6m) of the ITF in 2015/16 will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014/15 as the first half of the £1bn, paid on 1st April 2015, is likely to be based on performance in the previous year. NHS England will be working with central Government on the details of this scheme, but they anticipate that it will consist of a combination of national and locally chosen measures.

The funding locally therefore includes:

- Social Care Transfer funding of £3,971,000 that currently flows from NHS England Local Area Team to SCC
- Additional Social Care Transfer £925,000 for 14/15. Funding source currently unknown.
- Re-ablement funding of £1,387,000 which is held by the CCG and the majority is invested in SCC reablement services.
- CCG Carers Breaks funding.

This is summarised in the table below.

Description	National	Southampton **estimated** Share	Comment
	£000	£000	
National £859m	859,000	3,971	Already exists. Funding flows: DH>LAT>SCC
Additional funding 14/15	200,000	925	Funding flows unknown. Assumed from CCG baseline.
Capital	350,000	1,618	Held nationally.
Re-ablement	300,000	1,387	Already exists. Funding flows: CCG>SCC or Provider
Carers Breaks	130,000	601	200k already earmarked carers funding in CCG baseline. Remaining 401k assumed to be from CCG Baseline
Additional funding	1,900,000	8,783	Assumed from CCG Baseline
Total	3,739,000	17,258	

It should be noted that the ITF is not new money. A significant proportion is assumed to come from CCG baselines which are already committed and funding much of the community health provision that is critical to the integrated care agenda. There is therefore an acknowledgement that some of the ITF will continue to be used for existing community services which fall within its scope, albeit with some service redesign.

3. Context

The aim of the ITF is to provide an opportunity to transform care so that people are provided with better integrated care and support. The main focus being on development of high quality, co-ordinated care for frail older people and those with long term conditions.

The NHS England statement on the ITF states that: The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The ITF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. It should be seen as a significant catalyst for change.

The ITF will be subject to the following national conditions which will need to be addressed in the plans:

- Plans to be jointly agreed
- Protection for social care services (not spending)
- As part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning

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- Ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached/outcomes not delivered
- Agreement on the consequential impact of changes in the acute sector, hospital activity will have to change to support new models of care

The features of the models include concepts such as:

- Personalisation approach, strong investment in preventative services and towards self management of care
- Risk stratification to identify those who will benefit most from integrated care
- Care co-ordination, including co-ordination that starts as soon as person enters hospital
- Well managed transitions
- Single electronic care records
- Multi disciplinary teams working around primary care practices
- Holistic approach, including integration between physical and mental health

The elements described above, including the definition of integration, are all key features of the Integrated Person Centred Care strategic priorities identified locally.

4. Project Scope

At this stage, the assumption is that the focus of the ITF will be on frail older people and those with two or more long term conditions. This will need to be confirmed when further guidance becomes available later in the year.

The ITF local delivery plan will cover the following:

- key principles
- key outcomes to be achieved
- client group
- scope of provision to be included and how this interfaces with wider system
- review of the current provision in scope and what needs to change/improve
- development of service specifications for the provision in scope with agreed KPIs and information requirements
- option appraisal for service delivery vehicle and recommendations
- financial modelling for the ITF, ensuring that funding flows reflect strategic drive towards community care and away from the acute sector
- heads of terms for the pooled fund
- risks and mitigation plans
- governance arrangements for pooled fund

5. Key Principles

The following principles will underpin the development of the local plan for the ITF:

- The ITF will be established as a pooled fund, jointly managed by the CCG and City Council (as opposed to a transfer of funding from health to the local authority)
- It is acknowledged that some of the ITF will continue to be used for existing community

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health services which fall within its scope, although this provision may be redesigned.

- Use of the ITF will be outcome focussed and there will be service specifications in place for all components of service delivery with clear KPIs and outcome measures.
- The ITF will be seen as a catalyst for change, with a strong focus on delivering the existing integrated person centred care agenda
- The City Council and CCG will work together to ensure that the funding to be transferred from the CCG baseline reflects as much as possible the drive towards supporting people in their own home and community and out of the acute sector.

6. Project Organisation

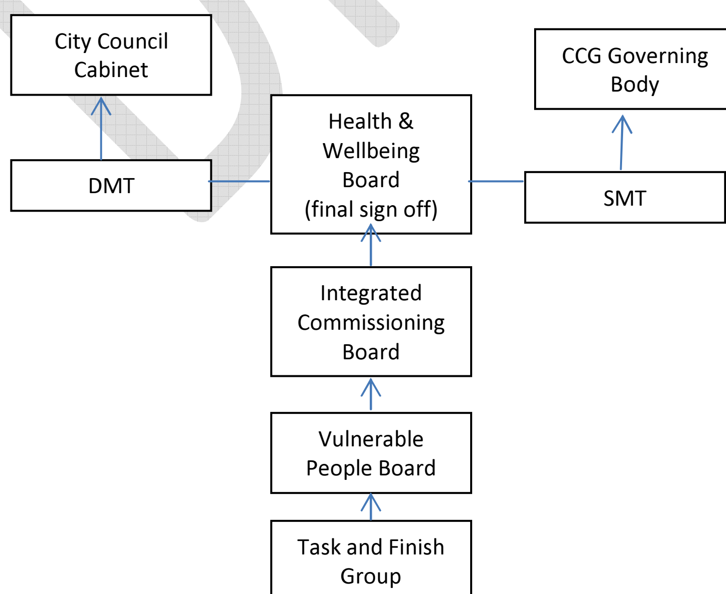
The development of the local plan will be the responsibility of a small task and finish group (TFG) with the following membership:

- Director of Integration
- Associate Director Integrated Care
- GP Clinical Lead
- Head of financial planning
- Senior Commissioning Managers – integrated care
- Joint Commissioning Manager - mental health
- Finance Manager, Adult Social Care
- Health Partnerships and Strategic Business Manager – Public Health
- Senior Contract Manager, CSU

Members of the TFG will be allocated the tasks within this PID. The TFG will be coordinated by the Associate Director, Integrated Care and **will meet fortnightly**.

The TFG will report to the Vulnerable People commissioning board/strategic commissioning group on a monthly basis. This group has representation from UHS, Solent NHS Trust, Southern Health, voluntary and community sector and primary care.

7. Governance



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8. Timeline

7. Timescales / Project Plan

Milestone	Tasks/Description	Deadline	By Whom – Lead
Benchmarking and horizon scanning	Review local and national practice in relation to ITF and build into local planning	Ongoing	All members TFG
Scope	Definition of scope of provision to be included and how this interfaces with wider system Review of services within scope (health and social care) - What outcomes are being achieved - What's working well - What needs improving/changing - Where there are gaps - Current spend versus budget Consider fit with personalisation agenda Development of service specifications with clear KPIs and information requirements for all elements within scope	31 October 13 January	JS with support from stakeholders and other members of TFG
Service delivery vehicle	Appraisal of options for delivery the services – eg. options may include joint venture, social enterprise, lead provider arrangement, mixed market Recommendation for preferred model	13 November	AL/JS With support from stakeholders and other members of TFG
Financial Modelling	Identification of existing and committed funding streams which will transfer into ITF Financial modelling around acute care tariff Financial modelling linked to QIPP – e.g. admission avoidance, reduction XBDs	7 November	PH/DCu with support from other members of TFG

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Performance measures	Review the local and national targets for performance related components of the ITF – awaiting national guidance Identify current position and performance gap Ensure that service delivery for the ITF is designed to achieve local and national targets	7 November	DCh
ITF Risk and mitigation strategy	Development of risk management strategy	5 December	JS
Heads of terms and governance arrangements for pooled fund	Development of heads of terms for a pooled fund agreement. To include: - Key principles - Outcomes to be achieved - Risk management - Governance arrangements - Monitoring arrangements - Conflict resolution - Handling of variations and terminations - Liabilities	5 December	DCh
Finalisation of local plan	1st draft Second draft Final high level version	13 November 6 December 13 January	DCh
Planning for 14/15	Develop implementation plan for 14/15 to: - Ensure delivery of local and national targets linked to performance related component of ITF - Firm up on arrangements for 15/16	31 March 2014	DCh

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8. Outline Risk Register for development of robust local plan

Risk Description	Impact (H/M/L)	Probability (H/M/L)	Mitigation & Contingency Plans	Lead
Stakeholders unable to provide necessary commitment to project – e.g. non attendance at meetings; not submitting requested information about current provision/need	H	H	PID to be shared with providers at high level meetings – system chiefs, strategic exchange as well as at vulnerable people board	SR
Information systems unable to provide required financial or activity information in timely manner	H	H	Identify early on information required and submit requests as high priority Escalate if necessary	PH
Unable to deliver project to timescales within current resources	H	M	Project management and regular meetings/feedback Continued sign up from all organisations to deliver the project against plan and commit required resources	DCh
Solent re-basing exercise still unknown – uncertainty of funding	M	M	Establish early on as part of financial modelling principles regarding which figures should be used – propose that this is pre-re-basing figures. Ensure that this is made clear at system chiefs.	PH
Contractual processes and timescales do not align, e.g. contract negotiations with UHS do not align with planning for ITF and therefore unable to achieve necessary service change	H	M	Establish timescales for contract negotiations and brief contracting leads early on regarding plans for ITF and key dependencies, e.g. splitting of tariff. KH to liaise with acute contracting colleagues.	KH

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DECISION-MAKER:	HEALTH AND WELLBEING BOARD			
SUBJECT:	PROPOSAL TO JOIN THE SMOKEFREE ACTION COALITION			
DATE OF DECISION:	23RD OCTOBER 2013			
REPORT OF:	DIRECTOR OF PUBLIC HEALTH			
CONTACT DETAILS				
AUTHOR:	**Name:**	**Ginny Cranshaw**	**Tel:**	**023 8083 4398**
	E-mail:	**ginny.cranshaw@southampton.gov.uk**		
Director	**Name:**	**Andrew Mortimore**	**Tel:**	**023 80833204**
	E-mail:	**andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report proposes that the Health and Wellbeing Board submits an application on behalf of the Council to join the Smokefree Action Coalition (SFAC), the national campaign network for tobacco control. The SFAC has over 100 member organisations across the country representing health, social care, trading standards, environmental health and many other parts of civil society. Membership is **free** to local authorities, provides many benefits, and sends a strong message of the Council's commitment to tackling tobacco control. Smoking remains the main cause of preventable deaths in England, and is a major cause of health inequalities.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board submits an application for membership of the Smokefree Action Coalition on behalf of the Council.

REASONS FOR REPORT RECOMMENDATIONS

1. By joining the Coalition the Council will send a clear message of its intention to tackle the harm done by tobacco in this city.

2. It will be able to engage with the numerous other local authority members of the Coalition regarding Tobacco control issues, engage in national level campaigns, and have access to policy support.

   Free membership provides:

   - **Support** – Coalition core members provide advice and support to other members such as engaging local stakeholders or responding to national consultations.
   - **Information** –regular emails about national and regional activity with detailed briefings made available on core topics.
   - **Profile** – being part of the SFAC is a symbol of the organisation's commitment to ending the harm caused by tobacco.

- **Network –** The Coalition is an excellent way to stay in touch across the country
- **Collective action** - Opportunities to be part of the national platform on tobacco control, including taking part in collective action regionally or nationally.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. By not joining the SFAC, the Council will not maximise this opportunity to instigate more effective tobacco controls, and will continue to see smoking as a major cause locally of health inequalities, and the city will continue to bear the financial costs of this.

DETAIL (Including consultation carried out)

4. Nearly one quarter of the population of Southampton still smoke. Compared to the national picture where smoking prevalence has decreased to 20%, prevalence in Southampton is 22.6%. More people die in Southampton as a result of smoking than the national average (age-standardised rates of 236 per 100 000, compared to 210.6 in England), and deaths from lung cancer and chronic obstructive pulmonary disease are also higher than the national average (Southampton Health Profile 2013).

5. Smoking is a major cause of health inequalities and prevalence rates vary across the city, with the highest rates in Weston, Redbridge and Thornhill. Hospital admissions in the city due to smoking are higher than the national average, with the highest rates in Bitterne and Redbridge wards (age-standardised rates of 2426 per 100,000 and 2369 per 100,000 respectively for 2009/10 - 2011/12). This compares to the city average of 1747 per 100,000, and 1420 per 100,000 nationally. Smoking rates are higher amongst the city's routine and manual classes at 36.8% compared to the national average of 30.3%. Smoking in pregnancy rates are also higher than average at 16.6%, compared to the national average of 13.2%.

6. Information modelled by Action for Smoking and Health (ASH) indicates that smoking in Southampton costs our population £70.9m annually (ASH). Local employers and businesses lose from increased sickness, and an estimated £81.1m annually is lost to Southampton's local economy by spending on cigarettes and tobacco. £1.9 million is spent by the council each year on picking up litter from tobacco products.

7. Historically Southampton City PCT worked collaboratively with partners across Hampshire and the Isle of Wight to develop a Tobacco Control plan for the region for 2010-2013. The work of this partnership has now been reported on, providing a platform for the next stage in developing this key work. A local tobacco control plan is being drafted for the city which outlines work with a range of partners on tobacco control measures designed to reduce levels of smoking in the city and the harm caused by tobacco smoke. This will contribute towards improving the Health and Wellbeing of the

residents of Southampton City, supporting the aims of the Council's *Health and Wellbeing Stratgey*, which identifies smoking and tobacco control as a priority preventative measure. By reducing the spend on tobacco and other products, and the associated costs of tobacco control, this will also support the Economic Development strategies for the city.

8. The Tobacco Control Plan for the city will include commissioning citywide Stop Smoking Services, supporting action to reduce the availability of cheap and illicit tobacco, and working with Early Years settings to stop the inflow of new smokers and protect families and young children from the dangers of secondhand smoke.

9. Services to support people wanting to stop smoking are currently commissioned by the Public Health team from Solent Quitters, Community pharmacies and GP Practices. Trading Standards and Environmental Health undertake key tobacco control work in partnership with the local business community, aiming to ensure compliance with legislation in local businesses, and limit illicit tobacco by controlling smuggled and counterfeit tobacco.

10. Membership of the SFAC means the Council will be part of national advocacy work on national level interventions which will have a significant local impact. This will ensure that activities and interventions that are commissioned are linked to a strong evidence base and provide a return on investment and value for money.

RESOURCE IMPLICATIONS

Capital/Revenue

11. None. Membership of the Coalition is free.

Property/Other

12. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. The Health and Social Care Act 2012 transferred public health smoking services to upper tier local authorities.

Other Legal Implications:

14. The Local Government Pension Scheme Advisory Board is currently seeking legal advice on whether owning tobacco stocks clashes with councils' new responsibilities to promote public health. Nationally many local authority pension schemes invest in tobacco-producing firms, but Hampshire council only invests an estimated 2% of its £3.6bn pension scheme holdings in tobacco-producing firms.

POLICY FRAMEWORK IMPLICATIONS

15. None.

KEY DECISION No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

- www.smokefreeaction.org.uk/
- Southampton City Council Health and Wellbeing Strategy
- Southampton Joint Strategic Health Assessment 2012
- Integrated Household Survey 2009
- Southampton Health Profile, available at: http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=so15®ION=50159&LA=50148&AR=

Equality Impact Assessment and Other Background documents available for inspection at:

Public Health, Civic Centre, Southampton.

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Report Tracking

VERSION NUMBER:	V.3
DATE LAST AMENDED:	14.7.10.2013
AMENDED BY:	Claire Heather

DECISION-MAKER:	HEALTH AND WELLBEING BOARD			
SUBJECT:	CHAIR'S REPORT			
DATE OF DECISION:	23RD OCTOBER 2013			
REPORT OF:	COUNCILLOR DAVE SHIELDS, CHAIR, HEALTH AND WELLBEING BOARD			
CONTACT DETAILS				
AUTHOR:	Name:	Councillor Dave Shields	Tel:	023 8083 4960
	E-mail:	councillor.d.shields@southampton.gov.uk		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

To note the actions taken by the chair of the Health & Wellbeing Board since the August 2013 meeting

RECOMMENDATIONS:

(i) To note the actions taken by the chair of the Health & Wellbeing Board since the August 2013 meeting.

REASONS FOR REPORT RECOMMENDATIONS

1. This report provides a brief snapshot of the activities undertaken by the chair of the Health & Wellbeing Board in between formal meetings
2. This report also details correspondence entered into by the chair of the Health & Wellbeing Board in between formal meetings

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None.

DETAIL (Including consultation carried out)

4. Since the August meeting of the Health & Wellbeing Board the Chair has been involved in the following activities:

- Informal meeting with Kevin Brooks of the University of Southampton in respect of prospective links with Wessex Academic Health Science Networks – Southampton (2nd September 2013)
- Attendance at the South East Chairs of Adult Social Care network meeting and South East branch of ADASS - London (6th September 2013)
- Informal meeting with Andy Burnham, MP prior to addressing Southampton Pensioners Forum – Southampton (9th September 2013)
- Informal meeting with Cllr. Spencer Flower, chair of Dorset County Health & Wellbeing Board – Dorchester (13th September 2013)
- Attendance at and provider of an inaugural address to Public Health England Wessex Centre 'going live' launch event – Chilworth (20th

September 2013)

- Attendance at a briefing from NHS England (Wessex Local Area Team) on the process for commissioning specialised services – Chilworth (20th September 2013)
- Attendance at LGA conference on showcasing national best practice for Health & Wellbeing Boards – London (1st October 2013)
- Informal meeting with Cllrs. Ann McNair Scott and Elizabeth Fairhurst, cabinet members serving on Hampshire County Health & Wellbeing Board - Winchester (7th October 2013)

RESOURCE IMPLICATIONS

Capital/Revenue

5. None.

Property/Other

6. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

7. None.

Other Legal Implications:

8. None.

POLICY FRAMEWORK IMPLICATIONS

9. None.

KEY DECISION No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule

		12A allowing document to be Exempt/Confidential (if applicable)
1.	None	
2.		

Report Tracking

VERSION NUMBER:	1
DATE LAST AMENDED:	14/10/13
AMENDED BY:	Cllr Shields

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