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Health and Wellbeing Board

Wednesday, 14th May, 2014 at 6.00 pm

Council Chamber - Civic Centre

This meeting is open to the public

Members

Councillor Shields (Chair)
Councillor Jeffery
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

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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.
Dates of Meetings: Municipal Year 2014/15

2014	2015
14 May	28 January
30 July	25 March
1 October	
3 December	

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 INTERESTS

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

DISCLOSABLE PECUNIARY 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
b) 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 an, '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 26th March 2014 and to deal with any matters arising, attached.

STRATEGIC DEVELOPMENTS

5 NHS ENGLAND SPECIALIST SERVICES CONSULTATION

Report of the Director of Public Health, requesting that the Health and Well Being Board and the Health Overview and Scrutiny Panel respond to the general principles of the consultation, and encourage more detailed responses from local organisations, patients, carers and clinicians on the content of the specifications, attached.

DECISION MAKING

6 HEALTH AND WELLBEING BOARD FACILITATED SELF-ASSESSMENT

Report of the Assistant Chief Executive, seeking the Board's agreement to undertake the Local Government Association's (LGA) self assessment tool for Health and Wellbeing Boards, attached.

BOARD UPDATES

7 BETTER CARE SOUTHAMPTON UPDATE

Report of the Chief Executive, Southampton CCG and the Director of People, providing an update on progress towards the implementation of Better Care Southampton, attached.

8 MENTAL HEALTH CRISIS CARE CONCORDANT

Policy Briefing from the Deputy Police and Crime Commissioner providing details of non-statutory guidance issued by the Department of Health and partner agencies, aimed at tackling and preventing mental health crises and improving outcomes for those experiencing such crises, attached.

Tuesday, 6 May 2014 Head of Legal and Democratic Services

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 26 MARCH 2014

Present: Councillors Baillie, Lewzey, Shields (Chair) and Jeffery
Dr Mortimore, Dr Townsend (Vice-Chair), Dr Ward, Stephanie Ramsey and Rob Kurn

40. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The Board noted the apologies of Councillor McEwing and Alison Elliott and that Stephanie Ramsey was in attendance and representing Alison Elliott for the purposes of this meeting.

41. **DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS**

Councillor Shields declared a personal interest in that he was a member of Healthwatch England and a Council appointed representative of Solent NHS Trust and remained in the meeting and took part in the consideration and determination of items on the agenda.

Councillor Lewzey declared a personal interest in that he was a Council appointed representative of Southern Health NHS Foundation Trust and remained in the meeting and took part in the consideration and determination of items on the agenda.

42. **STATEMENT FROM THE CHAIR**

In accordance with accepted practice a statement was made by the Chair in relation to Public Health England's report on water fluoridation.

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

RESOLVED that the Minutes of the Meeting held on 29th January 2014 be approved and signed as a correct record.

44. **LSCB ANNUAL REPORT**

The Board considered the report of the Independent Chair of LSCB, attaching the 2012-13 Annual LSCB Report and Business Plan

The Board noted the following points:-

- That it was important to engage all partners as well as listen to "the voices" of young people in the city.
- Two challenges for which the LSCB had to be prepared was the forthcoming Ofsted inspection in Children's Services which would now include scrutiny of the the LSCB and the number of Serious Case Reviews currently being undertaken which are likely to create both media and public interest.

- Changes to legislation in the Children and Family Bill would bring new arrangements for Children's Services involving responsibility for young people with special educational needs up to the age of 25 years and children in care up to the age of 21 years. It was important that there was a close working relationship between the Adult Safeguarding Board and Children's Trust.
- LSCB's priorities going forward were to ensure that safe practices were in place, thus would be achieved via thorough audits and examination of complex data sets, direct contact with young people and working closely with the MASH (Multi-Agency Safeguarding Hub) which was launched on 1 April.

RESOLVED

(i) that the Health and Wellbeing Board noted the LSCB 2012-2013 Annual Report and the priorities set out in the Business Plan;
(ii) that future links and joint working between the Health and Wellbeing Board and the LSCB be agreed; and
(iii) that an update report which would include progress on the MASH would be tabled at the meeting on 30th July 2014.

45. **PUBLIC HEALTH ANNUAL REPORT**

The Board received the report of the Director of Public Health attaching the Public Health Annual Report 2013/14, setting out the City's key health issues.

The Board also received a presentation from the Director of Public Health providing details of key elements of the Annual Report. It was noted that there were 4 themes summarised in the report ie

- Wider impacts on health and wellbeing covering housing and violent crime
- Health lifestyles covering smoking and happiness
- Protection from health threats covering sexual health and common infectious diseases
- Living long, living well covering diabetes and chronic kidney disease

The Board highlighted the following points:-

- Housing – 38% of privately owned and rented homes in the city did not meet the Decent Homes Standard and robust privatisation and regeneration of the city's large estates would be a key issue.
- Economic wellbeing - 26% of Southampton's children lived in poverty.
- Lifestyle – smoking remained one of the biggest causes of premature mortality in the City.
- Over the period 2009 to 2013 the rate of children in care increased by 58% in Southampton compared to an 11% increase nationally.
- Serious sexual crimes were up by 25% and robust focus was required in this area.
- Profiles on a ward by ward/ locality basis enabled elected members and GP's to note any problem areas and better engage with people.

RESOLVED that the Health and Wellbeing Board welcomed the Public Health Annual Report and noted the implications for the future work of the Board.

46. **NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING STRATEGY 2014-2019 "A HEALTHY AND SUSTAINABLE FUTURE"**

The Board considered the report of the Chief Executive, Southampton City CCG, providing details of Southampton's Five Year Strategy.

The Board also received a presentation from the Chief Executive, Southampton City CCG and the Vice Chair of the Health and Wellbeing Board, providing further information on the strategy.

The Board noted that the five goals outlined in the strategy were:

- making care safer by nurturing a diverse range of safe and competent providers;
- making care fairer by reducing health inequalities;
- improving productivity (achieving more with less, more effectively) by streamlining urgent care, efficient planned care, earlier detection and diagnosis and services closer to home;
- shifting the balance of care through Better Care Southampton by co-ordinated local care, better discharge and reablement and engaged and resilient communities; and
- sustainable finances.

It was AGREED that providers would be invited to the informal Health and Wellbeing Board meeting on 23rd April where the CCG strategy would be discussed further.

RESOLVED

(i) that the Health and Wellbeing Board supported the strategic direction outlined in the report and presentation;
(ii) that the consultation process be noted and that the finalised strategy would be presented at the Board Meeting scheduled for 14th May 2014; and
(iii) that authority be delegated to the Chair of the Health and Wellbeing Board, in conjunction with the Chair of the CCG to agree the final quality premium metrics.

47. **SOUTHAMPTON'S RESPONSE TO GOVERNMENT PLEDGE FOR BETTER CHILDREN AND YOUNG PEOPLE'S OUTCOMES**

The Board considered the report of the Director of Public Health providing details of the Government pledge for "Better Children and Young People's Outcomes" and requesting that Southampton sign up to the national pledge.

It was noted that there were extensive indicators involved and that it was important that focus was attributed to the key issues for the City

RESOLVED:

(i) that the Health and Wellbeing Board signed up to the National Pledge for better health outcomes for children and young people; and
(ii) that the Children and Young People's Trust Board be accountable to the Health and Wellbeing Board for delivery of the pledge by initiating an action

plan to ensure that organisations worked in partnership for the benefit of children and young people.

48. **TACKLING TEENAGE PREGNANCY**

The Board considered the report of the Director of Public Health providing details of a new sexual health plan for Southampton, incorporating teenage pregnancy as a priority.

The Board noted that:-

- In March 2014 a task and finish group had been convened to provide a renewed focus on sexual health and had identified teenage pregnancy as a priority area.
- Although the rate of teenage pregnancy had declined in Southampton over the last decade, it still remained significantly higher than the rate in the South East and England nationally.
- That the two areas that had been identified as having the largest impact on reducing teenage pregnancy rates was high quality sex and relationships education (SRE) for all young people and good access to effective contraception for young people who were sexually active.

RESOLVED:

(i) that the Health and Wellbeing Board supported the development of a refreshed sexual health plan for Southampton, incorporating teenage pregnancy as a priority;
(ii) that the Health and Wellbeing Board noted that Councillor Challoner, the Cabinet Member for Safeguarding, had been appointed as the champion for tackling teenage pregnancy, supported by Councillor Kaur, the Cabinet Member for Communities; and
(iii) that the Southampton sexual health strategic group should work closely with the Cabinet Member champions on teenager pregnancy issues.

49. **TOBACCO CONTROL PLAN**

The Board considered the report of the Director of Public Health, detailing the Tobacco Control Plan which provides a co-ordinated approach to prevent the damage done by smoking to the city's population.

The Board also received a presentation from the Public Health Practitioner/ Commissioning Lead providing further information on the Tobacco Control Plan.

The Board noted that the estimated smoking prevalence in Southampton was 22.6%, that there had been 2113 hospital admissions in 2012 attributable to smoking and smoking was the primary reason for the gap in life expectancy between the rich and poor.

RESOLVED:

(i) that following consultation with the Director of Public Health, the Tobacco Control Plan be ratified by the Health and Wellbeing Board; and

(ii) that the Public Health Team established a working group with key stakeholders to deliver the actions outlined in the Action Plan and report back to the Health and Wellbeing Board on progress.

50. **BETTER CARE SOUTHAMPTON UPDATE**

The Board received and noted the report of the Director of Quality and Integration providing details of progress made towards the implementation of Better Care Southampton.

The Board noted the following:-

- That the first iteration of the Better Care Southampton local plan had been submitted on 14th February and positive feedback had been received from NHS England.
- Changes to the plan were in progress for the final submission on 4th April 2014.
- That the plan changed the whole model of how services were delivered and it was essential that both the Council and CCG committed to the pooled budget.

RESOLVED that progress towards the implementation of Better Care Southampton be noted.

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DECISION-MAKER:		HEALTH AND WELL BEING BOARD AND HEALTH AND OVERVIEW SCRUTINY PANEL		
SUBJECT:		NHS ENGLAND SPECIALIST SERVICES CONSULTATION		
DATE OF DECISION:		14 MAY 2014		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dr RA Coates**	**Tel:**	**023 8083 3537**
	E-mail:	**Bob.Coates@southampton.gov.uk**		
Director	**Name:**	**Andrew Mortimore** **Alison Elliott, Director of People**	**Tel:**	**023 8083 3204** **023 8083 2602**
	E-mail:	**Andrew.Mortimore@southampton.gov.uk** **Alison.Elliott@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

A Joint Health and Well Being Board and Health Overview and Scrutiny Panel meeting on 14th May will consider a local response to NHS England's consultation on specialist services. The consultation runs until 21 May 2014, focusing on a number of changes to service specifications while also seeking some broader views on the wider implications of these changes. The specifications should be read alongside the operating model called "Securing Equity & Excellence in commissioning specialist services.

The consultation asks 3 questions, each framed around the specifications listed in the consultation:

- In your view, what would be the effect of the proposed changes on the service?
- What further changes, if any, do you think need to be made to this document?
- Are there any other considerations not reflected in the document that you wish to draw to our attention?

RECOMMENDATIONS:

That the Health and Well Being Board and the Health Overview and Scrutiny Panel are recommended to respond to the general principles of the consultation, and encourage more detailed responses from local organisations, patients, carers, and clinicians on the content of the specifications.

REASONS FOR REPORT RECOMMENDATIONS

1. The specifications require expert help to understand the ramifications for patients, clinicians, and health and social care commissioners. Patient views are particularly important.
2. Achieving a consensus nationally on service specifications is an important step toward more effective specialist commissioning in future.
3. The new specifications could be used to underpin service reviews with a more systematic and consistent approach.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

4. No consideration of the consultation.

DETAIL (Including consultation carried out)

5. NHS England took on responsibility for national specialised services when Primary Care Trust confederations were abolished. The change occurred on 1st April 2013. During this first year, and the shadow period leading up to it, more local and varied commissioning arrangements have been re-organised and pulled together in a single national organisation.
6. Specialised services account for approximately 10% of the total NHS budget, with an annual spend of around £11.8bn. The services commissioned via this route are diverse, including highly specialised services such as heart and lung transplantation, paediatric intensive care, renal dialysis and specialised and secure mental health services.
7. One of the first tasks for NHS England has been creation of a single set of specifications for specialised services. This is designed to provide a framework for commissioning to ensure equity and excellence in service provision, by setting out how a single, national system will ensure patients are offered consistent, high quality services across the country. The specifications are supported by more detailed policies. Consultation seeks to collect views on the content of the specifications and information on potential health inequalities.
8. Last year, NHS England developed and consulted on a single, nationally consistent set of commissioning policies and service specifications, (the first ever produced in this format). This is the second iteration of those specifications and the second round of consultation. These specifications include significant changes in the following service areas:
   - Kidney dialysis services – including haemodialysis and peritoneal dialysis, and acute kidney injury. (x 5 specifications)
   - Adult cardiac surgery x1
   - Complex disability and prosthetics x1
   - Paediatric critical care x4
9. Service specifications set out what is expected from service providers, and define access to a service. They also set out a series of core and developmental standards. Core standards are those that any reasonable provider of a service should be able to demonstrate, whilst developmental standards improve services over a period of time, encouraging them to achieve excellence within a particular field.
10. Changes to specialist service specifications need to be understood better to inform Health and Wellbeing boards and scrutiny committees, both in Southampton and across Wessex, the population covered by the Area Team of the NHS Commissioning Board.
11. The specifications in this consultation cover a small proportion of the 130 different services commissioned by NHS England. The NHS England Specialised Services Consultation Guide is attached at Appendix 1. The specifications should be read alongside their operating model “Securing Equity & Excellence in Commissioning Specialist Services”: http://www.england.nhs.uk/wp-content/uploads/2012/11/op-model.pdf
12. The renal specifications relate mainly to regional **Kidney dialysis** services provided by Portsmouth Hospitals Trust with linked satellite dialysis units

across Wessex. Home based dialysis is predominantly peritoneal dialysis, but some haemodialysis is also available. Some services are subcontracted via the private sector, but would be subject to the same specification and standards.

Acute kidney injury is managed in acute hospital trusts across the Wessex area, with the more complex case-mix in the intensive care or high dependency facilities.

Adult Cardiac Surgery and its sub-specialities are based in UHS in Southampton, while some work is sent to London providers, and less complex percutaneous stent and angioplasty interventions can be performed in hospitals across Wessex. .

Complex disability and prosthetics following limb loss has a specification that is designed to assist rehabilitation. The cross government agreement with the armed forces is designed to give additional support, and special access to modern prosthetics.

Paediatric intensive care is arranged in a network configuration across Wessex. Commissioners and providers have worked on developing a network collaboration to provide safer transfers and standards of care. The centre of the paediatric network is based in Southampton where adjacent specialities in paediatrics are on hand.

13. Efforts by commissioners and providers over the last 20 years have gradually centralised cancer, cardiac, and specialised children's services such as neonatal and paediatric intensive care. Each change has taken many years to achieve, but with each consolidation of specialist services, improvements in clinical outcomes, quality and safety have followed.
14. The Wessex based services that are affected by the current changes in specification are well equipped to respond positively, having largely been reformed and centralised effectively over the last decade. The changes do not appear to raise any major questions about local service provision, and are not likely to impact negatively on local commissioners plans and procurement of health and social care.
15. Examples of local specialist services where a common specification may have more significant repercussions might include paediatric heart surgery, or adult vascular services, for example, where protracted reviews involving different levels of service integration have not been possible despite years of consultation. The availability of common national specifications in these areas may afford a new opportunity to gain a consensus on the future service configuration and quality.

RESOURCE IMPLICATIONS

Capital/Revenue

16. It is not clear what capital or resource implications could arise from these specifications for the NHS or local authorities. This is an area where further enquiry is needed. Care pathways into and discharges from specialist services do have important impacts on NHS services commissioned by CCGs, and local authorities, who will need to examine the service specifications in some detail before the implications are clear.

Property/Other

17. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

18. These powers apply to NHS England in this instance and are laid out in the revisions to the Health and Social Care Act 2012.

Other Legal Implications:

19. None immediately obvious. The service specification should not attract legal sanctions directly, but their application in processes of service review, for example, or development of proposals for service reconfiguration, may come under very close legal scrutiny. More legal implications will occur where NHS England translates specifications into more specific clinical policies.

POLICY FRAMEWORK IMPLICATIONS

20. Commissioning plans and policies developed by integrated commissioning may need to take careful account of any relevant specifications developed by NHS England.

KEY DECISION? NO

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	NHS England Specialised Services Consultation Guide

Documents In Members' Rooms

1.	The full set of consultation documents can be found at: http://www.england.nhs.uk/ourwork/commissioning/spec-services/get-involved/consultations/
2.	The operating model can be found at: http://www.england.nhs.uk/wp-content/uploads/2012/11/op-model.pdf

Equality Impact Assessment

Does the implications/subject of the report require an Equality Impact	Yes*

Assessment (EIA) to be carried out? *Yes – this is the responsibility of NHS England	

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	

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Agenda Item 5

Appendix 1

NHS England Specialised Services Consultation Guide – February 2014

THE NHS CONSTITUTION

the NHS belongs to us all

NHS England INFORMATION READER BOX		
Directorate		
Medical	**Operations**	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01149**
Document Purpose	Consultations
Document Name	NHS England Specialised Services Consultation Guide - February 2014
Author	NHS England National Specialised Services Team
Publication Date	February 2014
Target Audience	Foundation Trust CEs , NHS England Regional Directors, NHS England Area Directors, NHS Trust CEs
Additional Circulation List	CCG Accountable Officers, CSU Managing Directors
Description	A guide to NHS England's specialised service specification consultation for February 2014 - why we are consulting and how to respond.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	NHS England National Specialised Services Team Operations Directorate Skipton House 80 London Road SE1 6LH 0207 972 5736

Document Status

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NHS England Specialised Services Consultation Guide - February 2014

A guide to NHS England's specialised service specification consultation for February 2014 – why we are consulting and how to respond

First published: 26 February 2014

Prepared by NHS England National Specialised Services Team

Contents

Introduction

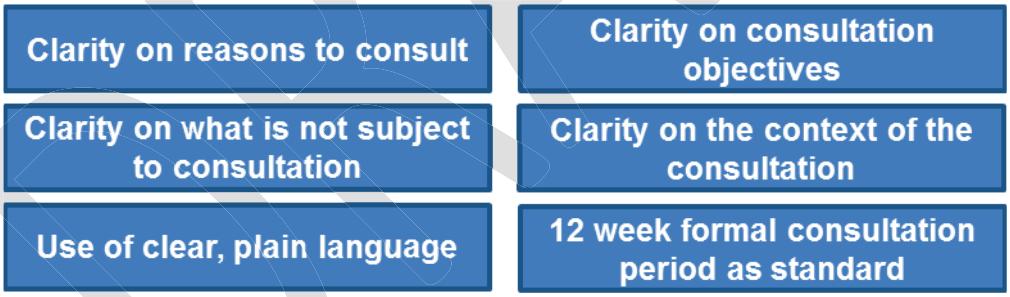
1. This short guidance accompanies NHS England's current consultation on specialised service specifications and clinical commissioning policies. It is aimed at any individual or organisation with an interest in engaging with the development of specialised services.

2. In seeking to achieve consultation best practice, this guidance summarises the objectives, context and reasons for this consultation, as well as outlining the steps which will follow the close of the consultation.

Achieving best practice

3. NHS England is committed to ensuring that all future specialised service consultations comply with best practice, to ensure feedback can be heard more systematically and that best use is made of respondents' time.

4. This year, and in all future consultations on specialised service specifications and clinical commissioning policies, NHS England will seek to comply with the best practice consultation principles issued by the Cabinet Office in 2012. They are available in full here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60937/Consultation-Principles.pdf. The main elements of the guidance with bearing on NHS England's specialised services consultations are the following:



5. NHS England is also clear that engagement with patients, the public and any interested stakeholders is not limited simply to periods of formal consultation. Throughout its specialised commissioning function, NHS England will seek to remain open, engaged and transparent.

Specialised commissioning

What are specialised services?

6. Specialised healthcare services typically treat patients with rare and complex conditions and are often provided by a small number of specialist centres, covering patient populations of more than one million people.

7. Specialised services cover a range of conditions, including treatments for long-term conditions such as renal (kidney) dialysis services as well as neonatal care, severe burns care and some mental health and children's services.

8. Since April 2013, specialised or 'prescribed' services have been defined as those meeting the four factors set out in the Health and Social Care Act 2012, which are:

    - The number of individuals who require the service;
    - The cost of providing the service or facility;
    - The number of people able to provide the service or facility and
    - The financial implications for Clinical Commissioning Groups if they were required to arrange for provision of the service or facility themselves.

9. The resulting definitions of specialised services can be found in NHS England's Manual for Prescribed Services. This defines precisely the elements of care which fall under NHS England's specialised commissioning responsibility, with other care falling to Clinical Commissioning Groups to commission. The Manual can be found here: http://www.england.nhs.uk/wp-content/uploads/2012/12/pss-manual.pdf.

10. NHS England is the sole direct commissioner of NHS specialised services for all patients in England. The ambition of NHS England is to bring equity and excellence to the provision of specialised care and treatment, based on a commissioning approach which is patient-centred and outcome-based, as well as fair, consistent and value for money.

11. NHS England is committed to reducing health inequalities throughout the health service. For specialised services, consultation provides the opportunity to gain information about any potential impact on health inequalities which might arise as a result of new or changed service specifications.

12. NHS England's approach to commissioning specialised services is described in detail in the single operating model, *Securing equity and excellence in commissioning specialised services* (http://www.england.nhs.uk/wp-content/uploads/2012/11/op-model.pdf.)

13. Further details of NHS England's specialised commissioning are available on the NHS England website, here: http://www.england.nhs.uk/ourwork/commissioning/spec-services/

14. NHS England's planning guidance, *Everyone Counts: Planning for Patients 2014/15 to 2018/19* also sets out some of NHS England's future ambitions for

specialised services. It is available to read here: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Service specifications and clinical commissioning policies

15. NHS England commissions providers to deliver specialised healthcare services through contracts managed by ten of its 27 Area Teams. These contracts are underpinned by uniform national service specifications and clinical commissioning policies, which describe the care that NHS England will purchase from providers on behalf of patients.

16. Service specifications set out what is expected from providers and define access to a service. They also set out a series of core and developmental standards. Core standards are those that any reasonable provider of a service should be able to demonstrate, whilst developmental standards improve services over a period of time, encouraging them to achieve excellence within a particular field.

17. Over a hundred service specifications are in place for 2013/14, covering services such as Neurosciences and Haemophilia.

18. Clinical commissioning policies set out NHS England's position in relation to the commissioning of a particular treatment, describing what will, and will not, be commissioned.

19. A clinical commissioning statement differs from a clinical commissioning policy in that it describes the position to be adopted until such time as a full policy is developed.

20. Many specialised services will be part of a larger patient pathway. This means that the specialised element of care will only be one part of the total care that a patient receives. For example, patients requiring neurosurgery may also call upon routine care and rehabilitation services which are commissioned by other organisations.

21. The contracts that NHS England holds with providers relate only to the specialised elements of care, on the basis of the definitions in the Manual for Prescribed services. The service specifications and clinical commissioning policies therefore also relate exclusively to the specialised elements of care.

Consultation

Why is NHS England consulting?

22. Specialised services are an important part of NHS care, which anyone might have need to call upon. It is essential to ensure that these services are the best that they can be.

23. NHS England's objective is to deliver safe, high quality specialised care, underpinned by consistent and equitable commissioning policies and service

specifications.

24. In conducting a full, public consultation on these documents, NHS England is seeking to ensure that its specialised commissioning is well informed, evidence-led and in line with the expectations of patients and the public.

25. As a result of the consultation, NHS England intends to be in a position to consider all feedback before reaching final decisions on policies and specifications, calling upon further advice from its service-specific Clinical Reference Groups as required.

What is being consulted upon?

26. NHS England is consulting upon material changes to existing service specifications and clinical commissioning policies, as well as on any new specifications or policies.

27. NHS England has already consulted publicly on existing service specifications and clinical commissioning policies. We are now consulting on changes to these documents, which are clearly marked in the documents. While we welcome comments on the documents as a whole, particular focus should be on the proposed changes.

28. In some cases, NHS England will make minor or technical amendments to existing documents without issuing these changes for public consultation. However, where an amendment is likely to have a substantial impact, a public consultation will be held.

29. In order to determine whether or not an amendment to an existing document is substantial or not, Clinical Reference Groups test all proposed amendments with their registered stakeholders. Further information about Clinical Reference Group stakeholders, as well as details of how to register, are available here: http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/crg-reg/

30. Clinical Reference Group stakeholders are asked how substantive the proposed changes are likely to be and whether, in their view, public consultation on the changes would be required.

31. In deciding whether or not to consult upon such changes, NHS England's Clinical Priorities Advisory Group will consider the views provided by stakeholders alongside recommendations from the relevant Clinical Reference Group and Programme of Care.

32. NHS England seeks views on the content of the consultation documents which, when finalised, will form the basis of contracts with providers of specialised care. Feedback relating to other parts of NHS care should be directed to the responsible commissioner.

How can I make my views known?

33. Responses to the consultation can be made through the online portals at: https://www.engage.england.nhs.uk/consultation/8be1c4ce and https://www.engage.england.nhs.uk/consultation/03c168a3 Comments can also be sent directly to Julie Cunningham at julie.cunningham2@nhs.net

34. Any comments that relate to services or issues outside of the scope of the consultation will be noted and passed on accordingly.

Post-consultation process

NHS England approval

35. Following the public consultation, NHS England will review the feedback received. This will be managed through the five national Programmes of Care, into which each of the service-specific Clinical Reference Groups are grouped. If necessary, Clinical Reference Groups will be asked to provide further advice in the light of consultation feedback to reach a final proposal.

36. Feedback will be grouped into four categories by the Programmes of Care, as follows:

    - Feedback which can be incorporated into the draft document immediately to improve its accuracy or clarity
    - Feedback on an issue already considered by the Clinical Reference Group in its development of the draft document which require no further changes
    - Feedback that would result in a more substantial change, requiring careful further consideration by the Clinical Reference Group in its work programme and therefore considered as part of the development of the next iteration of the document
    - Feedback on issues which fall outside the scope of the specification and NHS England's direct commissioning responsibilities

37. Once the Programmes of Care have assessed and incorporated all feedback as required, NHS England's over-arching Clinical Priorities Advisory Group and Directly Commissioned Services Committee will need to approve final service specifications and clinical commissioning policies.

38. Finalised documents will then be published, with six months' notice for providers of NHS specialised services before changes are enacted in contracts.

39. Due to the likely number of responses to the consultation, NHS England will not be able to provide replies to individual submissions.

40. An overarching report of the consultation process, demonstrating how NHS England dealt with feedback received through the consultation, will be published following the release of the final documents, subject to review and approval by the Clinical Priorities Advisory Group.

Future consultations

41. In future, NHS England intends to consult on new and modified service specifications and clinical commissioning policies regularly throughout the year. This is intended to enable a rolling programme of policy development, rather than a single, large tranche of consultation.

42. Further details on future consultations will be released in due course.

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		HEALTH AND WELLBEING BOARD – FACILITATED SELF ASSESSMENT		
DATE OF DECISION:		14 MAY 2014		
REPORT OF:		ASSISTANT CHIEF EXECUTIVE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Caronwen Henderson**	**Tel:**	**023 802524**
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Director	**Name:**	**Suki Sitaram**	**Tel:**	**023 802060**
	E-mail:	**Suki.sitaram@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

The Local Government Association (LGA) have offered to pilot an updated self assessment tool for Health and Wellbeing Boards in Southampton. This paper seeks the agreement of the Board to take part.

RECOMMENDATIONS:

(i) The Health and Wellbeing Board agree to invite the LGA to facilitate a session with the Board, piloting the new self assessment tool.

REASONS FOR REPORT RECOMMENDATIONS

1. To seek the Boards agreement to take part in a free facilitated session.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. Health and wellbeing boards were established under the Health and Social Care Act 2012. The intention was that they would act as a forum for key leaders from the health and care system to work together to build strong and effective partnerships which improve the commissioning and delivery of services across NHS and local government, leading in turn to improved health and wellbeing for local people.

They have a duty to promote integrated working, produce a Joint Strategic Needs Assessment and develop a joint Health and Wellbeing Strategy.

4. The formal Southampton Health and Wellbeing Board has now been in existence for 1 year, following 1 year of the Board being run in shadow form. During this time the integration landscape has developed significantly particularly with the introduction of the Better Care Fund and the role of HWBs in taking it forward:

"Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the (better care) funding should be spent, as part of their wider discussions on the use of their total

health and care resources". – NHS England Planning Guidance 2014-19

The additional focus on promoting integration means that it is now a good time for HWBBs to review progress and strengthen their system leadership role.

5. The Local Government Association has worked with partners including the Department of Health, NHS England and Healthwatch to develop a self assessment tool for HWBs. The tool aims to assist boards to:

- Explore their strengths and opportunities;
- Improve their performance;
- Inspire their ambition to develop a clear sense of purpose and an approach which will help transform services and outcomes for local people.

It offers HWBs a tool to evaluate their position using a maturity model, describing characteristics of a 'young', 'established', 'mature' and 'exemplar' HWB against six dimensions for an effective partnership.

6. The tool is currently being revised to reflect the new context for HWBs with regards to integration and other major challenges. The LGA are just finalising the revised tool and they are keen to pilot it with some HWBAs. As such they have offered to facilitate a session with the Southampton HWB and a date is being explored for this to take place. A copy of the previous tool is attached at appendix 1 (please note this is not the updated version).

7. This would be a good opportunity to take advantage of professional expertise and knowledge of best practice to help the HWB take stock of progress and indentify areas for improvement in the context of the current integration landscape.

RESOURCE IMPLICATIONS

Capital/Revenue

8. None.

Property/Other

9. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

10. N/A

Other Legal Implications:

11. None.

POLICY FRAMEWORK IMPLICATIONS

12 N/A

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All.

SUPPORTING DOCUMENTATION

Appendices

1.	Self Assessment Tool (prior to update)

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/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	

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Local Government Association

Department of Health

Public Health England

NHS England

NHS CONFEDERATION

healthwatch

Health and Wellbeing System Improvement Programme

Development Tool

September 2013

Agenda Item 6

Appendix 1

Development tool for Health and Wellbeing Boards

Introduction

Working with Health and Wellbeing (HWB) partners, we have co-produced this tool as an alternative to peer challenge. Whilst aligning with the peer challenge methodology, it offers HWBs an opportunity to evaluate their position using a maturity model. The tool describes characteristics of a 'young HWB'; an 'established HWB'; a 'mature HWB'; and an 'exemplar HWB' against six dimensions for an effective partnership.

The tool is one part of the wider offer on health and wellbeing system improvement. HWBs are encouraged to use the statements in the tool as a prompt to consider and challenge their own practice, to benchmark with others and as a stepping stone towards developing an improvement plan. We see it as a tool intended to help shape a local conversation rather than a scoring exercise. How individual HWBs use the tool is up to them and we recognise that some may wish to use it flexibly.

The content of the tool will be kept under review to ensure it meets the future needs of HWBs. Comments and feedback about how the tool might be further improved and how HWBs have used this development tool would be welcomed. Please send your feedback, reflections and stories to caroline.bosdet@local.gov.uk.

HWBs are challenged to develop complex and innovative approaches that require new ways of working. Help is available from several national and regional organisations. A good starting place for assistance is the health and wellbeing system improvement programme web resource (http://goo.gl/9FWfSk).

Guiding principles

The following guiding principles, developed with HWB partners, underpin the development tool:

- **Promoting a local narrative**: The tool aims to promote an honest narrative within individual HWBs, to assist them in exploring their strengths, challenges and opportunities to improve.
- **Promoting partnership, shared leadership and shared decision making**: The tool intends to build on the foundations that have already been established, to support continual development and challenge in becoming an effective operating HWB across local health and social care economies.
- **Engaging stakeholders**: The tool reflects the need to put stakeholder engagement at the heart of the HWB, underpinned by transparency and mechanisms that allow stakeholders to contribute.
- **Understanding and striving for effectiveness**: The tool promotes an evidence-based approach through the cycle of: needs assessment; prioritisation; decision making; implementation; and evaluation of outcomes.
- **Assurance, learning and self-development**: HWBs should be learning forums, self-driven and undertake continual reflection on progress and address emerging issues. Benchmarking and aspiring to the highest level of performance should be the norm.
- **Celebrating success, sharing innovation and recognising barriers**: This tool also aims to encourage HWBs sharing their own practice and identifying and addressing barriers to progress.

	Young HWB	Established HWB	Mature HWB	Exemplar HWB
Vision	The HWB has a clear vision, shared by all partners in the system, which outlines its core purpose and values and its role in the local health and care system. The HWB has sought, heard and listened to the views of local communities and citizens and this is reflected in the HWB vision. The HWB has a planned approach to define its membership as well as stakeholder engagement and management.	Stakeholders and partners understand the vision, values and core purpose of the HWB. There is an understanding of the opportunities and constraints of partnership and joint leadership within the HWB. The HWB understands and can articulate the shape of the local health and care system that is required in order to deliver its own vision, and how it will work with partners to achieve this. Partners, providers, users and wider stakeholders agree there has been meaningful engagement in the development and delivery of the vision. The vision is rooted in local evidence – data and voice – and politicians support the vision and purpose of the HWB. All strategies and actions from the strategic plan directly align with the vision of the HWB.	Local communities, citizens, service providers and service users 'get' the vision and purpose and feel they have shared ownership of it. Service providers and partners refer to the vision in their own strategies and commissioning plans. They acknowledge it as a vision for the 'local place'. The vision is revisited regularly as part of an on-going strategic plan review with members challenging the vision in light of changing circumstances.	The decisions and actions of the HWB are entirely driven by the shared vision. The HWB is strategically aware, a social innovator, a partnership that makes a difference in all it does. The HWB is an organisation that is supported by all the partners who have a stake in it and the communities that it serves. The leadership of the HWB has a relentless focus on its vision to improve health and wellbeing services and outcomes for local people. There is a shared clinical and political resolve to deliver the vision.

	Young HWB	Established HWB	Mature HWB	Exemplar HWB
Strategy	The HWB has a compelling narrative describing its purpose and ambitions for its local community. The narrative sets out '*where we are now*' and is underpinned by intended outcomes. The strategy can demonstrate how it has taken account of the public voice. All members of the HWB can articulate the strategy. The strategy is reflected in partner strategies and commissioning plans. Service providers are engaged and have contributed to the strategy. A shared communications strategy is in place that includes visible engagement and articulation of the strategy to the public and stakeholders. It is easily accessible on a dedicated HWB website, and is embedded in the web-presence of partners and related partnerships or networks.	The strategy has been refined and refreshed in light of feedback and new intelligence. Stakeholders and partners, including providers, can articulate the strategy. The strategy is having a demonstrable impact on commissioning plans with clear measurable outcomes upon which the HWB can hold itself to account. Regular reports articulate progress of the strategy, celebrating success and identifying blockages.	The HWB regularly assesses its delivery against the strategy, refining and regaining momentum, where needed. The HWB can describe what it has achieved, the changes made for local people and future improvement plans ('*where we are going'*). There are clear links and interdependencies with other relevant plans and strategies. Reconfiguration and de-commissioning has been handled professionally and transparently from strategy to implementation with strong shared clinical and political support. The community can describe how the HWB has made a difference.	The HWB has a demonstrable and recognised track record for leading improvements in outcomes and service change. It systematically identifies and addresses systemic issues and drives integration of health and social care. There are examples and evidence of system transformation and whole system benefits.

	Young HWB	Established HWB	Mature HWB	Exemplar HWB
Leadership	HWB members understand and work towards achieving shared system leadership, involving all statutory core members plus other members of the HWB. The HWB has a code of conduct which is explicit about expectations of behaviour and the values it aspires to and has an agreement about minimum attendance at meetings. Trust has been established, constructive challenge is the norm, and a conflict resolution process is in place. The HWB understands its own development needs and has plans in place to address these. The HWB has brought together Councillors, local Healthwatch representatives and CCG members in an informal setting and spent time on HWB team building and development.	The HWB is viewed as an entity in its own right and stakeholders understand and appreciate its system leadership role. Leadership influence is distributed among many members and individual team members may lead at different times depending on their skills and knowledge. There is a 'can do' culture. HWB members look for win-win solutions focused on beneficial outcomes for the community. The HWB is able to demonstrate mature dispute resolution. Major risks and issues are discussed openly and honestly, without members leaving the table. HWB members understand the culture of individual member organisations and support each other to pursue shared priorities. Relationships enable members to influence beyond their own organisations. Regular development sessions are the norm.	The HWB and its vision and strategy has withstood political challenge and political change. Leadership succession planning is in place. Local organisations seek to contribute to the work of the HWB. The HWB has led on contentious issues (e.g. service de-commissioning) without activities that would undermine shared leadership. All members take responsibility for unforeseen risks / problems and credit for success. Board members view each other as leaders and peers. The HWB is a beacon of excellence in relation to equality and diversity and can show positive outcomes for the health and wellbeing of minority groups. The HWB shares good practice with others.	Leadership is strong across the HWB and resolution to challenges is achieved quickly and without negative impact on the work of the HWB. All core members feel that they are allowed to contribute to the success of the HWB. Transformation has taken place at scale and pace. Leadership is distributed across all members of the HWB. The leadership of the HWB proactively seeks out excellence in all it does and the way it operates and is relentlessly focussed on delivering improvements with, and for, local people.

	Young HWB	Established HWB	Mature HWB	Exemplar HWB
Needs assessment and management of priorities	The JSNA and JHWS are jointly developed in line with legislative requirements and formally agreed with all partners. Individual CCG and LA commissioning plans are being aligned. The JSNA and JHWS explicitly recognise the needs of vulnerable people and hard to reach groups; priorities are designed to tackle health inequalities. The JSNA and JHWS consider the needs of all age groups across the population, and recognise key transitions. The HWB has agreed a realistic set of specific priorities through robust debate and challenge and the process included community engagement. A process exists for managing priorities. Prioritisation considers where the greatest impact can be made within available resources. Priorities balance the short, medium and long term and balance issues across physical and mental health and wellbeing. They are linked to clear measurable outcomes.	The JSNA and JHWS are embedded in plans of service providers. The JSNA and JHWS are kept under constant review and revised regularly. They are realigned with commissioning plans to reflect changes. A wide range of evidence, including data and voice (e.g. service user and patient stories) are systematically assessed to determine priorities. All priorities directly align with the vision of the HWB and there is constructive challenge of plans to make this happen. The HWB has put in place lines of accountability and decision making to enable it to have a grip on the things only it can do. The HWB has achieved some of its shared priorities and can demonstrate improvements it has made to outcomes and services for local people.	The JSNA process improves iteratively, learning from previous experience and best practice elsewhere. The HWB has a track record of delivering its priorities and is able to communicate to communities about how it has made a difference to improving services and outcomes for local people. Priorities have been robustly challenged and reviewed and this can be demonstrated with new priorities coming forward as previous priorities have been achieved or revised. JHWS and commissioning plans are aligned with those of neighbouring HWBs where relevant (e.g. meeting specialised needs where HWBs may need to plan across a larger population or tackling service re-configuration across a larger geography).	Local communities and citizens recognise the priorities of the HWB as their own. The HWB can demonstrate long term buy in to, and achievement against, its priorities. The HWB has a track record of enabling efficient, effective and integrated commissioning of services, working across administrative boundaries where appropriate.

	Young HWB	Established HWB	Mature HWB	Exemplar HWB
Governance, risk sharing and assurance of outcomes	HWB membership, governance, operational structures, scheme of delegation and mechanisms for engaging partners are clear, transparent and accessible to the public. Partners are clear about their individual and collective roles, responsibilities and accountabilities. The HWB understands its accountabilities in relation to other partnerships. HWB accountabilities are incorporated into partner governance arrangements The HWB has dedicated and skilful officer support, available to all members of the HWB. The HWB has an agreed set of outcome measures, matched to its priorities. Local Healthwatch is empowered to act as an independent and effective voice for users, communities and the public. The relationship between scrutiny and external regulators is agreed and an initial effectiveness review has been completed.	A clear framework exists for deciding on contentious issues. Decisions of the HWB are accepted and acted on by all member organisations. HWB partners are able to have honest discussions about budgets and financial positions. The HWB invites peer scrutiny and works constructively with regulators and scrutiny bodies. The HWB reviews itself regularly against benchmarks and adapts plans as necessary. The HWB receives regular and timely updates on progress against indicators and takes corrective action if necessary. The HWB can demonstrate it has considered and acted upon the views of local people, feedback obtained from the community and evaluation of citizen experience. The HWB seeks assurance on progress towards integrated care.	The wider system understands how the HWB and related structures operate. Reporting and governance is evaluated across partners and streamlined where appropriate. Systems are in place to ensure decisions result in direct action across the partnership. Resources are pooled where appropriate, whether in back office functions or integrated commissioning, with good governance. Barriers to achieving priorities are identified and reviewed, and plans are in place to overcome/minimise these. The HWB regularly demonstrates and communicates its achievements of outcomes. Whole system safeguarding mechanisms are in place, including accountabilities.	Integrated decision making, commissioning and governance are the 'norm' for the HWB. The HWB has an integrated 'whole system' (rather than individual organisation measures) outcomes framework of high level indicators, supported by a 'dashboard' across the health and wellbeing system. Budget planning is open and resources are directed to support agreed priorities and improvements for local communities. Risk sharing agreement exists between the LA, CCGs and other relevant partners.

	Young HWB	Established HWB	Mature HWB	Exemplar HWB
Information and intelligence	The JSNA provides a clear population profile and identification of health and wellbeing needs of all local communities and identifies inequalities. Services and provision are mapped against local need and assets. Engagement structures are mapped and include and build on partners' own processes, e.g. Healthwatch. The HWB shares information and intelligence across members.	The JSNA is in the public domain and a 'real time' document and the engagement of local people is clearly evident in its development. The HWB understands the power of, and utilises, quantitative and qualitative 'voice' data, for examples, from service users, patients, carers and communities, alongside data from other sources to give a full picture of local needs and resources. Shared population data is used in individual partner organisations' business planning and feeds commissioning strategies. HWB partner organisations have aligned their engagement structures and plans around key priorities so that there is a coordinated approach to involving and engaging communities and citizens. The HWB recognises where there are gaps in the intelligence base in the local population and has a strategic approach to ensuring that the information is understood.	HWB informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across the health and wellbeing system. Integrated information available to GPs, politicians and services users. Effective data and intelligence sharing across partners drives the development of shared strategies and commissioning plans. HWB monitors evidence of the outcomes from and impact of its strategy, and uses this to update JSNA and JHWS.	The HWB has the ability to disaggregate data to CCG and district level and below (e.g. locality). The HWB has shared data resources accessible to all partners, which brings together all needs assessments and the wider determinants of health and wellbeing (e.g. Housing, justice, child poverty, citizens' views). The HWB understands its communities and their needs, has a single clear population profile across all partners and all services. It knows the total spend invested in an area and the extent to which that investment is being directed to meet the identified needs.

DECISION-MAKER:	HEALTH AND WELLBEING BOARD			
SUBJECT:	BETTER CARE SOUTHAMPTON UPDATE			
DATE OF DECISION:	14 MAY 2014			
REPORT OF:	DIRECTOR OF QUALITY AND INTEGRATION			
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296075**
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STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

The final version of Southampton's Better Care local plan was submitted on 4 April 2014. At this point, Southampton is still awaiting feedback from NHS England; however work is well underway to progress implementing the ambitious level of change required to deliver Southampton's vision and aspirations for Better Care.

This briefing provides an update on progress over the last month.

RECOMMENDATIONS:

(i) The Health and Wellbeing Board notes progress towards implementation of Better Care Southampton.

REASONS FOR REPORT RECOMMENDATIONS

1. This is an ambitious agenda which requires strong engagement and buy in from all partners. The Health and Wellbeing Board has a key role to play in providing strategic leadership for this

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. Each Health and Wellbeing Board in England is required to submit and deliver a plan developed jointly by the council and CCGs.

DETAIL (Including consultation carried out)

3. At the core of Southampton's Better Care model is the integration of health and social care within a strong empowerment, person centred ethos. Southampton is looking to achieve this by moving to a locality cluster model. These clusters will bring together community nurses, therapists,

geriatricians, MH nurses, primary care, social care, housing and voluntary sector to work in an integrated way around local people and communities. The clusters will be based on GP practice registered populations; key features of the model will include:

- 7 day working
- Proactive engagement with communities and local networks
- Development of a personalised care promoting workforce
- Greater adoption of Personal Health Budgets ,Personal Budgets and uptake of direct payments
- Introduction of a common trusted assessment and planning tool
- A greater focus on early identification and intervention
- Proactive assessment and rapid response to meeting needs and ensuring that people are in the most appropriate setting
- Development of a reablement ethos across the board which promotes independence
- Full integration of mental health into the integrated care model
- Increased use of self management approaches
- Increased use of technology for delivery of services and support.

Key targets that Southampton's Better Care model will need to meet this year are set out below:

Indicator	Baseline	Performance for April 2015 payment	Performance for October 2015 payment
Permanent admissions of older people to residential & nursing homes	319 (12/13)	291 (14/15)	
% older people still at home 91 days post discharge from hospital into reablement services	87% (12/13)	90% (14/15)	
Delayed transfers of care (bed days)	906 (Dec 2012 – Nov 2013)	894 (Apr – Dec 2014)	876 (Jan – June 2015)
Avoidable admissions (average per month)	5426 (Oct 2012 – Sept 2013)	2439 (Apr – Sept 2014)	2864 (Oct 14 – Mar 15)
Service user experience	Awaiting national indicator		
Injuries due to falls in older people	951 (2012/13)	959 (2014/15)	910 (2015/16 – based on Apr – Sept 15)

Delivery of this model and achievement of the outcomes requires strong governance structures as well as buy in from all stakeholders.

Updated Governance arrangements

The revised governance structure is set out at appendix 1. This sets out the

groups overseeing the implementation of the Better Care model and how they report into the corporate governance arrangements for the CCG and City Council. The vulnerable people board has been renamed the Integrated Care Board, following feedback from voluntary and community sectors. This group oversees the Better Care programme ensuring that implementation is on track and that targets are being met. Reporting to this group the System Change Implementation Group (formally called Interagency operational group) has been set up to action the changes required. This group comprises senior managers and clinicians from all the main health providers, primary care, the Local Authority, Health watch and voluntary sector and had its first meeting on 9 April 2014. The next two meetings of this group (which is meeting monthly) will focus on:

- Acting on the feedback from the cluster consultation – primarily beginning to set up the clusters, defining the function and form, developing the standard operating procedures
- Planning the implementation of a shared care plan and joint assessment tool, based on the work of the Demonstrator site

A commissioning task and finish group is meeting fortnightly and is focussing on:

- Scoping the pooled fund
- Putting in place and monitoring the performance framework
- Exploring contractual and payment model options to best support the principles and aims of Better Care

A detailed action tracker and risk log are being developed.

Locality cluster team implementation

Significant work has been undertaken over the last two months to develop a proposal for the clusters which is now being shared across the health and social care system, including local community and voluntary groups. The proposal is for 6 geographical integrated cluster teams based around GP practice populations. A paper outlining the process of engagement for this proposal is attached at Appendix 2. Feedback from key stakeholders will be presented to the Integrated Care Board on 15 May and the final configuration of the clusters agreed by the end of the month.

Work is also underway in partnership with public health to produce a joint strategic needs assessment for each of the 6 proposed clusters to support service planning.

Coproduction and engagement

Key to the success of Southampton's Better Care plan is strong engagement and co-production of the model. During April and May three locality workshops are being held with wide representation from frontline workforce and local community and voluntary groups. These workshops are being used to raise awareness of the Better Care vision but more practically to begin to design the various aspects of the model (e.g. how the cluster teams will operate, what a shared care plan will look like). The workshops are also providing feedback on the cluster proposal. At the Central and East locality

workshops on 16th and 23rd April the following were cited by frontline staff as key priorities:

- joining up health and social care teams
- Information sharing, including IT systems, single care plans
- Improved communication and mechanisms to do this
- Care navigator role
- Heighten/raise public awareness
- Central database of voluntary groups
- Continued involvement, voluntary sector, housing, environmental health, employment
- Focussing on prevention rather than cure
- Full commitment from all stakeholders including GP's

At the Integrated Care Board on 17 April each provider organisation/group was also asked to feedback on what the Better Care agenda means for them. The following is a summary of the key points which fell into three broad headings:

New ways of working

- General agreement to shift to cluster focus
- Health and social care working much closer together
- Physical and mental health integrated working
- Promotion of self management
- New relationship with voluntary sector
- 7 day working across system – e.g. ability to discharge at weekends

Workforce development

- New, exciting roles – e.g. care navigator function
- Roles that cross hospital and community eg. therapies
- Workforce will need to become:
    - Less task based, more client centred
    - More proactive, less reactive (move from medical dependency model)
    - Multi skilled
    - Ability to trust others assessments/ referrals
- Culture shift

Infrastructure

- Information sharing, data etc
- Single point of access for users
- Estates – need to look at from interagency perspective
- Mobile working
- What is organisational structure of future - collaboration versus cooperation

Communications and branding

Finally there has been considerable work undertaken over the last month by the CCG and City Council communications teams to develop a branding for Southampton's Better Care model in order to raise awareness and engagement with the general public and local communities as well as with staff.

RESOURCE IMPLICATIONS

Capital/Revenue

4.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Southampton City Council	TBC	924,000.00	*1,526,000.00*	*5,457,950.00*
Southampton City CCG	TBC	1,287,000.00	*15,325,000.00*	*52,869,000.00*
BCF Total		2,211,000.00	*16,851,000.00*	*58,326,950.00*

Analytical work is underway to look at finance and activity data to inform pooled fund decisions.

A draft Section 75 agreement is also being complied. The finalised pooled fund agreement will be brought to a future Board meeting. It is not required until 2015/16.

Property/Other

5. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

6. NHS England Publications Gateway Ref. No.00314

Other Legal Implications:

7. None

POLICY FRAMEWORK IMPLICATIONS

8. Align with Health and Wellbeing Strategy and Council's Policy Framework Plans

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Governance arrangements
2.	Cluster proposal

Documents In Members' Rooms

1.	None

Equality Impact Assessment

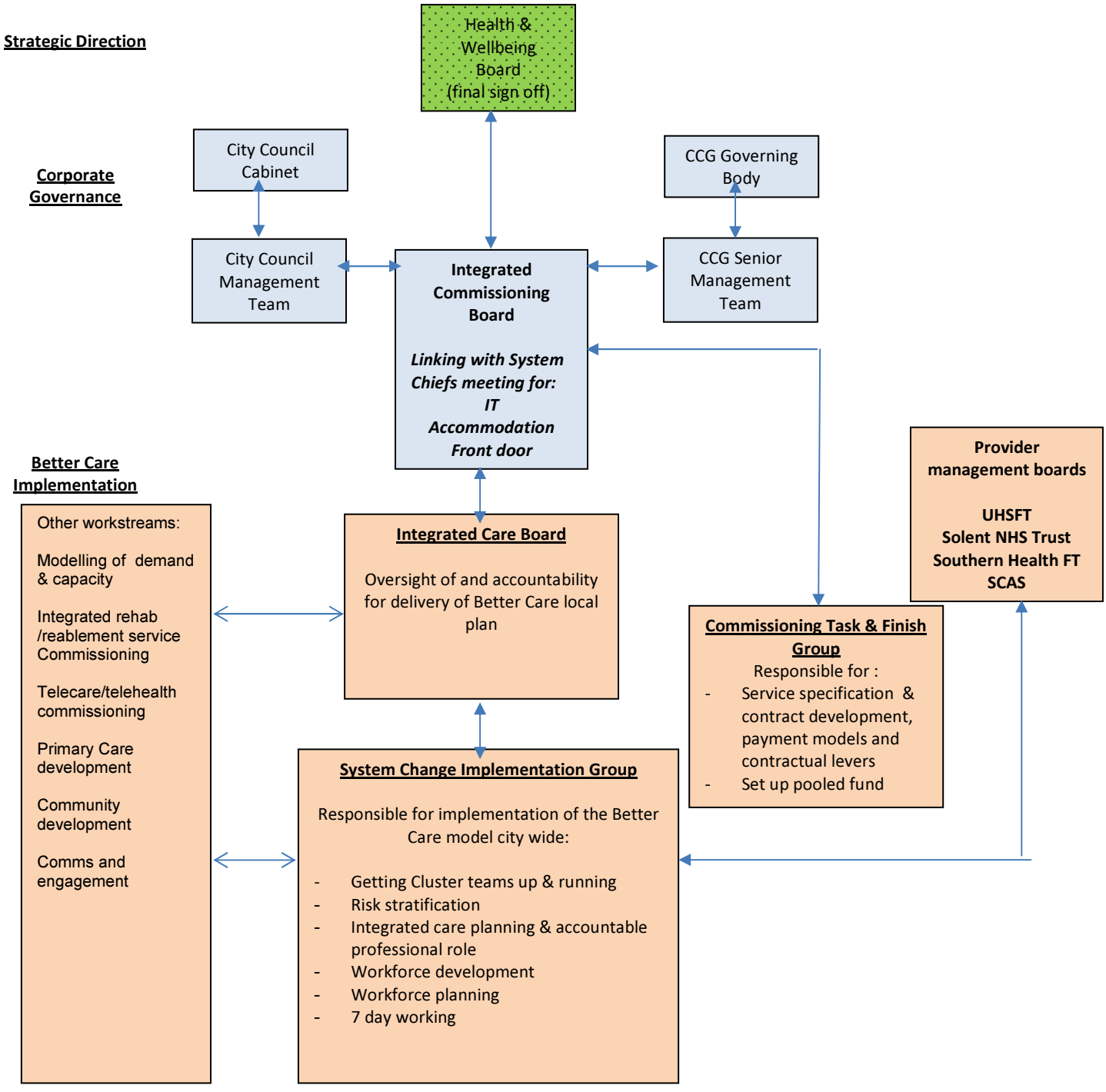
Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

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.	N/A	

Better Care Implementation (Interim Governance Structure for the implementation period)



Strategic direction

Corporate governance

Better Care implementation

Note: this governance structure will be reviewed by the System Change Implementation Group and Integrated Care Board as part of the implementation process, acknowledging that the development of the cluster teams will also need to consider their governance.

Southampton City Clinical Commissioning Group

Southampton Better Care - Engagement

Development of Integrated Care Teams clustered around GP Practices.

Background

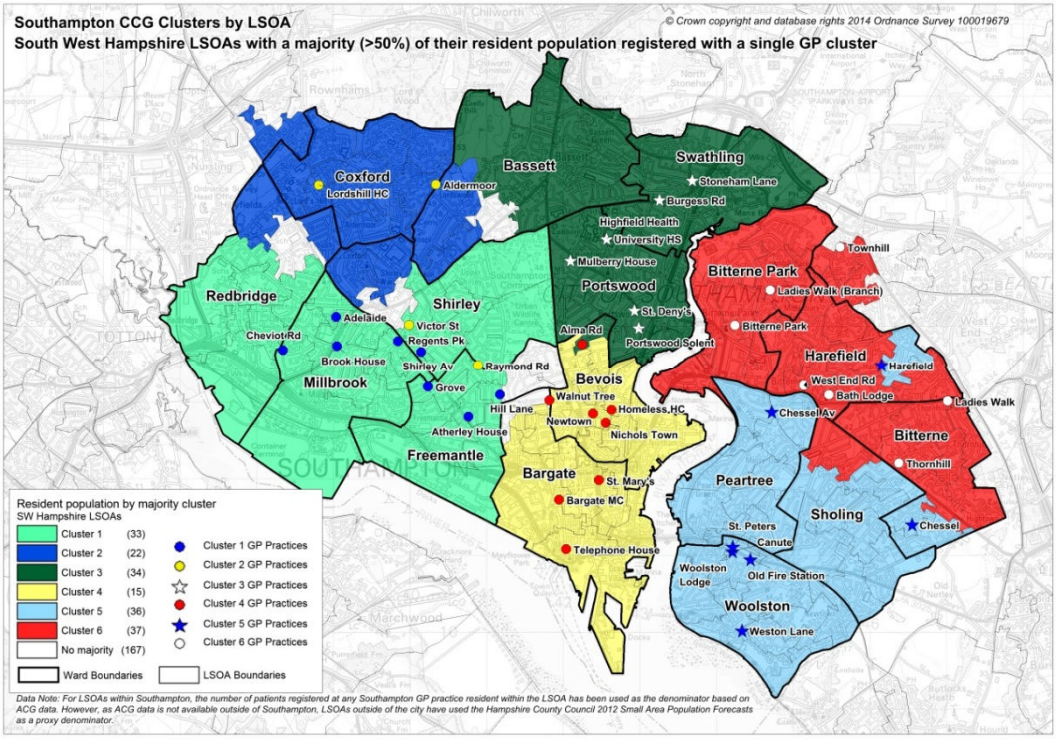
Southampton City Clinical Commissioning Group (CCG) and Southampton City Council, along with providers, community and voluntary organisations, are working together on a programme called Better Care Southampton. The aim is to work more closely together to improve the health and wellbeing of local people. This involves joining up our services, with the individual at the centre, and taking a much more preventative approach.

We believe that a 'one city' approach with active partnership between health, housing, social care, the voluntary and community sector and local people will deliver the following aims:

- Put individuals at the heart of their own care
  - Empowered and supported by integrated local services & communities
- Focus on prevention and early intervention
  - Through sharing of information and proactive person centred planning
- Build community capacity
  - Recognising and valuing the role of neighbourhoods and local communities
- Help people to retain and regain their independence

Our Proposals

We are proposing to establish 6 integrated care teams clustered around GP Practices.



Initial discussion with primary care identified how neighbouring practices could work together and cluster. The proposed 6 clusters build on the clustering already established for Community Nursing.

The cluster boundaries have been defined where over 50% of the population are registered with the practices within it. The white areas on the map denote those areas where there is not an over 50% majority.

It is therefore proposed to:

1. Establish 6 Integrated Care Teams serving GP registered practice populations
2. Teams will be made up of the following
    a. GP's & Primary Care Team
    b. Community Services - District Nursing, Community Matrons, Specialist Nursing, Community Geriatricians
    c. Social Care Assessment & Support
    d. Elements of Housing Services
    e. Mental Health Services (adults & older people)
    f. Links with local voluntary and community sector
3. The core teams will identify individuals who are at risk of needing high levels of health and social care support.
4. The core team will work with the individual to develop a person centred care plan and provide co-ordinated care via a single case manager.
5. The individual will be supported to self-manage their needs gaining additional support from community resources.

Principles we have adopted in determining the clusters

- To develop our proposals through co-production - Involving public, patients, services, voluntary sector
- To organise service structures to support communities served by GP practice populations
- To have a geography which is understandable.
    - ✓ People see as a community
    - ✓ Needs to take into account district centres
    - ✓ Needs to take into account transport routes
- To be based on GP practice populations
- To have a balance between:
    - ✓ Economies of scale
    - ✓ Local responsiveness
    - ✓ Cost effectiveness
- To reflect the use of local resources and knowledge of the community. Community resources to consider:
    - ✓ Schools
    - ✓ Churches and other faith communities
    - ✓ Libraries and Housing Offices
    - ✓ Voluntary Groups

Engagement

We are now seeking stakeholder views on these proposals to inform the agreed way forward.

Who have been involved so far?

- ✓ Southampton City CCG GP Practices locality meetings – February 2014
- ✓ Health & Wellbeing Board - 26 March 2014
- ✓ Integrated Care Board – 20 March 2014
- ✓ Local people, NHS providers and voluntary services attending the Southampton City CCG stakeholder event - 11 March 2014

Who else do we need to hear from to help make a decision?

- ✓ All Southampton City CCG, GP Practices
- ✓ Solent NHS Trust
- ✓ Southampton City Council (including social care, housing, and other relevant departments)
- ✓ Southern Health Foundation Trust
- ✓ University Hospitals Southampton Foundation Trust
- ✓ South Central Ambulance Service
- ✓ Healthwatch Southampton
- ✓ Voluntary Sector organisations operating in the City
- ✓ Faith groups active in the City
- ✓ Patients, Carers and members of the public

Timescale & Action Plan for engaging stakeholders

1. In order to seek people's views, we are holding a series of workshops across the city which have been organised to bring together people from health (Primary Care, Solent, Southern, UHS), City Council social care and housing, workers form the voluntary sector and local faith groups and organisations.
   The workshops will take place on the following dates:-

   - North Central Locality (12.30 – 3.30, 16th April, Venue to be confirmed)
   - East Locality (12.30 – 3.30, 23rd April Central Hall, St Mary Street, SO14)
   - West Locality (12.30 – 3.30, 14th May Holiday Inn, Southampton)

2. We will also be formally asking members of the Integrated Care Board to share the proposals within their organisations and formally respond to the questions below. This will include:
   - Solent NHS Trust
   - Southern Health Foundation Trust
   - University Hospitals Southampton Foundation Trust
   - Voluntary Sector (via Southampton Voluntary Services)
   - Southampton City Council (social care, housing)
   - South Central Ambulance Service

3. We will be writing formally to every GP practice in Southampton via our GP clinical leads to seek their views on the proposals.

4. We will be formally writing to Healthwatch to ask them to share the proposals with their members and respond to the questions below.

5. We will be publishing this proposal and a short comments box on our Better Care webpages (available on both the City Council and CCG websites) to seek the views of a broad range of stakeholders, including patients, carers and members of the public.

6. We will be sharing these proposals at all stakeholder events during April and the first two weeks of May to seek views.

The formal engagement period for these proposals will commence on 1st April 2014 and will close on the 14th May2014.

What Next

At the end of the engagement period all feedback will be considered and any changes made to the proposal. The results of the engagement exercise will be presented to the Integrated Care Board on the 15th May 2014. With a final decision made by Southampton City CCG Governing Body meeting on the 28th May 2014 and Southampton City Council Management Team on the 27th May 2014.

A summary of the feedback and final decision will then be shared with all stakeholders.

The next steps will be to:

- Determine the functions of the cluster teams
- Identify who will be in each team
- Commence mobilisation

This work will be led by the Better Care System Change Implementation Group that has been established to implement the Better Care Southampton model and comprises senior clinical and operational representation from all NHS providers, primary care, commissioning, the voluntary sector and Healthwatch.

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Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis

Summary

Updated non-statutory guidance has been issued by the Department of Health and partner agencies, aimed at tackling and preventing mental health crises, and improving outcomes for those experiencing such crises.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf.

Status:
Non-statutory guidance, issued by the Department of Health and partner agencies.

Overview

The Concordat builds on and does not replace existing guidance. Current service provision should continue while the improvements envisaged in this document are put in place.

Provisions include:

Local Mental Health Crisis Declarations

The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions to embed the principles of the Concordant into service planning and delivery at a local level.

This should include:

- A jointly agreed local declaration across the key agencies that mirrors the key principles of the national Concordat – establishing a commitment for local agencies to work together to continuously improve the experience of people in mental health crisis in their locality;
- Development of a shared action plan and a commitment to review, monitor and track improvements;
- A commitment to reduce the use of police stations as places of safety, by setting an ambition for a fast-track assessment process for individuals whenever a police cell is used; and

- Evidence of sound local governance arrangements.

Local Protocols use of Police Powers under the Mental Health Act

Every area should have a local protocol in place, agreed by NHS commissioners, the police force, the ambulance service, and social services. This should describe the approach to be taken when a police officer uses powers under the Mental Health Act.

These local protocols should ensure that:

- When the police make contact with health services because they have identified a person in need of emergency mental health assessment, mental health professionals take responsibility for arranging that assessment;

- Individuals in mental health crisis are taken to a health based place of safety rather than a police station. The Mental Health Act Code of Practice states that 'a police station should be used as a place of safety only on an exceptional basis'. Local protocols should set out an agreement about what constitutes a truly exceptional basis, for example seriously disturbed or aggressive behaviour. Local Mental Health Crisis Declarations should include local ambitions to reduce the use of police cells as places of safety;

- Protocols should help to ensure that police custody is never used as a place of safety for children and young people, except in very exceptional circumstances where a police officer makes the decision that the immediate safety of a child or young person requires it. Even in cases where police stations are used, the use of cells should be avoided, and alternatives considered wherever possible.

Commissioning

Accommodation and facilities, including community based solutions, designed to be suitable for patients younger than 18 years must be commissioned at a level that ensures local provision in response to a young person in urgent need.

Quality and Treatment and Care for Children and Young People in Crisis

If a child or young person needs treatment, the first principle should be to treat at home or in the community if possible. If treatment is needed in an inpatient bed, local accessibility is important, so that the young person is close to home, friends and school, so long as none of these is contributing to the crisis. Units attached to adult wards in mental health hospitals can be used as places of safety if child-dedicated facilities are unavailable – under the Mental Health Act 2007, hospitals should provide 'age-appropriate' facilities that are separate from adult wards.

Young people need easily accessible and age appropriate information about the facilities available on the inpatient unit, geared towards their specific needs. This includes information on their rights and how to complain. They require extra support to settle in from a single key worker who remains the same throughout their stay where possible. They should be able to phone their families and friends. The units need to be safe, warm and decorated at an appropriate age level, and not appear to be an institution. Families should have regular meetings with the ward staff.

Training

Each statutory agency should review its training arrangements on a regional basis and agree priority areas for joint training modules between NHS, social care and criminal justice organisations. Although it is desirable that representatives of different agencies be trained together, it is not essential. It is more important that the training ensures that staff, from all agencies, receive consistent messages about locally agreed roles and responsibilities.

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