Public Document Pack

Health and Wellbeing Board

Wednesday, 30th July, 2014 at 6.00 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Shields
Councillor Jeffery
Councillor Baillie
Councillor Lewzey
Councillor Chamberlain

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

Contacts
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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:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

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 "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 ELECTION OF CHAIR AND VICE-CHAIR

To appoint a Chair and Vice-Chair to the Health and Wellbeing Board for the 2014/2015 Municipal Year.

3 DISCLOSURE OF PERSONAL AND PECUNIARY 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.

4 STATEMENT FROM THE CHAIR

5 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 14th May 2014 and to deal with any matters arising, attached.

STRATEGIC DEVELOPMENTS

6 SOUTHAMPTON CITY STRATEGY 2014-2025 AND COUNCIL STRATEGY 2014-2017

Report of the Director of Public Health, seeking comments from the Health and Wellbeing Board on the content and implications of the Southampton City Strategy 2014-2025 and the Council Strategy 2014-2017, with particular reference to the health and wellbeing actions, attached.

7 SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP (CCG) FIVE YEAR STRATEGY (2014-2019) AND TWO YEAR OPERATIONAL PLAN

Report of the Chair and Chief Executive Officer, Southampton City Clinical Commissioning Group, requesting that the Health and Wellbeing Board endorse the Clinical Commissioning Group's Five Year Strategy and Two Year Operational Plan, attached.

8 PRIMARY CARE DEVELOPMENT

Report of the Chief Officer, Southampton City Commissioning Group, seeking the Health and Wellbeing Board's support of the Expression of Interest for Southampton City Clinical Commissioning Group undertaking co-commissioning of primary care with NHS England, attached.

9 PHARMACEUTICAL NEEDS ASSESSMENT (PNA)

Report of the Director of Public Heath, requesting that the Health and Wellbeing Board acknowledged both the statutory requirements and the approach being taken to complete the PNA by the statutory deadline and to consider methods of support for the stakeholder consultation element of the PNA process, attached.

BOARD APPROVALS

10 SOUTHAMPTON CITY POLICY STATEMENT FOR WORKING WITH CHILDREN AND ADULTS WITH LEARNING DISABILITIES WHOSE CARERS AND/OR SERVICES ARE CHALLENGED BY THEIR BEHAVIOUR

Report of the Director of Quality and Integration, Southampton City Commissioning, Southampton City Council, seeking the Health and Wellbeing Board's support of the final Joint Commissioning Policy and Action Plan for "Working with Children and Adults with Learning Disabilities whose Carers and/or Services are Challenged by their Behaviour", attached.

BOARD UPDATES

11 BETTER CARE SOUTHAMPTON UPDATE

Report of the Director of Quality and Integration, for the Health and Wellbeing Board to note the progress made towards implementation of Better Care Southampton, attached.

Tuesday, 22 July 2014 — Head of Legal and Democratic Services

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 14 MAY 2014

Present: Councillors Baillie, Lewzey, McEwing, Shields (Chair) and Jeffery
Andrew Mortimore, Dr Steve Townsend (Vice-Chair), Dr Stuart Ward and Rob Kurn

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

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

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

Councillor Shields declared a personal interest in that he was 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.

53. **STATEMENT FROM THE CHAIR**

The Chair made a statement in accordance with accepted practice and welcomed Health and Overview Scrutiny Panel members, Dr O'Shea and Mr Westbury from Southern Health who were attending the meeting for the NHS England Specialist Services Consultation item and thanked members of the Board for the progress made during the first year.

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

RESOLVED that the Minutes of the Meeting held on 26th March 2014 be approved and signed as a correct record.

55. **NHS ENGLAND SPECIALIST SERVICES CONSULTATION**

The Board considered the report of the Public Health Consultant providing details of the local response to NHS England's consultation on specialist services.

The Board noted that:-

- the consultation was an ongoing process on 130 specialist services;
- as a number of specialist services were located at the University Hospital in Southampton, the city should not experience significant changes;
- financial monitoring would be required as increased spending on specialist services would result in less funding for district hospitals;
- the following were specialist services:-
  - acute kidney injury

- adult cardiac surgery
    - complex disability and prosthetics
    - paediatric intensive care;
- specialist services for mental health issues required prioritisation;
- an entirely new funding provision for specialist services, separate from the CCG budget, had commenced on 1 April 2013 and this would create very real cost pressures for the NHS in the short to medium term; and
- the final decision in terms of where the specialist services would be located would have a political impact and it was essential that these decisions should not be swayed by political party issues.

RESOLVED that the Health and Wellbeing Board and the Health Overview and Scrutiny Panel agreed to the general principles of the consultation and encouraged more detailed responses from local organisations, patients, carers and clinicians on the content of the specifications.

56. HEALTH AND WELLBEING BOARD FACILITATED SELF-ASSESSMENT

The Board considered the report of the Improvement Manager providing details of a self- assessment tool for Health and Wellbeing Boards which the Local Government Association (LGA) had offered to pilot in Southampton free of charge.

It was noted that this self-assessment tool would enable the Board to explore their strengths and opportunities, improve performance and with the increased focus on integration, enable them to strengthen their system leadership role and develop a clear sense of purpose which would help transform services and outcomes for local people.

The Board further noted that:-

- the new version of the self-assessment tool would be available by the end of May 2014;
- Mr Andrew Cozens, a leading Policy and Improvement Specialist for health and social care had agreed to facilitate the session which would be free of charge; and
- available dates for the facilitated self assessment session would be circulated to Board Members.

RESOLVED that the Board agreed to take part in the free facilitated self-assessment session.

57. BETTER CARE SOUTHAMPTON UPDATE

The Board received and noted the report of the Director of Quality and Integration, providing an update on the progress of Southampton's Better Care local plan.

The following points were highlighted:-

- a very successful informal meeting had been held on 23rd April, focussing on the implementation of Better Care in Southampton. The session covered how providers' 2014/2015 strategies were linked to the Better Care initiative, what

barriers and challenges needed to be overcome and how the Health and Wellbeing Board could work most effectively with providers in the future. It was AGREED that providers' presentations would be forwarded to the Health and Wellbeing Board members;
- Southampton was working towards a locality cluster model and were proposing to establish 6 integrated care teams clustered around GP practices;
- very challenging targets had been set which required strong governance structures involving all stakeholders; and
- in order to raise awareness of the general public, local communities and staff of the Southampton Better Care model, a branding required to be developed and marketed.

58. **MENTAL HEALTH CRISIS CARE CONCORDANT**

The Board received and noted the 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.

The following points were highlighted:-

- mental heath was a cross cutting issue in the City and the development of a joint task and finish group was necessary to consider this issue which was reaching crisis proportions;
- a mental health crisis declaration was in the process of being drafted for sign up by the Health and Wellbeing Board;
- the Health Overview and Scrutiny Panel had undertaken a recent inquiry on the "Impact of Housing and Homelessness on Single People", where it had been evidenced that mental health had been a core issue in terms of homelessness of single people and that the Police and other partners had been reluctant to become involved with mental health issues; and
- that there was only one place of safety bed in Southampton.

It was AGREED that:-

- the commissioning of mental health services was a top priority and an in-depth investigation required to be undertaken;
- officers would brief the Cabinet Member for Health and Adult Social Care on mental health issues; and
- mental health should be a standard item on both the Health Overview and Scrutiny Panel and the Health and Wellbeing Board agendas.

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		SOUTHAMPTON CITY STRATEGY 2014-2025 AND COUNCIL STRATEGY 2014-2017		
DATE OF DECISION:		30th JULY 2014		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Martin Day**	**Tel:**	**023 80917831**
	E-mail:	**Martin.day@southampton.gov.uk**		
Director	**Name:**	**Dr Andrew Mortimore**	**Tel:**	**023 80833204**
	E-mail:	**Andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The report presents 2 major strategies to the Health and Wellbeing Board for information. Both strategies set out health and wellbeing aspirations which are reflected in the Joint Health and Wellbeing Strategy.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board notes and comments on the content and implications of the Southampton City Strategy 2014-2025 and the Council Strategy 2014-17 with particular reference to the health and wellbeing actions, and those affecting the wider determinants of health.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Health and Wellbeing Board to review the contents of the Southampton City Strategy 2014-2025 and Council Strategy 2014-2017

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. At its meeting on 16th July 2014 the Council meeting considered 2 major strategy documents. The Southampton City Strategy 2014-2025 is produced by Southampton Connect, the partnership comprising leaders of key public, private and voluntary organisations in the city which believe that through collaborative action, implementation of the strategy will help to maximise

opportunities and address challenges for the city. A copy of the strategy is attached at Appendix 1. The Council agreed to endorse this strategy document, and delegated authority to the Chief Executive, as the incoming Chair of Southampton Connect, to agree the Council's final contribution which will reflect feedback from Southampton Connect partners.

4. At the same meeting, the Council approved the Council Strategy 2014-2017. This strategy sets out the priorities for the coming 3 years, and a copy is attached as Appendix 2 to this report. The Council also delegated authority to the Assistant Chief Executive, in consultation with the Leader of the Council, to make any in-year changes and to refresh the relevant sections of the strategy in 2015 and 2016 so that it aligns with any new budgetary or policy developments.

5. Both the strategies identify priorities and actions for health and wellbeing. The Southampton City Strategy identifies healthier and safer communities as a priority and improving mental health is identified as one of 4 cross-cutting themes. It commits Southampton Connect to work with key city partnerships, including the Health and Wellbeing Board, to deliver the vision. The Director of Public Health is currently a member of the Southampton Connect Board.

6. The Council Strategy 2014-17 also contains specific health and wellbeing commitments. Prevention and early intervention and the protection of vulnerable people are identified as priorities.

7. It is encouraging the both these major strategy documents also contain actions which will impact on the wider determinants of health, including employment, housing and community cohesion.

8. The health and wellbeing matters in both of these strategies align with actions and measures identified in the Health and Wellbeing Strategy developed through the Health and Wellbeing Board in 2013, and adopted by both the Council and Southampton City Clinical Commissioning Group.

RESOURCE IMPLICATIONS

Capital/Revenue

9. There are no additional capital or revenue implications for 2014/15 arsing from the proposals outlined in this report.

Property/Other

10. None as a consequence of the recommendations contained within this report.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11. The Health and Social Care Act 2012 requires upper tier local authorities to establish Health and Wellbeing Boards.

Other Legal Implications:

12. None.

POLICY FRAMEWORK IMPLICATIONS

13. None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Southampton City Strategy 2014-25
2.	Council Strategy 2014-17

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.	

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Appendix 1

DECISION-MAKER:		CABINET COUNCIL		
SUBJECT:		SOUTHAMPTON CITY STRATEGY 2014-2025		
DATE OF DECISION:		15 JULY 2014 16 JULY 2014		
REPORT OF:		LEADER OF THE COUNCIL		
AUTHOR:	Name:	Suki Sitaram	Tel:	023 8083 2060
	E-mail:	Suki.sitaram@southampton.gov.uk		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

Southampton Connect (the partnership comprising leaders of key public, private and voluntary organisations in the city) has identified the top city priorities detailed in its draft City Strategy. The partnership believe that through collaborative action, implementation of the strategy will help to maximise opportunities and address challenges for the city.

As a key member of Southampton Connect, the Council with other main partners, has been requested to endorse the draft City Strategy 2014 - 2025, and to contribute to delivering the priorities and outcomes contained within the attached draft strategy.

RECOMMENDATIONS:

CABINET:

(i) To endorse the draft Southampton City Strategy 2014 - 2025 prepared by Southampton Connect and to recommend its approval to Council on 16th July 2014.

COUNCIL:

(i) To endorse the draft Southampton City Strategy 2014 - 2025 prepared by Southampton Connect.

(ii) To delegate authority to the Chief Executive, as the incoming Chair of Southampton Connect, to agree the Council's contribution to the final City Strategy 2014 – 2025 which will reflect feedback from Southampton Connect partners.

REASONS FOR REPORT RECOMMENDATIONS

1. The council is a significant partner within Southampton Connect and is therefore being requested to endorse the draft city strategy along with all key partners.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None as the draft Southampton City Strategy 2014 - 2025 has been developed by Southampton Connect.

DETAIL (INCLUDING CONSULTATION CARRIED OUT)

3. Launched in 2011, Southampton Connect replaced Southampton Partnership as the key strategic partnership for the city and agreed a City Plan for 2012-2015 in October 2011.

4. Under the leadership of the Chief Executive of Southampton Voluntary Services, Southampton Connect has forged closer working relationships with other city partnerships, including the recently formed Future Southampton. It has been effective in bringing organisations together to improve outcomes, particularly around the city's response to Welfare Reforms and promoting the 50th anniversary of Southampton gaining city status.

5. Reflecting changing opportunities, needs and resources within the city, and the necessity to focus on addressing fewer key strategic challenges, Southampton Connect have drafted the city strategy for Southampton covering the period 2014 to 2025.

Vision and priorities

6. The draft City Strategy 2014 – 2025, attached as Appendix 1, articulates Southampton Connect's vision for the city which was developed with key partners from across the city with 3 key priorities for the city and accompanying outcomes.

7. The 3 priorities within the draft strategy are:
   - Economic growth with equality
   - Skills and employment
   - Healthier and safer communities.

8. As identified in the strategy, progress in delivering the stated outcomes will be led by the strategic partnerships in the city that have strategic responsibility in these areas, with Southampton Connect keeping an overview of progress.

9. The strategy also identifies four cross-cutting themes that require the collective action of Southampton Connect partners to progress over and above the work of the strategic partnerships. The 4 cross cutting themes are:
   - Improving mental health
   - Building community capacity
   - Fostering city pride and identity
   - Delivering whole place thinking

10. Southampton Connect will be developing mechanisms to progress the cross cutting themes by Autumn 2014.

How were the priorities and cross cutting themes determined?

11. The priorities and cross cutting themes have been decided following consultation with Southampton Connect partners and reflect extensive

feedback from city residents, Southampton's aspirations within the region, and analysis of information about the city.

Feedback from residents

12. In March and April 2014 the first City Survey since 2010 was undertaken. Southampton Connect, the Safe City Partnership, Health (Southampton City Clinical Commissioning Group) and the Council commissioned the City Survey, to find out what residents think of Southampton and the services we all provide. The main feedback was:
    - 82% of residents are satisfied with their local area as a place to live
    - Increasing jobs and employment, as well as reducing crime and antisocial behaviour, were among the top priorities identified.
    - 63% of residents feel safe in their local area at night - compared to 93% during the day.
    - 63% of residents feel a strong sense of belonging to their local area, compared to the national average of 78%.
    - 36% of residents feel they can influence decisions affecting their local area.
    - One third of residents feel they have little or no influence over decisions about their healthcare.
    - 60% of residents have not taken part in any voluntary activity in the last year.

Regional Aspirations

13. These include:
    - Promoting the area as the UK's leading growth hub for advanced manufacturing, marine and aerospace both at home and, more importantly, in the global marketplace.
    - Ensuring people have the right skills to access employment and support our growing sectors.
    - Increasing and accelerating the number of jobs and housing by releasing key sites and helping to provide the infrastructure needed to regenerate and develop them.
    - Helping young people, the long-term unemployed and those who may be made redundant get into work.

City Profile

14. Southampton is the second highest ranking city in England for 'good growth' based on the "Good Growth Index 2013". This index compares how 39 UK above average cities for 'good growth' perform on job, income and skills measures. The city is now ranked 4th overall for economic growth in the UK and the 2nd highest English city for good growth. Southampton showed the most improvement of any other city, between 2012 and 2013. This is a rise of 10 ranking places since the 2012 survey, demonstrating the city's commitment to growth and economic development opportunities. We are ensuring that we capitalise on this by being actively involved in the region's developing Strategic Economic Plan to access the Single Local Growth Fund. This will help us to drive the key developments in the city, particularly Royal Pier, and continue the critical work on waste

transformation and estate regeneration.

15. Analysis of information contained within publications such as the Joint Strategic Needs Assessment (Health and Wellbeing), the Strategic Assessment (Community Safety), and the Digest of Key Statistics provides us with an overview of the strategic needs across Southampton. This profile identifies the following:
    - The achievement of children and young people at school and college has significantly improved over recent years, but further improvement is still needed.
    - Wages are below the regional average.
    - Southampton is the most deprived area in the south east for older people living in poverty with above average levels of child poverty
    - An increasing number of people are living in private rented accommodation.
    - There has been a significant increase in demand for specialist safeguarding services for vulnerable children, young people and families.
    - A high number of people are claiming benefits due to mental health issues and mental health problems are increasing.
    - The number of people with dementia and those who are frail elderly are increasing.
    - Although crime is falling the comparable position for all crime is 6th out of 9 core cities.
    - Southampton has high levels of alcohol related crime and ill health.

16. The Leadership Foundation for Higher Education also provided input into the development of the draft strategy. A group of academics and senior managers in higher education were invited to undertake a strategic challenge in Southampton on 15th May 2014. They conducted desk based research and interviews with key city leaders to help identify the top 3 challenges and opportunities where partnership working could add real value. Their conclusions helped to inform the discussion at a workshop on 29th May 2014 where draft priorities were identified by Southampton Connect members and additional invitees made up of leaders from a cross section of organisations and partnerships in the city.

17. To enable progress to be tracked Southampton Connect identifying a number of measures against which performance in delivering the outcomes identified in the strategy will be monitored.

18. The priorities within the City Strategy 2014 – 2025 need to be reflected within the priorities of the key partners within Southampton Connect to ensure that the city works collaboratively to meet the challenges it faces. To this end the priorities contained within the draft Council Strategy 2014-17 clearly show how the council will contribute to meeting the priorities outlined in the draft City Strategy.

19. As the draft Southampton City Strategy 2014 - 2025 has been developed by Southampton Connect, formal organisational sign-up is now being sought from all key partners so that it can be formally launched in Autumn 2014. As part of the approval process, delegated authority is sought for the Chief

Executive, in her capacity as the incoming Chair of Southampton Connect, to finalise the strategy for launch. This will incorporate any changes requested during the approval process.

FINANCIAL/RESOURCE IMPLICATIONS

Capital/Revenue

20. There are no additional capital or revenue implications for 2014/15 arising from the proposals outlined in this report.

Property/Other

21. None as a consequence of the recommendations contained within this report.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

22. None.

Other Legal Implications:

23. None.

POLICY FRAMEWORK IMPLICATIONS

24. Whilst the City Plan is no longer a statutory requirement or part of the council's Policy Framework, it is expected that other plans and strategies within the Policy Framework will seek to address the challenges in the City Plan and contribute to the priorities and projects detailed within it.

SUPPORTING DOCUMENTATION

Appendices

1	Draft Southampton City Strategy 2014 - 2025

Documents In Members' Rooms

	None

Background Documents

	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.	

FORWARD PLAN No: N/A **KEY DECISION** Yes

WARDS/COMMUNITIES AFFECTED: All wards and communities in Southampton will be affected by the implementation of the proposals set out in the Council Strategy

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Appendix 2

DECISION-MAKER:		CABINET COUNCIL		
SUBJECT:		COUNCIL STRATEGY 2014 - 2017		
DATE OF DECISION:		15 JULY 2014 16 JULY 2014		
REPORT OF:		LEADER OF THE COUNCIL		
AUTHOR:	Name:	Suki Sitaram	Tel:	023 8083 2060
	E-mail:	Suki.sitaram@southampton.gov.uk		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

The Council Strategy is a key strategic document, setting out what we will do, how we will work and how we will contribute to the draft city strategy (2014 – 2025). It sets out our priorities for the next three years, the outcomes we expect to achieve by 2017 and the measures we will use to monitor our progress. It will influence all other strategies and policies developed during this period, as well as spending decisions; directorates and services will also use it to plan service delivery. It is part of the council's Policy Framework and must be approved by Council.

Once agreed, it will be made published on the council's website and be available to staff, residents and stakeholders. It has been drafted as an easy to read, accessible document, which focuses on key priorities, rather the trying to describe all 'business as usual' activities.

It replaces the current Council Plan, which received positive feedback, and has been used to set the strategic direction for the council since its development. It has been refreshed in light of feedback from residents and the changing local and national context.

RECOMMENDATIONS:

CABINET:

(i) To note the recommendations made by the Overview and Scrutiny Management Committee, as reported verbally at the meeting, which, if approved by Council, will be reflected in the final version of the Council Strategy.

(ii) To recommend the draft Council Strategy 2014-2017, including the council priorities attached as Appendix 1, to Council for approval.

COUNCIL:

(i) To note the recommendations made by the Overview and Scrutiny Management Committee and Cabinet, to be reported verbally at the meeting, and which, if approved, will be reflected in the final version of the Council Strategy 2014 - 2017.

(ii) To approve the draft Council Strategy 2014-2017, including the council priorities attached as Appendix 1.

(iii) To delegate authority to the Assistant Chief Executive, following consultation with the Leader of the Council, to finalise the draft Council Strategy 2014 -2017, including incorporating any changes made at the meeting and to make any in

year changes and to refresh relevant sections of the strategy in 2015 and 2016 so that it aligns with any new budgetary or policy developments which will impact on the council's activities during 2014- 2017.

REASONS FOR REPORT RECOMMENDATIONS

1. The Council Strategy is a key element in the council's policy framework, as it sets the direction of travel and priorities for the council for 2014-2017. It will influence all other strategies and policies developed during this period, as well as spending decisions. Whilst it sets the overarching strategic direction for the council, ongoing review and changes will be necessary over the three year period, in response to a number of factors. Delegated authority is therefore sought to review and make changes in the future.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (INCLUDING CONSULTATION CARRIED OUT)

3. The draft Council Strategy 2014-2017, attached as Appendix 1. The strategy describes how the council will contribute to the priorities set out in Southampton Connect's City Strategy 2014 -2025.

4, The previous Council Plan was published in July 2013. Key achievements against last year's plan are attached as Appendix 2. Highlights include:

- Agreement on the development of the Royal Pier with key partners and commenced work on phase 1 of the Station Quarter Development and Centenary Quay, as part of the City Centre Master Plan.
- Successful City Deal submission, jointly with Portsmouth City Council which is expected to lever significant funding to support local economic growth and jobs for local people.
- Improvement in the levels of educational attainment at both Key Stage 2 and Key Stage 4 (GCSE) by the city's children and young people including those from disadvantaged backgrounds.
- Launch of a new mobile app 'Recycle for Southampton' to help residents check collection dates, set reminders and find their nearest recycling point.
- Over 10,000 residents have signed up for the garden waste collection service.
- Establishment of a joint Multi Agency Safeguarding Hub (MASH) to improve the effectiveness of responses to all children's referrals.
- Started work on the Southampton New Arts Complex.
- Established a joint Integrated Commissioning Unit between the council and Health (Southampton City Clinical Commissioning Group) within a unified management structure.
- Establishment of an independent Fairness Commission to consider issues of fairness and equality in Southampton.
- Delivered 300 affordable homes and brought 100 empty homes back into

use.

- Conducted the first City Survey since 2010 in partnership with Southampton Connect.

5. We face a number of challenges including financial pressures and improving our performance in some areas. The final performance report for 2013-14 is available on the council's website, and provides an overview of progress to date. The key areas for improving council performance in the coming year have been incorporated into the draft Council Strategy 2014 -2017 and are:
   - Improving educational attainment for all children and young people.
   - Improving children's safeguarding services including of increasing the number of care leavers in suitable accommodation and in employment, education or training.
   - Increasing direct payments and reducing delayed transfers of care.
   - Increasing recycling rates and transforming waste services.

6. In developing the Council Strategy, we have also considered feedback from residents, both from the pre-budget priorities survey, and the more recent City Survey 2014. It is reassuring to note that despite the fact that in the last few years the council has had to make difficult decisions in light of financial challenges. The feedback shows that:
   - Satisfaction with how the council runs things has gone up since 2010 by 7% to 59%.
   - 44% agree that the council provides value for money which is 4% higher than in 2010.
   - Over 75% are satisfied with parks and open spaces, bin collections and recycling.
   - Over 60% are satisfied with our play parks/areas, libraries, sports and leisure, local tips and recycling.

7. We have also given particular attention to the key feedback points:
   - The top priorities for improvement were roads and pavements and local transport and travel congestion.
   - 88% of Southampton residents have access to the internet.
   - 28% use email alerts and 27% use the website as the main source of information about the council.

8. The draft Council Strategy 2014 -2017 sets out the following priorities:
   - Jobs for local people
   - Prevention and early intervention
   - Protecting vulnerable people
   - Affordable housing
   - Services for all
   - City pride
   - A sustainable Council

9. The strategy details the outcomes we expect to achieve by 2017 and the key success measures we will use to monitor our performance. Quarterly performance reports will be published on the council's website and be available for the Overview and Scrutiny Management Committee (OSMC) to consider.

10. In addition to setting out our key priorities, the strategy reflects our priority to become a sustainable council in the context of our ongoing financial pressures. A separate report is on this agenda detailing the next phase of our Transformation Programme to enable us to achieve this priority by 2017.

11. The Overview and Scrutiny Management Committee (OSMC) is due to consider the draft Council Strategy 2014 - 2017 on 10th July 2014 and their recommendations will be reported verbally at the Cabinet and Council meetings.

12. The final version of the Council Strategy 2014- 2017 will be published on the Council's website, following consideration of the feedback from OSMC, Cabinet and Council.

FINANCIAL/RESOURCE IMPLICATIONS

Capital

13. There are no additional capital implications for 2014/15 arising from the proposals outlined in this report.

Revenue

14. There are no additional revenue implications for 2014/15 arising from the approval of the report's recommendations. The measures contained within the strategy will be met from the resources allocated to portfolios through the 2014/15 budget setting process and future approved budgets.

Property

15. None as a consequence of the recommendations contained within this report.

Other

16. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

17. The statutory powers for producing this strategy can be found in the Local Government & Housing Act 1989, Local Government Acts 1972, 1999 and 2000 and s.1 Localism Act 2011. The council has a statutory duty to secure best value. The production of the Council Strategy demonstrates that the council has an integrated and planned approach to this requirement.

Other Legal Implications:

18. In preparing the Strategy the council has had regard to its duties under the Equalities Act 2010, the Human Rights Act 1998 and s.17 of the Crime and Disorder Act 1998.

POLICY FRAMEWORK IMPLICATIONS

19. The Council Strategy forms part of the council's Policy Framework, as set out in Article 4 of the Council's Constitution. The Executive is, for almost all functions, responsible for implementing the policies and spending the budget in accordance with the Policy Framework and budget. Each of the proposed actions in this strategy will be subject to the council's normal decision making processes, including detailed legal and financial assessments as necessary.

In developing this strategy, consideration has been given to known national policy and budgetary changes which will have a significant impact on the city. Progress over the next few years will be partially dependent on the availability of funding from external sources or the identification of new income sources. As it is not possible to guarantee the outcomes in some cases, the Council Strategy is subject to in year variation. It is therefore proposed to delegate authority to the Assistant Chief Executive, following consultation with the Leader of the Council, to finalise the Council Strategy, including incorporating any changes made at the meeting and to make any in year changes and to refresh relevant sections of the strategy in 2015 and 2016 so that it aligns with any new budgetary or policy developments which will impact on the council's activities during 2014- 2017.

SUPPORTING DOCUMENTATION

Appendices

1	Draft Council Strategy 2014 - 2017
2	Council Plan 2013 - 16 Progress highlights

Documents In Members' Rooms

	None

Background Documents

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.	

FORWARD PLAN No: N/A **KEY DECISION** Yes

WARDS/COMMUNITIES AFFECTED: All wards and communities in Southampton will be affected by the implementation of the proposals set out in the Council Strategy

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		SOUTHAMPTON CITY CCG FIVE YEAR STRATEGY (2014-2019) AND TWO YEAR OPERATIONAL PLAN		
DATE OF DECISION:		30th JULY 2014		
REPORT OF:		CHAIR AND CHIEF EXECUTIVE OFFICER, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP (CCG)		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80**
	E-mail:	**Stephanie.ramsey@southamptoncityccg.nhs.uk**		
Director	**Name:**	**John Richards, Chief Executive Officer**	**Tel:**	**023 80**
	E-mail:	**John.Richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
Not applicable				

BRIEF SUMMARY

The Southampton City Clinical Commissioning group five year strategy is firmly rooted in what our public and stakeholders say is important to them and is driven by a need to have healthy and sustainable services. It sets out what we intend to do between now and April 2019 to bring the system together and improve the health and wellbeing of local people. It describes our vision, goals and approach, demonstrating how these have been developed. It also includes detailed action plans which describe how we will achieve this much needed transformation of health and care services.

RECOMMENDATIONS:

(i) The Health and Wellbeing Board is asked to receive, welcome and endorse the CCG strategy

REASONS FOR REPORT RECOMMENDATIONS

1. The CCG five year strategy and associated action plans describe the approach the CCG is taking to play its part in delivering the Southampton Joint Health and Wellbeing Strategy. The CCG ambitions therefore are not a parallel process –but part of the integrated and joined-up vision for the City. The strategy was approved by the CCG Board in May 2014 and adopted by the CCG General Assembly in June. It has been submitted to NHS England for assurance.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not applicable

DETAIL (Including consultation carried out)

3. In October 2012, the Board approved a draft clinical commissioning strategy as part of the preparation for CCG authorisation. This has been the subject

of various engagement events since that time and has served as the basis for development of the new five year strategy.

4. The CCG submitted to NHS England extensive documentation on 14 February 2014 in compliance with mandated key lines of enquiry (KLOE) proformas and trajectories, together with its Better Care Fund submission. Feedback from NHS England has been fully incorporated into the preparation of this document.
5. The document itself has been structured to reflect the Vision, Values, Mission, Goals, Interventions and Outcomes agreed by the CCG members and Governing Body
6. The strategic direction has been developed over several months. The Southampton Health Conference attended by numerous key stakeholders (held on 11 March) received various presentations themed around our Plan on a Page workstreams and involved several interactive sessions designed to gain feedback on our strategy. It produced a wealth of material that has been used in compiling this document.
7. The strategy takes into account the views, ideas, comments and suggestions of patients, services users, communities, the public, clinicians and a range of other key stakeholders. What people said and how this feedback has been used is described within the strategy document.
8. The main document is comprised of 73 pages supported by extensive annexes. The first 30 pages describe the strategic direction and various factors that drive the strategy. Part 3 comprises the action plans for each of the five goals and these are set out in tabular form showing the aim for 2019, what will be achieved by 2017, how we will track our progress and what will be different as a result.
9. The strategy has been summarised into a Plan on a page and that can be seen on page 32 in the document.
10. The strategy outlines how the established five goals to support the delivery of the Vision and Mission. The five goals are the culmination of in-depth work to understand and agree with partners and stakeholders the priority health and care issues, needs and challenges facing the City. The five goals are the organising and driving aims for all the CCG our work over the next five years:

    A. **Make Care Safer:** We will commission care from safe competent providers**.** We will listen to local people, gather their feedback on their experiences of local services and act upon it.

    B. **Make it Fairer:** We will tackle the inequalities in access to care across our population.

    C. **Improve Productivity (doing more for less):** We will prepare the ground for a transformation in care, doing all we can to bring control to the acute healthcare system.

D. **Shift the Balance:** We will integrate health and care services to ensure a better more streamlined experience for local people. Together with patients, communities and partners we will co-produce coordinated care through the Better Care Southampton programme.

E. **Delivering Sustainable Finances:** We will plan strategically for sustainable finances ensuring that we are driven by quality whilst being pragmatic about our resources.

11. Increasingly, as can be seen through this strategy, the intention is to work very closely with Southampton City Council to fully join up commissioning work for care and community based support across the city, as core members of the Health and Wellbeing Board for the City.

RESOURCE IMPLICATIONS

Capital/Revenue

12. The document is cast within the context of the financial outlook and known CCG allocations. It contains a strategic financial plan for the period, details of savings plans and operational plans for 2014/15 and 2015/16 that are compliant with the requirements of the national operating framework, Everyone Counts, including the requirement to deliver a planned surplus of 1%.

Property/Other

13. Not applicable

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. Not applicable

Other Legal Implications:

15. Not Applicable

POLICY FRAMEWORK IMPLICATIONS

16. Not applicable

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Southampton City CCG “A Healthy Southampton for All, Bringing together a Healthy and Sustainable System. Our 5 year strategic plan (2014-2019)”

Documents In Members' Rooms

1.	None
2.	

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: Southampton City CCG website

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	

NHS
Southampton City
Clinical Commissioning Group

A Healthy Southampton for All

Bringing together a Healthy and Sustainable System

Our 5 year strategic plan
(2014-2019)

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Part 1: Bringing it together

Foreword

Our city, our approach, our strategy

NHS Southampton City Clinical Commissioning Group (CCG) exists to plan and buy (commission)[1] health services for local people. We are led by GPs and other clinicians and are one of over200 CCGs across the country, a new type of NHS organisation introduced following the 2012 health reforms.

We have 33 GP member practices who all have a say in how we are run as members of our General Assembly, a formal body which oversees our work. This delegates the running and accountability of the CCG to our Governing Body[2].

We serve a diverse and vibrant population which includes a significantly higher than average number of younger people;[3] greater ethnic diversity than many cities of our size; and a forecast 20% increase in the number of people under 5 years and over 70 years by 2017.

Our vision, *A Healthy Southampton for All,* is about using our new organisation to bring a radically different approach to how we serve our diverse communities. Our city's needs and challenges cannot be addressed by doing the things we have always done: our population is changing; health and care needs are becoming more complex; our care providers are under severe pressure; and the financial outlook for public services is demanding. These are city-wide issues and no one organisation can hope to address them alone – we need to think creatively about what we can to bring the whole health and care system together.

As clinical commissioners, we will play a leading role in making this happen. That is because clinical decision makers commit resources every day and we firmly believe we must take responsibility for both the quality and costs of care. We are taking a **One City** approach to health and care services, working jointly for the common good. We will put the health and care needs of the people of our city first and, make sure that organisational interests never trump those of patients. We will remove barriers to better care and pull together all the key partners to help deliver the services that an individual might need - from home to hospital and back home again.

This is more than just a pledge to work better together; to underscore our commitment we will be pooling a substantial proportion of our budgets with the City Council over the coming years to deliver services in new and better ways. Only through such big thinking can we achieve***A Healthy Southampton for All.***

Our 5 year strategy is firmly rooted in what our public and stakeholders say is important to them and is driven by a need to have healthy and sustainable services. It sets out what we intend to do between now and April 2019 to bring the system together and improve the health and wellbeing of local people. It describes our vision, goals and approach, demonstrating how these have been developed. It also includes detailed action plans which describe how we will achieve this much needed transformation of health and care services.

We hope you find it an interesting read.

Dr. Steve Townsend
Clinical Chair

John Richards
Chief Executive Officer

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[1]For more information about Commissioning see Appendix 1 *'What is Commissioning?'*
[2]See Appendix 2 for more information about our Governing Body
[3]Due largely to our two Universities and other further education establishments

About us

We start in this first section with more details aboutwho we are, what we do and our approach along with introducing the key strategic goals that are the guiding force for all our plans and work.

We were established on 1 April 2013 with a clear remit to ensure that family doctors and other clinicians play a leading role in deciding and directing how our local NHS resources should be used. We sit at the heart of the NHS and are set up to listen to and act upon the views and needs of patients, carers and the public as well as working closely with local authorities and other partners. Our role as a CCG is to help meet the health and care needs of our population. We are allocated a budget to achieve this and must use it to plan and buy (or 'commission') health and care services from a number of service providers. We:

- Serve a population of around 269,687, covering 28 square miles
- Have 33 constituent member GP practices
- Have a budget of just over £292 million (in 2014/15) to cover acute hospital services, community services and prescribing
- Share the same boundaries as Southampton City Council

We buy care from the following main providers:

- Care UK (Elective and GP Out of Hours care).
- Solent NHS Trust (for general community and child and adolescent mental health services)
- South Central Ambulance Service NHS Foundation Trust
- Southern Health NHS Foundation Trust (adult mental health services)
- University Hospital Southampton NHS Trust (which incorporates our main acute Hospital)

We also purchase services from a range of private and charitable organisations who provide care on our behalf

Increasingly, as can be seen through this strategy, we are working very closely with Southampton City Council to fully join up our commissioning work for care and community based support across the city, as core members of the Health and Wellbeing Board for the City. Together we have recognised that we will better be able to meet the health and social care needs of our population by working in a more joined up, or integrated way. That is why in November 2013 the CCG and City Council formally established an **Integrated Commissioning Unit** - a single group tasked with using an evidence based approach to commissioning to jointly plan and buy health and social care services. By pooling capabilities and purchasing power in this way, both organisations can exercise much greater control over what we need and buy at affordable prices and with the right level of quality.

For the reasons set out above, the fundamental building block of our strategic planning, or so-called planning footprint, is SouthamptonCity. Nevertheless, we also play a full part in broader strategic themes such as the configuration of providers across Wessex as a whole, both in respect of acute and community services. To do this, we work collaboratively with both neighbouring CCGs and NHS England[4] (Wessex Area Team).

We recognise there are factors[5] driving further centralisation of specialist expertise, and are therefore mindful of the relationship between developments in Southampton and neighbouring centres. We support University Hospital Southampton's (UHS) development as a premier provider of specialised services and recognise the benefits this has brought to local people. We also work particularly closely with West Hampshire CCG because of our shared interest in Southampton

[4] NHS England commission primary care (GP, dental, ophthalmic, and pharmaceutical services) and specialist services for our population and across the wider area.
[5]Evidence shows very specialist or complex procedures need to be concentrated in specialist centres.

General Hospital, and increasingly so with Portsmouth CCG because of a similar shared interest in Solent NHS Trust.

Following recent announcements by NHS England, we are also keen to explore greater involvement in primary care commissioning, (see page 21) especially given the central role we expect to be played by General Practice in delivering integrated local services.

Membership, Clinical Leads andGoverning Body

As with all CCGs we are a membership organisation which means that all GP practices in the City are our 'members'. Our aim is to shift decision-making as close as possible to patients, using membership to ensure local GPs and other clinicians are given power and responsibility for planning healthcare services. Our 33 member practices have all signed up to our constitution and are shaping and influencing the future development of health services.

To further enhance this we have appointed GPs and practice staff to work with us on a number of ad hoc projects such as developing a business case for falls services, developing an urgent care dashboard[6] and GP direct access diagnostics. We have also engaged three GPs as diabetes champions to help drive service improvements in this important area.

In addition, we have six clinical leads – City GPs appointed by the CCG to lead various areas of work and to ensure the experience and views of local doctors is fed into our planning.

The workstreams covered by our GP and clinical leads include:

- Quality
- Planned and urgent care
- Maternity and Child Health
- Sexual health
- Integrated care
- Long Term Conditions
- Safeguarding
- Diabetes
- Community Nursing Review
- Ambulatory Emergency Care projects[7]

To further underscore our approach, our Governing Body is also clinically-led – there are nine clinical leads (including six GPs one of whom is our chair, our Chief Nurse, the City's Director of Public Health, and a secondary care doctor) along with two lay (public) members, the Chief Executive Officer and Chief Finance Officer[8]

Further details about our Governing Body can be found in Appendix 2.

Our vision, mission, values

This document sets out our strategic ambitions and shows how we will lead the bringing together' of the local health and care system so that we can jointly tackle the needs of our population.

[6]A systemthat collates the previous day's urgent care activity data and brings it all together in a user-friendly graphical display, integrated with GP practice data. GP practice staff may access the dashboard via secure login

[7]These are emergency/urgent conditions (for example acute abdominal pain)that have the potential to be managed on an ambulatory basis. The underlying principle is that admission to a hospital bed should only take place if the acute illness that requires inpatient care.

[8]Our Chief Nurse & Chief Quality Officer also serves as Director of Quality & Integration

To guide and drive our work we have set out clear statements of our vision, mission, and values. In developing these, we have worked closely with patients, patient groups and networks, hospitals, commissioners and others to reach a shared understanding of our purpose.

We have discussed with our stakeholders the strategic challenges we face and the work we need to do to overcome them, and we have assessed how we need to allocate resources to meet the care needs of our patients whilst delivering our joined-up programmed of work. The culmination of all this work is set out below:

Our vision

A Healthy Southampton for all

The purpose of our vision is to set out a clear and memorable statement of the desired future state of health in the City. This vision is not solely within our direct control – by setting our vision in the context of the whole system and entire City, we are cementing our commitment to playing a clear leadership role in steering it forward, working through our wider partnerships with the Health and Wellbeing Board and the wider system of healthcare provision. A key part of our role is to helpcreate the right conditions for improvement.

Our vision statement means:

- ✓ **Healthy:** strong and resilient communities that are supported to maximise their potential to live fulfilling and prosperous lives; underpinned by strong, healthy organisations working together in a climate of trust and open, business-like healthy relationships
- ✓ **Southampton:** our City's future is our purpose, firmly shared with our partners
- ✓ **For all:** we are determined to reduce the unacceptable inequalities in health and wellbeing.

Our values:

Our values underpin our vision, drive our behaviour and determine what we do and the way we go about it. We try to live up to these values and they provide a compass to guide us at all times.

- ✓ Patients First, Every Time
- ✓ Relentless about the quality of care
- ✓ Respect for others and their dignity
- ✓ Courage to do what we believe is right
- ✓ Integrity – be honest and decent

Our mission:

Our mission summarises our purpose and the work we are doing right now to set us on the way to delivering our vision:

To ensure that care is coordinated, safe, sustainable and designed to meet the needs of the people of Southampton.

We have set our mission to ensure we take responsibility for providing leadership and co-ordination of the City's health and social care system. We are setting priorities and allocating resources to make sure that it works together in a coordinated, safe and effective way. Through our Better Care Southampton programme (see pages 19 and 56 for more information) we are already putting this ambition into action and working to commission care that is 'joined up' so that it works much more effectively for patients and service users.

Bringing it all together – Our Five Goals

We have established five goals to support the delivery of our Vision and Mission. The five goals are the culmination of our in-depth work to understand and agree with our partners and stakeholders the priority health and care issues, needs and challenges facing our City[9]. Our five goals therefore are more than just a summary of our findings; they are the organising and driving aims for all our work over the next five years.

Our five goals are to:

A. **Make Care Safer:** We will commission care from safe competent providers**.** We will listen to local people, gather their feedback on their experiences of local services and act upon it.

B. **Make it Fairer:** We will reduce the inequalities in access to care across our population.

C. **Improve Productivity (achieving more with less,more effectively):** We will prepare the ground for a transformation in care, doing all we can to bring control to the acute healthcare system.

D. **Shift the Balance:** We will integrate health and care services to ensure a better more streamlined experience for local people. Together with patients, communities and partners we will co-produce coordinated care through the Better Care Southampton programme.

E. **DeliveringSustainable Finances:** We will plan strategically for sustainable finances ensuring that we are driven by quality whilst being pragmatic about our resources.

More information on our goals including the guiding principles behind them and the interventions that support them are detailed in Part 3 of our plan.

Our Approach

Playing the leading role in bringing the system together demands that we take a new approach to the way we do business and way we manage our finances.

Principles guiding our approach

We have established some key principles to help guide our work. These principles will underpin all our plans and objectives over the coming years.

We will:

- Lead and coordinate the system, bringing people and organisations together in order to find the best solutions to our challenges.

[9]For more details on the drivers and challenges, see Part 2 'Our City& Our Challenges'

- Adopt a fully integrated approach to commissioning health and social care with our partners in the City Council.
- Create real clinical ownership throughout the system of the quality and costs of care.
- Focus our efforts on the areas where we will make the greatest impact.
- Change our approach to allocating funding to cement our ambitions to bring the system together; by changing the way we buy services we will change the way health and care services are delivered.

Doing things differently: total integration

The requirements of the local health and care system are changing: we are living longer,often with multiple and complex long term conditions.. Alongside this, our hospitals and care providers are under great pressure (more on page 17); and the financial outlook for public services is challenging with funding flat-lining over the coming years.

Currently, we spend around 54% of our total commissioning budget on acute care[10] and demand has been growing. Continuing this trend is unsustainable both financially and clinically –acute services are under immense strain, potentially compromising quality and safety, whilst at the same time better prevention and maintaining independence in community settings needs investment.. However, whilst the benefits of providing more effective and sustainable care in community and primary care settings are well understood, making this shift happen in reality has proved to be very challenging for the NHS.

The introduction of the Better Care Fund (BCF), creating a pooled budget with the City Council to pay for better out of hospital care, marks a step change in approach and a new opportunity to make change happen . This nevertheless comes with its own demands – in order to pay for better out of hospital care we have to deliver a corresponding shift of work and money out of acute services. In all we have to achieve a 15% reduction in non-elective admissions over the next 5 years (3% per year). We must also take into account that the Better Care programme is operating in the context of an austere outlook for social care funding which is set to reduce by a third over the coming years.

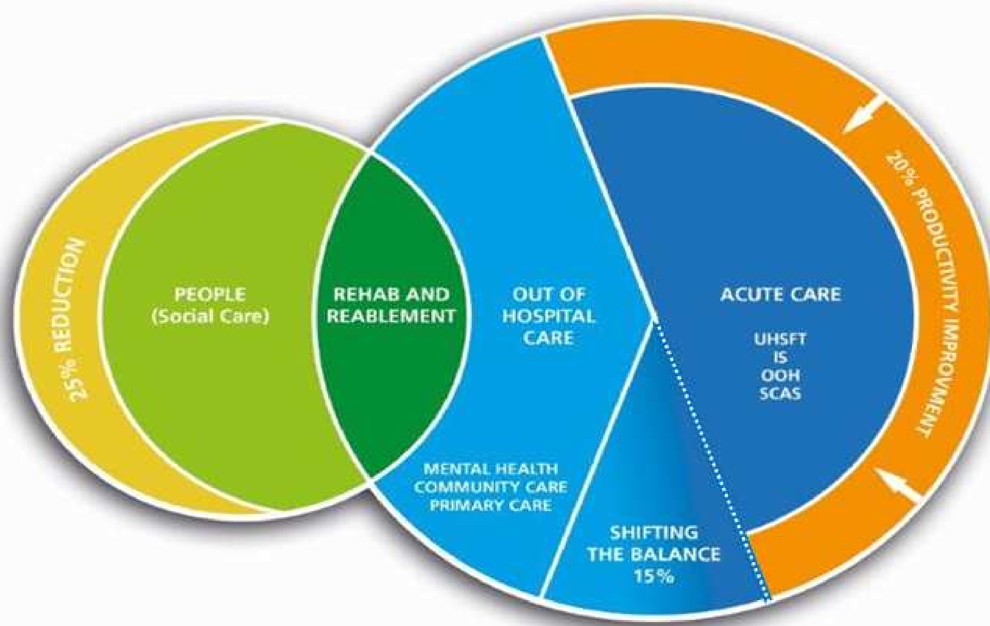
Making such substantial savings means services have to become something quite different – we cannot just provide less of the same. Together with the City Council, we have taken a joint view that neither of us can deliver such huge changes and savings in isolation and that therefore, a more radical and joined up approach is essential. Our joint aspiration is to view the whole of our out of hospital and social care spend as a single resource for Better Care, planned and delivered together. This 'total integration' approach exceeds the minimum requirements of the Better Care Fund policy, but we believe it is the level of ambition we must have in order to succeed.

Our **Better Care Southampton**programme*'Joining up Your Care'*is our joint response to this challenge and brings together our ambitious plans for making this a reality. Achieving success will be a major test but it is by no means impossible. The alternative risks a steady decline and degradation of care and we are not prepared to let that happen

You can find full details about our **Better Care Southampton** programme on pages 19 and 56.

The diagram overleaf illustrates the main areas of activity and the opportunity to shift the balance (15%) of care from acute to out-of-hospital settings whilst making further productivity improvements:

[10] This encompasses contracts with: our main hospital provider (University Hospital Southampton Foundation Trust), local NHS acute and Independent sector hospitals and ambulance services.


25% REDUCTION
PEOPLE
(Social Care)
REHAB AND
REABLEMENT
OUT OF
HOSPITAL
CARE
MENTAL HEALTH
COMMUNITY CARE
PRIMARY CARE
ACUTE CARE
UHSFT
IS
OOH
SCAS
SHIFTING
THE BALANCE
15%
20% PRODUCTIVITY IMPROVMENT
UHSFT - University Hospital Southampton Foundation Trust
IS - Independent Sector
OOH - Out of Hours
SCAS - South Central Ambulance Service

Part 2: Our City & Our Challenges

Introduction

In this section we detail the information and data we have used to help us understand the health needs of our City and the challenges we need to address. We have divided this part of our strategy into seven distinct areas each of which represents a key factor driving our work (our 'drivers'). It is the analysis of all these factors that we have used to set our strategic direction, plans and actions which we will be pursuing over the next five years:

- **Population and health trends**- an overview of the City's health needs including public health data (taken from the Joint Strategic Needs Assessment or JSNA) and our commitment to the city's Health and Wellbeing Strategy.
- **Ensuring safe high quality services** – spelling out the rationale behind our organisational commitment to quality, a pivotal factor driving our plans.
- **Hospitals on the edge** – an analysis of our hospital providers, their struggle to meet demand and the role we must play in addressing this.
- **Views and feedback from our member practices** – briefly outlining how the input of local GPs and practice staff has shaped our strategy.
- **National imperatives**– clearly setting out the national drivers for change including standards, initiatives and targets set to ensure high quality care for all.
- **The financial challenge** – setting the financial context for our strategy which is key in shaping the scope of what we can achieve.
- **Your views –** showing how we have taken the views of local people - patients, service users, voluntary groups and other key stakeholders into account when drawing up our plans.

Our City – population and health trends

Baseline data about our population - 2011 Census

Information about population and health trends is always vital when planning health services. The last Census in 2011 told us that the population of Southampton was 236,900[11]. The population has increased by 19,400 since 2001, approximately 8.9%. Most growth since has been in the working age groups, the 16-44s increased by 12.4%. There was also an increase in children aged 0-4 years (27.8%).

Other key facts include:

- 17% of the population is between the ages of 18 and 24 (compared with national average of 9.5%);
- 71% of people are of working age;
- 17% are from non-White British backgrounds (larger than most cities of the size of Southampton)
- We expect to see a 20% increase in the number of people under 10 and over 70 years by 2017.
- 4.2% of 16-74 year olds were unemployed and 18.1% (32,517) were students (compared to 4.4% and 9.2% respectively for England)
- Of all people aged 16 and over, 21% (40,991) have no qualifications (compared to 22.5% nationally)
- 29.5% of households have no car or van (compared to 25.8% nationally)
- 13.6% of households are overcrowded (compared to 8.7% nationally)
- 39.9% of dwellings in the city are flats, maisonettes or apartments and 60% are houses
- 33.8% of households are comprised of people living alone (compared to 30.3% nationally) `

[11] Around 269,687 people are registered with GP practices within the City and this is therefore the population figures used by the CCG for planning purposes (see also footnote [1])

- 7.0% of households are lone parents with dependent children (compared to 7.1% nationally)
- 7.7% of households have no people for whom English is the main language (compared to 4.4% nationally)
- 49.8% of households own their home (or buying with a mortgage) (compared to 63.4% nationally)

Deprivation

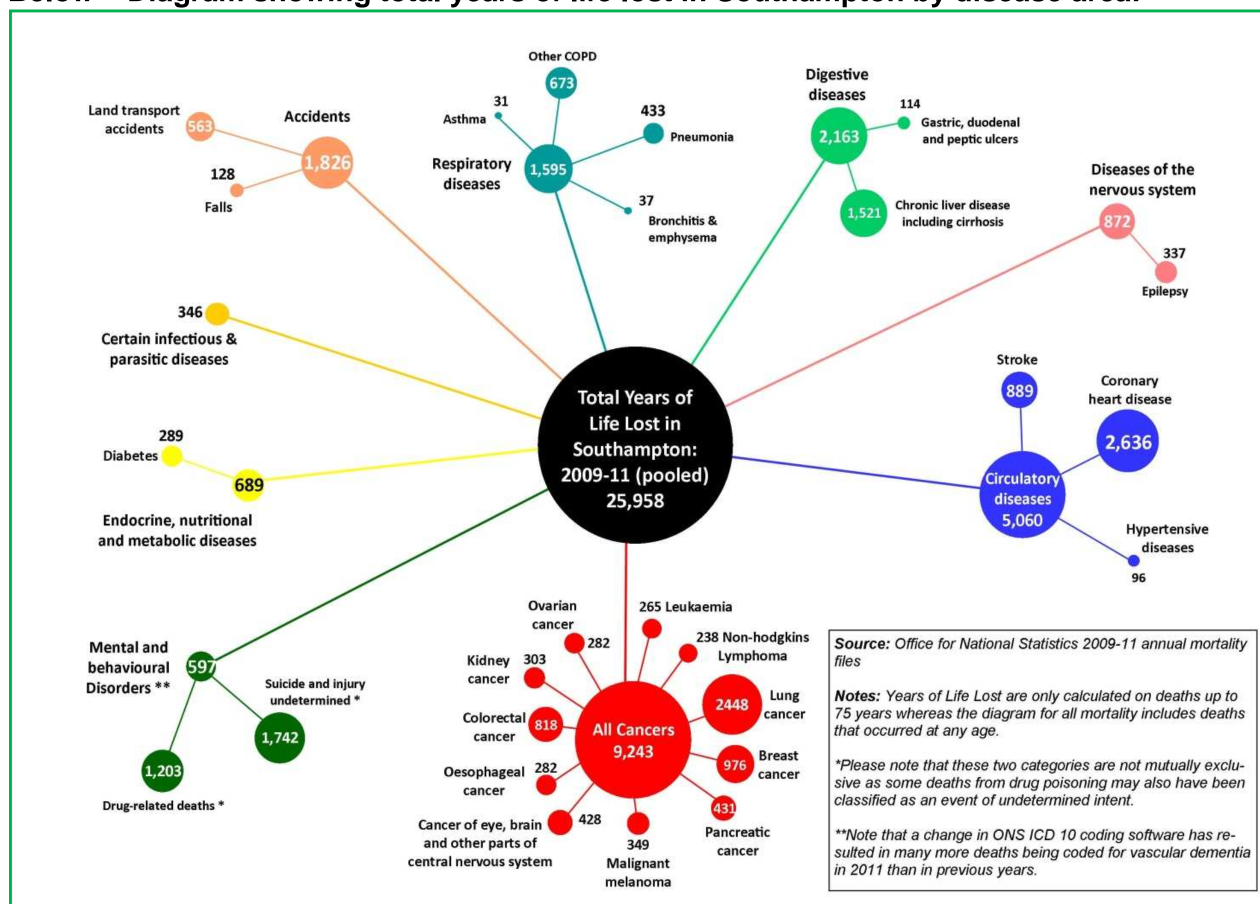
Nationally, Southampton is the 81st most deprived local authority (out of 326), and the 5th most deprived in the South East. 23% of residents live in the most deprived Lower Super Output areas (LSOA's) in England. Deprivation is higher than average for children with 27.5% of Southampton's child population living in poverty compared to 21.3% in England (in some wards this is as high as 42%).The Joint Strategic Needs Assessment (see below for more information) shows that a significant number of people are classified as highly disadvantaged in the city. In addition it shows considerable variation in the level of deprivation experienced by and between communities.

Health Trends

Health inequalities are still a dominant feature of health in Southampton. Levels of teenage pregnancy, GCSE attainment (despite improvement) and tooth decay in children are worse than the England average (2010) as are rates of sexually transmitted infections, road injuries and smoking related deaths. Poor diet and lack of physical activity remains an issue, with 22% of the population classified as obese.

Early deaths from cancer are high especially in priority neighbourhoods and there are considerable risks for those living with mental ill health, learning disabilities or physical disabilities; equally breast, bowel and cervical cancer screening uptake is challenging, resulting in poorer survival rates.

Below – Diagram showing total years of life lost in Southampton by disease area:



Cardiovascular disease, accounts for over 5,000 potential years of life lost in the city. This is a condition that has common risk factors such as raised cholesterol, physical inactivity, obesity and high blood pressure – all these can be addressed through appropriately organised health and care services.

Around 86,000 people in Southampton, 32% of the population, are estimated to be living with a long term condition such as asthma or diabetes. Although many of these are chronic conditions, it is possible to keep people healthy in their own homes local communities and thus prevent acute problems and reduce the need for hospital admission.

Unplanned admissions to hospital for those with chronic Ambulatory Care Sensitive (ACS) conditions are high in Southampton in comparison to other CCGs. We need to do more to improve our performance relative to similar CCGs across the country in areas of emergency hospital admissions and for other acute conditions that should not usually require hospitalisation.

There are also health challenges associated with key population changes that we need to plan for and address. In the next 5 years people in age groups 5 to 9 years and 70 to 74 years will increase by 20% each. The number of people over 85 will have grown to over 6,000 residents by 2017, an increase of over 15%.

For further detailed information on health outcome challenges and deprivation please see Appendix 3 and Appendix 4.

Southampton Joint Health and Wellbeing Strategy
(Including the Joint Strategic Needs Assessment)

Working together, Southampton City Council, NHS England and our CCG have developed a Joint Health and Wellbeing Strategy for the City. The strategy sets out the approach and plans for addressing the key health and care needs over a three year period (starting in 2013/14).

The content of the strategy, fully adopted by ourselves and the Council, was informed by the Joint Strategic Needs Assessment (JSNA) and through conversations and feedback with stakeholders and the public. The Joint Strategic Needs Assessment is a process undertaken jointly by the City Council and the CCG where data on the health of people living in Southampton, their care needs and a number of the key wider determinants that affect health and wellbeing (including housing and employment) are collated, analysed and published. The JSNA is a web-based resource that is periodically updated as new data become available. It can be viewed at http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/?locale=en

Specific challenges highlighted in the JSNA include:

- Demographic pressures, especially the growth in the city's birth rate (around 35% in seven years).
- The increasing proportion of older people and accompanying increase in dementia
- Deprivation and children in poverty
- The increase in unhealthy lifestyles leading to preventable diseases
- The need to ensure high quality services for specific care groups, including those living with mental ill health, physical disabilities and learning disabilities
- The need to ensure that provider services are joined up and seamless to create robust care pathways for a 'whole person' approach
- The need to support carers to care and the need for volunteering
- Work stresses and worklessness and the impact on mental health
- Recognising the impact on health of wider determinants (education, poor housing, transport and economic regeneration)

From this foundation actions have been identified through the strategy to address the City's health and care needs. These actions are grouped into three themes:

a) **Building resilience and using preventative measures to achieve better health and wellbeing**

b) **Best start in life**

c) **Living and ageing well**

The three themes are intended to secure a life-course approach to improving health and wellbeing and provide a means of reducing health inequalities. Crucially, they also provide scope for improved joint working across health and care systems as they enable a shared ambition and vision of success.

Our five year strategy and associated action plans describe the approach we are taking to play our part in delivering the joint strategy. Our ambitions therefore are not a parallel process – they are part of the integrated and joined-up vision we have for the City.

We have pulled together they key points from the Joint Strategy in Appendix 4. This extract provides more information about the three themes, the key JSNA data we are using and the actions we will be taking with our partners to address the challenges. A copy of the full strategy can also be found here:
www.southampton.gov.uk/Images/Joint%20Health%20and%20Wellbeing%202013%20to16_tcm46-348430.pdf

Ensuring safe, high quality services

Putting quality and safety first

Quality and safety has quite rightly been a matter of significant public debate in recent years and as such is a key driver in our strategic planning. The national scandals surrounding Mid Staffordshire Hospitals Trust and Winterbourne View in South Gloucestershire have brought into sharp focus the need for staff at all levels to change behaviours, systems and processes so that safety and quality are the organising principles of health and care services.

The Francis Report into Mid Staffordshire, the Report into Winterbourne View and Don Berwick's report into patient safety were published following the failings in care. All reports have reinforced that quality is about our behaviours and attitudes and the need to address this to ensure high quality care for all.

A common and deeply disconcerting characteristic of all of the failures has been the sense that many health professionals (clinicians and managers) did not seem to take seriously enough their personal responsibility to own the quality of care and to be willing to do something about it.

This is why our very first strategic goal is **Make it Safer**. We see addressing safety and quality as our central purpose. We are committed to ensuring that the recommendations in the Francis, Berwick and Winterbourne View reports are not only delivered but are part of every relationship we have with our partners and patients. In bringing the system together, we will work with all of our providers, partners, GP members and communities to ensure that they are providing competent, safe and effective care whatever the setting - supporting them and challenging them where appropriate to drive standards higher. Our response to the recommendations and requirements coming out of these reviews are central to the strategic ambitions, goals and action plans set out in this document.

As part of our commitment to making care safe we have established a dedicatedQuality Team, working jointly with Southampton City Council, to take a system-wide view on care standards. The team has been working together with commissioners, providers and GP practicesto ensure the very best quality services are being provided to the people of Southampton.

Some of the team's early successes include:

- ✓ Establishing a culture of zero tolerance for dealing with hospital acquired infections
- ✓ Significant reductions in the numbers of people acquiring the *C.difficile* infection both in hospital and in primary care
- ✓ Improvements in the quality of services at our main providers through a reduction in surgical related 'never events' (the kind of mistake that should never happen)
- ✓ A focus on a system-wide approach to quality assurance which has supported a number of Nursing Homes to improve the quality of service provision.

These are the excellent foundations on which we have developed our plans and ambitions for the next five years.

Please see Appendix 5 for more details

Patient Experience

As set out below, our strategy has been developed with the engagement of the public, patients and other key stakeholders. However, it also essential that we have mechanisms in place to continuously capture feedback both in terms of how services are performing and how we are progressing against our plans and ambitions (as experienced by patients through the services they use).

Our strategic approach of bringing the system together will be key in helping us continue to develop patient feedback mechanisms. For example, over the next five years we will work with providers to ensure the full roll-out of the national Friends and Family test across all settings as this gives us a valuable temperature gauge of the public view of services[12].

To ensure we put patients at the centre, making the whole health and care system work on their behalf, we will also continue to develop our patient experience service to gain valuable patient insight. We set up our own in-house service (from April 2014) as a direct result of feedback from patients, carers and families that the complaints system was difficult to navigate and confusing. Our service receives details of patient experiences from across the local healthcare system and co-ordinates responses from the appropriate providers.

Patient and service user experience is one of our key drivers and we will continue to develop our approaches to gathering and acting upon data.

Safeguarding

During 2013 the Government published updated policies and guidance on Safeguarding encompassing all services and agencies that work with or support Adults or Children. These new directions take into account the NHS reforms of 2013 and sets out the responsibilities of both new and reformed public agencies.

[12]Provider performance against the test is monitored via monthly Clinical Quality review meetings that highlight trends and themes. In line with our strategic approach and values, we will support providers develop action plans to address negative feedback.

We have no doubt about our role in making sure every service works to protect the vulnerable adults and children; we also see the opportunity to use our position and approach as key leaders in the local health and care system to ensure we take these responsibilities into all aspects of our strategy and plans.

With the establishment of the integrated commissioning unit (see Appendix 6), we have been able to introduce a new joint Head of Safeguarding post (for commissioned services). The post holder will provide expert advice in both children and adult safeguarding to commissioners in health and social care, be an active participant in local safeguarding boards and ensure the CCG is discharging its safeguarding duties. Key to this process will also be holding all providers – across the full range of health and social care services – to account for their safeguarding work.

Hospitals on the edge

Another important ‘driver’ for our strategy is the significant challenge facing our hospitals. Demand for care is growing and, as people live longer, this demand is becoming more complex. This changing pattern of use is putting strain on the entire health system, particularly hospitals.

In order to capture and set out the full magnitude of the challenges facing acute care services, the Royal College of Physicians published a report *Hospitals on the Edge? The Time For Action*[13] (September 2012), calling for co-ordinated action to save hospital services from collapse.

As with hospitals up and down the country, the challenges and issues detailed in the report also reflect our experiences in Southampton.

In recent years we had seen a steady rise in the number of emergency admissions to University Hospital Southampton (UHS) and particularly fromthose in older age groups and those with more complex conditions.

In 2012, following sustained difficulty in maintaining the national A&E waiting time standard (of 95% of people being admitted or discharged within four-hours), the Emergency Care Intensive Support Team (ECIST) carried out a review of provision both within UHS and across the wider health and social care system. They concluded that, despite some successes, there had been an over-reliance on schemes to avoid admission and insufficient emphasis on improving discharge planning and onward care. In essence they concluded the whole health and care system needed to change from a culture of trying to ‘push’ people out of hospital to release capacity, to one where community services intervened to help ‘pull’ patients through by means of pre-planning effective community or home-based support.

The ECIST findings were recognised as the way forward and comprehensive action plans were developed and implemented. And yet, the pressure on services has continued. Throughout 2013, it became clearer that sustained very high levels of bed occupancy (in excess of 95%) were creating difficulty in admitting patients in urgent need, and creating unacceptable risks to the safety and quality of patient care across the hospital.

In October 2013, following similar concerns nationwide, the National Audit Office published a report, *Emergency Admissions to Hospital: Managing the Demand* which concluded that:

“Many emergency admissions to hospital are avoidable and many patients stay in hospital longer than is necessary…Improving the flow of patients through the system will be critical to the NHS’ ability to cope with future winter pressures”

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[13]See www.rcplondon.ac.uk/projects/hospitals-edge-time-action

Right now, the pressure on urgent care services continues to be the single most acute concern in Southampton. There have been some positive signs of greater resilience in services with considerable investment in schemes to support complex discharges giving rise to faster discharge from hospital. We are also starting to see a decline in the number of A&E attendances and there is some evidence that the growth in emergency admissions has been stemmed. There is renewed determination across the whole system to build on progress, to sustain efforts to alleviate these problems and to support the hospital in every way possible.

However, performance against the 95% standard remains less than acceptable and this is important because this standard is a key indicator of challenges across the entire system: failure to safely and effectively discharge people leads to significant pressure on elective capacity which in turn means that meeting other crucial national standards (such as referral to treatment times and waiting times for cancer[14]) becomes challenging.

That is why over our 5 year strategic period, the urgent care programme must continue to demand the highest priority from all partners. We need to bring our hospitals back from the edge by creating sustainable longer term solutions and in working with partners to create a whole system response. We are determined to reduce the burden on acute services and are working with provider organisations on a number of urgent care projects to streamline services and remove unnecessary steps which will not only enable patients to move more quickly through the system, but also improve their overall experience.

Alongside this, our transformational Better Care Southampton programme will bring lasting solutions to the challenges. This integrated, joined-up approach to designing and delivering health and care services prioritises prevention, independence and coordinated person centred (out of hospital) care and thus gets to the heart of pre-emptively addressing those needs that currently end up a hospital admissions.

Views and feedback from our member practices

As a Clinical Commissioning Group it is vital that we not only gather feedback from our member practices but also reflect this in our strategic planning. Our elected GP Board members have contributed to this strategy by sharing their thoughts and experiences through a series of strategy development events, meetings and workshops.

Our member practices have also contributed by:

- **Giving feedback via our General Assembly Meetings** – these formal strategic meetings to which each practice is invited have proved an important way for GP and practice members to feed into our strategic planning. Matters discussed and incorporated into our final strategy include: views on the overall strategic direction of the CCG, the scope and impact of clinical leads, the direction of travel for planned and unplanned care, and the development of integrated commissioning.

- **Attending whole system meetings to develop Better Care Southampton** - this key element of the CCG's future strategy has seen GPs from across the city attend workshops, meetings and discovery events designed to gather views on the integrated care agenda. Their feedback on everything from the future shape of integrated services to the development of local 'clusters' of practices has informed our Better Care work, a key part of our five year strategy.

[14] The standards set out in the NHS constitution state that: patients should start consultant-led treatment within a maximum of 18 weeks from referral for nonurgentconditions; and be seen by a cancer specialist within a maximum of two weeks from GP referral for urgentreferrals where cancer is suspected.

- **Locality meetings and direct contact with CCG Chair -** feedback has also been gathered via our locality meetings led by locality lead GPs and attended by GP representatives from each practice. In addition our GPs have an open and honest relationship with our GP Chair. Many feel free to contact him directly by phone or email and the varied insight gathered via lively e-debates as well as feedback about patient stories and experiences have also informed our strategic direction.

In addition to the mechanisms outlined above we have recently launched a GP Portal featuring a discussion forum and giving easy access to direct contact with our commissioning managers. Our GP and practice nurses forums and TARGET (Time for Audit Research Governance and Training) meetings are other opportunities for us hear what our member practices think and to feed views into our service and strategic planning.The process of continually gathering feedback from our GP members is ongoing and will continue to drive our planning.

National policy

As well as the local considerations and needs set out above, some targets and priorities are set nationally. Such targets are intended to help ensure consistency across all services and organisations and to set our minimum standards of care and quality. It is essential we not only meet these standards and priorities but that we strive to exceed them wherever possible.

The Better Care Fund

As outlined in part 1, Better Care will be a central plank of our five year strategy. The Better Care Fund,a national initiative announced by the Government in the June 2013 spending round, is the financial mechanism that makes this possible. The Government's aim is to commit £3.8bn of NHS funding to deliver a transformation in integrated health and social care through the pooling of budgets in local areas.

The Better Care Fund (BCF) offers a unique opportunity to bring resources together to address immediate pressures on services and lay foundations for a much more integrated system of health and care delivered at scale and pace. But it will create risks as well as opportunities. The £3.8bn is not new or additional money - it is funded from national CCG allocations in addition to NHS money already transferred to social care. Every CCG in the country, working with their Health and Wellbeing Board, must therefore have plans in place to realise the benefits of the BCF

Creating *Better Care Southampton*

Throughout this strategy we describe how we believe our commitment to integration will lead to sustainable solutions for our city's most pressing health and care needs. In fact, we had already embarked on a system-wide Integrated Person Centred Care change programme before the BCF was confirmed; it follows therefore that we see the BCF as a great opportunity to go further, faster.

This is why we have we have created the Better Care Southampton programme. It pulls together existing and new strands of work that are necessary to deliver the requirements of the BCF to fully integrate services through transformational change.

Our Better Care Southampton programme is supported by the Integrated Commissioning Unit (ICU)–which has been jointly established and resourced by the CCG and City Council. The ICU have created a vision for integrated care within the city:*"Health and social care working together with you and your community for a healthy Southampton"*

To bring further clarity and focus to our far reaching ambitions we have also established a set of organising principles for all our programmes. These statementshave taken inspiration from the

National Voices' *Principles for Integrated Care*[15] initiative and describe what we aim to achieve and how we aim to do it:

- ✓ **Person Centred** - individuals will have maximum choice and control through person centred care planning and supported self management of their health and wellbeing.
- ✓ **Personal control** –patients and service users can decide how the money allocated for their care should be spent.
- ✓ **You, not your illness** - the approach to care will be holistic and not focussed around diseases or conditions.
- ✓ **Being the best we can be** – we will make the most of the skills and resources available to us, building on the strengths of people, their families, carers and local communities.
- ✓ **Integrated and seamless** - services will be delivered in an integrated way at all levels wherever possible with a focus on local care.
- ✓ **Round the clock** - out of hospital care will be a 7-days-a-week service and will be consistent both in and out of hours.
- ✓ **Community-led** – the vast majority of people's needs will be managed in the community by the local cluster teams. Community services will be the first port of call for people seeking help for themselves or others.
- ✓ **Efficient and consistent** - care planning and assessment may be undertaken by any agency using a common trusted tool.

The BCF is therefore a major driver for us and will play an important part in all that we do over the next five years. You can find out more information about our integration work and Better Care Southampton in Appendix 6 and by visiting our website: www.southamptoncityccg.nhs.uk/have-your-say/better-care-southampton-joining-up-your-care

Compassion in practice

As part of the national commitment to driving up service quality in the NHS, *Compassion in Practice* – the national nursing, midwifery and care strategy – was launched in December 2012. It is a vital national initiative providing a framework and a clarion call to everybody involved in the delivery of care. At its core, the strategy is seeking to ensure we are delivering quality of care as well as quality of treatment.

The framework is organised around six fundamental values – known as the 6Cs – which are: Care, Compassion, Competence, Communication, Courage and Commitment. These 6Cs have been shown to resonate strongly with both staff and people who use services across the full range of health and care settings. Each area of action within the framework has an associated implementation plan with national, local and individual actions.

As part of our strategy, we have made an unequivocal commitment to engaging *all* healthcare professionals, working together with our partners to implement the principles of the framework across the city. This will not just apply to NHS providers but wherever patients and service users access treatment and support - from nursing homes and treatment centres to voluntary organisations and community settings. Where we have direct commissioning responsibility, we will ensure the 6Cs are embedded as part of quality service development.

[15] See: www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/principles_for_integrated_care_final_20111021.pdf

The advent of co-commissioning of primary care

Announced in May 2014, CCGs are soon to get the opportunity to co-commission primary care. Although these plans are still at an early stage, a vibrant and sustainable primary care sector is pivotal to our strategy, especially Better Care Southampton. This development is therefore potentially a very useful enabler and is likely to have a significant impact on strategic planning over the next five years.

NHS England invited those CCGs that are interested in an expanded role in primary care to come forward and show how the new powers would enable them to drive up the quality of care, cut health inequalities in primary care, and help put their local NHS on a sustainable path for the next five years and beyond.

CCGs are required to submit expressions of interest in taking on enhanced powers and responsibilities to co-commission primary care. Applications need to meet a number of tests, including showing they will help advance care integration, raise standards and cut health inequalities in primary care. They will also need to show how they will ensure transparent and fair governance -with a continuing oversight role for NHS England to safeguard against conflicts of interest – all in the context of the CCG's five-year plan for its local NHS services. Each proposal will be discussed by the applicant CCG and the local Area Team of NHS England, which will subsequently make a recommendation for approval by the Board of NHS England.

Anticipating this direction of travel, in 2013, the CCG began developing a vision for a sustainable model of general practice in Southampton. This latest development gives us an opportunity to accelerate progress and we will continue to work with NHS England (Wessex Area Team) as we develop more detailed plans (see our action plan on page 58 for more information).

NHS Constitution – the NHS belongs to us all

The NHS is there for us from the moment we are born. It takes care of us and our family members when we need it most. The NHS Constitution has been created to protect the NHS and make sure it will always do the things it was set up to do in 1948 – to provide high-quality healthcare that's free and for everyone. No government can change the Constitution without the full involvement of staff, patients and the public. The Constitution is a promise that the NHS will always be there for us all.

The Constitution sets out our rights as NHS patients, covering how patients access health services, the quality of care received, the treatments and programmes available, confidentiality, information and the right to complain if things go wrong.

Our entire organisational approach - our vision, values, mission, strategy and plans – have been designed and developed with the principles of the NHS Constitution firmly in mind. We will continue to take account of the Constitution as we review and refine our strategy over the nextfive years.

NHS Outcomes Framework – the Five Domains

The NHS Outcomes Framework has been designed to provide national-level accountability for the outcomes the NHS delivers and to drive transparency, quality improvement and outcome measurement throughout the NHS. Development and delivery against the framework is led by NHS England who work with CCGs to design local delivery plans.

To support this work, a CCG Outcomes Indicator Set has been developed so that performance can be monitored, measured and acted upon at a local level. The CCG Outcomes Indicator Set provides clear, comparative information for CCGs, Health and Wellbeing Boards, local authorities, patients and the public about the quality of health services commissioned by CCGs and the

associated health outcomes. All of the indicators have been chosen on the basis that they contribute to the overarching aims of the five domains in the NHS Outcomes Framework.

Our Outcome Ambitions

To help drive delivery of the domains, NHS England has established a range of Outcome Ambitions that, taken with the Outcome Indicators, enable CCGs to determine their priority actions for delivering against the 5 Domains.

We have carried out a detailed analysis of our current position and have selected the key outcome ambitions we believe will make a real difference to the health and wellbeing of our city (see table overleaf). We have focussed on areas where we will have the greatest impact and where we need to improve our performance comparative to our 'peer' CCG organisations. As with all our main challenges and needs, our analysis clearly demonstrates that successful outcomes against these ambitions depend on bringing together a whole system approach to prevention, treatment and care.

The key actions required to meet or exceed the ambition standards are incorporated throughout our strategic action plans (see section 3). For full details of our Outcomes analysis work, please see Appendix 7

Outcome Ambition	What we will use to measure progress	What is our target performance?	What is our current Performance? (2013/14)	Why did we choose this outcome ambition?
1. Improved Patient Safety and User Experience	1. Reductions in healthcare associated infections 2. Number of never events 3. Friends and Family Test (FFT) 4. Numbers of pressure ulcers	1. No MRSA infections Reductions year on year in C.difficile cases 2. No never events 3. Top quartile performance for FFT 4. 20% reduction on 2014/15 baseline in pressure ulcers	1. MRSA 5 cases C.difficile 58 cases 2. 3 Never Events 3. TBC 4. Using data gathered in 2014/15 as baseline	Patient safety is paramount in all our healthcare services and the measures chosen reflect quality of service provision across all providers. Driving down numbers of healthcare associated infections and pressure ulcers will contribute to improved standards of quality and safety in all settings and FFT provides a measure of patient satisfaction across all services
2. Reduced Inequalities In Life Expectancy	Potential Years of Life Lost = rate per 100,000 population (male & female)	**2083.4** By 2018/19	*2277.7*	At present our performance does not compare well with other CCGs. Our ambition is to move our performance to the middle of next best quintile (based on CCG's 2012 quintile)[16] by 2018/19
3. Reduced Avoidable Emergency Admissions	Rate of admissions per 100,000 population (the emergency admissions composite indicator)-	**2046.2** By 2018/19	*2407.3*	This is central to our goal to shift the balance of care in Southampton. Our target is a 15% reduction by 2018/19 on our current performance.
4. More Older People (over 65) Living Independently - 91 Days After Reablement	Proportion of older people who are still at home 91 days after discharge from hospital into reablement services	**90 % of people discharged into reablement services** By 2015/16	*87.7 %*	This is one of our Better Care national targets and will reflect our success in supporting people to live independently in their own homes, which is a key aim of our local programme. We are already performing well in this area so this target will be challenging but we are determined to continue to improve.
5. Fewer Permanent Admissions To Nursing Homes	Permanent admissions of older people to residential and nursing care homes per 100,000 population	**881.8** By 2015/16	*1005.6*	This is a key area for us as we have a relatively high rate of permanent admissions which we need to address. Our aim is to achieve a 12.3% reduction in all types of admissions in per capita terms.

[16] A quintile is a statistical measure where ordered data is split into 5 equal sized subsets. The 212 CCGs are split into 5 groups best performing to worst performing. We wish to move performance into the next quintile (or section).

Outcome Ambition	What we will use to measure progress	What is our target performance?	What is our current Performance? (2013/14)	Why did we choose this outcome ambition?
(older people over 65)				If we can achieve this it will be a strong indicator that service performance across the board is dramatically improving as a result of our Better Care agenda.
6. Fewer Delayed Transfers Of Care	Number of delayed transfers of care (delayed days) from hospital per 100,000 population = average per month	**441.9** By June 2015	*465.6* *For the period Dec 2012 to Nov 2013*	The numbers of patients in inpatient beds who are clinically ready for discharge on any one day continues to remain too high, in Southampton signifying a failure in our system. It impacts on our ability to respond to patients needs in a timely way and promotes an ethos of dependence rather than one of recovery and independence. Achieving a significant reduction in this area is a key focus of our Better Care agenda and will make a significant difference to both patients and the system as a whole**.**
7. Reduced Injuries Due To Falls In People Over 65	Standardised rate of emergency admissions for injuries due to falls for people over 65 per 100,000 population	**2334** By 2015/16	*2354*	Our strategy has a significant focus on prevention and supporting people in their own homes and communities. Our aim is to reduce the number of injuries due to falls requiring hospitalisation each week by 12.5%.
8. 20% Productivity Improvement In Elective Care	24% reduction in first face to face outpatient attendances 34% reduction in face to face follow up attendances 4% reduction in outpatient procedures 25% reduction in day case procedures 14% reduction in elective inpatient admissions	To reduce total spend on Acute Elective Care to £33m; reduce number of attendances / interventions to 136,300 Should release £8m saving - based on 49,000 fewer attendances in or interventions.	Total current spend on Acute Elective Care is £41m - based on c. 185,250 attendances / interventions	More informed decision making by users and clinicians Increased support, education and provision in primary and community care Fewer routine follow ups, better use of technology and support for self-management Shift from day cases to outpatient procedures, reduction in procedures of limited clinical value, reductions in length of stay and reduced readmissions or “re-do” operations

Seven-Day Services

Patients need the NHS every day. Although some NHS services like hospitals are open every day, services at weekends are reduced. The limited availability of some services across the health system at weekends can have a detrimental impact on outcomes for patients. Therefore nationally work is underway to secure better access to services seven days a week.

The National Medical Director of NHS England has set up a Seven-Day Services Forum which has looked into the consequences of the non-availability of clinical services across the seven day week – it is also currently exploring proposals for improvements and examining the key issues which affect delivery of a seven day service.[17]

Locally we are committed to seven day services and our contracts for 2014/15 already include an expectation of providers that they will begin scoping work and readiness planning in preparation for the standards and requirements that will emerge from the national Forum work.

Seven day working is also a key principle of our integrated care model (see Better Care on page 19 and Appendix 6) and it is recognised that it is a 'must do' to ensure we can fully achieve our plans to join up care and transfer funds from the acute hospital sector.

The Financial Challenge

Spending on the NHS in the UK as a share of national income has more than doubled since its introduction in 1948, rising by an average of 4.8% in real terms. This period of rapid growth has now come to an end and yet funding pressures on the NHS continue to rise.

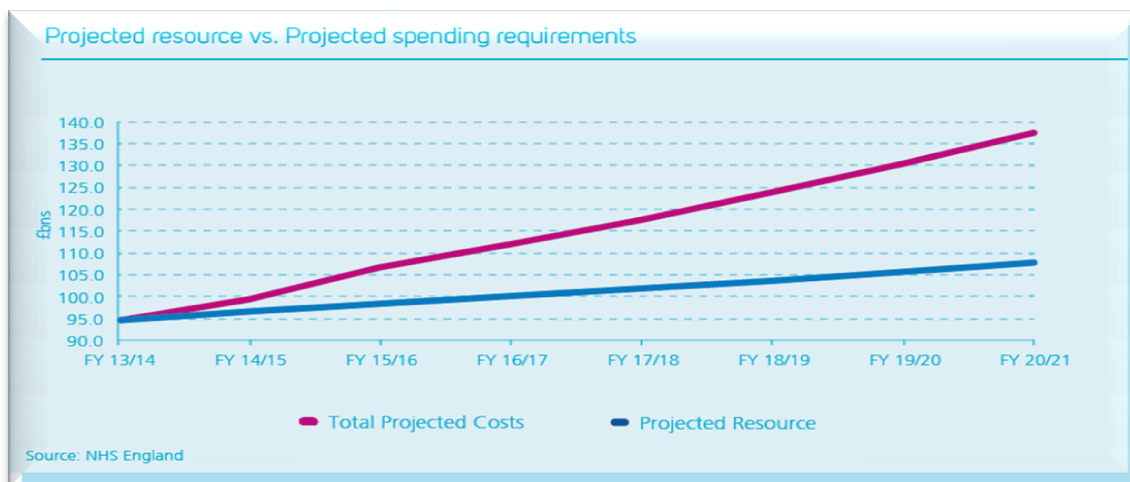
At the same time there has been significant growth in demand, changes in the population make-up (people living longer), increasing costs of new treatments as well as inflationary cost pressures (for example, the cost of drugs, running NHS estate and salaries) all adds up to significant funding gap for the NHS.

The 'QIPP Challenge' first set out in 2009 recognised the need for action to address the funding issues. Focusing on schemes around Quality, Innovation, Productivity and Prevention (QIPP), the aim has been to make efficiency savings of £20bn (4% a year) over 5 years. Crucially, the QIPP approach seeks to drive a fundamentally better approach to delivering financial sustainability by improving quality and avoiding, as tragically illustrated by the Francis's report into the shameful events at Mid Staffordshire Hospitals, the dangers of ruthlessly cutting back.

Recently, the nationalfunding position has been reviewed to take account of initial QIPP progress and further expected changes in funding allocations and demand / inflation. This has led to expectations that the funding gap will increase by a further £30bn by 2020/21 whilst at the same time income will continue to be relatively flat.

This is captured in the chart overleaf:

[17]The Forum is organised into five workstreams covering: clinical standards; commissioning levers; finance and costing; workforce; and provider models. Membership is made up of health commissioners, providers, clinicians and organisations such as: the National Institute for Health and Care Excellence (NICE), NHS Improving Quality and the NHS Confederation.



The QIPP challenge therefore is the means by which all NHS organisations must endeavour to close this gap. By transforming services and improving productivity (doing more for less) and innovating in an effort to reduce costs we can meet the financial challenge:

- **Quality** – Sustain high quality care and continuously improve quality and outcomes for patients, adding years to life, and life to years.
- **Innovation** – Horizon scanning for best practice and transforming patients' pathways with rapid diffusion across the system to meet the population's healthcare demands.
- **Productivity** – Improving efficiency and creating better value for money.
- **Prevention –** Keeping people healthy by promoting healthy lifestyles and delivering healthcare in the right place, at the right time to reduce dependency on health and social care.

Our QIPP challenge

We have modelled our QIPP challenge over the next 7 yearsand have identified that we need to reduce our costs by at least £89m over the period (equating to 31% of our £280m budget for 2013/14)[18]; this will form our contribution to the national £30bn gap.

Our forecast QIPP gap

	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s	2019/20 £000s	2020/21 £000s
CCG Available Funds	289,322	298,542	303,751	308,718	313,769	318,350	322,997
QIPP Challenge	10,485	17,685	12,462	12,463	12,463	12,463	12,463
QIPP Challenge %	3.62%	5.92%	4.10%	4.04%	3.97%	3.91%	3.86%

Meeting the financial challenge

The expected financial position is clearly a vital determinant of what we can and cannot achieve and what we do and do not prioritise over the next five years. Our strategy is therefore designed to deliver improvements and transformation within our financial limits.

[18] Figures are subject to change as projections around future demand and funding settlements are not fixed.

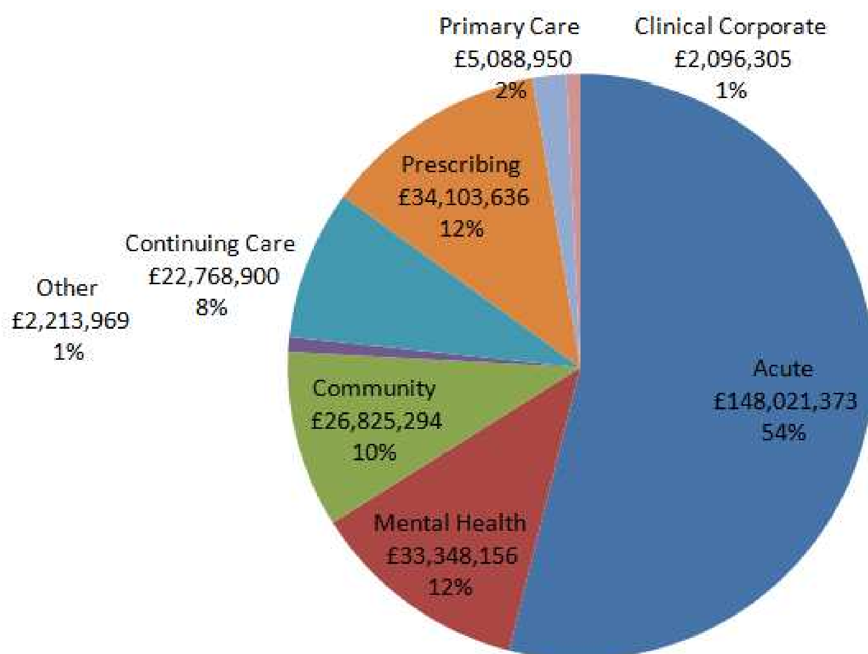
Whilst we received a 2.14% uplift (£5.878m) in funding for 2014/15 the costs of healthcare in the city are increasing at a greater rate. We also face an additional challenge in that we are 'overfunded' – this means we are getting a higher financial allocation than the Government says we need. The reason for this is a change in the basis of CCG funding formulas in 2014/15[19] which will result in us getting a lower uplift than other CCGs in the coming year; put simply we will get less than our anticipated annual allocation year on year until this funding gap is erased.[20]

This affects our five year strategic planning as our anticipated budget will effectively be shrinking in the coming years, increasing our QIPP challenge.

For planning purposes from 2016/17 to 2018/19 CCGs are expected to assume a continuity of the current allocations policy. CCGs have been asked to assume that allocations grow in line with the GDP deflator: for 2016/17 - 1.8%; 2017/18 - 1.7%; and 2018/19 - 1.7%. Whilst this growth is significant in comparison to other providers it fails to grow at the level to meet predicted demand. For example, in 2014/15 our spend per head of registered population will be £1,034.00 (excluding running costs); to give a sense of the size of the financial challenge we face it is worth comparing this £1,034.00 with some typical treatments:

- A hip replacement costs over £6,000
- An outpatient attendance around £200,
- A basic Emergency Department (ED) attendance £57,
- A standard maternity pathway £2,800
- Some complex surgery costing over £30,000
- Continuing healthcare packages may cost over £300,000 per year.

The chart below shows where our 2014/15 commissioning budget will be spent. It is the benchmark for our progress – we aim to see a significant change in future years through the achievement of our goal to shift in the balance of care:



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[19]CCG funding formals are largely determined by age – the overfunding challenge in Southampton has been created by a change in the financial weighting for different parts of the population. As a city we have a high student population - generally student age members of the population utilise less healthcare so less funding is received for them. However, the funding formula is not advanced enough to recognise having such a disproportionate student population in a relatively small city may lead to increased healthcare costs.

[20]By the end of 2014/15 we will be 1.4% over funded (£3.923m) and by the end of 2015/16 we will be 1.11 % over funded. There will be decreases each subsequent year with the demands on services likely to increase throughout.

Better Care Fund Finances

As outlined on page 19, in the UK as a whole £3.8 billion has been set aside to support the Better Care Fund initiative. In December 2013 it was confirmed how much each CCG should be putting into the pooled fund as a minimum. Our local minimum requirement is £16.85m in the first year, however, underscoring our strategic approach, we have exceeded this and committed to pooling in excess of £100m over the next 5 years.

Business Rules

NHS England sets CCG a number of financial requirements which they must meet. For example CCGs are expected to deliver a 1% surplus each year. Any surpluses made by CCGs are not lost but returned to the CCG the following year. A CCG may be able to spend some of its surplus however this has to be agreed with NHS England and is driven by agreements by NHS England and HM Treasury.

Meeting the challenges

Making the most of our QIPP opportunities, integrating services though our Better Care Southampton programme and our strategic commitment to bringing the whole system together, we firmly believe we can drive changes that not only mean we can live within our means but which lead to major improvements in outcomes, quality, and patient experience.

For more information on our financial modelling please see Appendix 8.

Your views

In developing our strategy we have taken into account the views, ideas, comments and suggestions of patients, services users, communities, the public, clinicians and a range of other key stakeholders. We have done this through a range of activities including:

- **Southampton Health Conference** – we hosted our first city-wide health conference at St Mary's, the Southampton FC Stadium. The event was attended by almost 150 people from voluntary sector organisations, community and religious groups, health interest groups, the city council and NHS organisations. We were able to share our progress and gain input for our plans for the next five years.

- **Reaching out to our communities** – we organised an event designed for people to have their say about local health services at the Gurdwara Guru TeghBahadur Sahib temple in Southampton. Attended by over 300 local people, the event proved an excellent way for the CCG to work with our local community, and for organisations across Southampton to come together to discuss the future of our health and care services in the city

- We engaging with our **Equality & Diversity Reference group** - members of which represent all nine 'protected characteristics'[21]

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[21] It is against the law to discriminate against anyone because of: age; being or becoming a transsexual person; being married or in a civil partnership; being pregnant or having a child; disability; race including colour, nationality, ethnic or national origin; religion, belief or lack of religion/belief; gender; sexual orientation. These are called 'protected characteristics'.

- We engaged with our **Engaging with Communications and Engagement Reference group** - members of which include voluntary groups, carer representatives, charities, co-production groups and pressure groups.

- **Call to Action Consultation –** this nationally-led, locally-delivered engagement programme focussed on how we address the challenges of growing demand, changing needs and reducing funding allocations over the next five years; we used this as an opportunity to discuss the challenges in our city and to help us identify priority areas.

What people told us

The key themes to emerge from this work are captured below; they clearly show the issues of importance to stakeholders and these have been incorporated into our strategic ambitions and planning:

Access
- A desire for more care locally, around the clock
- Better access to GP services was a common theme and need
- There was great support for making better use of the technology –particularly ensuring systems talk to each other (to avoid patients repeating their needs) and making better use of tele-health

Prevention
- People fully supported earlier, better managed discharge from hospital and efforts to avoid readmission / re-enabling people to stay in their own homes
- People are very open to prevention and self management of conditions
- There was a strong feeling that all agencies should support prevention – typical suggestions include addressing community hazards such as broken pavements.

Involving people
- Overwhelming support for involving people in their own care – either supporting self management of long term conditions or through help with making decisions with treatment or care options.
- Strong views that carers needs / role should part of the holistic assessment of health and care need

Involving communities
- Our stakeholders have demonstrated quite clearly that there is a great seam of untapped expertise and energy in the community which needs to be used for the good of all.

Involving other agencies
- There was a recurring theme around the need to take a bigger picture view of health and care needs within communities – we need to do more to bring together housing, education, other Local Authority Services, police and health to address challenges and develop interventions.

You said – We did Framework

Delivering our ambitions relies on open engagement and involvement of our patients, service users, carers, partners and other key stakeholders. As well as activities of the kind described above, we have developed a systematic and embedded approach to insight gathering and engagement and involvement work, via our You Said-We did Framework. Further details can be found in Appendix 9.

Equality Impact Assessment

As part of our commitment to ensuring that all services we commission are fair, equitable, sustainable and of high quality for all people in Southampton, we have carried out an Equality Impact Assessment on this five year strategy. This can be found at Appendix 10.

Part 3: Delivering our Five Goals

Introduction

In this section we detail how we will deliver our strategy. Starting with our **Plan on a Page** (next page), we outline each of our goals in turn explaining what they mean, setting out the guiding principles behind them, and the detailed action plans that support them.

NHS SOUTHAMPTON CITY CCG STRATEGY

THE VISION: *A HEALTHY SOUTHAMPTON FOR ALL*

NHS
Southampton City
Clinical Commissioning Group

OUR MISSION

To ensure that care is coordinated, safe, sustainable and designed to meet the needs of the people of Southampton.

OUR VALUES

These underpin the vision, drive our behaviour and determine what we do and the way we go about it. We try to live up to these values and they provide a compass to guide us at all times.

Patients First, Every Time | Relentless about the quality of care | Respect for others and their dignity
Courage to do the right thing | Integrity – be honest and decent

GOALS	INTERVENTIONS
A. Make Care Safer	A.1. Nurture a Diverse Range of Safe, Competent Providers A.2. Improved Quality Assurance &Safeguarding A.3. Prioritise Quality Development A.4. Business-like Contract Management of Accountable Providers
B. Make It Fairer	B.1. Reduce Health Inequalities B.2. Promote Equality and Diversity B.3. Uphold the NHS Constitution
C. Improve Productivity ***(Achieving more with less, more effectively)***	C.1. Streamline Urgent Care C.2. Efficient & Reliable Planned Care C.3. Prevention, EarlierDetection and Diagnosis
D. Shift the Balance **(Better Care Southampton)**	D.1. Person-Centred &co-ordinated care closer to home D.2. Better Discharge and Reablement D.3. Engaged & Resilient Communities
E. Delivering sustainable finances	E.1. Strategic Financial Plan Driven by Quality E.2. Plan for the Right Capacity E.3. Deliver Enabling Plans (eg IT, Comms, OD, Estates, Workforce, Research & Innovation)

OUTCOMES

- Improved Patient Safety and User Experience
- Reduced Inequalities In Life Expectancy
- Reduced Avoidable Emergency Admissions
- More Older People Living Independently (91 Days After Reablement)
- Fewer Permanent Admissions To Nursing& Residential Homes
- Fewer Delayed Transfers Of Care
- Reduced Injuries Due To Falls In People Over 65
- 20%Productivity Improvement In Elective Care

Actions Plans – Goal A. Make Care Safer

A.Make Care Safer– this means: we will commission care from safe competent providers**.** We will listen to local people, gather their feedback on their experiences of local services and act upon it:

- Ensuring that we have access to a vibrant, contestable and diverse marketplace and working with providers to drive up the quality of the care they can provide.
- Specifying the quality standards and outcomes that we expect.
- Closely monitoring the quality and safety of services provided and taking decisive action to protect patients when this falls short.
- Cultivating an environment where people learn from mistakes and continuously improve the quality of their services.
- Having effective systems and opportunities for gathering patient feedback.
- Expecting providers to be fully accountable for delivering agreed plans.

Make Care Safer – interventions:

A1. Nurture a Diverse Range of Safe, Competent providers
A2. Improved Quality Assurance & Safeguarding
A3. Prioritise Quality Development
A4. Business Like Contract Management of Accountable providers

A1. **Nurture a Diverse Range of Safe, Competent Providers**

What we plan to do by March 2019 (our aims)	**What we will achieve by 2017 (our expected progress)**	**How we will track our progress**
• The landscape of our locally provided care and support services will be different, with a range of providers and innovative service solutions in place to meet our population's needs. *The aim also links with intervention E2:* Plan for the right Capacity	– We will undertake a thorough analysis of the local care market dynamics to: predict trends in the utilisation of service types across care groups; develop a comprehensive and nuanced picture of service areas where the market is failing to meet demand for local care and support; to empower health and local authority commissioning leads to proactively shape the future landscape of local care and support services. – We will utilise market intelligence to develop a rolling programme of thematically focused and segmented market	✓ A Market Position Statement and forward plan have been developed ✓ Targeted market engagement carried out in advance of any procurement initiation ✓ Expansion in the local supply of tenanted models of care, including those which are suitable for individuals with a low level of nursing need.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	position statements, which will be used to nurture the market for future service providers. – Through our commissioning intentions we will be identifying opportunities, stimulating the expansion of provider capacity, and enabling collaborative work with providers to develop alternative models to traditional care and support. – We will raise the external profile of the Integrated Commissioning Unit as an entity which purchases care and support services on behalf of health and local authorities; this collective influence will enable greater leverage in the development of provision.	
What will change as a result of our plans: ✓ We will have a diverse range of safe, competent providers from whom we can commission quality services for local people.		

A. Make Care Safer

A1. Nurture a Diverse Range of Safe, Competent Providers:
Learning from Francis, Berwick and Winterbourne View

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Francis • All the recommendations from the Francis Report that relate to Southampton will have been fully embedded across all our providers and within our clinical commissioning group **Winterbourne View** • Providers will have a full understanding of the implications and context of what happened at Winterbourne View, and have put in place systems to	– Contracts will include provision for meeting the recommendations and quality and safety requirements. – We will be active participants in the National Patient Safety Collaborative when launched in the autumn of 2014. – Work with providers to ensure key national requirements are implemented including duty of candour, whistleblowing, best practice guidance in determining staffing levels	✓ Ongoing monitoring throughout the year via Clinical Quality Review Meetings. ✓ Visit and assessments reports from the Quality Team

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
ensure safe and effective services **Berwick** • There will be a culture of continuous learning and diffusion of best practice across all commissioners and providers.	– Further strengthen GP involvement in quality assurance of providers – The Core Specification Toolkit all learning disabilities services will be in place, ensuring care of clients with learning disabilities is paramount with a clear focus on reasonable adjustments. – Building on this use, serious incident management will be routinely used to identify themes and trends across the Southampton System and within providers	
What will change as a result of our plans: ✓ The people of Southampton can be confident that they will receive safe, effective, high quality care with a good experience, no matter what health, care or service need they may have.		

A. Make Care Safer

A1. Nurture a Diverse Range of Safe, Competent Providers:

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Infection Prevention and Control • Southampton is recognised as a leader in Infection Prevention and Control, with zero MRSA cases and low numbers of C.diff cases • Achieve high levels of awareness and compliance with the Infection Prevention and Control agenda across Southampton City.	– By 2017 there will be no MRSA bacteraemia cases in Southampton City CCG residents. – The numbers of C.difficile cases will reduce year on year in line with expected national requirements. – The incidence of super resistant bacteria will be monitored and actions taken in line with local and national requirements and recognised best practice to reduce the impact of these infections – Continue work to raise awareness of good hand hygiene and other best practice infection prevention and control standards across the city, supporting reducing the impact of Norovirus and other easily spread infections	✓ MRSA bacteraemia cases will be monitored monthly with Root Cause Analysis conducted in all cases ✓ C.difficile cases will be monitored monthly with trends and themes identified ✓ Super resistant bacterial infections monitored in conjunction with main provider ✓ Audit awareness levels via surveys and focus groups.

<table>
<tr><th>What we plan to do by March 2019 (our aims)</th><th>What we will achieve by 2017 (our expected progress)</th><th>How we will track our progress</th></tr>
<tr><td></td><td>– Work with Public Health on the wider infection prevention agenda including Tuberculosis surveillance, HIV and infection prevention in the Southampton City wider community</td><td>✓ Monitoring via regular multi- agency infection prevention quality meetings.</td></tr>
<tr><td>Continuing Health Care (CHC)
• Robust and comprehensive management of CHC across all settings to ensure all eligible patients in Southampton City receive

• CHC support in a timely and effective manner with high quality service provision balanced with cost effective services.

• We will establish an integrated approach to CHC management with Southampton City Council including a shared budget

• Establish and embed a children's clinical nurse specialist post for assessment and monitoring of continuing care for children and young people</td><td>– The trajectory for the rate of completed CHC review will be
o 90% by the end of 2014/15
o 95% by the end of 2015/16
o 98% by 2017

– Elderly mentally infirm reviews completed reaches and maintains 100% compliance

– 98% of all self-funding funded nursing care reviews completed by 2017

– Integration of Personal Health Budgets (PHB) into CHC processes so all clients are offered a PHB

– Improved range and scope of the CHC liaison post at University Hospital Southampton to encompass additional impact on complex discharge

– Establishment of the Continuing Care Children Nurse Specialist post</td><td>✓ Reported success against targets

✓ New service / nursing provision in place</td></tr>
<tr><td colspan="3">What will change as a result of our plans:
✓ Zero MRSA bacteraemia cases in Southampton City CCG patients
✓ Reduction in the number of cases of C.difficile
✓ Raised awareness of super resistant bacteria and minimal or zero cases in Southampton and how to manage / prevent these
✓ Raised awareness in the general population of infection prevention and control
✓ All CHC clients in all care groups, adults and children, will receive timely and effective assessments in line with or better than nationally required timescales.
✓ Assessments and reviews will be high quality and always include the option for personal health budgets for all clients if they wish to take this up.
✓ CHC will facilitate transfers and discharge from hospitals</td></tr>
</table>

A. Make Care Safer

A2. Improved quality assurance and safeguarding:

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Safeguarding adults and children • Southampton will be a safe and health city for vulnerable children and adults.	– Strengthen processes for identifying and monitoring safeguarding standards in all providers – Review contractual standards to ensure they are updated to reflect learning from national and local serious case reviews and policy drivers – Finalise and embed *Integrated Commissioning Unit Domestic Abuse Strategy* and ensure it is put into operation through procurement processes and collaborative working with local partners – Ensure learning from serious case reviews, partnership reviews and single organisation reviews is shared and learning embedded into practice across the city. – Continued active participation in the safeguarding adult and children's multiagency boards in Southampton: multiagency training, audit and promotion of best practice in safeguarding – Continue the quality assurance work with Nursing Residential and Home Care Providers to drive up standards of care and reduce the numbers to zero of those providers being formally managed in safeguarding processes	✓ Audit of safeguarding standards carried out in all providers ✓ Audit and monitoring of the implementation of the Domestic Abuse Strategy ✓ Monthly monitoring of providers being formally managed via safeguarding processes. ✓ Monitor activity via multiagency safeguarding boards for adults and children

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
System wide approach to pressure ulcer prevention • Number of pressure ulcer incidents amongst the lowest in the country making Southampton of the safest places to receive care.	– By 2017 we will expect to see a minimum of a 20% reduction in the development of all grades of pressure ulcers – Ongoing development of a system wider approach to pressure ulcer prevention and management building on the work completed in 2013/14 by CCG's, Providers and NHS England. – This work will include seeking a shared view across Wessex on grading, monitoring and reporting pressure ulcers. A particular focus will ensure the Nursing Home sector is part of the project to support whole system working.	✓ Providers will submit to the CCG monthly data on the numbers of pressure ulcers developed in their care
Serious Incident Management • Serious Incident management processes are embedded in the healthcare system with an open assessment of incidents and diffusion of learning • There will be no never events in the city's provider trusts	– A process of annual deep dives will be in place covering areas identified by the CCG Clinical Governance Committee as areas of concern or focus to address CCG requirements – Work with providers to ensure mechanisms are in place to reduce to zero Never Events with a particular focus on those relating to operative and interventional procedures	✓ Deep dives will be reported to the CCG Clinical Governance Committee on a quarterly basis ✓ Monthly monitoring of Never Events by CCG Quality Report
Primary Care Quality Assurance • Systems will be in place for the monitoring of the quality of services provided within Southampton by GPs. • This will build on the work undertaken by the Primary Care Commissioning Development Manager and team to support CCG Board level assurance on the quality of services.	– First report to be prepared for Q1 completed by 31st July 2014 – We will have clarity and plans for how we how we can further engage primary care practitioners in developing and providing this evidence	✓ GP Quality Report to be presented to CCG Clinical Governance Committee in Quarter 2 2014/15

What will change as a result of our plans:

We will have a safe and effective care across our city:

- ✓ Safe care in all providers
- ✓ Local providers are up to date on national and local learning and this is embedded in practice
- ✓ The Domestic Abuse strategy is in place and being implemented across Southampton
- ✓ No Nursing homes, residential homes or home care providers in Southampton are subject to safeguarding processes and have cautions/suspensions in place
- ✓ System wide sharing of trends, themes and learning from serious incidents to support embedding learning across Southampton
- ✓ No Never Events affecting patients of, or in providers working with, Southampton City CCG
- ✓ To provide the CCG Board with quarterly assurance about the quality of primary care services in Southampton

A. Make Care Safer

A3. Prioritise Quality Development:

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Compassion in practice • All local NHS and non-NHS providers (including the Nursing Home Sector) are implementing Compassion in Practice extending this to all healthcare professionals not just nurses	– Compassion in Compassion in Practice will be embedded across all relevant providers	✓ Monitored via Clinical Quality Review meetings with and via CCG visits to providers
Strengthening clinical leadership • Clinical leadership will be the norm in front line teams with identified clinical champions	– Providers will be actively encouraged to embed robust, high quality clinical leadership in all front line teams – The CCG will have a clear set of clinical champions for all areas of activity	✓ Monitored via contracting and clinical meetings
Best Practice Guidance Implementation • A database supporting the implementation of the range of NICE guidance will be in place. This will include regular horizon scanning for early identification of new guidance	– First version of database will be complete by 30th June 2014 with ongoing development through 2014/15	✓ Monitored via contract performance meetings which include quality, quality assurance visits and other intelligence about providers ✓ Monitored monthly via the CCG Quality Report and Clinical Governance Committee
What will change as a result of our plans: ✓ Patients will receive safe, compassionate services which provide the best care possible, from all healthcare professionals (whatever the setting).		

A. Make Care Safer

A3. Prioritise Quality Development

Prescribing and Medicines Management

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• There will be safe prescribing of items with proven efficacy. • We will be amongst the best performing CCG areas in the country for shared learning through reporting of medication incidents, including Serious Incidents Requiring Investigation (SIRIs).	– We will have more data about performance allowing us to address issues and develop shared learning. This will come through increased reporting by large providers as part of the Quality Premium in during 2004/15 and through GP reporting of incidents to the National Reporting & Learning System (NRLS), as part of the local Quality Improvement Schedule. – GP practices supported to report and keep track of numbers via NRLS – Partnership working with NHS England around community pharmacy NRLS reporting or alternative future options.	✓ Increased rates of reporting by all large providers compared to 2013 baseline levels. ✓ All practices have reported at least one medication incident to the NRLS by July 2015. ✓ Outcome reports and learning points from incidents are reported and shared.
• Electronic Prescribing Systems (EPS) will be embedded in Primary Care GP practices and Community Pharmacies • We will be making the most of Scriptswitch costs as new suppliers and providers enter the market	– EPS will be in place across the whole City by March 2017 (assumes at least one new practice going live every month for 3 years). – At least 10 new or revised pathways involving medicines input each year. – The Eclipse Live pilot (the testing of specialist software for tracking medicines use and compliance) will finish in 5 practices in 2015. If the findings are positive, roll-out across the city will follow.	✓ Quarterly report on number of practices and pharmacies live with EPS, and number of patients receiving repeat prescriptions electronically. ✓ Quarterly report on progress with Eclipse Live, linking with CCG colleagues around medication safety and admission avoidance. ✓ Half yearly report on Scriptswitch costs, savings and acceptance rates by GP practices., followed by full review in March 2016 ✓ Annual review of map of medicine input and planning

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Financial sustainability • Growth in local prescribing costs will be contained to no more than 3% on average every year. • NICE and other good practice guidance will have been fully implemented during the period.	– Annual reviews of patent experiences and new generic savings – Annual reviews of the local impact of national price changes. – Local strategic decision-making on individual medicines and NICE decisions via District Prescribing Committee – Annual reviews of targets within GP Quality Improvement Scheme.	✓ Annual QIPP planning and monitoring of delivery ✓ Half yearly reports to the Clinical Executive Group
What will change as a result of our plans: ✓ Further improved safety, efficacy and financial controls in key areas of prescribing and medicines management		

A. Make Care Safer

A3. Prioritise Quality Development:

Using patient experiences for maximum benefit

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• We will have an understanding of patient experience in every aspect of the services we plan and commission. • Our systems will be comprehensive and focussed on extracting and analysing as much useful data as possible. • Every time a citizen 'touches' the services that we commission, we want to know the nature of the experience. We will then use this feedback to improve services.	– Baseline review of current mechanisms and best practice – Development and delivery of comprehensive programme to create the mechanisms to capture and analyse data. – Demonstrable use of the data in ways the inform and influence services	✓ All current methods of collecting patient experience feedback are mapped and understood. ✓ Regular reports on trends and how they are being used to influence services. ✓ Agreed programme for transforming data collection in place.

Improving Patient and Staff satisfaction		
• Friends and Family Test (FFT), including the Staff FFT will be embedded across all providers in all health sectors. • Happy, well-motivated staff deliver better care which in turn improves outcomes and patient experiences. We will have in place clear mechanisms which support and encourage providers to help staff to do the best job they can.	– Further roll out of Friends and Family Test (FFT) to services in line with national guidance including outpatients and day services in acute providers and across services in non-acute providers – Support providers in the roll out of the Staff FFT, in line with national requirements – Southampton City CCG providers will be in the top quartile for performance in FFT – The new Patient Experience Service the CCG will be fully embedded to support the collection and analysis of patients and staff feedback.	✓ Monthly reporting via the CCG Quality Report to Clinical Governance Committee

What will change as a result of our plans:

- ✓ The services that we commission are reflective of patient need.
- ✓ Feedback is used as a positive way of improving services.
- ✓ We are collecting patient insight on a scale never before attempted in Southampton
- ✓ Patients using services commissioned by Southampton City CCG will recommend services to their family and friends and the overall number of negative responses will be significantly reduced. Staff working in providers SCCCG commissions services from will recommend the services to their family and friends.

A. Make Care Safer

A4. Business-like Contract Management of Accountable Providers

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Contract management • Our contracts are set at a reasonable level, with clear targets, standards and outcomes to be achieved; there will be clear ownership of contracts within the CCG.	– Systematic monitoring of contracts in place – Good, business-like relationships with providers	✓ Monitoring use of contract levers ✓ Monitoring contract compliance and achievement of standards and targets ✓ Contracts agreed on time ✓ Minimal under and over-performance indicating we have contracted the right volumes.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
		✓ Development of remedial / recovery plans where appropriate.
Integrated Commissioning Unit • The Integrated Commissioning Unit will be leading the planning, buying and development of services and for managing contracts across all aspects of health and care that will benefit from joined up approaches.	– We will develop a combined register of contracts held by the CCG and council that are relevant to the objectives of the Integrated Commissioning Unit (ICU), using this as a tool for coordinating a consistent approach to contracts. – We will have developed an operational policy detailing the agreed to contract management including: procurement, mobilisation, performance monitoring, performance/ risk/ quality management, payments, negotiations, variations, and terminations. – All arrangements made for the provision of care and support services (including individual packages of care), will be underpinned by appropriate contractual terms and documentation.	✓ ICU Contracts register developed ✓ Contract management policy developed and adhered to
What will change as a result of our plans: ✓ Enforceable contracts that are used positively to drive achievement, continuous improvement and value for money. ✓ Improved outcomes, patient safety and user experience ✓ Service agreements that deliver demonstrable benefits to patients and value for money		

Actions Plans – Goal B. Make It Fairer

B. Make it Fairer– this means we will reduce the inequalities in access to care across our population through:

- Eliminating variations in the quality of and access to care
- Hearing the voice of disadvantaged people
- Putting people's needs first when commissioning services
- Implementing our equality and diversity policy
- Being accountable for all we do

Our guiding principles/core standards to make care fairer:

1. We will recognise and value the diversity of the local community
2. We will ensure that equality is central to the commissioning of modern, high quality health services.

Make It Fairer – interventions:

B1. Reduce Health Inequalities
B2. Promote Equality and Diversity
B3. Uphold the NHS Constitution

B1. Reduce Health Inequalities		
What we plan to do by March 2019 (our aims)	**What we will achieve by 2017 (our expected progress)**	**How we will track our progress**
• We will have reduced health inequalities through targeted approaches and improved access to existing services by protected groups • Better information and advice will be provided about services available in appropriate and accessible formats • People will be able use a Single Integrated Point of	– The expectation of reduced inequalities in health outcomes will be embedded in all our service specifications and contracts – We will have developed and introduced a standardised local system that informs healthcare providers of an individual's learning disability and related health and care needs.	✓ Achievement against the agreed Health and Wellbeing Strategy measures ✓ Achievement against our Outcome Ambitions ✓ Increase in dementia diagnosis rates

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Access to health and social care services, enabling rapid assessment of needs or be directed to the most appropriate service. • We will in particular have reduced health inequalities for people with a learning disability	– Increased dementia diagnosis and improved support following diagnosis	✓ The number of people with learning disabilities and/or mentalhealthissuesaccessing health screening increases year on year.
• We will have addressed health inequalities for people with Mental health conditions by fully implementing the *Parity of Esteem Programme* – a national initiative to reduce the 20 year gap in life expectancy for people with severe mental health illness. This includes working in partnership to tackle areas such as: ▪ Support for young people ▪ Employment ▪ Carer support ▪ Assessing physical and mental health needs holistically ▪ Rapid access to support ▪ More services in local settings ▪ Increasing access to psychological therapies for all sections of our communities • Staff will work with confidence to identify and meet the needs of people mental health conditions across all service areas, ensuring an approach that treats people holistically – addressing both mental health and physical health – through planned programme of training and support.	– Emotional wellbeing is important in minimising the risk of children and young people making poor choices in relation to their long term wellbeing. We will: o Introduce a systematic approach to earlier identification and improved support for young people with mental health problems. o Improve prevention approaches, especially suicide prevention and improved health promotion for those with severe mental illness o Implement an 'Emotional First Aid' programme in schools across the city – Training programme to improve capacity and confidence of frontline staff when addressing both mental health and physical health needs will be running. – Provision for those with dual diagnosis will have improved – People will have early access to "talking therapies" and services which help people retain and return to employment	✓ Annual increase in the number of carers who received health checks. ✓ All mental health providers commissioned by the CCG can evidence assessment of the physical health of inpatients and service users, liaising with their GP's as appropriate. ✓ Increases in number of people appropriately accessing mental health services in Emergency Departments and Inpatient wards. ✓ Tracking the number of older people, BME communities, veterans and children and young people accessing psychological therapies, to ensure improvements. ✓ Take up of places on training courses increases year on year. ✓ Increase in dementia diagnosis and post diagnosis support

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• We will have made improvements in addressing health inequalities by implementing the five most cost-effective high impact interventions (see next column) which have been recommended by the National Audit Office's *Health Inequalities Report* and the Public Accounts Committee Report into *Tackling Inequalities in life expectancy*	– We will have made progress against the five high impact interventions by: o Increasing prescribing of drugs to control blood pressure o Increasing prescribing of drugs to reduce cholesterol o Working with Public health colleagues to increase smoking cessation services, (including focus on people with serious mental health conditions) o Increasing anticoagulant therapy in atrial fibrillation; o Improving blood sugar control in diabetes	✓ Impact on years of life lost from all cardiovascular disease
What will change as a result of our plans: ✓ We will close the gap on health inequalities ✓ Our patients and staff can recognise that the all elements of the Health and Wellbeing Strategy are being implemented locally ✓ People will experience parity of esteem – that is the same access to mainstream services and improved health outcomes if they have mental health needs and or a learning disability		

B. Make It Fairer

B2. Promote Equality & Diversity

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Services will be commissioned in ways that ensure all patients and citizens have the opportunity to take control by adopting a co-production, co-design and co-delivery approach • We will have a truly embedded culture which embraces Equality, Diversity and Human rights, and where staff are confident and feel valued	– Improved equality information and data for commissioning and service planning – Proactive engagement of diverse communities and disadvantaged groups in commissioning decisions – Ensuring all providers collect equalities data and information as part of their contract responsibilities to measure equality and drive improvements	✓ Achieving across all outcomes of the NHS Equality Delivery system (EDS2) ✓ Equality & Diversity Reference group to assess CCG against the 9 patient focused outcomes of the Equality Delivery System ✓ Providers will achieve access rates which more closely reflect the population of Southampton.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	– Embedded approaches to monitoring outcomes and patient, carer and public experiences – Established a representative Citizens Panel in partnership with the City council – Embedded the use of the NHS Equality Delivery system across the CCG and local health system	✓ Increase in numbers of Equality Impact assessments undertaken
What will change as a result of our plans: • People in the most deprived communities and protected groups have access to services and improved health outcomes which more closely reflect the population of Southampton.		

B. Make It Fairer

B3. Uphold the NHS Constitution

The NHS Constitution runs through everything we do and all the actions described in these plans will help us not only fulfill, but exceed our obligations. This intervention is therefore not an end in itself but is intended to ensure we are able to capture our progress in all these different endeavours against the expectations in the Constitution and to ensure that any additional actions are carried out to ensure full compliance.

B3. Uphold the NHS Constitution

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• We will have delivered and upheld the principles, values and pledges concerning provision of care within the NHS constitution, including: • Commissioning sufficient capacity, and creating a vibrant range of provision to ensure equal access, patient choice (as appropriate) and high quality care	– We will have developed strategic modelling tools to test scenarios across health and social care to help refine future commissioning plans to ensure sufficient capacity is available – We will be commissioning efficient and effective emergency care services to provide consistent clinical standards and outcomes seven days a week	✓ Achievement of NHS constitution standards monitored through regular reports to the Governing Body. ✓ Friends and Family test results and patient experience surveys.

<table>
<tr><th>What we plan to do by March 2019 (our aims)</th><th>What we will achieve by 2017 (our expected progress)</th><th>How we will track our progress</th></tr>
<tr><td>• All components relating to urgent and emergency care services consistently throughout the year

• Having informed health providers who are able to support patients in making a choice about local health services.

• Delivery of safe, effective and patient-centred care across the whole health system

• Enable active and influential citizen participation in shaping and developing health and care services</td><td>(in line with the 10 national clinical standards for seven day working)

– We will have the systems and processes in place to be able to offer Personal Health Budgets to adults, young people and children who would benefit from this.

– We will be working closely with NHS England's direct commissioning teams and the Wessex Strategic Clinical Networks to ensure that Specialised Services are safe and sustainable, with is sufficient capacity in the local system.</td><td></td></tr>
<tr><td>• We will have delivered and upheld the principles, values and pledges concerning staff and members:

• We will have active leadership from, and engagement with CCG members, using appropriate processes and systems with clear, relevant and timely feedback

• We will be a knowledgeable and high performing organisation which attracts motivated people and members

• We will be an organisation where people can develop and progress in their careers

• Our employees will have access to effective support to improve their own health and wellbeing (see also Organisational Development Plan on p 66)</td><td>– We will have made great progress against our Organisational Development (OD) framework, which is aligned to our 5 year strategy and annual business plans, and covers staff and CCG membership development.

– We will be running bespoke packages of leadership development opportunities (clinical and managerial) aligned to organisations strategy; there will also be identification of leaders and active succession planning

– We will continue to develop apprenticeship opportunities and graduate trainee opportunities

– We will have in place a clear method for encouraging, capturing and acting on new ideas and innovations amongst CCG members will be encouraged and acted uponthrough a clear method of capturing and sharing these with the members</td><td>✓ GP membership satisfaction ratings regarding to their relationship with the CCG

✓ Use of feedback tools by clinicians

✓ Delivery against the OD action plan

✓ Staff feedback and personal development plan reviews

✓ Successful recruitment of apprentices and graduate trainees

✓ Staff retention rates</td></tr>
<tr><td colspan="3">What will change as a result of our plans:
✓ Our patients and staff can recognise that the all elements of the NHS constitution are being implemented locally</td></tr>
</table>

Action Plans – Goal C. Improve Productivity

C: Improve Productivity *(achieving more with less, more effectively)*

We will bring control to the acute healthcare system. This means:

- Providing swift access to the right care when people become unwell
- Providing effective alternatives to hospital admission
- Ensuring people receive the most effective and efficient care when they need treatment in hospital
- Supporting people to get the onward care they need as soon as they are ready to move on from hospital

Our guiding principles/core standards for improving productivity:

1. Uphold the NHS Constitution by ensuring that patients receive treatment within the requirements of the NHS constitution by commissioning capacity that is available and accessible to all.
2. Care is high quality and in particular that patients experience is good, with the best possible clinical outcomes.
3. The delivery of care is designed around the needs of the patient, not organisations.

Improve Productivity – interventions:

C1.Streamline Urgent Care
C2. Efficient & Reliable Planned Care
C3. Prevention, Earlier Detection and Diagnosis

C1. Streamline Urgent Care

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• A clearly defined Urgent and Emergency Care System that aligns with the national requirements to be detailed in NHS England Review of Urgent and Emergency Care	– The NHS England review will take place in 2014/15 – will create a full action plan in response to the recommendations and begin implementation. – We will develop our Urgent and Emergency Care system in light of: o The learning that the system has done during the delivery of the Emergency Care Intensive Support Team (ECIST) Whole System Action Plan since it began in 2012/13.;	✓ An agreed joint urgent and emergency care vision in line with national strategy across all localities ✓ Effective joint working and collaboration with key local CCGs, members, providers and stakeholders ✓ An urgent and emergency care system

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	o The progress of our Better Care Southampton programme and its impact on the Urgent and Emergency care work o The needs of Specialist Commissioning working through the Strategic Clinical Networks (especially Major Trauma) to ensure local services are safe and sustainable	map that shows: · patient flows · number and location of emergency and urgent care facilities · services provided · the pressing needs and future needs for our population
Patients will be choosing services appropriate to their urgent care needs: • People are well informed about the services that are available and are able to choose well • NHS 111 is being used as *the* gateway into an Urgent and Emergency Care system that is easy to navigate.	– The NHS 111 Directory of Services will be developed to show the map of Urgent and Emergency Care, to aid decision making. – The early findings from the initial implementation of the Better Care Southampton will be being considered for inclusion in the NHS 111 Directory of Services. – We will have a single set of call taking software being used in 999 and NHS 111 services to eliminate waste and confusion. – Shared decision-making techniques will be being tested in Urgent and Emergency Care – Where clinically appropriate, NHS 111 will be able to book patients into the right place – Ambulance services will be supporting the delivery of urgent and emergency care across the system with a focus on the needs within a non-acute environment	✓ Increased use of 111 ✓ Increased use of the Minor Injuries Unit ✓ Reduced conveyances to hospital ✓ Increased levels of self-management by patients and carers
• There will be demonstrable improvements in clinical decision making	– Ability to 'treat' over the phone will be enhanced – NHS 111 will have piloted access to clinical opinion based on the well-developed concepts for elective clinical decision making (Map of Medicine and Advice and Guidance)	✓ Reduction in frequent 'callers and attendees' ✓ Improved management of patients at risk of falling
• New approaches to dealing with Serious or Life Threatening Emergency Care needs will see: ▪ Consistent levels of senior clinical staffing. ▪ Senior clinical decision making seven days a week in accordance with demand profiles. ▪ Consistent access to rapid diagnostics seven days a	– The right level of Emergency Care capacity will be in place at our main acute service provider (University Hospital Southampton (UHS)) to cater for current and future needs – Core requirements of a Major Emergency Centre have been fully implemented at UHS.	✓ Reduced length of stay for those patients requiring admission ✓ Fewer patients spending time in a Clinical Decision Unit and being discharged having not had a procedure

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
week. • Where patients are admitted, they can expect the following to be in place: ▪ Daily consultant led ward rounds ▪ Early and frequent review. ▪ No delays: patients move through the care pathway with no differences in discharge flow rates because of the day of week.	– Clinical decision support tools are being tested in 50% of specialties – Full provision of support services in place: on site critical care, acute medicine, acute surgery, Trauma &Orthopaedics, Major Trauma. – Real time capacity management in support areas. – Management of patient flow across providers and by providers against a set of jointly commissioned flow metrics – Ambulatory Emergency Care is being used as much as possible to support the wider system capability and response.	✓ Reduced emergency re-admissions within 30 days of discharge from hospital ✓ Improved pathway and patient experience for patients attending hospital with chest pain ✓ Reduced number of Ambulatory Care Sensitive admissions ✓ Reduced number of Delayed Transfer of Care ✓ Ambulatory Emergency Care provision and performance will be benchmarked against national comparators
• There will be improved levels of efficiency and resilience of the Urgent and Emergency care System	– Improved system capacity through more joined up planning and management: o Predictive and resilient planning and management by providers across pre hospital, hospital and community services – Plans for effective management of surges in demand will be developed and implemented	✓ Sustained achievement of performance standards across all urgent and emergency care providers

What will change as a result of our plans:

- ✓ Patients receive treatment within the requirements of the NHS constitution by commissioning sufficient capacity
- ✓ Care is of a high quality and in particular the patients experience is good, with the best possible clinical outcomes
- ✓ Delivery of care is designed around the needs of the patient
- ✓ 15% reduction in emergency activity
- ✓ Delivery of Better Care Southampton Outcomes
- ✓ Value for money is delivered

C. Improve Productivity (*Achieving more with less, more effectively)*

C2. Efficient & Reliable Planned Care

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Patients and carers will be at the heart of commissioning decisions for elective care	– We will be using large scale patient insight to improve services – There will be significant patient and carer involvement in the development of new service specifications, review of current services and tender evaluations – Shared decision making will be standard practice in all elective clinical decisions – We will also seek to improving patient awareness, access to screening and ways to self-manage conditions	✓ Increase in use of Shared Decision Making. ✓ Patient surveys
Getting people to the right place first time: • All referrals will be through an electronic system which will eliminate duplication and waste. • Decisions to refer will be supported through clinical decision support tool (currently Map of Medicine) and Advice and Guidance from secondary care	– Referrals for routine and urgent care through an electronic system become the norm. – Shared decision making will be standard practice in all elective clinical decisions	✓ Level of utilisation of e-referral by referrer and provider ✓ Monitoring the take up of shared decision making.
Eliminate waste and duplication across all stages of treatment: • Patients will need to attend hospital on fewer occasions to be treated. This means: ▪ Access to diagnostic results on first attendance to assist more rapid clinical decision making ▪ Face to face follow ups with consultants will reduce, with more telephone advice, community based nurse led care, and patients in control using decision support tools.	– GP Direct Access services in place – Development of Rapid Access to diagnostics - one stop models of rapid diagnostics tested and recommendations made – All providers are using the electronic Picture Archiving and Communication System (PACS) to support faster diagnostics – Increased levels of community based consultant and non-consultant led outpatient services	✓ Patient insight into service effectiveness ✓ Reduction in intervals between treatment along pathways ✓ Reduction in face to face follow ups inT&O; ENT; dermatology and ophthalmology

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	– More treatment opportunities closer to the patient in community settings – Targeted reductions in face to face follow ups forTrauma&Orthopaedic (T&O), Ear Nose & Throat (ENT)	
We will re-shape the way Acute Hospital Services are delivered: • Using new techniques and ways of working to deliver more outpatient procedures instead of day cases. • Where there is a requirement for more detailed treatment, more will be carried out as day cases instead of inpatient stays overnight. • In tandem with this, the length of stay for patients will be reduced through the use of Early Supported Discharge, Enhanced Recovery Programmes and 'Hospital at Home' initiatives. • Developments will be supported by a clinically led rolling programme of work to review and re-specify pathways at specialty level.	– Pathways in T&O, ENT , Dermatology and Ophthalmology services will have been redesigned and commissioned to reflect the productivity criteria – Shared decision making will become a standard practice in all elective clinical decisions	✓ 8% productivity improvement ✓ Reduce Acute Length of Stay (occupied bed days)
• 20% Productivity Improvement In Elective Care	– Progress against the following targets: o 24% reduction in first face to face outpatient attendances o 34% reduction in face to face follow up attendances o 4% reduction in outpatient procedures o 25% reduction in day case procedures o 14% reduction in elective inpatient admissions – Progress will be achieved through the Better Care Southampton programme (see Goal D below) and particularly in relation to: o More informed decision making by users and clinicians o Increased support, education and provision in primary and community care o Fewer routine follow ups, better use of technology and support for self-management	✓ Activity and Performance reporting to the Governing Body and Senior Management Team ✓ Progress of the Better Care Southampton programme.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	○ Shift from day cases to outpatient procedures, reduction in procedures of limited clinical value, reductions in length of stay and reduced readmissions or "re-do" operations	

What will change as a result of our plans:

- ✓ Patients receive treatment within the requirements of the NHS constitution by commissioning sufficient capacity for example, within 18 weeks from referral to treatment for routine care.
- ✓ Care is of a high quality and patients experience in particular is good, with the best possible clinical outcomes.
- ✓ Delivery of care is designed around the needs of the patient.
- ✓ Value for money is delivered
- ✓ 20% Improvement in productivity in Elective care

C. Improve Productivity (*Achieving more with less, more effectively)*

C3. Prevention, Earlier Detection & Diagnosis

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Ensuring that services that provide early diagnosis and detection are performing in the top 20% nationally. • We will have fast access to diagnostic tests and reports will be shared electronically amongst the relevant health professionals and the patient	– Cancer two-week-wait pathways reviewed and re-specified – Scope of NHS England's direct commissioning screening is understood and correctly deployed to meet our city's needs. – Closer working with the relevant strategic clinical networks to develop and implement solutions – Shared decision will become a standard practice in all elective clinical decisions	✓ Compliance with Cancer Standards

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
What will change as a result of our plans: ✓ Patients are seen more quickly with faster decisions on treatment options ✓ Better outcomes, better experiences ✓ More efficient use of service capacity and capability		

Actions Plans – Goal D. Shift the Balance (Better Care Southampton)

D Shift the Balance: We will work hard to integrate health and social care services to ensure a better more streamlined experience for local people. Together with patients, communities and partners we will co-produce coordinated care through the Better Care Southampton programme. This means:

- Engaging with people and communities to find out what works best for them and building community assets
- Prioritising prevention and early identification of illnesses.
- Creating integrated locally based health and social care teams to provide community based care that is tailored to the needs of individuals; providing more care closer to home.
- Shifting the balance of care from treating acute illness towards prevention and maintaining independence.

Shift the Balance – interventions:

D1. Person-Centred & co-ordinated care closer to home
D2. Better Discharge and Reablement
D3. Engaged & Resilient Communities

D1. Person-Centred &co-ordinated care closer to home

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Health and care services are integrated around local clusters of practices. • Multidisciplinary teams of health staff (community nursing, therapists, geriatrician, MH nurses, and primary care staff), social care staff, housing workers and the voluntary sector are fully operational.	– 6 x cluster teams in operation across the city which bring together health and local authority staff alongside voluntary sector and other community workers to provide joined up care – Common assessment tool in place and fully operational – Shared care plans for 2% of the population with identified accountable professional – 7 day working within teams – Development of a personalised care promoting workforce across all services	✓ Increase in number of integrated person centred care plans in each cluster ✓ Year on year growth in positive feedback from service users and their carers ✓ More staff with the skills to promote person centred care ✓ Increased engagement in community services ✓ Increased uptake of direct payments/ personal health budgets

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	– Greater adoption of Personal Health Budgets, Personal Budgets and uptake of direct payments as the method of arranging care and support to meet individual need – 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.	✓ More people have self management plans ✓ Increased use of telecare/telehealth
• Single point of access for integrated health and social care will be operational providing easy access city wide to good quality user friendly information that allows people to assess their own needs and choose the best solutions.	– Single point of access tested ready for full roll-out. – Support mechanisms implemented and information needs identified and met.	✓ Positive feedback from service users and their carers ✓ Increased engagement in community services

What will change as a result of our plans:

- ✓ People will feel more in control and better able to maintain their independence, drawing on their own strengths and resources and those of their community.
- ✓ People will be able to draw up their own care plan, in partnership with professionals and others where they choose.
- ✓ If they choose to do so, more people will be able to receive their personal budget as a direct payment and source their own support.
- ✓ Professionals from different sectors will work together as a single team, trusting each others' assessments, thereby reducing duplication and the need for people to keep repeating their stories.
- ✓ People's needs will be met earlier and there will be a greater focus on planned care with fewer unplanned attendances and admissions.

D. Shift the Balance (Better Care Southampton)

D1. Person-Centred &co-ordinated care closer to home

Co-commissioning primary care

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Develop a city-wide sustainable model for primary that is able to support and deliver a wider range of integrated services in the community (to help meet the challenge of complex needs and growing demand) • Have in place a model of primary care that is able to respond to major planning developments and to drive and influence collaborative commissioning across pathways to ensure seamless, integrated services • GP practices have also developed “cluster” groups within local neighbourhoods and community nursing has realigned their services around these clusters.	– Develop and agree a clear vision for the provision of hospital services (supported by business cases to deliver new provision where needed) – We will have carried out a significant programme of engagement with local individuals, groups, services and organisations in to discuss and agree fundamental changes – Working strategically with our neighbouring CCG (NHS West Hampshire CCG) we will have assessed the benefits and be implementing the outcomes of co-commissioning primary care with NHS England – Building on our progress already we will have completed the national roll out of a Risk Stratification & Care Planning Directed Enhanced Services (DES)	✓ Partnership approach with NHS England agreed ✓ GP engagement plan agreed and being implemented ✓ Public & Stakeholder plan agreed and being implemented ✓ Regular reports to Governing Body

What will change as a result of our plans:

- ✓ A modernised, sustainable primary care model for Southampton that is able to effectively manage with 21st century demands on services
- ✓ Systematic and active CCG engagement in the planning of local primary care and specialist services to address local population need

D. Shift the Balance (Better Care Southampton)

D2. Better Discharge & Reablement

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• An integrated health and social care discharge and reablement service that is available 7 days a week. • Enhanced level of provision to provide more to people with reablement opportunities, supporting effective and timely discharge and reducing the risk of readmission.	– A single enhanced discharge and reablement service and pathway will be in place	✓ Evidence that discharge planning is starting at the point of admission - monitoring of expected discharge dates and plans in inpatient notes ✓ Evidence that assessment of people's community care needs is being undertaken in community setting (as opposed to in hospital) ✓ Reduction in delayed transfers of care ✓ Increased numbers of people accessing reablement services ✓ Fewer people being readmitted within 91 days following discharge into reablement services
• Implementation of a strong reablement culture across wider community provision which promotes independence and supports people to engage with existing support in the community	– Development of a strong reablement focus, through awareness raising, training and clear service specifications within: o The 6 x cluster teams o Domiciliary care o Nursing and residential home providers	✓ Increased engagement in community services ✓ Evidence that providers are building independence-promoting activities into their routine contact with clients ✓ Positive feedback from service users and carers

What will change as a result of our plans:

- ✓ More people will be supported to maintain their independence for longer or regain independence following a period of illness
- ✓ There will be reduced demand for nursing/residential care or long term social care input
- ✓ There will be less demand on acute inpatient care – reduction in admissions/readmissions, shorter lengths of stay, fewer delayed transfers of care

D. Shift the Balance (Better Care Southampton)

D3. Engaged & Resilient Communities
Building Community capacity

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Provision will be in place that maximise local capacity to support health and well-being of community, including local action to reduce loneliness and social isolation	– Proactive support through voluntary sector partners to attract and maximise alternative funding opportunities (eg. Big Lottery, Trust funds) into local communities of identity (eg. ethnicity, diagnosis, neighbourhoods) – Provision of an integrated health and social care information, advice and guidance service, linked to single point of access – Development of markets and communities to provide an active and vibrant environment for social enterprise, micro enterprises and self-help mechanisms to flourish – A care/support navigator role to act as a single point of contact in each cluster.	✓ Increase number of community groups and activities within each cluster (based on 14/15 baseline) ✓ Greater knowledge of community resources available (more information available) – tested via surveys and usage rates ✓ Increased engagement of local people in community services (based on 14/15 baseline)
• Increased support for carers, underpinned by better information for carers, greater identification within community services and increasing assessments	– Increased range of carer support services – Provision of an integrated health and social care carers' information, advice and guidance service, linked to single point of access – Greater awareness and identification of carers needs amongst frontline services	✓ Increase in numbers of carers identified from baseline of 3,000 in April 2014 ✓ Positive feedback from service users and carers ✓ Greater knowledge of carers support - more information available through range of resources
• Greater encouragement and support for individuals to understand and maximise opportunities for developing social capital through peer support, mentoring, time banking, local networks and community integration	– Implementation of support planning services to empower and enable individuals to plan their own care – Support to those with single diagnosis or low to moderate	✓ Quarterly increases in the number of people involved in planning their own care.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
	eligibility for care service support (using the Fairer Access to Care Services methodology).	

What will change as a result of our plans:

- ✓ Engaged and resilient communities and citizens who feel part of their local network
- ✓ Less reliance on public sector services
- ✓ Reduction in admissions to acute sector
- ✓ Reduction in permanent admissions to residential and nursing homes
- ✓ Reduction in readmissions
- ✓ Improvement in numbers of delayed transfers of care from hospital

Actions Plans – Goal E. Deliveringsustainable finances

E. Delivering sustainable finances

We will build a strong and robust foundation to enable us to tackle the challenges we face and effectively deliver our plans. This means:

- Planning sustainable finances - taking a realistic long term view about future resources
- Developing a balanced financial plan
- Developing a contracting plan to deliver the agreed outcomes that is fit for purpose
- Recognising the interdependence of partners in the system and the need for strong viable providers

Delivering sustainable finances – interventions:

E1. Strategic Financial Plan Driven by Quality
E2. Plan for the Right Capacity
E3. Deliver Enabling Plans (Communications, OD, IT, Estates and Workforce)

E1. Strategic Financial Plan Driven by Quality

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Through our Better Care Southampton programme we will have shifted the balance of funding by 15% from acute to community provision: o Our current 54% spend on acute care will reduce to 47% of our annual budget o Our spend on community will rise from 10% to 17% of annual budget.	– By 2017 our spend on community care will have increased to 14% and our acute spend fallen to 50%. This will be achieved through the plans relating to our Better Care Southampton programme.	✓ We will regularly track and report on the allocation of budgets to measure our progress against our aims to shift the balance of funding across our services.
• We will have ensured that national requirement to reduce our running costs by £692,000 over the next 5 years does not lead to gaps in the delivery of our plans.	– A full review of our services / support needs will have taken place to determine the most cost effective ways for delivery – this could be a mixture of efficient in-house provision, services provided in partnership with the commissioning support unit, council or another CCG. – The findings of the review will be implemented	✓ Review progress and outcomes ✓ OD plan as a key enabler

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Our share of the national funding gap (the 'QIPP challenge') will reach as much as £89m by 2020/21. By 2019 we will have delivered 85% of our QIPP target with clear plans in place to achieve the remaining 15% by 2021.	– We will have a transformational change programme which looks forward 3 years (rather than the current 1 year). – Programme management team in place to support the transformation – Our transformational change programme will have a key focus on the quality of services, recognising quality is a key driver of efficient and safe services.	✓ Programme management team progress and exception reports
What will change as a result of our plans: ✓ We will have sustainable finances which gives freedom to invest in services which enhance the quality of care for the patients of Southampton ✓ We will have in place clear longer term (rolling) transformational programmes which support our ambitions		

E. Delivering sustainable finances

E2. Plan for the Right Capacity

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• There will be a broad spectrum of providers delivering capacity to the system and helping to ensure safe and sustainable routine elective capacity for our patients and service users.	– A procurement of routine elective capacity at the Treatment Centre at the Royal South Hants Hospital will take place in 2015. – We will be working with co-commissioners on strategic capacity planning and management, using near real-time information. – We will be working in partnership with NHS England's Specialist Commissioning and Strategic Clinical Networks to ensure safe and sustainable specialised services	✓ No 'on the day' cancellations due to lack of capacity ✓ No medical outliers due to lack of capacity. ✓ Consistent delivery of Referral to Treatment standards by all providers across all specialties ✓ Consistent delivery of the Emergency Department Type 1 Operating Standard at UHS to ensure capacity and outcomes
• We will have a vibrant and contestable provider market within the city covering a range of health and care service	– Working jointly with SCC we will clarify our intentions over a 3	✓ New providers (or new services from existing providers) are commissioned

demand. • Patients and service users will have more choice and greater provision in their communities See also A1'Nurture a diverse range of Safe, Competent providers'	year period through a statement of requirements. – This will be underpinned by regular briefings to potential providers in order that the opportunities can be understood and potential bidders are able to develop provision and become 'business ready'. – Increasing opportunities for self-reliance and community resilience	✓ Increased inward investment in the city ✓ New providers / services create jobs ✓ Waiting times for new services are within agreed targets, expected outcomes are achieved ✓ There is demonstrable development of business start-ups ✓ Equality of provision is achieved across all the city's communities
What will change as a result of our plans: ✓ Patients and service users will have more choice and greater provision in their communities. ✓ Equality of provision willbeachieved across all the city's communities. ✓ Services will be joined up and more responsive to patient, service user and carer needs.		

E. Delivering sustainable finances

E3. Deliver Enabling Plans (eg IT, Communications, OD, Estates and Workforce)

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Information Technology • By 2019 the information technology used by the CCG, its GPs and the local health economy will support innovation and the requirement for IT systems to "talk to each other". • Our IT systems will enable the provision of a comprehensive patient record for clinicians to use in supporting the delivery of joined up health and care services for patients.	– The programme of work should be close to completion by with mobile working in place to support care provided to patients outside of a hospital setting.	✓ An agreed IT strategy and action plan is in place ✓ Development group established to drive and monitor progress against the strategy, ensuring close working with the Better Care Southampton programme. ✓ Roll-out of testing during 2016/17 ✓ Our IT Development Group will monitor the progress.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Business Intelligence • GP members will routinely receive detailed information in relation to their usage of acute capacity, enabling them the nature and pattern of understand referral and how this compares with an indicative budget. • GPs will be able to query patient level data (in relation to their patients) to inform assessment of need the commissioning of the right pathways and services. • Sources of data will be better integrated to provide a single view of activity between the CCG and Providers – this will be providing us with an increased complexity and depth of analysis, improving our ability to easily compare provider performance and benchmark locally.	– We will have fully mapped data sources to support our work across the commissioning cycle. – A significant project to strengthen the ability of the Provider Management Service to scrutinise providers in key areas and to improve provider management reporting to us will be concluded and findings implemented. – Work to enable integration of data sources will be complete.	✓ Our IT Development Group will monitor the progress of this workstream.
Communications & Engagement • People will be involved in planning, developing and monitoring services at all levels. • We will have a strong reputation as an open, responsive, clinically led and successful organisation. • Patients and services users will be able to access information sources about what is going on, about their care and about their choices in a variety of ways and formats – from traditional paper and print to the very latest in mobile accessible information, • Staff and clinical members will feel part of our organisation, our communities and our success.	Through our communications strategy and plan and our engagement plan, we will have: – Created a range of opportunities for people to be involved with our work, making the most of user-led technologies to encourage participation and engagement with protected groups. – Established up easy to use channels to gather patient feedback and ensure this is suitably analysed and used to support decision making – Engaged member GP practices in our work, encouraging and enabling them to become champions and leaders of change and innovation – Developed and implementing plans for: media, campaigns, web/digital & social media, and internal communications (as part of the overarching strategy) as essential enablers for the above achievements. – Established or become members of networks across the public and voluntary sector (living the ethos of integration) to work together in partnership to ensure messages, opportunities, innovations and collaborations are used to maximum effect and impact.	✓ Agreed communications strategy and action plan published during 2014/15 ✓ Year on year improvements in staff, members and patient feedback (/surveys) scores which test how engaged, informed, involved people feel. ✓ Stakeholder reputation survey ✓ To test progress and to ensure findings support decision making.

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
Organisational Development (OD) • To have further developed the capability and capacity of individuals, teams, departments and members of the governing body • There will be continued dedicated time for all member practices set aside for audit, research, education and training • Our staff, members and partners recognise the vision, mission and values of our CCG, enacting and championing them as appropriate. • Our organisation is recognised as a leader integration and attracts the highest calibre clinical and management talent.	– OD plan in place delivering: o Development of clinical leadership roles o Review of effectiveness each year o Chair to undertake 1-1 sessions to plan for future leadership of the CCG o Facilitated development programme for board members o An embedded performance development framework to enable and support delivery on an individual, team and organisational level o An enhanced appraisal process which reviews performances and aligns staff to our goals; roles and responsibilities are clear and learning and development is identified and supported (supported by PDP's) o An organisation where membership and core CCG business are one and the same; GP members feel involved, valued and recognise opportunities to influence and drive improvements o Clarity across the organisation of our vision, mission, values and objectives – For TARGET to be in place 6 times a year (four main events and two in house events)	✓ Clinical involvement and engagement in projects and service re-design with regular review with the Chair, Clinical Executive Group and Board ✓ Ongoing programme of TARGET days and evaluation ✓ Agreed OD and action plan in place ✓ Staff survey responses ✓ Appraisal completion rates and quality assurance ✓ Membership survey responses ✓ Recruitment & retention performance.
Workforce • We will achieve the standards set out in the 'Mindful Employer' Charter • Staff feel valued, supported and properly organised to deliver our ambition programme	– We will have completed a formal assessment under the Mindful Employer Charter, using outcomes and recommendations to help us achieve the standards set out – Policies and procedures will be fully operational to ensure a safe and healthy work place – Develop channel to effectively work with and support member practices – Clear links with OD and communications are made and maintained	✓ Mindful Employer status ✓ Staff survey results ✓ Turnover, recruitment, retention and sickness rates ✓ Exit interview data
Estates • Health estate will be rationalized as part of a wider City Programme to better manage the public estate and thereby ensure value for money	– Working jointly with the council, partners, patients and the public, we will have developed a plan that rationalizes the Public Estate in Southampton City. – Phase one covering three strategic sites will be underway.	✓ Agreed estates strategy and implementation plan in place ✓ Clear rationale and intended benefits understood

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
		✓ Estates strategy enables joined up working and service integration.

What will change as a result of our plans:

✓ We will be high performing, lean CCG organised in the most effective ways, using highly committed skilled staff and GP members to help drive and deliver our vision of *A Healthy Southampton for All*

E. Delivering sustainable finances

E3. Deliver Enabling Plans

Research & Innovation

What we plan to do by March 2019 (our aims)	What we will achieve by 2017 (our expected progress)	How we will track our progress
• Our commitment to research and innovation will be delivering benefits across our entire strategic programme with a continuous pipeline of activity that stretches beyond the life of our current 5 year strategy	– Report and recommendation from the formal assessment of the integrated care demonstrator site in Woolston and Weston will have produced results for diffusion across the city and beyond. – Demonstrable use and return on investment from our commitment to the University of Southampton's to Whole System Capacity Modelling Tool and use of discipline of "Systems Dynamics", Operational Research Techniques	✓ Demonstrable contributions to priority setting of the Collaboration for Leadership in Applied Health Research and Care ✓ Membership of the Wessex Academic Health Science Network ✓ Active participation in Southampton Connect, an inter-sectoral forum that includes both universities in the City. ✓ Reports from formal research projects, particularly those underway in partnership with University of Southampton ✓ The development of a Whole System Capacity Modelling Tool (in partnership with University of Southampton)

What will change as a result of our plans:

- ✓ Research and Innovation will be central enabler in the way we approach planning and development of service provision
- ✓ Our work will yield local and national benefits
- ✓ Patients will benefit from improved outcomes and a safe and sustainable local healthcare system.

NHS
Southampton City
Clinical Commissioning Group

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		PRIMARY CARE DEVELOPMENT		
DATE OF DECISION:		30th JULY 2014		
REPORT OF:		CHIEF OFFICER, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296923**
	E-mail:	**Stephanie.ramsey@southampton.gov.uk**		
Director	**Name:**	**John Richards**	**Tel:**	**023 80**
	E-mail:	**John.Richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
NOT APPLICABLE				

BRIEF SUMMARY

The delivery of high quality primary care services is a fundamental part of achieving improvements in health and wellbeing within the city and a main contributor to the key themes in the joint Health and Wellbeing Strategy. Expectations on primary care to support a different model of health service delivery are high and ever rising at a time that pressures are increasing and capacity is significantly impacted upon.

There is a recognised need for a clear strategic approach to supporting the development of general practice to create a model of primary care that is sustainable long into the future. The Phase 1 Report of 'A Call to Action for General Practice' describes a model of general practice that operates at greater scale and in greater collaboration with other providers, professionals, patients, carers and local communities. It also pledges to support more efficient ways of working and remove unnecessary bureaucratic burdens on general practice to free up time for delivery of more proactive, person-centred care. General Practice is recognised as a key enabler in the successful delivery of co-ordinated care.

However Primary care is commissioned by several different routes currently and this reduces the ability to develop a coherent strategy for development that is agreed and owned by practices which will help to define the actions to support the improved quality, capability and productivity of primary care and to create capacity to ensure that patients received the very best in primary care.

Clinical Commissioning Groups have the opportunity to co-commission primary care in partnership with NHS England and Southampton City CCG has recently submitted an expression of interest to take on delegated responsibility for commissioning elements of primary acre . Co-commissioning is potentially a very useful enabler and is likely to have a significant impact on strategic planning over the next five years.

RECOMMENDATIONS:

(i) The Board is asked to support the Expression of Interest for Southampton City Clinical Commissioning group undertaking Co-commissioning of primary care with NHS England

REASONS FOR REPORT RECOMMENDATIONS

1. Co-commissioning gives us an opportunity to accelerate progress on the redesign of primary care and link this in with the ambition for integrated care.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. The alternative option would be to do nothing and continue with the current disjointed approach; move to greater CCG involvement in influencing commissioning decisions made by NHS England area teams or joint commissioning arrangements, whereby CCGs and area teams make decisions together, potentially supported by pooled funding arrangements. None of these options will allow the CCG and Health and Wellbeing board to have the influence required to meet the needs of our local population and to make changes to the strategic direction at the scale and pace needed.

DETAIL (Including consultation carried out)

3. In May 2014 Simon Stevens, Chief Executive of NHS England, announced a new option for Clinical Commissioning Groups to co-commission primary care in partnership with NHS England. Clinical Commissioning Groups were asked to submit expressions of interest to develop new arrangements for co-commissioning of primary care services by the 20th June 2014.

4. There are currently three organisations directly contracting with practices for services:
   - NHS England, Wessex Area Team, lead contracting for general medical services and enhanced contracts for additional work plus Public Health Wessex for immunisations and screening
   - Clinical Commissioning groups hold some local contracts for clinical services and local improvement schemes such as phlebotomy
   - Local authorities hold some local contracts for public health related local improvement schemes such as NHS Health checks, chlamydia screening, smoking cessation.

5. The intended benefits of co-commissioning are:
   - achieve greater integration of health and care services, in particular more cohesive systems of out-of-hospital care that bring together general practice, community health services, mental health services and social care to provide more joined-up services and improve outcomes
   - raise standards of quality (clinical effectiveness, patient experience and

patient safety) within general practice services, reduce unwarranted variations in quality, and, where appropriate, provide targeted improvement support for practices

- enhance patient and public involvement in developing services, for instance through asset-based community development
- tackle health inequalities, in particular by improving quality of primary care in more deprived areas and for groups such as people with mental health problems or learning disabilities.

The submission of interest needed to show how they would help with the achievement of these outcomes and how they fit with the Clinical Commissioning Groups' five year strategic plan.

6. Commissioning of primary care encompasses a wide spectrum of activity, including:

- working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities
- designing and negotiating local contracts (e.g. PMS, APMS, any enhanced services commissioned by NHS England)
- approving 'discretionary' payments, e.g. for premises reimbursement
- managing financial resources and ensuring that expenditure does not exceed the resources available;
- monitoring contractual performance
- applying any contractual sanctions
- deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice mergers.

7. There are a number of potential forms that co-commissioning could take, for instance greater Clinical Commissioning Group involvement in influencing commissioning decisions made by NHS England area teams or joint commissioning arrangements, whereby Clinical Commissioning Groups and area teams make decisions together, potentially supported by pooled funding arrangements.

8. However after detailed consideration by the CCG members and the Governing body the CCG is proposing to move to a position of Delegated commissioning arrangements for the functions outlined above. In this instance the Clinical Commissioning Group will carry out defined functions on behalf of NHS England and the area team will hold the Clinical Commissioning Group to account for how effectively they carry out these functions. The CCG has no desire, or capacity, to take on the transactional operations and activities that are associated with these functions and instead would prefer to agree a contractual arrangement that allows NHS England to discharge these functions on the CCG's behalf.

9. A number of functions were explicitly excluded from the potential Expressions of Interest which included Management of Performers List,

revalidation, appraisals and commissioning for community Pharmacy and Dental services. However the CCG has expressed a willingness to be involved in joint commissioning of Community Pharmacy Services. The current arrangement means that opportunities for the CCG to interact with community pharmacists are limited. There are concerns about the quality and safety of essential services that are difficult to address without a formal role in commissioning the service. Co-commissioning will provide the opportunity to build closer local links that can better support contractors by more focused input from a dedicated CCG-specific Medicines Management Team.

10. The submission was made to NHS England on 20th June and is now being assessed.

RESOURCE IMPLICATIONS

Capital/Revenue

11. To be determined.

Property/Other

12. Not applicable

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. There will be delegated authority. The CCG will be held to account by NHS England

Other Legal Implications:

14. Publications Gateway Ref. Number 01599 Co-commissioning of primary care services

POLICY FRAMEWORK IMPLICATIONS

15. Not applicable

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.	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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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		PHARMACEUTICAL NEEDS ASSESSMENT (PNA)		
DATE OF DECISION:		30 JULY 2014		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Rebecca Wilkinson**	**Tel:**	**023 80 833871**
	E-mail:	**rebecca.wilkinson@southampton.gov.uk**		
Director	**Name:**	**Andrew Mortimore**	**Tel:**	**023 80 833738**
	E-mail:	**andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report is to inform members of the Health & Wellbeing Board of their statutory duty with regard to the Pharmaceutical Needs Assessment (PNA). The report also explains the approach being undertaken to fulfil this duty and the timetable for this work.

Members of the Board are asked to note what future input will be needed from them to ensure that the PNA is delivered appropriately and to the statutory deadline.

RECOMMENDATIONS:

(i) The Board acknowledge the statutory requirements of the PNA

(ii) The Board acknowledge the approach being taken to complete the PNA by the statutory deadline of 1st April 2015.

(iii) The Board consider how they can support the stakeholder consultation element of the PNA process

REASONS FOR REPORT RECOMMENDATIONS

1 Due to the latest legislation the Board is now responsible for completing a PNA by 1st April 2015.

2 Due to internal resource constraints and revised requirements for a PNA, it is no longer feasible for this work to be completed internally by the Public Health team and, therefore, the decision has been made to contract the work to a private provider.

3 There is a legal requirement for a 60 day consultation with stakeholders on the draft PNA. Members of the Board, and the organisations they represent, are well placed to support this consultation process.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

4 A simple refresh, by the Public Health team, of the 2010 PNA was considered but rejected due to capacity issues and also due new legislative requirements now set for the PNA.

DETAIL (Including consultation carried out)

5 The Health and Social Care Act 2012 gave the Health and Wellbeing Board for Southampton the statutory duty to develop and publish a Pharmaceutical Needs Assessment (PNA) for the city by April 1st 2015. This process includes formal consultation with specific stakeholders for a minimum of 60 days.

A PNA describes currently provided community pharmaceutical services and gives recommendations to address identified gaps, taking into account future needs. A PNA supports the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers.

The most recent Southampton PNA[1] was produced in 2010 and, although it is a useful reference, subsequent changes in guidance mean that a simple refresh of this report is not appropriate. Due capacity issues in the Public Health team, there is insufficient resource internally to undertake this statutory piece of work. Therefore, the decision has been made to contract this work out to a private provider.

The requirements for a PNA are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013[2]. These regulations cover the minimum information to be included in a PNA, the matters which must be considered, and the process to be followed.

These regulations explain that the PNA is no longer a traditional needs assessment that the Public Health team are experienced in producing. Instead it is a tool for control of market entry and should only include those pharmaceutical services commissioned by NHS England. As the purpose of a PNA is to support market entry decisions, this document will not deal directly with the provision of public health activity within pharmacies but will link to relevant strategies and needs assessments.

Following the publication of the PNA in 2015, there is a requirement to refresh the PNA within 3 years, or sooner if there has been a significant change. The PNA must include a map of current pharmacy locations and this must be kept up-to-date (all other data in the PNA is to remain static).

The procurement process has begun. The formal invitations to tender were sent on 26/06/2014 and the deadline for quotes is 11/07/2014 and we anticipate that the contract will be awarded by 18/07/2014. This will allow the

[1] http://www.publichealth.southampton.gov.uk/Images/PNA_November_19th_v2.pdf
[2] http://www.legislation.gov.uk/uksi/2013/349/contents/made

provider to start work week commencing 21/07/2014.

Providers have been asked to submit plans for producing the PNA according to the following timetable. Members of the Board are asked to note the dates of future meetings where the developing PNA report will need to be discussed and eventually approved:-

6

Date	Task	Responsibility
26/06/2014	Invitations to tender sent to potential providers	Public Health
11/07/2014 5pm	Deadline for submission of quotes	Potential providers
16/07/2014	Evaluation meeting to decide preferred provider	Public Health (& NHS England)
18/07/2014	Award contract	Public Health
23/07/2014 10.30am	Initial meeting between PH and chosen provider	Public Health & provider
23/07/2014 11.30am	First steering group meeting	Provider with Public Health support
31/07/2014	Identification of stakeholders for engagement and consultation	Provider with Public Health support
01/10/2014	Presentation of pre-consultation draft to **H&WB Board**	Provider
Until 31st Dec 2014	60 day consultation	Provider
28/01/2015	Post-consultation draft to **H&WB Board**	Provider
25/03/2015	Approval of final PNA by **H&WB Board**	Provider
31/03/2015	Publish final PNA on Public Health website	Public Health

Members of the Board are also asked to consider how the organisations they represent can support the stakeholder consultation element of the PNA.

A steering group for the PNA is being established. Members of the steering group will include:-

Debbie Chase Consultant in Public Health
Dan King Senior Public Health Information Specialist
Julia Booth Contracts Manager (Pharmacy)
Sue Lawton Locality Lead Pharmacist for West
Rob Kurn Healthwatch Manager

Debby Crockford   Chair of LPC

Representatives from the chosen PNA provider

RESOURCE IMPLICATIONS

Capital/Revenue

7 There will be a cost for procuring the services of a private provider to conduct the PNA. This will be met from the 2014/15 Public Health budget. There are also resource implications in terms of staff time to manage the contract and collating some data. The stakeholder consultation has resource implications for the Public Health team, other SCC departments and for partner organisations.

Property/Other

8 None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

9 As stated above, the requirements for a PNA are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013[2].

Other Legal Implications:

10 None

POLICY FRAMEWORK IMPLICATIONS

11 None

KEY DECISION? N/A

WARDS/COMMUNITIES AFFECTED:

The PNA covers the whole city but areas of disadvantage and their access to pharmaceutical services will be a major consideration

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.	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	

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		SOUTHAMPTON CITY POLICY STATEMENT FOR WORKING WITH CHILDREN AND ADULTS WITH LEARNING DISABILITIES WHOSE CARERS AND/OR SERVICES ARE CHALLENGED BY THEIR BEHAVIOUR		
DATE OF DECISION:		30th JULY 2014		
REPORT OF:		DIRECTOR QUALITY AND INTEGRATION, SOUTHAMPTON CITY COMMISSIONING, SOUTHAMPTON CITY COUNCIL		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296923**
	E-mail:	**stephanie.ramsey@southamptoncityccg.nhs.uk**		
Director	**Name:**	**Alison Elliott, Director of People** **John Richards , Chief Executive**	**Tel:**	**023 8083 2602** **023 8029 6923**
	E-mail:	**Alison.Elliott@southampton.gov.uk** **John.Richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The Winterbourne View Final Report Transforming Care was released in November 2012. This followed an investigation into physical and psychological abuse suffered by people with learning disabilities and challenging behaviour at Winterbourne View private hospital. Transforming Care requires that by April 2014, each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care set out within Transforming Care.

Good practice guidance on supporting people with learning disabilities, autism and those with behaviour which challenge emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs/challenging behaviour
- that services/support should be provided locally where possible.

Southampton's Joint Challenging Behaviour Policy Statement and associated action plan is our response to this requirement. To deliver this, the Challenging Behaviour Local Implementation Group was formed, which has representatives across Southampton's statutory and voluntary sector.

The Challenging Behaviour Policy Statement identifies areas of development that will

support commissioning intentions including ensuring systems are in place for preventative measures and early identification of those at risk, in order to avoid crisis. Also ensuring that those with the most complex needs, who are currently living within in-patient settings, are supported locally, with good quality provision. Service development will be tested within the commissioning cycle, to ensure improved individual outcomes.

In January 2014 Southampton's Health and Wellbeing Board was requested to support further consultation regarding the policy statement and for commissioners to scope and design the action plan. The action plan runs from 2014 – 2016. This is a live document and will be refreshed on an ongoing basis.

Information within the Southampton City Policy Statement for Working with Children and Adults with Learning Disabilities whose Carers and/or Services are Challenged by their Behaviour has been consulted on with various stakeholders across the city. Appendix 3 within the Policy Statement shows a summary of this consultation.

RECOMMENDATIONS:

(i) Southampton Health and Wellbeing Board is requested to support the final Joint Commissioning Policy Statement for Working with Children and Adults with Learning Disabilities whose Carers and/or Services are Challenged by their Behaviour.

(ii) Southampton Health and Wellbeing Board is requested to support the Joint Action Plan Working with Children and Adults with Learning Disabilities whose Carers and/or Services are Challenged by their Behaviour.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the governance arrangements outlined in the Winterbourne Concordat there is a requirement to gain Health and Wellbeing Board validation.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. The Department of Health has indicated it expects Health and Wellbeing Boards to be confident that the right leadership and infrastructure is in place to secure delivery of the plan and reporting of the self-assessment required.

DETAIL (Including consultation carried out)

3. The Challenging Behaviour LIG includes members from Health and Social Care across children's and adults' services. Throughout the process we have engaged with stakeholders including service users and their families/carers, Advocacy agencies, Solent NHS Trust, Southern Health Foundation Trust, Voluntary Sector and Housing.

4. The Policy Statement provides the city with a clear direction of travel within

it's vision, objectives and outcomes for the next five years in order to make necessary changes to support improvements in health and well-being for individuals who present behaviour that is challenging.

5. The key areas of priority for the policy include ensuring:
   - safeguarding systems are proactive, rather than reactive;
   - the safety of persons at risk by integrating strategies, policy systems and services within the framework of relevant legislation and promotion of human rights.
   - that prevention occurs in the context of person-centred support and personalisation, empowering individuals to make choices and supporting them to manage risks
   - that the health and social care system have robust quality monitoring in place
   - that information systems are capable of identifying and recording people with challenging behaviour across health, education and social care systems
   - there is comprehensive implementation across GP practices of annual physical health checks, with targeting of individuals at high risk, with access to expert opinion if needed.
   - that the outcomes for young people who present challenges are improved through the development of the 0-25 SEND Service
   - that plans are in place that meet the needs of people with learning disabilities who are ageing

6. The key areas for improvement (service gaps) include the following themes:
   - People living Out of Area
     - To develop supported living services for individuals currently living in inpatient care and residential care facilities, by implementing Complex LD Housing Business Case
     - Review how adults "at risk" due to challenging behaviour are monitored and supported through the Winterbourne at risk register, taking learning from children's services.
   - Access to meaningful activities
     - To improve the vocational educational opportunities for individuals and develop supported employment for individuals "at risk" due to challenging behaviour
     - To review day activities available to "at risk" individuals
   - Healthcare
     - To review the role of the Community Learning Disability Team and the Intensive Support Team
     - To ensure that all individuals at risk due to challenging behaviour have an annual health check, are supported to access all relevant screening programmes
     - To review how GP's are supported to assess, diagnose and treat individuals with highly complex needs, taking learning from children's services.
     - To review all physical intervention approaches to ensure that

individuals and cares are safe and well supported.
  -

- Housing – supported by the Complex Housing Group
  - To strengthen partnership work with housing providers to ensure that suitable accommodation is available, to prevent crisis, reduce admissions to inpatient services and prevent placement in residential care out of area.
- Carers/siblings & Respite and short breaks
  - To ensure that carers and family siblings are well supported, have access to appropriate training and respite care is available.
- Education
  - To ensure that children and young people at risk are supported and special schools work in partnership with families.
  - To consider pathways re residential provision for children within the city
- Transition
  - To implement Children and Young People Development Service (0 – 25 years) and ensure that individuals and families have access to specialist knowledge and skills to assess and manage behaviour that challenges.
- Workforce Development
  - To development and audit of a Good Practice Standards Checklist and develop a system wide workforce strategy.

7. The Action Plan (Appendix 1) identifies how these areas will be addressed. Additionally, Southampton's Lifelong Autism Strategy 2012 – 2015 provides a strong outline of the City's need as well as a clear vision and action plan. Key areas for action aimed at improving the lives of children and adults with autism, including increasing awareness, ensuring access to diagnosis, improving access to services such as education and employment. The Strategy is not just about putting in place autism services but about enabling equal access to mainstream services, support and opportunities. This Strategy is currently being refreshed in line with the national strategy Think Autism.

RESOURCE IMPLICATIONS

Capital/Revenue

8. Within the Integrated Commissioning Unit (ICU) the Challenging Behaviour Action Plan will be implemented with ICU lead working across the system.

9. Evidence has shown that supporting people whose behaviour challenges with the correct model of care generates efficiencies.

Property/Other

10. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11. Autism Act 2009
    Equality Act 2010

Other Legal Implications:

12. None.

POLICY FRAMEWORK IMPLICATIONS

13. LD Joint Health and Social Care Self-Assessment Framework (JHSCSAF)
    Valuing People Now (2009)
    Fulfilling and Rewarding Lives (National Adult Autism Strategy report (2010)
    Think Autism (2014)
    Transforming Care: A National Response to Winterbourne View Hospital Dept Health Final Report (2012)

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Southampton City Challenging Behaviour Action Plan 2014 – 2016
2.	Southampton City Challenging Behaviour Policy Statement

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: Contact Kate Dench kate,dench@southampton.gov.uk

	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.	The Winterbourne View Final Report – DH	
2.	The Concordat of Action – DH	

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Southampton City Challenging Behaviour Action Plan 2014 – 2016

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Area of Development (as per policy statement)	Outcome based on recommendation from Policy Statement	Action/s required	Lead/Group Responsible	Completion Date
People out of Area				
A1				
	Southampton's Winterbourne View register established to improve risk management and implementation of care plans, preventing crisis and improve the planning and delivery of services locally.	• Formal review Southampton's current register to include review of Care Coordination role for people who are responsibility of NHS England (Secure LD services) and treatment plans to articulate outcomes. Need to be in line with national guidelines on CPAs. • The review to take the learning from the existing Multi Agency Resource Panel process in place in local Childrens services to align processes. • The review to consider children in long term residential care as a result of challenging behavior and learning disabilities	Kate Dench	June 2015
A2				
	Personal Health Budgets infrastructure supports people with challenging behavior, and is in line with the target of 2% increase year on year, resulting in more personalised, local services that offer choice and meet need.	• Reasonable adjustments need to be made and included in the Knowledge Hub and Peer Support so that the infrastructure is responsive to their needs • Continue our drive for increased uptake of personal health budgets in Continuing Healthcare • Scope and develop opportunities for Personal Health Budgets for key groups, tracking those with learning disabilities to ensure best practice is applied.	Sandy Jerrim	April 2016
Access to meaningful activities				
B1	Outcome based on recommendation			
	Day support services ensure clients	• Work with key stakeholders to review current provision	Sandy Jerrim	March 2015

	and families are well supported with a range of person centred options that work to reducing levels of challenging behaviour	against needs of this group • Implement market development options as a result of any changes identified • Monitoring of behaviours linked to contracts/service requirement demonstrates robust plan covering recruitment/training/use of DoH guidelines for Positive Behaviour Support		
B2	Outcome based on recommendation			
	Skills and Supported Employment to be available to those people presenting challenges to services/carers	• Review provision of Supported Employment and fit with broader services (coordinating efforts with the Department of Work and Pensions/Skills and Regeneration). • Development of Skills and Employment Strategy ensuring a route to employment opportunities for people with complex needs	Denise Edgehill	March 2015
B3	Outcome based on recommendation			
	Learning Disabilities Advocacy to be available to those with behaviour that challenges, including those individuals that live outside of the area and through the safeguarding processes	• Review of Southampton's advocacy services • New model to be agreed August 2014 • Procurement to commence September 2014 • Placement guidelines to ensure that all people that are living out of area that require advocacy support, are facilitated to gain access to advocacy.	Adam Wells	March 2015
Health care for individuals at risk due to challenging behaviour				
C1	Outcome based on recommendation			
	Annual Health Checks for people with Learning Disabilities are offered to those that may challenge services, and reasonable adjustments are made to support access and improved quality of the checks	• Joint work with Southern Health Foundation Trust to implement CQUIN re LD Annual Health Checks • Data report on uptake of people with more complex needs to support city wide plan re improvement in uptake • Training offered to all staff as part of broader case/care management review training.	Sam Ray	March 2015
C2	Outcome based on recommendation			

	Health Action Plans templates are widely available and used throughout services so that prevention/early intervention is across the system	• Health action plan template agreed • Plan to distribute including main channels identified, including links to wider health and social care assessment • Quality team support to embed • Contractual requirements embed • Development work undertaken at forums such as residential and domiciliary/Learning Disabilities Partnership Board	Sam Ray	April 2014
C3	Outcome based on recommendation			
	Improved uptake and diagnosis rates of cervical and bowel cancer	• A programme regarding improved coding based on needs assessment work undertaken with primary care to be put in place • Obtain evidence of reasonably adjusted services linked to screening services/lessons learned to be shared • Accountability issues to be resolved with Wessex AT	Sam Ray	March 2014
C4	Outcome based on recommendation			
	Individuals presenting with challenging behaviours have access to expert physician/s support so that health management is robust	• To review access to physician support during the Intensive Support Team review (linked to the Challenging Behaviour Pathway). • Adjustments to be made to the pathway, based on feedback from the review.	Ian McDonald	September 2014
C5	Outcome based on recommendation			
	Update the Joint Strategic Needs Assessment to ensure the health needs for Learning Disabled population are recognised.	• Undertake data snapshot during Qtr 2 2014 of Learning Disabilities health and social care needs. Develop summary to evidence with the Joint Strategic Needs Assessment. • Ensure equality profiles are built into commissioning and operational practice requirements • Work with commissioners to design a statement requiring equality of access to services and share best practice examples from providers	Sam Ray	October 2015

C6	Outcome based on recommendation			
	Southampton's Adult Intensive Support Team are delivering the required outcomes in relation to a reduction in residential placements/crisis management/behavioural support plans	• Service review with updated specification • Monitoring through Contract Quality Review Meetings (CQRM).	Ian McDonald	September 2014
C7	Outcome based on recommendation			
	The Community Learning Disability Adults Specialist Team is able to proactively support people with challenging behaviours.	• To link with H1. To be undertake as part of full service review for Learning Disabilities Community Team.	Ian McDonald	June 2015
C8	Outcome based on recommendation			
	Individuals can access telecare and telemedicine technology to support the assessment, monitoring and care and support of individuals	• Telecare Business Case to be drafted to support city wide telecare/telehealth services to support key groups such as carers/long term conditions/those at risk of falls. Ensure any newly commissioned services make reasonable adjustments to the services and this is monitored	Sandy Jerrim	(TBC) 2015
C9	Outcome based on recommendation			
	There is access to local learning disabilities inpatient bed provision for individuals who present challenges and the quality of the provision meets standards required so the pathway is efficient and effective.	• Liaise with West CCG regarding opportunities for access agreements services commissioned. • Implement the SHIP wide plan with Wessex Area Team • Undertake trajectory/planning work with Wessex regional network for those stepping up/down from inpatient services.	Ian McDonald	September 2014
C10	Outcome based on recommendation			
	Mental health needs of individuals with a Learning Disability (adults) ensure that service pathways implement reasonable adjustments. In children's	• Development of Green light Action Plan (MH and LD services plan), to ensure services meet demand appropriately. • Plan to ensure that access to appropriate mental health	Katy Bartolomeo	December 2014

	services ensure gap is bridged with 0-25 SEND services and broader health services if necessary e.g. Children and Adolescent Mental Health Service (CAMHS).	support meets needs within children's services		
C11	Outcome based on recommendation			
	The least restrictive approaches are being used in the city (and for commissioned placements)	• Map Southampton's current practice against Positive and Proactive Care policy guidance (DoH March 2014). Links to H1. • Develop city wide plan which all stakeholders sign up to.	Sue Lickley	March 2015
Housing				
D1	Outcome based on recommendation			
	Bespoke housing is available for individuals who are placed out of area (and those that require Supported Living Services)	• Implement the LD Complex Housing Business Case • Housing market provider event • Develop partnership agreement for housing developments • Review clients and establish housing needs • Development of a Vulnerable Persons Housing Strategy to align with SCC's Housing Strategy	Adrian Littlemore Matthew Waters	September 2016 April 2015
D2	Outcome based on recommendation			
	The Disabilities Housing Panel ensures that housing needs are met for people with challenging behaviours.	• Review completed with new Terms of Reference	Lee Simmonds	September 2014
Carers/siblings & Respite and short breaks				
E1	Recommendation			
	City wide services for Carers Strategy ensure that carers and siblings of individuals with learning disability who present challenges are recognised as a priority.	• Current carers support services recognise the needs of people with learning disabilities (new services to commence 1st September 2014) • Expression Of Interest put out to market for the next joint carers strategy to redevelop the Carers Strategy. • Assessments of individuals and carers needs to	Sandy Jerrim	January 2016

		recognise the role and impact on siblings and consideration given to recognising the benefit of accessing young carer services via Young Carers Services. (new services to commence 1st September 2014) • Review of hidden carers includes young carers. • Older carers needs to be specifically addressed within carers services • Review of respite to link to this outcome (E2). Working with families and carers in a coproductive way with flexible approaches to care is essential		
E2	Outcome based on recommendation			
	Learning Disabilities Respite provision to widen opportunities for those with behaviour that challenges, including the use of increased personalised approaches respite provision	• Complete review of respite services and develop services to ensure needs are met based on coproduction methods	Kate Dench	March 2015
Schools/education				
F1	Outcome based on recommendation			
	MASH/Early Help/Head Start to offer effective and efficient services to children and young people presenting with challenging behaviour.	• Develop a mechanism to identify children displaying challenging behaviour • Establish reporting processes and any impacts from Early Interventions and Head Start to monitor outcomes • Multi professional team review of five case studies to demonstrate improvements in effective working, building into service reviews.	Ed Harris	April 2015
F2	Outcome based on recommendation			
	Parents and carers will be better skilled to support the children they look after that display challenging	• Links to H1 and C5 as the requirement to support unpaid carers needs to link strategy to Intensive Support and Workforce Development plans	Ed Harris	April 2016

	behaviour	• Consideration with education regarding early intervention support for parent carers		
F3	The least restrictive interventions are used within schools and a programme of Positive Behavioural Support is embedded to ensure better outcomes and reduction in challenging behaviours	• Review of restrictive interventions, mirroring aligning to Positive and Proactive Care policy guidance (DoH March 2014) and DfE guidelines. • Southampton to develop a plan to ensure that key areas such as Key Principles and Southampton's Guidance Framework is agreed and audited.	Ed Harris	April 2014
Transition				
G1	Outcome based on recommendation			
	To support the Children and Families Bill 2013 implementation which will extend the special educational needs (SEND) system from birth to age 25.	• Development of a 0-25 SEND Service that supports the use of EHCP up to the age of 25yrs. • To develop a " clear pathway for transition " as part of the 0-25 SEND Service utilising professionals from both adult and children's services (across partners)	Robert Hardy	Sept 2014 (for SCC) – April 2015 for wider integrated service April 2015
G2	Outcome based on recommendation			
	Review MARP/TOG in light of the implementation of Childrens and Young Peoples Development Service 0-25 SEND Service, ensuing that the clinical, social and educational needs of individuals are met into adulthood.	• TOG will be reviewed as part of the service delivery processes associated with the developing 0-25 SEND Service and the refocus on transition • TOG feeds into MARP therefore in light of a review of TOG there will need to be a review of the future role of MARP in relation to transition	Robert Hardy	Sept 2014 Dec 2014
G3	Outcome based on recommendation			
	Ensure that all transition plans will include person centred behaviour management plans which address the communicative functions of individuals.	• EHCP's are designed to be multi-professional, holistic and person centred and thus behaviour management and positive communication forms part of the overall planning which is contextualised including consideration within transition.	Robert Hardy	By Sept 2016 all those aged 16 and over who meet

				the criteria will have an EHCP
Workforce				
H1				
	Southampton's workforce plan supporting people with challenging behaviour will be based on Positive and Proactive Care (2014) to provide a framework to radically transform culture, leadership and professional practice to deliver care and support which keeps people safe, and promotes recovery.	• Map Southampton's current practice against Positive and Proactive Care policy guidance (DoH 2014) • Develop city wide plan which all stakeholders sign up to. • Note to include older carers.	Sue Lickley	March 2015
H2	Outcome based on recommendation			
	People supporting those with challenging behaviours will be able to communicate with individuals more effectively, using the Five Good Communication Standards (Royal College of Speech and Language Therapists 2013).	• Workforce plans to incorporate investment within the Five Communication Standards.	Sue Lickley	March 2015

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Southampton City Policy Statement for Working with Children and Adults with Learning Disabilities whose Carers and/or Services are Challenged by their Behaviour

2014 - 2019

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Appendix 3 – Consultation Report

1.0 Executive Summary

1.1 The Winterbourne View Final Report Transforming Care was released in November 2012. This followed an investigation into physical and psychological abuse suffered by people with learning disabilities and challenging behaviour at Winterbourne View private hospital. Transforming Care requires that by April 2014, each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care set out within Transforming Care.

1.2 Good practice guidance on supporting people with learning disabilities, autism and those with behaviour which challenge emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs/challenging behaviour
- that services/support should be provided locally where possible.

1.3 Southampton's Joint Challenging Behaviour Policy Statement and associated action plan is our response to this requirement. To deliver this, the Challenging Behaviour Local Implementation Group was formed, which has representatives across Southampton's statutory and voluntary sector.

1.4 The Challenging Behaviour Policy Statement identifies areas of development that will support commissioning intentions including ensuring systems are in place for preventative measures and early identification of those at risk, in order to avoid crisis. It also, ensures that those with the most complex needs, who are currently living within in-patient settings, are supported locally, with good quality provision.

1.5 In parallel to the work undertaken to refresh Southampton's Challenging Behaviour Policy Statement, Southampton's Autism Strategy Group have also been working to implement an action plan (2012-2015). There are obvious alignments within the work programmes due to the high incidence of co-morbidity of Autism/Learning Disabilities and Challenging Behaviour (20-30%). Southampton has made good progress in the area of Autism, which was reflected in the Autism Self Assessment Framework submission to Improving Health and Lives (IHAL) in September 2013.

1.6 This Policy Statement sets out our vision of how Southampton will respond to the needs of people with learning disabilities and behaviours that challenge, whilst meeting the needs of their carers.

1.7 The Challenging Behaviour includes members from Health and Social Care across children's and adults' services. Throughout the process we have engaged with stakeholders including service users and their families/carers, advocacy agencies, Solent NHS Trust, Southern Health Foundation Trust, Voluntary Sector agencies and Housing.

1.8 The Policy Statement provides the city with a clear direction of travel for the next five years in order to make necessary changes to support improvements in health and well-being for individuals who present behaviour that is challenging.

1.9 The key areas of priority within the Policy Statement include ensuring:

- safeguarding systems are proactive, rather than reactive;
- the safety of persons at risk by integrating strategies, policy systems and services within the framework of relevant legislation and promotion of human rights.
- that prevention occurs in the context of person-centred support and personalisation, empowering individuals to make choices and supporting them to manage risks.
- that the health and social care system have robust quality monitoring in place.
- that information systems are capable of identifying and recording people with challenging behaviour across health, education and social care systems.
- that there is comprehensive implementation across GP practices of annual physical health checks, with targeting of individuals at high risk, with access to expert opinion if needed.
- that the outcomes for young people who present challenges are improved through the development of the 0-25 SEND Service and associated pathway for transition.
- that plans are in place that meet the needs of people with learning disabilities who are ageing.

1.10 The key areas for improvement (service gaps) include the following themes and these have been informed through consultation with the Learning Disabilities Partnership Board:

- ➢ People living Out of Area
- ➢ The need to develop supported living services for individuals currently living in inpatient care and residential care facilities, by implementing the Complex LD Housing Business Case
- ➢ Reviewing how adults "at risk" due to challenging behaviour are monitored and supported through the Winterbourne at risk register, taking learning from children's services.

- ensuring access to meaningful activities
  - ➢ improving the vocational educational. opportunities for individuals and developing supported

employment for individuals “at risk” due to challenging behaviour.
  - reviewing day activities available to “at risk” individuals.

- Healthcare
  - reviewing the role of the Community Learning Disability Team and the Intensive Support Team.
  - ensuring that all individuals at risk due to challenging behaviour have an annual health check, are supported to access all relevant screening programmes.
  - reviewing how GP’s are supported to assess, diagnose and treat individuals with highly complex needs, taking learning from children’s services.
  - reviewing all physical intervention approaches to ensure that individuals and cares are safe and well supported.

- Housing – supported by the Complex Housing Group
  - strengthening partnership work with housing providers to ensure that suitable accommodation is available, to prevent crisis, reduce admissions to inpatient services and prevent placement in residential care out of area.

- Carers/siblings & Respite and short breaks
  - ensuring that carers and family siblings are well supported, have access to appropriate training and respite care is available.

- Education
  - ensuring that children and young people at risk are supported and special schools work in partnership with families.
  - ensuring there is provision for further and lifelong education for people with behaviour that challenges.

- Transition
  - implementing 0 – 25 Services and ensuring that individuals and families have access to specialist knowledge and skills to assess and manage behaviour that challenges.

- Workforce Development
  - development and audit of a Good Practice Standards Checklist and developing a system wide workforce strategy.

1.11 The scope of the Policy Statement includes:

- Children from birth through to adults of all ages who have a Learning Disability and Challenging Behaviour and who live within the boundaries of the city. In addition, the health aspects of the project will extend to those who are registered with a Southampton GP regardless of their Ordinary Residence.
- Children or adults who are currently not resident within the city but for whom the LA or Southampton CCG are the responsible commissioner, for example those individuals placed in out of area placements.
- The parents and carers of those with LD and Challenging Behaviour who meet the criteria above/or who are at risk of this.

1.12 To support the change needed, the Challenging Behaviour Local Implementation Group (LIG), was formed in October 2012. This group is committed to a programme of action to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them and to improve their quality of life.

2.0 Background

2.1 The Policy Statement aims to understand and support differing communities to ensure that services are fit for purpose. It will be respectful of culture and work in the individual's best interest with individual human rights paramount.

2.2 The overall aim of the Policy Statement is for people with learning disabilities, who present challenges, to be able to lead fulfilling and purposeful lives within their local communities, optimising their health and wellbeing.

2.3 The way that support has been delivered has changed considerably over the years. Until the 1950s, it was generally accepted that people with learning disabilities could enjoy a better quality of life living with other disabled people in segregated institutions rather than in the community with their families.

2.4 In 1971 the Government produced a White Paper "Better Services for the Mentally Handicapped" which recommended that long-stay hospital settings for people with learning difficulties should gradually be replaced with support in the community.

2.5 Thirty years later in 2001 they published the White Paper Valuing People: A New Strategy for Learning Disability for the 21st Century which committed the Government to helping people with learning

disabilities to live “as normal a life” as possible, without unnecessary segregation from the community.

2.6 Community services were developed, in the form of Locally Based Hospital Units (LBHUs) and an increase in residential care (group homes). Additionally parents were better supported to care for their children into adulthood.

2.7 Southampton set up a programme of work in 2005-2008 to move people from LBHUs to individualised supported living schemes within the city. Investment was made by the Department of Health which supports capital investment in housing. This programme was driven nationally by the Department of Health, under Campus Re-provision standards. The investment improved the quality of life for those individuals. However, no additional funding was identified from the Department of Health to support the ongoing generations of people requiring bespoke housing to support their needs. It is expected health and social care organisations will work with a broader range of stakeholders to develop local services to support ongoing need.

2.8 In 2007 the Department of Health released the Mansell Report “Services for people with learning disabilities and challenging behaviour or mental health needs” which highlighted that the lack of development of appropriate services for people with Challenging Behaviour had led to an increase in the use of expensive placements away from the person’s home and not necessarily of good quality.

2.9 Client engagement from the Valuing People National Policy group also highlighted that people wanted more independence and choice. The City Council has introduced Personal Budgets and a person who is eligible for adult social care funding can have their personal budget as a direct payment (paid directly into a bank account) or as part direct payment and part directly provided services (a traditional care package managed by the Council). Unlike direct payments in the past, a personal budget can be used more flexibly to meet a person’s assessed needs. Southampton City Council and Clinical Commissioning Group (SCCCG) are implementing Personal Health Budgets from April 2014 which will be actively offered for those individuals meeting Continuing Health Care needs.

2.10 Think Local Act Personal (TLAP) is a national, cross-sector leadership partnership focussing on maintaining the impetus towards personalised, community-based social care and is driving forward these changes which SCCCG support.. SCCCG is a pilot area for implementation of personal health budgets, and we are encouraging individuals and their families who may have behaviours that challenge to take control of their support. This will provide better outcomes for this population.

2.11 The Mansell Report (2007) describes a positive style of commissioning, where local services are sought that really do address individual needs, and therefore give higher priority to funding services with more staff and more training and management input.

2.12 Preventing challenging behaviour is achieved through understanding the reasons for a person's distress, by recognising their vulnerability, anticipating their needs and designing care accordingly.

3.0 What is Behaviour That Challenges?

3.1 This Policy Statement is about the practice of supporting people with learning disabilities who present behavioural challenges. The terms, 'challenging behaviour' and 'learning disability', are often applied with wide variation and inconsistency. Challenging behaviour is a description of a set of problems, not a diagnosis in its own right.

3.2 Mencap defines a Learning Disability as reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone people for their whole life. People with a learning disability tend to take longer to learn and may need support to develop new skills, understand complex information and interact with other people.

3.3 The Challenging Behaviour Foundation have identified that challenging behaviours are more common in people with a learning disability as compared to their peers without a learning disability.

3.4 The term 'challenging behaviour' has become distorted from its original meaning and has come to be misused as a diagnostic label. Severely problematic or socially unacceptable behaviour should be seen as a challenge to services rather than the person being stigmatised as being violent and aggressive. This Policy Statement seeks to respond to this challenge by promoting positive behavioural support, reducing the occurrence of damaging behaviour and maintaining people's access to a decent quality of life despite continuing behavioural difficulties.

3.5 This Policy Statement acknowledges the difficulty in defining and categorising behaviour which can be seen as subjective. There are differing understandings of the levels of challenging behaviour – for example an informal carer at home may classify behaviour at a different level than someone who is working in an inpatient setting. For the purposes of this document the following definitions around behaviour have been adopted:

- "We have defined Challenging Behaviour as culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour that is

likely to seriously limit use of, or result in the person being denied access to ordinary community facilities" (Emerson1995).

- The report “Challenging behaviour: a unified approach” (Royal College of Psychiatrists,: March 2007) proposes the adoption of a modified definition that builds on that of Emerson: “Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion”. This report indicates that a person with a learning disability may be expressing unhappiness in their current environment through their behaviour and that all behaviour has meaning or function and does not occur in isolation. It identifies that there are a number of underlying causes of behaviour that are a challenge to others.

3.6 One of the main functions of learning disability health teams in the UK is to work with people with a learning disability whose behaviour presents a challenge.

3.7 For the purpose of this document three categories of behaviour have been identified and it is acknowledged that this can be subjective to perception and experience:

1: **episodic behaviour** that challenges – mild behavioural difficulties that are not continuous.
2: **moderate behaviour** that challenges which is managed with the right support where the behaviour poses some challenge or risk to self or others.
3: severe behaviour that challenges and which poses a serious and constant challenge or risk to self or others.

3.8 Behaviour that Challenges is a demonstration of distress and an attempt by the person to communicate their unmet needs. It may result from an individual feeling threatened, fearful or anxious or be in response to a difficult situation, or a misinterpretation of the actions of other people. The behaviour can be in response to:

Environmental factors - for example:

- Over or under stimulating environments.
- Inappropriate supports.
- Poorly organised supports.
- Lack of understanding of support staff/carers.

Personal factors - for example:

- Mental ill health, autism, and syndromes with a risk of high behavioural support needs.
- Physical (for example pain).

- Emotional (for example bereavement).
- Communication difficulties.

3.9 The consequences of not addressing challenging behaviour can be far reaching and can include:
- Ineffective delivery of healthcare.
- An overreliance on anti-psychotic medication, seclusion and physical interventions (Restrictive Practice).
- An increase in physical injuries and psychological ill health among Clients, staff and families.
- Inability of an organisation to meet its legal duties to protect staff and vulnerable individuals.

3.10 This Policy Statement aims to improve the management of people who are at risk of behaviour that challenges whilst improving the approaches, skills and attitudes that minimise distress and meet needs. Practical strategies need to be developed to risk assess and manage behaviour that challenges.

3.11 Assessment and intervention must address the person, the environment and the interaction between the two as challenging behaviour is a product of an interaction between an individual and their environment. Historically challenging behaviour was managed by high levels of sedative medication and punitive approaches. These approaches are now discredited although a culture of blaming the individual is still present in services and society. Non-punitive approaches are now recognised as being best practice, rewarding and supporting positive behaviour.

4.0 Why changes need to be made

4.1 Historically individuals with learning disabilities who present challenges have often been excluded from some services or experienced restrictive or abusive care. These individuals have the same rights as others to an equitable service. This will be seen as inclusive services that provide a genuine choice of service options to people in their local community.

4.2 People with learning disabilities who present challenging behaviours are often marginalised, disempowered and excluded from mainstream society. Although long stay hospital provision has almost disappeared, there has been a growth in the provision of a range of residential and long stay care which can compromise the values of enabling people with learning disabilities to live ordinary, non- segregated lives.

4.3 In May 2011, The BBC Panorama programme – “Undercover Care: The Abuse Exposed”, showed disturbing scenes of people with a learning disability and autism being abused in a secure hospital at

Winterbourne View in Bristol. In October 2012 the BBC broadcast a follow up Panorama programme, "Winterbourne View - the hospital that stopped caring". Using undercover footage the programme revealed new evidence of poor training and false record-keeping.

4.4 The abuse revealed at Winterbourne View hospital was criminal. Staff whose job was to care for and help people instead routinely mistreated and abused them. Its management allowed a culture of abuse to flourish. Warning signs were not picked up or acted on by health or local authorities.. A key lesson is that when delivery of care is sub-standard, a person's distress can be exacerbated and perpetuated leaving staff unable to cope, and abusive practices can become the norm. The abuse at Winterbourne View Hospital had serious repercussions on the safety, wellbeing and dignity of patients.

4.5 In response to this the Local Government Association and NHS Commissioning Board (NHSCB) have established a joint improvement programme to provide leadership and support to transform services locally. This involves key partners including the Department of Health (DH), The Society of Local Authority Chief Executives and Senior Managers (SOLACE), the Association of Directors of Adult Social Services (ADASS) and Association of Directors of Children's Services (ADCS) and the Care Quality Commission (CQC) and will closely involve service providers, people with learning disabilities and autism and their families in their work. The Concordat aims are to:

- Ensure better care outcomes so that people have fulfilling and safe lives in local communities.
- Change and improve the quality of care and support for all people with learning disabilities or autism, who have mental health conditions or behaviour that challenges, and their carers.
- Transform the way services are commissioned and delivered, in a sustainable manner.
- Support local areas to work together to commission a range of personalised support, and
- Allow individuals a voice and a choice in how these services are designed and delivered.

4.6 For many people however, even the best hospital care will not be appropriate care. People with learning disabilities, which may include autism, will sometimes need hospital care but hospitals are not where people should live. Too many people with learning disabilities, which may include autism, are doing just that.

4.7 The Policy Statement identifies areas of development that will support our commissioning intentions including ensuring systems are in place for preventative measures and early identification in order to avoid crisis. The responses to the survey sent to families, carers, providers

and people whose behaviour challenges indicated that people want support before they reach a crisis point.

5.0 National Policy Drivers

5.1 General learning disabilities national priorities which underpin this Policy Statement are outlined in the overarching Strategy "Valuing People". However, there are a number of specific policy initiatives and key reports that have fundamentally influenced the development of this Policy Statement.

5.2 On an annual basis we have a requirement to undertake the Joint Health and Social Care Learning Disability Self-Assessment Framework. This is a single delivery monitoring tool that supports Clinical Commissioning Groups (CCGs), and Local Authorities (LAs), to assure NHS England, Department of Health and the Association of Directors of Adult Social Services on the following:

A. Key priorities:
- Winterbourne View Final Report
- Adult Social Care Outcomes Framework
- Public Health Outcomes Framework
- National Health Service Outcomes Framework
- Health Equalities Framework

B. Key levers for the improvement of health & social care services for people with learning disabilities:
- Equality Delivery System
- Safeguarding Adults at Risks requirements
- Health & Wellbeing Boards
- Consultation and co-production with people with learning disability and family carers

C. Progress Report on Six Lives and the provision of public services for people with learning disabilities.

5.3 This assessment has subsumed the previous LD Health Self-Assessment Framework (health led) and the Valuing People Annual Report (local authority led). It seeks to combine both previous reports, and local authorities are asked to the lead the return. There is a requirement to take our return the Health and Well being Board for sign off on an annual basis.

5.4 In December 2012 the Dept Health Final Report "Transforming care: A National response to Winterbourne View Hospital" was released. This draws firm conclusions about what went wrong:

a. No one commissioner had a lead or strong relationship with the hospital
b. Almost half of the patients were placed a long way away from their homes
c. For just under half of the patients the main reason for referral was crisis management suggesting a lack of local responsive services
d. People were staying for lengthy periods – with the average stay 19 months but some people were there for over 3 years
e. There was a very high number of physical restraints
f. Opportunities to pick up poor quality of care were repeatedly missed by multiple agencies
g. Routine healthcare checks were not being attended to
h. Patients had limited access to advocacy and complaints were not dealt with
i. There was a failure by commissioners to follow up on safeguarding concerns
j. There was a failure to monitor the assessment of individuals' needs or to promote their rehabilitation
k. The lack of any substantial evidence that people had meaningful activity to do in the day
l. Staff recruitment and training did not focus on experience in working with people with learning disabilities or autism and challenging behaviour. The training focused on restraint techniques

5.5 We recognise that there are some areas for improvement in Southampton and therefore our rationale for change will be based around our learning from the events at Winterbourne View. Whilst we have not found any evidence of abuse we acknowledge that we too have some of the above issues as follows:

a. We do have a number of people out of area and we are planning for their return. We are aware of blocks in the system around housing and have set up a Complex Housing Group which is working towards bespoke housing.
b. We recognise that our prevention and response to an individual's crisis could be better managed to enable the person to be well supported locally.
c. Currently not enough people in Southampton with a learning disability are accessing their Annual Health.
d. We need to maintain access to advocacy services and will be re-commissioning services in 2015.
e. We need to review the need for residential respite and develop more individual options – this review has commenced.
f. People need to be supported to access employment and community based services and have things to do during the day. A review of in house day support will be undertaken in 2014.

g. An autism training strategy and standard has been developed.

5.6 In 2007, Mencap released its report "Death by Indifference", which revealed that people with learning disabilities were not being treated as well as other people by the NHS. This was followed by the independent Michael report the following year, which found that the NHS was failing to ensure equal access to care for people with learning disabilities.

5.7 On 5th December, 2013 the NHS launched a new guidance document 'Meeting needs and reducing distress: Guidance for the prevention and management of clinically related challenging behaviour in NHS settings'. The purpose of this guidance is to provide practical strategies to prevent and minimise a person's distress, meet their needs and ensure high quality care is delivered within a safe environment whilst in NHS settings.

5.8 The Care Act 2014 takes forward the Government's commitments to reform social care legislation and with carers being treated as equal to the person they care for – putting them at the centre of the law and on the same legal footing.

5.9 An Independent Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD) followed the "Death by Indifference" Report. This inquiry was tasked with investigating the avoidable or premature deaths of people with learning disabilities through a series of retrospective reviews of deaths. In summary the findings were that the quality and effectiveness of health and social care given to people with learning disabilities has been shown to be deficient in a number of ways. Despite numerous previous investigations and reports, many professionals are either not aware of, or do not include in their usual practice, approaches that adapt services to meet the needs of people with learning disabilities. Recommendations from the report are in Appendix 1.

5.10 The Five Good Communication Standards (Royal College of Speech and Language Therapists) 2013, outlines the standards as:

Standard 1: There is a detailed description of how best to communicate with individuals.
Standard 2: Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.
Standard 3: Staff value and use competently the best approaches to communication with each individual they support.
Standard 4: Services create opportunities, relationships and environments that make individuals want to communicate.
Standard 5: Individuals are supported to understand and express their needs in relation to their health and wellbeing.

Everyone that supports an individual with a learning disability and or challenging behavior must work towards these standards.

6.0 Local Policy Drivers

6.1 TLAP (as mentioned within background) brings together people using social care and family carers with central and local government, major provider bodies, third sector, voluntary and other key sector groups. It is complemented by the support of many additional organisations and initiatives and links strongly to regional and local groups concerned to support personalisation.

6.2 Within Southampton these national drivers are being addressed through Southampton's Integrated Commissioning Unit, working jointly across health and social care.

6.3 Moving away from traditional models of care, services should now support service users to maintain their interests and ambitions and to have choice and control over key decisions in the care and support they receive. This ambitious shift in focus requires Providers to offer more innovative, flexible and responsive care which works with the individual, their carer and family to ensure needs are met in an individualised way.

6.4 This agenda presents real opportunities to improve commissioning practices and service provision but means commissioners and providers will face many practical challenges in order to build more responsive, personalised services that promote independence.

7.0 How Many People Present Challenges to Services?

7.1 Defining behaviour that challenges presents its own difficulties. It can be subjective to peoples' differing skills and tolerances. Behaviour can vary in intensity, duration and frequency and can be reactive to poor environmental management.

7.2 Behaviour that presents challenges is an area of immense clinical and social need. Between 10% and 15% of people who are supported in learning disability services show behaviours that are considered to cause a serious management problem, or would do without specific measures being in place (Emerson et al, 1997). These behaviours are generally seen as presenting a risk to the person (e.g. self injury, running off, eating inedible objects etc) or a risk to others (e.g. aggression, destroying furnishings, inappropriate sexual behaviour etc).

7.3 Prevalence rates for seriously challenging behaviours were comparable to those reported in the earlier studies, thus confirming previous findings. The prevalence of less serious challenging behaviour also has major clinical significance and emphasises the need for enhanced understanding and skills among personnel within primary and secondary tier health, education and social care services, and for strengthening the capacity of community teams to provide behavioural expertise.

7.4 Challenging behaviour (e.g. aggression, self-injury, destruction of environment) is a long-term, high-impact health problem in people with learning disabilities which is seen in about 10–15% of the population. It peaks at the ages of 20–50 and has severe impact on individuals and their social network as it can lead to exclusion and placements out of area. (UCL Policy Briefing Lessons for the Care of People with Learning Disabilities and Challenging Behaviour 2011).

7.5 Behaviour that presents challenges is the single most likely reason for someone to be placed in an out of city placement. A study undertaken in 2006 (Goodman et al) in the West Midlands showed that across two Strategic Health Authorities (total population 3.91 million), 623 adults were placed out of area at a cost of £35 million per year. 'Behaviour that presents challenges' and 'autism' were the main reasons given for the placements.

7.6 The number of people identified as challenging services is small in any given area. Estimates vary but it is likely that about 24 adults with a learning disability per 100,000 total population present a serious challenge at one time. The numbers of young people who challenge services and are in transition to adulthood are believed to be increasing and so will also need consideration. The length of time needed for support also varies but it is likely to be long term, and many people may present a serious challenge for much of the time or throughout their life. (Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs (Revised Edition), DH (Ed Prof J Mansell) 2007).

7.7 However, this comparatively small number could increase substantially if learning disability services as a whole are not skilled at supporting people with less complex behaviour who, if supported inappropriately, have the potential to place greater demands on services. Commissioners therefore need to pay attention to ensuring a general level of service competency in working with people who challenge, as well as ensuring that there are specialist skills available for working with the smaller number of people whose behaviour challenges services significantly.

8.0 How Many People Who Present Challenges are from Southampton?

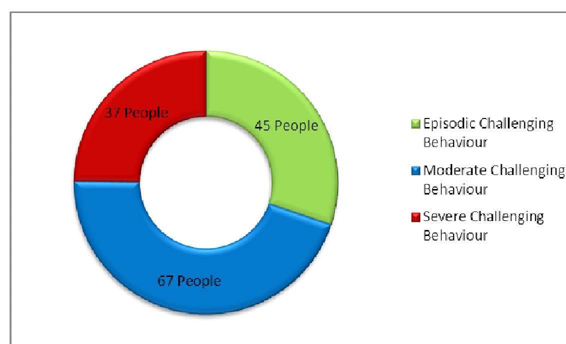
8.1 Public Health Southampton Intelligence Briefing Paper - Southampton Learning Disability Profile July 2012 details that "In England approximately 1.2 million people have learning disabilities (LD). This means that roughly 2% of the population has a learning disability although only 21% of this 1.2million were known to learning disability services." In Southampton the numbers of children and adults with a learning disability known to services is shown in the chart below, however the figures do not reflect the estimated 2% of Southampton's population of approximately 243,336

Table 1:

Number of People with a Learning Disability in Southampton (Dec 2013)		
0 -13 years		466
14 -17 years		187
18 - 19 years	31	
20 – 29 years	288	
30 – 39 years	185	
40 – 49 years	208	
50 – 59 years	175	
60 - 69 years	117	
70 - 79 years	39	
80 and over	13	
Total	**1056**	**653**

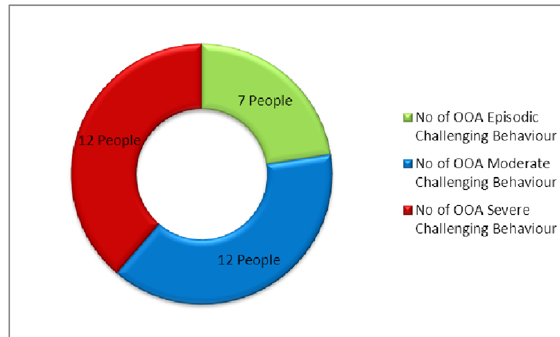
8.2 Emerson et al (1997) report that between 10% and 15% of people who are supported in learning disability services show behaviours that without specific measures would cause a serious management problem.

8.3 In Southampton 149 adults have been identified as having behaviour that challenges out of a total of 1056 known to services (i.e. 14%).This equates to 3% of the learning disability population of 4927. The following chart identifies the level of behaviour for these 149:

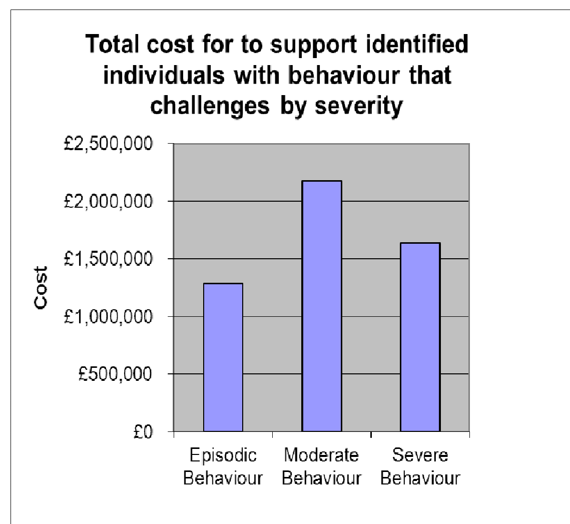


8.4 Goodman et al, (2006) identified “Behaviour that presents challenges is the single most likely reason for someone to be placed in an out of city placement”.

Out of the above 149 adults with challenging behaviour, 31 have been placed outside the city. The following chart identifies the level of the behaviour for these 31 adults:



8.5 The total cost to Southampton City Council and Southampton CCG to support the care of the 31 adults identified is £5,099,693 This can be broken down in the following ways:



8.6 We need a strategy to make sure that our community’s resources are used in the most effective ways to support people with a learning disability and their families locally now and in the future. To enable

this, people with learning disabilities who present challenges, need a co-coordinated approach to their support needs. This needs to be an evidenced based strategy based on research and best practice.

8.7 We need to have a multi-professional/multi-agency approach to service development and improvement, which comprises of a skilled responsive workforce that can meet the specific needs of people with learning disabilities who present challenges.

9.0 Safeguarding and Quality

9.1 SCC and health employees working across a broad range of teams and services have responsibility for implementing the Safeguarding Adults Multi-agency Policy, Procedures and Guidance and to ensure that the range of local Safeguarding Adults procedures is followed. Following training, practitioners and managers in a number of teams, and the Safeguarding in Provider Services team have responsibility for assessing, investigating and managing Safeguarding Adults concerns in partnership with other agencies.

9.2 Safeguarding Adults Multi Agency Policy has been developed by the four local safeguarding adults boards (4LSAB) covering Hampshire and the Isle of Wight to meet the requirements of No Secrets (2000), Department of Health and to support current good practice in adult safeguarding.

9.3 This Policy represents the commitment of organisations to work together to safeguard adults. Each local partnership is committed to adopting this Policy so that there is a consistent framework across Southampton, Hampshire, Isle of Wight, and Portsmouth in how adults are safeguarded from abuse, neglect and exploitation.

9.4 The report on the consultation on No Secrets (2000) found that prevention should be the foundation of safeguarding services. Our action plan details how this should lead to the services that people want to use, with the potential to prevent crises from developing.

9.5 Physical restraint of individuals is sometimes required to protect individuals, other service users and staff from injury and harm. Physical restraint must be viewed as a last resort with a greater emphasis place on diffusion strategies and techniques. Within the health, social and education system, staff are provided with varied training and skills to manage dangerous incidents. There is a need to review these approaches and standardise the approach so that staff and carers who work across settings are familiar and skilled. There is also a need to ensure that any restraint used is recorded, reported, reviewed and evaluated to ensure that the person is being supported in the best way possible.

9.6 In April 2014 the Department of Health released the Policy "Positive and Proactive Care: reducing the need for restrictive interventions". Increasing concerns about the inappropriate use of restrictive interventions across health and care settings led to this guidance. Across the full range of health and social care services delivered or commissioned by the NHS or local authorities in England, people who present with behaviour that challenges are at higher risk of being subjected to restrictive interventions. Many restrictive interventions place people who use services, and to a lesser degree, staff and those who provide support, at risk of physical and/or emotional harm. Appendix 2 outlines the key actions from this Policy.

9.7 One commonly used approach in Southampton and nationwide is the LaVigna Multi Element framework, which is widely used within positive behaviour support services. This framework looks at four intervention areas to reduce challenging behaviours and is intended to work as a long term group of interventions. The areas are:

- ecological strategies (to better meet the person's underlying needs and match the environment to these needs).
- positive programming strategies (to develop functional skills the person may then use instead of challenging behaviours to meet their needs).
- focused support strategies (to bring about rapid reduction in the severity and frequency of challenging behaviours).
- reactive strategies (to reduce the severity/impact of incidents as they occur).

9.1 Southampton's Integrated Commissioning Unit's (see below) ongoing monitoring with residential care providers ensures that the provision can demonstrate compassionate care and value based recruitment. The Quality Team runs quarterly forums for residential and domiciliary care providers where guest speakers share good practice.

9.2 In order to prevent people being detained against their will inappropriately, the 'Deprivation of Liberty Safeguards' (DoLS) came into force in 2009 and are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can be asked if a person can be deprived of their liberty. Care homes or hospitals must ask either a local authority or health body if they can deprive a person of their liberty. This is called requesting a standard authorisation. There are six assessments which have to take place before a standard authorisation can be given. If a

standard authorisation is given, one of the most important safeguards is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend. Other safeguards include rights to challenge authorisations in the Court of Protection without cost and access to independent mental capacity advocates (IMCAs).

10.0 Local Commissioning Framework

10.1 Southampton's Integrated Commissioning Unit (ICU) is made up of two key partners - Southampton City Clinical Commissioning Group (SCCCG) and Southampton City Council (SCC).

10.2 The ICU commission in a more joined up way so that outcomes can be improved for residents in Southampton. Treating health, public health, social care, and other local authority functions such as housing, education and leisure, as a whole system rather than lots of individual services will improve outcomes, make it easier for people to understand and access services and make better use of our resources.

10.3 The ICU has made a strategic shift towards commissioning services which focus on better and more effective use of resources. There are three commissioning work streams:

- Prevention and Positive Lives.
- Supporting families.
- Integrated Care for Vulnerable People.

10.4 This third work stream (Integrated Care for Vulnerable People 2013 – 2015) aims to prevent or intervene early to avoid, reduce or delay the use of costly specialist services whilst promoting independence, choice and control in the community through integrated risk profiling and person centred planning processes. The high level outcomes are:

- More individuals have a personalised care plan and greater use of direct payments/personal health budgets, providing greater choice and control.
- Reduction in the use of acute services and residential care.
- Increased access to self-help/management information.
- More people using self management approaches.
- Reduction in delayed discharge /transfers of care.
- Greater mobilisation of community services focusing on person centred care.
- Fewer permanent admissions to nursing and residential homes.

10.5 Southampton's analysis of the needs of people with a learning disability is set out in detail in our draft overall Lifelong Disabilities Strategy. This

describes how needs are changing and increasing. Looking ahead, over the next ten years there will be increasing numbers of:

- young adults with a learning disability, including young adults with the most complex needs, with autism, profound and multiple learning disabilities and behaviours which challenge services.
- people living with older family carers.
- older people with a learning disability and therefore with an increased likelihood of dementia. People with a learning disability may develop dementia up to 30 years before the rest of the population.
- people with a learning disability from different cultures who may have a cultural model of disability.
- people for whom English is a second language.

10.6 Since September 2011 Southampton has been working as a Pathfinder, with families and professionals to develop a number of areas in response to the governments proposed Special education Needs & Disability (SEND) reforms, including:

- Development of an Education, Health & Care Plan (EHCP).
- Development of a Local Offer.
- The option for families to have more choice and control over their support through Personal budgets.
- Joint commissioning of services between the Council and SCCCG.

10.7 The ICU and our broader safeguarding function, driven by the Safeguarding Adults Multi Agency Policy (2013) have a role in improving the quality of provision for vulnerable people.

10.8 The strategic direction for the Council and SCCCG for improving health and social care for people with learning disabilities is through established pooled budgets, joint commissioning arrangements and the development of integrated care and support pathways. This will ensure early intervention and better integration across health, housing and social care.

10.9 We know that a number of changes have occurred within the city over the last five years. Our successes include:

- Developing an Intensive Support Team that supports people with behaviours that challenges in order to support them more effectively and prevent crisis/breakdown.
- Implementing better systems across the operational teams so that we joint work more effectively.
- Developing alternative forms of communication (e.g. the iPad system), that supports people to communicate using a range of apps, that enhances outcomes and access to primary and secondary health care services.

- Working with housing partners, so we can plan more effectively for future generations.
- Focusing advocacy services on those with more complex needs, so that equality of access to services is strengthened.
- Working in partnership with West Clinical Commissioning Group, and the Commissioning Support Unit, to commission more effectively assessment and treatment provision, for those that do require these services.
- Focusing on quality of provision, using the Francis Inquiry guidance, to ensure that we see services, assess their quality at the front end of service delivery, and work with providers to develop improvement plans where service delivery is not to the standard we require.
- Southampton's Multi Agency Resource panel (MARP) was set up to discuss the needs of complex children who required consideration outside the normal funding processes of each of the statutory services and an agreement of how such needs would be funded by each of the agencies. This prevented overlap of funding and joint responsibility and management of these children. It also provided a forum to anticipate needs and planning in order to reduce the need for crisis management. The MARP process updates the plans it agrees, including reviews of the placements that may be used for these young people for their continued appropriate use.

10.10 We know that there remain challenges for the system and therefore the Challenging Behaviour Local Implementation Group has been established. This is multi agency group that focuses on the Policy Statement requirement and action plan for the next five years. This group reports to the Learning Disability Partnership Board (LDPB), the Southampton Safeguarding Adults Board (SSAB), the Integrated Commissioning Board and the Health and Wellbeing Board (HWWB).

11.0 Our Vision, Objectives and Outcome

11.1 To support the change needed, the Challenging Behaviour Local Implementation Group (LIG), was formed in October 2012. This group identified the following Vision, Objectives and Outcomes to be achieved. The Group recognises that wider consultation with users, families and services is needed and that the policy and priorities may shift as a result.

- Each person will be regarded as a full and valued member of the community of their choice with the same rights as everyone else, and with respect to their diversity.
- Each person has the right to receive person centred services, which are flexible and responsive to changes in their circumstances, health and wellbeing.

- We will provide support and training to carers and families who are supporting people who they find challenging.
- We will ensure that services are delivered in the least restrictive manner and are able to respond to individual needs.
- We will strive to continually improve using the latest evidence to provide best treatment, care and support.
- We will work in partnership with individuals, their natural carers and across the full range of services (the voluntary sector, providers, GPs and the police) to ensure good quality integrated support.
- We want people with learning disabilities whose behaviour challenges services to be fully included in their local community with access to appropriate accommodation.
- We will ensure that we safeguard their wellbeing.
- We will work with commissioners to ensure that opportunities for short breaks tailored to individual needs are available to every family supporting a person whose behaviour presents a challenge at home.
- We will work with commissioners to look at reducing the reliance on specialist challenging behaviour homes to that of developing more individualised local solutions.

11.2 Objectives:

- There will be a competent and appropriate workforce and this will be evidenced and this includes providers and staff.
- Families will feel supported in a crisis.
- Strategies, policy systems and services will be integrated within the framework of relevant legislation to ensure that the promotion of human rights and the safety of persons at risk.
- People who are identified as at risk will have their services monitored.
- Person centred plans and advocacy will be available and plans will be monitored to ensure implementation.
- data collection on people who challenge services will be used to improve services.
- comprehensive implementation across GP practices of annual health checks with referral to specialist services where applicable.

11.3 Outcomes from the vision:

- An increase in people moving back to Southampton, if they choose to
- An increase in people with behaviours that challenge will be involved in meaningful activities based on their Person Centred Plan
- More people will be in work/exploring work options
- More people will be in supported living accommodation

12.0 Where We Are Now?

The Challenging Behaviour LIG has undertaken consultation with experts from a range of services and professionals to develop and map services against models of care that should be delivered under the Winterbourne View Report. These areas for development are detailed below:

Area for Development - People out of area **A**	
Current Position and Identified Gaps	• There are currently approximately 33 people with a learning disability with behaviour that challenges who are residing more than 10 miles out of Southampton. This is due to historic placement patterns due to lack of local provision. • There are currently five people identified that are receiving care and treatment within inpatient settings/medium secure units. • There are a further 18 people that have been identified that are at risk of needing bespoke arrangements to meet their needs. • Work is underway to identity the risks of maintaining the care for these individuals and plans put in place to mitigate concerns. Individuals and families will be fully involved in the development of these plans as appropriate. • All individuals (known to the CCG) have an allocated Continuing Health Care Case Manager who liaises with NHS England (Specialist Commissioning) regarding those within inpatient settings. • The level of planning for individuals varies and consistency across health and social care needs to be improved. Continuity concerns and crisis response time for distance placements are an issue.
Recommendations	A1. Undertake a review of the local (Winterbourne) register to improve risk management and implementation of care plans, preventing crisis and improve the planning and delivery of services locally. The review to take the learning from the existing Multi Agency Resource Panel process in place in local Childrens services. A2. Ensure Personal Health Budgets are used as appropriate

Area for Development - Access to meaningful activities **B**	
Current Position and Identified Gaps	• Person Centred Planning and Advocacy available to all with a learning disability through commissioned services. • There is a lack of services to support individuals who present challenging behaviour locally.

	• The skills of local day support staff are limited. • Individuals have very limited opportunities to work, or access education and leisure opportunities. • There are limited supported employment services, with access to job finding and job coaching expertise limited.
Recommendations	B1. Review of day support services to be undertaken in 2014. B2. Development of Supported Employment Strategy to ensure that expert skills are developed for individuals to access.(e.g. a range of employment opportunities to be explored for individuals including, job carving, micro firms, and cooperatives B3. LD Advocacy will be re-commissioned in 2014, to ensure that the needs of people with complex needs and behaviour that challenges are met within the city.

Area for Development - Health care for individuals at risk due to challenging behaviour *to include physical, mental, specialist roles (Prader Willi), support in a crisis – inpatient care.* **C**	
Current Position and Identified Gaps	• Too few people with a learning disability and behaviour that challenges are accessing their Annual Health Check (42% in 2012/2013) and that some behaviour may be as a result of a physical condition. • 74% of the LD population had their BMI recorded in the last two years and 36% of these are in the obese range and 0.6% in the underweight range. • 2.3% of adults with a LD are known to have coronary heart disease, 6% diabetes, 14% asthma, 2.6% dysphasia and 13% have epilepsy. • The health needs of individuals with a learning disability are gaining greater recognition in the Joint Strategic Needs Assessment (JSNA). • One LD Hospital Liaison Nurse at Southampton General Hospital covers the whole of the admissions for Hampshire. • The role of the Community LD Specialist Teams and the Intensive Support Team needs to be reviewed to ensure that health priorities are being met. • A subsequent skill mix review will be required to ensure that individuals who present challenges have access to specialist therapy e.g. Speech & Language Therapy and Psychology and specialist nurses as all behaviour is communicative in nature. • Improved access to telecare and telemedicine technology is needed to improve the assessment and support of individuals who present challenges. • A review of the need for inpatients care beds is required to inform future commissioning intensions. • A review of mental health provision needs to be made to ensure that all aspects of the “Greenlight toolkit”, which sets out best practice, have been adequately addressed locally. • Work needs to be undertaken to map out the current use and competence of staff deploying the range of physical restraint

	approaches being used • People have been placed in our area as they have a Southampton GP but they may not have any link or connection to the area. • Children's medical needs are mainly managed by Paediatricians however at transition this reverts to the GP who may not have the history or the expertise around genetic complexities.
Recommendations	C1. Annual Health Checks for people with Learning Disabilities are offered to those that may challenge services, and reasonable adjustments are made to support access and improved quality of the checks C2. Health Action Plans templates are widely available and used throughout services so that prevention/early intervention is across the system C3. Improve take up of Health Screening for people with a LD particularly Cervical and Bowel. Breast screening is more in line with the General Population. C4. Review access to expert physician support to assess, diagnose and treat individuals who have physical health causes for challenging behaviour C5. Review Joint Strategic Needs Assessment to ensure the health needs for LD citizens are recognised. C6. Review the role and function of the Intensive Support Team C7. Undertake a skill mix analysis of Community LD Specialist Team. C8. Improve access to telecare and telemedicine technology to support the assessment and care of individuals C9. Review the need for future LD inpatients bed provision for individuals who present challenges. C10. Undertake a review of the mental health needs for individuals with a LD to ensure that service pathways implement reasonable adjustments. In children's services ensure gap is bridged between LD and Children and Adolescent Mental Health Service (CAMHS). C11. Review the physical intervention approaches being used in the City and develop an improvement plan.

Area for Development – Housing D	
Current Position and Identified Gaps	• Many individuals with a learning disability who have complex needs are currently cared for in residential care settings. • Individuals with complex needs benefit from bespoke service designs to more appropriately support their physical, social and

	psychological needs. It is recognised that individuals' health and wellbeing can be more effectively supported if the person has control over who, where and how they live. • Many people with behaviours that challenge still do not live in supported housing and remain either in high cost residential care, hospital placements or at home with families who can find it difficult to support them. • Re-assessment as needs change (particularly in children) takes too long. • Access to stock is poor. • There are poor or no adaptations especially in private rented accommodation. • For adults there is a lack of accommodation in appropriate locations due to noise level needs.
Recommendations	D1. Bespoke housing is available for individuals who are placed out of area (and those that require Supported Living Services) D2. The Disabilities Housing Panel ensures that housing needs are met for people with challenging behaviours.

Area for Development - Carers/siblings & Respite and short breaks **E**

Current Position and Identified Gaps	• Southampton, Hampshire, IOW and Portsmouth (SHIP) launched an online Directory of Services in November 2013 which provides information and support for carers and siblings of people with autism. • Mencap's Carers' sub group operates in Southampton. • Carers are members of the Learning Disability Partnership Board. • Family Link service is commissioned by Southampton Council. • Greater attention needs to be made to ensure that siblings are also offered support and opportunities to develop. Often siblings are not recognised as carers and there would be benefit in recognising their careering role and the impact this has on their life. • A service review of residential respite for people with learning disabilities with a strong focus on the provision for people with behaviour that challenges is currently being undertaken. Only one adult with severe behaviour challenges is currently accessing the council's overnight residential respite service. The service does not cater for this group mainly due to compatibility issues. • There are 10 children/young people with severe behaviour accessing the service and 4 are out of area as local services are unable to meet their needs. • Emergency respite with appropriately skilled staff is available but this does not extend to the severe behaviour group • Review of Learning Disabilities Respite provision to widen opportunities for those with complex needs include use of personal budgets for respite provision
	E1. City wide services for Carers Strategy ensure that carers and siblings of individuals with learning disability who present challenges are recognised as a priority. E2. Learning Disabilities Respite provision to widen opportunities for those with behaviour that challenges, including the use of increased personalised approaches respite provision

Area for Development - Schools/education **F**	
Current Position and Identified Gaps	These are the areas that it is felt need to be explored to establish the current position: • MASH (Multi Agency Safeguarding Hub), operational for children. • Head Start bid successful pilot in Polygon can support wider learning • Early Help teams in place with strong liaison across city services • Person Centred Planning takes place in all Special Schools. • There are a number of children excluded from school due to physical aggression/verbal abuse. Southampton has a high rate of excluding nationally and is deemed to be a significant

	issue. • There are a small number of children placed out of area due to their behaviour. • The ability of parent/carers to follow behavioural interventions with adequate support and training from services needs to be addressed in order to ensure improved behavioural management. • In relation to transport, there is a requirement to consider the journey length and any trigger linked challenging behaviour, including opportunities to reduce this if necessary. Transport escorts do receive training regarding the management of challenging behaviour. • Children's emerging sexuality and associated behaviours requires further work in terms of scope/improvements to services • Mental health needs of children with learning disabilities requires wider support to ensure improved management • Joint work between school and home to support continuity of interventions • Behaviour accepted as being part of a individuals disability creating long standing repertoire of behaviours which become increasingly difficult to manage as an individual grows • The city has a small group of psychologists that offer training regarding conflict management based on Positive Support
Recommendations	F1. MASH/Early Help/Head Start to offer effective and efficient services to children and young people presenting with challenging behaviour. F2. Parents and carers will be better skilled to support the children they look after that display challenging behaviour F3. The least restrictive interventions are used within schools and a programme of Positive Behavioural Support is embedded to ensure better outcomes and reduction in challenging behaviours

Area for Development – Transition G	
Current Position and Identified Gaps	• Southampton has an established Transitional Operational Group (TOG) and Transition Multi – Agency Resource Panel (MARP). Young people, who are perceived as likely to need specialist adult services, receive a professional coordinated transition into adulthood. • The Council and providers use a range of communication systems which can cause operational issues for service planning. • The City is a Pathfinder Site for implementation of the SEND (Special Educational Needs and disabilities) reforms with the Children and Families Act 2014. The Children and Families Act

	becomes law on 1 September 2014. Preparing for Adulthood is a significant focus of the reforms. • The City is developing 0-25 SEND Service which will provide an integrated assessment and intervention service for children and young people 0 to 25 years of age, including statutory education, health and care assessment and plans. This service is due to be operational by April 2015 • Full time college courses are available but only for an average 3-4 days per week, with individuals unable to access structured activity for the rest of the week. Courses lack an employment focus and tend not to support a person to take up employment opportunities. • Employment prospects/opportunities are part of the assessment during the transition process, but very few are able to access paid work. • City Limits are working closely with colleges and SEN schools. • Families have a high expectation around the transition to adult services and are not always adequately prepared for what could be a lesser care package. • The Multi Agency Resource Panel (MARP) includes a transition planning meeting three times a year to which adult services are invited. They are then able to see which children are receiving care in children's services and have the opportunity to include them in financial planning. • The MARP process ends when adult responsibility takes over. This is not necessarily the same age for each young person. Young people who have statements of educational need will continue their *education* funding until their statement ends. If there is *social care funding*, this is handed to adult services at 18. *Child health services* provided as part of a statement of educational need will continue until a statement ends but continuing care health funding will pass to adult continuing care services if the adult criteria for continuing care are met. • Education, Health and Care (EHC) Plans will replace the current statementing and S139a processes from September 2014.. The EHC plan is intended to continue, with annual review; until the young person leaves education (up to the age of 25) This new structure has implications for MARP because of the change in ages that the new structure is intended to cover. There are also planned changes within the social care structure to accommodate the 0 – 25 age range. • In Southampton we are currently hosting the 'next steps' project funded by the National lottery to work with young people through transition. There are two workers based within Pathways team, one to work with children in care through the process of transition out of care. The other works with young people transitioning out of custody. • Southampton's Transition Strategy was developed in 2013.
Recommendations	G1. To support the Children and Families Bill 2013 implementation

	which will extend the special educational needs (SEN) system from birth to age 25. G2. Review MARP/TOG in light of the implementation of Childrens and Young Peoples Development Service 0-25 SEND Service, ensuing that the clinical, social and educational needs of individuals are met into adulthood. G3. Ensure that all transition plans will include person centred behaviour management plans which address the communicative functions of individuals.

Area for Development – Workforce H	
Current Position and Identified Gaps	• Children services are reviewing how professionals work together with the development of the role of the Lead Professional. There are some specific areas where there are capacity issues e.g. Speech and Language Therapists (SALT) where access for communication purposes is limited. • For adults, training is provided via a range of routes including: Voluntary Independent Providers (VIP). • Intensive Support Team provide training to carers and support staff. • Expertise and knowledge shared via the Quality Team. • Guest speakers available at the Provider Forums. • Dignity Forums ongoing supporting Core Principles. • Specific training can be agreed via flexible “one council” learning service.
Recommendations	H1. Southampton’s workforce plan supporting people with challenging behaviour will be based on Positive and Proactive Care (2014) to provide a framework to radically transform culture, leadership and professional practice to deliver care and support which keeps people safe, and promotes recovery. H2. People supporting those with challenging behaviours will be able to communicate with individuals more effectively, using the Five Good Communication Standards (Royal College of Speech and Language Therapists 2013).

13.0 What Are We Going to Do Now?

13.1 The time frame covered by this Policy Statement is 2014 to 2019. The action plan covers a two year period but is a live document and will be updated as there transformation takes place.

13.2 The Challenging Behaviour Local Implementation Group (LIG), will have responsibility for the action plan.

14.0 Consultation on the draft Policy Statement

14.1 The draft Policy Statement was developed by a small group of learning disability clinicians and service managers who provide services to children and adults who present challenges.

14.2 Consultation has taken place in June 2014. See Appendix 3 for detail.

14.3 Following the consultation process the Policy Statement has been refreshed with final sign off by Health and Well being Board in July 2014.

14.4 The Challenging Behaviour Local Implementation Group will be ongoing with task and finish group/s dependent on themed areas, encompassing health, social care, children services, adult' services and cross sectors including education and housing. The Challenging Behaviour LIG will be seeking to set up formal strucures regarding groups August 2014. The Challenging Behaviour LIG will report to the Learning Disabilities Partnership Board, NHS England and the Health and Wellbeing Board.

Appendix 1

The key recommendations from the CIPOLD review of deaths

1	Clear identification of people with learning disabilities on the NHS central registration system and in all healthcare record systems.
2	Reasonable Adjustments required by, and provided to, individuals, to be audited annually and examples of best practice to be shared across agencies and organisations.
3	NICE5 Guidelines to take into account multi-morbidity.
4	A named healthcare coordinator to be allocated to people with complex or multiple health needs, or two or more long-term conditions.
5	Patient-held health records to be introduced and given to all patients, with learning disabilities, who have multiple health conditions.
6	Standardisation of Annual Health Checks and a clear pathway between Annual Health Checks and Health Action Plans.
7	People with learning disabilities to have access to the same investigations and treatments as anyone else, but acknowledging and accommodating that they may need to be delivered differently to achieve the same outcome.
8	Barriers in individuals' access to healthcare to be addressed by proactive referral to specialist learning disability services.
9	Adults with learning disabilities to be considered a high-risk group for deaths from respiratory problems.
10	Mental Capacity Act advice to be easily available 24 hours a day.
11	The definition of Serious Medical Treatment and what this means in practice to be clarified.
12	Mental Capacity Act training and regular updates to be mandatory for staff involved in the delivery of health or social care.
13	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Guidelines to be more clearly defined and standardised across England.
14	Advanced health and care planning to be prioritised. Commissioning processes to take this into account, and to be flexible and responsive to change.
15	All decisions that a person with learning disabilities is to receive palliative care only to be supported by the framework of the Mental Capacity Act and the person referred to a specialist palliative care team.
16	Improved systems to be put in place nationally for the collection of standardised mortality data about people with learning disabilities.
17	Systems to be put in place to ensure that local learning disability mortality data is analysed and published on population profiles and Joint Strategic Needs Assessments.
18	A National Learning Disability Mortality Review Body to be established.

The Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) Norah Fry Research Centre University of Bristol 8 Priory Road Bristol BS8 1TZ Tel 0117 331 0973 Fax 0117 331 0978 Email ci-team@bristol.ac.uk

Appendix 2

Positive and Proactive Care: Reducing the Need for Restrictive Interventions - Key actions

Improving care

Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor.

If restrictive intervention is used it must not include the deliberate application of pain.

If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.

Staff must not use seclusion other than for people detained under the Mental Health Act 1983.

People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support.

Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.

Leadership, assurance and accountability

A board level, or equivalent, lead must be identified for increasing the use of recovery-based approaches including, where appropriate, positive behavioural support planning, and reducing restrictive interventions Boards must maintain and be accountable for overarching restrictive intervention reduction programmes.

Executive boards (or equivalent) must approve the increased behavioural support planning and restrictive intervention reduction to be taught to their staff.

Governance structures and transparent polices around the use of restrictive interventions must be established by provider organisations

Providers must have clear local policy requirements and ensure these are available and accessible to users of services and carers.

Providers must report on the use of restrictive interventions to service commissioners, who will monitor and act in the event of concerns.

Boards must receive and develop actions plans in response to an annual audit of behaviour support plans.

Post-incident reviews and debriefs must be planned so that lessons are learned when incidents occur where restrictive interventions have had to be used.

Transparency

Providers must ensure that internal audit programmes include reviews of the quality, design and application of behaviour support plans, or their equivalents.

Accurate internal data must be gathered, aggregated and published by providers including progress against restrictive intervention reduction programmes and details of training and development in annual quality accounts or equivalent.

Service commissioners must be informed by providers about restrictive interventions used for those for whom they have responsibility.

Accurate internal data must be gathered, aggregated and reported by providers through mandatory reporting mechanisms where these apply, e.g. National Reporting and Learning Service (NRLS) and National Mental Health Minimum Data Set (NMHMDS).

Monitoring and oversight

Care Quality Commission's (CQC) monitoring and inspection against compliance with the regulation on use of restraint and its ratings of providers will be informed by this guidance.

CQC will review organisational progress against restrictive intervention reduction programmes.

CQC will scrutinise the quality of behaviour support plans which include the use of restrictive interventions.

Appendix 3

Challenging Behaviour Policy Statement Consultation: A report on the survey and consultations carried out in May, June and July 2014

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Partnership & Comme

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		BETTER CARE SOUTHAMPTON UPDATE		
DATE OF DECISION:		30TH JULY 2014		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80**
	E-mail:	**Stephanie.ramsey@southampton.gov.uk**		
Director	**Name:**	**John Richards, Chief Executive** **Alison Elliott, Director of People**	**Tel:**	**023 80**
	E-mail:	**John.Richards@southamptoncityccg** **Alison.Elliott@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

Since submission of Southampton's Better Care local plan on 4 April 2014, Clinical Commissioning groups (CCGs) and Local Authorities have been awaiting feedback and a clear steer from NHS England on the next steps A joint update was released by Department for Communities and Local Government and the Department of Health on 11th July 2014. There remains a strong emphasis on the achievement of integrated care but also a requirement for an increased focus on reduction of unplanned admissions. A revised plan template now requires completion with additional financial data around metrics, planned spend and projected savings. Revised plans will be submitted at the end of the summer.

However considerable work has been ongoing locally to progress with the plan in order to deliver Southampton's vision and aspirations for Better Care. This briefing provides an update on progress over the last month as well as detail on the latest requirements.

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 supporting 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)

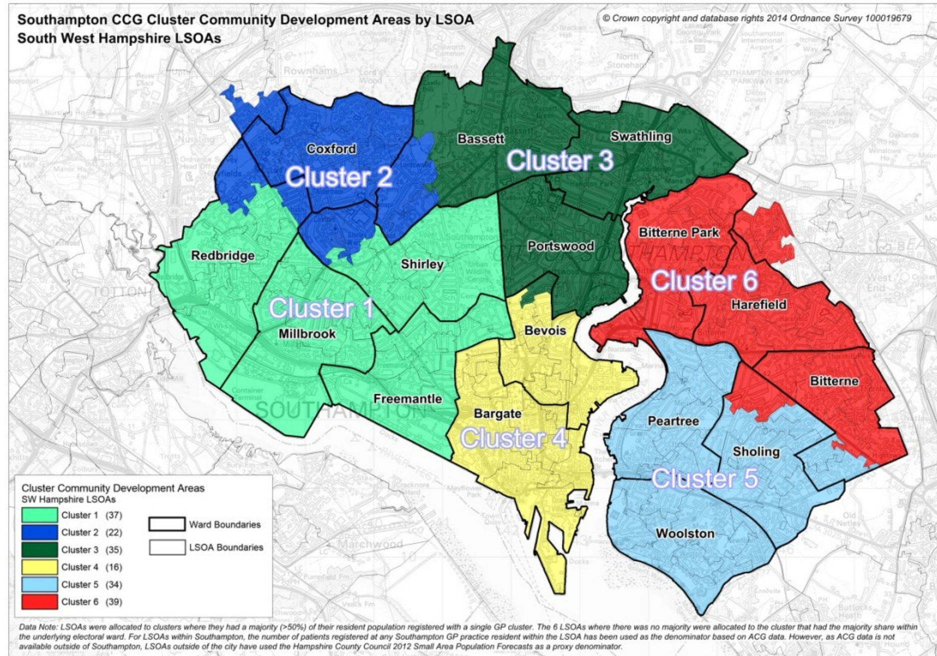
3. **Progress on implementation of local integrated person centred care (cluster teams)**

3.1 Over the next 5 years, our vision is to completely transform the delivery of care in Southampton through our jointly led City Council and CCG Better Care programme so that it is fully integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, empowered and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention.

3.2 The development of integrated working in clusters is a key building block in the new system. These clusters will bring together community nurses, therapists, geriatricians, mental health workers, 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. Specialist services will also reconfigure to actively work within the clusters and some outpatient clinics currently located in the hospital will be delivered locally.

3.3 The clusters are intended to be generic in their scope, although initially they will focus on over 75s and adults with complex long term conditions (LTCs).

3.4 After extensive consultation, the following 6 clusters have been agreed:



3.5 The intention is to implement the cluster model during 2014/15 with a view to all 6 clusters being up and running in some form by the Autumn and fully operational by March 2015.

3.6 The Better Care System Change Implementation Group has been meeting since May 2014 to define exactly how the clusters will work. Core functions will include:

- Identification of people at risk of deterioration such that they would need admission/ long term care
- Work with practices to develop care plans which are anticipatory and goal orientated
- Promotion of self-management
- Early intervention/prevention
- Management of crises/change in care needs in the community, wherever possible enabling the person to stay in their own home
- Co-ordinating care – providing a single lead professional for each service user
- Sign posting to community resources within local area
- Facilitating discharge from acute care
- Facilitating access to aids, adaptations, telecare/telehealth to promote independence

3.7 The Group are working through the composition of the teams and key principles of integrated working. The intention is to produce a high level

standard operating model which can be tailored to meet local circumstances and need.

4. To support the model of integrated working, discussions are now also progressing in relation to Information sharing and development of a prototype shared care plan accessible via the Hampshire Health Care Record.

5. **Learning from the Demonstrator Site**

The demonstrator site in Woolston and Weston has been piloting a number of the new integrated ways of working, including a multiagency risk stratification tool and joint working with housing and the local community and voluntary sector. This work has now been rolled up in the development of the 6 city wide clusters; however, a report on the learning will be issued shortly to inform the development of the model.

6. **Rehabilitation and reablement services redesign**

6.1 This is another key aspect of the Better Care model focussing on:

- Earlier access to rehab and reablement
- Embedding the reablement ethos into all provision, eg. external domiciliary care provision
- Joining up rehab (NHS) and reablement (City Council) provision to reduce duplication and gap

Work is underway to redesign current pathways and provision.

Reducing injuries relating to falls

6.2 This was chosen as Southampton's Better Care local target and will also have a significant impact on reducing avoidable admissions (national target) and permanent admissions to residential homes (national target).

6.3 A proposal for a future model of service has been developed with a particular focus on:

- Better identification and follow up of older people who have fallen, ensuring that more receive a comprehensive falls assessment and appropriate interventions, including medication.
- Making available evidence based exercise and balance programmes for those who have fallen to improve core stability and balance.

Work is ongoing to implement these proposals, working with the existing health providers to redesign current provision and exploring options for provision of exercise and balance programmes.

7. **Commissioning arrangements**

7.1 The Integrated Commissioning Board has also been considering various procurement and provider options for delivering Southampton's Better Care agenda. The approach being taken is to work with existing providers through the existing contractual arrangements and the wider NHS, community and voluntary sector market to co-produce the model and promote the changes in working and culture required. In the longer term there may be a benefit in

tendering all or part of the model but in the meantime it was not felt that the market was mature enough for such a shift.

7.2 To underpin this more collaborative working model, a system wide service specification is being developed based around a core set of principles and outcomes.

8. **Monitoring performance**

A performance dashboard is being developed o reflect all elements of the programme and this will be shared at future meetings

8.1 Trajectories and performance reports are being produced by the CCG and City Council information teams for each of the 5 national indicators (avoidable admissions, delayed transfers of care, permanent admissions to residential and nursing homes, effectiveness of reablement services and patient experience on which we are awaiting national guidance) and local falls indicator. So far this information is available for delayed transfers of care which is currently on target (as at May 2014) and permanent admissions to residential and nursing homes which is slightly over performing against target (as at May). The trajectories and reports for the remaining indicators will be available in the next two weeks.

9. **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. The intention is to use "Discover Southampton" for posting information about developments. A newsletter is being produced.

10. **Plan development – next steps**

10.1 Following a review of 151 local area 'Better Care' plans, NHS England and the Local Government Association (LGA) found that more than 80% of local area plans are on course to transform 'out of hospital' services. However further assurance is now required and a joint update was released by Department for Communities and Local Government and the Department of Health on 11th July 2014 (Appendix 1). This letter makes it clear that Government remains fully committed to the Better Care Fund, are clear that pooled health and care budgets will be an enduring feature of future settlements and remain convinced that the shift to integrated care is the right way to deliver a sustainable health and social care system that can provide better quality care and improve outcomes for individuals.

10.2 The Government is finalising arrangements for the pay for performance element of the fund and putting in place a clear framework for local risk sharing. As part of this each area is asked to propose their own performance pot based on their level of ambition for reducing emergency admissions – with a guideline reduction of at least 3.5 per cent. A proportion of the current performance allocation to Southampton, the share of the national £1bn

performance element of the fund, will be paid for delivery of this target. Where local areas do not achieve their targets the money not released will be available to the CCGs, principally to pay for the unbudgeted acute activity.

10.3 NHS England and the LGA will shortly be issuing guidance on what a good final plan should look like. In addition, NHS England will issue a revised plan template which will request additional financial data around metrics, planned spend and projected savings. It is expected that revised plans will have to be submitted by the end of the summer.

RESOURCE IMPLICATIONS

Capital/Revenue

11.

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

12. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. NHS England Publications Gateway Ref. No.00314

<u>Other Legal Implications</u>:

14. None

POLICY FRAMEWORK IMPLICATIONS

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

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

<u>SUPPORTING DOCUMENTATION</u>

Appendices

1.	Letter from Jon Rouse and Helen Edwards re Better Care Fund 11th July 2014

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	

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Agenda Item 11

Appendix 1

Department of Health

Department for Communities and Local Government

Dear Health and Wellbeing Board Chair

11 July 2014

BETTER CARE FUND

Thank you for the progress you have made so far with your preparations to implement the Better Care Fund. We know that local plans contain a clear commitment to ensure more people receive joined-up, personalised care closer to home. This letter sets out how you will continue to be supported to get the plans ready for implementation from April 2015. Following the recent announcement on the Better Care Fund, we also want to tell you about some changes we are making to further develop the programme.

We remain convinced that the shift to integrated care is the right way to deliver a sustainable health and social care system that can provide better quality care and improve outcomes for individuals. That is the way we can preserve people's dignity by enabling them to stay in their own homes, and to receive care and support when and where they want and need it. That is why the Government remains fully committed to the Better Care Fund and are clear that pooled health and care budgets will be an enduring feature of future settlements.

The Better Care Fund is deliberately ambitious. The majority of local draft plans submitted in April showed that same ambition. We recognise the scale of the task of transforming local services and the plans show how significant progress has been made in bringing together organisations and moving to a new and more collective way of working. We were particularly pleased to learn that most of the plans were addressing key conditions such as a commitment to seven day working, better sharing of information and protection of social care services.

We know that we need to shift as quickly as possible from improving and assuring the plans to letting local areas get on with delivery. However, we believe there is more to do over the next few months to ensure a strong first year.

Pay for Performance and Risk Sharing

First, as announced earlier in the month we are finalising arrangements for the pay for performance element of the fund and, as part of that, putting in place a clear framework for local risk sharing.

We know that unplanned admissions are by far the biggest driver of cost in the health service that the Better Care Fund can affect. We need the plans to demonstrate clearly how they will reduce emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community.

We are therefore asking each Health and Wellbeing Board to propose their own performance pot based on their level of ambition for reducing emergency admissions – with a guideline reduction of at least 3.5 per cent. A proportion of your current performance allocation (i.e. your area's share of the national £1bn performance element of the fund) will be paid for delivery of this target. That proportion will depend on the level of ambition of your target. Where local areas do not achieve their targets the money not released will be available to the CCGs, principally to pay for the unbudgeted acute activity.

The balance of your area's current performance allocation (i.e. the amount not set against the target for reduced admissions) will be available upfront to areas and not dependent on performance. Under the new framework, it will need to be spent on out-of hospital NHS commissioned services, as agreed locally by Health and Wellbeing Boards.

In reality we know of course that a lot of the investment from the Fund will be in joint services. We welcome that and will find a simple way to account for that investment.

This change will mean that while it is likely that local authorities will continue to receive the large majority of the Better Care Fund, the NHS will have the assurance that plans will include a strong focus on reducing pressures arising from unplanned admissions.

This change also means that, because of its importance in terms of driving wider savings, reductions in unplanned admissions will now be the sole indicator underpinning the pay for performance element of the BCF. Performance against the other existing metrics will no longer be linked to payment. However, we will still want to see evidence of strong local ambition against them as part of the assurance of plans.

Plan Improvement and Assurance

Second, certain aspects of local plans need to be strengthened to ensure we are ready to deliver from April 2015. NHS England and the LGA will shortly be issuing guidance on what a good final plan should look like. NHS England will also be publishing exemplar plans from a small number of areas to help the process.

In addition, NHS England will issue a revised plan template which will request additional financial data around metrics, planned spend and projected savings. They will also provide further detailed guidance on the revised pay for performance and risk sharing arrangements.

We expect that areas will be asked to submit revised plans and any further information at the end of the summer. NHS England, supported by the LGA, will also set out the assurance

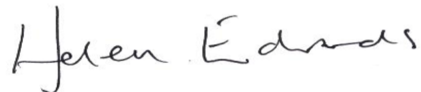
and moderation process. Where localities need support to complete their plans NHS England, supported by the LGA, will discuss how best to provide this.

The plans will be further reviewed by DCLG Permanent Secretary Sir Bob Kerslake and NHS Chief Executive Simon Stevens in the autumn prior to submission to Ministers to ensure they are ambitious enough to achieve improvements in care and that every area is on track to begin in April next year.

Better Care Fund Programme Team

Third, in order to drive this through at pace an expanded joint Better Care Fund programme team has been established, working across Whitehall, local government and the NHS. Dame Barbara Hakin, National Director: Commissioning Operations, NHS England, will take on overall responsibility for delivery through this team. The expanded team is headed by Andrew Ridley as the new BCF Programme Director. A key priority for the new team will be ensuring that, given the fast-moving nature of the programme, you are kept fully up to date and provided with the support you need to deliver effective plans and move into implementation. Andrew will be writing to you shortly to outline his plans for doing this, and to begin a regular programme of communication with local areas.

We recognise that in order to make integrated services a reality, you have achieved a lot already over a short space of time. We would like to thank you again for your hard work, and to reiterate that the Government remains absolutely committed to making the Better Care Fund and integrated services a success. We know that you share our ambition to transform local services for the benefit of all who use them.



JON ROUSE **HELEN EDWARDS**

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