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HEALTH OVERVIEW AND SCRUTINY PANEL

Thursday, 27th February, 2020
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Council Chamber - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor White (Vice-Chair)
Councillor Bell
Councillor Houghton
Councillor Professor Margetts
Councillor Noon
Councillor Payne

Contacts

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PUBLIC INFORMATION

ROLE OF HEALTH OVERVIEW SCRUTINY PANEL (TERMS OF REFERENCE)

The Health Overview and Scrutiny Panel's responsibilities and terms of reference are set out within Part 3 of the Council's Constitution: Responsibility for Functions

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

MOBILE TELEPHONES: - Please switch your mobile telephones to silent whilst in the meeting.

USE OF SOCIAL MEDIA: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

SMOKING POLICY – the Council operates a no-smoking policy in all civic buildings.

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent lives
- Southampton is an attractive modern City, where people are proud to live and work

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 Council Procedure Rules as set out in Part 4 of the Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

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 of 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.

DATES OF MEETINGS: MUNICIPAL YEAR 2019/2020

2019	2020
27 June	27 February
29 August	23 April
24 October	
5 December	

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 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.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

Pages 1 - 4)

To approve and sign as a correct record the minutes of the meeting held on 5 December 2019 and to deal with any matters arising, attached.

7 UPDATE ON OPHTHALMOLOGY

(Pages 5 - 14)

Report of the Divisional Director of Operations - UHS, providing the Panel with an update on Ophthalmology services.

8 WINTER PRESSURES 2019/20

(Pages 15 - 32)

Report of the Director of System Delivery, NHS Southampton City CCG, providing the Panel with an overview of system resilience for the Christmas period for 2019.

9 DELAYED TRANSFERS OF CARE
(Pages 33 - 48)

Report of the Director of Quality and Integration updating the Panel on developments relating to Delayed Transfers of Care.

10 PRIMARY CARE IN SOUTHAMPTON
(Pages 49 - 78)

Report of the Director of System Delivery, NHS Southampton City CCG, informing the Panel of developments in Primary Care, including the East Southampton Primary Care Estates review.

11 MONITORING SCRUTINY RECOMMENDATIONS
(Pages 79 - 84)

Report of the Service Director - Legal and Business Operations, enabling the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.

Wednesday, 19 February 2020 Service Director – Legal and Business Operations

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 5 DECEMBER 2019

Present: Councillors Bogle (Chair), White (Vice-Chair), Bell, Houghton, Professor Margetts, Noon and Payne

15. **STATEMENT FROM THE CHAIR**

The Chair and the Panel expressed the Panel's condolences to the friends and family of Sally Denley upon learning of her death and acknowledged the help and support that she provided to the Panel over the years.

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

RESOLVED: that the minutes for the Panel meeting on 24 October 2019 be approved and signed as a correct record.

17. **HAMPSHIRE WHEELCHAIR SERVICE**

The Panel considered the report of the Director of Quality and Integration providing an update on the Hampshire Wheelchair Service.

Stephanie Ramsey (Director of Quality and Integration – Integrated Commissioning Unit (ICU)), Donna Chapman (Associate Director System Redesign - ICU), Annette Cairns (Clinical and Quality Director – Millbrook Healthcare Ltd), Lydia Rice (Regional Manager – Millbrook Healthcare Ltd), Steve Trembath (Commissioner - West Hampshire CCG), Georgia Cunningham (Commissioner - Southampton CCG) and Joe Hannigan were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- The performance of the service. The Panel noted that the figures had shown little improvement since the Panel considered the performance of the service in April 2019. The Panel explored the reasoning why the introduction of the proposed new measures in April had yet to address the delays in receiving a suitable wheelchair;
- The complexity of patient pathways through the service. It was explained that a number of different consultations and appointments would be involved in the provision of a wheelchair that matched a client's clinical need.
- Workforce issues where explored and it was explained there was a national shortage of specialist rehabilitation engineers and that opportunities to train existing members of staff were limited;
- The service redesign to try to reduce the level of bureaucracy. Changes to processes that were being developed to enable specialist staff to focus on service delivery rather than administration.

RESOLVED that:

1) The Panel are provided with performance data that enables comparisons to be made between the performance of the Hampshire Wheelchair Service and other wheelchair services in England;

2) Given the shortage of specialist rehabilitation engineers, consideration is given to whether there is the potential for regional, sub-regional or STP led NHS commissioning of training programmes to increase the number of trained specialists in this area; and
3) NHS Southampton City CCG, and partner commissioners, ensure that the contractual model and specifications for the post March 2021 wheelchair service are flexible enough to enable creative solutions to be developed and appropriate collaboration with other service providers to grow.

18. **SUICIDE PREVENTION AND SOUTHAMPTON'S DRAFT 2020-23 SUICIDE PREVENTION PLAN**

The Panel considered the report of the Interim Director of Public Health requesting that the Panel consider the draft Southampton Suicide Prevention Plan.

Debbie Chase (Interim Director of Public Health), Amy McCullough (Public Health Consultant), Chris Watts (STP Suicide Prevention Programme Manager), Sabina Stanescu (Public Health Practitioner) and Joe Hannigan were in attendance and, with the consent of the Chair, addressed the meeting.

Officers delivered to the Panel a presentation which detailed issues relating to suicide prevention within the City. The Panel discussed a number of points including:

- The potential of using the Council's planning policies to design in suicide risk reduction measures for new developments at the start of the process;
- The steps taken to engage with men in their 50's, a high risk group, and whether there had been any engagement with Trade Unions to proactively target suicide prevention initiatives and advice;
- That the prevention strategy should reflect and link to measures seeking to combat bullying through social media;
- Whether the strategy should reflect the potential to target access to over the counter medicines;
- Whether more could be done linking community support for families to build resilience and raise community awareness and support through locally based teams within the City;
- The action that had been taken to heighten awareness of the dangers of suicide within services that interact with potentially vulnerable people to ensure that they are able to identify risk factors and make referrals;
- The importance of ensuring that the prevention plan becomes embedded and that practices are sustained after the initial project work has been undertaken; and
- The importance of consulting on the draft suicide prevention plan with those agencies that interact with vulnerable people.

RESOLVED that

1) Consideration is given to including within the Southampton 2020-23 Suicide Prevention Plan reference to the following:
    a. Opportunities to design in suicide risk reduction measures for new developments at the start of the process, potentially through the use of the Council's planning process.

b. Reflecting the risk profile for middle aged men, engaging with the Trade Unions to proactively target suicide reduction initiatives and advice.
c. Social media and bullying, reflecting the whole school approach to mental health and wellbeing in Southampton.
d. Action to target the over prescribing of over the counter medicines if evidence support this.
e. Linking the proposals for locality based teams that support families in Southampton with suicide prevention activity to raise awareness of support and build community and family resilience.
f. Opportunities to expand networks with service providers that interact with vulnerable people when evidence suggests the risk of suicide is heightened, such as debt advice and relationship counselling services, to ensure that they are able to identify risk factors and signpost to support services.

2) That sustainability is embedded within the Suicide Prevention Plan reflecting the funding limitations.
3) That the agencies and service providers that interact with vulnerable people when evidence suggests the risk of suicide is heightened are consulted on the draft Suicide Prevention Plan.

19. **MONITORING SCRUTINY RECOMMENDATIONS**

The Panel considered and noted the report of the Director, Legal and Governance enabling the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON OPHTHALMOLOGY		
DATE OF DECISION:		27 FEBRUARY 2020		
REPORT OF:		DIVISIONAL DIRECTOR OF OPERATIONS - UHS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Duncan Linning-Karp**	**Tel:**	**023 8120 8605**
	E-mail:	**Duncan.Linning-Karp@uhs.nhs.uk**		
Director	**Name:**	**Duncan Linning-Karp**	**Tel:**	**023 8120 8605**
	E-mail:	**Duncan.Linning-Karp@uhs.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

Ophthalmology services both locally and nationally have been under significant and sustained pressure for a number of years. There is evidence nationally that 88% of trusts have backlogs in diabetes and glaucoma and there are over 80 consultant vacancies in England. The reasons for this are well-rehearsed, but include an aging population (10% of the population over the age of 75 will develop glaucoma) and an increased ability to maintain sight for longer and better in patients with chronic eye conditions.

At UHS, significant backlogs in diabetes and glaucoma were first widely understood as a result of several incidents in 2017. An oversight board chaired by the Medical Director and Director of Nursing / OD was set up and a comprehensive action plan developed with the service. The majority of the diabetes backlog was quickly addressed but the glaucoma backlog remained a significant and ongoing risk. General patients in Lymington have also been booked out of time. The introduction of an insourcing firm in October 2019 has finally allowed the majority of patients in glaucoma to be seen.

Further work is needed across the system to ensure adequate longer-term capacity within hospital eye services, as well as better access to out-of-hospital services.

RECOMMENDATIONS:

(i) That the Panel considers the notes the report.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the committee to effectively scrutinise the issues impacting on hospital eye services in Southampton.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. University Hospital Southampton, along with most trusts in the country, has been unable to meet demand in the glaucoma and diabetes eye services. This problem has been driven by increasing demand (approximately 7% per

annum), improved treatments, an inability to recruit, and the fragmentation of pathways.

4. The problem has been recognised since at least 2017 and the Trust and wider system has taken a number of steps to try to address this, including:

- Expanding the operating available to attract further consultant ophthalmologists (by an additional theatre, or 50%)
- Multiple rounds of recruitment for consultant ophthalmologists (2 appointed in glaucoma, one who has started and one starting later in 2020). We are out to recruit further if possible
- Appointing additional nurses and optometrists
- Reviewing pathways, including West Hampshire CCG commissioning a community eye service for stable glaucoma pathways (Southampton City already has one)
- Risk stratifying all patients
- Using high cost locums where possible.

5. The Healthcare Safety Investigation Branch recently published an investigation into delays in glaucoma nationally and highlighted the significant problems. The Royal College of Ophthalmologists commented on the report, stating:

"…because the same severe capacity issues are present in every ophthalmology department in the country and, unfortunately experience is by no means unique.

The investigation has correctly identified a fundamental lack of capacity within hospital eye services to deliver glaucoma monitoring and treatment, exacerbated by inappropriate referrals, risk adverse behaviour, lack of glaucoma specialists and lack of continuity of care caused by locums"

Source: https://www.rcophth.ac.uk/2020/01/rcophth-responds-to-hsib-report-on-lack-of-timely-monitoring-for-patients-with-glaucoma/

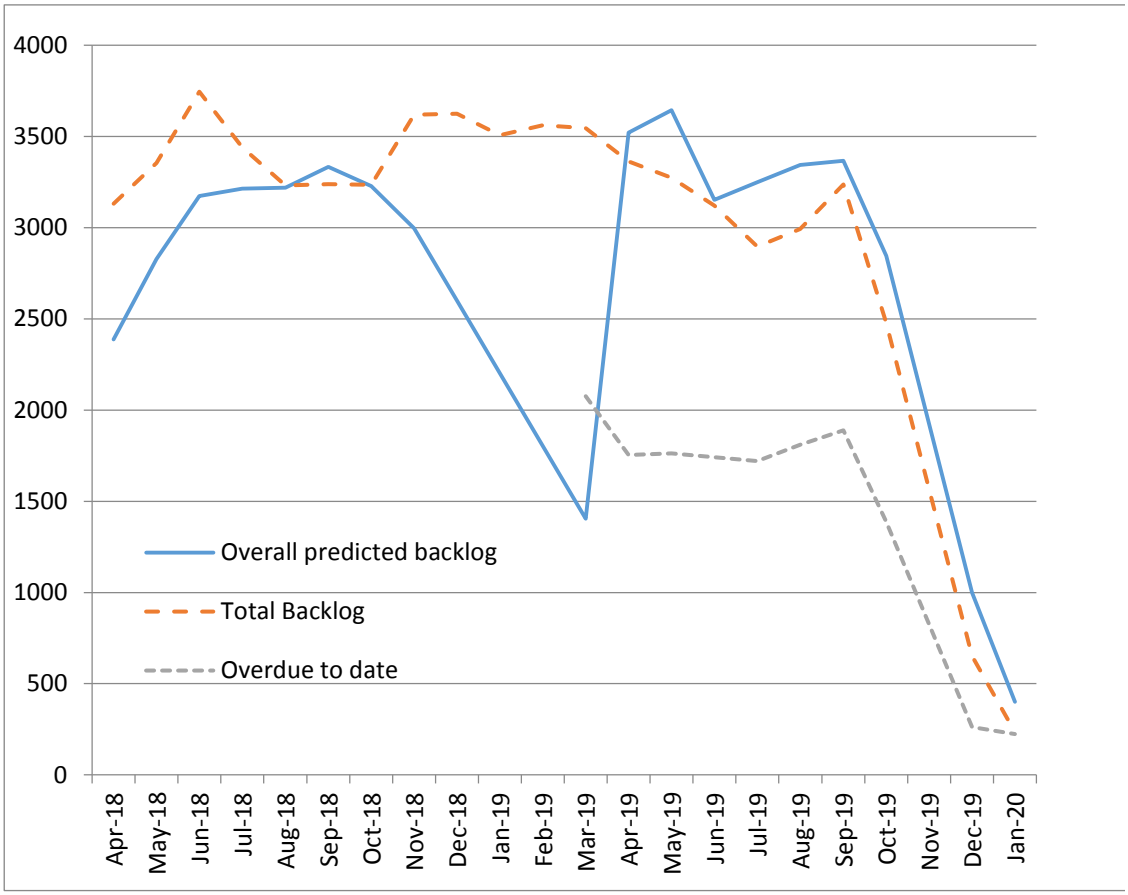
6. While UHS has had delays for a number of years, over the last few months we have made significant progress in addressing these, reducing the overall backlog of patients from 3,500 to 200.

7. The backlog has been addressed largely through an insourcing company as we have an ongoing inability to recruit enough staff in glaucoma, and existing staff have been affected by the tax and pension issue and are therefore unwilling to take on additional sessions.

8. Seeing so many patients has inevitably meant that more have been listed for surgery, leading to potential delays in glaucoma surgery. We have tried to mitigate this by putting on additional operating at Lymington, moving our glaucoma surgeons from clinics to theatre and asking commissioners to identify other centres with surgical capacity, which to date they have been unable to.

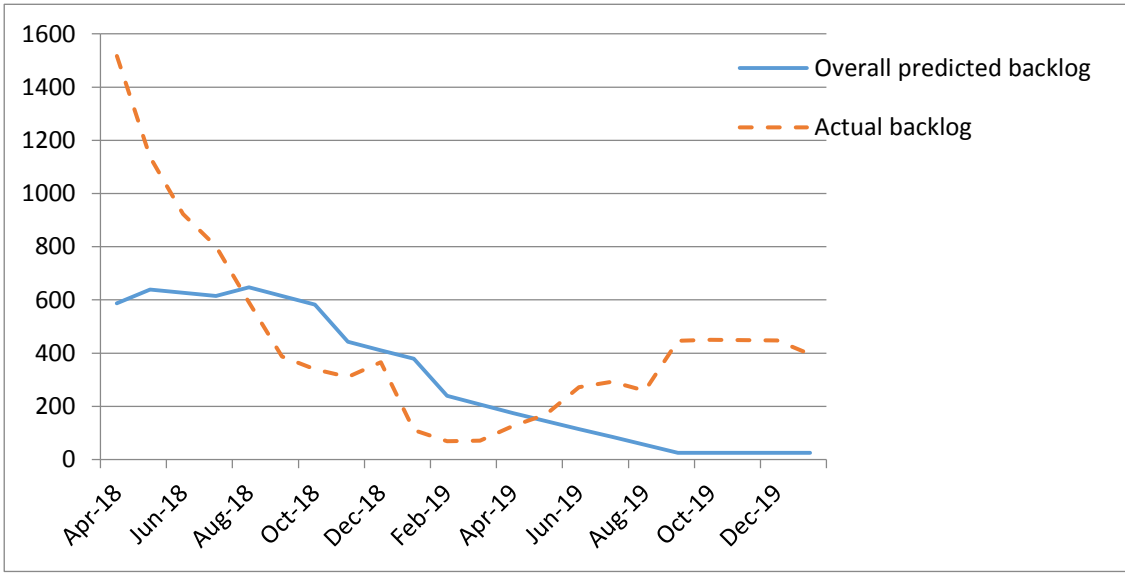
9. While the longer term plan has to be to recruit more substantive staff, UHS will need to continue using insourcing for the foreseeable future.

10. The current trajectory for glaucoma is:



11. The original backlog in diabetes was addressed quickly, with only those patients who we could not contact / would not accept a different appointment left. A high level of vacancies has seen a small increase in the last month, however a locum consultant has started and this should be addressed in February. The current trajectory for diabetes is:

12.



13. Patients being booked out of time in Ophthalmology had been on the Trust's risk register since 2014. However, the full scale of the problem was not appreciated until 2017.

14. University Hospital Southampton NHS Foundation Trust conducts a robust review of all patients identified to have potentially come to harm as a result of delays in their treatment. This is triggered by the patient's clinician completing an adverse event report (AER) any time they review a patient who has been delayed and has experienced deterioration in their vision during this period. A patient safety review meeting will then be held which will be attended by the care group management team including an ophthalmic consultant, the organisation's patient safety team, and the divisional governance team. They will review the length of delay, the patient's history and the current clinical picture, to determine whether the deterioration in vision is likely to be as a result of the delay. This will be recorded on a bespoke investigation template (designed for this purpose in consultation with the Trust executives and local Clinical Commissioning Group) which includes an assessment of the extent of the impact to the patient, which in turn determines whether or not any harm caused fulfils the criteria to be reported as a SIRI (Serious Incident Requiring Investigation) in line with the national serious incident (SI) framework. Patients fulfilling any of the criteria below would be reported as a SIRI:

    - Lost complete vision in one or both eyes as a direct consequence of the delay
    - Been registered severely vision impaired as a direct consequence of the delay
    - Have lost their driving licence and/or employment as a direct consequence of the delay.

15. If patients do not fulfil the criteria above but it is identified that the patient has come to harm, their individual circumstances will be assessed in further detail including whether or not they have needed to make amendments to their daily living activities; whether there has been any impact on their next of kin or dependents (i.e increased care needs or inability to fulfil existing caring responsibilities); and, whether the deterioration in vision is in line with natural disease progression. If it is ascertained that the harm or impact does not fulfil the SIRI criteria under the SI framework, but moderate/significant harm (for example partial sight loss) has been sustained as a result of the delay, this would be classified as an SEC (Significant Event Clinical). These incidents are subject to the same level of scrutiny as SIRIs within the organisation and are reviewed at the Trust's monthly SISG (Significant Incident Scrutiny Group) meeting to ensure that all appropriate learning has been identified and that actions are in place to mitigate against further incidents. This would include any incidental learning identified through review of individual patients. The group also review the SIRI/SEC classification as an additional level of scrutiny independent to the initial patient safety review meeting.

16. The investigation templates including the assessment of harm and SIRI/SEC determination are shared with patients as part of the organisation's commitment to be open and honest with patients, and fulfil duty of candour.

17. A breakdown of incidents to date is:

Number of patients reviewed as part of cohort	Glaucoma	Diabetes	AMD*	Total
	67	24	3	94
SEC	11	9	1	21
SIRI	26	6	0	32
No Harm	30	9	2	41

*Age-related Macular Degeneration

Conclusion

18. Ophthalmology has finally and successfully addressed the vast majority of delayed patients in glaucoma and diabetes. Because of a national shortage of ophthalmologists this has taken significantly longer than we would have wished.

19. However, as this is a lifelong condition all the patients will require follow up appointments in the future. These are currently being booked in time, but this is dependent on the continued use of insourcing. A further expansion of both staff and space is needed. There is also a need to review the current fragmented commissioning pathways.

RESOURCE IMPLICATIONS

Capital/Revenue

20. None.

Property/Other

21. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

22. The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.

Other Legal Implications:

23. None

RISK MANAGEMENT IMPLICATIONS

24. None.

POLICY FRAMEWORK IMPLICATIONS

25. None

KEY DECISION	No	
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Risk Stratification Pathway	
2.	Patient Information Leaflet	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?		No
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) 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	

Appendix 1

UHS Risk Stratification in Glaucoma

Glaucoma Suspects (disc or field)	**Virtual/Community hospital led care clinic**
Untreated Ocular Hypertensives (low risk) (***IOP ≤ 25mmHg**, normal discs / VF, no FHx)*	**Virtual/Community hospital led care clinic**
Stable Ocular Hypertensives (treated)	**Virtual/Community hospital led care clinic**
Untreated Ocular Hypertensives (high risk) (***IOP >25mmHg**, normal disc s/ VF, no FHx, age <60)*	**Optom led (future plan) clinic/SMS**
Unstable Ocular Hypertensives (start or change medical Rx)	**Consultant clinic**
Stable early POAG *(MD better -6dB stable at 2 visit, IOP at target and no co-morbidity)*	**Virtual/Community hospital led care clinic**
Stable moderate POAG *(MD between -6dB & -12dB stable at 2 visits, IOP at target and stable co- morbidity)*	**Virtual/Community hospital led care clinic**
Stable early and moderate POAG (only eye, traby or tube)	**Community hospital led care clinic**
Suspected Unstable POAG *(IOP not at target or possible VF / new OD findings)*	**Consultant clinic**
Definite Unstable POAG + change in med Rx *(IOP not at target or definite VF / OD progression)*	Compliance /Treatment Clinic (Independant Prescriber Led Clinic Future) Currently – Consultant led clinic IOP check *(depending on level of IOP & stage of glaucoma)*
Secondary OAG	**Consultant clinic**

PAC suspects, PAC and PACG		
Phakic PAC suspects / PAC post PI	1 week (gonio) then	**Consultant clinic**
	* If open angles (TM visible at least 3 quads), monitor annually with gonio for 2 years and then **discharge to local Optometrist** if < 3 clock hours PAS, normal IOPs, discs & VFs for annual review * If ITC present > 1 quadrant monitor annually with gonioscopy until pseudophakic	**Community hospital led care clinic**
Phakic PAC with OHT or PACG on Rx	Reviews same as for primary OHT & POAG	
Pseudophakic no Rx	**Discharge to local Optometrist**	
Pseudophakic on Rx	**Virtual led clinic**	

Post-ops and lasers	Consultant clinic
Cataract surgery + no trab	1 week then as per glaucoma severity
Cataract surgery + functioning trab	weeks 1, 3 and 6
Cataract surgery + PAC	weeks 1 and 6, 1yr then **Discharge to local Optometrist** if normal IOPs, discs & VFs
Trabeculectomy	day 1, weeks 1, 2, (3), 4, (6), 8, 12
Tube	day 1, weeks 1, 2, 4, 8
Cyclodiode laser	1-3 weeks, 6-8 weeks
Laser PI	1 week + gonioscopy, dilation if patent PI
SLT	6-8 weeks (consider week 1) IOP check

NHS
University Hospital Southampton
NHS Foundation Trust

Patient information factsheet

Glaucoma monitoring service

Your glaucoma monitoring clinic appointment

If you have been diagnosed with glaucoma or ocular hypertension, or are suspected of having glaucoma, your condition will require regular monitoring.

We would like to assess your current status to check if there have been any changes and make a further plan for your care. If appropriate we may continue to see you in the monitoring clinic.

What to expect

When you attend the clinic you will have several eye tests including:

- **Tonometry** – eye pressure check
- **Visual fields** – a test to evaluate whether there is any sight loss affecting your side vision
- **Digital imaging** – specialist instruments will be used to give a detailed assessment of the appearance of the optic nerve at the back of your eye

The tests will be performed by ophthalmic practitioners and you will not see a doctor on the day. However, the results will be reviewed by a consultant glaucoma specialist and they will advise when your next clinic appointment needs to be.

Your tests will be reviewed within two weeks and you will be advised by post of the outcome.

What happens if there is a change in my eye condition?

If you have any concerns about your vision or have noticed changes, please inform the practitioner during your appointment. They will ensure any issues are brought to the attention of the consultant glaucoma specialist.

If the consultant detects any change in your condition during the assessment of your test results, you will be contacted via telephone to discuss this or invited to attend the hospital for further examination in the consultant-led clinic.

How long is the appointment?

We aim to finish all of your tests within one hour, although on occasion it make take longer.

Should I attend my other eye clinic appointments?

We are only assessing for glaucoma so you should still attend any other screening or eye clinic appointments you have.

Further information

For further information please visit www.uhs.nhs.uk and search for 'glaucoma clinic'.

If you need a translation of this document, an interpreter or a version in large print, Braille or on audiotape, please telephone 023 8120 4688 for help.

Version 1. Published March 2019. Due for review March 2022. Ref 2221

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		WINTER PRESSURES 2019/20		
DATE OF DECISION:		27 FEBRUARY 2020		
REPORT OF:		ASSOCIATE DIRECTOR OF SYSTEM DELIVERY, SOUTHAMPTON CITY CCG		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Lucie Lleshi**	**Tel:**	**023 8029 6080**
	E-mail:	**Lucie.lleshi@nhs.net**		
Director	**Name:**	**Peter Horne**	**Tel:**	**023 8072 5660**
	E-mail:	**phorne@nhs.net**		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
The paper attached at Appendix 1 is a summary report prepared as an overview of system resilience for the Christmas period for 2019.		
RECOMMENDATIONS:		
	(i)	To note the impact winter pressure had on health and social care in Southampton for 2019/20 Christmas period.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To enable the Panel to have an overview of system performance over the Christmas period for 2019/20 compared to the same period in 2018/19.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not applicable	
DETAIL (Including consultation carried out)		
3.	At the request of the Panel, attached as Appendix 1 is an overview from the South West Hampshire Operational Resilience Group (ORG), the group responsible for planning and responding to periods of pressure in the local health and social care system. This document captures a brief overview of the planning undertaken for winter 2019/20 and a comparison of performance over the Christmas period for 2019/20 to the same period in 2018/19. This comes ahead of a full overview of winter pressures that will be collated for June 2020.	
4.	The HOSP are requested to note the report	
5.	Attached as Appendix 2 is an overview of Emergency Department Performance at University Hospital Southampton produced by Duncan Linning-Karp, Divisional Director of Operations at UHS.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
6.	None	

Property/Other	
7.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	None
Other Legal Implications:	
9.	None
RISK MANAGEMENT IMPLICATIONS	
10.	None
POLICY FRAMEWORK IMPLICATIONS	
11.	None

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	South West Hampshire Winter 2019/20 Summary Report – Southampton City CCG
2.	UHS ED Performance

Documents In Members' Rooms

1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (PIA) to be carried out.	**No**
Other Background Documents **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	

South West Hampshire Winter 2019/20 Summary Report - Southampton City CCG

1. Aim of briefing

1.1. The aim of this report is to provide an early view on system resilience and performance in the local health and social care system for winter 2019/20. The paper will cover

- An outline of the winter resilience planning for 2019/20
- A summary of demand and performance over the Christmas period
- Early indications for 2019/20 Quarter 4 and next steps

1.2. It should be noted that the data used for this report is only available until 31st December 2019. January 2020 data is not yet available.

2. Winter resilience planning

2.1. The following principles have been developed to underpin the method of operation and ways of working.

- **Leadership and Decision-Making**. Managers at all levels must have the confidence to make decisions. Implicit in this is the requirement for managers to understand the bigger picture at both 1 and 2 levels above them. It is axiomatic that clear and concise communication is therefore required up and down the chain of command. This allows decisions to be made confidently and at the right level. 'Honest' mistakes must be tolerated and we should all be able to learn from them.
- **Empowerment at the Operational Level**. As a system, we should ensure that the right environment exists whereby we can let providers get on with their job. Operational staff must be given the time and space to solve problems and to do their job. We should minimise information and meeting requirements; use Single Health Resilience Early Warning Database (SHREWD) (or equivalent) as the first port of call to get information and to plan. There is little added value in Executives taking over the operational details.
- **Information and Intelligence**. All planning and procedures will be derived using historical data (min 3 years) and 'lessons identified' process. Operational management of pressure in local systems will rely on 'near-real time' info systems (for example, SHREWD). By doing this, operational managers can take pre-emptive action and time is not wasted collating data to use on system conference calls.
- **Anticipation at all levels**. System pressure is usually predictable and can normally be pre-empted in-hours; this should be the norm because these staff are in the best position to plan (rather than On Call personnel later during crisis). People should strive to plan ahead and take actions in advance of a situation deteriorating. Teleconferences (TCs) are generally pre-planned in advance of a crisis. It is easier to cancel a TC rather than set them up.
- **Consistency**. Standard Operating Procedures (SOPs) and the Escalation Framework have been developed to ensure that pressure is managed well. SOPs including agreed escalation frameworks need to be followed. There should be no deviation from agreed protocols without the risk and consequences being thought through in detail. It follows therefore that the decisions on proposed changes need to be taken by those who will

bear the most risk on their operations. Further, there needs to be a long lead time (hours) to implement any proposals in order to enable the operational staff to have a chance of enacting the change in a coherent manner.

- **Economy of Effort**. Managers at all levels need to ensure that they add value by the actions that they are taking; senior managers should resist the temptation to do the work of their subordinates. For example, senior managers should think carefully about the purpose and frequency of update meetings during a crisis and ensure that there are tangible outputs. Meetings need to be focused and output/action/product/results oriented; briefings should be brief.
- **Coordination, Control & Command**. Providers have routine actions that they take to support each other on a daily basis. This is normally managed between control rooms and should be seen as the default setting. When responding and managing pressure, we should guard against creating additional reporting requirements that impedes delivery at the operational level.

2.2. The winter resilience planning is the responsibility of the South West Hampshire Operational Resilience Group (ORG), which is a sub-group of the Accident & Emergency Delivery Board (AEDB).

2.3. The ORG are responsible for planning and responding to periods of pressure in the local health and social care system. The area covered is Southampton City and the New Forest, as well as the area immediately surrounding Southampton to the North and East (Eastleigh and Test Valley South), all of which feed into University Hospital Southampton NHS Foundation Trust.

2.4. The following organisations are represented at ORG:

- University Hospital Southampton NHS Foundation Trust (UHSFT)
- South Central Ambulance Service (SCAS)
    - 999
    - 111
    - Non-Emergency Patient Transport Service (NEPTS)
- Care UK - Southampton Urgent Treatment Centre (UTC)[1]
- Partnering Health Ltd (PHL) – supporting Integrated Urgent Care (IUC)
- Southampton City Council (SCC) – Adult Social Care
- Hampshire County Council (HCC) – Adult Social Care
- Solent NHS Trust – Community Provider
- Southern Health NHS Foundation Trust (SHFT) – Community & Mental Health
- Southampton Primary Care Ltd (SPCL) – Enhanced & Urgent Access Primary Care
- Southampton City CCG
- West Hampshire CCG

2.5. The ORG started long-range planning for winter in June 2019, drawing on the following principles:

- Use activity and performance data from the last three years to drive planning and decision making.

[1] UTC at Royal South Hants Hospital site, in place since August 2019, previously Minor Injuries Unit (MIU)

- Take learning from previous years – what worked well, what could have been done better.
- All system partners share their organisational plans, so that all system partners are aware of each other's actions.
- All system partners clearly articulate what support they expect from other organisations, and what support they can provide to others during escalation.
- Monthly face-to-face ORG meetings to keep a focus and momentum on winter planning.
- Monthly multi-system planning meetings to refine and align surge and escalation plans across the Hampshire and Isle of Wight (HIOW) footprint.

2.6. Plans were scrutinised at local and HIOW level in advance of Winter 2019/20:

- A pan-Hampshire peer review of winter surge and escalation plans took place on 11th September 2019.
- The ORG completed a table-top exercise to test plans based on a case scenario from the previous winter on 12th September 2019.

2.7. Learning and feedback from the pan-Hampshire peer review and table top exercise helped further shape and refine the Southampton and South West Hampshire 2019/20 Winter Plan:

- At the pan-Hampshire event, the plan was peer-reviewed by North Hampshire CCG. It was well received, and the main feedback was a suggestion to increase the focus on what community and voluntary sector could do to support the system.
- The table-top exercise was based on a scenario from winter 2018/19, testing the plan against a situation of severe weather and prolonged pressure over the New Year period continuing through to March. Key learning points included a need for more detailed planning on severe weather and preparations for January, identifying early warning signals to pro-actively trigger system calls at known times of pressure, and increasing flexibility of capacity across the system.
- The plan was subsequently updated and signed off by AEDB on 2nd October 2019.

2.8. As part of the winter planning process, the Urgent and Emergency Care Programme of the HIOW STP identified 6 key risks, and 5 key priorities across the system to be covered with winter plans:

- Risks:
    - Noro virus outbreak
    - Influenza
    - Severe weather
    - Demand above forecast
    - Workforce capacity
    - Brexit
- Priorities:
    - Plan for a longer duration of 'winter'
    - Admission/attendance avoidance
    - Rehabilitation and reablement 'flow'
    - Public communications through an aligned media campaign
    - New initiatives with a plan-do-study-act approach

2.9. Winter Pressures funds (£1.3 million) were made available by system partners to Southampton and South West Hampshire in November 2019. A total of 16 schemes were funded across the system. Selection was based on agreed criteria, learning from previous years, and expected impact on attendance/admission avoidance or discharge and flow. Selected schemes included:

- An Advanced Practitioner Therapist to bolster Community Independence Service, to support admission avoidance
- Weekend Community Therapy provision at the Royal South Hants Hospital, to support discharge and flow.
- A Social Worker in the SCAS ambulance call centre, to prevent ambulance dispatch and conveyance to hospital.
- Additional Discharge to Assess beds, to support discharge and flow.
- Enhanced community in-reach to UHSFT, to support discharge and flow.
- Enhancement of homecare packages, to support discharge and flow.
- Extension of 'SHREWD Escalation' (IT solution for visibility of real time system pressures) to facilitate communication and issue resolution, and support discharge and flow.
- Additional medical support to the UHSFT Emergency Department (ED), to bolster capacity and support admission avoidance.
- System wide patient communication - 'Use the Right Service' - co-ordinated across the Southampton CCG and Hampshire CCG footprint to provide a consistent message around choosing the right service, to support ED demand management.

3. Demand and performance over the Christmas period

3.1. Between 18th December 2019 and 31st December 2019, Southampton City CCG demand compared to the same time period over last two years was as follows:

Activity/performance	2019/20	2018/19	2017/18
Calls to 111	3,428 (+27% vs 2018/19)	2,701	3,248
UTC attendances	1,338 (+30% vs 2018/19)	1,032	1,206
ED attendances	2,402 (+21% vs 2019/19)	1,984	2,104
Ambulance conveyances to ED	1,125 (+9% vs 2018/19)	1,034	1,054
Non-elective admissions to UHSFT	1,101 (+8% vs 2018/19)	1,018	1,018

3.2. All urgent and emergency care activity for Southampton City CCG patients was higher over the Christmas period compared to the same period last year. It should be noted that A&E activity has been higher than previous years for the last 12 months, and this is not unique to Southampton.

3.3. Daily performance against the 4-hour access target at UHSFT improved during the Christmas period compared to previous months in 2019/20, but was below the same time period last year,

broadly in line with the national average (averaging 83.1% across the period compared to 91.7% last year). The average was brought down by the weekend of the 28th and 29th December 2019, when performance fell to below 70% on both days. Performance over 90% was achieved on just one day (24th December 2019) compared to 16 days during the same period last year.

3.4. Ambulance handovers remained minimal at UHSFT, with good process in place and consistently good performance irrespective of demand. There were 2 handovers over 60 minutes during the period, compared to 3 last year, and these were due to complexity of patient rather than process issues.

3.5. There were a number of beds closed due to Norovirus during the period, up to 20 on some days, compared to none during the same period last year.

3.6. There was an increase in flu cases at UHSFT towards the end of December 2019. Flu vaccination uptake and PHE GP consultation data was reviewed at ORG on 9th January 2020. The system has planned for a spike in flu presentations mid-February 2020.

4. 2019/20 Quarter 4 (January to March 2020)

4.1. Due to the timing of this paper and the availability of data, this report focuses only on the Christmas 2019 period. Throughout January and in to February, demand on Urgent and Emergency Care services remains high, continuing at a level seen now for the last 12 months, following a step-change in January 2019.

4.2. A full report examining 2019/20 winter pressures, operational resilience, and the effectiveness of the plan will be carried out by the ORG in June 2020, once all the data is available. This analysis, and lessons identified, will form the basis of planning for next winter.

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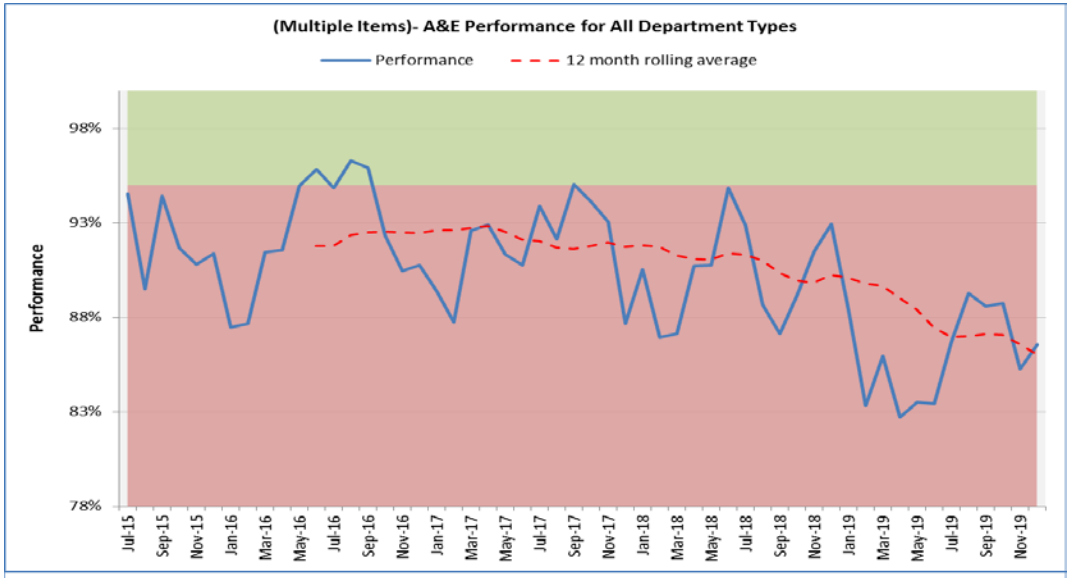
University Hospital Southampton ED Performance

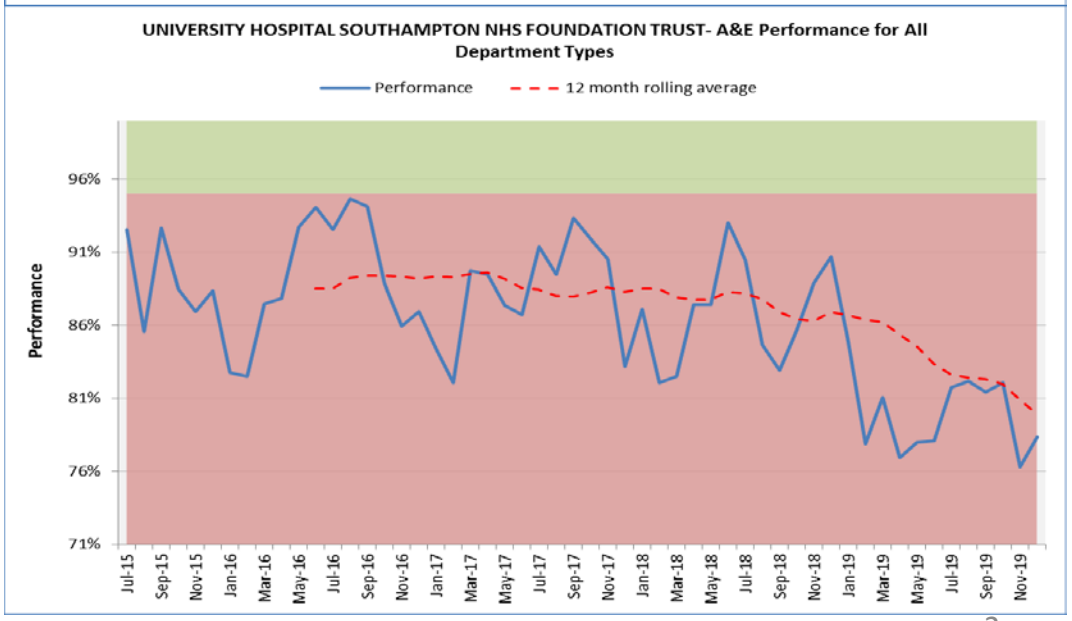
UHS Emergency Department

System Performance 4 hour A&E Target

- November position was 88.72**%**
- December position was 86.57%

System performance combines Type 1, 2 and 3 activity to give the overall achievement of the Southampton & West Hampshire system, and Type 3 activity has historically contributed 3-4%





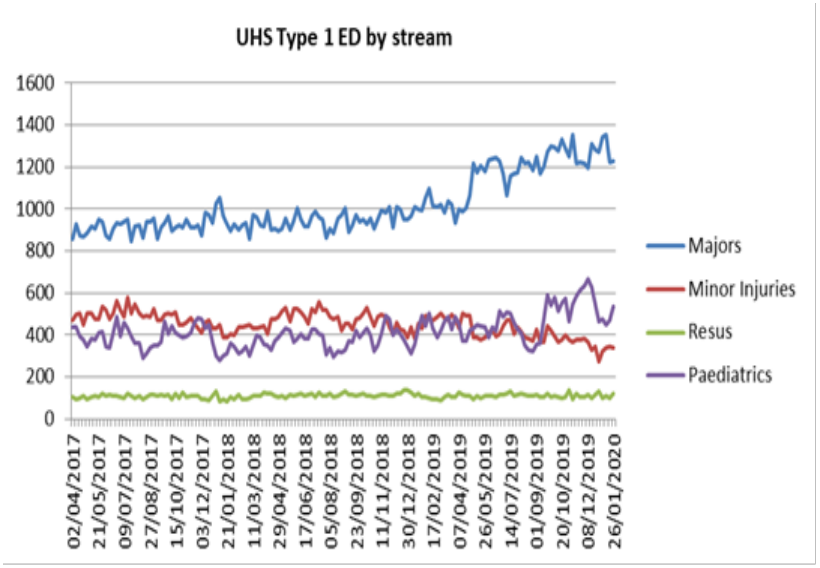
UHS Performance (Type 1)

- December is a provisional **78.34%**
- January is at a provisional 77.55%
- Q4 is provisionally 76.37%

UHS Emergency Department

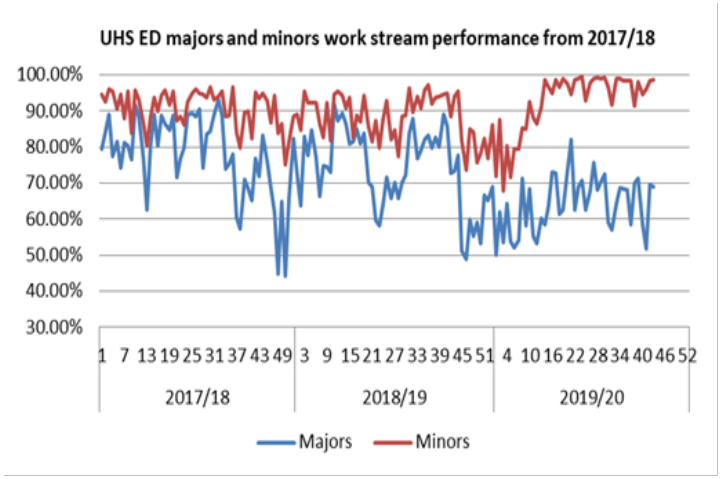
Majors / Minors Attendances

- Further focus on streaming, ambulatory majors, productivity in minors, and demand and capacity. These form part of an immediate recovery plan requested by NHSE/I to support recovery of performance against trajectory
- Year to date there have been 11,525 more type 1 attendances and 9,619 more breaches than for the same time period last year.



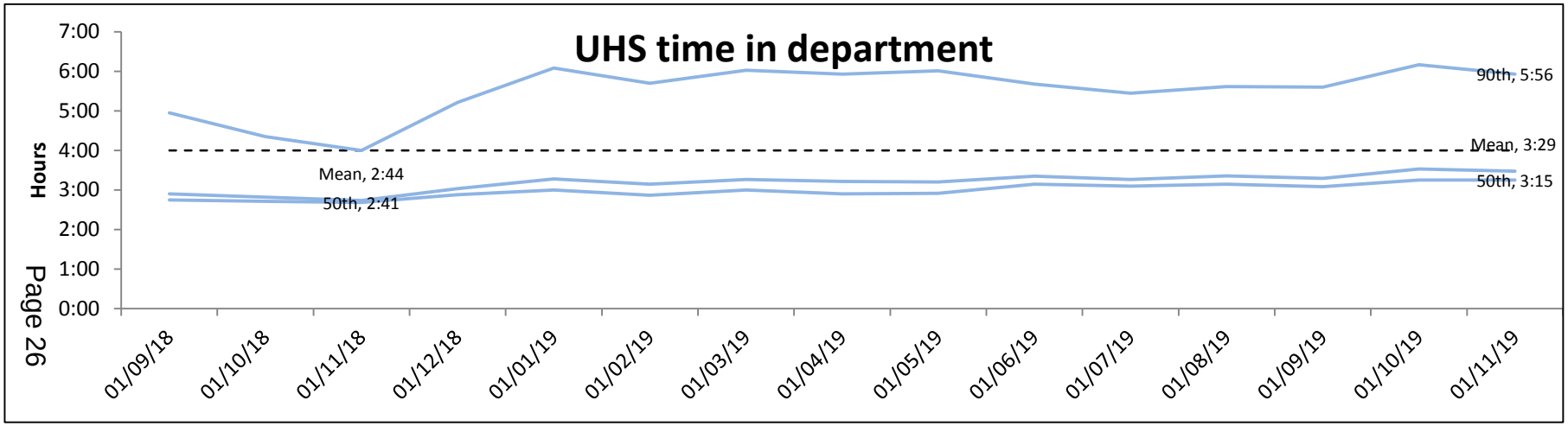
Minors / Majors Performance

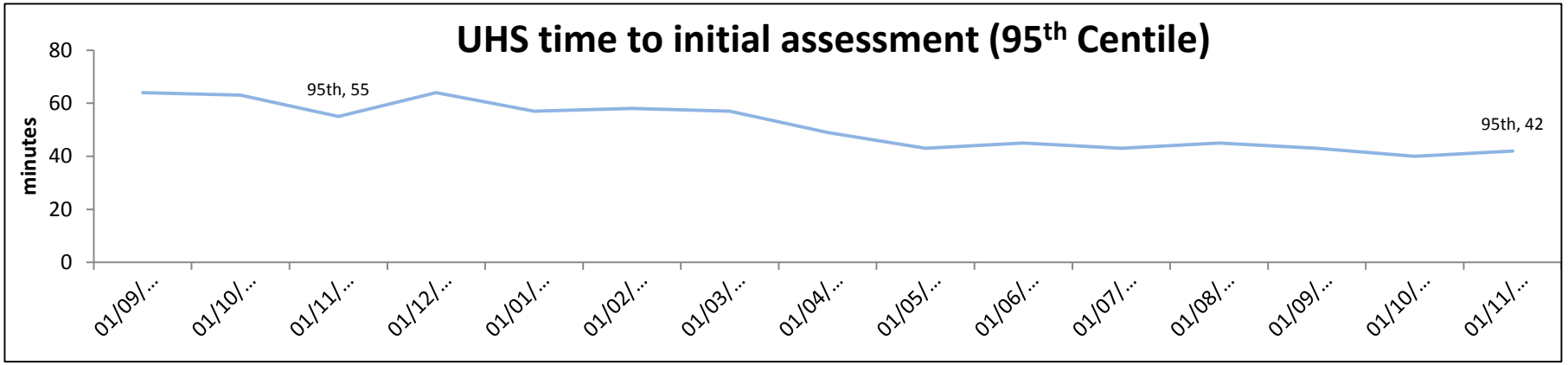
- **Majors** stream performance was at 68.9.6% for the week (averaging 63.8% year to date compared to 75.4% for the same time period last year).
- **Minors** stream performance was at 98.8% for the week (averaging 92.2% year to date compared to 89.0% for the same time period last year). There has been a sustained improvement in the minors work stream from week 14 (early July), as a result of implementing recommendations from Matthew Cook and 25 of the last 30 weeks have achieved over 95%.
- 52.2% of breaches are attributed to late being seen/breach before seen.



UHS Emergency Department

- Time in the department has stayed relatively static but time to initial assessment has seen a significant improvement in recent months.



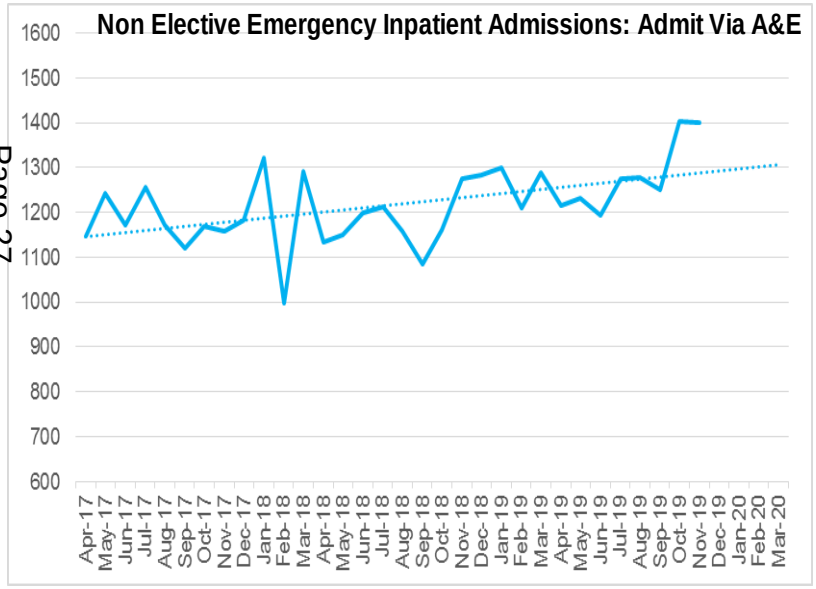


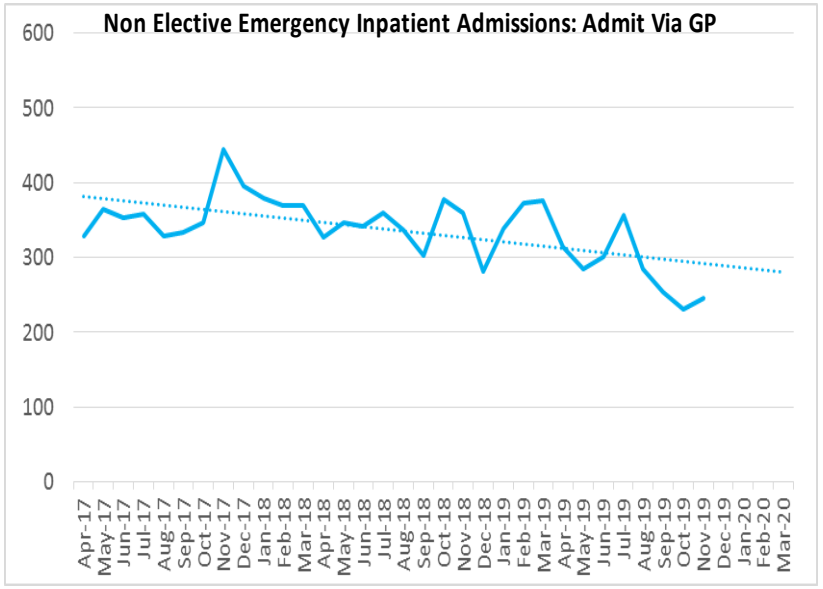
Non-Elective Admissions

Non elective admissions for UHS:

- via A&E are 14,716 YTD for 19/20 up 2.8% on 18/19
- via GP are 2,271 YTD for 19/20 down 17.4% on 18/19
- via Other are 2,196 YTD for 19/20 down 0.1% on 18/19

Total Non elective admissions for UHS are 19,183 YTD for 19/20 down 0.45% on 18/19





UHS	YTD
2017/2018	14,382
2018/2019	14,320
2019/2020	14,716

396

2.8%

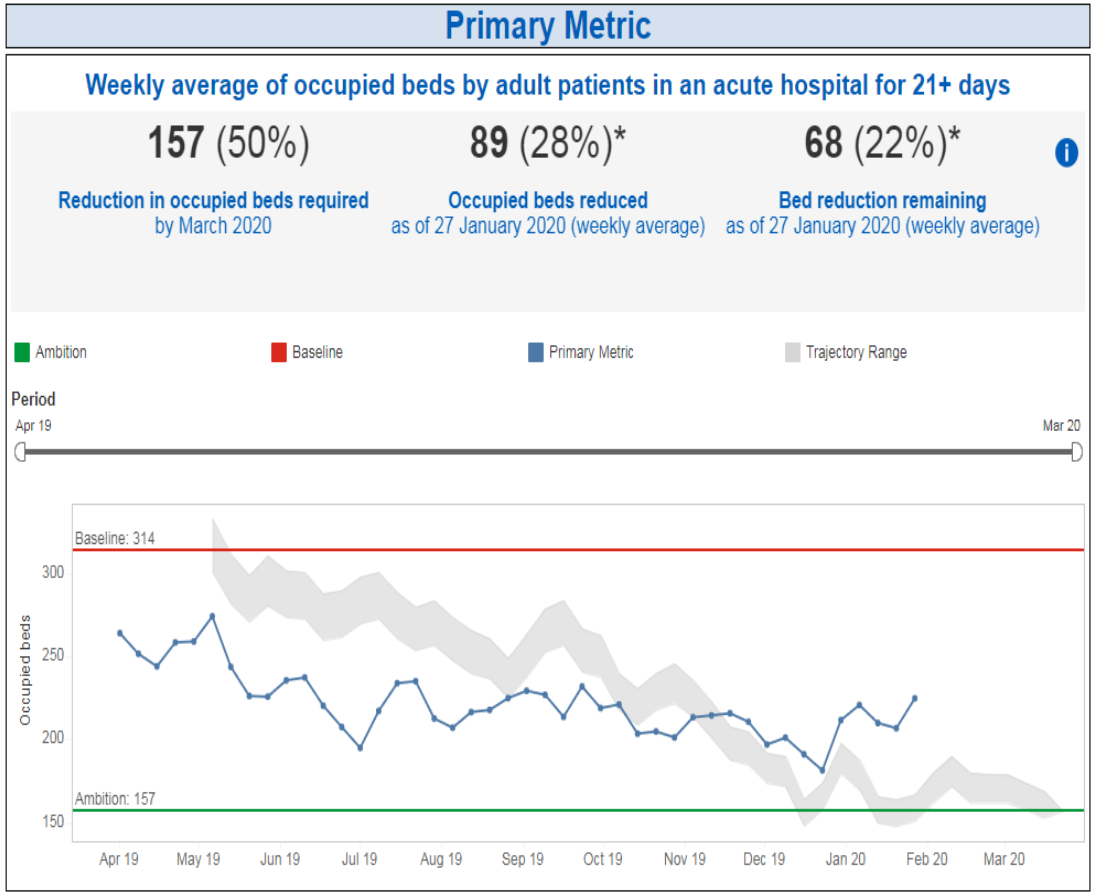
UHS	YTD
2017/2018	2,856
2018/2019	2,750
2019/2020	2,271

-479

-17.4%

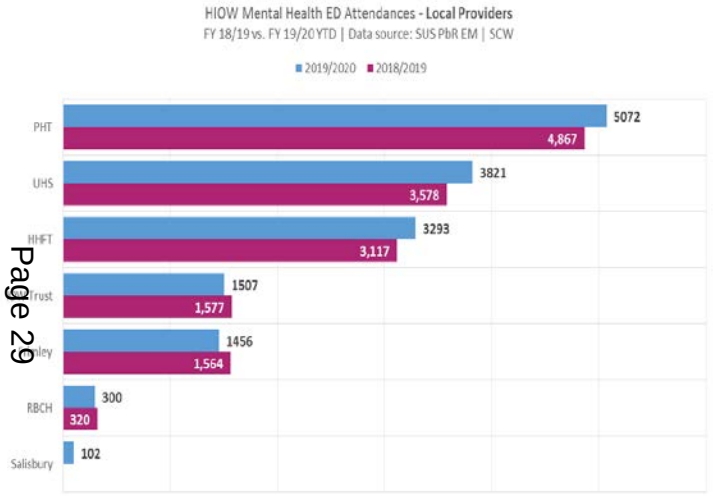
UHS Long Stay Patients

- For 19/20, UHS are expected to build upon recent improvements, reducing patient stays over 21 days by a further **19%**
- The monthly trajectory has been proposed as 4 extra patients per month to deliver the ambition by March 2020.

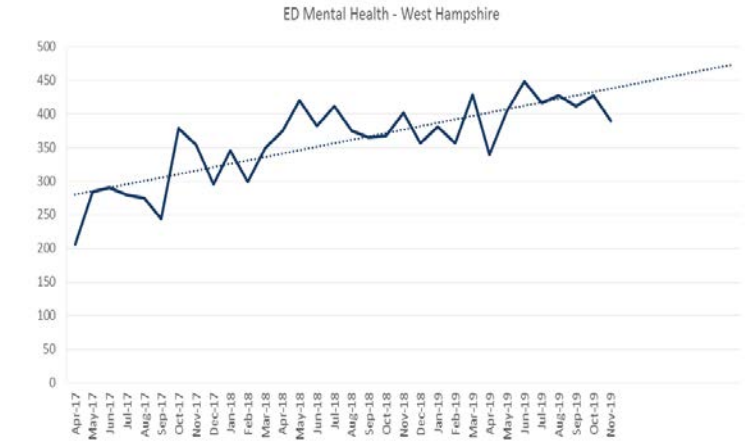


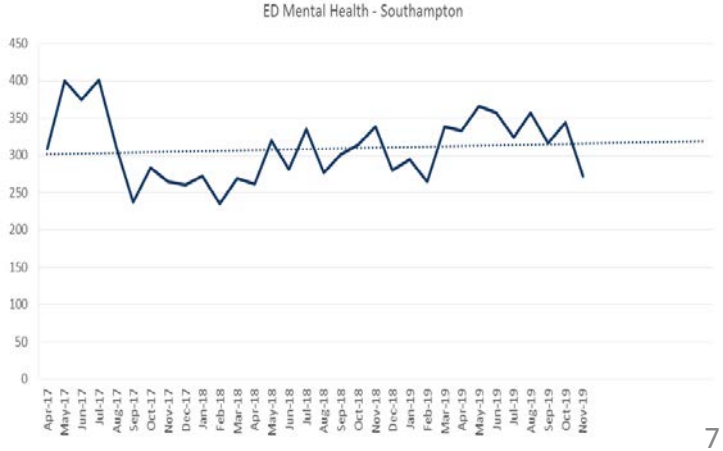
Mental Health

- UHS has seen an increase of 6.8% in MH attendances in the last year
- The percentage of MH A&E attendances waiting over 4hrs in A&E at UHS has increased by 9% in 19/20.



	UHS		
M1 - M8	2017/2018	2018/2019	2019/2020
Up to 1 hour	114	49	65
Up to 2 hours	259	234	254
Up to 3 hours	618	532	549
Up to 4 hours	1,883	1,679	1,471
Over 4 hours	813	1,084	1,468
% Activity			
Up to 1 hour	3%	1%	2%
Up to 2 hours	7%	7%	7%
Up to 3 hours	17%	15%	14%
Up to 4 hours	51%	47%	39%
Over 4 hours	22%	30%	39%





NHSI/E Feedback

- UHS had a System Assurance Visit in November 2019. Feedback was received in January 2020. The feedback noted the significant performance challenges in Emergency Care but also the number of schemes and pathway changes that are being implemented to drive improvement.
- UHS was commended on its strong minor injuries performance, but it was also noted that efforts to improve elsewhere had not been successful quickly enough.
- UHS was asked to continue to work with system partners to ensure robust governance and effective system wide plans, which will be monitored monthly.

Always Improving

- UHS has recently started an 'Always Improving' project in both inpatients and the ED. Significant external support is helping to facilitate. In ED the focus is on key pathway improvements and standardisation. Key areas of improving ED performance are:

- Clarify & standardise roles & responsibilities - make documentation fit for purpose.
- Coaching & process confirmation to ensure long term adherence.
- Maintain senior decision maker at PitStop / Streaming to ensure early patient differentiation.
- Implement ED Operations Hub - location for Nurse in Charge, ED huddles, escalation & support.
- Implement 2 hourly huddles (target length 8 minutes) - to proactively manage differentiation, in department flow and all potential breaches.
- AMU and ASU to be represented at ED huddles.

- Review all Pathways - standardise and clarify.
- Outline appropriate escalation routes.
- Define and implement appropriate governance structure.
- Coach ED staff to use Pathways and escalation for non adherence.
- Work with AMU and ASU 'always improving inpatients' coaches to improve 'pull' of patients.
- Work with 'always improving inpatients' Ward & Site team coaches to promote use of revised Pathways and Escalation policies.

- Process confirmation and coaching to ensure digital systems are utilised.
- Consolidate management reporting and embed its use for decision making.
- Use ED huddle structure to systematically review all potential breaches on Symphony.

System plans

- UHS has worked with the wider system to develop plans across the system to improve ED performance:

Prevention:
- Choose Well Campaign
- Enhanced frailty offer
- Increased use of alternatives to ED

Responsive Services:
- Additional transport
- Scale-up SDEC and community support
- Move the crisis lounge to Shirley

Effective Flow:
- Enhanced re-ablement capacity
- Repatriation plan
- 'Where's Best Next' and 'Use the Right Services' campaigns
- D2A
- Deep dive into community flow
- Improve services supporting patients to return to their care home

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		DELAYED TRANSFERS OF CARE (DTOC)		
DATE OF DECISION:		27 FEBRUARY 2020		
JOINT REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman/Sharon Stewart**	**Tel:**	**023 8083 2660**
	E-mail:	**Sharon.stewart@southampton.gov.uk** **d.chapman1@nhs.net**		
Director	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 8029 6941**
	E-mail:	**stephanie.ramsey1@nhs.net/** **Stephanie.Ramsey@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY

Not applicable

BRIEF SUMMARY

Reducing Delayed Transfers of Care (DToC) is a key focus of Southampton City's Better Care plan and has always been seen as a joint priority and collective effort between the Council, Southampton City CCG and the city's health and social care providers. The city measures its performance against two targets:

- the NHS England (NHSE) national target of 3.5% for hospital Trusts (i.e. DTOC to be no more than 3.5 % of all available beds)
- the Health and Wellbeing Board (HWBB) target of no more than 26.7 average daily delays in acute and community hospitals (which gives a rate of 13.2 per 100,000 population), which we have broken down locally as follows:
    - University Hospital Southampton (UHS) (acute) – 20 average daily delays
    - Solent NHS Trust (community hospitals) – 2.7 average daily delays
    - Southern Health Foundation Trust (Adult Mental Health and Older Person's Mental health wards) – 4.0 average daily delays.

RECOMMENDATIONS:

(i) To note developments to improve Delayed Transfers of Care

REASONS FOR REPORT RECOMMENDATIONS

1. The Chair of the Health Overview and Scrutiny Panel has requested an update on Delayed Transfers of Care (DToC.)

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not applicable.

DETAIL (Including consultation carried out)

3. Clear plans are in place for reducing DToC. Because of the joint focus on University Southampton Hospital NHS Trust (which accounts for approx. 75% of discharges for Southampton), Southampton works very closely with Hampshire County Council and West Hampshire CCG and joint DTOC action plans across the Southampton and South West Hampshire System have been in place for some time, overseen by the Southampton and South West Hampshire System A&E Delivery Board, and, more specifically the Southampton and South West Hampshire System Integrated Discharge Bureau (IDB) Leaders Group.

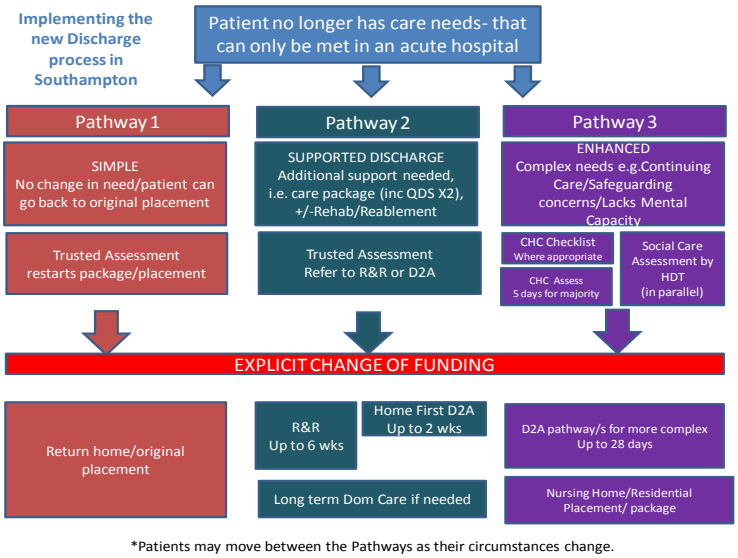
4. The IDB leaders group meets on a monthly basis and includes senior representation from Southampton City CCG, Southampton City Council, West Hampshire CCG, Hampshire County Council, University Hospital Southampton NHS Foundation Trust (UHS), Solent NHS Trust and Southern Health NHS Foundation Trust (SHFT). Together the partners have appointed a single IDB operational manager (in post since 2015) who provides operational oversight across the system on a day to day basis (employed and based in UHS).

5. Three standardised discharge pathways have been adopted across the whole of the system in order to simplify and streamline discharge processes, as follows:

    - Pathway 1 Simple discharges - managed by the wards through trusted assessment with support as necessary from the IDB and strong links back to the patient's community care team. Primarily this includes package re-starts and return to home or previous placement. Ward staff are responsible for identifying and assessing these patients.
    - Pathway 2 Supported discharges - managed by the Rehabilitation and Reablement teams, which in Southampton is an integrated Council/Solent NHS Trust service. The Rehab and Reablement teams will work with ward staff to facilitate discharge through a "community pull" approach. This includes those situations where additional support in the community is required for example a long term care package, rehabilitation, reablement or bed based care. Ward staff are responsible for identifying and directing these patients to the Rehab and Reablement Teams who "in reach" into the hospital.
    - Pathway 3 Complex discharges - managed by the IDB and hospital discharge team. This involves those patients requiring complex assessments, e.g. those who are likely to be Continuing Health Care or where there are Safeguarding concerns. Ward staff are responsible for identifying and directing these patients to the IDB.

6.

Integrated Discharge Model



*Patients may move between the Pathways as their circumstances change.

Progress to date

7. Southampton has modelled its DToC work on the 8 High Impact Change Model published jointly by the Local Government Association (LGA), Department of Health, Monitor, NHS England and ADASS in 2015 and a summary of the most recent self-assessment can be seen in Appendix 1.

8. A significant proportion of the improved Better Care Fund (iBCF) over the period 2017 - 2020 has been allocated directly to schemes that reduce DToC as follows:

- Extending Discharge to Assess (D2A) to the Royal South Hants (RSH), Snowden and Western Community Hospitals (mirroring the scheme that is already in place at UHS). It has been successful both in accelerating discharge and also supporting people to return to independence with 40% of clients going on to have no ongoing care needs.
- Establishing a Discharge to Assess (D2A) Scheme for supported/complex discharge (pathway3) – The scheme is jointly funded (50/50) by the Council and the CCG and the funding also covers additional social work capacity and capacity within the Care Placement Service. Evaluation of the scheme has shown that on average hospital length of stay is reduced by 27 days for each client. The Joint Commissioning Board agreed to mainstream the scheme in January 2020.
- Expanding 7 day social care operation in the hospital discharge team We have used the iBCF funding to recruit permanent staff to this team, rather than relying on locums. This is increasing social care professional input in the Integrated Discharge Bureau.

- Increased capacity in the home care market, in particular to support 7 day working and temporary (bridging) support whilst longer term care is finalised.

Additional investment has also been transferred by the CCG to the Council to fund additional home care hours from both the Domiciliary Care Framework contract (280 hours a week) and also reablement care (120 hours a week) from the integrated Rehabilitation and Reablement Service. Some of this investment has also been used to support training home care providers to meet the needs of patients with specific health needs, e.g. collar care, enteral feeding. Some has also been used to fund additional capacity within the Care Placement Service.

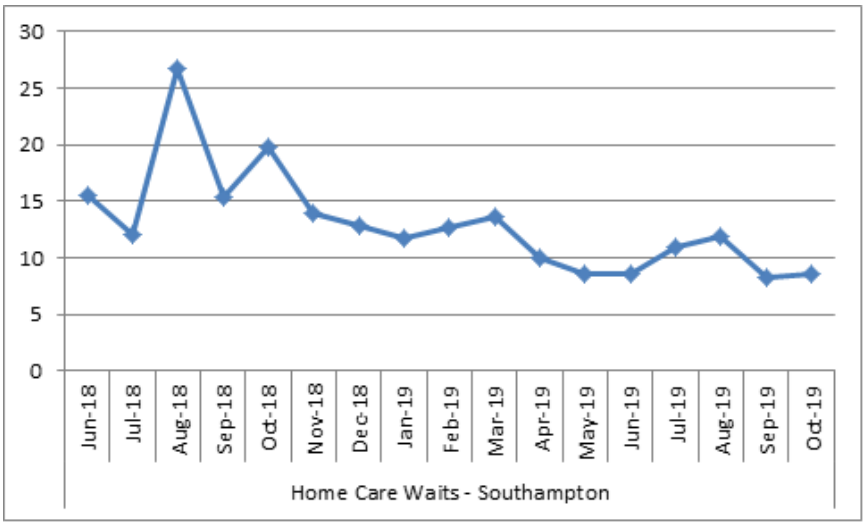
9. Overall there has been an increase in home care capacity from 2018 to 2019 as follows:

Month	Hours a week	Month	Hours a week
Sept 2018	**22,326**	**Sept 2019**	**22,834**
Oct 2018	**22,598**	**Oct 2019**	**23, 094**
Dec 2018	**21,953**	**Dec 2019**	**23,500**

NB. Please note available hours do vary, as a provider leaves the market for example or has difficulties in recruitment, but overall the trend in available hours is demonstrating an increase.

10. The number of people being supported to source home care is increasing year on year. For example December 2018 we supported on average 147 people but in December 2019 the figure was 173. Of these, last year 16 people per month were acute hospital discharges, with this year the figure being 20.

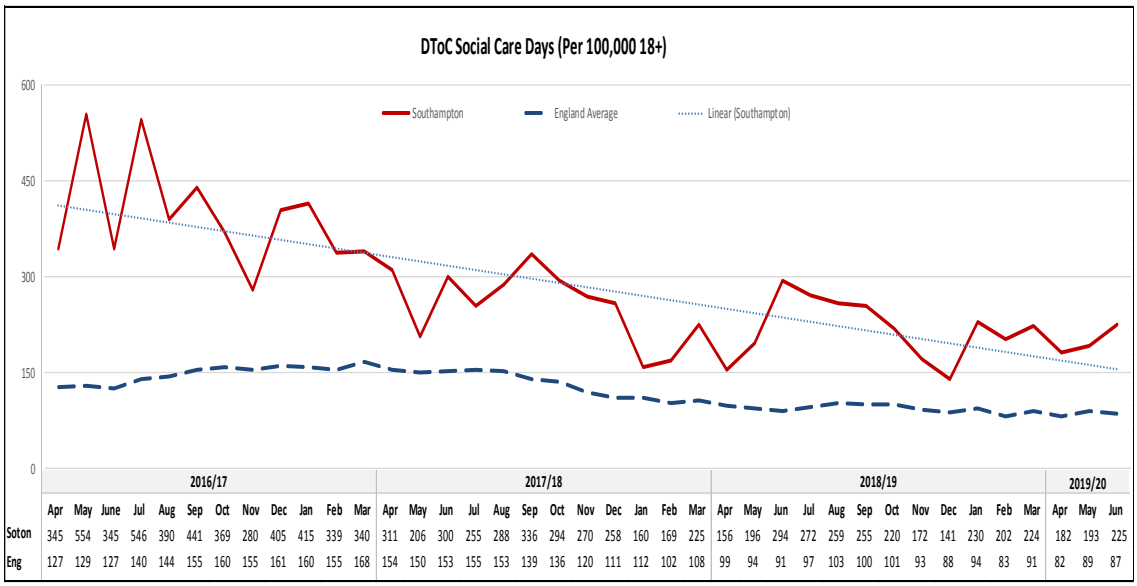
11. There has also been an improvement in the waiting times for home care as shown in the chart below which shows the waits for home care from referral point:–



NB. It should be noted that the chart includes all clients who require support from Home Care and does not show that responses to the acute hospital are significantly faster than that of other sites/referral sources.

Impact

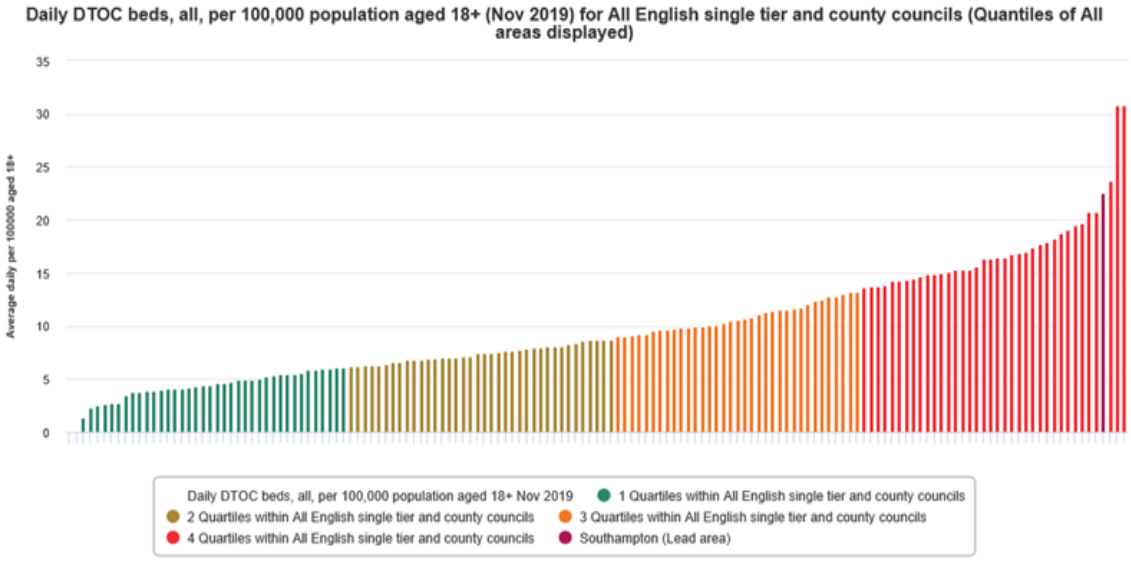
12. The improvement work undertaken to date has resulted in a significant reduction in DToC since 2016/17 as can be seen in the chart below.



	2016/17												2017/18												2018/19												2019/20		
	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Soton	345	554	345	546	390	441	369	280	405	415	339	340	311	206	300	255	288	336	294	270	258	160	169	225	156	196	294	272	259	255	220	172	141	230	202	224	182	193	225
Eng	127	129	127	140	144	155	160	155	161	160	155	168	154	150	153	155	153	139	136	120	111	112	102	108	99	94	91	97	103	100	101	93	88	94	83	91	82	89	87

13. Data comparing December 2019 with December 2018 shows that we are discharging more patients than ever (96 patients discharged in December 2019 compared to 74 in December 2018) and the overall length of stay is reducing.

14. However, Southampton remains a long distance from its national targets and benchmarks poorly against other Local Authorities as shown in the chart below.



Current Position

15. As at November 2019 Southampton's percentage DToC across all hospitals was 6.6% against the NHS England target of 3.5% with a year to date average of 5.6%. The average daily number of delays for November 2019 was 45.5 against the national target for Southampton of 26.7, with a year to date average of 38.1. The charts in Appendix 2 show how this breaks down by delays attributed to the NHS, Social care and both agencies, illustrating that the increase has been more marked in social care delays. The increase in delays recorded as "both" is

primarily linked to a change in recording whereby reablement delays, previously recorded as social care delays, are now recorded as “both”.

16. In terms of overall hospital discharges for Southampton residents, UHS accounts for around 75%, Solent for 10% and Southern Health for 15%. Trust level data on DToC is shown in the charts in Appendix 3 below against the 3.5% NHS England target and shows the greatest areas of challenge to be at UHS and Southern Health (mental health and older person’s mental health).

17. Further analysis of the Southern Health delays shows that the high proportion of DToC relates almost exclusively to the adult mental health wards.

18.

OPMH Delayed Transfers of Care Number of delayed days versus occupied bed days

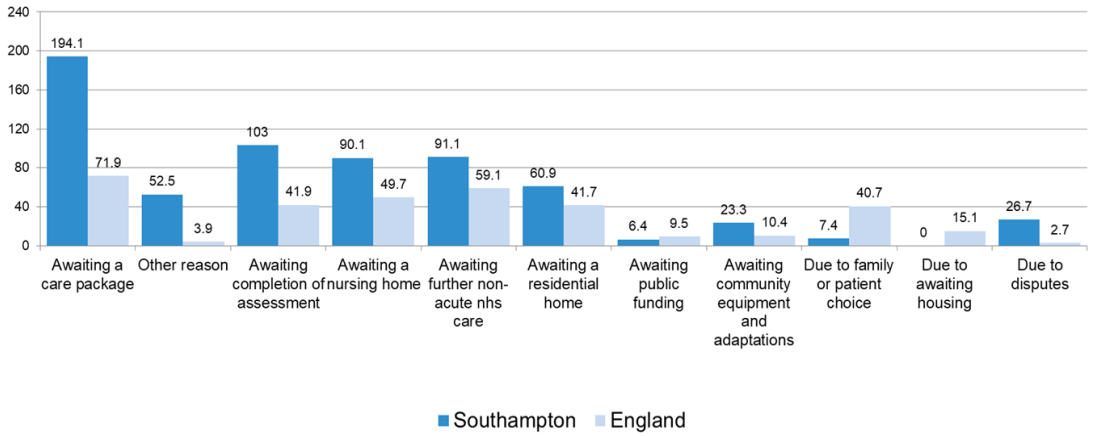
	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
OBD	576	598	597	623	457	554	639	629	625
DToC Days	32	58	46	2	0	0	0	0	0
Rate %	5.6%	9.7%	7.7%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%

AMH Delayed Transfers of Care Number of delayed days versus occupied bed days

Value	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
OBD	1813	1748	1718	1591	1580	1483	1615	1698	1897
DToC Days	91	65	188	217	237	194	152	219	202
Rate %	5.0%	3.7%	10.9%	13.6%	15.0%	13.1%	9.4%	12.9%	10.6%

19. The rise in DToC on the Adult MH wards from June 2019 is due to more robust identification, standardisation and governance of DToC that was put in place around this time. Southern Health has identified suitable supported housing as a significant discharge barrier in a number of cases. There are some particular challenges with a number of long stay patients on the male acute ward, which is a top priority for Southern Health and correlates to use of out of area beds.

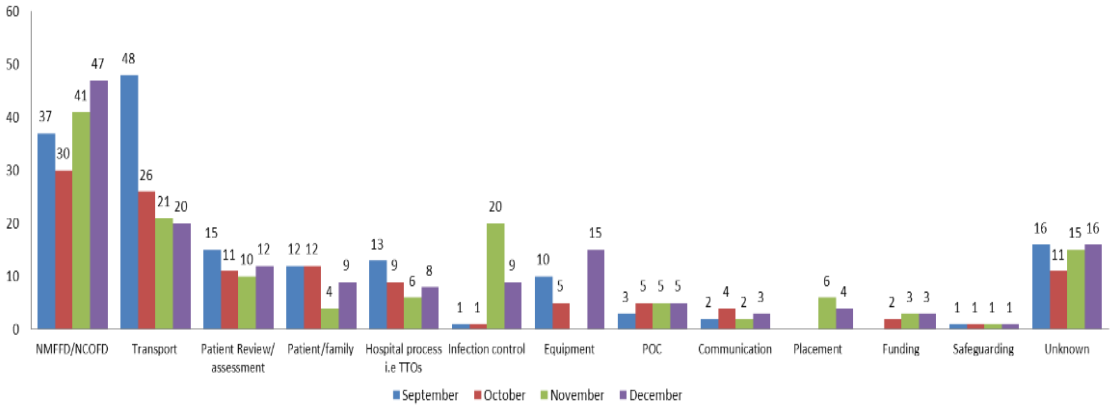
20. When reviewing the main reasons for delay across the board, home care placement is the most prominent, followed by awaiting assessment (which relates almost exclusively to social care providers coming into hospital to assess), nursing home placement and then awaiting further non acute NHS care.



21. Further analysis of the factors underpinning these delays shows that the main reasons are associated with increasing levels of complexity requiring more visits with two carers ("double up" care) or harder to source nursing home placements.

22. The delays in further non acute NHS care also seem to be related to increasing complexity and demand for specialist rehab beds e.g. Spinal or neurological rehabilitation, the main provisions being Salisbury Hospital (spinal rehab) and Snowdon (Solent) for neurological rehab.

23. Additionally it is recognised that internal hospital process issues are still contributing to a number of the delays. For example, hospital transport.



Summary of additional work underway to improve the position

24. Building on the output from the April 2019 DToC Peer Review facilitated by the Local Government Association on 30 April 2019, senior oversight and leadership has been strengthened by ensuring that there is a regular focus on DToC performance at the monthly Better Care Steering Board meetings; reporting processes and accountability have also been strengthened so that on any one day performance can be tracked against each of the 3 discharge pathways.

25. On top of this the Southampton and South West Hampshire system is taking the following additional actions:

<u>In recognition of Home Care capacity being the main cause for delay:</u>

- Use of Southampton and South West Hampshire System Winter Pressures Fund to increase home care, bridging and Discharge to assess capacity:
    - 300 additional hours
    - An additional reablement bed in the residential care sector from September 2019
    - 2 additional Discharge to assess Pathway 3 beds (on top of existing 5 beds) from 31 December 2019
- Employment of an Occupational Therapist locum to review double up home care packages in view of making them single handled care.

26. In recognition of waits for Care Home assessment and placements being a key cause for delay:

- Piloting a trusted assessor scheme for care homes in order to improve responsiveness and reduce the number of repeat assessments for patients by different homes.
- Care Home Hotline introduced by UHS in December 2019 for post discharge medical advice and support within the first 48 hours of post discharge – in response to care home concerns around being able to contact someone should a resident's condition deteriorate

27. In recognition of NHS non acute onward care being a key cause for delay:

- Advanced Practitioner Therapist post in the Community Independence team to undertake Comprehensive Geriatric Assessment with a view to reducing hospital length of stay.
- Additional therapy capacity over weekends at the Royal South Hants Hospital to improve flow.
- Enhanced Community 'In-reach' to UHS over the weekends to facilitate weekend discharges.

28. In addition the following actions are being taken to improve flow:

- A system wide marketing campaign to promote key messages to the public and staff about the benefits of "home first" and out of hospital provision, linked to other work we are doing on "ageing well". This was launched 20 January 2020.
- Delegation of small budget to "unblock" common causes of delay such as patient transport to enable someone to go home on time.
- British Red Cross have specifically been commissioned to provide additional transport capacity.

29. Work is underway with UHS ward staff (as part of the "Always Improving Inpatient Care" programme being led by PWC for UHS) to improve the interface between the Integrated Discharge Bureau (IDB) and the ward. In addition, the IDB leaders group is planning to undertake a series of Rapid Improvement Workshops during March and April to process map each of the discharge pathways and identify key areas for improvement. Pathway 3 will be the initial priority.

30. In addition the following specific actions there are numerous actions being taken to address discharge delays at Southern Health.

Better Care Support Visit

31. Southampton has been offered 15 days of peer-facilitated support by the national Better Care Programme as part of its national support offer – to be used before April 2020. The Better Care Support programme has commissioned the Local Government Association (LGA) to undertake this programme of work.

32. This support will be tailored to meet the needs of our system and officers will be actively involved in selecting the best-fit peers to meet our needs, and in agreeing the scope and key lines of enquiry of this work. It will align with the PWC work outlined above.

33. As a city we have proposed that this support is used to undertake a deep dive into each of the Discharge pathways to test and challenge current practice, identifying bottle necks in the process and thereby informing an improvement plan. Also to focus on:

- data, projections and reporting
- market development.
- Impact of admissions avoidance work
- System processes and leadership
- Mental health delays

The scope is still being refined.

RESOURCE IMPLICATIONS

Capital/Revenue

34. No implications.

Property/Other

35. No implications.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

36. Not applicable.

Other Legal Implications:

37. Not applicable.

RISK MANAGEMENT IMPLICATIONS

38. The approach to improve Delayed Transfers of Care in Southampton will help to mitigate legal, financial and reputational risks.

POLICY FRAMEWORK IMPLICATIONS

39. This supports the council's objective of supporting people to live safe, healthy, independent lives and the council's priority to improve wellbeing as part of its 2025 investment programme.

KEY DECISION?	**~~Yes~~/No**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	High Impact Changes
2.	Average delays
3.	Community Health Provider Data

Documents In Members' Rooms

1.	None.

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	**~~Yes~~/No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	**~~Yes~~/No**

Other Background Documents
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	

High Impact Changes

High Impact Change	Self Assessed Position	Commentary
Early discharge planning	**Progress made but still more to do**	• Use of Expected Date of Discharge (EDD) established and electronically recorded on hospital discharge system (APEX) • Hospital has in place Board Rounds and Red and Green days However there is still more work to be done in ensuring that discharge planning commences at the point of admission, including planning for discharge at the hospital front door and ensuring that patients who are likely be complex are identified early on and case managed through their stay in hospital.
Systems to monitor patient flow	**Progress made but still more to do**	Whilst systems are in place (SHREWD), challenges still exist in terms of sourcing capacity to meet demand, most specifically related to: • Increasing levels of complexity amongst patients being discharged. • Sourcing complex “double up” care packages. • Sourcing care home placements particularly for patients with dementia • Flow in NHS specialist rehabilitation beds
Multi-disciplinary/multi-agency discharge teams	**Mature**	A system wide Integrated Discharge Bureau (IDB) has been in place for some years with a system wide manager appointed in 2015, jointly accountable to the Acute Trust (University Hospitals Southampton), both CCGs (Southampton and West Hampshire) and both Local Authorities (Southampton and Hampshire). The IDB is made up of teams from UHS, Adult Social Care, Rehab and Reablement and Hospital at Home.
Home first/discharge to assess	**Mature**	Discharge to Assess (D2A) for pathway 2 (people requiring reablement or some level of additional support in their own homes) is now mainstreamed for all people leaving hospital (UHS as well as the community hospitals RSH and Snowden). There is evidence that discharge to assess and reablement for this group is reducing the need for ongoing care. In addition since November 2017 we have also introduced D2A for the more complex group of people leaving hospital on Discharge Pathway 3. This is now mainstreamed
Seven-day service	**Not in place across all areas**	Whilst 7 day processes are in place for rehab and reablement and the hospital discharge team, all partners need to expand their offer to support 7 day working including hospital transport and primary care. Brokerage services only operate Monday-Friday at present and there are challenges with social care providers taking new or receiving back residents over the weekend.
Trusted assessors	**Not in place across all areas**	Trusted assessment is in place for Pathway 1 with hospital staff making decisions regarding return to placement. However we do not have Trusted Assessment in place for care home assessment processes. We are in the process of scoping a Trusted Assessor scheme with care homes. A nurse was appointed in January 2020 to take this work forward, engaging with homes to design the model.
Focus on choice	**Mature**	A choice Policy (referred to locally as complex discharge policy) has been in place for some years and has recently been reviewed and updated.
Enhancing health in care homes	**Progress made but still more to do**	The EHCH Programme is well established within the residential care sector and we are planning on rolling this out to nursing homes over the next few months.

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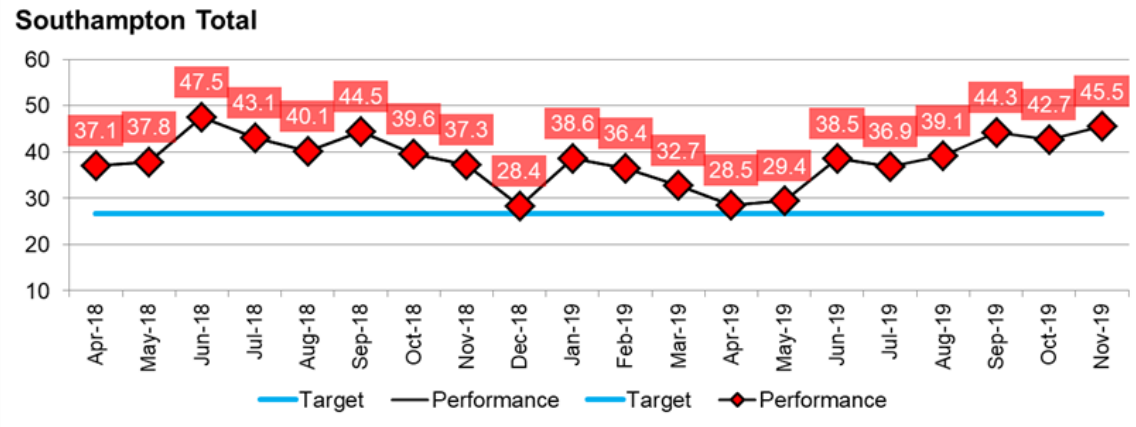
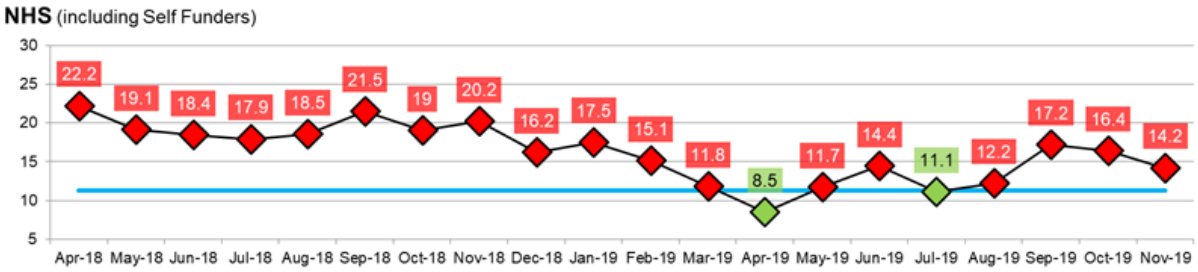
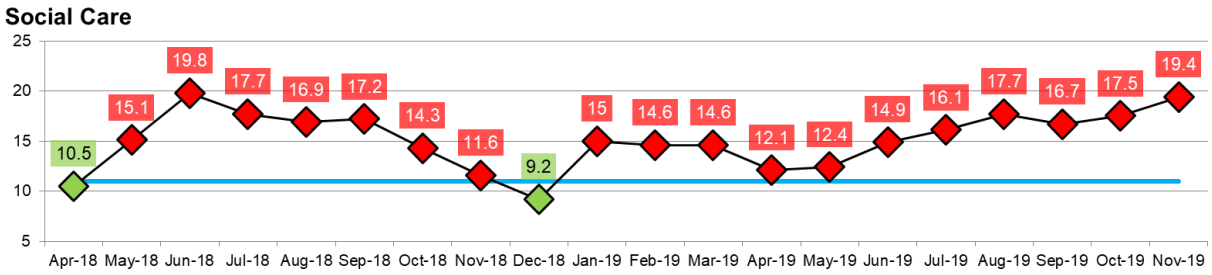
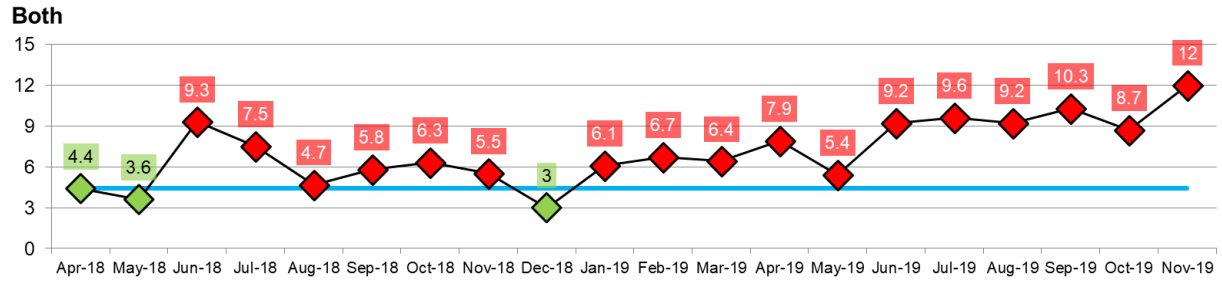
Southampton Average daily delays (across all hospitals)









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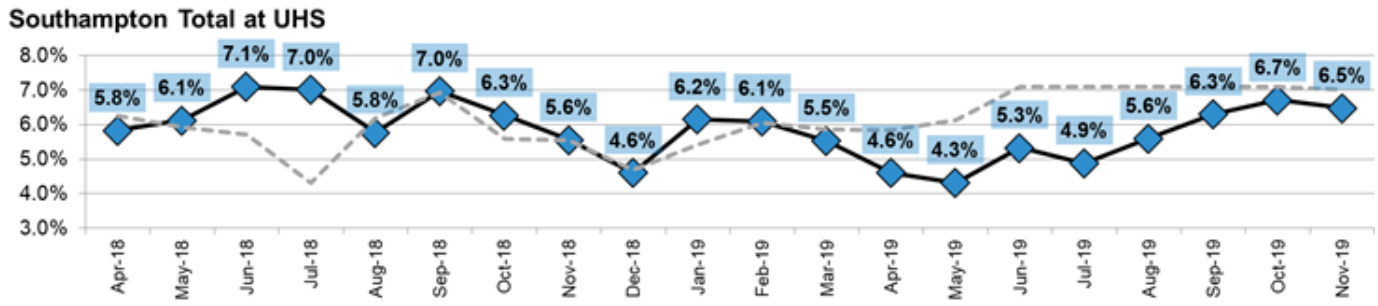
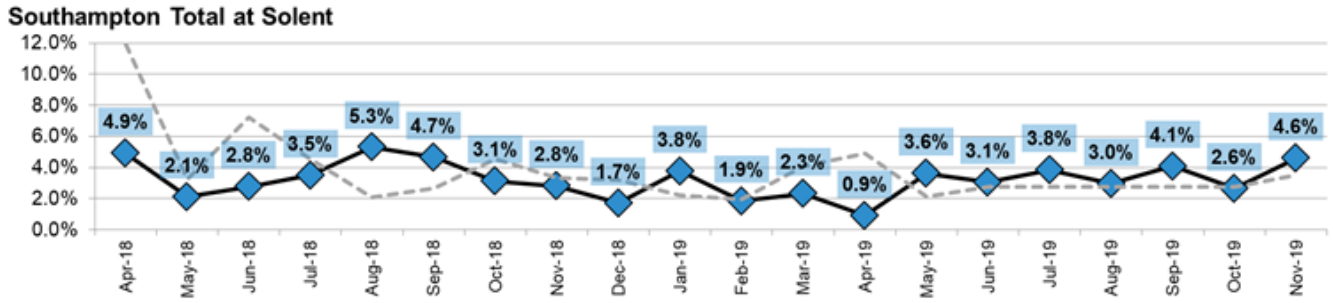
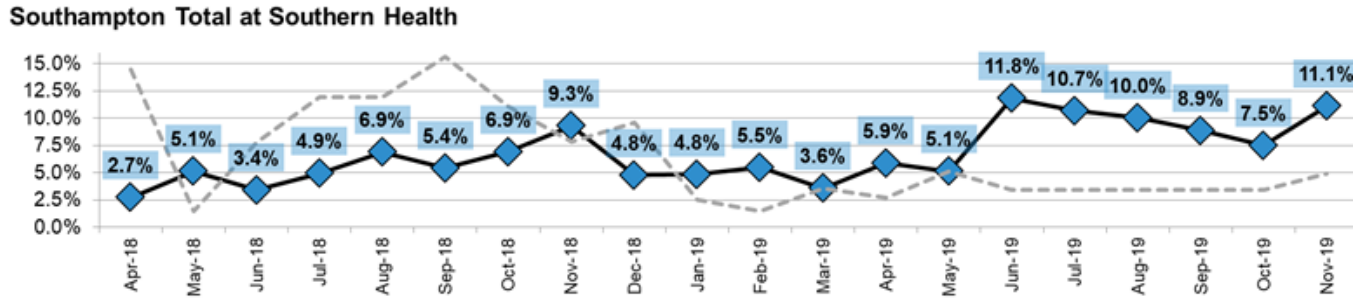
Community Health Provider Data

The dotted line shows the trend for the previous year.







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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		PRIMARY CARE IN SOUTHAMPTON		
DATE OF DECISION:		27 FEBRUARY 2020		
REPORT OF:		PETER HORNE, DIRECTOR OF SYSTEM DELIVERY, NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Phil Aubrey-Harris**	**Tel:**	**023 8029 6904**
	E-mail:	**phil.aubrey-harris@nhs.net**		
Director	**Name:**	**Peter Horne**	**Tel:**	**023 8029 6904**
	E-mail:	**phorne@nhs.net**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The papers (see appendices) provide:

- A general briefing on the CCG's work programmes related to delegated Primary Care commissioning functions and the implementation of Southampton City's own Primary Care Strategy as well as national policy – including the NHS Long Term Plan and associated 5 Year GP Contract Framework (2019 – 2024). The report includes a brief summary of some key achievements, priorities, risks and plans for 2020/21.
- A summary of emerging ideas from the current East Southampton Primary Care Estates and Access Review. These slides will be presented at the Panel meeting.

RECOMMENDATIONS: That the Panel

(i) notes and provides feedback on the briefing report

(ii) notes and provides feedback on the emerging idea from the East Southampton Primary Care Estates review

REASONS FOR REPORT RECOMMENDATIONS

1. To ensure the Health Overview and Scrutiny Panel has an understanding of primary care in Southampton and new developments, and considers the implications of the proposed estates review.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not applicable.

DETAIL (Including consultation carried out)

3. The CCG leads on the commissioning of Primary Care Services for the City via a delegation agreement with NHS England. The paper attached in

Appendix 1 gives an overview of the current plans and, priorities for the CCGs Primary Care Commissioning functions going into 2020.

4. As part of these responsibilities the CCG has established a review of Primary Care Estate and Access – starting first in the East of the City. This first phase will be complete by end of April 2020 at which time the work will be similarly undertaken in the Central and West localities of the City during the financial year from April 2020 to March 2021. The aims of this GP estates review are to:

   a) refresh estates strategies for primary care and associated out-of-hospital services, up-to-date national policy and local strategic developments;

   b) consider current estate, including, but not limited to condition, compliance, utilisation, functional suitability, quality and environmental management, geographic orientation, tenure, and opportunities for development.

   c) consider emerging future care models of care, including, but not limited to, core primary care, Primary Care Network (PCN) network services, Better Care Southampton emerging integrated care models and new ways of working and access (e.g. via video consultations);

   d) engage with local stakeholders including most notably local communities, and patients, care providers and other stakeholders, ensuring that estates plans resonate with organisational priorities;

   e) consider opportunities for development and improvement of estate including review of development opportunities, potential sites and available funding sources;

   f) identify and explore options and preferred pragmatic solutions that are most widely supported, maintain choice and access, are fit for the future and are affordable;

   g) consider risks and issues and how these might be mitigated.

5. The slides, attached as Appendix 2, summarise the context for the review and work that has been undertaken to date. The last few slides of the pack outline in summary some of the emerging ideas of options coming from the work to date.

6. The CCG will now work to conduct further feasibilities on these ideas and options and also engage the public, primary care providers and other stakeholders before producing a final report on all of the work, including recommendations for future estate development.

7. It is important to note that the final report will provide a plan for future estate development. Any specific variations to primary care contracts relating to service locations or any associated investments will be subject to applications from primary care providers, further and specific public and stakeholder engagement and the approval of the CCG.

RESOURCE IMPLICATIONS

Capital/Revenue

8. Not applicable.

Property/Other

9. The Estates Review will inform health components of the proposed Bitterne Hub Development being led by Southampton City Council.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

10. Not applicable.

Other Legal Implications:

11. None.

RISK MANAGEMENT IMPLICATIONS

12. None.

POLICY FRAMEWORK IMPLICATIONS

13. Not applicable.

KEY DECISION?	No	
WARDS/COMMUNITIES AFFECTED:	ALL	
SUPPORTING DOCUMENTATION		
Appendices		
1.	PRIMARY CARE BREIFING (FEBRUARY 2020)	
2.	EAST SOUTHAMPTON PRIMARY CARE ESTATES REVIEW – EMERGING IDEAS AND OPTIONS (FEBRUARY 2020)	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
1.	None	

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Primary Care Briefing
February 2020

NHS
Southampton City
Clinical Commissioning Group

1 Introduction and context

1.1 This report summarises the CCGs work programmes related to delegated Primary Care commissioning functions and the implementation of Southampton City's own Primary Care Strategy[1] as well as national policy – including most significantly the NHS Long Term Plan and associated 5 Year GP Contract Framework (2019 – 2024). The report includes a brief summary of some key achievements, priorities, risks and plans for 2020/21.

1.2 The CCGs work programmes for commissioning and transformation of primary care, currently and going forward involve a high degree of collaborative working at a number of levels:

- Individual practice level (10,000 to 30,000 population – 26 practices in city)
- Primary Care Network (PCN) level (30,000 to 80,000 population – 6 PCNs in city)
- Locality level (80,000 to 100,000 population – 3 localities in city)
- City / CCG level (290,000 population)
- Integrated Care Partnership (ICP) level (circa 500,000 – Hospital catchment area)
- Integrated Care System (ICS) level (circa 1.5 million population)

1.3 The CCG is a member organisation of 26 GP practices that serve the populations of Southampton City. For the majority of our Primary Care commissioning functions, including the commissioning of PCNs, governance oversight is provided via the CCG's Primary Medical Care Committee (PMCC). Primary Care has a significant role in the delivery of integrated care and as such the CCG, PCN Clinical Directors and other primary care stakeholders are represented in city wide and locality governance arrangements of our Better Care programme.

1.4 At a Hampshire and Isle of Wight level, the CCG and other City stakeholders are now represented on the Sustainability and Transformation Partnership (STP) Primary Care Programme Board and associated working groups. These are evolving arrangements and through 2020/21 we will continue to work with other CCGs to consider the best levels for the delivery of Primary Care work programmes. This will balance consistency and efficiencies of "doing things once" with the benefit of trusted relationships and more local approaches.

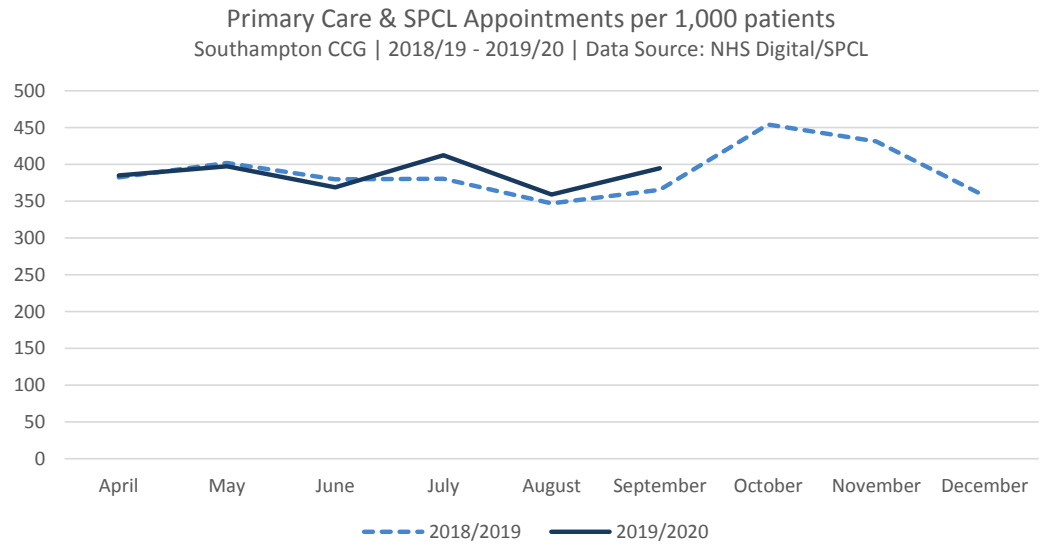
2 High quality & sustainable services

2.1 Through 2019/20 the CCG has continued to undertake contract visits, quality visits and internal Quality & Performance meetings to consider relevant data, discuss exceptions, seek assurance and where necessary plan support and remedial actions.

[1] The CCG's strategy "Transforming Primary Medical Care in Southampton 2016-2021" is currently under review as part of collaborative work within the city to develop a 5 year strategy for health and social care. The CCG is currently working with other partners to review and develop our plans for primary care in the light of our current environment and relevant national policies.

2.2 These arrangements are delivered via our Link Manager arrangements which continue to promote trust and understanding between local practices and the CCG team, often working in partnership with others including most notably the Local Medical Committees (LMC) and Southampton Primary Care Limited (SPCL). The development of our Primary Care quality surveillance and performance reporting arrangements will be further progressed with a view to revised reporting for 2020/21.

2.3 During Nov 2019 the CCG instigated work with our Commissioning Support Unit (CSU) and other local CCGs to produce some consistency in reporting around primary care capacity for Hampshire and Isle of Wight (HIOW). This work will be built on in 2020/21 and will form part of regular reporting via the CCGs Performance Board. Year to date the reports (below) show that primary care capacity has broadly kept up with population growth.



2.4 Through our Quality and Performance arrangements the CCG has been able to respond in a timely way to provide a range of support measures to struggling practices. Risks to service continuity remain a concern and feature on the CCG's corporate risk register. The main threats to primary care resilience relate to rising demand, workforce constraints, rising costs (e.g. locums) and partner liabilities. Unprecedented list movements and reduction of Personal Medical Services (PMS) premiums also presents challenges for some city practices. During 2020/21 we will undertake further work locally with our PCNs, SPCL and others, plus across our wider ICS partnership to further reinforce contingencies to mitigate service failure.

2.5 During 2019/20 2 city practices have been recipient of NHS England (NHSE) GP resilience programme and to date in 2019/20 the CCG has made £320k in Section 96 payments. These payments are non-recurrent support payments to maintain service continuity and are only made following significant due diligence. At the time of writing 1 city practice has formally restricted new registrations (approved by PMCC Oct 2019 with a view to review Apr 2020). During quarter 3 of 2019/20, two further smaller practices in the city temporarily restricted registrations (for a maximum of three months). The CCG has maintained a close level of surveillance with these practices and will endeavour to support the re-opening of lists as soon as possible in 2020.

3 Access

3.1 In June 2019 the Enhanced and Urgent Primary Care Service (EUPCs) commenced, delivered by SPCL. The service builds on the previous Hub services delivered by SPCL, originally funded by Prime Ministers' Access Fund since 2016 and provides valuable additional choice for patients and additional capacity to support local practices. Variation in rates of usage between patients of different practices remains significant but this has narrowed through 2019. The CCG continues to work with SPCL, local practices and via publicity campaigns to promote awareness of EUPCs. The service also provides urgent care services (GP out-of-hours) as part of Integrated Urgent Care (IUC) pathways. Since June SPCL have contributed to resilience arrangements in times of system pressure. SPCL also form a "first line" partner for CCG contingencies for GP practice service failure.

3.2 The new GP Contract Framework outlines intention from NHSE that CCG funding for GP Improved Access services (or Enhanced Access – i.e. part of EUPCs) will form part of PCN entitlements from April 2021. NHSE are currently reviewing this aspect of the Framework in the light of CCGs like Southampton with existing contractual commitments. Outcomes from the review may influence the future partnership and contractual arrangements between the CCG, PCNs and SPCL for the delivery of EUPCS and other services. Similarly NHSE have expressed an ambition that in future PCNs will evolve to have a significant role in the coordination of urgent care for their populations, including IUC services. This direction presents another argument for establishment of local CAS arrangements with strong alignment with primary care in the city.

3.3 There are opportunities to further refine urgent primary care pathways and the CCG has facilitated a regular IUC pathways group for the city including all relevant providers to help maximise appropriate and efficient pathways and care transfers. These arrangements will be further improved with the commissioning of IUC services (3.2 above) from June 2021.

4 PCNs – collaboration and integration

4.1 The New 5 Year GP Contract Framework commenced in April 2019 and from July 2019 the city's six Primary Care Networks (PCNs) were formed, headed up by 8 new Clinical Directors (CD's). NHS England expectations for PCNs are that they will:

- Stabilise primary care, including the partnership model
- Help solve capacity gap, growing workforce by over 20,000 additional staff
- Become a platform for future investment
- Dissolve the divide between primary and community services
- Clear, positive and quantifiable benefits for people, patients and the wider NHS

4.2 The CCG continues to engage with our GP practices (via GP forum meetings and newsletters) and our PCNs (via monthly meetings with PCN CDs, attendance at individual PCN meetings, 1:1s with CD's and other communications). Over 2019/20 the CCG will develop arrangements for engaging with PCN CD to ensure their influence in planning and commissioning decisions.

4.3 Since July 2019 the CCG has worked with PCNs to identify organisational development plans - funded by NHS England (circa £200k for Southampton PCNs for 2019/20).

Through 2020 the CCG will work to support the ongoing organisational development of PCNs.

4.4 The main investments offered to PCNs under the new contract framework are the Additional Roles Reimbursements. During 2019 some PCNs have taken up this opportunity and by end December 2019 around 50% of roles (Pharmacists and Social Prescribers) are in post or starting imminently. During the remainder of 2019/20 the CCG will work with PCNs and other partners to explore opportunities and options for deployment of these new roles

4.5 In December 2019 NHSE issued draft specifications for PCNs for commencing in 2020/21:

- Structured Medication Reviews
- Enhanced Health in Care Homes (EHCH)
- Anticipatory Care
- Personalised Care
- Supporting Early Cancer Diagnosis

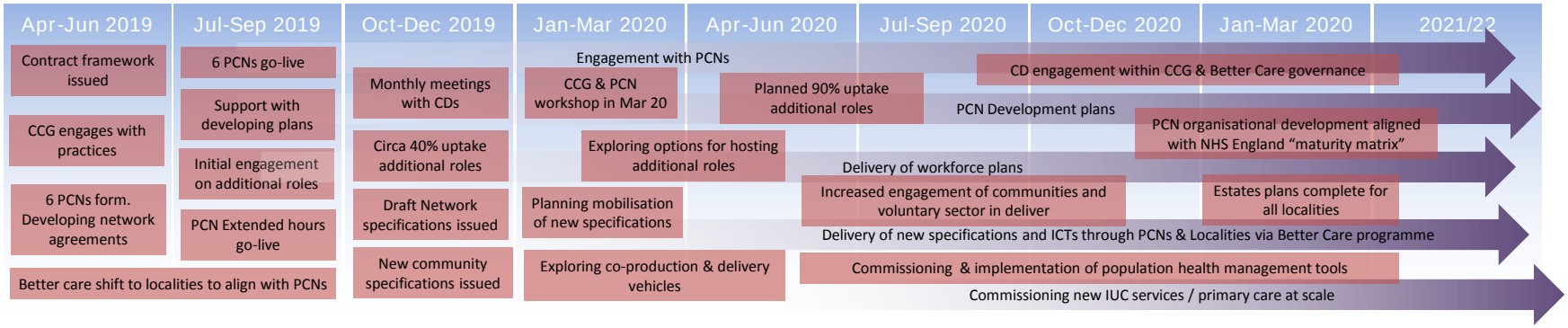
4.6 The specifications are currently out for consultation which closes imminently in mid-January 2020. Initial response from Primary Care stakeholders nationally (e.g. via professional journals) has been critical and it is expected that there could be some adjustment of the specifications between now and 1st April 2020.

4.7 There are overlaps between the draft specifications and ongoing initiatives in the city. For example, the CCG commissions EHCH services from SPCL which has been successful in improving outcomes for patients resident in care homes and reducing unnecessary hospitalisation. Additional investment is planned for 2020/21 to expand the service into Nursing Homes. During the last quarter of 2019/20, the CCG will work with PCNs and the SPCL to review the current EHCH service in line the new draft NHS PCN EHCH specification. This process of co-production is likely to prove a useful approach for other PCN specification for 2020 onwards and possibly in future for other areas of commissioning for Primary Care services.

4.8 Pan Hampshire and Isle of Wight this work is being coordinated via the STP Primary Care Board to support consistency and share learning.

PCN	Practice	Raw Pop @ Jan 19	Weighted Pop (GSUM)	PCN Raw Pop @ Jan 19	PCN Weighted Pop (GSUM)
West	Lordshill	11,540	11,357	86,711	82,580
	Victor Street	12,308	12,168		
	Cheviot Road	15,515	14,615		
	Shirley Health Partnership	14,560	13,494		
	Aldermoor	8,179	7,758		
	Atherley House	5,211	4,713		
	Raymond Road	4,516	4,604		
	Hill Lane	9,337	8,687		
	Brook House	5,545	5,184		
Central	St Marys	24,249	21,410	62,968	59,615
	Alma Road	9,746	10,335		
	Mulberry	6,174	5,911		
	Walnut Tree	4,259	3,970		
	Homeless Healthcare	465	374		
	Solent GP surgery	18,075	17,615		
North	Burgess Road	9,503	7,682	42,339	32,353
	University Health Service	19,037	12,798		
	Stoneham Lane	7,124	6,845		
	Highfield Health	6,675	5,058		
Bitterne	Bitterne Surgery	14,094	13,863	35,033	34,532
	Peartree	20,939	20,669		
Woolston & Townhill	Woolston Lodge	14,557	14,579	34,553	33,747
	Old Firs Station	8,767	8,623		
	Townhill	5,398	4,825		
	St Peters	5,831	5,720		
Living Well Partnership	Living Well Partnership	28,074	26,813	28,074	26,813

Fig 4.9.1 (above) PCNs in Southampton mapped to Better Care Localities AND Fig 4.9.2 (below) timeline for PCN developments through to 2021/22



5 Workforce and skills

5.1 Workforce constraints present a major challenge to the delivery of sustainable primary care services. In 2018 SPCL worked in partnership with PA Consulting to undertake a detailed audit of current primary care workforce in the city, modelling future population growth and demand and projecting future workforce requirements. This exercise projected a requirement for an additional 12 whole time GPs and 2 whole time Associate Nurse Practitioners above current levels by 2023. This projection also made assumptions about the ability for practices to keep up with workforce turnover.

5.2 During the audit work in 2018 we established significant opportunities for developing a more diverse skill mix in the city primary care workforce. This opportunity will be further developed through the new Contract Framework, PCNs and the opportunities to employ additional Pharmacists, Social Prescribers, Physicians Associates, Physios and Paramedics. In January 2020 most local PCNs have (or have concrete plans for imminent recruitment for) at least one Social Prescriber or Pharmacist. The CCG is currently working with PCNs and other stakeholders (including Solent NHS Trust and SPCL) to maximise the deployment of these Additional Roles. This includes the organisational hosting of roles (e.g. PCN Physios) within existing professional services and rotational posts to promote recruitment and retention.

5.3 Primary Care Workforce is covered locally within the Better Care workforce work streams and also at Integrated Care System (ICS) level via the STP Primary Care Workforce working group. In January 2020, CCGs across Hampshire and IOW have agreed to the deployment of national funding to Health Education Wessex to develop new and extend existing schemes to promote primary care workforce recruitment, retention and skills development across the wider geography.

6 Estates

6.1 The CCG is currently conducting a review of Primary Care estates and access in the city. The first phase of this work is focused on the East locality of the city and will aim to conclude with recommendations by spring 2020. During the remainder of 2020 the CCG will shift the focus of this work to cover the Central and then West localities.

6.2 The work is being undertaken in partnership with GB Partnerships, who are specialists in NHS estate. It includes a thorough stock-take of current estate; considering location of sites, condition, proximity to other amenities, utilisation and a range of other information. The review will involve significant engagement with our local communities, Primary Care providers and other stakeholders and will consider a range of options for optimising primary care estate. This may include consideration of some site rationalisation where this can be shown to lead to improved access and/or facilities in the long run.

7 Digital

7.1 The CCG is an active contributor to the Hampshire and Isle of Wight ICS Digital Roadmap programme which has a number of work streams associated with the transformation of IT infrastructure and maximisation of digital systems across our healthcare system.

7.2 Most of the Digital Roadmap work streams have direct or indirect impact for Primary Care including:

- GP IT. These service provide and maintain all of the IT infrastructure in GP practices and are currently in process of being re-procured. New contracts will go live in 2021.
- Population Health Management. – These systems support commissioners, PCNs and other providers with a range of information to help predict demand and focus resources. The new systems are being procured at ICS level.
- Interoperability. There are a range of initiatives, including a new national framework for GP IT providers to help promote the effective transfer of care and visibility of clinical information between different clinical systems. This is essential for the delivery of more integrated care. GP Connect is currently under development and the CCG will work through 2020 to deploy this to support direct booking of appointments between 111 and local primary care providers
- Digital First Primary Care. Increasingly, other industries offer customers to access services on-line, via chat services or video conferencing. 26 of the cities GP practices now offer patients the opportunity to access on-line consultations, where GPs review submitted queries from patients and respond appropriately without the need for a face to face appointment unless this is deemed clinical necessary. By 2021 all patients should have access to video consultations and the Digital Roadmap programme is currently exploring options for this at Hampshire and IOW level.

8 Summary

8.1 This paper has provided an overview of the CCGs strategy and work programme as related to the commissioning of delegated Primary Care Medical Services. The current challenges faced by our GP Practices and other Primary Care services is significant and it essential that these services are supported to change to help make them more sustainable for the future and reinforce their role at the centre of our health and care systems.

8.2 Over the next five years the CCG will continue to work with our communities, GP Practices, other health and care providers our neighbouring CCGs and other system partners to prioritise the resilience and transformation of our Primary Care Services with a view to delivering:

- Improved outcomes and experience for patients through more timely access to the right information, advice and services to meet individual needs
- Wider range of services tailored to patient and population needs provided at practice, Primary Care Network (PCN) and city levels
- Sustainable and resilient GP practices that gain strength through collaboration within their Primary Care Networks and their close partnerships with other heath and care providers and local voluntary organisations

- A Primary Care workforce led by GPs and made up of a wider range of trained professionals and specialist clinicians
- Population health management systems to support targeting of individualised person centred care planning
- Primary Care clinical leadership at the heart of local Integrated Care Teams, coordinating care for people with more complex needs
- Advances in IT systems enabling more effective sharing of patient records to support assessments and enabling many more patients to access services digitally e.g. via their smartphones
- Effective estate with Locality “hubs” in district centres hosting a range of services and open 8am till 8pm, 7 days per week plus the right number of more local neighbourhood surgeries to support access and choice

NHS
Southampton City
Clinical Commissioning Group

East Locality Estates & Access Review

Emerging ideas & options

February 2020

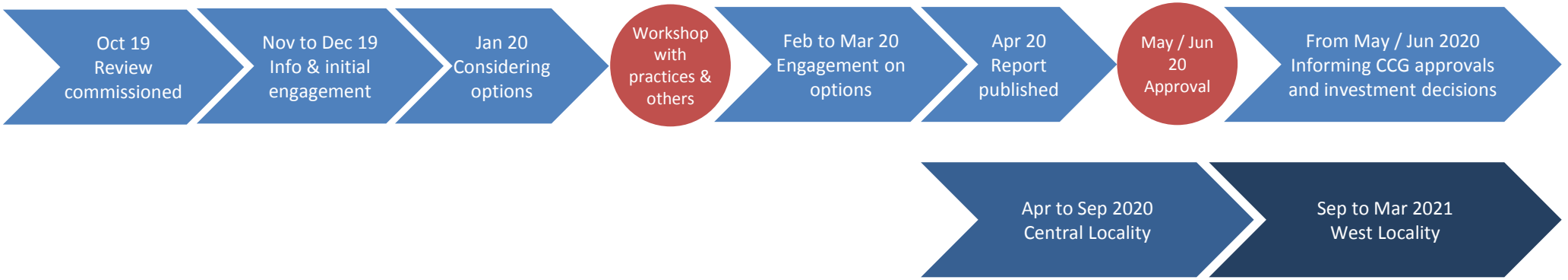
Agenda Item 10

Appendix 2

Current Primary Care sites in East Southampton

Background & proposed timeline for review

- Commissioning high quality services has geographic context
- Recognition of challenges– including the “burden” of estate
- Relative autonomy of Primary Care providers
- Individual applications without context
- Call for more strategic approach



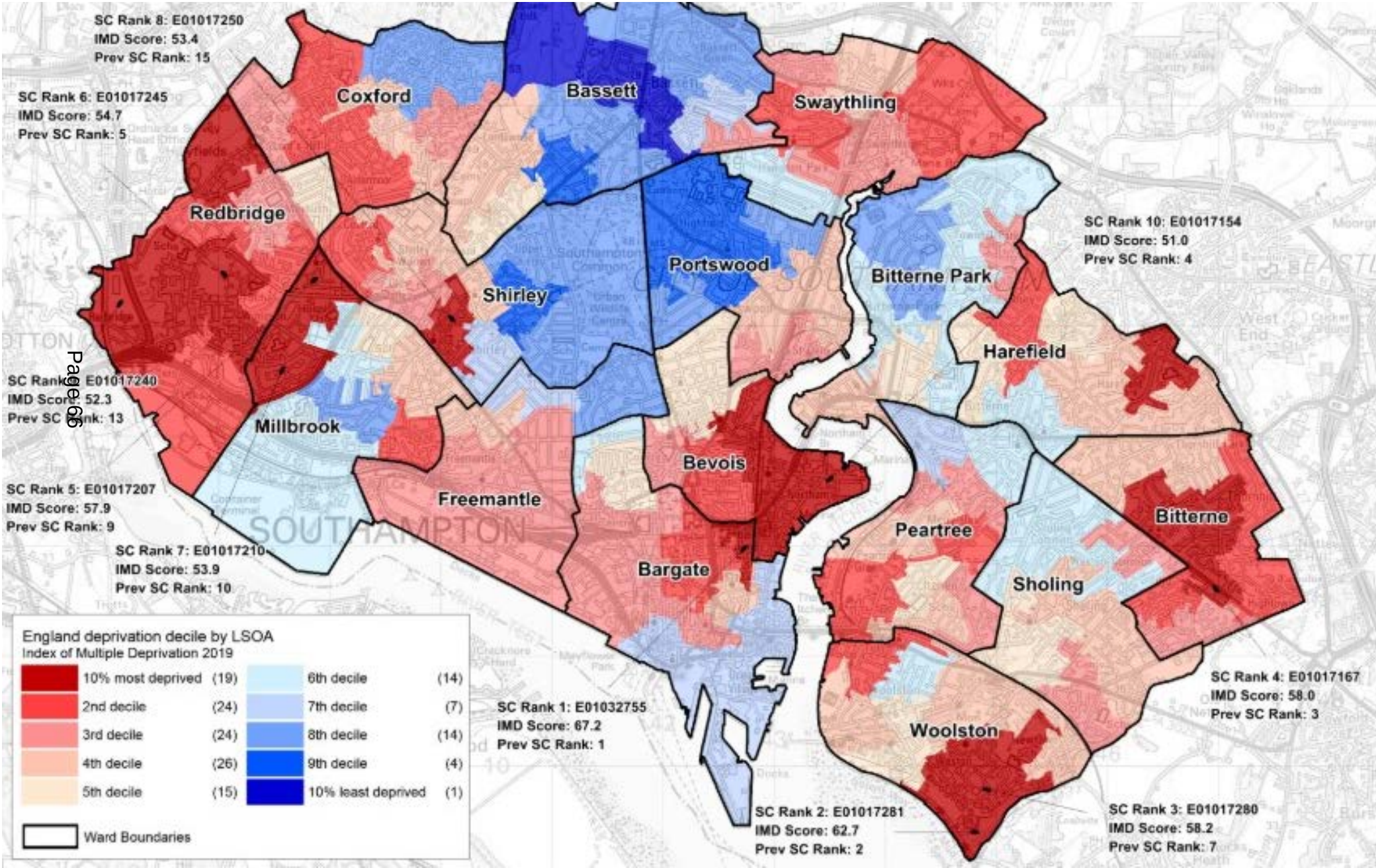
Context – Primary Care

- Current challenges present existential threats to primary care Rising demand, workforce supply, burden of estate etc.
- Recommendations of nationally commissioned reviews (2018)
- New Primary Care Contract Framework and Primary Care Networks (PCNs)
- Increasing skill mix within practices and at PCN level
- Investment in new roles (e.g. PCN Physiotherapists)
- Increased access (8am till 8pm and 7 days per week)
- Integrated Care Teams to support people with complex needs
- Increasing emphasis on digital access

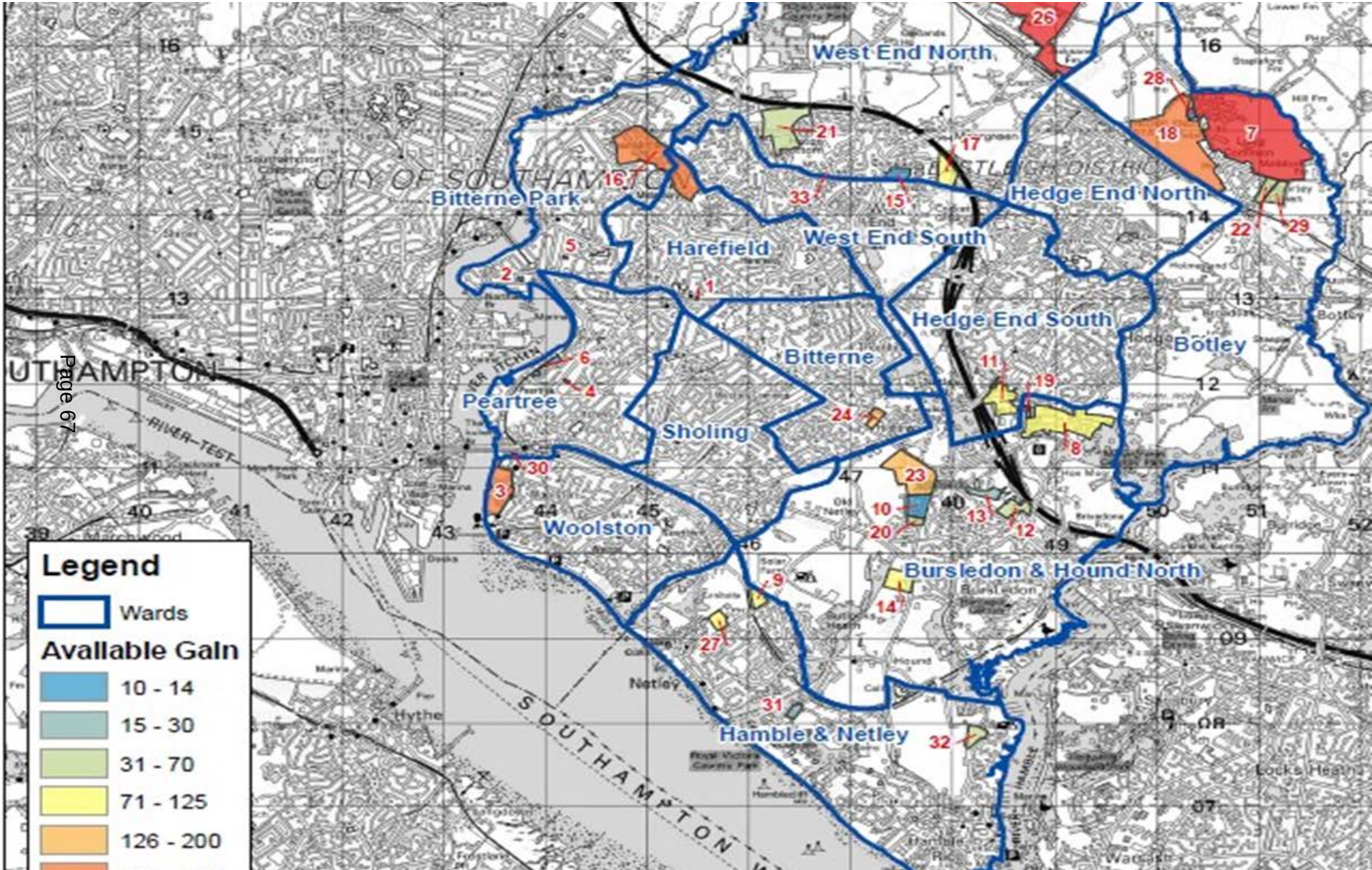
Context - Future of Primary Care

- Most GP practices are non-NHS organisations
- Most GP practices are run by partnerships
- Most GP contracts are in perpetuity
- NHS England (via the CCG) reimburses practices reasonable costs for the provision of their own accommodation
- There is a mixed tenure of GP premises – some partnerships own their sites freehold
- Practices can apply to the CCG to make variations to their contracts – including closing branch sites or moving sites
- The CCG is obliged to decide on these applications reasonably

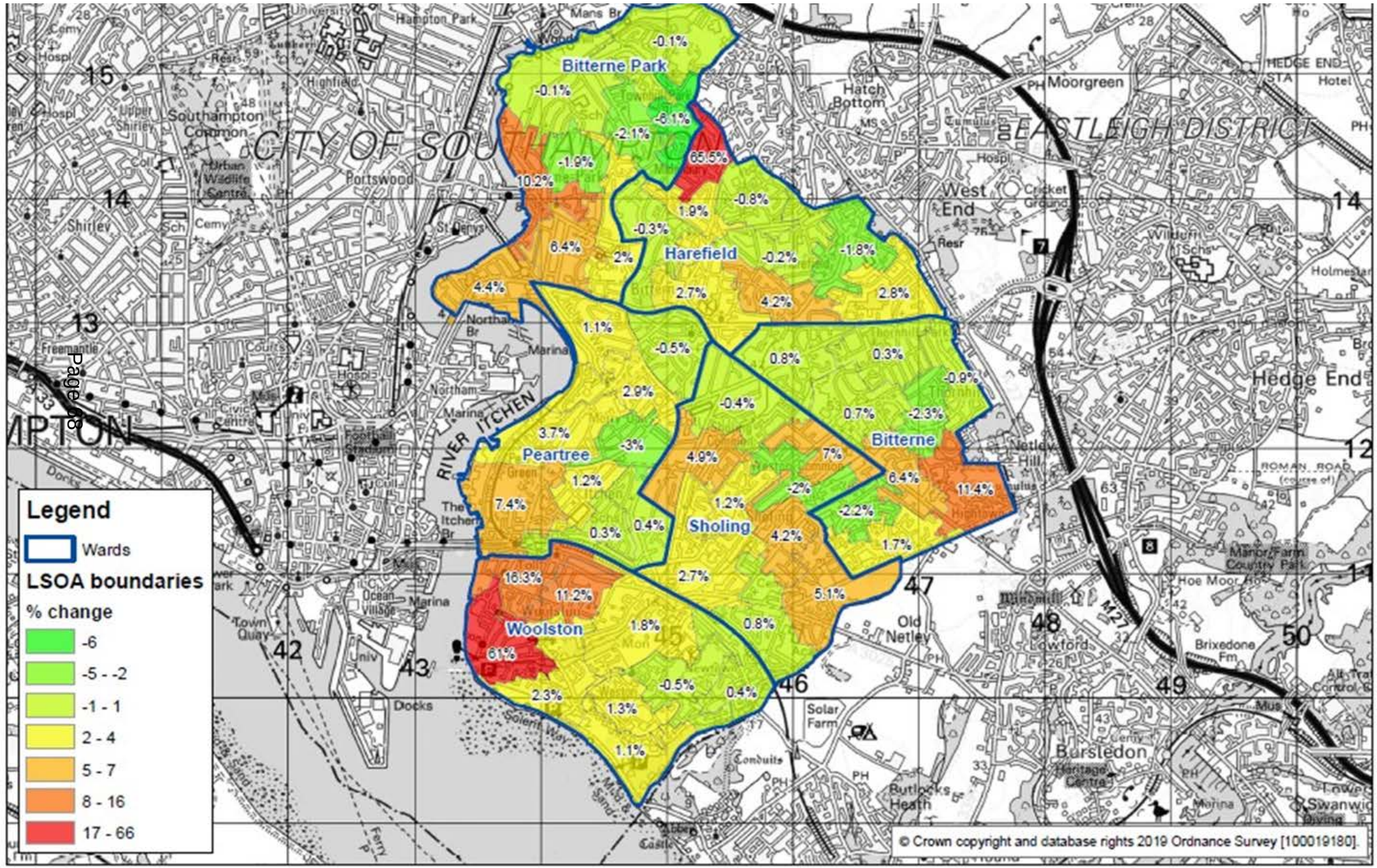
The review is taking into account – deprivation & inequalities



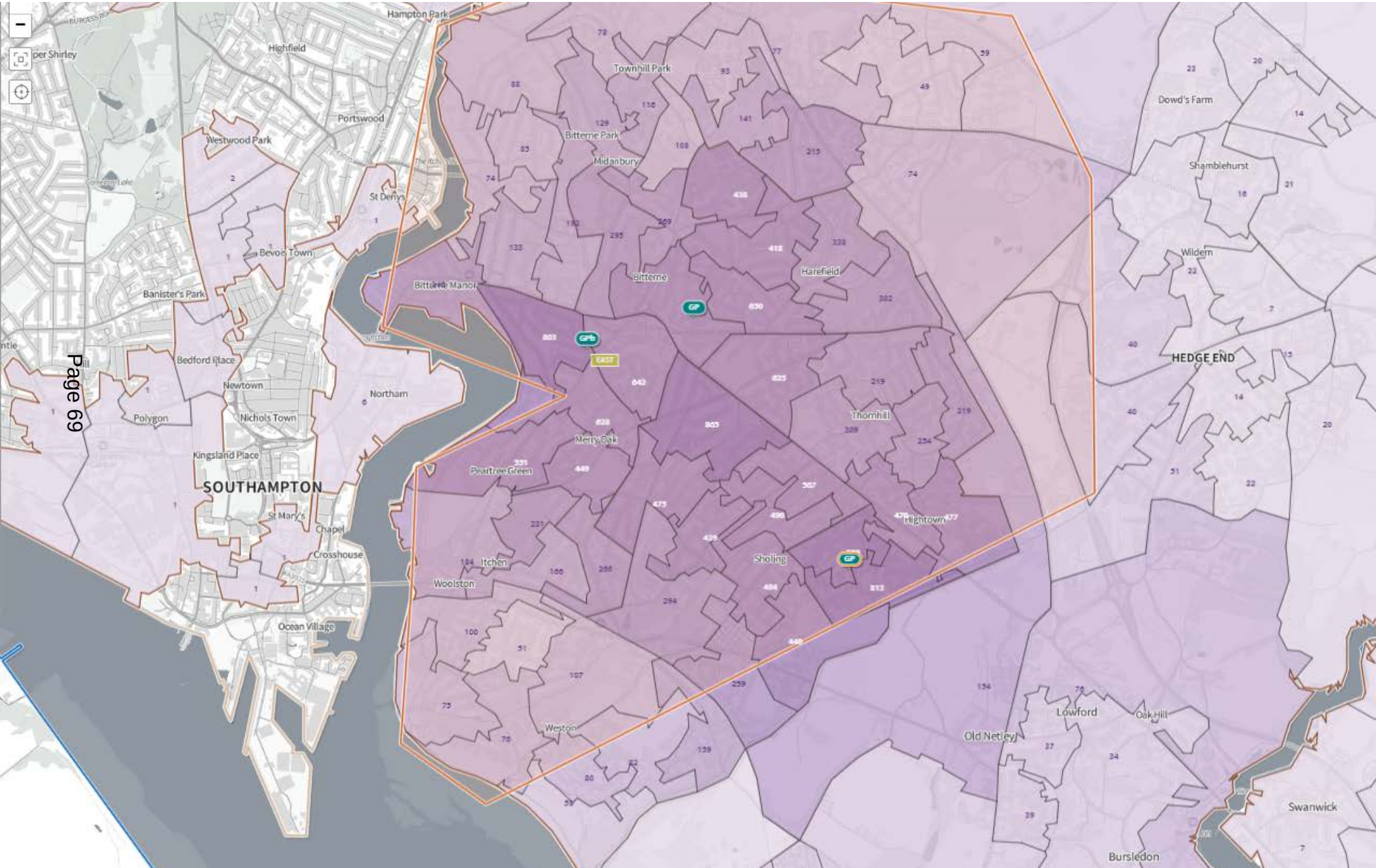
The review is taking into account – planned developments



The review is taking into account – expected population growth



The review is taking into account – where patients live



The review is taking into account – patients views on estate

900+ responses to date

How important is it that your GP surgery is located as close as possible to the following :

Location	Rating scale average
My home	4.02
Parking	3.96
Pharmacy	3.77
Bus stop	3.17
Other NHS facilities	2.72
Precinct / shopping parade / local shops	1.76
Community centre	1.72
Railway station	1.60
Major supermarket	1.45
Library	1.43
Place of worship	1.27

(closer to 5 = most important)

Testing extreme scenarios: Which of the following scenarios would you prefer?

Attending a smaller GP surgery, which is closer to your home, but open less often	24.47%
Attending a larger GP surgery, which is located near local facilities but could be further away from your home, and has longer opening hours	48.60%
Don't know	22.46%

- Over 60% of respondents indicate that they would be willing to travel further if it meant getting an appointment with an appropriate clinician more quickly, but clear preference to travel as little as is possible
- Car and walking most common ways of travelling to a surgery
- Almost 90% say they do not have problems travelling to their surgery at present, but issues raised about distance to travel to particular sites on periphery of city (e.g. Sholing) and difficult parking arrangements
- Patients for all sites overwhelmingly indicate the buildings they use are fit for purpose and safe. Issues / concerns raised about physical access on slopes; waiting rooms space for young children/pushchairs; disabled toilets.

The review is taking into account – patients views on access

- Significant issues with booking appointments – most commonly:
  - regarding telephones (length of time to wait / calls unanswered)
  - no appointments available to book at time of contact
  - difficult booking procedures, e.g. only able to book routine appointments during set times of the day
- Concerns raised about low numbers of GPs and that closure of sites is inevitable
- Increasing awareness of GP hubs: 74% have heard of the service (including 34% say they have used the service). More work to do to raise awareness of e-consult, NHS app (launched in 2019), and other ways to book appointments online.
- Patient engagement on review commence in Dec 2019 and will continue to end of April 2020 before final report submitted. Currently analysing age and practice breakdown of results to date prior to engagement on emerging options.
- Future public and patient engagement will include refreshed survey, drop in sessions, and focus groups.

Some initial principles to aim for?

- High Quality estate fit for modern healthcare
- The right number of sites with capacity and access mapped to our communities
- Locality “hubs”
  - In district centres – co-located with other amenities
  - Good transport links and local parking
  - Including core primary care plus other health and care services
  - Open 8am till 8pm – 7 days per week
- Preservation of choice for patients
- Enabling new service models including Primary Care Networks and Integrated Community teams
- Affordable for CCG and GP partnerships

Emerging ideas and options

Informed by our Estates and Access Review that includes:

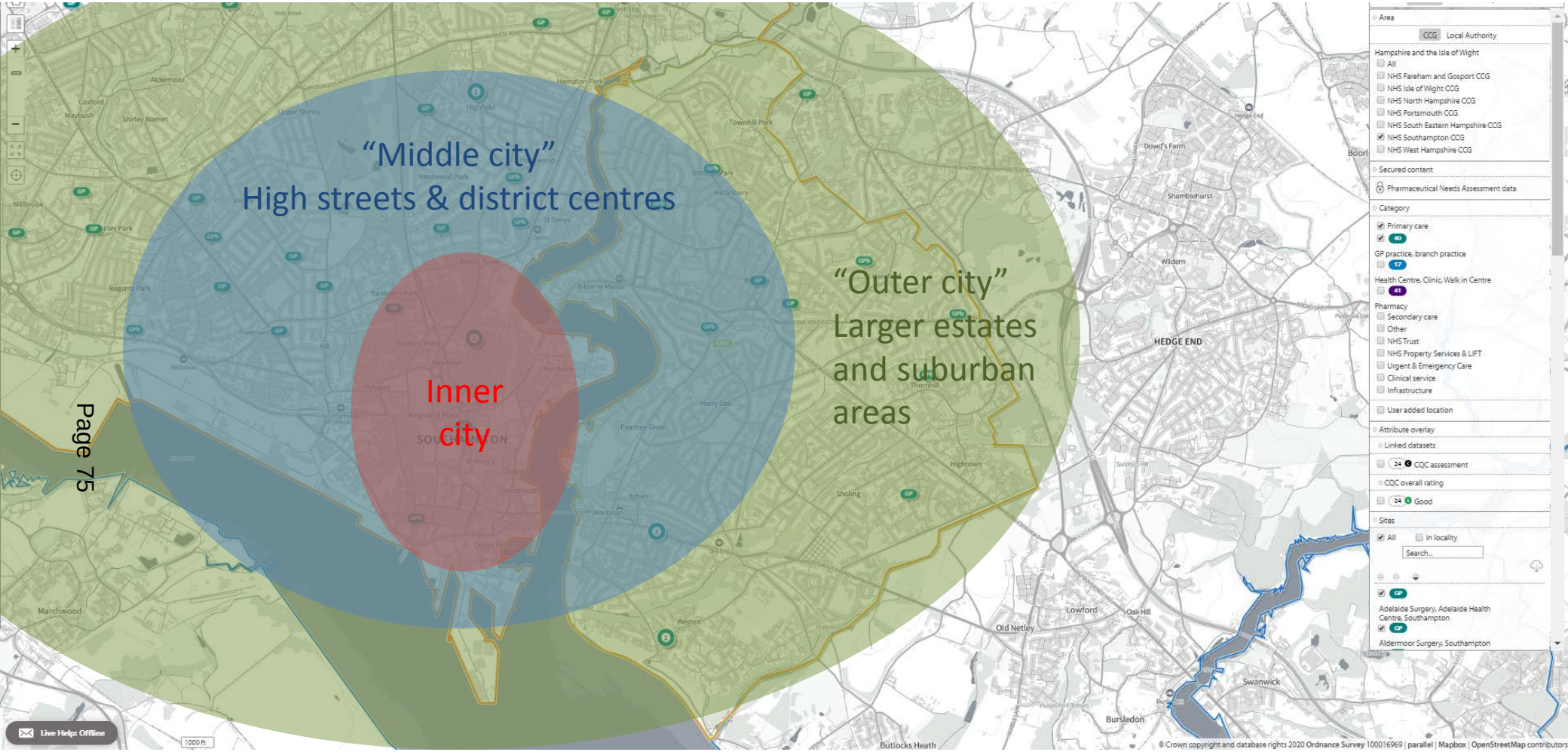
- Stock-take of current sites
- Considering population and environmental factors
- Considering strategic programmes – e.g. PCNs, Better Care Southampton
- Understanding of opportunities – e.g. Bitterne Hub
- Initial analysis of engagement with patients / public
- Aspirations & plans of local practices*
- Aspirations & plans of other local providers*

** Including workshop on 31st January 2020 for GP practices, other health providers and Healthwatch*

Assumptions and caveats

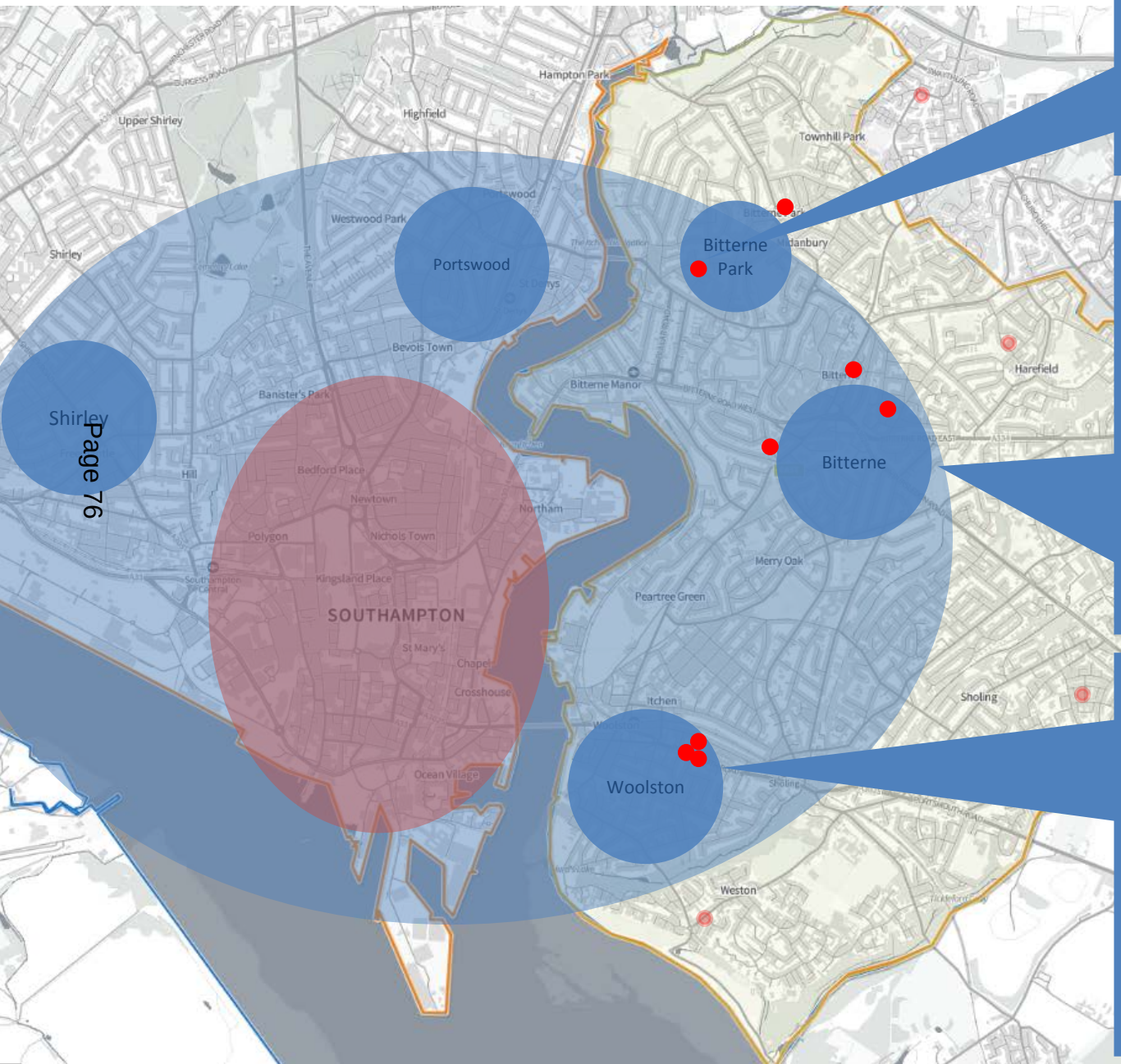
- We assume that there is an opportunity to improve primary care estate and access in the East of the city
- All ideas and options are subject to further engagement with communities, Practices and other stakeholders
- All ideas and option are subject to further feasibilities to consider viability
- All ideas and options will require Practices “buy in” – any specific proposals for change need to be mutually agreed
- Any variations to GP contracts, including branch closures or site moves are subject to approval by the CCG

Geographic orientation of city



- Inner city - diverse communities, significant deprivation in some parts, lots of amenities/services & good transport links
- Middle city – higher numbers of houses of multiple occupation, high streets and district centres, transport hubs & local amenities
- Outer city – some significant large areas of deprivation, lack of amenities, transport links to city centre via district hubs
- Need to capitalise on co-location in district centres – extended services for localities
- Need to redress balance of service provision on East – perceived bias of service locations on West of River Itchen
- Need to be mindful of amenities and communities on city periphery – e.g. Eastleigh Southern Parishes

Emerging options – District Centres



- Smaller district centre
- Buses to city centre, Townhill Park and Portswood
- Bitterne Park Medical Centre and Midanbury operated by Living Well Partnership – both part time branch sites
- Significant capacity in accommodation across 2 sites

1. Opportunity to "right-size" primary care
provision and possible site consolidation
Opportunity to consider service mix at Bitterne Park

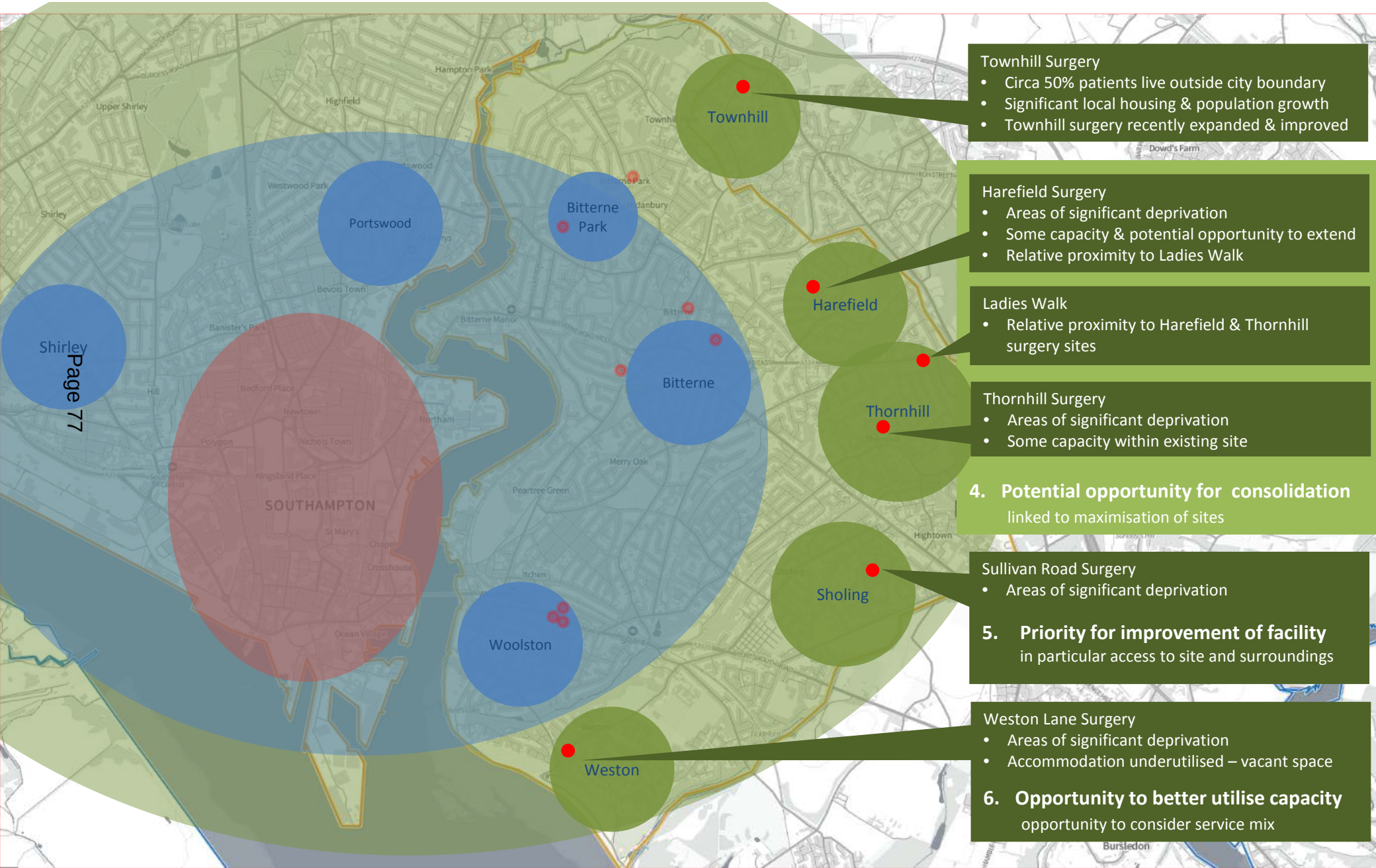
- Larger district centre
- Bus route hub with routes to city centre, Townhill, Hedge End, Harefield, Thornhill, Sholing and Woolston
- Chessel Avenue and Bitterne Health Centre operated by Peartree plus West End Road operated by Bitterne Surgery
- Bitterne Health centre could be an ideal site for co-location of community health and social services teams
- A new community Hub in Bitterne could offer further opportunity & re-provide sites – including for other health and care services for East Locality

2. Opportunity for site consolidation
Application from Peartree – decision deferred
Opportunity to revisit service mix at Bitterne HC
Opportunity to improve – potential new facility

- Larger district centre
- Bus route hub with routes to city centre, Bitterne, Sholing, Thornhill, Hightown, Weston, Netley, Bursledon
- Woolston Lodge, Old Fire Station & St Peters all adjacent on Portsmouth Road
- Sufficient capacity across current Woolston sites for some future growth and possibly other health and care services for East Locality
- Opportunity to extend Woolston Lodge to support site consolidation
- Potential capacity at Weston Lane

3. Opportunity for site consolidation
Opportunity to consider service mix in Woolston sites

Emerging ideas and options – Outer city



Townhill Surgery
- Circa 50% patients live outside city boundary
- Significant local housing & population growth
- Townhill surgery recently expanded & improved

Harefield Surgery
- Areas of significant deprivation
- Some capacity & potential opportunity to extend
- Relative proximity to Ladies Walk

Ladies Walk
- Relative proximity to Harefield & Thornhill surgery sites

Thornhill Surgery
- Areas of significant deprivation
- Some capacity within existing site

4. Potential opportunity for consolidation
linked to maximisation of sites

Sullivan Road Surgery
- Areas of significant deprivation

5. Priority for improvement of facility
in particular access to site and surroundings

Weston Lane Surgery
- Areas of significant deprivation
- Accommodation underutilised – vacant space

6. Opportunity to better utilise capacity
opportunity to consider service mix

Emerging ideas and options – in summary

1. **Bitterne Park & Midanbury**
   Opportunity to "right-size" primary care provision and possible site consolidation
   Opportunity to consider service mix at Bitterne Park

2. **Bitterne**
   Opportunity for site consolidation
   Opportunity to revisit service mix at Bitterne Health Centre. Opportunity to improve – potential new facility
   Application from Peartree pending – decision deferred.

3. **Woolston**
   Opportunity for site consolidation
   Opportunity to consider service mix in Woolston sites

4. **Harefield & Thornhill**
   Potential opportunity for site consolidation to be explored
   Linked to maximisation of sites

5. **Sholing**
   Priority for improvement of facility
   In particular access to site and surroundings

6. **Weston**
   Opportunity to better utilise capacity
   Opportunity to consider service mix

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		MONITORING SCRUTINY RECOMMENDATIONS		
DATE OF DECISION:		27 FEBRUARY 2020		
REPORT OF:		SERVICE DIRECTOR - LEGAL AND BUSINESS OPERATIONS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**Mark.pirnie@southampton.gov.uk**		
Director	**Name:**	**Richard Ivory**	**Tel:**	**023 8083 2794**
	E-mail:	**Richard.ivory@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This item enables the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.

RECOMMENDATIONS:

(i) That the Panel considers the responses to recommendations from previous meetings and provides feedback.

REASONS FOR REPORT RECOMMENDATIONS

1. To assist the Panel in assessing the impact and consequence of recommendations made at previous meetings.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. Appendix 1 of the report sets out the recommendations made at previous meetings of the Health Overview and Scrutiny Panel. It also contains summaries of any action taken in response to the recommendations.

4. The progress status for each recommendation is indicated and if the Health Overview and Scrutiny Panel confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Panel does not accept the matter has been adequately completed, it will be kept on the list and reported back to the next meeting. It will remain on the list until such time as the Panel accepts the recommendation as completed. Rejected recommendations will only be removed from the list after being reported to the Health Overview and Scrutiny Panel.

RESOURCE IMPLICATIONS

Capital/Revenue

5. None.

Property/Other

6. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

7. The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.

Other Legal Implications:

8. None

RISK MANAGEMENT IMPLICATIONS

9. None.

POLICY FRAMEWORK IMPLICATIONS

10. None

KEY DECISION No

WARDS/COMMUNITIES AFFECTED: None directly as a result of this report

SUPPORTING DOCUMENTATION

Appendices

1. Monitoring Scrutiny Recommendations – 27 February 2020

Documents In Members' Rooms

1. None

Equality Impact Assessment

Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out? No

Data Protection Impact Assessment

Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) 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	

Health Overview and Scrutiny Panel (HOSP)

Scrutiny Monitoring – 27 February 2020

Date	Title	Action proposed	Action Taken	Progress Status
5/12/19	Hampshire Wheelchair Service	1) That the Panel are provided with performance data that enables comparisons to be made between the performance of the Hampshire Wheelchair Service and other wheelchair services in England.	Please see this to link to the NHS Digital National Wheelchair Data set: https://www.england.nhs.uk/statistics/statistical-work-areas/national-wheelchair/publication-files/ This data provides information on Wheelchair services by each Clinical Commissioning Group (CCG) for 2019/20 up until the end of December 2019. Unfortunately data is not available nationally by individual providers of wheelchair services. NHS England and NHS Improvement have identified the need to improve the current collection of the national data set. The National Wheelchair Advisory Group has already consulted on and made recommendations to resolve the main issues that include the interpretation of the national guidance, which has led to significant variation across the county in reported performance. Southampton City CCG continues to work with Millbrook Healthcare to improve our local outcomes.	
		2) That, given the shortage of specialist rehabilitation engineers, consideration is given to whether there is the potential for regional, sub-regional or STP led NHS commissioning of training programmes to increase the number of trained specialists in this area.	Southampton City CCG is having ongoing discussions with partners across the region on training needs and other workforce issues.	
		3) That NHS Southampton City CCG, and partner commissioners, ensure that the contractual model and specifications for the post March 2021 wheelchair service are flexible enough to enable creative solutions to be developed and appropriate collaboration with other service providers to grow.	Southampton City CCG has taken on this approach since designing the specification for the new service and, once the procurement has concluded, will work with the provider to encourage further collaboration with the system.	

Date	Title	Action proposed	Action Taken	Progress Status
5/12/19	Suicide Prevention	1) That consideration is given to including within the Southampton 2020-23 Suicide Prevention Plan reference to the following: a) Opportunities to design in suicide risk reduction measures for new developments at the start of the process, potentially through the use of the Council's planning process. b) Reflecting the risk profile for middle aged men, engaging with the Trade Unions to proactively target suicide reduction initiatives and advice. c) Social media and bullying, reflecting the whole school approach to mental health and wellbeing in Southampton. d) Action to target the over prescribing of over the counter medicines if evidence support this. e) Linking the proposals for locality based teams that support families in Southampton with suicide prevention activity to raise awareness of support and build community and family resilience. f) Opportunities to expand networks with service providers that interact with vulnerable people when evidence suggests the risk of suicide is heightened, such as debt advice and relationship counselling services, to ensure that they are able to identify risk factors and signpost to support services.	a) PH is working with Planning colleagues to develop a protocol that outlines when and how PH will be engaged in planning processes; for example providing a PH response to pre-planning and planning applications, and potentially guidance to developers. We have drafted a checklist that we are trialling to support our assessment of pre-planning and planning applications, and suicide risk has been embedded under community safety. There is an action in relation to Planning and suicide risk in the draft 2020-23 Suicide Prevention Plan. b) The STP Suicide Prevention Programme will be engaging with Trade Unions and industry/business representative organisations to develop workplace suicide prevention tools and initiatives in targeted industries. Actions specific to target groups, including middle-aged men are embedded in the draft 2020-23 Suicide Prevention Plan. c) A work-stream on promoting a whole-school approach to mental health and wellbeing is in place, and a multi-agency Task and Finish Group has been set up to take it forward, chaired by Public Health and reporting to the Social and Emotional MH Partnership meeting. The first phase will focus on developing a resource that outlines what a whole-school approach is, how it can be achieved and best practice examples (drawing upon the resources and good practice already available), with key stakeholders engaged, and the second phase will focus on implementation. Links have been made with the Mental Health Support Team programme; these teams will be a key lever	

Date	Title	Action proposed	Action Taken	Progress Status
			for promoting a whole school approach. This action is reflected in the draft Southampton Suicide Prevention Plan. Schools are already funded to have access to PSHE Association resources, which includes guidance and tools in relation to social media and bullying. d) An action has been embedded in the draft Southampton Suicide Prevention Plan. e) An action has been embedded in the refresh of the Southampton Suicide Prevention Plan. f) An action has been embedded in the refresh of the Southampton Suicide Prevention Plan. Also links with the STP suicide prevention.	
		2) That sustainability is embedded within the Suicide Prevention Plan reflecting the funding limitations.	Sustainability is one of the criteria against which STP Suicide Prevention projects and interventions are assessed. Transitioning projects into sustainment or business as usual will be built into project plans. Sustainability is also a principle informing of Southampton's Suicide Prevention Plan.	
		3) That the agencies and service providers that interact with vulnerable people when evidence suggests the risk of suicide is heightened are consulted on the draft Suicide Prevention Plan.	Key agencies and service providers have been mapped and are being consulted.	

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