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Health and Wellbeing Board

Wednesday, 29th May, 2013 at 5.30 pm

Council Chamber - Civic Centre

This meeting is open to the public

Members

5 Elected Members to be appointed at the Meeting of Cabinet 21 May 2013

Harry Dymond – Health Watch
Alison Elliott – Director of People
Dr A Moritimore – Director of Public Health
Dr S Townsend – Clinical Commissioning Group
Dr S Ward – NHS England Wessex Local Area Team

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Democratic Support Officer
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BACKGROUND AND RELEVANT INFORMATION

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

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

Southampton City Council's Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

Proposed Municipal Year Dates

2013	2014
23 January	29 January
27 March	26 March
29 May	
31 July	
25 September	

Responsibilities
The board is responsible for developing mechanisms to undertake the duties on the health and wellbeing board, in particular:

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

Smoking policy – The Council operates a no-smoking policy in all civic buildings.
Mobile Telephones – Please turn off your mobile telephone whilst in the meeting.
Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take
Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

27 November	

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED

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

RULES OF PROCEDURE

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

QUORUM

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

DISCLOSURE OF INTERESTS

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

DISCLOSURE OF INTEREST

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

DISCLOSABLE PERSONAL INTERESTS

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

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

a) the total nominal value fo the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
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 a, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

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

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

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

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 ELECTION OF CHAIR AND VICE-CHAIR

To elect the Chair and Vice Chair for the Municipal Year 2013/14.

3 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

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

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

4 STATEMENT FROM THE CHAIR

5 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 27th March 2013 and to deal with any matters arising, attached.

6 PATIENTS FIRST AND FOREMOST: THE INITIAL GOVERNMENT RESPONSE TO THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Report of the Chair of the Clinical Commissioning Group detailing the Government's initial response to the public inquiry into the Mid Staffordshire NHS Foundation Trust, attached.

7 STEPS TOWARDS JOINT AND INTEGRATED COMMISSIONING

Report of Head of Integrated Commissioning/Director of Quality and Integration detailing steps toward joint and integrated commissioning, attached.

Monday, 20 May 2013 Head of Legal, HR and Democratic Services

SHADOW HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 27 MARCH 2013

Present: Councillors Rayment (Items 7 and 8), Stevens (Items 7 and 8), Baillie, Turner, Dr S Townsend, Dr S Ward, Ms M Geary and Dr A Mortimore

Apologies: Councillors Bogle and Mr H Dymond

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

The Panel noted that Joe Hannigan was in attendance as a nominated substitute for Harry Dymond.

Dr Steve Towsend, Vice Chair was in the Chair.

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

RESOLVED that the Minutes of the meeting held on 23rd January 2013 be approved and signed as a correct record.

19. **SOUTHAMPTON LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2011/12**

The Board received and noted the report of the Independent Chair, Southampton Local Safeguarding Children Board detailing the Annual Report for 2011/12 and highlighting initiatives that were being progressed or completed. The Board noted that in accordance with New Working Together 2013 there was a requirement for the Annual Report to be submitted to the Chair of the Health and Wellbeing Board.

Donald McPhail, Independent Chair was in attendance and with the consent of the Chair addressed the meeting.

The Board particularly noted the requirement for the implementation of the Governments review of Safeguarding, the Munro Review which had identified a stronger sense of professional discretion and judgement in social work and a more focussed emphasis on achieving outcomes for children and their families as key areas. There would also be implications for how future Serious Case Reviews were conducted.

It was also noted that a significant focus of a number of the Serious Case Reviews had been chronic neglect; a lot of work had been done in the aftermath of those to ensure greater understanding and working together. Current local priorities also included children sexually exploited, missing children, children looked after placed outside of the City, the early intervention role of the Board and any other issues that required response as part of the national agenda at any given time.

The Board made reference to home educated children who did not feature in any agencies systems. Donald McPhail advised the Board that there was not currently an issue for concern in Southampton; however acknowledged that this may not always be the case. It was noted that whilst there was not a requirement to register with the Local Authority there was good awareness knowledge and working relationships with

agencies in the City specifically those involved in children and young people who may be trafficked and those that were missing.

The Board noted that working relationships between the Local Safeguarding Children Board and the Health and Wellbeing Board would need to develop over the forthcoming months particularly in relation to key/parallel priorities for each Board.

20. **JOINT HEALTH AND WELLBEING STRATEGY**

The Board considered the report of the Director of Public Health detailing the final version of the Joint Health and Wellbeing Strategy for formal recommendation to the City Council Cabinet and Southampton City Clinical Commissioning Group for adoption.

Mr Eayrs, Member of the Public was in attendance and with the consent of the Chair addressed the meeting. Mr Eayrs made reference to the strategy and that it focussed on recovery of conditions without reference to "management" of conditions as not all conditions were recoverable. The Board acknowledged that this was a well made point, would enhance the document and recommended that it be included in the final strategy.

The Board also made reference to the following points which would require amendment within the final version of the strategy:-

- Page 9, 4th bullet point, "consults on the introduction of an Additional Licensing Scheme for all HMO's" – this would need to be amended to reflect the fact that the scheme was now in place.
- Page 19, 3rd bullet point, Key Information JSNA – amend wording to reflect diagnosis that "included dementia" as opposed to "dual diagnosis of dementia".

The Board acknowledged that the published version of the strategy would be in a glossary format; Alison Elliott, People Director would need to replace Margaret Geary and Clive Webster in the membership details.

RESOLVED

i. That the Joint Health and Wellbeing Strategy be approved for submission to the City Council Cabinet and Southampton City Clinical Commissioning Group subject to the inclusion of the three amendments identified above; and

ii. That authority be delegated to the Director of Public Health, following consultation with the Chair and Vice Chair of the Board to make any minor drafting or other amendments necessary prior to submission to the City Council Cabinet and Southampton City Clinical Commissioning Group.

21. **PROPOSALS FOR USE OF FUNDING TRANSFER FROM NHS TO SOCIAL CARE IN 2013/14**

The Board considered the joint report of the Chair, Clinical Commissioning Group and Director of Adult Health and Social Care detailing proposals for use of funding transfer from NHS to Social Care 2013/14.

It was noted that since 2010/11 the Department of Health had allocated funding to Primary Care Trusts to transfer to local authorities to support health and social care joint working. This had been a time limited investment to act as a catalyst for change to increase sustainability in the system and improve the quality of patient outcomes. This was in addition to the funding for reablement services. From 2013/14, the funding transfer to local authorities would be carried out by the NHS Commissioning Board. The

funding must be used to support adult social care services in each local authority, which also had a health benefit. The amount for Southampton was £3,970,677. The guidance stated that the NHS Commissioning Board must make it a condition of the transfer that the local authority and health partners agreed how the funding was best used within social care and the outcomes expected from this investment. It was proposed that this should be done via the Health and Wellbeing Board. Proposals for the criteria and priorities for the use of the 2013/14 spend had been developed by the City Council Adult Health and Social Care and the Southampton Clinical Commissioning Group.

The Board noted the proposed priorities for funding as detailed in paragraph 3.6 of the report were in line with the Health and Wellbeing Board priorities. Reference was made to the point that the Health and Wellbeing Board in its established format as of 1st April 2013 would next financial year have a role to play as the interagency setting to determine local principles and deployment of resources.

RESOLVED

i. That the proposed use of the funding transfer from NHS to Social care (NHS Transfer) was based on priorities within the Joint Strategic Needs Assessment and existing commissioning plans for both health and social care;
ii. That the criteria outlined in 5.1 of the report be used to decide priorities for 2013/14 spend;
iii. That the proposed priorities outlined in 5.2 of the report be approved subject to the required funding requirements of paragraph 3.1 of the report;
iv. That the NHS Commissioning Board Wessex Local Area Team assure the Health and Wellbeing Board that the proposed priority areas would support adult social care services and have a health benefit; and
v. That the final detailed list of investments be approved and monitored by the Southampton Integrated Commissioning Board.

22. **PROPOSALS FOR LOCAL MEASURES OF QUALITY PREMIUM 2013/14**

The Board considered the report of the Chair, City Clinical Commissioning Group detailing proposals for local measures of quality premium 2013/14.

The Board noted that the NHS Commissioning Board would reward clinical commissioning groups for improvements in the quality of the services that they commissioned and for associated improvements in health outcomes and reducing inequalities through the use of a “quality premium”. The quality premium would be based on the achievement of four national measures based on measures in the NHS Outcomes Framework and three local measures based on local priorities identified in the Joint Health and Wellbeing Strategy.

The local priorities would be agreed between the Clinical Commissioning group and the area team of the NHS Commissioning Board after consideration with Health and Wellbeing Boards and key stakeholders.

The Board noted that the proposed measures were:

- Further increasing early access to psychological therapy/services
- Improving care for individuals with diabetes
- Increasing effectiveness of referrals

The Board also noted that in future years it would be appropriate for the Health and Wellbeing Board in its established format as of 1st April 2013 to review the alignment of appropriate priorities and measures with the Health and Wellbeing Strategy.

Mr Fogarty, Member of the Public was in attendance at the meeting and with the consent of the Chair addressed the meeting.

RESOLVED

i. That the proposed measures for the Quality Premium 2013/14 be approved; and
ii. That the identified local measures for the Quality Premium support priorities identified within the Health and Wellbeing Strategy.

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		PATIENTS FIRST AND FOREMOST: THE INITIAL GOVERNMENT RESPONSE TO THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY		
DATE OF DECISION:		29th MAY, 2013		
REPORT OF:		CHAIR, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dr Steve Townsend**	**Tel:**	**023 80**
	E-mail:	**Steve.townsend@nhs.net**		
Director	**Name:**	**John Richards**	**Tel:**	**023 80**
	E-mail:	**John.richards@southamptoncityccg.nhs.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The report of the public inquiry into the Mid Staffordshire NHS Foundation Trust led by Robert Francis QC (the Francis report) was published in February 2013. The government has now published its initial response, and the key points from this response are summarised for the Board's consideration.

RECOMMENDATIONS:

(i) That the Board receives and notes the issues highlighted in "Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC - *Patients First and Foremost*".

(ii) That the Board notes the work that is going on locally within the NHS and partner organisation to respond to the challenge of the Francis Report, supports its direction of travel and expects that the NHS and partner organisations foster a culture of care, with continuous improvement of quality, safety and patient experience.

REASONS FOR REPORT RECOMMENDATIONS

1. The Francis report and the government's response both raise a number of important issues for the local health and care system. As a high profile leadership board within the local system, it is appropriate for the Health and Wellbeing Board to consider the implications of the recently published government response.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. The Health and Wellbeing Board could choose not to consider and comment on the government's response, but this was rejected on the basis that the Board has a contribution to make in respect of this very important matter.

DETAIL (Including consultation carried out)

3. The Francis Report into failings at Mid-Staffordshire NHS Foundation Trust between 2005 and 2008 was published on 6 February 2013. It tells the story of an appalling breakdown of basic patient care, which probably resulted in the death of about 500 patients. Even more disturbing, this breakdown occurred against the backdrop of the trust becoming a foundation trust, with the board's emphasis on financial management rather than patient care. Though the many regulatory and supervisory bodies had concerns about the trust's performance, they failed to prevent or deal with the problems.

4. The lengthy report identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. A number of causes were identified, including:

- A culture focused on doing the system's business – not that of the patients;
- An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
- Too great a degree of tolerance of poor standards and of risk to patients;
- A failure of communication between the many agencies to share their knowledge of concerns;
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

5. The report contained 290 detailed recommendations, the essential aims of which were to:

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;

- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they what they do and to ensure that the public is protected from those not fit to provide such a service;
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

6. The Department of Health has considered the inquiry report and published an "initial government response", in which the Secretary of State says: "Action is needed at each level to enable the excellent care that already exists in the health and care system to become the norm, and to become what every person can expect of the NHS". This is statement that the Health and Wellbeing Board would want to endorse across local health and care systems.

7. The government response sets out a 5 point action plan to "revolutionise the care that people receive from our NHS…" The 5 key points are:

- Preventing problems
- Detecting problems quickly
- Tackling action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated

The main actions proposed under each of these heading are summarised below.

8. **Preventing problems**

- Time to care.
  A commitment to decrease bureaucracy, enabling staff to spend more time with patients.

- Safety in the DNA of the NHS – The Berwick Review
  Professor Donald Berwick, a well-known American expert on health safety will be working with NHS England to ensure a robust safety

culture in the NHS.

9. **Detecting problems quickly**

- The appointment of a Chief Inspect of Hospitals at the Care Quality Commission.
  This appointment will be made later this year, and the Chief Inspector will make an assessment of every NHS hospital's appointment, drawing on local views.

- Expert Inspectors, not Generalists.
  This measure will lead to more thorough inspections of hospitals. There will also be a "comply or explain" approach to known good practices such as nursing rounds.

- Ratings – A single balanced version of the truth
  The Care Quality Commission will work with the Nuffield Trust to develop a rating system, including clinical quality measures as well as financial ones. This will be similar to OFSTED ratings, and will include the Friends and Family Test.

- The appointment of a Chief Inspector of Social Care
  This Chief Inspector will adopt a similar approach to social care and rating care homes.

- Publication of Individual Speciality Outcomes.
  The publication of outcome measures about individual hospital departments will be extended to another nine areas.

- Penalties for Disinformation and a Statutory Duty of Candour.
  While the government has shied away from creating a criminal offence, as recommended by Francis, there will be a statutory duty of candour, which means that providers will have to inform people if their treatment has resulted in serious harm and provide an explanation.

- A Ban on Clauses Intended to Prevent Public Interest Disclosures
  NHS England has already instructed provider trusts not to use "gagging clauses".

- Complaints Review.
  A review of best practice on complaints to ensure that lessons are learnt by the NHS.

10.. **Taking action promptly**

- Fundamental Standards
  The Care Quality Commission will draw up an explicit list of minimum basic standards, which will be readily accessible.

- Time Limited Failure Regime for Quality as well as Finance.
  If failing hospitals do not improve, ultimately they will be put into administration (with arrangements to ensure continuity of care).

11. **Ensuring robust accountability**

- Health and Safety Executive to use criminal sanctions.
  It is of note that recommendation 87 of the Francis Report stated "The Health and Safety Executive is clearly not the right organisation to be focusing on healthcare." The government response, however, gives it the role of considering criminal prosecution where the Chief Inspector identifies criminally negligent practice.

- Faster and more proactive professional regulation
  The General Medical Council, the Nursing and Midwifery Council, and other professional regulators will be reviewed in order to simplify and update legislation.

- Barring Failed NHS Managers.
  There will be a national barring list for unfit managers, based on the scheme for teachers.

- Clear responsibilities for tackling failure

12. **Ensuring staff are trained and motivated**

- HCA training before nursing and other degrees.
  This is not one of Francis' recommendations. The proposal is that every student who seeks NHS funding for a nursing degree should be required to work for up to a year as a healthcare assistant.

- Revalidation for Nurses.
  This mirrors the revalidation system that has just been introduced for the medical profession.

- Code of Conduct and Minimum Training for Health and Care Assistants
  Standards of training and a code of conduct for Health and Care Assistants have been published, and the Chief Inspectors will ensure that they are properly supported.

- Attracting Professional and External Leaders to Senior Management Roles
  The NHS Leadership Academy will encourage clinical professionals and people from outside the NHS into top leadership positions.

- Frontline Experience for Department of Health Staff.
  Within 4 years every civil servant in the Department will have "sustained and meaningful experience on the front line".

13. The response also contains a Statement of Purpose signed by the leaders of 14 professional bodies; a pledging to bring about the necessary personal and institutional change to prevent a further incident of this nature. In

addition the government is proposing that all NHS hospitals will indicate how they intend to the Inquiry's conclusions before the end of 2013.

Implications and Issues for the Local Health and Care System

14. The two reports that Robert Francis has written about the failings in Stafford have shocked those working NHS, and produced a resolve for change to prevent a recurrence. It is apparent that we need to change our culture, and it is debatable how much the top down approach of this report will achieve that. One theme of the second report was that there was a failure of management culture, which was not only focussed on finance at the expense of quality, but was prepared to bully anyone who questioned what was going on. There have been calls for the resignation of the Chief Executive of NHS England, Sir David Nicholson, who was for a short while Chief Executive of the Strategic Health Authority responsible for Stafford. In this context, it is a pity that NHS England was not a signatory to the Statement of Common Purpose.

15. Another theme of the Francis Report was that nursing staff spent too much time on administration at the direct expense of patient care. The commitment to reduce bureaucracy is admirable, but the inspection regime proposed sounds bureaucratic. There is a parallel with OFSTED, which may have improved standards in schools, but is onerous for teachers.

16. We also need to accept the challenges of improvement in a health service which is facing substantial financial challenges. Francis commented on the problems resulting from inadequate staffing. We need to be sure that this does not become a reason to retain inefficient practices rather than face the discomfort of moving to efficient ones.

17. Nonetheless, there are undoubtedly opportunities for the NHS and social care systems in Southampton, and we must nurture the genuine desire of those working in local organisations to do their best for their patients, clients and customers. In Southampton City CCG we are committed to make quality the central theme of everything we do, and to do so using the transparent, supportive, "no blame" approach. This has improved safety in, for example, the aviation world and is very much the approach taken by Donald Berwick. We have set up a clinical governance committee, and have regular meetings with local provider trust to discuss quality and safety issues.

18. Francis was particularly scathing about the patient representative organisations in Stafford, which were over-deferential and consumed by in-fighting. Whilst Southampton LINk avoided those traps, we need to ensure that HealthWatch develops into an effective patient representative, and holds health and social services to account.

19. The response has quite rightly highlighted that within the NHS it is common

to see complaints as irritations to be managed defensively rather than vital information for improvement. We await the results of the review of best practice with interest. As a CCG, we would be pleased to act as a recipient of any complaints, particularly those reaching councillors from their constituents. We have already had a similar conversation with one of our local MPs.

20. The failures in Stafford were detected by many organisations, but were viewed separately. The Wessex Area Team has set up a Quality Surveillance Group to ensure that it, local clinical commissioning groups, Monitor, the CQC and patient representative organisations meet regularly to discuss safety matters. Southampton City CCG is also going to meet next month with West Hampshire CCG, the Local Medical Committee and consultants from University Hospitals of Southampton Foundation Trust to discuss how we exchange "soft" information about poor performance, particularly when that involves individual practitioners.

Conclusion

21. The events at Stafford Hospital have shocked the NHS, and led to a resolve to avoid a recurrence. There is much good work going on, though we need to ensure that momentum is maintained and leads to a change of culture in the NHS where quality and safety are considered much more systematically than they have in the past.

RESOURCE IMPLICATIONS

Capital/Revenue

22. The costs of implementing the recommendations in this report will be met from existing council and CCG budgets.

Property/Other

23. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

24. The powers and duties of Health and Wellbeing Boards are set out in the Health and Social Care Act 2012.

Other Legal Implications:

25. None.

POLICY FRAMEWORK IMPLICATIONS

26 None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

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

Other Background Documents

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

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

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		STEPS TOWARDS JOINT AND INTEGRATED COMMISSIONING		
DATE OF DECISION:		29th MAY 2013		
REPORT OF:		HEAD OF INTEGRATED COMMISSIONING/DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296941**
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Director	**Name:**	**Alison Elliott, People Director, Southampton City Council** **John Richards, Chief Executive Southampton City CCG**	**Tel:**	**023 8083 2602** **023 8029 6923**
	E-mail:	**John.richards@southamptoncityccg.nhs.uk** **Alison.elliott@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

Health and Wellbeing Boards are seen as key to ensuring integration of health and social care services with the ambition of improving local care. The Joint Health and Wellbeing Strategy stresses the need to have collective actions across the local authority and Clinical Commissioning Group (CCG) to foster commitment, involvement and collective effort to improving the health and wellbeing of those who live and work across the City. Southampton City Council (SCC) and the CCG have agreed a joint approach for commissioning supported by an overarching Joint Commissioning Strategy. The intention is to make best use of the combined resources to address identified priority health, social care and housing needs to achieve better outcomes. The vision is " *Working together to make best use of our resources to commission sustainable, high quality services which meet the needs of local people now and in the future.".* The proposal is to develop a Joint Commissioning Unit (JCU) to focus on effective commissioning to achieve better outcomes for identified groups of people within the population, including children and families, older people and people with mental health needs, a learning disability or life-limiting conditions. This will be achieved through integrating commissioning functions, strategies and resources across the council and between the council and health. The JCU will deliver the following objectives:

- Better outcomes for residents
- Better quality of services
- Significantly reduced costs

The aim is to commission to make a difference, and to ensure future health and social care services are based on the concept of "personalisation" and prevent or delay the need for specialist support or care services where possible. Local authority and health commissioning resources will be used jointly to encourage choice and quality of services in a sustainable market. This will be achieved against a back drop of robust processes to manage risk and keep people safe.

The priorities for commissioning will directly support achievement of the Health and Wellbeing Strategy outcomes.

RECOMMENDATIONS:

(i) The Board is asked to support the approach being taken to encourage integrated working and the priorities identified for Joint Commissioning

(ii) That a memorandum of understanding and protocols between the Health and Wellbeing Board and the Joint and Integrated Commissioning Board be developed and presented to the future meeting

(iii) That Board considers inviting the Health Overview and Scrutiny Panel to review the proposals and the memorandum of understanding and protocols to ensure that the Health and Wellbeing Board is meeting its requirements to develop integration

REASONS FOR REPORT RECOMMENDATIONS

1. The Health and Social Care Act 2012 places a requirement on Health and Wellbeing Board to encourage integrated working. The Health and Wellbeing Strategy identified key priorities to meet the health and social needs of the population. The Health and Wellbeing Board is asked to consider if the approach outlined to integrate commissioning will achieve both of these requirements

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

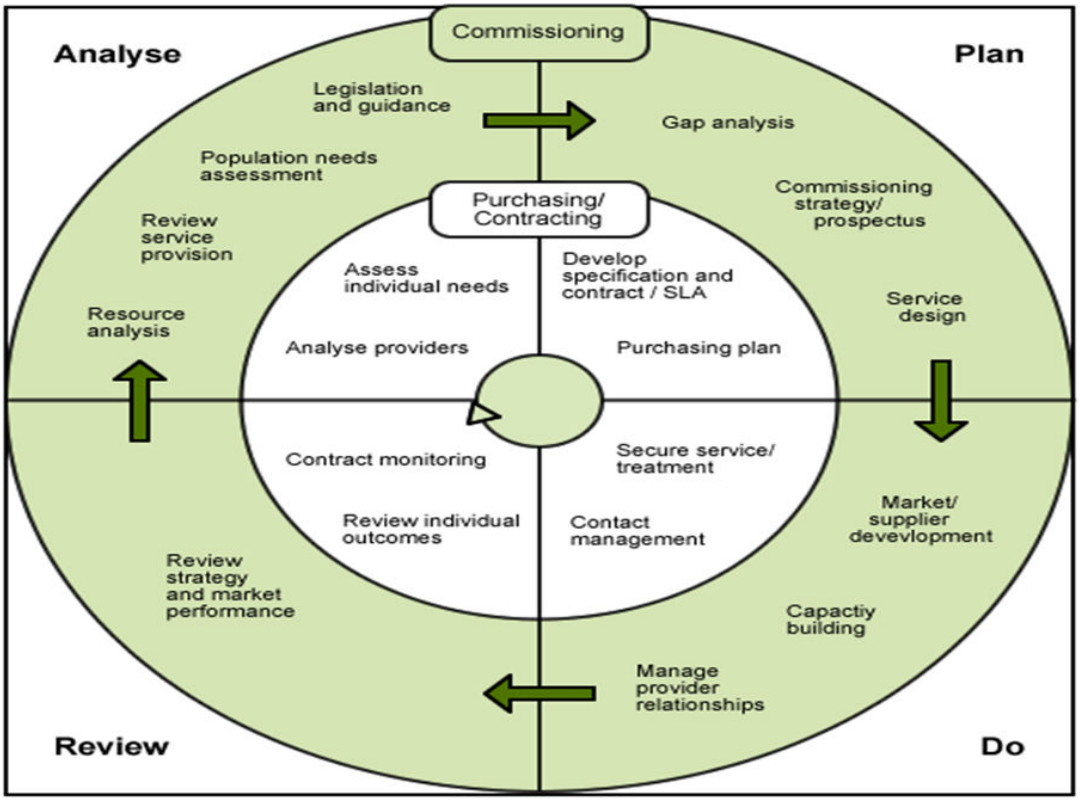
2. The commissioning priorities have been based upon detailed needs assessment and prioritisation including the Joint Needs Assessment, evidence of best practice and user and practitioner involvement.

A range of options were considered in the development of the Joint Commissioning Unit ranging from complete separation of Commissioning functions to total integration. The action chosen was identified as the most effective model to achieve change and make an immediate impact on commissioning outcomes

DETAIL (Including consultation carried out)

What is Commissioning?

3. Commissioning is a cycle of processes, as illustrated in the diagram below, carried out to assess need and define the services required, including how they will be delivered. Commissioning defines the services required and outcomes we want to achieve, it is focused on "what is needed", Commissioning is also about ensuring services are meeting quality requirements, the needs of our customers and providing value for money.

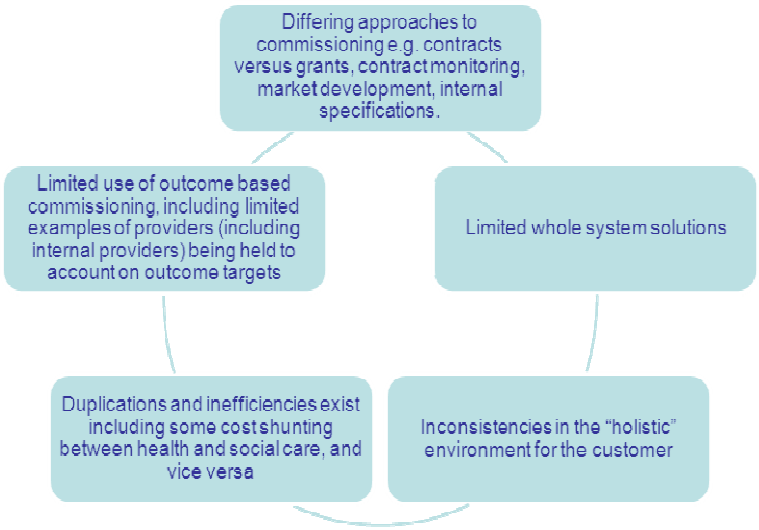


The Institute of Public Care Commissioning Framework from 'Key activities in commissioning social care', June 2007

4. Procurement helps organisations achieve the most appropriate and cost effective way to deliver services to achieve those outcomes, it can be summarised as "how do we get it". The procurement process runs alongside and enables commissioning. Procurement is a route through which the commissioning organisation can appoint a provider (or providers) to deliver the commissioning strategy for a given service, however not all commissioning will be done via procurement.
5. Effective commissioning helps organisations to focus on key priorities and plan their future direction. Informed decision making should be driven by commissioning. Good commissioning will support us to move away from piecemeal changes and increase long term planning, taking a 'whole system' approach to resources, better understanding costs, cash flows and cost drivers. It will ensure providers (including internal services) are held to account against outcome targets and incentivise high performance by developing a strong local performance management regime and internal accountability

Why Integrated Commissioning?

6. Commissioning in a more joined up way is crucial to improving life for residents in Southampton. Treating health, public health, social care, and other local authority functions such as housing, education and leisure, as a whole system rather than lots of individual services will improve outcomes, make it easier for people to understand and access services and make better use of our resources. The Commissioning process is resource intensive and there are efficiencies in doing this jointly. The current health and council structures do not always encourage either party to make savings that benefit the wellbeing system as a whole, as investment by one organisation often results in savings by another. Need is experienced by patients and service users as indivisible but the responses to meet that need are often diverse and sometimes disjointed. We know that transformation will not happen overnight, but by commissioning together SCC and the CCG want to encourage providers to work together and create more seamless services for our customers.
7. There are opportunities for commissioning across health and social care to be improved and aligned to create further benefits. This would include addressing inconsistencies across the two organisations such as:



8. SCC and the CCG have agreed a number of commissioning principles focusing on improving quality, value for money and improved outcomes. These can be seen in appendix 2

Benefits of Joint Commissioning?

9. The benefits to be delivered include:
    - improved outcomes for residents,
    - alignment of intentions and spend between SCC and the CCG,
    - facilitating the development of new market opportunities in the City,
    - improvements in core services,

- reduced duplication of effort and spend,
- increased focus on quality standards,
- the alignment and improvement of business processes for commissioning,
- better deployment of commissioning and other specialist skills and resources, and
- opportunity to significantly reduce costs.

10. The joint unit will be tasked with driving the transformation agenda through evidence about what works, what's required and then sourcing it innovatively and competitively. This will result in realigning spend to outcomes required – i.e. taking a non-service based view and re-specifying resources. Taking a whole SCC/CCG perspective, regardless of the current budget arrangement.
11. Currently commissioning is undertaken by managers and supporting staff within Children's Services, Adult Services, Public Health and Housing within the Council, and by commissioning managers within the CCG. In some cases these commissioning managers are already working in an aligned way. Through these arrangements, there are some elements of effective joint working already underway in the city, such as:
    - Redesigning of adult mental health pathways to move to more community based delivery with recovery orientated services and measurable improvements in clinical outcomes. This is expected to generate a contract reduction of over £3.6 m from 2010/11 to 2013/14.
    - Sexual health and wellbeing clinics in schools – this has resulted in increased uptake of services, reduction in conceptions and sexually transmitted diseases.
    - Redesign of alcohol services – this has led to an increase in earlier identification and brief intervention and an increase in the number of detox's at a reduced unit price (£850 versus £1,305).
    - Re-procurement of short breaks, residential and domiciliary provision for people with a learning disability/ older people is currently underway.

Commissioning Priorities for 2013/15

12. Commissioning priorities are based on the Joint Strategic Needs assessment and the priorities set by the Health and Wellbeing Strategy. The high level work programme for 2013 to 2015 can be seen in Appendix 1. The cross cutting themes of Promoting Positive Lives and Prevention, Supporting Families and Integrated Care for Vulnerable People align to the Health and Wellbeing themes of:
    - Building resilience and prevention to achieve better health and wellbeing
    - Best start in life
    - Ageing and living well

    The commissioning intentions included within each of these themes will contribute to the achievement of the Health and Wellbeing strategy outcomes.

13. Overall the commissioning changes within Promoting Positive Lives and Prevention are to improve access to advice and information to support good decision making and lifestyle choices. They will ensure provision of prevention programmes re smoking,

obesity, sexual health and physical activity as well as to build capacity within parenting and early years support. The Supporting Families theme will focus on systems and pathways to provide joined-up support to families with problems or challenges including the underpinning issues that are drivers for families with complex needs such as substance misuse, domestic abuse and mental ill-health. There will be redesign of provision to ensure cross age range integrated support and improved outcomes for - alcohol and drug treatment, mental health services and learning disabilities. This will include changes to housing/accommodation strategy, day care and approaches to personalisation.

14. Integrated Care for Vulnerable People will include a focus on developing the services people need to keep them in their own home for longer such as rehabilitation and reablement, telecare, adaptive equipment, supported housing and improving support for carers. The focus here is very much on early identification of need and proactive targeted support to prevent escalation of need and enable families to call on their own resources to resolve issues.

Governance

15. The development of a Joint Commissioning unit is currently being finalised. This will impact on approximately 40 whole time equivalent wte staff within SCC and the CCG who have a commissioning function. The structure of the unit is being developed and will go out for consultation in May/June 2013.

    The unit will report to the Joint and Integrated Commissioning Board which has been established and held its first meeting. This will ensure effective collaboration, assurance and good governance across the agreed areas of Local Authority and health commissioning. The Integrated Commissioning Board will:

    - Set commissioning priorities and approve service related strategies and action plans
    - Agree joint financial, procurement and contractual arrangements
    - Ensure strategic planning is implemented within the resources aligned accordingly
    - Support the development of a single commissioning system which puts service users and their families at the centre
    - Monitor performance against plans
    - Ensure effective risk management

    The Health and Wellbeing Board (HWBB), will provide strategic direction but ultimately the Joint and Integrated Board will be accountable to the Council's Cabinet and the CCG Governing Body. It will be informed by needs assessment, market analysis and feedback from consultation and engagement with customers. See Appendix 3 for a diagram of the relationships.

Challenges and Issues

16. Market development is a key challenge. Providers and contracts are currently not consistently managed, it is difficult to always demonstrate outcomes achieved

compared to money spent and poor quality is evidenced by high levels of safeguarding. The JCU presents an opportunity to influence the market across a wider scale, but will require specific skills and expertise to do this effectively

17. The principle that the commissioning process should aim to ensure the same approach (e.g. service specification and performance monitoring) is applied to all service provision activity to ensure fairness and that no delivery vehicle is given or gain unfair advantage will require a change in culture within SCC. This will require a clear distinction between commissioning and provider functions and responsibilities regardless of whether they co-exist within a single organisation. The role of the JCU in strategically allocating provider budgets will also need consideration
18. Close working will need to be maintained with the Local Area Team of

    NHS England as they are commissioning a significant proportion of children's services as well and acute provision and specialist care for the local population

RESOURCE IMPLICATIONS

Capital/Revenue

19. The joint commissioning approach will impact on the total of the CCG budget, but especially the community focussed spend of approximately £138m. The final amount of SCC spend to be directly and indirectly influencable through joint commissioning is currently being finalised. Adult social care commissioning budget for 12/13 was £73m

Property/Other

20. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

21. The Health and Social Care Act 2012 places a requirement on the NHS Commissioning Board, Clinical Commissioning Groups, Health and Wellbeing Boards and Monitor to encourage integrated working at all levels. Health and Wellbeing Boards are seen as key to ensuring integration with the ambition of improving local care. The Act encourages local government and the NHS to take much greater advantage of existing opportunities for pooled budgets, including commissioning budgets and integrating provision.

Other Legal Implications:

22. None

POLICY FRAMEWORK IMPLICATIONS

23. None

KEY DECISION? No -

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Integrated Commissioning team – High Level Work programme 2013/15
2.	Commissioning Principles
3	Governance structure

Documents In Members' Rooms

1.	None

Equality Impact Assessment

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

Other Background Documents

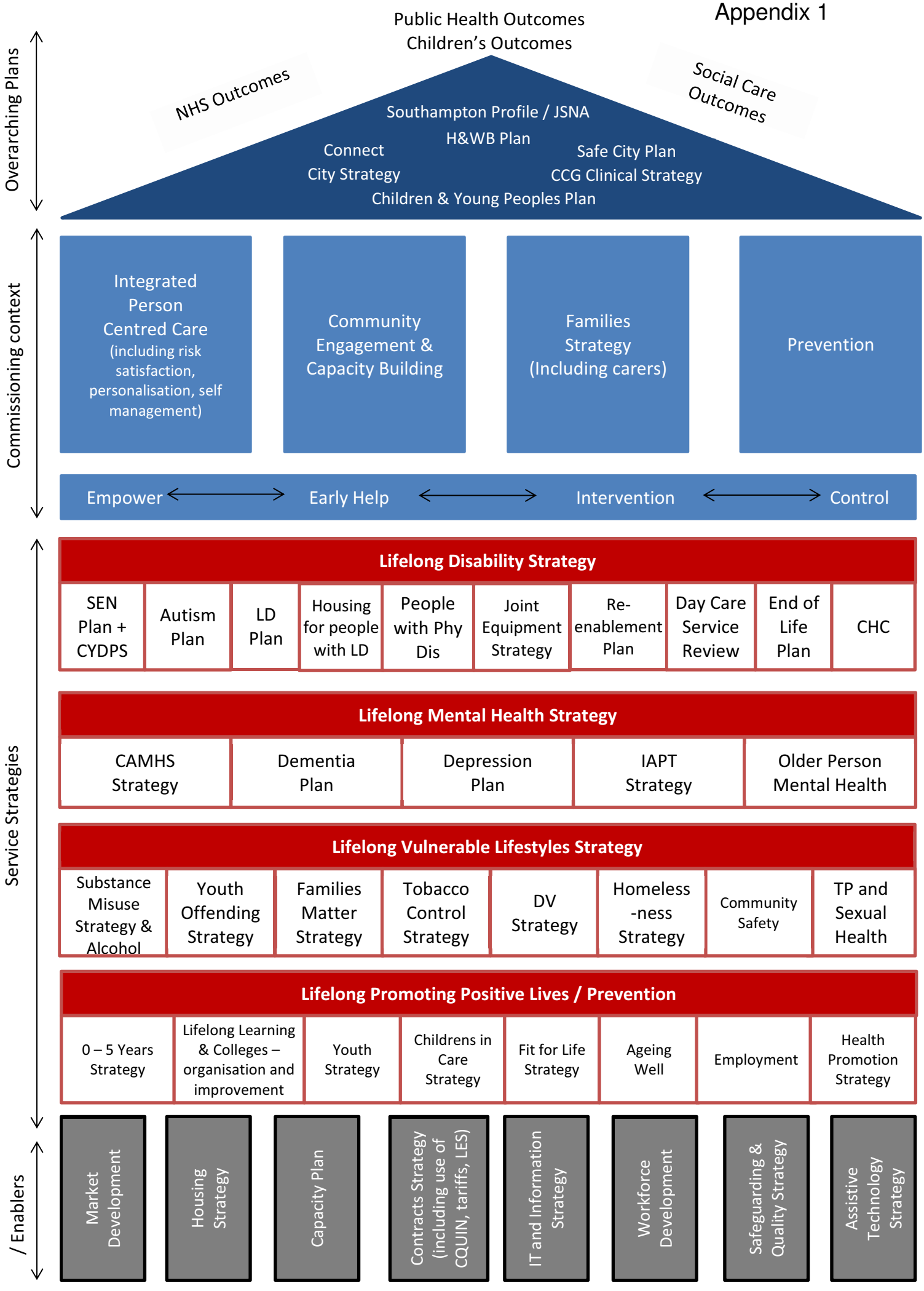
Equality Impact Assessment and Other Background documents available for inspection at:

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

Agenda Item 7

Appendix 1

Integrated Commissioning Team Strategic Framework



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Appendix 2

Commissioning Principles

1. **Improving outcomes** for the local population will be at the heart of the commissioning process with commissioners taking shared responsibility for outcomes on a City wide basis.

2. Commissioning should seek to meet needs in an **evidence based** way and contribute to the development of the local evidence base for effective practice.

3. The commissioning process will integrate services around the needs of **individuals and families**, recognise local diversity and support greater personalisation and choice so that people are empowered to take personal responsibility, shape their own lives and the services they use. The market will be developed to reflect the needs of a diverse local population.

4. Residents will be **active participants** in the commissioning process – planning, design, monitoring and evaluation.

5. There will be an increasing **focus on prevention** and early intervention and on tackling long-standing inequalities in outcomes.

6. Resource allocation and commissioning decisions will be transparent, contestable and locally accountable and driven by the goal to achieve optimum **quality**, **value for money** and outcomes. The importance of investment in the local community will be prioritised.

7. The commissioning process should aim to ensure that the same approach (e.g. service specification and performance monitoring) is applied to all commissioned activity to ensure **fairness** and that no delivery vehicle is given or gain unfair advantage. This will require a clear distinction between commissioning and provider functions and responsibilities regardless of whether they co-exist within a single organisation.

8.Commissioning arrangements will be sufficiently flexible and fluid to support a variety of different **partnership approaches**, e.g. with education, housing, other Local Authorities, the voluntary sector or other health partners, depending on the best way of delivering the required outcomes.

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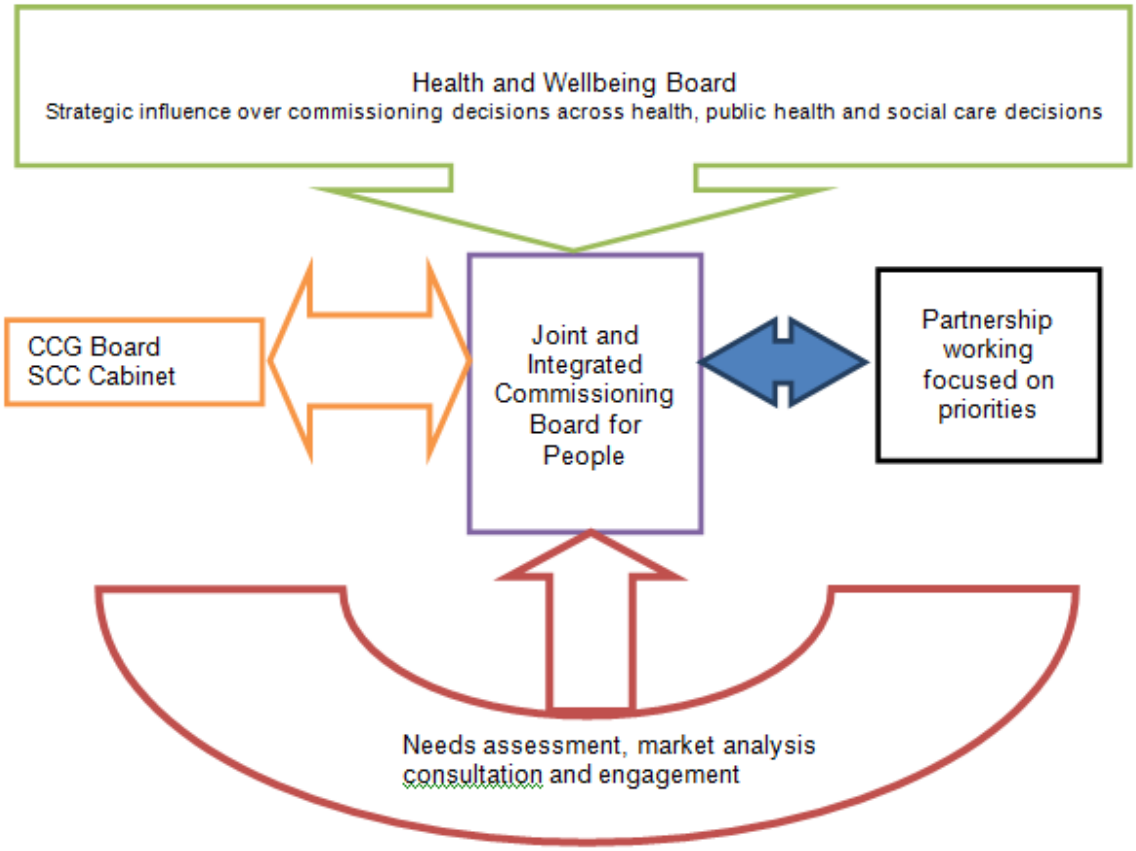
Appendix 3


Health and Wellbeing Board
Strategic influence over commissioning decisions across health, public health and social care decisions
CCG Board
SCC Cabinet
Joint and Integrated Commissioning Board for People
Partnership working focused on priorities
Needs assessment, market analysis consultation and engagement

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