Public Document Pack

# Health and Wellbeing Board

**Wednesday, 29th January, 2014**
**at 5.30 pm**

# Conference Room 3 - Civic Centre

This meeting is open to the public

**Members**

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

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

**Contacts**
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Democratic Support Officer
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## BACKGROUND AND RELEVANT INFORMATION

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

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

**Southampton City Council's Priorities:**

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

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

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

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

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

| 2013 | 2014 |
|---|---|
| 23 October | 29 January |
| 27 November | 26 March |
| | |
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| | |
| | |

## CONDUCT OF MEETING

### BUSINESS TO BE DISCUSSED

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

### RULES OF PROCEDURE

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

### QUORUM

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

### DISCLOSURE OF INTERESTS

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

### DISCLOSURE OF INTEREST

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

### DISCLOSABLE PERSONAL INTERESTS

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

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

a) the total nominal value fo the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
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 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

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

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

## 3 STATEMENT FROM THE CHAIR

## 4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

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

# STRATEGIC DEVELOPMENTS

## 5 BETTER CARE FUND - SOUTHAMPTON SUBMISSION

To consider the joint report of the Director of People, Southampton City Council and the Chief Executive, Southampton City Clinical Commissioning Group, providing details of the Better Care Fund proposals for Southampton for sign off for approval by the Cabinet and the CCG governing body, attached.

# BOARD APPROVALS

## 6 INTEGRATED PERSON-CENTRED CARE PROGRAMME - "MAKING IT REAL"

To consider the report of the Director of Quality and Integration, Integrated Commissioning Southampton City CCG/Southampton City Council requesting the Board's commitment to the Making it Real initiative, attached.

## 7 LEARNING DISABILITIES 2013/14 JOINT HEATH AND SOCIAL CARE SELF ASSESSMENT FRAMEWORK

To consider the report of the Director of Quality and Integration, Southampton City CCG/Head of Integrated Strategic Commissioning Southampton City Council, providing information on the introduction of the Learning Disability Joint Health and Social Care Self Assessment Framework (JHSCSAF) and to note that a further report on progress of the actions set out in the self assessment would be brought back to the Board in 12 months, attached.

## 8 JOINT COMMISSIONING POLICY STATEMENT FOR WORKING WITH CHILDREN AND ADULTS WITH LEARNING DISABILITIES WHOSE CARERS/SERVICES ARE CHALLENGED BY THEIR BEHAVIOUR

To consider the report of the Director of Quality and Integration Southampton City CCG/Head of Integrated Strategic Commissioning Southampton City Council, requesting support for consultation on the draft policy statement and the implementation of the initial action plan, attached.

## BOARD INFORMATION

## 9 SOUTHAMPTON HEADSTART PROGRAMME

To consider the report of the Director of Public Health, requesting the Health and Wellbeing Board's support of Southampton's potential interest in developing a proposal to be part of the HeadStart Programme and to note that Cabinet approval would be required prior to the 17 April deadline, to submit an application for the Year One Programme, attached.

TUESDAY, 21 JANUARY 2014 HEAD OF LEGAL AND DEMOCRATIC SERVICES

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 27 NOVEMBER 2013

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

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

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

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

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

Councillor Bogle declared that she was a Council appointed representative of University Hospital Southampton NHS Foundation Trust and remained in the meeting and took part in the consideration and determination of the items on the agenda.

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

24. **STATEMENT FROM THE CHAIR**

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

**RESOLVED** that the Minutes of the Meeting held on 23rd October 2013 be approved and signed as a correct record, subject to the following amendments:-

Apologies – Page 7 – Stephanie Ramsey was representing Alison Elliott

Item 16 – Page 7 – The NHS Commissioning Landscape – Third line should read Ms J Freeland.

Item 19 – Page 9 – Update on Integration Transformation Fund Implementation – Last paragraph first bullet point to read “The integrated transformation fund was not new money” – delete second half of sentence.

26. **INTEGRATED TRANSFORMATION FUND UPDATE**

The Board received and noted the report of the Chief Executive, Southampton City Clinical Commissioning Group and Director of People, Southampton City Council providing an update on the integrated transformation fund implementation and outlining the progress in developing the local plan which was required by March 2014.

The Board also received a presentation from the Deputy Chief Officer NHS providing feedback from the Workshop held on 22nd November 2013.

The following issues and comments were noted:-

- The funding would enable the following priorities:

  - greater service/organisational integration with more flexible structures to meet a different set of needs and practises;
  - implementation of shared care planning and systems;
  - stronger focus on prevention and identifying need earlier;
  - shift towards more person centred care across the whole system; and
  - a shift in resources and activity to an out of hospital model.

- the vision for integrated care in Southampton would be "I can plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me";
- the model would include community and voluntary agencies and the co-ordination of health and social care teams;
- the transformation would be scoped over a 5 year plan;
- the vision in 5 years would be one person to co-ordinate care taking a holistic approach, a single point of access and locality/cluster/ community working a multi-disciplinary team, reducing referrals working for the population; and
- more training to be provided so that decisions and actions could be made closer to the contact "grass roots" .

It was AGREED that officers would circulate papers to Board Members on the Stakeholder Workshop "Consulation/Challenge on the Proposed Draft Model" scheduled for 12th December 2013.

27. **SOUTHAMPTON SAFEGUARDING ADULTS BOARD ANNUAL REPORT**

The Board considered the report of the Independent Chair, Southampton Safeguarding Adults Board (SSAB), Dr Carol Tozer, providing the annual report 2012/2013 which outlined the work being undertaken by the SSAB in co-ordinating strategic and operational multi agency working to ensure the safety of adults at risk in Southampton.

Dr Tozer thanked the Board for their support during the year and it was noted that this would be her last meeting as she was standing down as Independent Chair.

The Board particularly noted the following points:-

- that in 2012/13, 285 people were identified as at risk and requiring support under local safeguarding adults' procedures which represented a reduction of 5% (17 people) compared to last year. On analysis of referrals it was noted that Southampton's 2011/12 referrals were lower than average by 40% compared to other similar local authorities and the most common form of abuse reported in 2012/13 was financial followed by physical; and
- key priorities for the coming year were:-

- to develop strategic links with partners such as GP's, Health Watch, the Crown Prosecution Service and the Police and Crime Commissioner;
- to strengthen the voice of adults at risk by listening to their experiences of safeguarding;
- embed and develop safeguarding operational practice such as ensuring fire safety action plans are in place; and
- continue to focus on staff development working across Hampshire to develop a training and development strategy, thereby integrating the provision of training.

**RESOLVED**:

(i) that the Annual Report of the Southampton Safeguarding Adults Board be welcomed and that the work priorities outlined in paragraph 13 be fully endorsed; and

(ii) that the incoming Chair of the SSAB be requested to report back on progress in six months, particularly referring to the implementation of the Winterbourne View local action plan.

28. **SAFE CITY AND YOUTH JUSTICE STRATEGY**

The Board considered the report of the Director of Public Health, detailing the Safe City Plan 2013/14 and the Youth Justice Strategic Plan 2013/14 for identification of any relevant implications in the attached plans for the Health and Wellbeing Board.

Superintendent Fulton was present and with the consent of the Chair addressed the meeting.

The following points were noted:-

- although there had been a significant reduction in crime in the City which was mainly due to productive partnership working, between agencies and local communities, there was a need to focus on improving our comparative position in relation to reducing reoffending, anti social behaviour and drug related crimes;
- Youth Justice Plan priorities were the reduction of youth custody, the number of first time entrants in the criminal justice system and reoffending and youth crime;
- investigation and analysis of collective data from the A&E would assist in obtaining a fuller picture and therefore assist in crime reduction;
- closer working with other partners such as the shared services in Redbridge of the police and the fire department.
- there should be closer alignment across the Council of community safety, emergency planning and enforcement functions;
- consideration by the Safe City Partnership and the Youth Offending Board of options for improving the governance arrangements for these areas; and
- consideration to combine the Safe City Partnership Plan and the Youth Offending Board Plan in order to commence the development of a single safer city and youth justice strategy; the Council was in dialogue with the Local Government Association about the benefits of a Peer Review for the wider community safety function early next year.

**RESOLVED**

(i) that the adoption of the 2013/2014 Safe City Plan and Youth Justice Strategic Plan be welcomed and commended to our NHS and local Healthwatch partners;

(ii) that the Chair be requested to meet with the Chairs of the Safe City Partnership and the Children and Young People's Trust Board to consider the most effective means for collaboration on areas of common concern; and

(iii) that the Joint and Integrated Commissioning Unit be urged to ensure that successful bidders for the integrated substance misuse service, currently out to tender, commit to working with the City Council and its partners to reduce the alarmingly high rates of harm to health and life from the misuse of alcohol, illegal drugs and unclassified substances.

29. **PUBLIC HEALTH SOUTHAMPTON : PROGRESS OF ARRANGEMENTS FOR HEALTH EMERGENCY PLANNING AND HEALTH PROTECTION**

The Board considered the report of the Director of Public Health, detailing the arrangements for health emergency planning and health protection that were local authority responsibilities from 1 April 2013.

It was AGREED that Councillor Bogle, who was a Governor of the University Hospital Trust would raise the issue of the public's perception of the Hospital's control of infections.

**RESOLVED**

(i) that the critical role of the Southampton City Health Protection Forum (SCJHPF) be recognised in providing assurance to the Director of Public Health and feeding into the Local Health Resilience Partnership (LHRP), thus fulfilling statutory requirements;

(ii) that the link between the impact of successful health protection mechanisms, for example vaccinations/immunisation programmes and ill health associated with higher levels of deprivation be recognised;

(iii) that the World Health Organisation's (WHO) 95% uptake target for vaccination be adopted (which would provide herd immunity to the remaining population; and

(iv) that the excellent multi-agency working through the Southampton City Joint Health Protection Forum and the key role played by the leads working in the SCC Safe City Team and the local Public Health team be commended.

30. **UPDATE FROM THE CHAIR, HEALTH AND WELLBEING BOARD**

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

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| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | BETTER CARE FUND – SOUTHAMPTON SUBMISSION | | |
| **DATE OF DECISION:** | | 29TH JANUARY 2014 | | |
| **REPORT OF:** | | DIRECTOR OF PEOPLE, SOUTHAMPTON CITY COUNCIL AND CHIEF EXECUTIVE, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR**: | **Name:** | **Stephanie Ramsey** | **Tel:** | **023 80296941** |
| | **E-mail:** | **Stephanie.ramsey@southamptoncityccg.nhs.uk** | | |
| **Director** | **Name:** | **Alison Elliott, Director of People SCC**<br>**John Richards, Chief Executive SCCCG** | **Tel:** | **023 80832602**<br>**02 380296923** |
| | **E-mail:** | **Alison.elliott@southampton.gov.uk**<br>**John.richards@southamptoncityccg.nhs.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None | | | | |

**BRIEF SUMMARY**

In the statement on the next comprehensive spending review made in summer of 2013 the Chancellor of the Exchequer announced that nationally a sum of £3.8 billion would be set aside for 2015/16 to ensure closer integration between health and social care. This funding has been described as "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities". Local authorities and the clinical commissioning groups (CCGs) operating in their area are required to submit a plan setting out how the pooled funding will be used to improve outcomes for patients, drive closer integration and identify the ways in which the national and local targets attached to the performance-related elements will be met. The local plan has been developed and the first cut of the Better Care plan template is now submitted to the Health and Wellbeing Board for approval prior to submission by 14th February. The final revised submission of the Better Care Plan has to be submitted, as an integral part of the CCG's Strategic and Operational Plan by 4th April 2014.

**RECOMMENDATIONS:**

(i) That the Better Care Fund proposals for Southampton be signed off for approval by the Cabinet and the CCG governing body;

(ii) That authority be delegated to the Director of People and the CCG Chief Executive, in consultation with the Chair and Vice-chair, to make any drafting or other changes required prior to final submission of the Southampton Better Care Fund application.

## REASONS FOR REPORT RECOMMENDATIONS

1. To meet the requirement of submitting a plan to the Department of Health by April 2014.

## ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

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

## DETAIL (Including consultation carried out)

3. At previous meetings the Health and Wellbeing Board has considered the government proposals for an Integration Transformation Fund. The government has now changed the name Integration Transformation Fund to the Better Care Fund, and this term is now used in this report and all subsequent documentation.

4. At the previous meeting on 27th November, the Board was informed of the stakeholder engagement activities underway, and members supported the details of strategic intent for developing an integrated health and social care system rooted in neighbourhoods and focussed on identifying need and intervening earlier. The Board approved a preliminary set of high level functions for integrated services, which were subsequently tested at a range of stakeholder events.

5. On 20th December 2013 NHS England published more detailed and updated guidance on the process for submitting proposals for local Better Care Fund proposals. This guidance has been incorporated into the work to develop the Better Care Fund project proposal for Southampton.

6. The guidance requires that Health and Wellbeing Boards provide the first cut of their completed Better Care Plan template by 14th February 2014. This plan will also be part of the CCG's Strategic and Operational Plan. All submissions across England will then be aggregated so that NHS England can identify where there are any particular areas where it has been challenging to agree plans for the Fund. There is then a requirement to submit a revised version of the Plan to NHS England by 4th April 2014. Recommendation (ii) proposes delegated power arrangements to enable any necessary changes to be made to the Southampton Plan.

7 The guidance identified 6 national conditions for access to the Fund:

a. Plans to be jointly agreed by the council and CCG and signed off by the Health and Wellbeing Board
b. Protection for social care services
c. 7-day services to support patients being discharged and prevent unnecessary admissions at weekends
d. Better data sharing between health and social care

e. A joint approach to assessments and care planning and where the funding is used for integrated packages of care there will be an accountable professional
f. Agreement on the consequential impact of changes in the acute sector

8. Nationally £1 billion of the £3.8 billion for 2015/16 will be linked to achieving better outcomes, and ministers have now agreed the basis on how the payment for performance element of the Fund will work. Half of the £1 billion will be released in April 2015. £250m will depend on progress against conditions b, c, e and f above and another £250m will relate to performance against a number of national and locally determined measures. The 2 national measures to be taken into account at that stage are delayed transfers of care and avoidable emergency admissions. The remaining £500m will be released in October 2015 and relate to further progress against the national and locally determined measures. The other national measures to be used at this stage are:

- admissions to residential and care homes
- effectiveness of reablement, and
- patient service user experience

9. Reduction in injuries due to falls in people aged 65 and over has been identified as the one local metric from the Public Health Outcomes Framework. The guidance states that local areas should set an appropriate level of ambition for improvement, and in signing off the local plans, Health and Wellbeing Boards should be mindful of the link to the level of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards are advised to be mindful of the following factors:

- Having a clear baseline against which to compare future performance
- Understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase
- Ensuring that any seasonality on the performance is taken into account
- Ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

10. The submitted plans will be subject to an assurance process involving NHS England and the Local Government Association, with ministers giving the final sign-off to plans and the release of performance-related funds. Sanctions for under-performance against the plans will not result in performance related funding being withdrawn in 2015/16, but this may be brought into force in subsequent years. For 2015/16 if an area fails to deliver 70% of the levels of ambition set out in each of the indicators in the plan then a recovery plan will be required developed with the support of a peer review process involving NHS and local government organisations in neighbouring areas. The process

will be co-ordinated by NHS England with the support of the LGA.

**Southampton's Better Care Plan**

11. The Southampton Better Care Plan is attached at Appendix 1, and is submitted to the Board for consideration and sign-off. The details of the plan are not re-iterated in this covering report, as the plan is a detailed stand-alone document. However, the Board is asked to note the following key points underpinning the plan:

- The 3 core components identified to develop integrated care are:
  - Local co-ordinated care
  - Responsive discharge and reablement to support timely discharge and recovery
  - Building capacity in a number of critical elements of the system
- There has been substantial stakeholder engagement in developing the plan
- A five year plan has been developed that goes beyond the initial vision required by NHS England for 2015/16 that can deliver real transformation to the widest possible range of people

12. It is vital that the Health and Wellbeing is in agreement with the level of ambition set out in the plan, as it will form a major stand for delivering a number of ambitions set out in the Joint Health and Wellbeing Strategy.

13. The metrics, activity and finance are still being developed and will be finalised for the full submission in April. Prior to final submission the plan will be reconsidered by the Health and Wellbeing Board and be submitted to Cabinet and CCG Governing Body for organisational agreement.

Engagement with local providers likely to be impacted on by the use of the fund has been an important aspect of the Local plan development. Providers, along with community, voluntary sector and public representatives have contributed to the shared view of the future shape of services. This has included work to ensure that the implications for local providers are fully understood

**RESOURCE IMPLICATIONS**

**Capital/Revenue**

14.

| **£1.9 billion existing funding continued from 14/15 this money will already have been allocated across the NHS and social care to support integration** | |
|---|---|
| £130 million Carers' Breaks funding | £350 million capital grant funding (including |

| | |
|---|---|
| | £220m of Disabled Facilities Grant). |
| £300 million CCG reablement funding. | £1.1 billion existing transfer from health to social care. |
| **Additional £1.9 billion from NHS allocations Includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. Includes £1 billion that will be performance related, with half paid on 1 April 2015 (which we anticipate will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in year performance).** | |

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

**Property/Other**

15. None.

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

16. The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to encourage and support integrated working.

**Other Legal Implications:**

17. None

**POLICY FRAMEWORK IMPLICATIONS**

18. None

**KEY DECISION?** Yes

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | All |

## SUPPORTING DOCUMENTATION

**Appendices**

| | |
|---|---|
| 1. | Better Care Fund Plan – Completed template |

**Documents In Members' Rooms**

| | |
|---|---|
| 1. | None |

**Equality Impact Assessment**

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

**Other Background Documents**

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

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

# Appendix 1
# Better Care Fund planning template– Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

## 1) PLAN DETAILS

### a) Summary of Plan

| | |
|---|---|
| Local Authority | **SOUTHAMPTON CITY COUNCIL** |
| | |
| Clinical Commissioning Groups | **SOUTHAMPTON CITY CCG** |
| | |
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| | |
| Boundary Differences | **Southampton City Council and Southampton City CCG boundaries are co-terminus. The only difference will be where non Southampton residents have chosen to register with a GP in Southampton.** |
| | |
| Date agreed at Health and Well-Being Board: | **<dd/mm/yyyy>** |
| | |
| Date submitted: | **<dd/mm/yyyy>** |
| | |
| Minimum required value of ITF pooled budget: 2014/15 | **£924,000** |
| 2015/16 | **£16,851,000** |
| | |
| Total agreed value of pooled budget: 2014/15 | **£0.00** |
| 2015/16 | **£59,226,200 (figure still under discussion)** |

### b) Authorisation and sign off

| | |
|---|---|
| **Signed on behalf of the Clinical** | Southampton City CCG |

| | |
|---|---|
| **Commissioning Group** | |
| **By** | John Richards |
| **Position** | Chief Officer |
| **Date** | <date> |

| | |
|---|---|
| **Signed on behalf of the Council** | Southampton City Council |
| **By** | Dawn Baxendale |
| **Position** | Chief Executive |
| **Date** | <date> |

| | |
|---|---|
| **Signed on behalf of the Health and Wellbeing Board** | Southampton City Health and Wellbeing Board |
| **By Chair of Health and Wellbeing Board** | Councillor David Shields |
| **Date** | <date> |

**c) Service provider engagement**

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Southampton City has an established Integrated Person Centred Care Programme which is jointly led by Southampton City CCG and Southampton City Council and already has strong engagement from health and social care providers. The programme is overseen by the Vulnerable People Strategic Delivery Board which has representation from each of the local health providers (South Central Ambulance Service, Solent NHS Trust, University Hospital Southampton NHS Foundation Trust and Southern Health NHS Foundation Trust), the City Council Heads of Service and the Voluntary Sector (Southampton Voluntary Services). This Board has overseen the development of Southampton's Better Care Fund local plan which has been based on the work of the Integrated Person Centred Care Programme.

As part of the communication and engagement plan (attached with project initiation document) for developing the local plan, we have held three large stakeholder workshops, in addition to meetings and individual discussions with providers. The workshops were held on 16 November, 12 December and 17 January and involved a wide range of stakeholders from all of the local health providers, primary care, voluntary sector groups, city council housing and social care. The workshops were led by the Director of Public Health, CCG GP clinical lead for integrated care and chair of the Health and Wellbeing Board who is the Cabinet Member with the portfolio for Health & Adult Social Care. They were used to develop and consult on our local plan.

In addition we have involved GP practices in the development of this plan through our locality meetings and TARGET (Time for audit, research, governance, education and training). The locality GP leads and lead GPs for integrated care have been part of the group developing the plan.

All providers have been asked to submit an impact assessment against our plan and we have also agreed our plan and discussed the implications at our System Chiefs meeting, which includes the Chief Executive of the City Council, Chief Officer for the CCG and the Chief Executives of each of the NHS provider trusts.

**d) Patient, service user and public engagement**

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

We have a continuous programme of patient/service user and public engagement in developing our plans for the Better Care Fund. Engagement and participation activity to date has involved 3 stakeholder workshops plus presentations at:

- Service user focus group
- Service users forum (Consult and Challenge)
- Patients Forum
- Older Persons Forum focus group
- Communications and Engagement reference group
- Pensioners Forum
- Equality Reference group
- Healthwatch
- Carers Strategic group

Service user and public insight has also been gained from a number of other sources e.g. complaints and patient experience data, NHS Choices, local services survey (online), Call to Action survey (online), carers network event and the stroke 'Have your say' event.

Our vision is based on what people have told us is important to them. Through the above consultation and engagement routes, we know what people want is more choice and control, good quality services and for their care to be planned with them and their families/carers and coordinated by a key worker or case coordinator to simplify communication and provide consistency. They tell us that good information and advice along with good communication are key. They want us to make better use of IT and technologies such as telecare/telehealth as well as computer and mobile phone support. The people we talked to also highlighted the important role of the voluntary sector and the need to make staff in statutory services more aware of what is out there in the community. One key point that came out of several consultations was how much people value NHS services and the principles of the NHS constitution and so we are mindful of the need to ensure we protect and build on what is good.

We have worked with people to come up with our vision statement "**Health and social care working together with you and your community for a healthy Southampton"** and will be working with them over the coming weeks to produce a user friendly summary of our plan. We are encouraging people to comment on our plan and give us their views via a number of routes, e.g. on line, e-mail, social media, website. Web pages are in development to ensure that we can continually update people about our progress. In February we will be holding a large stakeholder event in the City and we are currently developing plans with Southampton City Council to establish a citizens council.

**e) Related documentation**

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

| Document or information title | Synopsis and links |
|---|---|
| Project Initiation Document and Engagement Plan | Sets out the governance arrangements and processes for developing our Better Care Fund local plan, along with our plans for communication and engagement. |
| "Healthier Lives in a Healthier City" - | Southampton City's Health and Wellbeing |

| | |
|---|---|
| Southampton's Health and Wellbeing Strategy | Strategy which is based around 3 key priorities: to build resilience and use preventative measures to achieve better health and wellbeing; ensure a best start in life and support people living and ageing well. |
| Principles for defining cluster teams | Sets out the principles that have been agreed by key stakeholders within Southampton for defining the local cluster teams. Over the coming months, we will be using these principles to co-produce our clusters and how they will operate with front line staff, public and service users. |
| Integrated Reablement/Rehabilitation Service – Project Initiation document | Outlines the plan of work we have in place for developing our integrated reablement and rehabilitation service. |
| Strategic Context for Telecare and Telehealth in Southampton 2013 | Sets out our vision, aims and key principles for developing telecare and telehealth in Southampton and the model we propose to adopt. A business case is in development. |
| Southampton City commissioning framework for carers, 2013 | Sets out our plans for developing support for carers. |
| Southampton City self management framework, 2013 | Sets out how we will encourage, support and assist the wider development of self management with individuals and professionals in a wide range of care settings. |
| Southampton City personalisation – draft strategic intent, 2013 | Our strategy for personalisation in Southampton. |
| Southampton City Personalisation interim workforce learning and development plan, 2013 | Sets out our short – medium term plans for developing the workforce to deliver a more personalised health and social care system. |
| Integrated progress framework, 2014 | Southampton City CCG and Southampton City Council have signed up to Think Local Act Personal (TLAP) and 'Making it Real' (MiR). This document explores, identifies and sets out the key features to deliver Personal Health Budgets; 'Making it Real' and 'Integrated Person Centred Care' as well as presenting our self assessment. |
| IM&T Project plan for integrated care, 2013 | Sets out our IM&T plans to support our integrated care agenda. |
| Mapping of schemes against national and local metrics | Maps out the schemes we currently have in place or are planning for the coming year and how they contribute to delivery of the national and local metrics. |

# 2) VISION AND SCHEMES

### a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

**Background**

In 2011 the Census recorded the resident population of Southampton to be 236,900 with 268,200 people registered with GP practices in January 2013. The overall population is forecast to rise by 4% between 2012 and 2019. The over 65s population is set to increase by 11% and the number of people over 85 years from 5400 to 6100 between 2012 and 2019. In contrast, the proportion of the population of working age is steadily declining. The number of people with long term conditions is increasing. There are around 86,000 people in Southampton estimated to be living with long term health conditions, such as asthma, diabetes, heart disease, hypertension, epilepsy and severe mental illness. Analysis of ACG data with 12 practices shows that 85% of people aged over 65 have at least one chronic condition and 30% of them have more than four; By age 85 these have increased to 93% and 47% respectively. Social circumstances are also changing. There are far more people living alone - 11,283 households in the city consist of older people living alone with increased risk of loneliness and associated poor physical and mental health. More people also own their own homes.

The changing needs of the population is putting increased pressure on health and social care at a time when resources are reducing. Legislative changes, for example the duties posed by the new Care and Support Bill, are requiring services to identify need earlier and respond to a national minimum eligibility threshold. Attitudes and expectations are also changing. The expectations of people who will reach older age in the next 10 to 20 years will be different to older people now. People are used to expressing far greater choice and control over their needs and aspirations. Currently, people are much more socially mobile than before and have generally experienced a wider exposure to different goods and services. People now and in the future will expect more from their local authority, NHS and care providers in terms of the range and quality of services on offer. This change is being met with a commensurate, if not more ambitious move within health, voluntary sector and social care practice to offer a fully personalised service for individuals. It requires a significant culture change across all parties including individuals, carers, providers and commissioners.

The importance of prevention and early intervention are well evidenced to help people stay well, live independently and remain healthy for longer. It is important to ensure that a wide range of good quality preventative services are available to support people across the spectrum of need, including those who do not approach the Council for support or meet its eligibility criteria. This will ensure that people do not go without the support which could prevent critical needs developing in the future.

All this means that historical models of care are no longer appropriate or affordable. There is a need for more planned care, provided earlier in settings outside of hospital, greater integration between health and social care to improve service user experience and achieve efficiencies, better use of community resources, better service user information about what is available and a much more personalised approach to the way care is accessed and delivered, responsive to both clients eligible for social care and those who are self funders. This requires a radical transformation of primary, community and social care as well as the surrounding environment including individuals, family, carers and voluntary sector services.

**Southampton City vision for better care**

Southampton's Health and Wellbeing Board has made strong progress in agreeing the Joint Health and Wellbeing Strategy: ".Healthier Lives in a Healthier City" with priorities to build resilience and use preventative measures to achieve better health and wellbeing, ensure a best start in life and support living and ageing well. Our aim is to deliver better health outcomes for the people of Southampton by ensuring we have the very best health and social care services possible. We believe that by working together in a seamless and integrated way we can achieve this. That is why we have an established Integrated Person Centred Care Programme which is jointly led by Southampton City CCG and Southampton City Council. We have adopted a 'one city' approach with active partnership between health, housing, community and social care and have established an Integrated Commissioning Unit to take forward our plans for stronger integration and aim of moving investment from a traditional organisation-focussed model of service provision to personalised, people-focussed solutions which are based on prevention and early intervention. Our integrated person centred care work programme has the following areas of focus:

- People will be at the heart of their care, empowered and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing
- Neighbourhoods and local communities will have a recognised and valued role in supporting people
- Our services will focus more on prevention and early intervention

We have set our vision which describes where we want to get to:

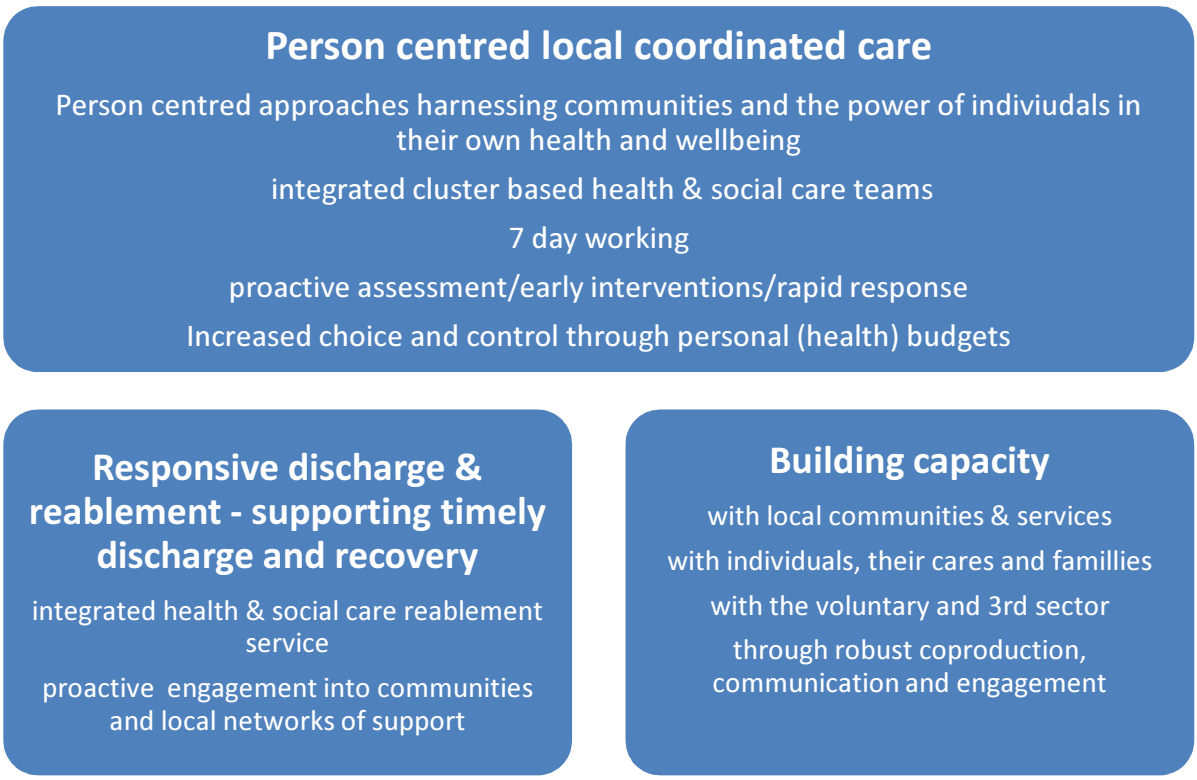
**Health and social care working together with you and your community for a healthy Southampton**

We have adopted the National Voices ambition **"I can plan my care with people who work together to understand me and my carer(s), [empower me to take] control, and bring together services to achieve the outcomes important to me"** (with some adaptation to reflect feedback we have received from community and voluntary sector partners).

Having good partnership working is different to developing the power of a strong inclusive community to boost health and wellbeing. We recognise the need to work with and learn from current and new partners to enable the development of strong, resilient and inclusive communities and to widen mutual understanding of interpretations, concepts or collective ideas around community development, encompassing social models, neighbourhood approaches, expert patient groups, mutual, cooperatives and peer support systems that transcend community, social and health environments.

Person centred care will be at the heart of everything we do. It changes and challenges personal, professional and organisational power - for community services and also fundamentally the way primary care is delivered. We are working with primary care to understand and overcome these challenges, and are working as a pilot site with TLAP to develop this approach within the city.

Our approach for system redesign has 3 basic components:




The core principles underpinning the model are set out below:

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

## Person centred local coordinated care

This includes:

- **Formation of multidisciplinary cluster teams -** Building on our principle of care being as local as possible, we will further develop our integrated nursing clusters and virtual ward model to create a number of fully integrated teams around clusters of practices. These teams will be multidisciplinary including health staff (community nursing, therapists, geriatrician, MH nurses, primary care staff), social care staff, housing workers and the voluntary sector and will inreach into acute settings to facilitate timely discharge. The teams will be co-located in each cluster area. It is expected that each team will cover a population of approximately 30,000 - 50,000. We will be working with our local practices, frontline staff and communities over the coming months to determine the most sensible cluster configurations. Specialist services will also reconfigure to actively work within the clusters and some outpatient clinics currently located in the hospital will be delivered locally. 2014/15 will be a period of transition, enabling staff to get to know each other and their local cluster area. A key focus in this year will be to foster amongst staff a sense of identity and knowledge of the geographical area in which they work. This will include identification of need in each area through the pooling of intelligence from each host agency and beginning to jointly identify those people most at risk who may benefit from early preventative planning or intensive care management. Throughout the transition stage there will be a focus on opportunities for joint training, shadowing and staff rotations.

- This new model of local cluster teams will be underpinned by:
  - **Implementation of the new GMS contract** which brings a significant shift of QOF into supporting older people. This includes the introduction of a named accountable GP for patients over 75, a contractual duty to monitor the quality of the Out of Hours service and support integrated care by record sharing and a new enhanced service for patients with complex needs. The enhanced service requires practices to improve access, ensure other clinicians can contact the GP for advice, carry out regular risk profiling to identify at least 2% of patients a year, provide proactive care and support for at risk patients with personalised care plans with a named accountable GP and care coordinator and work with hospitals to review and improve discharge processes.
  - **Primary care development programme** to expand capacity and support development of new models of working.
  - **Introduction a common trusted assessment and planning tool across health and social care** (building on the comprehensive geriatric assessment and adaptable for all client groups covering medical, mental health, functional capacity and social needs) together with proactive risk profiling to identify high risk patients using predictive tools and combined intelligence.
  - **A single management structure** with strong leadership. It is intended to identify early on locality/cluster managers to lead the development of each locality/cluster.
  - **Joint workforce development / development of core generic skills,** eg. person centred planning, risk profiling, self management, care coordination, brief intervention skills , working with those with dementia integrated care leadership. This will require working closely with the Local Education and Training Board.
  - **Implementation of the care coordinator/accountable professional role** for every person identified as at risk to oversee the person's integrated care plan, coordinate their care and act as a single point of contact for them and their family/carers, building on the existing case coordinator role for older people. During 2014/15 we will be developing a common skill set for this role and rolling out a programme of workforce development.

- **Full integration of mental health into the integrated care model.** People with long term conditions, eg. diabetes are more likely to have mental health problems. Where mental health co-morbidities exist, care can be 45-75% more expensive and patients are less likely to

be discharged in a timely way. Therefore it is crucial that the model considers mental health needs. This will include assessment of mental health needs as part of the common assessment tool as well as tailored psychological therapy when necessary. This will be delivered through skilling up the local primary care and community workforce to manage non complex mental health problems, improved psychiatric liaison and further roll out of IAPT.

- **Introduction of a single point of access for integrated health and social care.** This will include easy access city wide to good quality user friendly information that allows people to assess their own needs and choose the best solutions for themselves, when necessary, with help from trustworthy community based support. It will be staffed by people with the knowledge, skills and information to help people self manage and seek solutions for themselves or recognise the need to refer on for further assessment and intervention. During 2014/15 consideration will be given to the delivery model for this, including mapping existing points of contact and their functions, and consideration of the levels at which the unified point of access should operate (city wide or cluster level or both).The intention is to implement this during 2015/16.

## Responsive discharge and reablement

This includes:

- **Redesign of an integrated health and social care rehabilitation/reablement service for the city** bringing together the following individually managed services:
    - City Care First Support 7 day reablement service
    - Brownhill House (City Council reablement residential provision) and the RSH wards (managed by Solent NHS Trust)
    - Health and social care therapies
    - Telecare and telehealth
    - Joint Rapid Response admission avoidance/discharge support service, providing 24/7 crisis response to patients in their own settings

- Reablement and rehabilitation services help people maintain or regain their ability and confidence to live at home following a period of instability. Key aims of the new integrated service will be to:
    - sustain recovery momentum and build confidence
    - focus collective resources to improve potential for successful reablement
    - develop a culture that promotes independence and self management as the default position
    - reduce, delay or negate the need for people to access acute services through proactive management of care and risk in the community
    - support effective and timely discharge and reduce risk of readmission

- The integrated service will be available 7 days a week and enhanced to provide more people with reablement opportunities. Discharge planning will start at the point of admission or as soon as possible after stabilisation of a crisis and there will be a focus on reablement earlier in the patient's pathway to support speedier recovery. Service users will get tailored and practical support. Straightforward needs will be met early without the need first for extensive assessment. Reviewing processes will be developed to identify people who may not have been ready for reablement initially but following a period of care, reablement may become an option. Explicit methodology will be developed along with consistent, clear routes into reablement.

- There will be much stronger emphasis on embedding a reablement culture across wider community provision and supporting people to engage with existing support in the community, recognising that reablement is wider than the activity associated with a distinct team. This will

include enhancing the reablement focus within the locality/cluster teams and with domiciliary care, nursing and residential home providers. In developing the model consideration will also be given to which elements of the team should remain central city wide functions (e.g. community beds, out of hours cover) and which would be better integrated into the locality/cluster teams.

## Building capacity

This includes:

- **Increased support for carers -** The Council and CCG are pooling available resources to re-commission direct support services during 2013 so that they are in place and ready to commence in spring 2014. These services will streamline current provision while expanding the identification, advice, information and support provided to the increasing number of unpaid carers. This work will be ambitious in its remit and work with young, adult and older carers in appropriate ways. Services will be asked to meet the critical areas set out nationally and locally, in particular supporting those with caring responsibilities to identify themselves at an early stage, providing accessible and meaningful information through website, literature, face to face contact and wider technical communication channels, recognizing carers in their own right, maximising the education, employment, income and benefits of carers and building community capacity to improve the wellbeing of carers (and those cared for). The new service will continue to work closely with the Local Authority as it continues to deliver carers' assessments, and progress any new requirements emerging in the proposed Care & Support Bill and the Children and Families Bill. It is planned to substantially increase the number of carers identified from April 2014, rising from under 3,000 to over 5,000 by March 2015. This will include community and primary care settings. This will be supported by the creation of a single contact point for advice and information for all adult carers in Southampton.

- **Development of more person centred approaches.** The philosophy of personalisation is relevant to all residents, of all ages, in Southampton to ensure they have the greatest level of choice and control over the care and support needs relevant to them. This includes individuals being able to access good clear and accurate information to support them in making well informed and relevant decisions, through to personal budgets offered and taken by the individual in a way that they feel they have as much choice and control as they would like. Person centred care sits at the heart of personalisation and requires the workforce to work with the individual, once they need care and support, in partnership, so that the individual's expertise and skills about their own situation is combined with the expert knowledge of the professional. Over the next 5 years, we will be improving uptake of Direct payments for residents accessing adult social care and increasing access to personal health budgets for those eligible for continuing health care (from 2014) and those with long term conditions (from 2015). We will be developing our workforce to promote the philosophy of personalisation, implementing in 2014/15 a CQUIN scheme as part of all our NHS provider contracts that requires organisations to self assess where they are in terms of staff awareness, systems and practice and set their own action plans for improvement. Through commissioning we are ensuring a variety of Support Planning approaches that empower and enable individuals to plan their care and support, drawing on strength based approaches, maximizing individual assets and local communities. In 2014/15 we will also be making changes to our finance systems that support the delivery of a personalised health and social care environment.

- **Development of community assets -** This will include maximising use of local facilities and gathering and making available information about activities and support networks that promote good health and wellbeing such as access to public transport, housing advice and leisure options. Gathering of local community intelligence and building partnerships

with the community will be a key priority for each of the cluster teams working in shadow form during 2014/15. Community development will be further supported by:

- **Devolution of an element (to be defined) of the Better Care fund to cluster teams to incentivise the development of local solutions.** Further work will be undertaken during 2014/15 to determine the size of this budget and how it will be managed at a local level. It is envisaged that the devolved fund will be used for aspects such as personalised care packages and community development.
- **Introduction of a care/support navigator role to act as a single point of contact in each cluster.** This role will also include building a knowledge base of local resources/facilities, signposting staff and service users to services/community assets and stimulating community development. During the early part of 2014/15, our intention is to further define this role with a view to appointing the first care/support navigators during this shadow year. It is envisaged that this role could be undertaken by any discipline or agency and would not require a formal health or social care qualification.

- **Ensuring the right capacity in community support services -** over the coming months we will be reviewing capacity within community support services (including domiciliary care, residential and nursing home provision and day services) with a view to refreshing our demand and capacity plan to support the integrated care model. This will need to take into account profiling of future needs and changing demographic factors. For example it is expected that demand for long term residential and day services will change over time as many older people will want to stay at home for as long as possible. This will require changes in the market to maintain more people at home, remaining healthy and with a sense of wellbeing for longer. The Integrated Commissioning Unit will have a key part to play in shaping the market, for both commissioned provision and provision purchased directly by people through personal health budgets/direct payments or self funders. For this reason, the City Council and CCG have invested specifically in the development of a market development team which forms part of the Integrated Commissioning Unit.
- In the shorter term, the Integrated Commissioning Unit has embarked on a programme of quality and capacity development within nursing homes in order to reduce delayed transfers from hospital. This includes strengthening nurse leadership, improving nurse recruitment and development and negotiation with nursing homes who have voids to take social care clients.

## What difference will this make to patients and service users

For patients and service users, the changes we are making will mean:

- **I have access to easy to understand information which is consistent, accurate, accessible and up to date.** People will have easier access to information about the help available to them in their local communities through their local team and care navigator. Better information and advice will be provided about the services available and people will be able to telephone or visit the single integrated point of access to health and social care to assess their own needs or be directed to the most appropriate service.
- **I have as much control of planning my care and support as I want. I am supported to understand my choices and to set and achieve my goals.** People will be involved as equal partners in their care. They will draw up their care plan with professionals and

be able to make choices about the support they use, including drawing on their own family and wider community assets. If they choose to do so, more people will be able to receive their personal budget as a direct payment and source their own support. They will have better access to information and resources such as telecare/telehealth that help them manage their own condition at home.

- **The professionals involved with my care talk to each other. We all work as a team.** People will have a single integrated care plan which they can access and control and is used by professionals from health and social care so that they do not have to keep repeating their story. A named lead will coordinate their care and ensure continuity.
- **My carer/family have their needs recognised and are given support to care for me.** Carers will be identified and be given information about their rights and the support they can access to help them cope and live their lives to the full, whilst caring for their loved one.
- **I have access to a range of support that helps me live the life I want and feel part of a community.** People will have the opportunity to be linked into local voluntary sector schemes and community groups by their care coordinator, which enable them to develop a network of support and share experiences. People will be able to access a local time bank which will enable them to make a contribution to their local community and develop wider friendships.
- **After a set-back, my independence is valued and I am given the help I need to stay at or get back home.** Care coordinators will play a key role in proactively identifying when people need additional help or support to manage a crisis. When people are admitted to hospital, the care coordinator will coordinate everything that is needed to get that person back home as quickly as possible; planning for discharge will start as soon as someone is admitted. Reablement services will be more proactive in supporting people's recovery, available 7 days a week.

### b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our overall aims for integrated care in Southampton are:

- Putting **people at the centre of their care**, meeting needs in a holistic way
- Providing **the right care, in the right place at the right time**, and enabling people wherever safe and appropriate to stay in their own homes

- Making **optimum use of the health and care resources** available in the community, reducing duplication and closing gaps, doing things once wherever appropriate
- **Intervening earlier** in order to secure better outcomes by providing more coordinated, proactive services

These aims, along with our objectives, outcomes and measures for success are set out below:

| Aims | Objectives | Outcomes | Measures |
|---|---|---|---|
| **To put people at the centre of their care** | People are empowered and supported to manage their own conditions | Outcomes for people are improved<br><br>A sustainable health and social care system.<br><br>Needs are met<br><br>Health inequalities will be reduced | • Increased uptake of direct payments/ personal health budgets<br>• Increase in self management<br>• Increase in number of integrated person centred care plans<br>• Positive feedback from service users and their carers |
| | Physical health, mental health and social care needs are addressed in a joined up way | | |
| | Uptake of joint health and social care personal budgets is increased to maximise choice, flexibility and control. | | |
| | Plans include resources from community, carers, family, alongside health and social care elements to provide holistic person centred working | | |
| **To provide the right care, in the right place at the right time** | There will be easy access to high quality responsive primary care. | | • Fewer people in acute care for less time – reduction in admissions, shorter lengths of stay, fewer delayed transfers of care<br>• Fewer people in residential care<br>• Fewer people dying in hospital<br>• Increased engagement in community services |
| | Services will be provided in a timely way, when they are needed. This includes rapid response to urgent needs. | | |
| | People will only be in hospital for the time when they need care that can only be provided in the acute hospital setting. | | |
| | Reactive, unscheduled care will reduce and planned care will increase. | | |
| | Direct payments and personal health budgets will be used to secure right services for the individual | | |
| | Communities will provide increasing elements of local community services as an integral part of the care plan. | | |
| **To make optimum use of the health and care resources available in the community** | Carers are supported to help maintain them in the effective role they play | | • Increase in carers assessments<br>• Increased use of telecare/telehealth<br>• Increased community capacity and utilisation |
| | Use of new technologies is maximised, including telecare and telehealth | | |
| | People will be appropriately signposted to local voluntary sector and community support. | | |
| **To intervene earlier in order to secure better** | People's health and wellbeing are maintained for longer | | • Greater number of |

| | | | |
|---|---|---|---|
| outcomes | People are able to be as independent as possible<br>Integrated risk stratification and proactive care planning will be rolled out and there will be a much stronger focus on prevention | | anticipatory care plans developed following risk stratification<br>• Earlier identification and support for people with dementia<br>• Fewer falls |

**c) Description of planned changes**

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

To deliver its vision, Southampton City has already embarked on a system wide change programme (the Integrated person centred care programme) and therefore has a lot to build on. Success requires substantial change in the way services are provided and staff work with people, local communities as well as with each other. The Better Care Fund provides a timely opportunity to go further, faster. It will bring together a wider range of existing resources from across the CCG and City Council to commission in a more joined up way, coordinating care, driving out duplication and increasing efficiencies. We will be exploring how different contractual and funding models can support this. Efficiencies from improved utilisation of resources and reductions in activity projected to be made in the acute hospital sector will release money to be reinvested in the integrated out of hospital model.

**1. PERSON CENTRED LOCAL COORDINATED CARE**

We will use the Better Care Fund for:

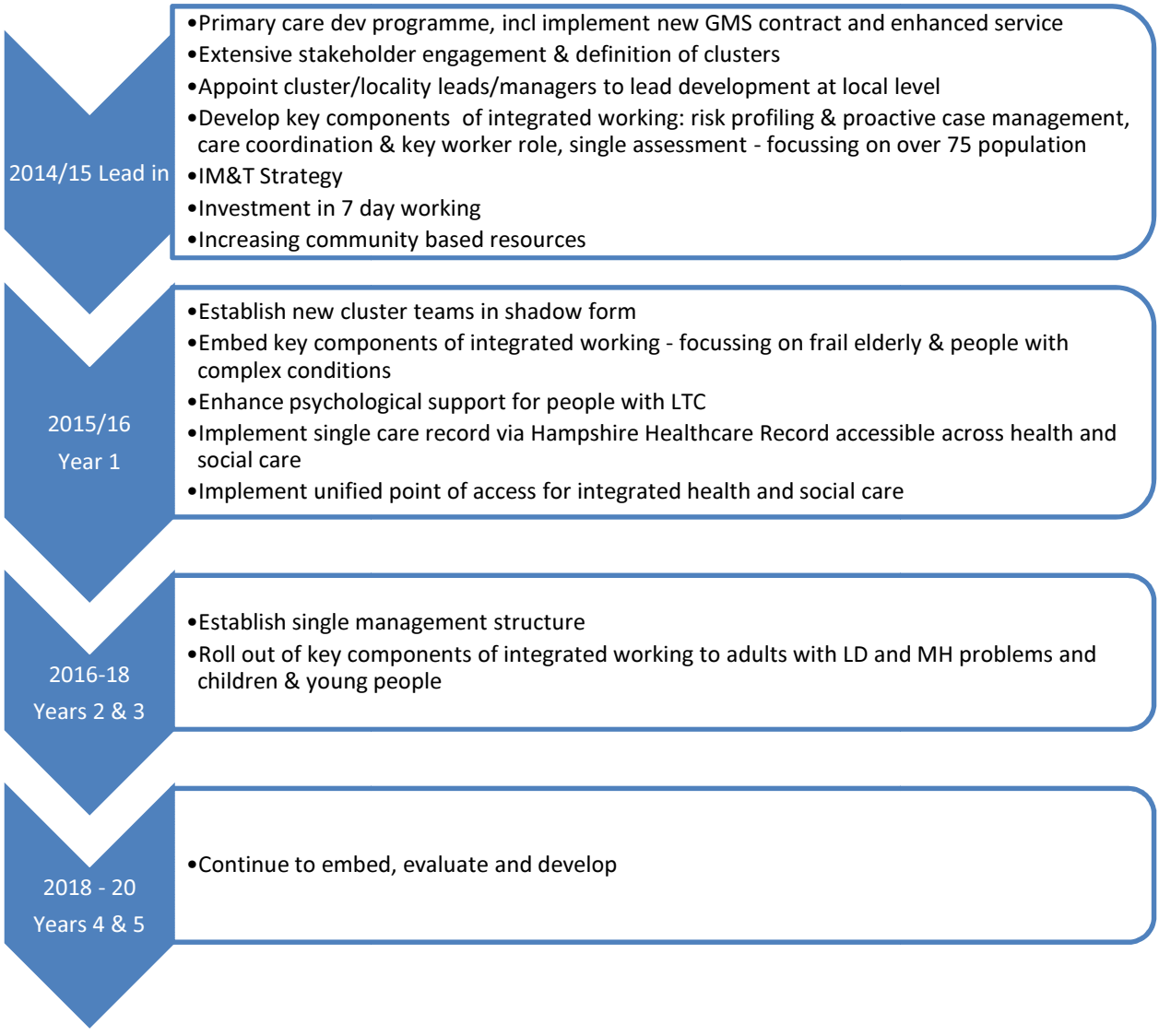
- Reconfiguration of health and social care into integrated cluster based health & social care teams under a single management structure, based on GP practice populations (teams to include community nurses, therapists, geriatricians, MH nurses, primary care, social care, housing and voluntary sector) – focussing initially on over 75s, extending to all adults with complex LTCs in 15/16, and then to adults with LD and MH problems and children with special needs/disabilities.
- 7 day working within teams
- Development of a personalised care promoting workforce across all services
- Adoption of Personal Health Budgets and Personal Budgets as the primary method of arranging care and support to meet individual need, underpinned by implementation of support planning services and changes to finance systems to support delivery of a personalised health and social care environment
- Introduction of a common trusted assessment and planning tool across health and social care plus proactive risk profiling using combined intelligence
- Implementation of accountable professional role for every person identified as at risk to oversee the person's integrated care plan
- Full integration of mental health into the integrated care model

- Introduction of a single point of access for integrated health and social care providing user friendly information that allows people to assess their own needs and onward referral for intervention
- Increased use of self management approaches
- Increased use of technology for delivery of services and support.

**Key success factors and dependencies for this part of our strategy include:**

- Good robust engagement and coproduction with all stakeholders
- Workforce development
- Primary care development and GPs signing up to new enhanced service for patients with complex needs
- Identification of suitable accommodation within each cluster area to provide a team base
- Information sharing agreements and interoperable IT across health and social care settings
- Strong leadership
- Increasing community resources

**Implementation timeline for this component of our strategy**



## 2. RESPONSIVE DISCHARGE & REABLEMENT - SUPPORTING TIMELY DISCHARGE AND RECOVERY

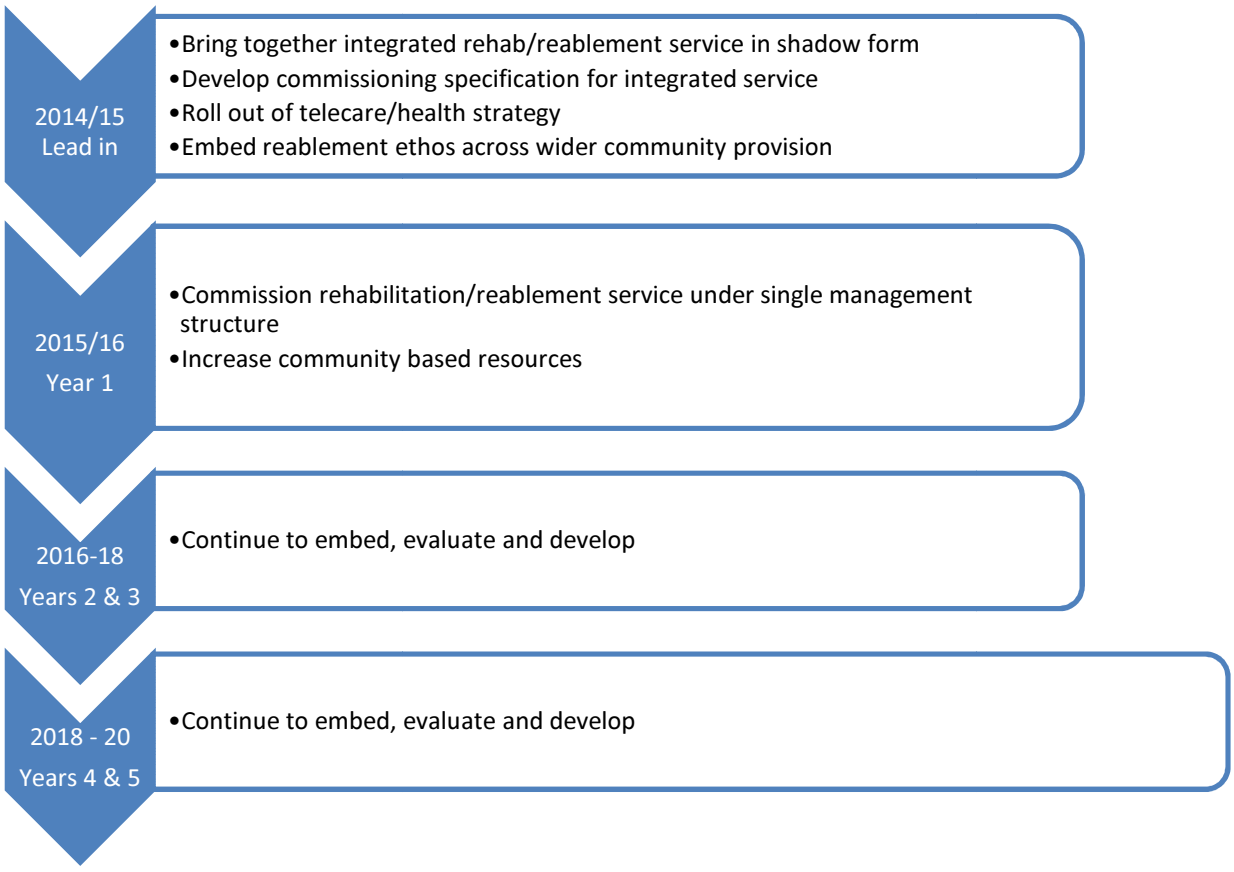
We will use the Better Care Fund for:

- Redesign of an integrated health and social care rehabilitation/reablement service bringing together City Care First Support, Brownhill House, RSH wards, Health and social care therapies, Telecare and telehealth, Joint Rapid Response admission avoidance/discharge support service.
- Ensure 7 day availability across service
- More proactive response to meeting straight forward needs
- Reablement culture built into wider community provision, eg. domiciliary care, nursing and residential providers
- Reablement function built into local cluster teams
- Increased use of self management approaches
- Increased use of technology for delivery of services and support.
- Improved focus on helping people plan to return to employment

**Key success factors and dependencies for this part of our strategy include:**

- Strong leadership
- Buy in and engagement of front line staff and workforce development
- Culture change to build reablement ethos into wider community services, e.g domiciliary care

**Implementation timeline for this component of our strategy**




## 3. BUILDING CAPACITY

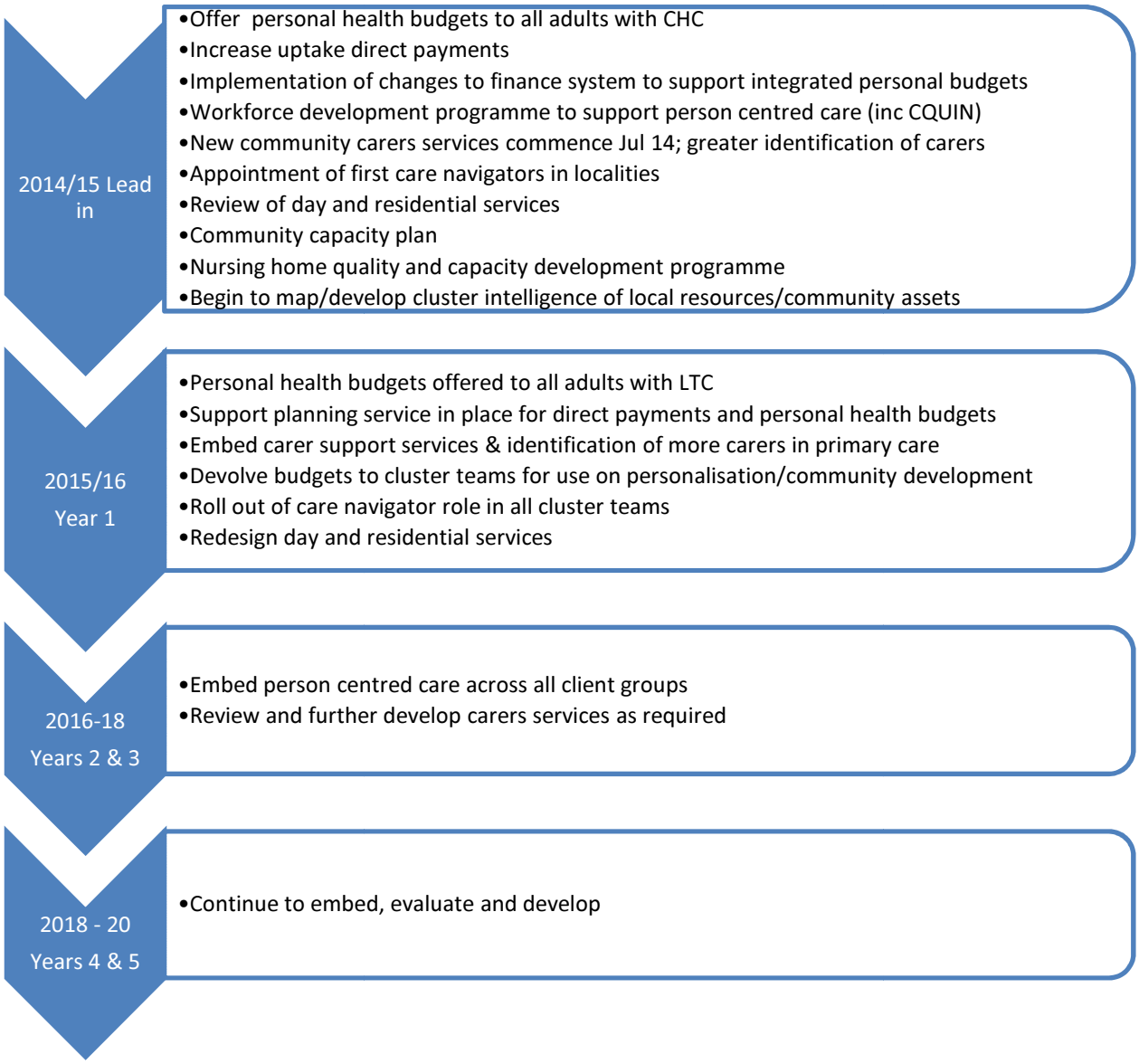
We will use the Better Care Fund for:

- Development of markets and communities to maximise local capacity to support health and well being of community, including local action to reduce loneliness and social isolation, Achieved through robust communication and engagement work
- Proactive support through voluntary sector partners to attract and maximise alternative funding opportunities (e.g. Big Lottery, Trust funds) into local communities of identity (e.g ethnicity, diagnosis, neighbourhoods)
- Devolution of an element (to be defined) of the Southampton Better Care fund to cluster teams to incentivise local solutions
- Community coproduced JSNA mapping of community assets and need
- Provision of an integrated health and social care information, advice and guidance service, linked to single point of access
- Development of markets and communities to provide an active and vibrant environment for social enterprise, micro enterprises and self help mechanisms to flourish
- Increased support for carers through new jointly commissioned support services, underpinned through better information for carers, greater identification within community services and increasing assessments
- Implementation of support planning services to empower and enable individuals to plan their own care and support to those with single diagnosis or low to moderate FACS eligibility.
- Work to help individuals understand and maximise opportunities for developing social capital through peer support, mentoring, time banking, local networks and community integration
- Greater encouragement and support for self management and person centred care planning through community and early contact points
- Refreshed demand and capacity plan for community support (nursing homes, residential homes, day care)
- Quality and capacity development programme with local nursing homes

**Key success factors and dependencies for this part of our strategy include:**

- Patient, user, carer co-production, engagement and buy in to the model.
- Good access to meaningful, accurate, up to date information.
- Finance systems capable of supporting integrated personal budgets.
- Primary care engagement and development.
- Development of capacity in social care to increase carer assessments.
- Workforce development and culture change in relation to person centred care.
- Robust market development.

**Implementation timeline for this component of our strategy**




**Alignment with JSNA and Joint Health and Wellbeing Strategy:**
The Better Care Plan works to meet a number of the objectives and deliver many of the key actions set out in the Joint Health and Wellbeing Strategy, which was adopted by the Health and Wellbeing Board in March 2013. In 2014/15 and 2015/16 the Plan will help to deliver a number of the actions set out in the living and ageing well theme of our Health and Wellbeing Strategy, in particular the following :

- Offer an annual health check to carers and promote support networks for carers across the City
- Review tele-care and tele-health services in the City, re-shape and re-launch these so that local people are more aware of the ways in which they can use technology to retain their independence
- Extend re-ablement services so that people can get help to regain their confidence and skills after an illness or mental health breakdown
- Promote healthy, active lifestyles through a dedicated team of Activity Coordinators
- Increasing the number of people who can say how best to spend the money allocated for their health and care, either through direct payments or personal health/care budgets
- Joining up health and social care services so that the number of assessments is reduced and a person's experience of moving between professionals is much smoother and less

fragmented

- Developing a shared understanding of how best to support people to retain their independence and make changes to practice which improve the achievement of this objective
- Promotion of a focus on recovery rather than simply procedures for admission avoidance and/or hospital discharge when people need any form of secondary care
- To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions.
- Work with GPs to more accurately achieve earlier diagnosis of those most at risk of experiencing dementia
- To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions.
- The development of extra-care services for people with long term conditions and those with dementia
- Launching a new approach to provision of aids and adaptations which encourage better access and information for individuals able to fund themselves and improves response times to those requiring equipment to maintain their independence
- Raising awareness amongst all care and health staff about appropriate responses for people with dementia, mental capacity issues including deprivation of liberty guidelines and protocols
- Work with the Clinical Commissioning Group and providers of social care to raise the standard of medicines management across the health and care system
- Increase public awareness and discussion around death and dying
- Extend palliative care to other diseases besides cancer and ensure access to physical, psychological, social and spiritual care
- Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service)
- Have timely bereavement counselling available

As the work develops into 2015/16 and the focus extends beyond elderly people and individuals with complex long-term conditions, the Better Care Plan will widen to support actions in the building resilience and using preventative measures to achieve better health and wellbeing and best start in life themes. The capacity building component of the strategy will embed resilience and prevention into communities, the existing council-led transformation programme will bring together housing with health and social care to address the housing outcomes identified in the Strategy, and the extension of Better Care principles across the whole life course will address key actions in the best start in life theme.

**d) Implications for the acute sector**

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Achieving our plans will require a significant investment in primary and community care and reduced activity in the acute sector.

For University Hospital Southampton, our main acute hospital provider, our plans will mean:

- More outpatient activity delivered outside the hospital on an outreach basis
- A more joint approach to working between secondary, primary and community care to manage risk in the community

- A more specialist advisory role to the community.
- Reduction in beds

We are projecting a X% reduction in avoidable admissions and a x% reduction in excess bed days in 2014/15 with a further x% reduction and x% reduction respectively in 2015/16. This equates to x beds and a £x reduction in spend in the acute sector.

We expect our plans to improve performance against NHS service delivery targets through:
- Much more proactive approach from the community to discharge patients, enabling more timely discharge, and the hospital to better manage capacity and reduce delayed transfers of care.
- More coordinated, preventative community provision, operating 7 days a week, preventing avoidable admission and thereby reducing pressures on the urgent care system
- Better information available to the hospital on admission (through access to the patient's care plan) supporting assessment and coordination of care.

The risk to our plans is that the extent of the change in out of hospital services does not happen or does not deliver the benefits expected in order to deliver the reduction in activity we are projecting. If we do not deliver the outcomes expected, then there will be a financial pressure on the local health system.

This will be managed through monthly monitoring of activity levels, daily review of delayed discharges through our Integrated Discharge Bureau and real time information in the urgent care dashboard to identify early warnings of non delivery. In the event of non delivery, cross system plans, with clear targets and milestones, will then be developed to deal with any pressures.
To support this we intend to shift to outcome based contracts with a risk sharing approach so providers are all actively committed to the achievement of the targets.

**e) Governance**

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

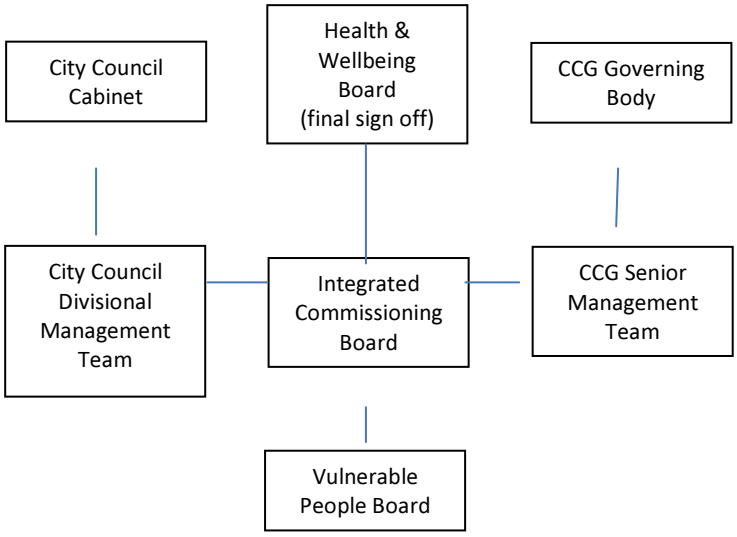
Development of Southampton's integrated care plan has been coordinated by the city's integrated commissioning unit through its Vulnerable People workstream. The Vulnerable People Strategic Delivery Board was set up two years ago to oversee the development and implementation of the strategy. This includes taking a system-wide view of outcomes and service provision for vulnerable adults and children across all sectors (health, social care, education, housing, public health, voluntary and community) and ensuring that resources across the board are prioritised and organised in a joined up way so as to maximise good outcomes, quality, safety and equity of provision. Specific functions of the board are to:

- Strategically inform and manage the delivery of the overall work.
- Review progress, identify any risks, blockages or constraints and ensure they are mitigated.
- Inform and deliver evaluation processes and measures of success that can be monitored.
- Engage with stakeholders to ensure their needs and the needs of all those affected by the Vulnerable People programme are recognised and considered and that the aims, objectives and actions of the vulnerable people programme are properly communicated across the system.

Membership of the Vulnerable People Strategic Delivery Board includes CCG clinical and commissioning leads for integrated care, Public Health consultant, Senior Social Care leads, Community and Acute health provider leads, Voluntary sector representative and Housing.

The Board reports to the Integrated Commissioning Board of the City Council and CCG which is a high level board comprising the Chief Executives of the Council and CCG, Director of Public Health, Chief Finance Officers and lead Directors.

The Health & Wellbeing Board provides high level oversight of these arrangements, ensuring that partnership arrangements are effective and that plans are robust and both ambitious and realistic in their aspiration.
These governance arrangements will continue to oversee the implementation of our local plan and are illustrated below:




At a more operational level we are considering the option of establishing an integrated management board during 2014/15 to oversee the implementation of the new service delivery arrangements. This board, reporting to the Vulnerable People Board, will include senior managers and professional/clinical leads from each NHS provider organisation, the Local Authority and primary care and will be responsible for implementing the cluster teams. The intention is to devolve operational management along with some budget to a locality or cluster level (to be defined over the coming months).

Commissioning responsibility for the integrated care model is brought together across care and health services through our Integrated Commissioning Unit. Single, integrated service specifications with an integrated performance management framework will be signed off by the Integrated Commissioning Board. Through the Integrated Commissioning Board, the leadership of the CCG and City Council will have clear and shared visibility and accountability in relation to the pooled Better Care Fund.

# 3) NATIONAL CONDITIONS

### a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

An element of the local definition is ensuring that resources are available to provide appropriate support for those who meet current eligibility criteria and effective signposting for those who are not. The key focus for achieving this though, within the challenge of growing demand and increasing budgetary pressures is to reduce the demand being made on social care. This is through the development of integrated approaches to identify need and intervene earlier as well as helping people regain their independence and through this reduce the need for ongoing care. For example helping older people to be independent for longer and delay the need for long term care services such as care homes.

There is already a strong commitment in Southampton to focus on outcomes for our population rather than for our organisations and this has been illustrated through proactive partnership working, such as regular joint meetings of the Council and CCG executive teams and the implementation of an Integrated Commissioning Unit.

Please explain how local social care services will be protected within your plans.

City plans such as the Health and Wellbeing Strategy and Joint Commissioning strategy informed the priorities used to inform the use of the funding transfer from the NHS to Social care. Part of this was maintaining current eligibility criteria and this element will be maintained within the Local plan. However the focus was also on a number of areas intended to reduce demand. These approaches will be sustained within the model:

- maximise independence through improved re-ablement and access to telecare/telehealth services, to help people regain their independence and reduce the need for ongoing care
- supporting increased pace of roll out of personalisation and direct payments – including market management and peer support development
- ensure carers feel supported
- Widen peer and community/voluntary sector support availability

The intention is to build on the resource identified within the Better Care Fund and existing pooled budgets to commit a greater combination of our health and care budgets into a pooled fund and base its use around the localities and people, not institutions. This will protect social care services to achieve the outcomes outlined within the plan which support a reduction in demand to allow existing resources to be used more effectively for those who are eligible. This will include use of information sources to target more precisely our increasingly scarce resources and truly find out how many of our resources are ineffectively used at present.

### b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Seven-day health and social care is a key principle of our integrated care model and will be developed as a priority over the next 5 years. It is recognised that only with 7 day working can

the outcomes of our local plan be realised and funding be released from the acute hospital sector.

Many of our community health and social care services are already providing a 7 day service (e.g. reablement, rapid response). During 2013/14, system leaders from across the City Council and local NHS have made a strong commitment to further developing 7 day working in the community through use of Winter pressure monies and a Change and resilience fund created by all organisations to bring about transformational change. This has included making investment in:

- expanding the integrated discharge bureau to cover the 7 day period
- 7 day working in inpatient therapy rehabilitation team with a view to increasing bed occupancy in community beds to 95%, reducing community length of stay to 17 days and increasing flow from acute hospital wards
- increasing the hours of the already 7 day community emergency department support team to operate later into the evening in order to support earlier discharge of patients who can be appropriately managed in the community before they are admitted to a ward.

Further development of 7 day working remains a priority.

Priorities include:

- implementation of GMS contract and improved primary care access with extended hours in each locality
- ensuring availability of 7 day social care assessment to support timely discharge and transfers
- 7 day access to geriatrician for advice to community teams and ambulance service
- extension of equipment service availability to Saturday afternoons and Sundays

A detailed plan for 7 day services will be developed during 2014/15 as part of our capacity modelling for implementation from 2015/16 onwards.

### c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence.

Adult Social Care are using NHS Number as the primary identifier, with 83% of known individuals having this recorded. By using NHS Number Adult Social Care services are able to link data with health information though the Hampshire Health Repository (HHR). The Council has achieved NHS Information Governance approval to share data.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

We are committed to using the NHS number as the primary identifier for correspondence and will continue to promote this.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Southampton City Council is PSN (Public Sector Network) compliant level 2.

The Council has also achieved GCFX and N3 compliance with the ability to connect to the NHS spine.

Solent NHS Trust and Southern Health NHS Foundation Trust are currently not fully compliant (National BT system Rio),or able to share real time currently. However they are looking to re-procure by Oct 2015 to become fully compliant.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott2.

The CCG has achieved IG toolkit level 2.

The City Council has achieved level 2 IG Toolkit status, with plans in place to gain level 3 by 2016.

Solent NHS Trust and Southern Health NHS Foundation Trust have achieved level 2 and are moving towards level 3 compliance.

University Hospital Southampton Trust is aiming to achieve level 2, moving towards level 3 compliance.

**d) Joint assessment and accountable lead professional**

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Southampton City CCG has been implementing a risk profiling tool (the ACG tool) across all its GP practices to identify patients with conditions that make them 50% more likely to be admitted to hospital in the coming 12 months. The ACG tool upgrade which is planned for the New Year will predict those patients at risk of emergency hospital admission within the next 6 and 12 months. This data can be filtered by age group.

All practices have signed up to the DES in 2013/14, have established the 1% of their registered populations most at risk of hospital admission and are working towards ensuring that all of these patients have a care plan with a named lead professional as a requirement of the DES. In addition to the DES, the CCG has also implemented a local Quality Improvement Scheme to monitor care outcomes.

The CCG's community health provider, Solent NHS Trust, is working with practices to establish

joint care planning through the community nursing cluster model. This has been incentivised over 2012/13 and 2013/14 through the local CQUIN.

All patients identified at high risk and being case managed have their care overseen by a community matron. Approximately 300 care plans, and approximately 700 less detailed ambulance anticipatory care plans are now in place and being rolled out for all case managed patients to avoid inappropriate conveyance to hospital. When called, the ambulance service can check the AACP and contact community services, thereby avoiding an unnecessary hospital admission. A CQUIN is also in place with University Hospital Southampton Trust, the CCG's acute hospital provider, to incentivise the use of anticipatory care plans in the assessment of patients presenting in the Medicine for Older People specialty.

Work is underway to establish a joint health and social care risk profiling and care planning process. This is being trialled within one neighbourhood (Demonstrator site) covering 18,000 patients, with two GP practices, community health services, older people's mental health services, social services, housing, community and voluntary providers. All partners have worked together to identify approximately 60 of the most at risk individuals in the neighbourhood for joint care planning and case management. With the support of Southampton University, the key aspects being trialled in the Demonstrator site (i.e. integrated care planning, risk stratification and the lead professional model of working) are being evaluated. Our plan is to roll these out to other areas across the city as we implement the cluster teams during 2014/15 and 2015/16.

Initially the roll out will focus on the 2% of people with complex conditions, most at risk of hospital admission, building on the 1% at risk identified during 2013/14 through the DES.

In future years (2016/17 onwards) we will roll this out to adults with learning disabilities, mental health problems and children and young people with complex needs.

## 4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

| Risk | Risk rating | Mitigating Actions |
|---|---|---|
| Failure to achieve the cultural change required to make this happen | MEDIUM | Strong leadership from all partners through Vulnerable People Strategic Delivery Board and integration management board.<br>Robust stakeholder engagement programme and involvement in developing the model.<br>Roll out of cluster/locality working during 2014/15 through workshops, co-location, joint working, prior to formalisation of cluster/locality teams.<br>Workforce development programme during 2014/15 focussing on key elements of the model, e.g joint assessment and care planning, care coordination/key worker role, self management and other person centred care approaches |
| Unable to reduce acute hospital activity leading to failure to release and reinvest funds in out of hospital model or double running and increased costs | HIGH | Robust activity and financial modelling, supported by whole system capacity planning tools.<br>Strong project management and performance monitoring throughout. |
| Demand for services increases beyond expectation putting additional pressure on system, increasing costs | HIGH | Thorough impact assessment to support plans:<br>- implications of Care and Support Bill<br>- demographic profiling |
| Failure to establish infrastructure soon enough to support integrated working, eg. IT systems, single telephone number, finance systems | MEDIUM | Strong focus of work during 2014/15 to be on developing infrastructure to support integrated working.<br>Robust project plan and management.<br>High level attention to infrastructure requirements at CCG and City Council Board level. |
| Unable to get buy in from GP practices to the scale of change required | MEDIUM | Extensive primary care engagement programme. GP clinical and locality leads to provide strong leadership.<br>Strong bottom up approach to development of detail of the model. |
| Primary care unable to make the change required due to lack of capacity or resistance to change | HIGH | Investment in organisation development programme for primary care during 2014/15. Strong clinical leadership through GP programme and locality leads. |
| Unable to get buy in from political leaders to scale of change | MEDIUM | Political leaders involved at each stage of local plan development. Councillor lead for programme development. |
| Contractual barriers, eg. unable to secure change fast enough because of contract notice requirements | MEDIUM | Outline specification for future model to be issued before 31 March 2014 to give providers 12 months notice prior to 2015 full roll out of model. Contractual levers used during 2014/15 to incentivise culture and organisational change required, eg. person centred care CQUIN. |
| Failure to incentivise providers to overcome | LOW | Senior leadership from all provider |

| Risk | Risk rating | Mitigating Actions |
|---|---|---|
| organisational boundaries | | organisations on Vulnerable People Strategic Delivery Board. Extensive consultation and engagement programme with all providers, including front line staff. Establishment of Operational Partnership Board to implement model. |
| Implementing change at scale may destablise existing providers | MEDIUM | Impact assessments completed by all main providers against the new model of integrated care. Risks to individual providers to be monitored throughout implementation. |
| Public do not have same level of confidence in community services as they do in acute hospital services and opt for ED as first port of call | MEDIUM | Strong Public and patient engagement programme. |
| Shortage of good quality providers in the market to meet need for home care | MEDIUM | Joint domiciliary care tender to expand choice and confidence in the market. Investment in new Associate Director post for market development within the Integrated commissioning unit to specifically focus on market development. |
| Inability to recruit to key posts in out of hospital model, eg. geriatricians | MEDIUM | Whole system wide recruitment targeting key posts, eg. therapies, geriatricians. Introduction of new innovative roles, e.g. joint posts working across agencies, hospital and community, joint training opportunities, rotations |

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|---|---|---|---|---|
| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | VULNERABLE PEOPLE BOARD - MAKING IT REAL | | |
| **DATE OF DECISION:** | | 29TH JANUARY 2014 | | |
| **REPORT OF:** | | DIRECTOR OF QUALITY AND INTEGRATION<br>INTEGRATED COMMISSIONING<br>SOUTHAMPTON CITY CCG/SOUTHAMPTON CITY COUNCIL | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR**: | **Name:** | **Sandy Jerrim** | **Tel:** | **02380 296039** |
| | **E-mail:** | **Sandra.jerrim@southamptonccg.nhs.uk** | | |
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| | **E-mail:** | **Alison.Elliott@southampton.gov.uk**<br>**John.Richards@southamptoncityccg.nhs.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None. | | | | |

**BRIEF SUMMARY**

Southampton City Council and Southampton Clinical Commissioning Group have made a commitment to the Integrated Person Centred Care Programme. This also formed the basis for a submission to the Department of Health Pioneer Bids. Although unsuccessful in the first wave of Pioneer Bids, all agencies including the council and the CCG have expressed their commitment to pursuing the core components including signing up to the Making It Real initiative. This report asks the Health and Wellbeing Board to declare its commitment to Making It Real.

**RECOMMENDATIONS:**

(i) That Health and Wellbeing board to declare their commitment to the Making it Real initiative.

(ii) That stakeholder mapping to be undertaken against the Markers of Progress for both Making it Real and NHS England roll out of personal health budgets.

**REASONS FOR REPORT RECOMMENDATIONS**

1. To provide leadership for the further development of Make It Real in order to take forward the Integrated Person-Centred Care Programme, which aims to provide a better experience for patients and their carers and families.

**ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

2. None. It is considered a priority to take this programme forward.

**DETAIL (Including consultation carried out)**

3. Making it Real is an initiative from Think Local Act Personal (TLAP), a national, cross sector leadership partnership focused on driving forward work with personalisation, and community-based social and more recently health care. Southampton City CCG and Southampton City Council fully support the work of TLAP and currently working with them to implement the TLAP Draft Framework for HWB Developing the power of strong, inclusive communities.

4. Making it Real sets out what people who use services and carers expect to see and experience if support services are truly personalised. They offer a set of "progress markers" - written by real people and families - that can help an organisation to check how well they are progressing towards transforming adult social care and more recently health services. The aim of Making it Real is for people to have more choice and control so they can live full and independent lives.

5. The Making it Real initiative has invited all agencies, including local authorities and clinical commissioning groups to sign up to the Making It Real initiative. Currently there are 599 agencies signed up to the initiative, including over 60 local authorities and 2 clinical commissioning groups.

6. The increasing political emphasis on personalisation, including personal health budgets, coupled with the government's commitment to the Making It Real initiative suggests sign up is seen as a key element of the both pioneer bids, integration and developing personalisation through both social and health care environments.

**MAKING IT REAL REQUIREMENTS**

7. Making It Real is asking Health and Wellbeing Boards to make a declaration, which commits the them to the following

- Registering the organisation
- Identify a named lead
- **Making a Board level declaration**
- Mapping the organisation against a series of 'I' statements. See Appendix A. This involves a self assessment and views gathered through discussion with service users and the public
- Develop (coproduce) a 'Make it Real' action plan. This should be shared publicly and the top 3 priority areas posted on the TLAP website. The 3 priority areas will reflect and draw from the priorities set out in the Southampton Personalisation Strategic Intent. They are Integration, coproduction, providing good advice & information,

developing the workforce, developing the support systems, developing a suitable finance system, offering personal health budgets, increasing take up of direct payments, developing the market place and ensuring risk and safeguarding are paramount and proportionate.

Agencies would then continue to

- produce reports and summaries of successful initiatives for local audience
- update against the 3 priority areas and
- update the action plan every 6 months.

8. Health and Wellbeing Board are being asked to declare a commitment to the Making it Real initiative. In doing so there is a recognition and acknowledgement by Southampton City Council and Southampton Clinical Commissioning group, supported by other members of the HWB, of the work needed to map each agency, through stakeholder engagement against the relevant markers of progress and 'I' statements.

9. Alongside the mapping and stakeholder engagement for Making It Real, there is also an opportunity to undertake stakeholder feedback about the NHS England Markers of Progress (for roll out of personal health budgets) at the same time. We would recommend both stakeholder engagement and consultations are undertaken at the same time.

10. An initial internal self-assessment against both markers of progress (TLAP and NHS England) has already been undertaken. Self assessments have been completed for each organisation, and then merged into one combined integrated document. This has provided early insight into the likely position of each organisation and reflects the areas of work covered in the priorities set out above (although it may vary once full internal and external stakeholder engagement completed). A copy of the documents (SCC, SCCCG and integrated) are available on request.

## RESOURCE IMPLICATIONS

### Capital/Revenue

11. A significant element of the work will be taken forward by the Integrated Commissioning Unit (ICU) to meet the city wide agenda for personalisation. Costs will be incorporated into this workstream, with requests for specific capital or revenue funding raised appropriately e.g. developing a support planning service, interim workforce development requirements.

There is currently no committed budget or the development of personalisation, although developments have been met and supported by the ICU

**Property/Other**

12. None.

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

13. Section 195 of the Health and Social Care Act 2013 places a duty on Health and Wellbeing Boards to encourage better service integration. Improved service integration will contribute towards better integrated person centre care.

**Other Legal Implications:**

14. None.

**POLICY FRAMEWORK IMPLICATIONS**

15 None.

**KEY DECISION?** /No

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | All |

**SUPPORTING DOCUMENTATION**

**Appendices**

| | |
|---|---|
| 1. | Think Local Act personal – I Statements |

**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. | |

## Appendix A

**Information and Advice. Having the information I need, when I need it.**

- I have the information and support I need in order to remain as independent as possible.
- I have access too easy to understand information about care and support which is consistent, accurate, accessible and up to date.
- I can speak to people who know something about care and support and can make things happen.
- I have help to make informed choices if I need and want it.
- I know where to get information about what is going on in my community.

**Active and supportive communities. Keeping friends, family and place**

- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.
- I have a network of people who support me - carers, family, friends, community and if needed paid support staff.
- I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities.
- I feel welcomed and included in my local community.
- I feel valued for the contribution that I can make to my community.

**Flexible integrated care and support. My support my own way**

- I am in control of planning my care and support.
- I have care and support that is directed by me and responsive to my needs.
- My support is coordinated, co-operative and works well together and I know who to contact to get things changed.

**Workforce. My support staff**

- I have good information and advice on the range of options for choosing my support staff.
- I have considerate support delivered by competent people.
- I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers.
- I am supported by people who help me to make links in my local community.

**Risk enablement. Feeling in control and safe**

- I can plan ahead and keep control in a crisis.
- I feel safe, I can live the life I want and I am supported to manage any risks.
- I feel that my community is a safe place to live and local people look out for me and each other.
- I have systems in place so that I can get help at an early stage to avoid a crisis.

**Personal budgets and self-funding. My money**

- I can decide the kind of support I need and when, where and how to receive it.
- I know the amount of money available to me for care and support needs, and I can determine how this is used (whether its my own money, direct payment, or a council managed personal budget).
- I can get access to the money quickly without having to go through over-complicated procedures
- I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this.

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**Appendix 1**

## Making it Real - Markers for change

**Information and Advice. Having the information I need, when I need it.**

- I have the information and support I need in order to remain as independent as possible.
- I have access too easy to understand information about care and support which is consistent, accurate, accessible and up to date.
- I can speak to people who know something about care and support and can make things happen.
- I have help to make informed choices if I need and want it.
- I know where to get information about what is going on in my community.

**Active and supportive communities. Keeping friends, family and place**

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|---|---|---|---|---|
| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | LEARNING DISABILITIES 2013/14 JOINT HEALTH AND SOCIAL CARE SELF ASSESSMENT FRAMEWORK | | |
| **DATE OF DECISION:** | | 29TH JANUARY 2014 | | |
| **REPORT OF:** | | DIRECTOR QUALITY AND INTEGRATION SOUTHAMPTON CITY CCG /<br>HEAD OF INTEGRATED STRATEGIC COMMISSIONING SOUTHAMPTON CITY COUNCIL | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR**: | **Name:** | **Stephanie Ramsey** | **Tel:** | **023 80296923** |
| | **E-mail:** | **stephanie.ramsey@southamptoncityccg.nhs.uk** | | |
| **Director** | **Name:** | **Alison Elliott, Director of People**<br>**John Richards , Chief Executive** | **Tel:** | **023 8083 2602**<br>**023 8029 6923** |
| | **E-mail:** | **Alison.Elliott@southampton.gov.uk**<br>**John.Richards@southamptoncityccg.nhs.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None | | | | |

**BRIEF SUMMARY**

This report informs the Health and Wellbeing Board of the introduction of the Learning Disability Joint Health and Social Care Self Assessment Framework (JHSCSAF).

The Learning Disability Health Self-Assessment began being used in England in 2007/8. It has become an important guide for the NHS and Local Authorities. It has helped them to recognise the overall needs, experience and wishes of young people and adults with learning disabilities and their carers. This has made it easier to bring these perspectives into the tasks of determining local commissioning priorities and monitoring services.

The Framework has helped to improve services for young people with learning disability in many parts of the country by raising awareness of their health needs, driving increased health and local authority resources and improving interagency co-ordination. However, the events at Winterbourne View and subsequent investigations have demonstrated there is still much to be done. As a result of this, the signatories to Transforming Care and The Concordat agreed to implement a joint health and social care self-assessment framework.

It has been designed so that it becomes the main source of intelligence and data on learning disability in future years.

**RECOMMENDATIONS:**

(i) To note there are areas that have been self-assessed as 'less effective' at this stage, identified within the Action Plan (Appendix 1)

(ii) That a further report on progress of the actions set out in the self assessment be brought back to the Health and Wellbeing Board in 12 months.

## REASONS FOR REPORT RECOMMENDATIONS

1. As part of the governance arrangements, requested by Public Health England - Improving Health and Lives (IHAL)there is a requirement to bring the Southampton's submission to the Health and Wellbeing Board

## ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

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

## DETAIL (Including consultation carried out)

3 The new framework replaces and combines the local authority Valuing People Now Self- Assessment and the NHS Learning Disability Health Self - Assessment and becomes a comprehensive needs assessment. The aim is to ensure that the information collected will support action that improves outcomes for people with learning disabilities and their families.

4. The framework provides a single, consistent way of identifying the challenges in caring for the needs of people with learning disabilities, and documenting the extent to which the shared goals of providing care are met. Locally, this will help Learning Disability Partnership Boards, Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) identify the priorities, levers and opportunities to improve care and tackle health and social care inequalities in their areas. It should also provide a sound evidence base against which to monitor progress.

5. Findings from the JHSCSAF will be used both locally and nationally.

Nationally, it will be used to report publicly and to Ministers on the progress in providing services in every part of the country to meet the aspirations of *Healthcare for All* and of *Transforming care: A National Response to Winterbourne View*.

Locally, it will be used to inform:

1. Joint Strategic Needs Assessment (JSNA)
2. Health and Wellbeing Strategy
3. Commissioning intentions/strategy
4. Winterbourne improvement joint plans
5. Learning Disability Partnership Board work programmes

The organisational arrangements of the new JHSCSAF will retain at its heart the principles of engaging with people with learning disability, their families and carers and of strengthening their voice. The governance arrangements

set out below are designed to support this.

6. The governance structure is designed to facilitate local arrangements for reporting, planning and action. It is assumed that local authorities, through their Health and Wellbeing Boards, will provide the central leadership. The geographic arrangements for the JHSCSAF will reflect this, with the exercise being undertaken in most cases for each upper tier local authority. It is good practice for NHS England Area Teams and Regional ADASS sector-led improvement networks to support the process of quality assurance in consultation with local area staff. The national ADASS LD Lead and the NHS England LD National Clinical Director will receive a report prepared by Improving Health and Lives (IHaL) – Public Health England (PHE) showing by region how areas compare locally, regionally and nationally. Conclusions will be fed back to the Ministerial Learning Disability Programme Board.

7. The JHSCSAF comprises three comprehensive sections which have been completed and submitted to Public Health England. These are:
• Data collation
• Self assessment against nationally agreed measures
• Shared stories completed by people with a learning disability, carers and other stakeholders.

The following section gives an outline of each area and our initial findings from the assessment. Information used to populate the assessment is taken from 12/13 as per PHE requirements.

8. <u>Data collation</u>
As part of the self assessment framework we are required to collate a comprehensive and a wide range of data across health and social care. This covers the following sections:

- Healthcare and health needs (such as numbers of people known to GP's)
- Those in inpatient services, continuing healthcare and those with challenging behaviour;
- Assessment and Social Care services;
- Inclusion and where I live (e.g. employment and housing);
- Quality (e.g. number of safeguarding alerts and money spent on training); Transition.

Completing the JHSCSAF meant gathering a large amount of data held on separate systems, regarding our learning disability population.

Headlines from data collection for the H&WBB to note are:

- 1478 people with a learning disability are identified on GP registers. These are: 653 0-17 year olds; 742 18-64 and 83 adults aged 65+. 108 of these people also have either profound or complex needs.
- 48% of people with a learning disability over 18 are identified as

having a BMI in the 'obese' range (with BMI recorded over the last two years)
- Screening levels for physical health problems were low in comparison to the population's average.

| Screening Type | Southampton Population Average | LD Population Average |
|---|---|---|
| **Cervical** | 68% | 32% |
| **Mammographic** | 44% | 36% |
| **Bowel** | 27% | 6% |

- 30% of those deemed eligible under the DES received an Annual Health Check.
- From 2013 we have 6 people with a learning disability or autism, with challenging behaviour in NHS funded care on the CCG register.
- 56 Young People aged 14+ are currently in receipt of a co-produced Transition Plan.
- 63 adults with a learning disability, known to the council, were in paid employment and 46 in some form of voluntary work.
- There were no adults identified with a learning disability in unsettled accommodation (i.e. homeless, rough sleeping or temporary accommodation).

9. Self assessment against nationally agreed measures (SAF)

As part of the SAF we were required to self assess ourselves against 27 measures using a RAG 'Traffic Light' system. These are aligned to the outcome frameworks – Adult Social Care Outcomes Framework (ASCOF), Public Health Outcomes Framework (PHOF), National Health Service Outcomes Framework (NHSOF), Winterbourne View Concordat and Health Equalities Framework (HEF). These nationally agreed outcome frameworks and policies were used as the evidence base for the three broad areas in the SAF, which are:

Section A – Staying Healthy

This asks questions about making sure people with learning disabilities can be as healthy as everyone else. It includes questions about making sure we have the right information about people, health action plans and annual health checks and assess that people are being supported to manage their own health. It also asks questions whether universal or mainstream health services are making reasonable adjustments.

Section B – Being Safe

This section looks at safeguarding and quality. Making sure that we design, commission and provide services which give people the support they need close to home, and which are in line with well-established best practice. This was highlighted in the Winterbourne Review Concordat.

Section C – Living Well

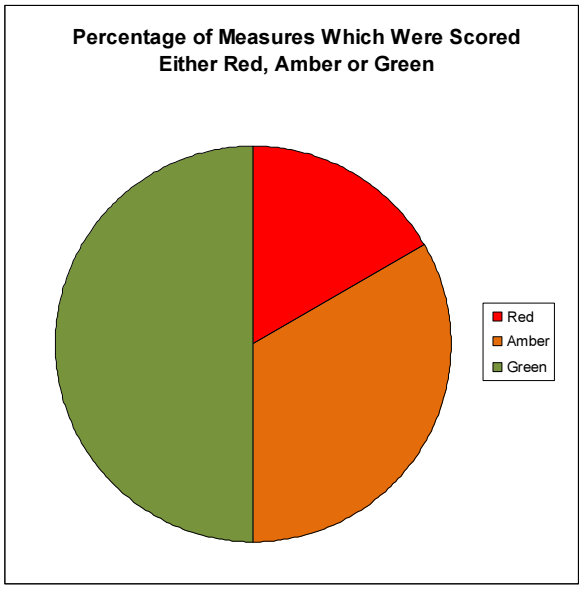
This section is about inclusion, being a respected and valued part of society and leading fulfilling and rewarding lives. People with learning disabilities and their family carers deserve an equal opportunity with the rest of the population to fulfil their lives as equal citizens of our nation safe from crime and intolerance.

The findings from the SAF show that plans are in place to continue delivering change and improvements in the commissioning and delivery of care for people with learning disabilities to address health inequalities and achieve comparable health outcomes.

Each of the domain areas has a range of performance measures, as listed in the self assessment template, against which there are three possible assessment outcomes:

| | |
|---|---|
| | Less Effective |
| | Effective |
| | Exceeds requirements |

The detailed SAF shows there were a number of measures (18%) where our position was assessed as less effective (red). Our responses and evidence to 37% of the questions were identified as effective (amber), and 56% were considered as exceeding requirements (green). This is shown visually in the chart below:




Further work will be required to continue to drive up service standards, as identified in the 13/14 LD JHSCAF Action Plan (Appendix 1).

10. Shared Stories

As part of this year's SAF we were required to ask people with learning disability and their carers to feedback on both good and poor experiences of health and social care services that they have received, through an exercise called "shared stories".

We were able to report in most cases a 'shared story' related to peoples experiences within the city per measure. We had twenty responses in total (some responses covered more than one area). These were collated through service user and carer forums, which are part of the Learning Disability Partnership Board structure, and local providers who completed workshops with their service users.

The main themes emerging from the shared stories were both the good and poor experiences of accessing local health care services (ranging from acute, community to primary care services).

Shared stories are discussed within the LD Health Group and used to inform service changes.

11 The Learning Disabilities Partnership Board will have formal feedback on the 6th March 2014. Health is a regular topic at the Board, and therefore on going updates will be given to outline progress. Quarterly updates will be tabled at the Vulnerable People Board.

**RESOURCE IMPLICATIONS**

**Capital/Revenue**

12. All future revenue implications will be met from the revenue budgets approved by council.

**Property/Other**

13. None.

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

14. Equality Act 2010

**Other Legal Implications:**

15. None.

**POLICY FRAMEWORK IMPLICATIONS**

16. None.

**KEY DECISION?** No

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | All |

## SUPPORTING DOCUMENTATION

**Appendices**

| | |
|---|---|
| 1. | Learning Disabilities Joint Health and Social Care Action Plan 2014 |

**Documents In Members' Rooms**

| | |
|---|---|
| 1. | None |

**Equality Impact Assessment**

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

**Other Background Documents**

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

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

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**Southampton Learning Disabilities Joint Health and Social Care Assessment Framework Annual Action Plan 13/14**

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| **Section A** - Staying Healthy | | | | | | | |
| A1 | LD QOF register in primary care | Learning Disability and Down Syndrome Registers reflect prevalence data<br>AND<br>Data stratified in every required data set (e.g. age / complexity / Autism diagnosis / BME etc.) | Amber | Learning Disability and Down Syndrome Registers reflect prevalence data but are not stratified in every required data set (e.g. age / complexity). | Data has been obtained however a further report to include wider data sets will be developed for benchmarking. To be monitored via the LD Health Group. | Annualised( Qtr 1) prevalence report | LD Health Group |
| A2 | People with learning disability are accessing disease prevention, health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease and Epilepsy | Comparative data in all of the health areas listed in the descriptor at each of the following levels;<br>Local Area Team<br>Clinical Commissioning Group<br>Individual GP Practice | Amber | Comparative data in some of the health areas listed in the descriptor at LAT/CCG/Practice | Channelling data is required from all systems to ensure benchmarking good practice. | Process established to benchmark | LD Health Group Wessex LAT |
| A3 | Annual Health Checks and Annual Health Check | Validated on a minimum of an annual basis and process in place for all people aged 18 or over to be put on register. | Red | Registers not validated since set up.<br>25% of people with learning disability on the | A city wide plan is developed covering, engagement with GPs, Wessex LAT, Southern Health, LDPB, Choices | Registers will be validated by close of Qtr 4 14/15 | LD Health Group Wessex LAT |

**Southampton Learning Disabilities Joint Health and Social Care Assessment Framework Annual Action Plan 13/14**

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | Registers | 80% of people with learning disability GP DES Register had an annual health check. | | GP DES Register had an annual health check. | Advocacy and LD population/carers. | Implementation to reach 50% (Amber) within 14/15. | |
| A4 | Health Action Plans are generated at the time of Annual Health Checks (AHC) in primary care and these include a small number of health improving activities. Refer to RCG guidance around health action plans. | GP Health Action Plan (HAP) contains specific health improvement targets identified during the AHC for 50% of patients (to be captured through AHC template. | Red | No evidence that the Annual Health Check and Health Action Plans are integrated. | To have a process to generate GP health action plan that is integrated, SCCCG are working up with other CCGs, ready for implementation in 14/15. | 10% of LD population to receive pilot of integrated HAP by Qtr 2 | LD Health Group Wessex LAT |
| A5 | Comparative data of people with learning disability vs. similar age cohort of non-learning disabled population in each | Numbers of completed health screening for eligible people who have a learning disability in every screening group;<br>AND<br>Comparative data of screening rates in the non LD population for every screening group;<br>AND<br>Scrutinised exception reporting and | Amber | Numbers completed and comparative data in place.<br><br>Limited evidence to suggest scrutinised exception reporting and evidence of reasonably adjusted services | Comparative data shows marked differences in uptake; therefore screening programmes need to demonstrate reasonable adjustments. A programme regarding improved coding. Accountability issues to be resolved. | Wessex LAT to identify | LD Health Group Wessex LAT |

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | health screening area for:<br>a) Cervical screening<br>b) Breast screening<br>c) Bowel Screening (as applicable) | evidence of reasonably adjusted services | | | | | |
| A6 | Primary care communication of learning disability status to other healthcare providers | Secondary care and other healthcare providers can evidence that they have a system for identifying LD status on referrals based upon the ld identification in primary care and acting on any reasonable adjustments suggested. There is evidence that both an individual's capacity and consent are inherent to the system employed | Amber | There is evidence of a LAT/CCG wide system for ensuring LD status and suggested reasonable adjustments if required, are included in referrals.<br>There is evidence that both an individual's capacity and consent are inherent to the system employed | This measure to be discussed at provider Clinical Quality Review Meetings (CQRM). Action plan to be developed pending item discussion for implementation Qtr 1 14/15. To be raised at Locality meetings with GPs to raise awareness for the need to pass information to providers. | Review of secondary system and identification of good practice guidance to services to be disseminated by Qtr 1 14/15. | Carol Alstrom (Quality Associate Director ICU ) Clinical Governance Board (CGB) |
| A7 | Learning disability liaison function or equivalent process in acute setting | Designated learning disability function in place or equivalent process, aligned with known learning disability activity data in the provider sites and there is broader assurance through executive board leadership and formal reporting / monitoring routes | Amber | Designated learning disability liaison function in place and details of the provider sites covered has been submitted.<br>Providers are not yet using known activity data to effectively employ LD liaison function against demand. | There is a work plan in place for Health Facilitation/Hospital Liaison Nurses for Learning Disabilities, in order to gain formal reporting. This measure to be discussed at UHS and SHFT CQRM to ensure board leadership. | Annual rolling programme to demonstrate board leadership. | Carol Alstrom (Quality Associate Director ICU ) Clinical Governance Board |

**Southampton Learning Disabilities Joint Health and Social Care Assessment Framework Annual Action Plan 13/14**

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| A8 | NHS commissioned primary and community care<br>* Dentistry<br>* Optometry<br>* Community Pharmacy<br>* Podiatry<br>* Community nursing and midwifery<br>This measure is about universal services NOT those services specifically commissioned for people with a learning Disability. | All people with learning disability accessing/using services are known and patient experience is captured.<br>All of these services are able to provide evidence of reasonable adjustments and plans for service improvement. | Amber | Some of these services are able to provide evidence of reasonable adjustments and plans for service improvements e.g. podiatry/community nursing. | Each has its own action plan to address requirements (due to diversity/system differences/providers).<br>CQUIN being worked up to cover patient experience<br>Where relevant some work will be taken across Hampshire and Portsmouth area with Wessex LAT.<br>A programme with carers to be put in place regarding reasonable adjustments in services. | CQRM to hold all providers to account in 14/15 to ensure all areas have clear action plans, | LD Health Group |
| A9 | Offender Health & the Criminal Justice System | Local Commissioners have good data about the numbers /prevalence of people with a learning disability in the CJS. Local commissioners have are working with regional, specialist prison health commissioners<br>Good information on health needs of people with LD in local prisons /wider criminal justice system and a clear | Amber | Assessment processes exist but tend to be focused around individual teams/pathways e.g. Mendos/LD forensic. There is easy read accessible information provided by the criminal justice system for adults with autism. | To review available data regarding population/need/prevalence.<br>To establish a process to propose action plan of which CJS coproduce. been agreed to identify people with LD in all offender health services e.g. learning | Hampshire Probation Trust KPI - Reduction of the differential in successful completion of orders between | HTP Equalities Consultation Panel<br><br>LD Health Group |

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | plan on how needs can be met. Prisoners and young offenders with LD have had an annual health check, or are scheduled to have one within 6 months (either as part of custodial sentence or following release, as part of GP health check cycle). They are offered a Health Action Plan. | | | disability screening questionnaire | offenders who have a learning difficulty and those who do not by March 2014 (currently 14%) | |
| **Section B**- Being Safe | | | | | | | |
| B1 | Regular Care Review | Evidence of 100% of all care packages including personal budgets reviewed at least annually | Red | SCC % of LD of any age 18 or over in 2012-13 who were in receipt of a service who were reviewed was 50.4 %. Services include residential, nursing, domiciliary, day care, meals, short stays, direct payments, professional support (mainly OT) or major items of equipment.<br><br>SCCCG has completed 63.3% of reviews based on a 12 month rolling average to end November 2013. | The review of the Adult Social Care Pathway will mean that reviews are completed more effectively.<br><br>SCC LD Team are preparing an action plan to achieve 90% (amber) annually including improved recognition of review when work is undertaken with clients.<br><br>SCCCG (Continuing Healthcare) are reviewing the service to raise to 85% in 2014/15. | 90% of reviews to be completed for SCC in 14/15.<br><br>85% of reviews to be completed for SCCCG in 14/15 | Andy Biddle (SCC Manager)<br><br>Carol Alstrom (Quality Associate Director ICU ) |
| B2 | Contract Compliance Assurance – For services | Evidence of 100% of health and social care commissioned services for people with learning disability have:<br>- had full scheduled annual contract | Red | SCC reviews of commissioned services for LD clients was 65% in 2012/13. Services include | B1 will support this action being completed (due to the fragmentation of the services). | % of commissioned services with contract | Carol Alstrom (Quality Associate Director ICU ) |

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | primarily commissioned for people with a learning disability and their families. | and service reviews.<br>- Demonstrate a diverse range of indicators and outcomes supporting quality assurance<br><br>Evidence that the number regularly reviewed is reported at executive board level in both health & social care | | residential, nursing, domiciliary, day care.<br><br>Reports are completed and action plans required from providers. These are monitored to ensure improvements.<br><br>Reports on progress relating to quality assurance reviews are made to SSAB | A new Individual Service Contract has been developed for all placements (SCC). SCCCG (Continuing Healthcare) are reviewing service contracts in line with new home care tender.<br><br>The ICU Scorecard, including Quality elements will report to IC Board and other relevant bodies' such as SSAB this will include the number of services reviewed | reviews per annum.<br><br>% of contract reviewed services with additional requirements. | Provider Relationships Associate Director |
| B3 | Assurance of Monitor Compliance Framework for Foundation Trusts Supporting organisations aspiring towards Foundation Trust Status Governance Indicators (LD) per trust within the locality. | Commissioners review monitor returns and EDS review actual evidence used by Foundation Trusts in agreeing ratings<br>Evidence that commissioners are aware of and working with non-foundation trusts in their progress towards monitor level & EDS compliance. | Green | Returns and evidence reviewed | Achieved. CQRM will ensure ongoing monitoring. This will be overseen by SCCCG Clinical Governance Committee and Governing Body/SCCCG Executive Board. | This requirement to be formally written into contracts for FT and Non FT providers. | Carol Alstrom (Quality Associate Director ICU) |

**Southampton Learning Disabilities Joint Health and Social Care Assessment Framework Annual Action Plan 13/14**

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| B4 | Assurance of safeguarding for people with learning disability in **all** provided services and support<br>This measure must be read in the context of an expectation that ALL sectors, Private, Public and Voluntary / Community are delivering equal safety and assurance. | Evidence of robust, transparent and sustainable governance arrangements in place in all statutory organisations including Local Safeguarding Adults Board(s), Health & Well-Being Boards and Clinical Commissioning Executive Boards<br>The provider can demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent.<br>Every learning disability provider service have assured their board and others that quality, safety and safeguarding for people<br>with learning disabilities is a clinical and strategic priority within all services.<br>Key lessons from national reviews are included.<br>There is evidence of active provider forum work addressing the learning disability agenda | Green | There is evidence of robust, transparent and sustainable governance arrangements in place in all statutory organisations including SSAB, HWBB and CCG Executive Board.<br>The provider can demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent<br>Every learning disability provider service have assured their board and others that quality, safety and safeguarding for people<br>with learning disabilities is a clinical and strategic priority within all services.<br>Key lessons from national reviews are included.<br><br>There is evidence of active | The SSAB will ensure ongoing monitoring. | 100% of services demonstrating compliance with CQC outcome 7 | SSAB |

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | | | provider forum work addressing the learning disability agenda through residential and domiciliary care forum as well as the LDPB. | | | |
| B5 | Training and Recruitment – Involvement | LD specific services: evidence of 100% of services involving people with learning disability and families in recruitment/ training and monitoring of staff including advocates.<br>Strong evidence of commissioners specifically raising the need for LD awareness training and reasonable adjustment within universal services in line with consultation by people with a learning disability and family carers.<br>Strong evidence of universal services embedding LD awareness training and making reasonable adjustments for people with a learning disability and family carers to access and use the services AND of universal service providers sharing good practice and experience. | Amber | Service audits undertaken evidence 90% of services involving people with learning disability and families in recruitment/ training and monitoring of staff.<br><br>Some evidence of universal services embedding LD awareness training and making reasonable adjustments for people with a learning disability and family carers to access and use the services. | Specifications for all retendered services to include outcome measure regarding involvement in recruitment/training and monitoring.<br><br>Advocacy services specification to include outcome to support this measure.<br><br>All contracts stipulate under Equalities Act requirement to ensure wider access to services.<br><br>Review to identify gaps in universal provision and reasonable adjustments. | 100% of services evidence involvement of users and families in recruitment, training and monitoring during QA visits.<br><br>100% of services have completed reviews of universal provision and | Provider Relationships Associate Director ICU<br><br>Carol Alstrom - Quality Associate Director ICU |

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | | | | | have plans in place to ensure reasonable adjustments are achieved | |
| B6 | Commissioners can demonstrate that providers are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture.<br>This is a challenging measure but it is felt to be vital that all areas consider this. | Clear evidence of commissioning practice that drives providers to demonstrate compassionate care and value base recruitment & management of the workforce<br>Evidence of this approach in relevant universal services | Green | Tender processes focus on values of organisations and require demonstrations on these values being put into practice. | Ongoing monitoring in place for all contracts using good practice e.g. service audits, Dignity in Care work. Social Value Act used prominently within tendering processes. | 100% of services evidence organisational values reflected in day to day work practices, with clear commitment to involvement of users and dignity being promoted. | Provider Relationships Associate Director |

**Southampton Learning Disabilities Joint Health and Social Care Assessment Framework Annual Action Plan 13/14**

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| B7 | Local Authority Strategies in relation to the provision of support, care and housing are the subject of Equality Impact Assessments and are clear about how they will address the needs and support requirements of people with Learning Disabilities. | Evidence of Commissioning Strategies and associated Equality Impact Assessments being presented to people who use services and their families and clear plans in place for the development of Care, Support and Housing for people with learning disabilities based on evidence of current and future demand. | Amber | SCCCG providers submitted CIP schemes to commissioners including details of EIA and Quality Impact Assessments. This was completed for 2013/14. | Commissioning Strategies and work stream areas identify EQI. The LDPB (which has 50% of people with LD sitting on this) inputs on commissioning strategies and associated equality impact assessments, these are shared via the LDPB website. Experts by Experience to considered. | 90% of all EIA's to be up loaded to LDPB website by Qtr 2 14/15, with repeat agenda item at LDPB for review/challenge. | System Redesign Associate Directors<br><br>Carol Alstrom - Quality Associate Director ICU |
| B8 | Commissioners can demonstrate that all providers change practice as a result of feedback from complaints, Whistle blowing | Evidence that 90 % of commissioned practice and contracts require evidence of improved practice, based on the use of patient experience data, and the review and analysis of complaints. There is evidence of effective use of a Whistle-blowing policy where appropriate. | Amber | Evidence from Southampton Service Audits is that 50 % of commissioned practice and contracts have evidence of improved practice, based on the use of patient experience data, and the review and analysis of complaints and that there is evidence of effective use of a Whistle-blowing policy | Providers will be requested to demonstrate that they are changing their practice, based on the feedback from the service users. Monitoring to record this to be put in place so that at least 90% of providers show this under service review/monitoring. Staff surveys' also to be used more formally to gain intelligence. | Evidence of changes in practice to be presented via provider service reviews / monitoring | Carol Alstrom - Quality Associate Director ICU |

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | experience. | | | where appropriate. | | | |
| B9 | Mental Capacity Act & Deprivation of Liberty | All appropriate providers have well understood policies in place and routinely monitor implementation of these in relation to, the Mental Capacity Act (including restraint, consent and deprivation of liberty). The provider can evidence action taken to improve and embed practice | Green | All appropriate providers have well understood policies in place and routinely monitor implementation of these in relation to, the Mental Capacity Act (including restraint, consent and deprivation of liberty). The provider can evidence action taken to improve and embed practice where necessary. | Maintain good practice. ? develop register of providers checked for compliance against MCA. | Breaches of MCA and DOLS to be reported – expectation no breaches in any providers | Carol Alstrom - Quality Associate Director ICU |
| **Section C** – Living Well | | | | | | | |
| C1 | Effective Joint Working | There are well functioning formal partnership agreements and arrangements between health and social care organisations.<br>There is clear evidence of pooled budgets or pooled budget arrangements, joint commissioning structures, intentions, monitoring and reporting arrangements. | Green | LD commissioning currently have one active Section 75. Further plans to expand are being consider under a broader programme of development linked to the Better Care Fund. | Plans to further develop partnership agreements will be processed through Southampton's Better Care Fund work area. | Number of jointly commissioned services | Integrated Commissioning Unit Board |

**Southampton Learning Disabilities Joint Health and Social Care Assessment Framework Annual Action Plan 13/14**

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| C2 | Local amenities and transport | Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully and build / maintain social networks e.g. support to use local transport services, Changing Places in shopping centres, Safe Places and evidence that such schemes are communicated effectively. | Green | | Review of transport services to be undertaken.<br><br>Training regarding reasonable adjustments for bus companies by people with LD being developed.<br><br>Safe places launched and updated, work currently being undertaken to include info on training for providers and council staff (KPI) Meetings with police to monitor scheme.<br><br>Continue to build on existing good practice. | Number of training sessions delivered to transport agencies by people with learning disabilities<br><br>Number of people being trained in Safer Places. | TBC<br><br>LDPB |
| C3 | Arts and culture | Numerous examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated effectively. | Green | | Info re accessible screenings and nightclub venues disseminated widely across sector, via email (KPI number of emails received, and could add to ldpb website)<br><br>Continue to build on existing good practice. | | LDPB |
| C4 | Sport & leisure | Extensive and equitably geographically distributed examples of people with learning disability having access to | Green | | Continue to build on existing good practice. | | LDPB |

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups, designated participation facilitators with learning disability expertise etc. and evidence that such facilities and services are communicated effectively. | | | | | |
| C5 | Supporting people with learning disability into and in employment | Relevant data available and collected. The targets nationally and locally determined (See ASCOF) have been met for people with learning disability supported into employment in the past 12 months<br>Employment activity of people with learning disability is linked to commissioning intent for future services<br>Commissioning is clearly linked to proportionate local need. | Green | | Work is in progress to ensure that all vulnerable groups access employment more effectively within the city (ICU Employment Plan drafted).<br><br>Implementation of employment advisor for people with complex learning disabilities approved. | | LDPB<br><br>System Redesign Associate Director in liaison with City Deal. |
| C6 | Effective Transitions for young people. A Single Education, Health and Care Plan (EHCP) for people with learning disability | Evidence of 85% of people with learning disability has a current and up to date Single Education, Health and Care Plan by 2014.<br>There is evidence of well-established and monitored strategy, service pathways and multi-agency involvement across Health and Social Care. There is evidence of very clear transition services or functions that have joint health & social care scrutiny | Red | I think the baseline should be set at 0 as in 12/13 we were only just beginning to agree assessment and EHC Plans. MH | There is a programme established to increase EHCP via the development of the 0-25 service development. | DC to add Just a suggestion for the KPI – the government are going to set a date of Sep 2017 for when 100% of children currently with | Children and Families Bill Steering Group<br><br>Childrens Transformation Programme |

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | and ownership. | | | | statements have to be transferred to EHC Plans. Could this be the long term KPI with intermediate steps along the way? MH | |
| C7 | Community inclusion and Citizenship | Clear commissioning intentions or action plans that address the social inclusion and citizenship needs of people with a learning disability, linked to data and Joint Strategic Needs Assessments.<br>Commissioning intentions and processes are aligned across both health & social care, supported by joint commissioning arrangements.<br>Clear evidence of strong consultation with local communities in developing what it means to be a citizen | Green | | Continue to build on existing good practice. | | LDPB |
| C8 | People with learning disability and family carer involvement in service planning and decision making | Clear evidence of co-production in universal services that the commissioners use this to inform commissioning practice | Green | | Continue to build on existing good practice with coproduction agenda. | | Carers Commissioning Group<br><br>LDPB |

| SAF | What the measure involves | How 'green' is rated | RAG Rating | 12/13 Baseline | Improvement plan in place | KPI | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | including personal budgets<br>This measure seeks to stimulate areas to examine what co-production means and demonstrate clear and committed work to embedding this in practice. | | | | | | |
| C9 | Family Carers | Commissioners are using needs assessment information relating to carers to shape services and provide a range of support.<br>There is clear evidence of a carers strategy that has been co-produced with family carers and that this has been consulted upon.<br>There is clear evidence that providers of LD services involve family carers in service development. There is clear evidence that such involvement has led to service improvement. | Green | | | Sandy to add | Southampton Carers Commissioning Group |

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|---|---|---|---|---|
| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | JOINT COMMISSIONING POLICY STATEMENT FOR WORKING WITH CHILDREN AND ADULTS WITH LEARNING DISABILITIES WHOSE CARERS AND/OR SERVICES ARE CHALLENGED BY THEIR BEHAVIOUR | | |
| **DATE OF DECISION:** | | 29TH JANUARY 2014 | | |
| **REPORT OF:** | | DIRECTOR OF QUALITY AND INTEGRATION<br>INTEGRATED COMMISSIONING<br>SOUTHAMPTON CITY CCG/SOUTHAMPTON CITY COUNCIL | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR:** | **Name:** | **Stephanie Ramsey** | **Tel:** | **023 80296923** |
| | **E-mail:** | **stephanie.ramsey@southamptoncityccg.nhs.uk** | | |
| **Director** | **Name:** | **Alison Elliott, Director of People**<br>**John Richards , Chief Executive** | **Tel:** | **023 8083 2602**<br>**023 8029 6923** |
| | **E-mail:** | **Alison.Elliott@southampton.gov.uk**<br>**John.Richards@southamptoncityccg.nhs.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None | | | | |

**BRIEF SUMMARY**

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

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

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

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

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

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

**RECOMMENDATIONS:**

(i) Southampton Health and Wellbeing Board is requested to support consultation on the draft policy statement

(ii) Southampton Health and Wellbeing Board is requested to support the implementation of the initial action plan recognising that this may change following consultation and note our submission to Improving Health and Lives is reflected in the Autism Self Assessment Framework and key areas of progress made.

**REASONS FOR REPORT RECOMMENDATIONS**

1. As part of the governance arrangements outlined in the Winterbourne Concordat there is a requirement to gain Health and Wellbeing Board validation for the actions taken in response to the Transforming Care initiative.

**ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

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

**DETAIL (Including consultation carried out)**

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

4. The Policy Statement provides the city with a clear direction of travel within its vision, objectives and outcomes for the next five years in order to make necessary changes to support improvements in health and well-being for

individuals who present behaviour that is challenging.

5. The key areas of priority for the strategy include ensuring:

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

6. The key areas for improvement (service gaps) include the following themes:

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

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

The Action Plan (Appendix 1) identifies how these areas will be addressed.

7. Southampton's Lifelong Autism Strategy 2012 – 2015 provides a strong outline of the City's need as well as a clear vision and action plan. Key areas for action aimed at improving the lives of children and adults with autism, including increasing awareness, ensuring access to diagnosis, improving access to services such as education and employment. The Strategy is not just about putting in place autism services but about enabling equal access to mainstream services, support and opportunities.

Delivery is strong, with recent successes of defining pathways for both children's and adults (pre, during and post diagnosis). Re-commisioning and system redesign have featured heavily in the pathway, with feedback positive about the pathways. This has led to improvement in outcomes such as timely access to diagnostic assessment services, an increase in people with autism participating in their local community activities.

8. The Autism Self Assessment Framework that IHAL requested all local authorities to undertake, provided benchmarks aligned with the National Autism Strategy, which we had set out within Southampton's Autism Strategy. The Framework has supported the city us to identify one area where we need to further develop, that of older people and autism. This was the only area that we reported red on out of 12 questions with RAG status. Southampton's Strategy has been reviewed and is tabled as an item at the next Autism Strategy Group.

9. Both strategies recognise the interdependencies and overlaps between the two work areas, as well as wider system impacts. Therefore information on both of these work areas will be reporting to the Vulnerable People's Board

quarterly to update on progress.

## RESOURCE IMPLICATIONS

**Capital/Revenue**

10. Within the Integrated Commissioning Unit (ICU) the Challenging Behaviour Action Plan will be implemented with the ICU lead working across the system. There may be a requirement for additional resources within the priority areas as highlighted in the Complex LD Housing Business Case approved at cabinet (17th December 2013).

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

**Property/Other**

12. None.

## LEGAL IMPLICATIONS

**Statutory power to undertake proposals in the report:**

13. Autism Act 2009
Equality Act 2010

**Other Legal Implications:**

14. None.

## POLICY FRAMEWORK IMPLICATIONS

15. None

**KEY DECISION?** No

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | All |

## SUPPORTING DOCUMENTATION

**Appendices**

| | |
|---|---|
| 1. | Draft Joint Commissioning Policy Statement for Working with Children and Adults with Learning Disabilities whose Carers and/or Services are Challenged by their Behaviour |
| 2. | Joint commissioning strategy for working with children and adults with learning disabilities whose behaviour challenges services – Action plan 2013/14. |

**Documents In Members' Rooms**

| | |
|---|---|
| 1. | None |
| 2. | |

**Equality Impact Assessment**

| | |
|---|---|
| Do the implications/subject of the report require an Equality Impact | No |

| | |
|---|---|
| Assessment (EIA) to be carried out. | |

**Other Background Documents**

**Equality Impact Assessment and Other Background documents available for inspection at: Contact Linda Lawless Linda.lawless@southampton.gov.uk**

| | Title of Background Paper(s) | Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable) |
|---|---|---|
| 1. | The Winterbourne View Final Report – DH | |
| 2. | The Concordat of Action – DH | |
| 3. | The Winterbourne View Stocktake – LGA | |
| 4. | Complex Housing Development Group ToR | |
| 5. | The Multi Agency Risk Assessment Conferenc (MARAC) | |
| 6. | Challenging Behaviour LIG ToR | |

# Appendix 1

# Draft Joint Commissioning Policy Statement for Working with Children and Adults with Learning Disabilities whose Carers and/or Services are Challenged by their Behaviour

## Draft: September 2013

## 2014-2019

**Contents**

1. Executive Summary
2. Background
3. What is Behaviour That Challenges?
4. Why changes need to be made?
5. National Policy Drivers
6. Local Policy Drivers
7. How Many People Present Challenges to Services?
8. How Many People Who Present Challenges are from Southampton?
9. Local Commissioning Framework
10. Our Vision ,Objectives and Outcomes
11. Where We Are Now?
    A. People out of area
    B. Access to meaningful activities
    C. Healthcare
    D. Housing
    E. Carers/siblings & Respite and short breaks
    F. Schools/education
    G. Transition
    H. Workforce
12. What Are We Going to Do Now?
13. Consultation on the draft Policy Statement
14. Bibliography

## 1. Executive Summary

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

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

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

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

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

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

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

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

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

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

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

1.10 The key areas for improvement (service gaps) include the following themes:

- People living Out of Area
  - To develop supported living services for individuals currently living in inpatient care and residential care facilities, by implementing Complex LD Housing Business Case
  - Review how adults "at risk" due to challenging behaviour are monitored and supported through

the Winterbourne at risk register, taking learning from children's services.

- Access to meaningful activities
  - To improve the vocational educational opportunities for individuals and develop supported employment for individuals "at risk" due to challenging behaviour
  - To review day activities available to "at risk" individuals

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

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  - To strengthen partnership work with housing providers to ensure that suitable accommodation is available, to prevent crisis, reduce admissions to inpatient services and prevent placement in residential care out of area.

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  - To ensure that carers and family siblings are well supported, have access to appropriate training and respite care is available.
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- Workforce Development
  - To development and audit of a Good Practice Standards Checklist and develop a system wide workforce strategy.

1.11 The scope of the joint Policy Statement includes children from birth through to adults of all ages who have a Learning Disability and Challenging Behaviour and live within the boundaries of the city.

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

1.13 The Policy Statement should also be understood in the broader context of Southampton's Autism Strategy 2012 – 2015, where there is strong implementation across the city. An element of the population identified that have autism, will also be addressed within this work (20-30% of those adults with learning disabilities will also have Autistic Spectrum Disorders and there is an increased risk of behaviours that challenge within this group).

## 2.0 Background

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

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

2.3 The scope of the Policy Statement includes:

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

2.4 The way that support has been delivered has changed considerably over the years. Until the 1950s, it was generally accepted that people with learning disabilities could enjoy a better quality of life living with

other disabled people in segregated institutions rather than in the community with their families.

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

2.6 Thirty years later in 2001 they published the White Paper Valuing People: A New Strategy for Learning Disability for the 21st Century which committed the Government to helping people with learning disabilities to live "as normal a life" as possible, without unnecessary segregation from the community

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

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

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

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

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

2.12 This Policy Statement does not specifically cover all the issues with people with forensic needs, dementia, autism and other specific conditions which will be picked up in other strategies.

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

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

**3.0 What is Behaviour That Challenges?**

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

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

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

3.4 The term challenging behaviour has become distorted from its original meaning and has come to be misused as a diagnostic label. Severely problematic or socially unacceptable behaviour should be seen as a challenge to services rather than the person being stigmatised as being violent and aggressive. This Policy Statement seeks to respond to this challenge by promoting positive behavioural support, reducing the

occurrence of damaging behaviour and maintaining people's access to a decent quality of life despite continuing behavioural difficulties.

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

- "We have defined Challenging Behaviour as culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour that is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities" (Emerson1995)

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

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

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

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

3.8 Behaviour that Challenges is a demonstration of distress and an attempt by the person to communicate their unmet needs. It may result from an individual feeling threatened, fearful or anxious or be in response to a

difficult situation, or a misinterpretation of the actions of other people. The behaviour can be in response to:

Environmental factors - for example:

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

Personal factors - for example:

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

3.9 The consequences of not addressing challenging behaviour can be far reaching and can include:

- Ineffective delivery of healthcare
- An overreliance on anti-psychotic medication, seclusion and physical interventions
- An increase in physical injuries and psychological ill health among service users, staff and families
- Inability of an organisation to meet its legal duties to protect staff and vulnerable individuals

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

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

## 4.0 Why changes need to be made

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

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

4.3 In May 2011, The BBC Panorama programme – "Undercover Care: The Abuse Exposed", showed disturbing scenes of people with a learning disability and autism being abused in a secure hospital at Winterbourne View in Bristol. In October 2012 the BBC broadcast a follow up Panorama programme, "Winterbourne View - the hospital that stopped caring". Using undercover footage the programme revealed new evidence of poor training and false record-keeping.

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

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

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

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

4.7 The Policy Statement identifies areas of development that will support our commissioning intentions including ensuring systems are in place for preventative measures and early identification in order to avoid crisis. The responses to the survey sent to families, carers, providers and people whose behaviour challenges indicated that people want support before they reach a crisis point.

**5.0 National Policy Drivers**

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

5.2 In 2013/14 we have a requirement to undertake the Joint Health and Social Care Learning Disability Self-Assessment Framework. This is a single delivery and monitoring tool that supports Clinical Commissioning Groups (CCGs), and Local Authorities (LAs), to assure NHS England, Department of Health and the Association of Directors of Adult Social Services on the following:

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

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

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

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

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

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

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

a. We do have a number of people out of area and we are planning for their return. We are aware of blocks in the system around housing and have set up a Complex Housing Group which is working towards bespoke housing.
b. We recognise that our prevention and response to an individual's crisis could be better managed to enable the person to be well supported locally.
c. Currently not enough people in Southampton with a learning disability are accessing their Annual Health Checks however a pilot is underway to improve this position.
d. We will be re-commissioning LD Advocacy in 2014.
e. A review of residential respite is being undertaken.
f. A review of in house day support will be undertaken early 2014.
g. An autism training strategy and standard has been developed.

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

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

5.8 The Care Bill May 2013 takes forward the Government's commitments to reform social care legislation and with carers being treated as equal to the person they care for – putting them at the centre of the law and on the same legal footing.

## 6.0 Local Policy Drivers

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

6.2 Within Southampton these national drivers are being addressed through Southampton's Integrated Commissioning Unit, jointly across health and social care. For domiciliary care this means moving away from prescribed time and task services to more flexible, person centred, outcome based care and support.

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

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

## 7.0 How Many People Present Challenges to Services?

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

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

7.3 Prevalence rates for seriously challenging behaviours were comparable to those reported in the earlier studies, thus confirming previous findings. The prevalence of less serious challenging behaviour also has major clinical significance and emphasises the

need for enhanced understanding and skills among personnel within primary- and secondary-tier health, education and social care services, and for strengthening the capacity of community teams to provide behavioural expertise.

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

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

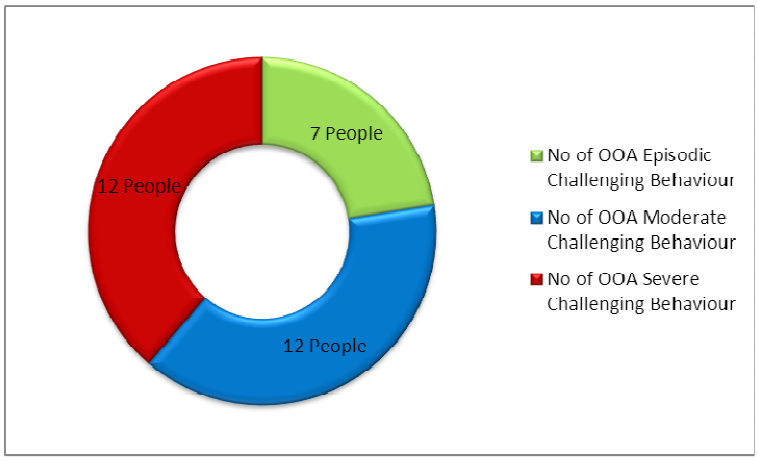
7.6 The number of people identified as challenging services is small in any given area. Estimates vary but it is likely that about 24 adults with a learning disability per 100,000 total population present a serious challenge at one time. The numbers of young people who challenge services and are in transition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

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

## 8.0 How Many People Who Present Challenges are from Southampton?

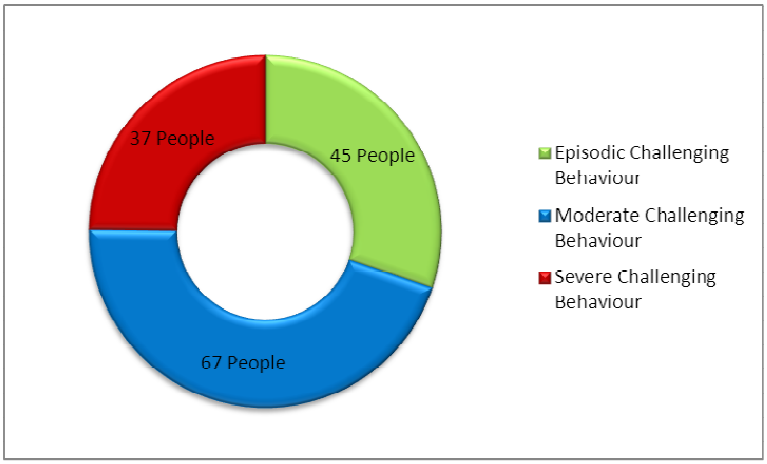
8.1 Public Health Southampton Intelligence Briefing Paper - Southampton Learning Disability Profile July 2012 details that "In England approximately 1.2 million people have learning disabilities (LD). This means that roughly 2% of the population has a learning disability although only 21% of this 1.2million were known to learning disability services.

8.2 As Goodman et al, (2006) identified "Behaviour that presents challenges is the single most likely reason for someone to be placed in an out of city placement". The following chart identifies the number of Southampton's out of area (over 10 miles) placements.

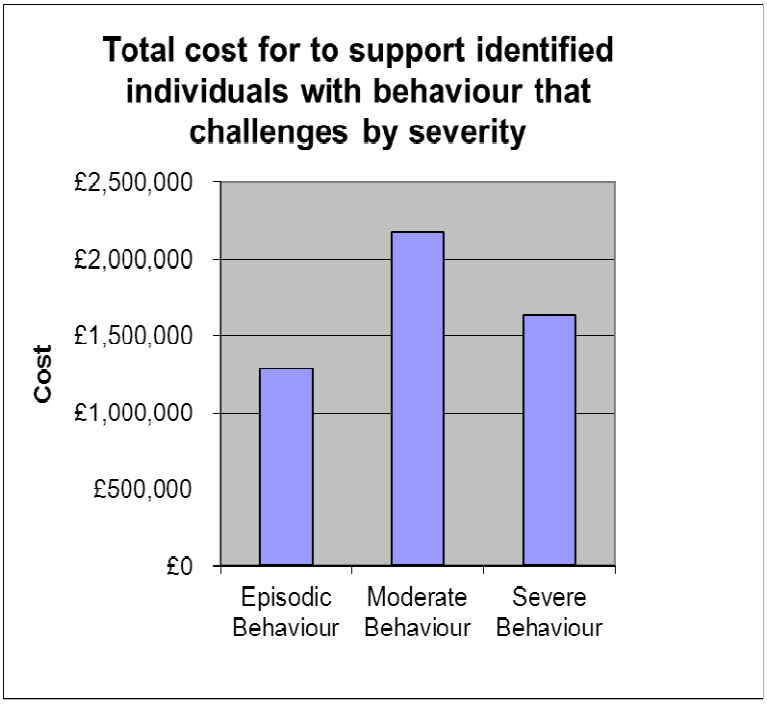



8.3 Emerson et al (1997) report that between 10% and 15% of people who are supported in learning disability services show behaviours that without specific measures would cause a serious management problem. In Southampton we have 149 people have been identified as having behaviour that challenges out of a learning disability population of 4927.

8.4 Currently there are around 150 people with a learning disability supported in services out of city. It is estimated that around 40% of whom were placed in these services as a result of their carers and/or services being challenged by their behaviour.



8.5 The total cost to Southampton City Council and Southampton CCG to support the care of the 150 people identified is £5,099,693. This can be broken down in the following ways:




8.6 We need a strategy to make sure that our community's resources are used in the most effective ways to support people with a learning disability and their families locally now and in the future. To enable this, people with learning disabilities who present challenges, need a co-coordinated approach to their support needs. This needs to be an evidenced based strategy based on research and best practice.

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

**9.0 Safeguarding and Quality**

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

9.2 Safeguarding Adults Multi Agency Policy has been developed by the four local safeguarding adults boards (4LSAB) covering Hampshire and

the Isle of Wight to meet the requirements of No Secrets (2000), Department of Health and to support current good practice in adult safeguarding.

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

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

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

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

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

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

## 10.0 Local Commissioning Framework

10.1 Southampton's Integrated Commissioning Unit (SICU) is made up of two key partners - Southampton City Clinical Commissioning Group (SCCCG) and Southampton City Council (SCC). For the purpose of this document both partners are referred to as the SICU.

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

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

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

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

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

10.5 Southampton's analysis of the needs of people with a learning disability is set out in detail in our draft overall Lifelong Disabilities Strategy. This describes how needs are changing and increasing. Looking ahead, over the next ten years there will be increasing numbers of:

- young adults with a learning disability, including young adults with the most complex needs, with autism, profound and multiple learning disabilities and behaviours which challenge services

- people living with older family carers
- older people with a learning disability and therefore with an increased likelihood of dementia. People with a learning disability may develop dementia up to 30 years before the rest of the population
- people with a learning disability from different cultures who may have a cultural model of disability
- people for whom English is a second language

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

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

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

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

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

- Developing an Intensive Support Team that supports people with behaviours that challenges in order to support them more effectively and prevent crisis/breakdown.
- Implementing better systems across the operational teams so that we joint work more effectively.
- Developing alternative forms of communication (e.g. the iPad system), that supports people to communicate using a range of apps, that enhances outcomes and access to primary and secondary health care services.
- Working with housing partners, so we can plan more effectively for future generations.
- Focusing advocacy services on those with more complex needs, so that equality of access to services is strengthened.
- Working in partnership with West Clinical Commissioning Group, and the Commissioning Support Unit, to commission more

effectively assessment and treatment provision, for those that do require these services.

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

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

## 11.0 Our Vision, Objectives and Outcome

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

- Each person will be regarded as a full and valued member of the community of their choice with the same rights as everyone else, and with respect to their diversity
- Each person has the right to receive person centred services, which are flexible and responsive to changes in their circumstances, health and wellbeing
- We will provide support and training to carers and families who are supporting people who they find challenging
- We will ensure that services are delivered in the least restrictive manner and are able to respond to individual needs
- We will strive to continually improve using the latest evidence to provide best treatment, care and support

- We will work in partnership with individuals, their natural carers and across the full range of services (the voluntary sector, providers, GPs and the police) to ensure good quality integrated support
- We want people with learning disabilities whose behaviour challenges services to be fully included in their local community with access to appropriate accommodation
- We will ensure that we safeguard their wellbeing
- We will work with commissioners to ensure that opportunities for short breaks tailored to individual needs are available to every family supporting a person whose behaviour presents a challenge at home.
- We will work with commissioners to look at reducing the reliance on specialist challenging behaviour homes to that of developing more individualised local solutions.

### 11.2 Objectives

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

### 11.3 Outcomes from the vision

- More people with be back in the local area
- More people will be involved in meaningful activities
- More people will be in work/exploring work options
- More people will be in supported living accommodation

### 11.4 Where We Are Now?

There are a number of areas of concern that we are working in Southampton to address and these are detailed below:

| **Area of Concern - People out of area A** | |
|---|---|
| **Current Position** | There are currently approximately 33 people with a learning disability with behaviour that challenges who are residing more than 10 miles out of Southampton. This is due to historic placement patterns due to lack of local provision.<br>There are currently five people identified that are receiving care and treatment within inpatient settings/medium secure units. There are a further 18 people that have been identified that are at risk of needing bespoke arrangements to meet their needs. Work is underway to identity the risks of maintaining the care for these individuals and plans put in place to mitigate concerns. Individuals and families will be fully involved in the development of these plans as appropriate. All individuals (known to the CCG) have an allocated Continuing Health Care Case Manager who liaises with NHS England (Specialist Commissioning) regarding those within inpatient settings.<br>The level of planning for individuals varies and consistency across health and social care needs to be improved. Continuity concerns and crisis response time for distance placements are an issue. |
| **Action Being Taken** | The local register of people who require additional or individualized packages of care support. These individuals are on the Southampton Register aligned to the Winterbourne View Concordat. An LD Complex Housing Business Case has been approved to rehouse a number of individuals who are currently out of area, with the plan to develop local services. As part of this project an increased range of housing will be developed and workforce skills developed to ensure that individuals are well supported. |
| **Recommendations** | A1. Implement the LD Complex Housing Business Case to develop bespoke services for all individuals who are place out of area.<br>A2. Undertake a review of the local (Winterbourne) register to improve risk management and implementation of care plans, preventing crisis and improve the planning and delivery of services locally. The review to take the learning from the existing Multi Agency Resource Panel process in place in local Childrens services.<br>A3. Ensure Personal Health Budgets are used as appropriate |

| **Area of Concern - Access to meaningful activities**<br>**B** | |
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| **Current Position** | Person Centred Planning and Advocacy available to all with a learning disability through commissioned services. There is a lack of services to support individuals who present challenging behaviour locally. The skills of local day support staff are limited. Individuals have very limited opportunities to work, or access education and leisure opportunities. There are limited supported employment services, with access to job finding and job coaching expertise limited. |
| **Action Being Taken** | To implement the recommendations as detailed below. |
| **Recommendations** | B1. Review of day support services to be undertaken in 2014.<br>B2. Development of Supported Employment Strategy to ensure that expert skills are developed for individuals to access.<br>B3. A range of employment opportunities to be explored for individuals including, job carving, micro firms, and cooperatives.<br>B4. LD Advocacy will be re-commissioned in 2014, to ensure that the needs of people with complex needs and behaviour that challenges are met within the city. |

| **Area of Concern - Health care for individuals at risk due to challenging behaviour** *to include physical, mental, specialist roles (Prader Willi), support in a crisis – inpatient care.* **C** | |
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| **Current Position** | It is recognised that too few people with a learning disability and behaviour that challenges are accessing their Annual Health Check (42% in 2012/2013) and that some behaviour may be as a result of a physical condition. Due to the complexity of the individuals identification of symptoms and subsequent diagnosis can be difficult and often out of the scope of a GP's role. A solution is required to ensure that individuals whose behaviour is thought to have a physical cause have access to highly skilled and experienced physicians with experience of supporting people presenting with challenging behaviour.<br>Data from CCG and health services for people with LD indicates that 74% had their BMI recorded in the last two years and 36% of these are in the obese range and 0.6% in the underweight range. 2.3% of adults with a LD are known to have coronary heart disease, 6% diabetes, 14% asthma, 2.6% dysphasia and 13% have epilepsy. The health needs of individuals with a learning disability are gaining greater recognition in the Joint Strategic Needs Assessment (JSNA).<br>There is one LD Hospital Liaison Nurse at Southampton General Hospital who covers the whole of the admissions for Hampshire.<br>The role of the Community LD Specialist Teams and the Intensive Support Team needs to be reviewed to ensure that health priorities are being met. A subsequent skill mix review will be required to ensure that individuals who present challenges have access to specialist therapy e.g. Speech & Language Therapy and Psychology and specialist nurses as all behaviour is communicative in nature.<br>Improved access to telecare and telemedicine technology is needed to improve the assessment and support of individuals who present challenges.<br>A review of the need for inpatients care beds is required to inform future commissioning intensions.<br>A review mental health provision needs to be made to ensure that all aspects of the "Greenlight toolkit", which sets out best practice, have been adequately addressed locally.<br>There is a range of physical restraint approaches being used in health and social care settings. Work needs to be undertaken to map out the current use and competence of staff deploying such approaches, in order to ensure that individuals supported and care staff are safe.<br>People have been placed in our area as they have a Southampton GP but they may not have any link or connection to the area.<br>Children's medical needs are mainly managed by Paediatricians however at transition this reverts to the GP who may not have the history or the expertise around genetic complexities. |

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| **Action Being Taken** | Southampton Mencap has taken forward an iPad project, which provides low cost augmentative communication technology. The apps that are loaded onto iPads provide a number of functions to assist with scene setting for everyday scenarios. Work is currently being undertaken to create apps to support dental and hospital visits, encourage a healthy lifestyle and increase awareness and take up of the Annual Health Checks.<br><br>Southampton has a new independent organisation representing service users and patients in health and adult social care. Healthwatch Southampton, based at Southampton Voluntary Services, is working to make sure that the overall views and experiences of people who use health and social care services are heard and taken seriously at a local and national level. They aim to build a local picture of the issues that matter most to the public and users of health and care services and use this evidence to influence those who plan and run services. They also offer a free independent NHS complaints advocacy service.<br><br>37 GP surgeries in Southampton are engaged in the DES (Directed Enhanced Service) scheme – an ongoing training programme for new surgeries opting in and update training for existing surgeries.<br><br>Southampton has an established a DES working group of Commissioners, Lead CCG GP and Health Facilitation Nurses with an action plan on delivering and reviewing DES across Southampton.<br><br>Health facilitators are supporting GP practices to validate their LD registers.<br><br>A number of Domiciliary Care Providers have an allocated Project Manager with a direct email contact with their GP proving instrumental support to staff. GPs have worked with Domiciliary Care Providers to listen to how to address the health and complex needs in and out of the home environment for people with a LD.<br><br>There is a work plan in place for Health Facilitation/Hospital Liaison Nurses to promote Health Action Plans. |
| **Recommendations** | C1. To monitor the implementation of the Learning Disability Directed Enhanced Service (DES).<br>C2. Annual Health Check to ensure all Care/Case Managers are trained.<br>C3. Health Action Templates to be uploaded to the HLDP website and local CCG websites.<br>C4. Improve take up of Health Screening for people with a LD particularly Cervical and Bowel. Breast screening is more in line with the General Population. |

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| | C5. Review access to expert physician support to assess, diagnose and treat individuals who have physical health causes for challenging behaviour<br>C6. Review Joint Strategic Needs Assessment to ensure the health needs for LD citizens are recognized.<br>C7. Review the role and function of the Community LD Specialist Teams with the development of the Children and Young People's Development Service (CYPDS).<br>C8. Review the role and function of the Intensive Support Team<br>C9. Undertake a skill mix analysis of Community LD Specialist Team.<br>C10. Improve access to telecare and telemedicine technology to support the assessment and care of individuals<br>C11. Review the need for future LD inpatients bed provision for individuals who present challenges.<br>C12. Undertake a review of the mental health needs for individuals with a LD to ensure that service pathways implement reasonable adjustments. In children's services ensure gap is bridged between LD and Children and Adolescent Mental Health Service (CAMHS).<br>C13. Review the physical intervention approaches being used in the City and develop an improvement plan.<br>C14. Develop procedures to assess the health needs of individuals placed in the Southampton catchment with LD services and Primary Care. |

| **Area of Concern – Housing**<br>**D** | |
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| **Current Position** | Many individuals with a learning disability who have complex needs are currently cared for in residential care settings. Residential care services provide support in communal arrangements and so personalised services are difficult to deliver. Individuals with complex needs benefit from bespoke service designs to more appropriately support their physical, social and psychological needs. It is recognised that individuals' health and wellbeing can be more effectively supported if the person has control over who, where and how they live. Many people with behaviours that challenge still do not live in supported housing and remain either in high cost residential care, hospital placements or at home with families who can find it difficult to support them. Re-assessment as needs change (particularly in children) takes too long. Access to stock is poor. There are poor or no adaptations especially in private rented accommodation. For adults there is a lack of accommodation in appropriate locations due to noise level needs. |
| **Action Being Taken** | Current business case presented which has four main aims:<br>• Provision of locally based housing to support personalised approaches of care.<br>• Improvement in quality of life for those with complex needs (e.g. by reducing challenging behaviours and crisis/breakdowns).<br>• Improved support for informal carers, ensuring that individuals maintain natural networks around them and informal carers wellbeing is supported.<br>• Reduced dependency on health and social care services by provision of effective and efficient local services.<br>A project is being undertaken to move 57 people into bespoke housing.<br>Housing strategy is being refreshed.<br>The services of an Occupational Therapist are now available as required. |
| **Recommendations** | D1. To implement a strengthened housing plan to support people with complex needs.<br>D2. To review and improve the long term management of existing housing stock with NHS/Council nomination rights, maximising development and rental opportunities.<br>D3. To work with housing providers in the City to ensure that appropriate housing is developed which addresses emerging need.<br>D4. To review the LD housing panel to ensure that housing needs and development opportunities pursued to support individuals to stay in Southampton.<br>D5. City Council and CCG to identify funding to support the development of bespoke properties. |

| Area of Concern - Carers/siblings & Respite and short breaks<br>E | |
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| **Current Position** | Southampton, Hampshire, IOW and Portsmouth (SHIP) launched an online Directory of Services in November 2013 which provides information and support for carers and siblings of people with autism. Mencap's Carers' sub group operates in Southampton. Carers are members of the Learning Disability Partnership Board. Family Link service is commissioned by Southampton Council. The needs of siblings living with individuals who present challenges are often over looked as most of the attention of services is on managing the immediate need. Living with someone who challenges is extremely stressful and impacts on many aspects a carer and siblings life. Greater attention needs to be made to ensure that siblings are also offered support and opportunities to develop. Often siblings are not recognised as carers and there would be benefit in recognising their careering role and the impact this has on their life.<br>A service review of residential respite for people with learning disabilities with a strong focus on the provision for people with behaviour that challenges is currently being undertaken. Only one adult with severe behaviour challenges is currently accessing the council's overnight residential respite service. The service does not cater for this group mainly due to compatibility issues. There are 10 children/young people with severe behaviour accessing the service and 4 are out of area as local services are unable to meet their needs. Emergency respite with appropriately skilled staff is available but this does not extend to the severe behaviour group |
| **Action Being Taken** | The Framework also sets out our intention to commission services that are based on good practice and will support carers, give access to meaningful information, safeguard their time in education or employment, be personalised, and recognises the carers own support needs. Importantly the principles pay particular attention to young carers to ensure they are enabled to be children and young people as well as carers. Southampton City wide carers' support service is to go live from April 2014. This includes carers' support with an emphasis on siblings. The views and involvement of both adult and young carers across the city are being sought by Southampton City Council and the Southampton Clinical Commissioning Group to help review the role of the city's Carer's Strategy Group.<br>Business case to be completed by end February 2014 and this will identify gaps and areas for further development. |
| **Recommendations** | E1. Complete the Carers Strategy review and ensure that carers and siblings of individuals with learning disability who present challenges are recognised as a priority.<br>E2. Assessments of individuals and family's needs to recognise the role and impact on siblings and consideration given to recognising the benefit of accessing young carer services.<br>E3. The training needs of carers needs to be recognised in the |

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| | learning disability workforce development plans as most would benefit from access to this specialist training.<br>E4. A small number of individuals who present challenges are supported by elderly carers, planning for their future needs to be prioritised.<br>E5. Complete the review respite services offered in the City and ensure that the needs of people who present challenges are addressed.<br>E6. Recommendation for children's services to continue with the short break procurement |

| **Area of Concern - Schools/education**<br>**F** | |
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| **Current Position** | These are the areas that it is felt need to be explored to establish the current position:<br>Person Centred Planning takes place in all Special Schools.<br>Number of children excluded from school due to CB and age profile<br>Number of children sent home as a result of an incident in school<br>Number of children placed out of area due to the child's behaviour.<br>Parenting skills linked to deprivation and ability of parent/carers to follow behavioural interventions.<br>Children's Transport long (time length) journeys linked to CB<br>Children's emerging sexuality and behaviour associated<br>Forensic needs of children<br>Joint work between school and home to support continuity of interventions<br>Behaviour accepted as being part of a individuals disability creating long standing repertoire of behaviours which become increasingly difficult to manage as an individual grow<br>Behaviour is a communicative message for pain as a result of undiagnosed symptoms e.g. tooth ache. As set out in the Children and Families Bill, each school must have a SENCO in place who must be a qualified teacher at the school. The Code sets out some of their key responsibilities, such as overseeing the day-to-day operations of the school's SEN policy and coordinating provision for children with SEN. |
| **Action Being Taken** | |
| **Recommendations** | F1.<br>F2. |

| Area of Concern – Transition G | |
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| **Current Position** | Southampton has an established Transitional Operational Group (TOG) and Transition Multi – Agency Resource Panel (MARP). Young people, who are perceived as likely to need specialist adult services, receive a professional coordinated transition into adulthood. The aims of the TOG are:-<br>• to "flag" young people to specialist adult services as needing a dedicated transition plan,<br>• to monitor planning progress,<br>• to offer advice and support problem solving and pathway options,<br>• to ensure continuity,<br><br>Some young people's needs are particularly complex requiring resources that need commissioning and senior management input and funding in adult services. In these situations a plan is developed and monitored, is presented on a quarterly basis to TOG/MARP.<br>Issues exist operationally for operational staff in sharing information between organisations for service planning. The Council and providers use a range of communication systems.<br>The City is a Pathfinder Site for Education Health Social Care Plan.<br>The City is developing a Children and Young Peoples Development Service (CYPDS) which will provide an integrated assessment, intervention service for children and young people 0 to 25 years of age, including an education health and social care joint care plan. This service is due to be operational by April 2015.<br>Full time college courses are available and proved education for an average 3-4 days per week, with individuals unable to access structured activity for the rest of the week. Courses lack an employment focus and tend not to support a person to take up employment opportunities.<br>Employment prospects/opportunities are part of the assessment during the transition process, but very few are able to access paid work.<br>City Limits are working closely with colleges and SEN schools. Currently City Limits are working with 3 local colleges where young people are engaged firstly at college, then at home to involve families and then in the community to enable skills to be discovered that might not be apparent in the classroom setting.<br>Families have a high expectation around the transition to adult services and are not always adequately prepared for what could be a lesser care package.<br>The Multi Agency Resource Panel (MARP) includes a transition planning meeting three times a year to which adult services are invited. They are then able to see which children are receiving care in children's services and have the opportunity to include them in financial planning.<br>The MARP process ends when adult responsibility takes over. This |

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| | is not necessarily the same age for each young person. Young people who have statements of educational need will continue their *education* funding until their statement ends. If there is *social care funding*, this is handed to adult services at 18. *Child health services* provided as part of a statement of educational need will continue until a statement ends but continuing care health funding will pass to adult continuing care services if the adult criteria for continuing care are met.<br>Children and Young Person's Development Plan (CYPDS)<br>Southampton is a pathfinder for the CYPDS to take over from the current statementing process. This involves the introduction of a Health, Education and Social Care Plan to take the place of the statement of educational need. The plan is intended to continue, with annual review; until the young person reaches 25 as long as the young person remains in education (this does not include higher education). This new structure has implications for MARP because of the change in ages that the new structure is intended to cover. There are also planned changes within the social care structure to accommodate the 0 – 25 age range.<br>In Southampton we are currently hosting the 'next steps' project funded by the National lottery to work with young people through transition. There are two workers based within Pathways team, one to work with children in care through the process of transition out of care. The other works with young people transitioning out of custody.<br>Southampton's Transition strategy was developed in 2013. |
| **Action Being Taken** | |
| **Recommendations** | G1. To support the Children and Families Bill 2013 implementation which will extend the special educational needs (SEN) system from birth to age 25.<br><br>G2. Review MARP/TOG in light of the implementation of Childrens and Young Peoples Development Service 0-25 year's service, ensuing that the clinical, social and educational needs of individuals are met into adulthood.<br><br>G3. Ensure that all transition plans will include person centred behaviour management plans which address the communicative functions of individuals. |

| Area of Concern – Workforce<br>H | |
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| **Current Position** | Children services are reviewing how professionals work together with the development of the role of the Lead Professional. There are some specific areas where there are capacity issues e.g. Speech and Language Therapists (SALT) where access for communication purposes is limited. |
| **Action Being Taken** | There is need to develop a workforce strategy to improve the consistency and quality of care in all settings and this will be supported by Southampton's Workforce Strategy and Action Plan for people with Autistic Spectrum conditions. The roll out and review of a Good Practice Standards Checklist for people whose behaviour changes which is to be used in conjunction with the client annual review process. |
| **Recommendations** | H1. Further up skill the workforce to ensure competency and confidence in supporting people whose behaviour challenges services. Service specifications and improved monitoring will identify areas for development. |

## 12.0 What Are We Going to Do Now?

12.1 The time frame covered by this joint commissioning Policy Statement is 2014 to 2019. A five year implementation plan has been developed that will include annual reviews and an evaluation of success and monitoring against national and local guidance.

12.2 We have conducted a survey amongst families, carers, people whose behaviour challenges and providers. These surveys were shared by post, at a post 16 event at a local special school, in Mencap Southampton's Learning Disability News and at a Healthy Lifestyles Event for people with Learning Disabilities.

12.3 Part of a wider consultation will include a Steering Group made up of representatives of the wide range of stakeholders, including family carers and people with learning disabilities.

## 13.0 Consultation on the draft Policy Statement

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

13.2 A plan is being developed to take the draft Policy Statement out for wider consultation. The steering group is particularly keen to ensure that education services have an opportunity to input into the strategy development.

13.3 During the spring of 2014 consultation will take place with the following:

- Individuals with a learning disability
- Carers and families
- Special Education and local schools
- The Learning and Skills Team
- Primary Care
- Local providers of Social Care for adults and children (residential care & domiciliary)
- Pediatricians
- Local Health providers including University Hospitals Southampton, Solent, Southern Healthcare.

13.4 Following the consultation process the Policy Statement will be refreshed and finalised, with an aim of seeking final sign off for the strategy by June 2014.

13.5 The Challenging Behaviour Local Implementation Group will be ongoing with a task and finish group encompassing health, social care, children services, adult services and cross sectors including education and housing. This task and finish group will implement the action plan which is in appendix . They will report to the Valuing People Board, NHS England and the Health and Wellbeing Board.

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**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
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| **Section A** - Staying Healthy | | | | | | | |
| A1 | LD QOF register in primary care | Learning Disability and Down Syndrome Registers reflect prevalence data<br>AND<br>Data stratified in every required data set (e.g. age / complexity / Autism diagnosis / BME etc.) | Data has been obtained however a further report to include wider data sets will be developed for benchmarking. To be monitored via the LD Health Group. | | | | LD Health Group |
| A2 | People with learning disability are accessing disease prevention, health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease and Epilepsy | Comparative data in all of the health areas listed in the descriptor at each of the following levels;<br>Local Area Team<br>Clinical Commissioning Group<br>Individual GP Practice | Channelling data is required from all systems to ensure benchmarking good practice.<br><br>C6. Review Joint Strategic Needs Assessment to ensure the health needs for LD citizens are recognized.<br><br>C11. Refresh the "Greenlight Toolkit" to ensure that mental health needs for individuals are being appropriately met. | | | | LD Health Group<br>Wessex LAT |
| A3 | Annual Health Checks and Annual Health Check Registers | Validated on a minimum of an annual basis and process in place for all people aged 18 or over to be put on register.<br>80% of people with learning disability GP DES Register had an annual health check. | A city wide plan is developed covering, engagement with GPs, Wessex LAT, Southern Health, LDPB, Choices Advocacy and LD population/carers. Implementation to reach 50% (Amber) within 13/14.<br><br>C2. Annual Health Check to ensure all Care/Case Managers are trained. | | | | LD Health Group<br>Wessex LAT |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| A4 | Health Action Plans are generated at the time of Annual Health Checks (AHC) in primary care and these include a small number of health improving activities. Refer to RCG guidance around health action plans. | GP Health Action Plan (HAP) contains specific health improvement targets identified during the AHC for 50% of patients (to be captured through AHC template. | To have a process to generate GP health action plan, worked up with other CCGs, ready for implementation by 14/15<br><br>C3. Health Action Templates to be uploaded to the HLDP website and local CCG websites | | | | LD Health Group Wessex LAT |
| A5 | Comparative data of people with learning disability vs. similar age cohort of non-learning disabled population in each health screening area for:<br>a) Cervical screening<br>b) Breast screening<br>c) Bowel Screening (as | Numbers of completed health screening for eligible people who have a learning disability in every screening group;<br>AND<br>Comparative data of screening rates in the non LD population for every screening group;<br>AND<br>Scrutinised exception reporting and evidence of reasonably adjusted services | Comparative data shows marked differences in uptake; therefore screening programmes need to demonstrate reasonable adjustments. A programme regarding improved coding. Accountability issues to be resolved.<br><br>C4. Improve take up of Health Screening for people with a LD particularly Cervical and Bowel. Breast screening is more in line with the General Population. | | | | LD Health Group Wessex LAT |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
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| | applicable) | | | | | | |
| A1 | Primary care communication of learning disability status to other healthcare providers | Secondary care and other healthcare providers can evidence that they have a system for identifying LD status on referrals based upon the ld identification in primary care and acting on any reasonable adjustments suggested. There is evidence that both an individual's capacity and consent are inherent to the system employed | This measure to be discussed at provider Clinical Quality Review Meetings (CQRM). Action plan to be developed pending item discussion for implementation Qtr 1 14/15.<br><br>C1. To continue with the Learning Disability Directed Enhanced Service (DES)<br><br>C5. Review access to expert physician support to assess, diagnose and treat individuals who have physical health causes for challenging behaviour<br><br>C13. Develop procedures to assess the health needs of individuals placed in the Southampton catchment with LD services and Primary Care.<br><br>. | | | | Carol Alstrom (Quality Associate Director ICU ) Clinical Governance Board (CGB) |
| A7 | Learning disability liaison function or equivalent | Designated learning disability function in place or equivalent process, aligned with known learning disability activity data in | There is a work plan in place for Health Facilitation/Hospital Liaison Nurses for Learning Disabilities, in order to gain formal reporting. This | | | | Carol Alstrom (Quality Associate Director ICU ) Clinical |

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
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| | process in acute setting | the provider sites and there is broader assurance through executive board leadership and formal reporting / monitoring routes | measure to be discussed at UHS and SHFT CQRM to ensure board leadership.<br>C7. Review the role and function of the Community LD Specialist Team and the Intensive Support Team.<br><br>C8. Undertake a skill mix analysis of Community LD Specialist Team.<br><br>C9. Improve access to telecare and telemedicine technology to support the assessment and care of individuals<br><br>C10. Review the need for future LD inpatients bed provision for individuals who present challenges. | | | | Governance Board |
| A8 | NHS commissioned primary and community care<br>* Dentistry<br>* Optometry<br>* Community Pharmacy<br>* Podiatry<br>* Community nursing and midwifery | All people with learning disability accessing/using service are known and patient experience is captured.<br>All of these services are able to provide evidence of reasonable adjustments and plans for service improvement. | Each has its own action plan to address requirements (due to diversity/system differences/providers). CQUIN being worked up to cover patient experience Where relevant some work will be taken across Hampshire and Portsmouth area with Wessex LAT.<br>A programme with carers to be put in place regarding reasonable adjustments in services. | | | | LD Health Group |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
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| | | | | | | | |
| A9 | Offender Health & the Criminal Justice System | Local Commissioners have good data about the numbers /prevalence of people with a learning disability in the CJS. Local commissioners have are working with regional, specialist prison health commissioners Good information on health needs of people with LD in local prisons /wider criminal justice system and a clear plan on how needs can be met. Prisoners and young offenders with LD have had an annual health check, or are scheduled to have one within 6 months (either as part of custodial sentence or following release, as part of GP health check cycle). They are offered a Health Action Plan. | To review available data regarding population/need/prevalence. To establish a process to propose action plan of which CJS coproduce. | | | | LD Health Group |
| **Section B**- Being Safe | | | | | | | |
| B1 | Regular Care Review | Evidence of 100% of all care packages including personal budgets reviewed at least annually | The review of the Adult Social Care Pathway will mean that reviews are completed more effectively. SCC LD Team are preparing an action plan to achieve 90% (amber) annually including improved recognition of review when work is undertaken with clients. | | | | Andy Biddle (SCC Manager)<br><br>Carol Alstrom (Quality Associate Director ICU ) |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
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| | | | SCCCG (Continuing Healthcare) are reviewing the service to raise to 80-90% in year. | | | | |
| B2 | Contract Compliance Assurance – For services primarily commissioned for people with a learning disability and their families. | Evidence of 100% of health and social care commissioned services for people with learning disability have;<br>- had full scheduled annual contract and service reviews.<br>- Demonstrate a diverse range of indicators and outcomes supporting quality assurance<br><br>Evidence that the number regularly reviewed is reported at executive board level in both health & social care | B1 will support this action being completed (due to the fragmentation of the services).<br><br>A new Individual Service Contract has been developed for all placements (SCC). SCCCG (Continuing Healthcare) are reviewing service contracts in line with new home care tender.<br><br>The ICU Scorecard, including Quality elements will report to IC Board and other relevant bodies' such as SSAB this will include the number of services reviewed | | | | Carol Alstrom (Quality Associate Director ICU )<br><br>Provider Relationships Associate Director |
| B3 | Assurance of Monitor Compliance Framework for Foundation Trusts Supporting organisations aspiring towards Foundation Trust Status Governance Indicators | Commissioners review monitor returns and & EDS review actual evidence used by Foundation Trusts in agreeing ratings Evidence that commissioners are aware of and working with non-foundation trusts in their progress towards monitor level & EDS compliance. | Achieved. CQRM will ensure ongoing monitoring. This will be overseen by SCCCG Clinical Governance Committee and Governing Body/SCCCG Executive Board. | | | | Carol Alstrom (Quality Associate Director ICU ) |

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
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| | (learning disability) per trust within the locality | | | | | | |
| B4 | Assurance of safeguarding for people with learning disability in **all** provided services and support<br>This measure must be read in the context of an expectation that ALL sectors, Private, Public and Voluntary / Community are delivering equal safety and assurance. | Evidence of robust, transparent and sustainable governance arrangements in place in all statutory organisations including Local Safeguarding Adults Board(s), Health & Well-Being Boards and Clinical Commissioning Executive Boards<br>The provider can demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent.<br>Every learning disability provider service have assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. Key lessons from national reviews are included.<br>There is evidence of active | The SSAB will ensure ongoing monitoring.<br><br>C12. Review the physical intervention approaches being used in the City and develop an improvement plan. | | | | SSAB |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | provider forum work addressing the learning disability agenda | | | | | |
| B5 | Training and Recruitment – Involvement | LD specific services: evidence of 100% of services involving people with learning disability and families in recruitment/ training and monitoring of staff including advocates.<br>Strong evidence of commissioners specifically raising the need for LD awareness training and reasonable adjustment within universal services in line with consultation by people with a learning disability and family carers.<br>Strong evidence of universal services embedding LD awareness training and making reasonable adjustments for people with a learning disability and family carers to access and use the services AND of universal service providers sharing good practice and experience. | Specifications for all retendered services to include outcome measure regarding involvement in recruitment/training and monitoring.<br><br>Advocacy services specification to include measure to support.<br><br>All contracts stipulate under Equalities Act requirement to ensure wider access to services.<br><br>Review to identify gaps in universal provision and reasonable adjustments. | | | | Provider Relationships Associate Director ICU<br><br>Carol Alstrom - Quality Associate Director ICU |
| B6 | Commissioners can demonstrate that providers | Clear evidence of commissioning practice that drives providers to demonstrate compassionate care and value | Ongoing monitoring in place for all contracts using good practice e.g. service audits, Dignity in Care work. Social Value Act used prominently within tendering processes. | | | | Provider Relationships Associate Director |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture. This is a challenging measure but it is felt to be vital that all areas consider this. | base recruitment & management of the workforce Evidence of this approach in relevant universal services | H1 The development and audit of a Good Practice Standards Checklist to be used in conjunction with the client annual review process.<br><br>H2 Further up skill the workforce. Southampton's Workforce Strategy and Action Plan for people with Autistic Spectrum conditions will support this. Service specifications and improved monitoring will identify areas for development. | | | | |
| B7 | Local Authority Strategies in relation to the provision of support, care and housing are the subject of Equality Impact Assessments and are clear about how they will address the needs and support requirements of people with | Evidence of Commissioning Strategies and associated Equality Impact Assessments being presented to people who use services and their families and clear plans in place for the development of Care, Support and Housing for people with learning disabilities based on evidence of current and future demand. | Commissioning Strategies and work stream areas identify EQI. The LDPB (which has 50% of people with LD sitting on this) inputs on commissioning strategies and associated equality impact assessments, these are shared via the LDPB website. Consider developing Experts by Experience.<br><br>A1. Implement the LD Complex Housing Business Case to develop bespoke services for all individuals who are place out of area. | | | | System Redesign Associate Directors<br><br>Carol Alstrom - Quality Associate Director ICU |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | learning Disabilities. | | A2. Undertake a review of the local (Winterbourne) register to improve risk management and implementation of care plans, preventing crisis and improve the planning and delivery of services locally. The review to take the learning from the existing Multi Agency Resource Panel process in place in local Children's' services.<br><br>D1. To implement a strengthened housing plan to support people with complex needs.<br><br>D2. To review and improve the long term management of existing housing stock with NHS/Council nomination rights, maximising development and rental opportunities.<br><br>D3. To work with housing providers in the City to ensure that appropriate housing is developed which addresses emerging need.<br><br>D4. To review the LD housing panel to ensure that housing needs and development opportunities pursued to support individuals to stay in Southampton.<br><br>D5. City Council and CCG to identify | | | | |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | | funding to support the development of bespoke properties. | | | | |
| B8 | Commissioners can demonstrate that all providers change practice as a result of feedback from complaints, Whistle blowing experience. | Evidence that 90 % of commissioned practice and contracts require evidence of improved practice, based on the use of patient experience data, and the review and analysis of complaints. There is evidence of effective use of a Whistle-blowing policy where appropriate. | Providers will be requested to demonstrate that they are changing their practice, based on the feedback from the service users. Monitoring to record this to be put in place so that at least 90% of providers show this under service review/monitoring. Staff surveys' also to be used more formally to gain intelligence. | | | | Carol Alstrom - Quality Associate Director ICU |
| B9 | | | | | | | Carol Alstrom - Quality Associate Director ICU |
| **Section C** – Living Well | | | | | | | |
| C1 | Effective Joint Working | There are well functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of pooled budgets or pooled budget arrangements, joint commissioning structures, intentions, monitoring and reporting arrangements. | Plans to further develop partnership agreements will be processed through Southampton's Better Care Fund work area. | | | | Integrated Commissioning Unit Board |
| C2 | Local amenities and transport | Extensive and equitably geographically distributed examples of people with learning disability having access to | Review of transport services to be undertaken.<br><br>Continue to build on existing good | | | | TBC<br><br>LDPB |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | reasonably adjusted facilities and services that enable them to participate fully and build / maintain social networks e.g. support to use local transport services, Changing Places in shopping centres, Safe Places and evidence that such schemes are communicated effectively. | practice. | | | | |
| C3 | Arts and culture | Numerous examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated effectively. | Continue to build on existing good practice. | | | | LDPB |
| C4 | Sport & leisure | Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups, designated participation facilitators with learning disability expertise etc. and evidence that such facilities and services are communicated | Continue to build on existing good practice.<br><br>B1. Review of day support services to be undertaken in 2014 | | | | LDPB |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | effectively. | | | | | |
| C5 | Supporting people with learning disability into and in employment | Relevant data available and collected. The targets nationally and locally determined (See ASCOF) have been met for people with learning disability supported into employment in the past 12 months<br>Employment activity of people with learning disability is linked to commissioning intent for future services<br>Commissioning is clearly linked to proportionate local need. | Work is in progress to ensure that all vulnerable groups access employment more effectively within the city (ICU Employment Plan drafted).<br><br>Implementation of employment advisor for people with complex learning disabilities approved.<br><br>B2. Development of Supported Employment Strategy to ensure that expert skills are developed for individuals to access<br><br>B3. A range of employment opportunities to be explored for individuals including, job carving, micro firms, and cooperatives | | | | LDPB<br><br>System Redesign Associate Director in liaison with City Deal. |
| C6 | Effective Transitions for young people. A Single Education, Health and Care Plan (EHCP) for people with learning disability | Evidence of 85% of people with learning disability has a current and up to date Single Education, Health and Care Plan by 2014. There is evidence of well-established and monitored strategy, service pathways and multi-agency involvement across Health and Social Care. There is evidence of very clear transition services or functions that have joint health & social care scrutiny and ownership. | There is a programme established to increase EHCP via the development of the 0-25 service development.<br><br>G1. To support the Children and Families Bill 2013 implementation which will extend the special educational needs (SEN) system from birth to age 25.<br><br>G2. Review MARP/TOG in light of the implementation of Children's and Young Peoples Development Service | | | | Children and Families Bill Steering Group<br><br>Childrens Transformation Programme |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | | 0-25 year's service, ensuing that the clinical, social and educational needs of individuals are met into adulthood.<br><br>G3. Ensure that all transition plans will include person centred behaviour management plans which address the communicative functions of individuals. | | | | |
| C7 | Community inclusion and Citizenship | Clear commissioning intentions or action plans that address the social inclusion and citizenship needs of people with a learning disability, linked to data and Joint Strategic Needs Assessments.<br>Commissioning intentions and processes are aligned across both health & social care, supported by joint commissioning arrangements.<br>Clear evidence of strong consultation with local communities in developing what it means to be a citizen | Continue to build on existing good practice.<br><br>B4. LD Advocacy will be re-commissioned in 2014, to ensure that the needs of people with complex needs and behaviour that challenges are met within the city. | | | | LDPB |
| C8 | People with learning disability and family carer involvement in service planning and decision | Clear evidence of co-production in universal services that the commissioners use this to inform commissioning practice | Continue to build on existing good practice with coproduction agenda. | | | | Carers Commissioning Group<br><br>LDPB |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | making including personal budgets This measure seeks to stimulate areas to examine what co-production means and demonstrate clear and committed work to embedding this in practice. | | | | | | |
| C9 | Family Carers | | E1. Complete the Carers Strategy review and ensure that carers and siblings of individuals with learning disability who present challenges are recognised as a priority.<br><br>E2. Assessments of individuals and family's needs to recognise the role and impact on siblings and consideration given to recognising the benefit of accessing young carer services.<br><br>E3. The training needs of carers needs to be recognised in the learning disability workforce development plans as most would | | | | Southampton Carers Commissioning Group |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

| | Objective | Measures | Recommendations from Strategy | Statutory Timeline | | | Lead/Group Responsible |
|---|---|---|---|---|---|---|---|
| | | | benefit from access to this specialist training.<br><br>E4. A small number of individuals who present challenges are supported by elderly carers, planning for their future needs to be prioritised.<br><br>E5. Complete the review respite services offered in the City and ensure that the needs of people who present challenges are addressed. | | | | |

**Joint Commissioning Strategy for Working with Children and Adults with Learning Disabilities whose Behaviour Challenges Services Action Plan 13/14**

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| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | SOUTHAMPTON HEADSTART PROGRAMME BRIEFING PAPER | | |
| **DATE OF DECISION:** | | 29 JANUARY 2014 | | |
| **REPORT OF:** | | DIRECTOR OF PUBLIC HEALTH | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR**: | **Name:** | **Tim Davis** | **Tel:** | **023 8083 4970** |
| | **E-mail:** | **tim.davis@southampton.gov.uk** | | |
| **Director** | **Name:** | **Andrew Mortimore** | **Tel:** | **023 8083 3204** |
| | **E-mail:** | **andrew.mortimore@southampton.gov.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None | | | | |

**BRIEF SUMMARY**

This paper provides a brief overview of an application by the Council in respect of a national Big Lottery Fund programme called HeadStart. Southampton has been selected as one of 12 pilot areas across the England to take part in a one year programme, with funding of up to £0.5m, subject to the development of a local partnership based approach. The HeadStart programme will provide funding for a range of activities to improve the mental and emotional resilience of 10-14 year olds in relation to challenging life events with a view to improving their long term mental health. The report sets out the key areas of activity where Southampton is looking to develop its first year programme, and the key milestones and deadlines relating to the first year of the programme, and in relation to the selection process for a second phase of HeadStart, which could secure funding for a programme across a further five years.

**RECOMMENDATIONS:**

(i) That the Health and Wellbeing Board welcomes that Southampton has confirmed its potential interest in developing a proposal to be part of the HeadStart Programme, and notes that Cabinet approval to submit an application for the Year one programme will be needed in advance of the April 17 deadline for year one applications.

(ii) That the Health and Wellbeing Board suggest any broader partnership involvement and participation that would help further enrich the balance and reach of the Partnership working to develop Southampton's Year one HeadStart programme.

**REASONS FOR REPORT RECOMMENDATIONS**

1. There are a number of outcome measures relating to outcomes for children and young people: fixed term exclusions from school, persistent absence, hospital admissions for self harm, high levels of demand for children's social

care support which are indicative of many Southampton children facing challenging childhoods. This programme has the potential to develop interventions, self help resources and workforce skills that will help equip more of our children to successfully face challenges in their personal lives and still thrive as they enter adult life. Successfully helping children early on will improve their outcomes and should reduce future demand for some adult mental health services.

2. There is significant support from local partners in health services, children and family services, schools, the voluntary sector and other services working with children and young people for the idea that this initiative will dovetail well with the City's aspiration to become an early intervention City. For this, and the reasons set out in 1. above, the Health and Wellbeing Board is asked to note and support

**ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

3. The Council could decide not to support the development of a Year one HeadStart programme. This was rejected on the basis that the opportunity will bring significant new and additional needs to help address an acknowledged need in the City.

**DETAIL (Including consultation carried out)**

4. Southampton is one of 12 areas selected by the big Lottery fund to manage a local HeadStart programme. Big Lottery are looking to establish cross sector partnerships aimed at helping young people between the ages of 10 and 14 within the identified area, particularly those most at risk of poor mental health outcomes, with a view to increasing their long term resilience in relation to mental and emotional health.

5. The initial 12 areas were guaranteed funding for development funding to support them in the costs of developing a Year 1 programme for formal consideration by the Big Lottery Fund. Qualification for this initial development funding (up to £10,000) was dependent upon:

    1. Arrange a local workshop, facilitated by the Big Lottery Fund. In Southampton this was held on 9 January, and was well attended and supported by participants from a range of Council services and service partners, schools, health service commissioners and providers, voluntary sector partners and the universities.
    2. Submission of an initial application for participation in the programme that set out our local partnership approach and vision by 17 January 2014. This is under development at the time of writing, but will be available for the Health and Wellbeing Board by the time it meets.

6. This development funding is intended to help Southampton in developing a multi agency partnership approach, involve and engage children and young people in the City as to their needs, and articulate Southampton's vision for its HeadStart Year one programme.

7. Following this development work, a Stage 2 application will need to be submitted by the Partnership, for which the Council is the lead and accountable organisation, setting out the activity planned for the Year one

HeadStart Programme, and how this will facilitate significant improvements in the mental and emotional health resilience of 10-14 year olds in lasting ways. The deadline for the submission of this Year one programme 17 April 2014. The Southampton HeadStart programme can set out a programme requesting funding contributions of up to £0.5m from Big Lottery. A decision upon the outcome of the Southampton programme, and the level of funding approved for it will be made by the end of June 2014.

8. Big Lottery would like Year one activities to start during July 2014. The funding for Year one activities will run until the end of August 2015, so financial profiling for commissioning and budgeting for the programme will need to run across 2014-15 and 2015-16.

9. If successful in its application for a Year one programme, Southampton will be invited to submit a further application for consideration to be one of five or six of the original 12 areas for a further five years funding, in an expanded programme worth up to £10m total investment from Big Lottery.

10. The Council, on behalf of the local HeadStart partnership, will need to complete a more detailed application for its proposed 2015-2020 programme by 5 December 2014. A decision on which areas will be included in the extended programme will be made by the end of March 2015.

11. If successful in becoming part of the extended programme, this would formally start on 1 September 2015, running up until the end of August 2020.

12. A key part of the Big Lottery Fund's focus during year one will be upon early clarification around how the impact of the programme will be measured. As our application for inclusion in the extended programme will be a priority to realise the full potential benefit of this opportunity to support and transform the long term mental health and wellbeing of the City's young people, we will need to identify a range of measures that help us to robustly capture and demonstrate this benefit.

13. The initial management and co-ordination of the Southampton programme is being co-ordinated through the Integrated Commissioning Unit, on behalf of the City's Public Health team. The initial lead officer is Tim Davis, Senior Commissioner for Healthy Lives.

## RESOURCE IMPLICATIONS

### Capital/Revenue

14. The year 1 programme has an indicative resource allocation of up to £500,000 to fund programme related activities which will run between July 2014 and August 2015.

15. If Southampton is selected for inclusion in the extended programme, funding for the total programme (over a further 5 years) expands to up to £10m (approximately £1.9m per year). The intention is that this will be additional funding and not core funding for existing CAMHS services. If successful however, it should be anticipated that one benefit of the HeadStart programme would be a long term reduction in demand for CAMHS services for 14-19 year olds. At a strategic level this may provide either savings and/or sustainability funding for a longer term replacement for the 10-14 CAMHS activities funded through the HeadStart programme when it ends in 2020.

16. This briefing paper sets out very high level financial implications for the programme and has not benefited from detailed input from City Council or Southampton City CCG finance support. The Stage 2 application will require more detailed nominated support from Finance Teams.

**Property/Other**

17. Not applicable.

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

18. At this point the Council would be providing a leadership role in relation to the Southampton HeadStart partnership on whose behalf it is leading any future application under its general power of competence from the Localism Act 2011.

**Other Legal Implications:**

Not applicable

**POLICY FRAMEWORK IMPLICATIONS**

Not applicable

**KEY DECISION?** No

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | All |

## SUPPORTING DOCUMENTATION

**Appendices**

| | |
|---|---|
| 1. | Southampton HeadStart Stage 1 Application for Development Funding (available after 17 January) |
| 2. | Report on Southampton HeadStart Investment Workshop on 9 Jaunary (available after 17 January) |

**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 | |

# Fulfilling Lives: HeadStart

## Stage one application form

**For use in England only**

### About this form

This form is to explain your vision for your initial project. It also provides the opportunity to apply for development funding to develop your application for the initial project.

At this stage we are not expecting you to provide detailed information about the initial project. This form gives an opportunity to provide a broad overview of the project including the changes it will make and high level costs. The information on this form can be refined on the stage two application once the initial project is more developed.

To use this form you need Adobe Reader version 10.0 or above installed on your computer.

- If you have an earlier version or use other software the form won't work properly.
- Follow this link to get the latest version of Adobe Reader, which is free to install and use.

### Before you start

Make sure you've saved the form to your own computer before you start to fill it in.

### Filling in the form

You must answer all of the questions in the form. If you have any questions about completing this form, please contact your nominated Funding Officer.

### Sending us your application

Email a copy of this form to headstart@biglotteryfund.org.uk

We prefer to receive application forms and supporting documents by email, however if you don't have access to email post them to:

Fulfilling Lives: HeadStart
Big Lottery Fund
Apex House
3 Embassy Drive
Calthorpe Road
Birmingham
B15 1TR

### Deadline for applications

Your application must be submitted by 17 January 2014. We won't accept any applications after this.

# Programme Summary

**Throughout this form where we use the term Project we mean the activities or services your partnership wants to deliver during the initial project.**

## What's it all about?

This investment has been designed with young people in direct response to the mental health needs of adolescent young people in England. We know adolescence is a difficult time for many young people: they move from primary to secondary school, go through changes to their height, weight and appearance, and experience changes to how they feel about themselves and how they feel towards others, and changes to the way they think about the world around them. We also know that for some young people, mental health problems in adolescence increase and that half of all lifetime cases of mental ill health start by the age of fourteen.

Our HeadStart funding is intended to help equip young people to deal better with difficult circumstances in their lives, so as to prevent them experiencing common mental health problems. For example, we know young people's experiences in their school, communities or family lives, or on social media, can trigger problems that could be avoided or reduced through earlier support. Our funding will enable work in schools and with families, community groups, and charities to make sure that young people have a chance to benefit from this all-round support.

Our funding is for work to trial new ways of providing this early support both in and out of school. We'll then take whatever is learned and share it with organisations such as schools, community groups, local authorities, health providers and others who work with young people. The learning will help change the way future funding decisions are made, and influence how services are run in the future.

We'll be trialling these new ways of providing early support in 12 geographical areas in England. We looked at a number of factors in selecting areas, with a view to maximising the learning from the HeadStart investment. This pointed to selecting a set of different types of area, for example large and small geographic areas, urban and rural. We analysed a range of relevant area data and statistics, including levels of deprivation, self-harm, truancy, and other things which can be risk factors for mental health problems. In addition to this, we consulted a wide range of key practitioners and experts to gain feedback and use the benefit of their experience to inform the selection of the participating areas. For a list of the 12 areas and more detail of how they were selected visit www.biglotteryfund.org.uk/headstart

Our HeadStart funding breaks down as:

- up to £500,000 for initial projects in each of the 12 areas to start to test out new approaches.
- up to £10m per area to develop the initial projects into full projects in five-six areas
- support for all our funded projects to help them develop their new approaches, to evaluate how effective they are, and to use any findings to influence services provided for young people by a range of other organisations.

We want the 12 selected areas to focus on improving the resilience and the lives of young people by working in four areas:

- a child's time and experiences at school
- their ability to access the community services they need
- their home life and relationship with family members
- their interaction with digital technology.

These four areas where chosen for specific reasons.

- The school environment plays an important role in supporting young people to cope with difficult circumstances and offers the opportunity to work with a lot of young people in one setting.
- Connecting young people with community services will not only make it easier for them to get support but also help these services know what is needed and improve in the future.
- The relationships that young people have at home play a key role in how they develop relationships with others.
- The increased use of digital technology can influence young people in both a positive and negative way and can help to capture evidence and learning as well as providing access to services.

An example of what we would like our finding to achieve would be.

For young people aged 10-11 being taught how to cope with difficult circumstances through planned lessons in schools. The lessons would equip the young people with cognitive, coping and problem solving skills and encourage them to put these into practice during school and at home. During the lessons, young people with emerging mental health problems would be identified and given extra support from a school based counsellor and a dedicated team of trained volunteers. This will enable young people to get early access to services that can teach them how to change the way they think and behave.

Schools would work with local charities and community service providers to ensure young people with emerging problems can be helped when not at school. Schools would also work with parents and local health professionals to make sure young people have access to practical and specialist support that is timely and centred around their needs. Local charities would work with young people who were disengaged with school or have a disruptive school experience.

## Development funding and initial projects

Each of the selected areas can apply for funding to develop the application for the initial project. Development funding can be used to pay for activities that will help develop a well-planned, high quality application to the next stage. We want the development funding to be quick and simple to access so have kept the process of applying for it as easy as possible.

For more information please see below in What Can You Apply For?

Initial projects will run from July 2014 to the end to August 2015 and provide areas the opportunity to test and learn from 'on the ground' delivery to help inform their plans for a full project.

## Full projects

All areas that are successful in achieving funding for the initial project will be invited to apply for a full project which will run over five years. We expect to make five or six of these large investments.

All areas will continue to run their initial project until the end of August 2015. Those successful in obtaining funding for their full project will wait until their initial project comes to an end before starting their full project.

# What happens when?

The key stages and dates for investment are as follows:

| | | |
|---|---|---|
| | **Stage one** | |
| Vision November - January 2014 | This stage is where you tell us your vision for your initial project. This includes an indicative budget. This stage is also where you can apply for development funding to help develop your initial project. | You have between 1 December 2013 and 17 January 2014 to submit your stage one form.<br><br>We will tell you our decision on your stage one application within three weeks of receipt.<br><br>If you are invited to apply to stage two, we'll give you a stage two application form to complete and make any development funding offers. |
| | **Stage two** | |
| Development February 2014- April 2014 | This stage is where you will develop your plans for the initial project. | 17 April 2014 – deadline for stage two applications.<br><br>By the end of June 2014 – we will tell you our decision on your stage two application.<br><br>If you are successful, we'll give you a stage three application form. |
| Initial project delivery July 2014 - August 2015 | If you are successful at stage two, your initial project will start. This is an opportunity to test and learn from different approaches to delivery. | By end of July 2014 - initial projects start.<br><br>By the end of August 2015 - all funding for initial projects must be spent. |
| | **Stage three** | |
| Stage three - Full project applications | Part way through your initial project, you will have the opportunity to apply for a full project of five years. | 5 December 2014 - deadline for stage three applications.<br><br>By the end of March 2015 - we will tell you our decision on stage three applications and announce the final areas to be awarded. |
| Full project delivery September 2015- August 2020 | If your stage three application is awarded, your full project will commence in September 2015. | September 2015 - full projects start.<br><br>By August 2020 - all funding must be spent. |

## What are we looking for?

The ultimate aims of the programme are to equip young people better to prevent mental health problems occurring in the first place, and to build the evidence for service redesign and investment in prevention.

To achieve this we want to fund projects that bring about all of the following outcomes.

- Young people are better able to cope in difficult circumstances and do well in school and in life.
- Building resilience helps to prevent the onset of common mental health problems.
- Learning from different approaches contributes to an evidence base for service re-design and for investment in prevention.

To meet these outcomes we expect projects to work in the four areas listed above under What's it all about?

## Who can apply?

The application must come from a partnership with one organisation within the partnership acting as the lead applicant. The lead applicant will be solely accountable to us for all monitoring information, how all the money is spent and for the full and successful delivery of the project. The partnership must involve organisations from both the voluntary and community sector and the public sector, and could include health and well being boards, local authorities, schools, clinical commissioning groups, community organisations, and mental health charities. Although the participation of schools is vital in the partnership we would not expect a school to be the lead applicant as they may not have the resources to support the management of the project. The partnership will need to show that it can provide both a clear strategy and vision for improving resilience, and the practical ability to deliver it. Actively engaging young people into the design and delivery of the project is essential.

## How much is available?

The total funding available for grants is approximately £61million. Out of this amount we will award development grants of up to £10,000 and fund initial projects of up to £500,000 each. The remaining funds will be awarded for full projects lasting five years. There will also be up to £10 million for evaluation and support and development of the projects.

We recognise that the evidence base supporting early intervention in preventing mental health problems in young people is less strong than other areas, which is why we are committing serious levels of investment in evidence collection and the sharing of learning. We want to influence the hearts and minds of those who make funding choices in the future. At the heart of this work will be an evaluation and learning contract that will bring together the national evidence from what we fund and make the social and economic case for investing in resilience to help prevent common mental health problems in young people.

## How much can you ask for?

At this stage you can ask for between £1,000 and £10,000 development funding to help develop a stage two application.

At stage two you can apply for up to £500,000 for the initial project.

At stage three you can apply for up to £10,000,000 for the full project.

## What can you apply for?

### Development funding

At this stage, up to £10,000 development funding is available for each application. This funding is to cover the costs of developing your application to the next stage.

The purpose of development funding is to strengthen your project and ensure the best fit between what you want to do and what we want to invest in. We can fund a range of development activities to help you strengthen your stage two application including work to:

- develop your project's outcomes
- increase your ability to deliver these outcomes
- improve the scope and depth of your consultation and engagement with users and beneficiaries
- help you assess the viability of your project.

It can cover costs such as, beneficiary consultation or feasibility studies.

If development funding is required it should be requested at question 4.2. Tell us what the development funding will pay for and detail any services to be purchased. If you progress to stage two, the development funding must be spent and the development funding monitoring form submitted by 16th April 2014.

## Initial and full project funding

This section details what the funding for the initial project and full project can be used for. When considering your indicative budget for your initial project, please consider the following:

We'll pay for:

- some or all of your project costs for the lifetime of the project
- a contribution towards overheads.

### Overheads

By overheads we mean the costs to you as the lead organisation and the costs to your partners, for the recruitment, salaries and training of any staff directly responsible for the management and accountability of your project. The overheads must be reasonable and represent good value for money. We would expect them to be no more than 10 per cent of the total project costs.

Guidance on how to calculate your organisations overheads can be found on our website at www.biglotteryfund.org.uk/funding/funding-guidance/applying-for-funding/full-cost-recovery

We won't pay for:

- your day-to-day running costs, current or regular activities, general appeals, endowments or activities to raise funds for your organisation
- anything you start, spend money on or agree to spend money on before we confirm our funding
- activities that are statutory obligations or will replace statutory funding, including activities on the curriculum in schools
- land or building purchase or refurbishment work
- feasibility studies
- items that only benefit one person
- loans or interest repayments
- activities to promote religion or belief
- political activities
- travel outside the UK.

## What makes a good application?

At all three stages, we'll assess your application against the following criteria:

### Idea

- Need: Is the project needed?
- Outcomes: Will the project bring about the changes we are looking for?

**Delivery**

- Approach: Is the way the project will be delivered realistic?
- Capability: Do you have the skills, experience and resources to deliver the project?

At stages two and three we will consider the criteria in more detail. Since we are assessing the same criteria at each stage the forms will contain questions on the same topics. However the questions will allow the opportunity to provide the detail of information that is relevant for each stage and for the amount of funding requested.

## What else do I need to know?

**Project name**

We would like all projects to be easily identified as a Fulfilling Lives: HeadStart project. Therefore we completing question 1.1 please call you project HeadStart followed by the name of your area.

For example: HeadStart Cumbria

## Support and development

All applicants will be provided with a facilitated workshop ahead of submitting a stage one application. A second facilitated workshop will be provided to all areas who are successful at stage one. The purpose of the workshops are to:

- support with you in the design, approach and content of the applications
- support areas in their decisions regarding their vision and strategy of their projects
- act as critical friend, offering support and guidance on how your partnerships can work together to ensure successful delivery of the initial project
- provide a range of methods to help you identify your future support needs.

A support and development package will also be available to all areas which are successful at stage two. We will provide further details of the organisation providing this support to successful areas in June 2014.

## Evaluation

Evaluation and learning are the central focus of the investment, which aims to influence the way resilience is built up in young people. We will appoint a service provider with a proven track record in complex research projects to deliver the evaluation and learning package, which will enable successful applicants to identify what works well, for whom and in what circumstances, and to share their learning and improve practice. We will expect you to work with the service provider as a condition of your grant. We will provide more information when we award funding for the initial projects.

## Partnership agreement

If you are awarded funding, it will be a term and condition of your grant offer (for both the initial and full projects) that you have a formal signed partnership agreement with your partner organisations. If you are successful, the draft partnership agreement must be approved by us and finalised prior to any funding being released. We may request changes to the draft agreement before it is finalised. You can find guidance on what a partnership agreement should include at www.biglotteryfund.org.uk/headstart

## Annual accounts

In question 7.12 we ask you to send us the latest accounts or financial records for the lead organisation if we do not already have them. We would prefer if you send us your accounts by email. If this is not possible, we will still accept paper copies provide they are sent on time. You must be able to give us a copy of your most recent approved accounts, signed and dated by your chair, secretary or treasurer and by your auditor or independent examiner, where appropriate.

The accounts you send us should not be more than 12 months old. However, we realise that this can be difficult if your organisation's financial year-end coincides with the period in which you are sending us

your application. If this is the case for you, send us your previous accounts and a copy of your most recent management accounts. If you are a new organisation, you must send us signed and dated estimates of your income and spending for the first year of the grant.

## Beneficiary monitoring

We want to find out about the people who benefit from the projects we fund to understand the spread of our funding. We also want to learn from projects and programmes about their success in reaching different types of people to see if these approaches can be replicated elsewhere.

If you are successful in obtaining funding for your initial project, within six months from the date we receive your signed grant agreement, we will ask you to:

- estimate the percentage of people that will benefit from your project under a number of categories, for example, ethnic background, age, sexual orientation and gender
- think about how you will reach all of these people and how you will check whether or not you have been successful in doing so.

You should therefore start thinking about how you will collect this information when planning your project.

On an annual basis and at the end of your project, we will ask you to:

- tell us what percentage of people actually benefitted from your project, under the same categories, and the evidence you have to back up your figures
- tell us how successful you were at making sure that everyone who could benefit from your project was able to use it or get involved.

## How do I find out more?

For more information please visit www.biglotteryfund.org.uk, email us at headstart@biglotteryfund.org.uk

If you or your main contact have any particular communication needs, such as Braille, audiotape, large print, sign language or a community language, please call us on 0845 4 10 20 30 (text relay: 1801 plus 0845 4 10 20 30 available for those with a hearing or speech impairment).

# Part one: What will your project do?

## 1.1 What would you like to call your project?

Give your project a short title, something we can use in publicity. You can write up to 70 characters (including spaces).

Appendix 1 - HeadStart Southampton Stage 1 Submission - HeadStart Southampton

## 1.2 What does your project involve?

Summarise what you plan to do, using straightforward language. You can write up to 2,000 characters (about 300 words).

The vision of HeadStart Southampton is to raise young people's aspirations by providing them with the tools and access to activities to strengthen their resilience. It will utilise a range of child and family centred approaches which:

1. Are child and young people focused: services will be shaped by and centred around children and their families, and based upon need. Approaches will link to and build upon existing strategies, plans, services and community resources. Emphasis will be placed on engaging young people who are isolated within the community.
2. Promote positive activities and behaviours: encouraging emotional wellbeing and strengthening resilience through self-help materials and activities within communities, schools and on-line. The successful Emotional First Aid will be embedded across all Southampton schools as a central component of this approach.
3. Increase front-line capacity: Improving the capacity of our front line services to recognise and appropriately respond to emerging risks for children and young people. We will achieve this through targeted investment in Emotional First Aid training, workforce development and complementary approaches.
4. Develop, link and signpost services and other resources: Connecting the services and resources already available locally making it simpler for 10 –14 year olds to find and receive the support they need when they need it.

The Southampton HeadStart programme will focus its activities across four areas:

- In schools – Improving the experience of Southampton's children and young people at school, raising aspiration, focus and positivity for their future, and equipping more school based staff in supporting them at the earliest opportunity
- In communities – Improving access to community services needed by children and their families to assure their mental and emotional wellbeing, and developing the capacity of more staff to provide support.
- In families – Equipping children and their parents to better deal with life's pressure, challenges and conflicts, and the professionals working with them through proven approaches to developing resilience.
- In a safe online environment – Developing resources and services that improve access to help and support online, and to developing their resilience. Educating children and preparing them for the dangers that exist within these arenas, and the ways that they can use online resources to support them in dealing with the challenges they face.

## 1.3 What will you spend the money on?

Write a list or a description of what our money would pay for. You can write up to 2,000 characters (about 300 words).

The initial development (Stage 1) allocation will be used to scope the feasibility and prepare for the stage two programme described at high level in section 4.1. We intend to use it on:

1. (Approx £2,000)
Research and consultation costs in developing a proposal that will be needs, evidence and asset based. Setting up a consultation network of young people, existing and former Child and Adult Mental Health Service (CAMHS) users, families, schools and practitioners hereby their views and needs can inform the programme and provided services.

2. (Approx £3,000)
Ad-hoc costs of events, meetings and bringing together our target age group with our professionals and partnering organisations to develop a programme centred around young people and their needs. We will develop a performance management framework to demonstrate the impact of the programme with our local Higher Education partners.

3. (Approx £1,500)
Understanding best practice in respect of preventative CAMHS i.e. best delivery options for Emotional First Aid (EFA) approaches; exploring the potential for a peer-led approach.

4. (Approx £1,500)
Undertake an initial mapping exercise of our current CAMHS (preventative and early intervention) among front line professionals, and developing and costing our plans for embedding Emotional First Aid approaches more widely across the City in preparation for our Stage 2 programme application.

5. (Approx £2,000)
Direct additional staffing costs to develop our first year proposal, and the associated dedicated project management staffing costs of progressing this to:
a) Carry out initial mapping of multi-agency services/resources and expertise
b) Co-ordinate meetings and consultation events with children and young people and partners
c) Establish partnership and governance arrangements for the Southampton programme.

## 1.4 When are you planning to start and finish your project?

Make sure the dates you put fit with the dates under What happens when? at the beginning of this form and your start date is after the date when we'll confirm our decision.

| Start date (dd/mm/yyyy) | Finish date (dd/mm/yyyy) |
|---|---|
| 07/02/2014 | 17/04/14 |

## 1.5 Where will your project take place?

Give the location of the places where your project will happen.

- If your project will take place at (or be run from) a single location, enter its postcode, put 100 per cent and select it as the main location.
- If your project will take place at (or be run from) a number of locations and estimate a percentage for each one. Then select one postcode as the main location.
- If your project will delivered across the UK and you cannot specify exact locations (or you have not identified these yet), please enter the project's correspondence address.

If the location doesn't have a postcode, use one for a nearby building.

Please make sure you have selected a main location for this project and that totals add up to 100 per cent.

You can enter up to insert number of rows up to 20 locations in the table. If there are more than this select the top insert number of rows up to 20.

| Building name (or number) and street | Postcode | % per location | Main location |
|---|---|---|---|
| Southampton CC Civic Centre, Civic Centre Road | SO14 7LY | 100% | ☑ |
| | | | ☐ |
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# Part Two: Why is your project needed?

## Why is your project a good idea?

Explain why you want to do this project, how you know it's needed and what backing or support you have from the people, communities or organisations who will benefit.

Make sure it's clear how your answer fits with what we want this programme to achieve. We describe this under What's it all about? at the beginning of the form.

You can write up to 2,000 characters (about 300 words).

Given Southampton's high level of need in relation to mental health indicators, we are excited to be a part of the HeadStart programme. Poor emotional and mental health has long been indicated by schools and other partners as a major limiting factor to the wellbeing of children. This need manifests itself in a number of poor outcomes for our children and young people:

- We are among the poorest performing areas in the country in relation to: total absence, persistent absence and fixed term exclusions from school.
- Our Troubled Families programme currently works with families including 270 children across the City between the ages of 10 and 14 years.
- We have high levels of youth offending among 10-17 year olds with first time offending and re-offending levels amongst the worst in England.
- Demand for children's Social Care services is disproportionately high (typically about 30% higher) than similar areas.
- Domestic violence is a problem faced by many children. A recent audit of children subject of a Child Protection plan identified 80% of these families with domestic violence identified as a concern.
- Our rates of hospital admissions for deliberate or accidental injury to children and admission to hospital for alcohol and substance misuse for young people are much higher than in similar areas.

We already work closely with our partners including schools, health and voluntary sector organisations to tackle issues that often result in lifelong mental and physical ill-health. We look forward to the opportunity to develop our engagement with children and young people, improve our partnership working, our front line and community capacity and competence to support our children through the challenges they face in day to day life.

We already have a good platform for accessing children and young people views through school councils and a range of service user engagement groups. We seek to develop this platform further and ensure engagement in developing the programme. Services we develop will be based on young people's input. Their views will be crucial in informing the allocation of resources to new community and school based proposals.

# Part three: What difference will your project make?

## 3.1 How will people, communities or organisations benefit from your project?

Describe up to four changes you expect your project to bring about, using straightforward language. We call these your project outcomes.

You'll find the outcomes we want this programme to achieve under What are we looking for? at the beginning of the form.

Having more outcomes won't necessarily make your application stronger - we're interested in the kind of changes you're trying to bring about. To learn more about outcomes read our Getting funding and planning successful projects guide, which has examples of project outcomes, by visiting www.biglotteryfund.org.uk/funding/funding-guidance/applying-for-funding

You can write up to 150 characters in each box (about 30 words).

| |
|---|
| 1.<br>To raise aspirations through a better all-round school years experience; to be achieved through developing professional capacity in emotional resilience approaches and resources that instill and sustain positivity, hope and help young people to meet their aspirations. We will involve them in developing these and invest in our school based staff, accompanying resources and activities to ensure there is capacity to deliver. Our aim is to achieve reductions in exclusions and persistent absence, and better learning experience for children and young people across our City. |
| 2.<br>A better experience and access to community support: We will involve our children in developing community based activities and resources that provide support when they face difficult choices and circumstances and raise aspirations. We will invest in workforce capacity in community settings and measure children's experience of community support. |
| 3.<br>A better experience of family support: we will involve children and families in developing specific resources and activities that support them, particularly for those children whose family circumstances are most challenging in terms of the level of stress they place upon children's mental and emotional wellbeing. We will invest in the capacity of those working most closely with them to recognise those needing help. We would measure this through their feedback on services they receive, plus better outcomes in relation to their engagement and learning and better outcomes in relation to ongoing demand for social care input. |
| 4.<br>Enjoyment, education and less fear surrounding digital media and a decrease in the number of incidents that occur due to this. We will seek children and young people's views on approaches, scope feasibility and seek to develop digi-champions to help us in design and roll-out of different online resources and services to support professionals and young people. |

# Part four: How will you carry out your project?

## 4.1 How much will your project cost and how much would you like from BIG?

- Include the cost of everything you'll need for your project, even if you're not asking us to fund it.
- Only include VAT if you can't recover it from HM Revenue and Customs.
- Revenue costs include things like training, travel, venue hire and volunteer expenses. Include any overheads you want us to fund in your revenue costs. Guidance on how to calculate your organisations overheads can be found on our website at www.biglotteryfund.org.uk/funding/funding-guidance/applying-for-funding/full-cost-recovery

If you're asking us for all the costs make sure the total cost and amount from BIG is the same.

| | Total cost (£) | Amount from BIG (£) | How many years is this funding for? |
|---|---|---|---|
| **Revenue** | £575,000 | £500,000 | 1 |
| **Total** | £575,000 | £500,000 | 1 |

Are the total project costs more than the amount you'd like from us?

Yes ◉ No ○

If yes, where will you get the other funding from and have you secured it yet? You can write up to 2,000 characters (about 300 words).

The additional funding identified at this stage (£75,000) is an estimate of the resources currently invested in support and activities for the mental and emotional health and wellbeing of 10-14 year olds. It relates to estimated current funding for activities from a range of sources - council and health commissioned CAMHS services and lower level counselling and advice services, pupil premium funded activities and support for children on free school meals, school and other organisations' investment in the professional development of emotional first aid, emotional literacy support nurture groups and a range of other targeted support for children and young people facing particular challenging circumstances, some of whom are 10-14. This is a rough estimate as this funded activity is not part of a coherent package specifically targeted to meet the needs of this age group. Significant further work will be needed in relation to the development of our local partnership bid at Stage 2 to test and explore these costs and spending in more detail, and the extent to which it can and will be diverted to make it part of a coherent strategic package of joined up support and resources for 10-14 year olds as part of the Southampton HeadStart year one programme.

In this regard this additional funding is not secured specifically in support of this programme at the time of writing our Stage 1 bid, as the partnership work to engage all those commissioning this spend on the support for the mental and emotional health and resilience of children and young people in this age range has not yet had time to happen. It is anticipated that through the process of developing our Stage 2 application that we will have the opportunity to unpick current spending, and partners willingness to divert how they use resource for 10-14 year olds to more closely align it with the opportunity presented by the Southampton HeadStart year one programme.

We anticipate that the combination of our vision for the Southampton HeadStart programme, the commitment of the leading partners to the programme, and the fit between this and the City's "Be Well" strategy for mental health for all will help secure the realignment of existing resources to this opportunity. We expect to be in a position to confirm the additional resources we need by the time we submit our Stage 2 application for the Southampton HeadStart programme.

## 4.2 Do you require development funding?

Development funding is available to help you develop your application if you progress to the next stage. Check what development costs you can apply for at the beginning of this form. If you receive development funding this does not commit us to funding your application at the next stage.

Yes – Please complete the table below ◉ No ○

**How much development funding do you need?**

The development costs you can ask us for are explained under What can you apply for? at the beginning of the form.

- Include the costs of everything you will need to do to develop your project, even if you're not asking us to fund it.
- Be as detailed as you can, using clear headings followed by a short description.
- Only include VAT if you can't recover it from HM Revenue and Customs.
- Use a different row for each heading.

| Item or activity | Total cost (£) | Amount from BIG (£) |
|---|---|---|
| Temporary extra staffing costs to develop our year 1 proposal | £2,000 | £2,000 |
| Research on needs and consultation with children and services | £2,000 | £2,000 |
| Research on best practice locally, regionally and nationally | £1,500 | £1,500 |
| Mapping to outline initial workforce development priorities | £1,500 | £1,500 |
| Meeting/event costs for consultation with children/partners | £3,000 | £3,000 |
| Council/partner in-kind costs in developing Year 1 programme | £4,000 | £0 |
| See section 1.3 for more description of the above activities. | | |
| | | |
| | | |
| | | |
| **Total revenue costs** | £14,000 | £10,000 |

Are the total development costs more than the amount you'd like from us?

Yes ◉ No ○

If yes, where will you get the other funding from and have you secured it yet? You can write up to 2,000 characters (about 300 words).

The City Council and its partners in health, education and voluntary sector provision already commission significant activity relating to the emotional and mental health of children and young people, including 10-14 year olds. Those elements of developing this programme to ensure that it complements existing provision will to some extent be borne by those organisations. This will relate to mainly in-kind contributions to the development of our proposals that are complementary as opposed to significantly in addition to or different from existing provision.

# Part five: Do you have the skills, experience and resources to run your project?

### 5.1 How will you make sure you (the lead organisation) can deliver the overall project?

Explain how you'll find the time, money, people, skills and expertise you'll need.

You can write up to 2,000 characters (about 300 words).

Southampton City Council (Public Health, Children and Family Services, Leisure and Culture, together with wider council services) and its partners in the Clinical Commissioning Group, provider health services (School Nursing, CAMHS services etc.), schools, colleges, universities and a range of voluntary sector service providers can call upon extensive project management and specialist knowledge in relation to running multi-agency partnership projects.

Whilst developing its programme for the first year, the project management team will use this experience to scope its ongoing needs to ensure we deliver to our best ability both in first year, and in the development of a programme proposal for years two – seven.

This will include planning for capacity so that if we are successful in our application for the longer term programme, we are effective and timely in our commissioning of the programme. We need to ensure our commissioning of local services and resources is delivered in a seamless way. If unsuccessful in our application, we are effective in maximising our learning from the one year programme, and how we seek to build a legacy of what we have learned to ensure an ongoing and lasting benefit to Southampton.

We are lucky within Southampton City Council to have the expertise for this project management team. Within our Public Health team - which is integrated between the council and Southampton City Clinical Commissioning Group – we have significant health knowledge and experience relating to child and adolescent mental health and emotional wellbeing. To ensure the smooth transition and communication between the council and its partners, we have experience of multi-agency working and service delivery. Other specialist skills and knowledge will be identified through the project governance and brought in as required.

Given the size of the programme it is anticipated that some dedicated project management support for the programme will be required, and this will be scoped according to the characteristics of the year one programme and reviewed once the outcome of our Stage three application is known.

## 5.2 Partner organisations

Summarise:

- the relevant experience of your main partners
- their role within the project
- their involvement in the project so far.

You can write up to 2,000 characters (about 300 words).

• Southampton City Council is the accountable body and lead for the partnership. It brings knowledge and skills in relation to commissioning, managing and delivering many services that engage with children. Several services are involved in developing our ideas through suggesting service links, engaging chi and attending events. The project will be managed through the Integrated Commissioning Unit (ICU) under Public Health leadership. The Council's Public Health team will provide significant expertise as well as leadership.
• Southampton City CCG has extensive knowledge and expertise in the commissioning and management of health services and links to the wider health system, including the acute sector. The CCG will work jointly with the Council to deliver our programme through the ICU, adding to our collective project management capacity and expertise in leading the programme. The CCG has contributed to the development of the proposal to date through the participation of commissioners in both the visioning event and the bid.
• Schools will be the principal partners through which our children access the resilience building resources, services and activities we put in place through HeadStart Southampton. They have been already been involved in discussions about the development of the Stage 1 proposal, and are active participants in developing our Stage 2 application, including in the engagement of children through school councils etc.
• Southampton has two universities with a wealth of specialist knowledge and expertise in relation to a range of areas that will be useful for the HeadStart programme. They are both service partners for schools and interested in evaluation support for the programme and took part in the visioning event.
• Solent NHS Trust is the principal provider of community and specialist CAMHS and School Nursing services in Southampton. They bring expertise, service capacity, specialist knowledge and professional development options that will be important for HeadStart Southampton, and developed Emotional First Aid approach partners at the visioning event wanted to make central to our approach. They have been involved in contributing ideas for the bid, took part in the visioning event and have indicated their support in engaging children in the development of our Stage 2 application.
• Southampton has a thriving voluntary and community sector which provides a huge range of services that meet the emotional and mental health needs of children and young people in a range of ways. Many contributed to the visioning event and the Stage 1 bid through correspondence, ideas and offers of support in relation to engagement of children in the development of our Stage 2 application.
• NHS England brings links to both primary care and the commissioning of a range of specialist health services to the local partnership and have contributed to our programme through taking part in visioning and our wider strategy.

## 5.3 Working with children, young people or vulnerable adults

As a minimum we expect you to:

- have safeguarding policies appropriate to your organisation's work and what you are asking us to fund, which you review at least every year
- complete a rigorous recruitment and selection process for staff and volunteers who work with children, young people or vulnerable adults, including checking criminal records at least every three years and taking up references
- follow statutory or best practice guidance on appropriate ratios of staff or volunteers to children, young people or vulnerable adults
- provide child protection and health and safety training or guidance for staff and volunteers
- carry out a risk assessment and secure extra insurance, if appropriate.

Does your organisation meet these requirements?

Yes  No 

# Part six: Who will benefit from your project?

There are no model answers to these questions. Your answers help us understand who benefits from our funding but we don't use them to decide if we will fund your project. For more information on how we'll ask you to report on who benefits from your project if you are successful, visit www.biglotteryfund.org.uk/funding/funding-guidance/managing-your-funding/about-equalities

## 6.1 Will your project mostly benefit people from a particular ethnic background?

Yes ◉ No ○

If yes, which ethnic background? You can select up to three.

**White**

- [x] English/Scottish/Welsh/Northern Irish/UK
- [ ] Irish
- [ ] Gypsy or Irish Traveller
- [ ] Any other white background

**Mixed/Multiple ethnic groups**

- [ ] Mixed ethnic background

**Asian/Asian UK**

- [ ] Indian
- [ ] Pakistani
- [ ] Bangladeshi
- [ ] Chinese
- [ ] Any other Asian background

**Black/African/Caribbean/Black UK**

- [ ] African
- [ ] Caribbean
- [ ] Any other Black/African/Caribbean background

**Other ethnic group**

- [ ] Arab
- [ ] Any other

## 6.2 Will your project mostly benefit people of a particular gender?

Yes ○ No ◉

If yes, which gender?

Male ○ Female ○

## 6.3 Will your project mostly benefit people from a particular age group?

Yes ◉ No ○

If yes, which age group? You can select up to two.

- [x] 0 - 24 years
- [ ] 25 - 64 years
- [ ] 65 + years

## 6.4 Will your project mostly benefit disabled people?

Yes ○ No ◉

## 6.5 Will your project mostly benefit people of a particular religion or belief?

Yes ◉ No ○

If yes, which religion or belief?

- [ ] No religion
- [x] Christian
- [ ] Buddhist
- [ ] Hindu
- [ ] Jewish
- [ ] Muslim
- [ ] Sikh
- [ ] Other

## 6.6 Will your project mostly benefit lesbians, gay men or bisexual people?

Yes ○ No ◉

# Part seven: About your organisation

### 7.1 What is the full legal name of your organisation, as shown on your governing document?

Southampton City Council

### 7.2 Does your organisation use a different name in your day to day work?

Yes ○ No ◉

What other name do you use?

### 7.3 What is the main or registered address for your organisation?

| | |
|---|---|
| Flat number | |
| Building number | |
| Building name | Southampton Civic Centre |
| Street | Civic Centre Road |
| Town or city | Southampton |
| Postcode | SO14 7LY |
| Phone number one | 023 8083 4970 |
| Phone number two or text phone | 023 8083 |

### 7.4 What is the main email address for your organisation?

This should be the email address people use to contact your organisation?

tim.davis@southampton.gov.uk

### 7.5 Does your organisation have a website?

Yes ◉ No ○

What is its address?

www.southampton.gov.uk

## 7.6 What type of organisation you?

Select your organisation type from at least one of these categories.

| | | |
|---|---|---|
| **Charity** | ☐ Registered charity<br>☐ Charitable incorporated organisation<br>☐ Charitable unincorporated association<br>☐ Charity (Royal Charter or Act of Parliament) | ☐ Exempt charity<br>☐ Excepted charity<br>☐ Charitable trust |
| **Company or mutual society** | ☐ Company – limited by shares<br>☐ Company – limited by guarantee<br>☐ Company – listed publicly<br>☐ Community Interest Company – limited by shares<br>☐ Community Interest Company – limited by guarantee | ☐ Community Interest Company – listed publicly<br>☐ Limited liability partnership<br>☐ Industrial and provident society<br>☐ Co-operative |
| **Public sector** | ☑ Local authority<br>☐ Community Council<br>☐ Parish council<br>☐ Town council<br>☐ Non-departmental public body<br>☐ Police authority | ☐ Fire Brigade<br>☐ Health Authority<br>☐ NHS Trust - Foundation<br>☐ NHS Trust - Other<br>☐ Other |
| **School** | ☐ State school<br>☐ Community school<br>☐ Foundation or Trust school<br>☐ Voluntary-aided school | ☐ Voluntary controlled school<br>☐ Academy<br>☐ City Technology College |
| **Other** | ☐ Individual<br>☐ Sole trader<br>☐ Parochial Church Council<br>☐ Church-based faith organisation<br>☐ Non-charitable unincorporated organisation | ☐ Further or higher education<br>☐ Independent school<br>☐ University<br>☐ Partnership<br>☐ Other |

Give any reference or registration numbers you have.

Charity Commission for England and Wales

Charity Commission for Northern Ireland

Office of the Scottish Charity Regulator

Companies House

Financial Conduct Authority

Health Authority Number

School reference number

Other reference number (please specify)

You must send us a copy of your governing document if you are:

- an unincorporated association and
- not registered with the Charity Commission and
- your constitution has changed if you have sent it to us previously.

## 7.7 When was your organisation set up?

Give the date when your organisation adopted its current legal status (dd/mm/yyyy). 01/04/2013

## 7.8 What is your VAT status?

- (●) VAT registered
- ( ) Not VAT registered

If you are VAT registered, what is your VAT number?

GB189594982

## 7.9 Is your organisation independent, or a branch or department of a larger organisation?

◉ Independent

○ Branch or department

If you are a branch or department, what is the name and address of the larger organisation?

Name

Not applicable

Address

Not applicable

Postcode Not applicable

## 7.10 How many people are on the board or committee that runs your organisation?

Nine (9)

## 7.11 Are there any restrictions on who can join your organisation?

Yes ◉ No ○

If yes, what restrictions are they and why do you have them?

- If your organisation has a membership we expect this to be open to all and that anyone can join, unless you can provide a good reason why not.
- We will usually consider proposing and seconding to be unacceptable and we expect there to be the right of appeal for anyone refused membership.

You can write up to 400 characters with spaces (about 50 words).

Membership of the City Council is via election and is regulated through the Representation of the People Act and all associated legislation and statutory guidance. Southampton City Council operates a Leader with Cabinet model of Governance. The Leader is appointed annually by full Council and appoints his Cabinet Members, and allocates their respective portfolios.

## 7.12 What is your organisation's current financial position?

Select one option and fill in the amounts from your accounts or projection.

- (●) Information from the latest accounts approved by your organisation
- ( ) 12 month projection because you've been running less than 15 months

| | |
|---|---|
| Accounting year ending (dd/mm/yyyy): | 31/03/2013 |
| Total income for the year: | £ 681,293k |
| Total expenditure for the year: | £ 745,752k |
| Surplus or deficit at the yearend: | £ 64,459k (deficit - before adjustments) |
| Total savings or reserves at the yearend: | £ 75 778k (Earmarked - £45,855k, Gen Fund £29,923k) |

Where can we find your latest accounts?

- ( ) BIG already has our latest accounts.
- ( ) We're attaching our accounts to this form, or a projection if we've been running less than 15 months.

Have your accounts been independently audited?

(●) Yes ( ) No

If yes, what is the name and address of your auditor?

Name

Ernst and Young LLP

Address

Wessex House
19 Threefield Lane
Southampton

Postcode SO14 3QB

## 7.13 Who should we contact if we have questions about your application?

They must be someone who runs or works for your organisation. We need their date of birth and home address for our standard fraud prevention checks.

| Title | Forenames | Surname |
|---|---|---|
| Mr | Timothy Robert John | Davis |

Date of birth: 23/06/1970

Job title or position: Senior Commissioner - Healthy Lives

**Home address**

Flat number: Ground Floor

Building number: 193

Building name:

Street: Millbrook Road East

Town or city: Southampton

Postcode: SO15 1HS

Day time phone: 023 8083 3738

Evening phone: 023 8184 9870

Mobile phone: 07709 292428

Email address*: tim.davis@southampton.gov.uk

*This email address should be the one they use for your organisation. We'll use this whenever we get in touch about your project.

Have they lived at this address for the last three years?

○ Yes ◉ No

If no, give their previous home address:

| | |
|---|---|
| Flat number | |
| Building number | |
| Building name | Little Acre |
| Street | Bighton Lane |
| Town or city | Alresford |
| Postcode | SO24 9SW |

Tell us about any particular communication needs your main contact has. This might include textphone, sign language, large print, audiotape, Braille or a community language.

No particular communication needs.

What address should we use for any correspondence?

Write 'As above' if this is the same as the organisation's registered address.

| | |
|---|---|
| Flat number | N/A |
| Building number | |
| Building name | Southampton Civic Centre, Public Health, Lower Ground Floor |
| Street | Civic Centre Road |
| Town or city | Southampton |
| Postcode | SO14 7LY |

☐ We'd like to send you information about Big Lottery Fund and other Lottery good causes. Tick this box if you don't want to receive this information.

☐ We'd like you to help us improve our customer service by taking part in market research, surveys or product testing. This may involve passing your details to other organisations who do this work for us. Tick this box if you don't want to take part in these activities.

## 7.14 Who in your organisation will be legally responsible for the funding?

- For companies they should be a director or the company secretary.
- For schools they should be your head teacher.
- For local authorities and health bodies they should be your chief executive or a director.
- For town, parish or community councils they should be the clerk to the council (or office bearer).
- For all other types of organisations they should your chair, vice chair or treasurer.

They must be over 18 years old and can't be same the person we should contact if we have questions about your application. We need their date of birth and home address for our standard fraud prevention checks.

| Title | Forenames | Surname |
|---|---|---|
| Dr | Andrew | Mortimore |

Date of birth: 12/11/1953

Job title or position: Director of Public Health

**Home address**

Flat number:

Building number: 55

Building name:

Street: Belmont Road, Portswood

Town or city: Southampton

Postcode: SO17 2GD

Day time phone: 023 8083 3204

Evening phone: 023 8058 2018

Mobile phone: 07593 838994

Email address*: andrew.mortimore@southampton.gov.uk

*This email address should be the one they use for your organisation. We'll use this whenever we get in touch about your project.Home address

Have they lived at this address for the last three years?

◉ Yes ○ No

If no, give their previous home address:

| | |
|---|---|
| Flat number | |
| Building number | |
| Building name | |
| Street | |
| Town or city | |
| Postcode | |

Tell us about any particular communication needs your main contact has. This might include textphone, sign language, large print, audiotape, Braille or a community language.

No particular communication needs.

## Declaration

Check the box to confirm that:

- the information you have given is accurate and true
- your application has been authorised by the governing body of your organisation
- your organisation has the legal power to deliver the project you have described in this form
- you understand that if you make misleading statements or withhold information at any point, your application will be invalid and you will be liable to repay any money you have received
- you will be able to meet our Standard Terms and Conditions of grant, which are available on our website
- you agree we may use the information you have provided for the purposes described under Data Protection below
- you accept that if information about this application is requested under the Freedom of Information Act we will release it in line with our Freedom of Information Policy.

I agree

| Title | Forenames | Surname |
|---|---|---|
| Mr | Timothy Robert John | Davis |

## Data protection

The information you provide will be held and used by the Big Lottery Fund in accordance with the Data Protection Act 1998.

We will use the information you give us during assessment and during the life of your grant (if awarded) to administer and analyse grants and for our own research purposes. We may give copies of all or some of this information to individuals and organisations we consult when assessing applications, administering the programme, monitoring grants and evaluating funding processes and impacts. These organisations may include accountants, external evaluators and other organisations or groups involved in delivering the project.

We may share information with organisations and individuals with a legitimate interest in Lottery applications and grants or specific funding programmes. We have a duty to protect public funds and for that reason we may also share information with other Lottery distributors, government departments, organisations providing matched funding or for the prevention and detection of crime.

Your information may be transferred to an IT service provider based outside the European Economic Area (EEA). If your information is transferred outside the EEA, we will ensure it is sufficiently protected.

We might use personal information provided by you in order to conduct appropriate identity checks. Personal information that you provide may be disclosed to a credit reference or fraud prevention agency, which may keep a record of that information.

If you provide false or inaccurate information in your application or at any point in the life of any funding we award you and fraud is identified, we will provide details to fraud prevention agencies, to prevent fraud and money laundering. You can obtain further details explaining how the information held by fraud prevention agencies may be used from our Customer Services, by emailing dataprotection@biglotteryfund.org.uk or by telephoning our advice line on 0845 4 10 20 30, or by writing to: Customer Services, Big Lottery Fund, 2 St James Gate, Newcastle upon Tyne, NE1 4BE.

We might use the data you provide for research purposes. We recognise the need to maintain the confidentiality of vulnerable groups and their details will not be made public in any way, except as required by law.

## Freedom of Information Act

The Freedom of Information Act 2000 gives members of the public the right to request any information that we hold. This includes information received from third parties, such as, although not limited to grant applicants, grant holders, contractors and people making a complaint.

If information is requested under the Freedom of Information Act we will release it, subject to exemptions; although we may choose to consult with you first. If you think that information you are providing may be exempt from release if requested, you should let us know when you apply.

# Southampton HeadStart Investment Workshop

**Held at:**
Eastpoint Centre

9 January 2014

## Workshop Report

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## 1. Introduction

The Southampton HeadStart workshop was opened with a welcome from Tim Davis, Senior Public Health Commissioner, Integrated Commissioning Unit, Southampton City Council and a welcome from Claire Hodgkins of Big Lottery Fund.

Mia Eisenstadt introduced Reos Partners and their background in facilitating partnerships and community resilience, their role in supporting the development of each of the regional HeadStart partnerships and outlined the following objectives for the workshop:

1. To introduce the HeadStart investment.
2. To support the development of an exciting shared vision for what a HeadStart project could achieve in Southampton
3. To assist with the process of forming a partnership that will combine a suitable range of skills, perspectives and resources to successfully deliver an ambitious and impactful project.
4. To build an understanding of the existing assets and resources in the area that may be relevant to the development and delivery of the HeadStart project.
5. To identify next steps and any specific needs the partnership has to move forward in a productive manner.

After a run through of the agenda, and introductions of all the workshop participants, Claire Hodgkins from Big Lottery gave a presentation on the HeadStart investment (a copy of the presentation is included in the appendix).

## 2. Cynics and believers exercise

In order to surface the key hopes and concerns in relation to the HeadStart investment, participants were invited into a role-playing exercise – for half the room to play the role of 'cynics' and the other half to play the role of 'believers' – addressing the question of whether the Big Lottery HeadStart investment has the potential to create a step change in young people's wellbeing in the area over the next five years.

**Cynics**

- If you start with 9-10 year olds it's too late to intervene.
- What can you change in 1 year?
- Different agencies have different agendas.
- There will be squabbling over cash.
- This will function to replace the disinvestment in services.
- Young people have been let down by adults again and again.
- This may generate false hopes if we don't get the money.
- Some things that need to change are too big for a project like this to change such as unemployment.
- Year 6 in primary are looked after and then at year 7 kids end up wandering the streets whilst parents are at work.
- We don't have sufficient capacity therefore 500K over one year is not enough.
- We don't have a lot of youth services left due to cuts and "efficiencies".
- We need to build our own resilience in order to build the resilience of others.
- There has been a loss of good will amongst children and young people professionals over the past few years.
- People become concerned about their own organisations and due to insufficient funds try to destroy others.
- Tier 2 work is no longer commissioned and this is the biggest gap.
- There has been the loss of health schools teams who would otherwise have been supported.
- Are we going to add to the burden of professionals and services?
- The big money will go to the areas with the perceived greatest need, not necessarily the greatest need.
- There is a backlash already – need careful communications.
- Tried it all before.
- In estate today which has had most investment but not had an impact?
- What about outcomes?
- How do we keep pace with digital technology? Do we have the expertise in the room?
- Different ideas on how you spend money.
- Money skews priorities.
- There won't be time to meaningfully engage with young people.

- We will have our own project ideas and then take the young people along with them (rather than letting them decide).
- We will miss the opportunity when it comes to actually spending the money.

**Believers**

- We can engage children and young people by using technology for example Survey Monkey to get a quick picture to find out young people's perspectives on spending the money.
- We have achieved great things in Southampton.
- Interesting opportunity to transfer people downstream.
- Even if no money, we all gain from multi-agency working.
- Early intervention works.
- Lower level is a top priority.
- We have a good children's workforce – we need to capacity build the workforce to move forward the children's emotional well being agenda.
- Schools have better access at a lower level.
- Six years worth of funding, normally only 3, positive thing.
- We know what works and quick things to improve young people's mental health.
- Southampton has particular issues, it is misunderstood as being rich.
- The size of Southampton makes it a do-able project. School sectors are good at working together. There are structures that help them work together.
- There is the opportunity to take some risks or a leap of faith.
- You can't change society but you can help people cope with society.
- There are two big universities with good experience of evaluation.
- Young people are crying out for help – we have a duty to help them.
- As part of our training for people in universities – training should involve teaching on attachment, attachment theory and emotional well-being.
- We have a solid foundation.
- Southampton trained 400 people over four years in emotional well being in primary and secondary. More young teachers enables the spread of ideas.
- Loads of programs piloted, not just schools, need to work with parents and communities.
- Most commissioning focuses on high risk rather than doing wider areas or more of a community approach.
- Great FE (Further Education) provision.
- Southampton. Some strands have achieved good things; this funding could tie it all together.
- We've got evidence of what's missing.
- No Limits have worked out that one third of young people who need it don't have access to counselling. We know the evidence, just need to join them up.
- Good opportunity for self-referral of young people themselves and to have a qualified CAMHS person work with them.

## 3. Community Asset Mapping

The objective of the Community Asset Mapping exercise was to increase shared understanding between the participants of the assets available to support young people's well-being and resilience that could potentially be relevant for the HeadStart project in Southampton.

An asset was defined as "any factor (or resource), which enhances the ability of young people to maintain and sustain health and well-being – at the individual, family or community level". The range of assets considered included:

- Institutions & organisations
- People, partnerships & skills
- Community & physical
- Initiatives, programmes & policy

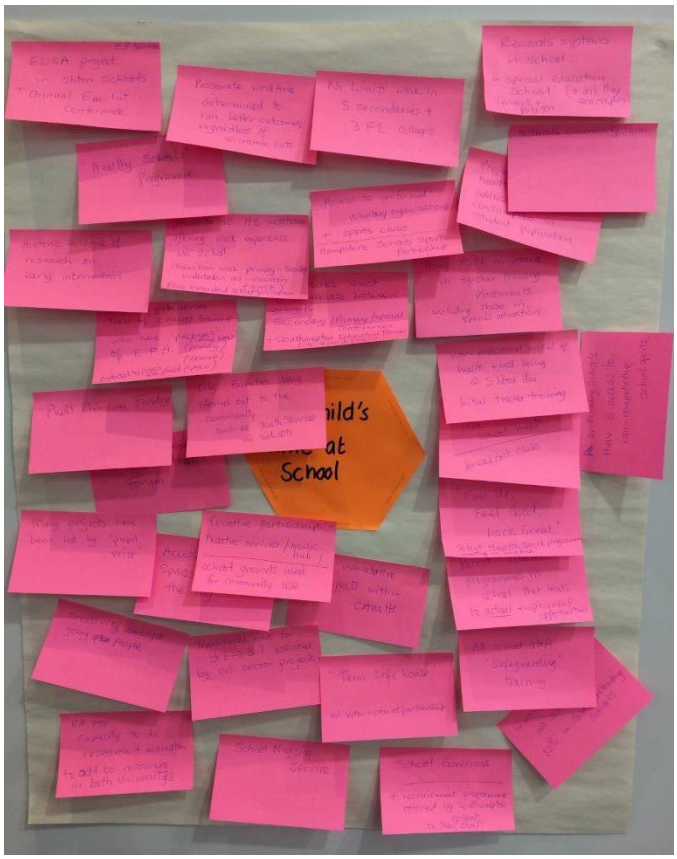
Groups were formed around four different tables to consider assets around the themes of:

1. a child's time in school
2. their ability to access the community services they need
3. their home life and relationship with family members
4. their interaction with digital technology

After generating ideas on one of these themes at each table, participants were asked to move to another table to cross-fertilise ideas and build on the theme.

**A child's time and experiences at school**

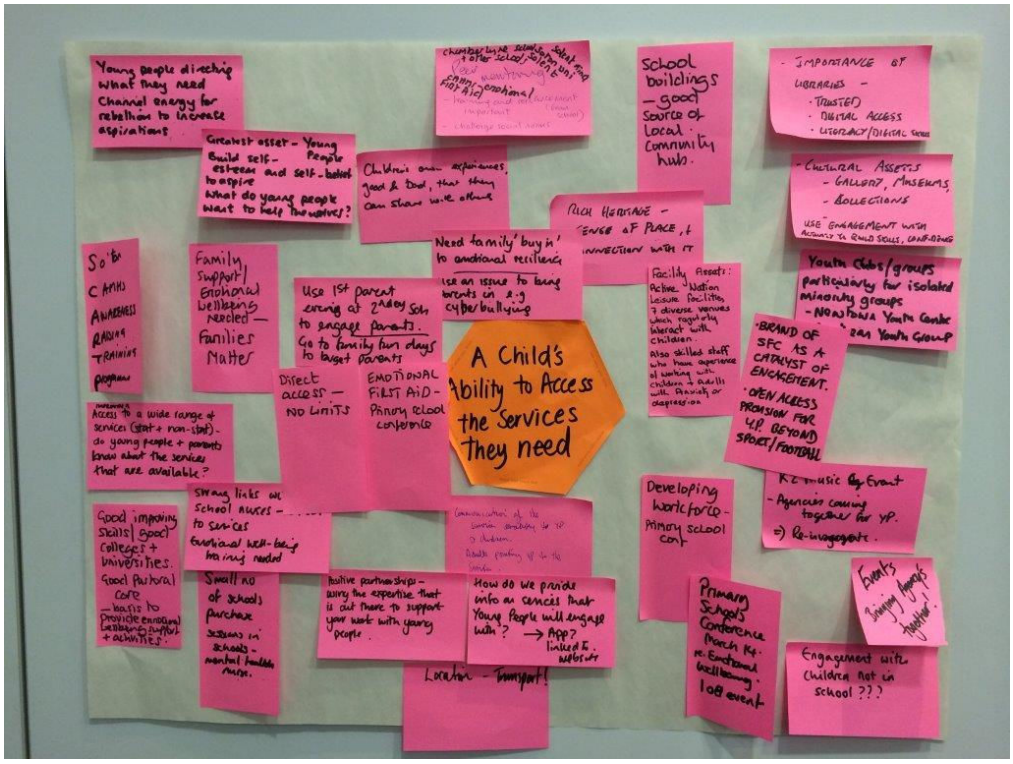
**Assets**




- All school staff "safeguarding" training
- Team safe house voluntary sector plus CAMHS (Child and Adolescent Mental Health Services) plus partnership
- Transitional work for yr 6 and yr 7 assisted by voluntary sector projects
- School nursing service
- School governors
- Recruitment programme offered by Southampton Solent to their staff
- Improving picture for all schools 82% in good/outstanding schools
- Educational psychology capacity to do research and evaluation to add to resources in both Universities
- Creativity in young people
- Small innovative projects within CAMHS
- Creative partnerships! Theatre services/music hub/ school grounds used for community use
- Parent volunteer programs in school that leads to actual employment opportunities
- Open spaces within the city
- Many projects have been led by pupil voice
- Secondary School Mental Health Forum
- Fuel Up, Feel Good, Look Great Solent Health Spark program, investing in the workforce.
- City facilities being offered out to the community such as youth services in schools
- Structures exist to collaborate between schools
- Secondary/primary/special conferences
- Southampton Education Forum
- Pupil Premium Funding
- Needs led, youth advised team of CAMHS trainers who have packages (learning disabilities, primary, parents, peer) of EFA (Emotional First Aid) endorsed by Oasis Mayfield
- Students at HE (Higher Education) institutions offering work experience in schools (transition work primary – secondary undertaken as innovative project) plus extended school provision
- Free school meals, breakfast clubs
- Healthy schools program
- Passionate workforce determined to run better outcomes regardless of economic cost
- In primary schools there is access to non-competitive school sports
- Project in sexual health clinics to help address alcohol consumption in student population

- Reward systems in school – special education school Vermont and Polygon
- Historic evidence of research on early intervention
- ELSA project in Southampton Schools and annual Emotional Literacy conference
- Nurture Groups in Southampton schools
- Access to uniformed voluntary organisations and sports clubs
- Hampshire School Sports Partnership
- No Limits work in 8 secondary's and 3 FE colleges
- Inter-professional model of health and well being at Southampton University – Initial teach training
- Using PSHE (Personal, Social and Health Education) competence in teacher training placements including those in special education

**A child's ability to access the community services they need**




**Assets**

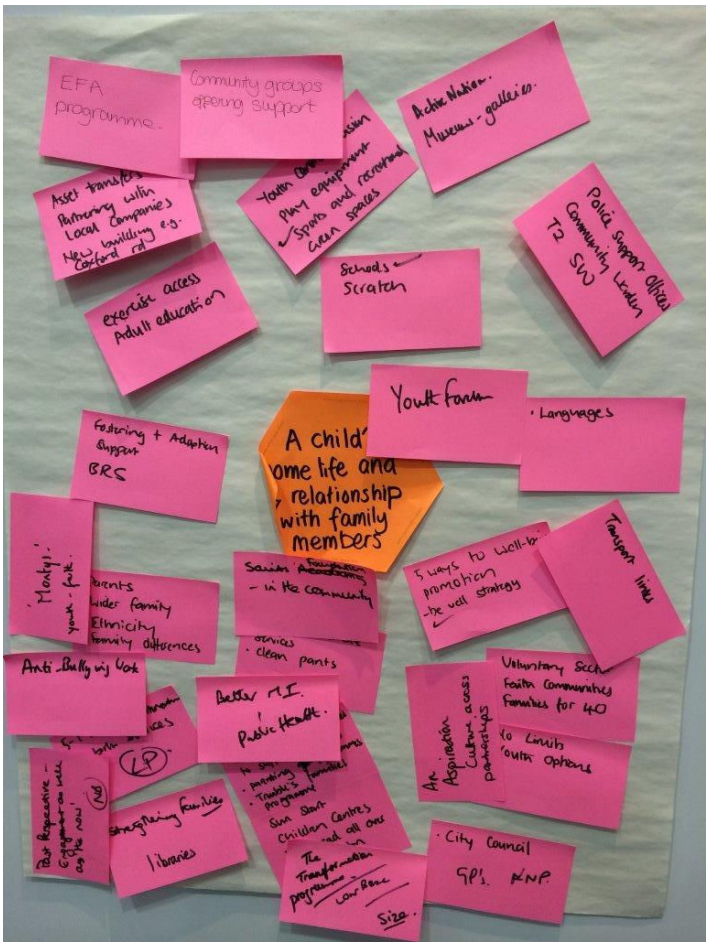
- Family support emotional well being needed, families matter
- School buildings – good source of local community hub
- Brand of Southampton Football Club as a catalyst of engagement
- Open access provision for young people beyond sport and football
- Children's own experiences good and bad, that they can share with others
- Young people are their own greatest asset, build self-esteem and self belief, aspire, what do young people want or need to help themselves?

- Young people directing what they need
- Use 1st parent evening at secondary school to engage parents, go to family fun days to target parent
- Improving access to a wide range of services (statutory and non-statutory do young people and parents know about the services that are available?
- Youth clubs and groups for isolated groups e.g. Newtown Youth centre, Caribbean Youth group
- Galleries, museums, collections – use engagement with activity to build skills and confidence
- Emotional first aid – primary school conference
- Libraries for safe space, digital access, literacy/digital skills
- Rich heritage – Southampton has a sense of place and many feel connection with it
- Facilities assets: Active Nation leisure facilities, 7 diverse venues which regularly interact with children, also skilled staff who have experience of working with children and adults with anxiety or depression.
- Communication of the service to young people and children. Adults pointing YP to the service
- Good transport links
- Positive partnerships – using the expertise that is out there to support work with young people
- Small number of schools purchase sessions in schools with a mental health nurse.
- Need family "buy-in" to emotional resilience, use an issue to bring parents e.g. cyber bulling
- Millbrook community team
- Strong links with school nurses
- Direct access – no limits
- Good improving skills/ good colleges and universities, good pastoral care – basis to provide emotional well being and support
- Peer mentoring
- Life Lab services linked to career development to help young people into jobs
- Events bringing agencies together!
- Developing workforce
- Primary schools conference March 14 re Emotional Well being, one off event
- How do we provide info on services that young people will engage with? App? Link to website

Comments:
How do we engage with children not in school?

**A child's home life and relationship with family members**

**Assets**

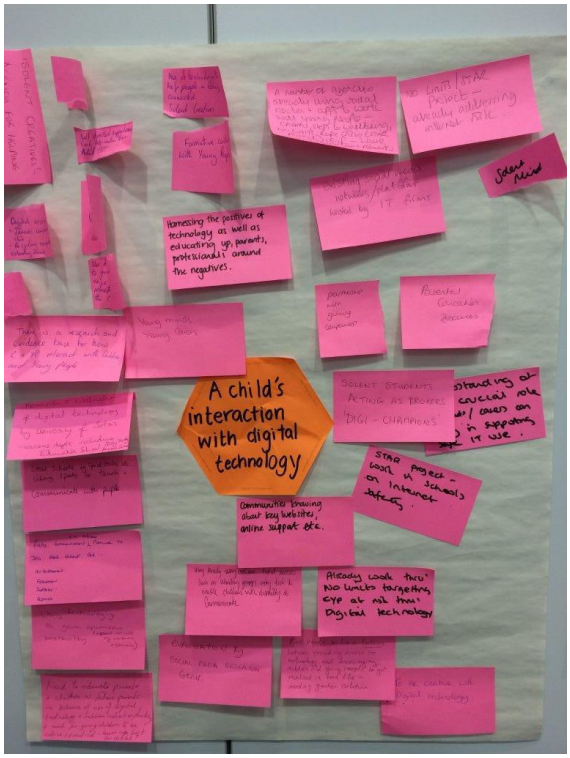



- Fostering and adoption support, BRS (Behaviour Resource Service)
- Addressing childhood obesity through the family, school nurses etc
- Anti-bullying 5-19 early intervention pre birth services
- Monty's – youth faith
- Saints Foundation in the community
- Children's Social Care Services: Clean Pants
- Community programs to support families
- Parenting programs
- Troubled Families programme (Families Matter)
- Sure Start children's centres widespread over Southampton
- An aspiration culture across partnerships
- Voluntary sector
- Faith communities
- Families for 40
- No Limits
- Youth Options
- Libraries
- City council
- GP Practices
- FNP (Family Nurse Partnerships)
- The People Directorate Transformation Programme
- Low Base
- Size of City and co-terminous boundaries supports partnership working
- Youth Forum
- Adult education
- Access to exercise
- Transport links
- Five ways to well being promotion
- Be well strategy
- Community Asset transfers
- Partnering with local companies e.g. new buildings on the Oxford road
- EFA (Emotional First Aid) programs and resources created and developed in Southampton

- Community groups
- Schools
- Active Nation
- Museums and galleries
- Police support officers
- Community warden T2 SW
- Extended family, parents, ethnic community
- Languages
- Youth centre provision
- Play equipment, sports and recreational, green spaces

**A child's interaction with digital technology**

**Assets**




- Local schools using Ipads to teach and communicate with pupils
- Rapid communication IT method failure to this age group for: information, education, support, advice.
- There is a research and evidence base for how children and young people interact with children and young people through digital technology
- Communities knowing about key websites, online support etc
- Already work through No Limits targeting children and young people at risk through digital technology.
- Websites specifically related to information for young people
- Harnessing the positives of technology as well as educating young people, parents, professionals around the negatives.
- Evaluation by social media research group
- Young minds, young carers
- Digital access e.g. Jamie's computer club, recycling computers through extending access.
- Use of electronic voting to quickly engage children and young peoples voice- we have an infrastructure for hearing this voice.
- Star project – work in schools on internet safety
- Needs to be a balance between use of technology and encouraging young people to get out and experience real life and avoiding greater isolation.
- To be creative with digital technology
- Solent Creatives – an agency for helping delivery using students
- Self directed support resource, early intervention team, adult cvt

- Research and evaluation of digital technology by University of Southampton- various departments including Education School/ Lucy Yardly, Marcus Grace
- Potential partnership with gaming companies
- Solent students acting as brokers, "digi-champions"
- Existing social media networks and platforms hosted by IT firms
- No limits/STAR project already addressing internet
- Use of technology to help people in being connected
- Southampton CAMHS awareness training program
- A number of agencies are already using social media and apps to work with young people- CAMHS, steps to well being, no limits, rape crisis (star project), EIP Lowe, there is local expertise and networks
- Access to VLE (virtual learning environment)
- Parental education resources
- Solent Mind
- Solent University "Digi Champions"

**Additional points and interconnections:**

- Parents need to be developed and used as "gatekeepers" in appropriate use of digital tech
- Parents and carers are crucial in supporting safe IT use
- There are gender differences in the use of technology
- Young people take up new technology quicker than older generations
- Could create an app with all the services for young people and mental health
- Tech needs to have a local slant
- The problem isn't with the technology its how it is used.

## 4. Big Ideas brainstorming


The purpose of this session was for participants to share their individual and joint ideas for impacting the lives of ten to fourteen year olds in the region in the HeadStart project.

In small groups at a number of tables, participants were asked to brainstorm ideas for difference they wanted to make to the lives of young people through the HeadStart investment. These ideas were written on to post-it notes.

A representative from each table then read out the ideas from that table and these were posted on to the wall.

Volunteers then clustered the ideas into different thematic areas and gave a name to each cluster.

Finally participants indicated with a single dot which cluster they felt had most potential. The themes are ranked in order of the number of dots they received. It was emphasised was that the purpose of the voting was to give a sense of the energy and interest of all attendees present, not to narrow down the list of ideas as a broad range of ideas are welcome for this first stage.

**1. Aspirations and Outcomes (10 votes)**

- A confident, competent, resilient, inspirational children and children's workforce.
- The City to have a view about the value of young people (not just an economic one).
- Well nourished and fit.
- Shift from negative leadership to positive leadership.
- Equips our children with realistic expectations of success and happiness and failure and sadness.
- Sense of worth and inclusion.
- Every young person has a part to play and a talent and a skill.
- Our young people have higher aspirations.
- Young people have opportunities to get work.
- Aspiration schemes and mentoring.
- For every child: pathways, strategies, and activities.
- Every child has aspiration, hope and ambition.
- To achieve economic well-being.
- Children to be happy: broad range of leisure and educational opportunities.
- Every young person to understand their own mental health and well being.
- All young people and children feel safe.

**2. EFA (Emotional First Aid) (7 votes)**

- Every young person completing an EFA program and parents and staff.
- EFA- All children and families including out of school and foster carers.
- Emotional well being to be embedded as a bigger component of the school curriculum.
- EFA is a part of every young person and participant's tool kit.
- In built resilience
- The tool kit to enable a young person to flourish.
- Young people do not feel cut adrift when they leave school, they have other communities/support.
- Non-school attendees/NEETS also need to access activities and services.
- Children who can feel empathy.

**3. Schools/Universal (4 votes)**

- Baseline wellbeing training for all adults about working with children
- Sport Solent work with home educated children
- Every young person is part of a positively looking peer group- interdependence and support
- Universal offer of activities capturing the best of things like The Princes Trust and the Saints Foundation.
- Universal provision
- Young people who are emotionally healthy and happy in their own skin
- Thriving PSHE program in the city (supporting well being)
- A controlled environment that resonates with the individual e.g. art, sport, gardening, theatre available.
- Given the choice to decide what they want/need in an controlled environment
- Implementation of school based evidence based whole school interventions that improve well being such as Friends for Life, CBT program or Dot B mindfulness program.
- Using an activity- not aware of what underlying learning is to make activities that combine emotional resilience and some activity like team games/orienteering attractive to young people e.g. Instagram photos from away days and promote interest amongst peers
- To raise educational aspirations more evenly amongst young people

**4. Families (3 votes)**

- All young people will have their own resources to cope with life's stresses- be part of community, know where to get help, feel confident to get help.
- Programs to equip parents with either skills or advocacy so that they have the confidence to deal with the support their children need.
- Support for families where they are worried about their children.
- Families skilled who are able to support children and young people's development and are supported themselves.
- Parents and schools working closer together in order to build resilience.
- Parent-child shared activities.

5. **Anti-Stigma (2 dots)**

- Measuring well-being across schools.
- Building rounded individuals not just a focus on educational attainment.
- A range of pathways to a variety of strategies.
- Young people not feeling ashamed if they do have a problem, including a MH problem.
- Greater awareness in society of mental health-combating stigma and discrimination.
- Engaging young women in activities
- Anti-stigma work

6. **Monitoring and Evaluation (1 vote)**

- Duke of Edinburgh approach "reflective journey", children and young people to evidence own path.
- Determine how to measure impact/degrees of success.
- Assess development of individuals/groups at different points in time via self-reflection.

7. **Services (1 vote)**

- Intervention with young mums earlier.
- No limits type service everyday in every school.
- Encouraging pride and engagement e.g. Rhinos.
- Access to independent information, advice and support.
- Break the cycle.

8. **Targeted CAMHS and Tier 2**

- An appropriately trained counsellor in every school.
- Less children being medicated for mental health issues.
- All children will be taught by a teacher who can identify and deal with emotional distress/low level MH and would know who to refer them to.
- Improved outcomes from school, not at the expense of well-being.
- Significantly lower levels of acute CAMHS and AMH (Adult Mental Health) issues amongst 14-21 year group.
- Anxiety clinics in every school.
- Strengthened CAMHS to enable a quicker response to need.
- Peer mentoring programs in every school.

9. **Digital Technology**

- Confidence, access to information, advice, guidance, support and to act on advice.
- Trial a number of different approaches involving children and young people and evaluate their impact.
- Self-access to services (confidence in those services).

- Digital communication to enable access and knowledge.
- Children and young people to be safe and to be shielded from the dangers of the Internet and social media (e.g. bullying etc).
- Every young person to know of the services on offer to them and how to access those services.
- The digital environment is seen more as a place of support and resources that can help rather than a source of distress and pain by both children and adults.

**10. Communication**

- Better multi-agency working through knowledge transfer and tweaking of own priorities for common good.
- Clearer lines of communications to services to support well-being
- Preventative support to prevent escalation of issues at all levels.
- Easy access to more targeted support.
- Fleet of foot, easy to access resources for projects from a range of providers at a range of scales. that can put in place activities and assets quickly e.g. simple grants based approach for some projects.
- Duplication and choice issues.
- Children and young people know where to go for advice and support.

## 5. Project planning

The final part of the workshop involved discussing the next steps to successfully meet the Jan 17th stage one application submission date and further development of the project ideas.

### 5.1. Key tasks


1. Those we look to fund should show how they are involving young people in demonstrating that their service proposition meets a need among young people.
2. Ensure that we specifically consider the needs of certain groups of children and young people potentially more exposed to difficult and challenging emotional circumstances, including, but not necessarily limited to: young carers, children looked after (CiC Council), home educated children, PRU and excluded children, children with disabilities, other 10-14 year olds resident in Southampton, but not at Southampton schools?
3. We should aim to be able to hit the ground running with approved programmes as soon as the funding is approved (June/July). This will mean getting ourselves organised in terms of people putting in bids for activities that can be considered pending release of the funds so we are absolutely ready to go, not waiting for this clearance before we start this evaluation process. This will require us to get Cabinet permission to establish delegated authority to award grant awards under the programme through an officer rather than through members - though we can build

regular reports to Cabinet Member and Scrutiny on what has been approved by way of safeguards.

4. Carry out a quick mapping exercise on the "tools" that are used by front line practitioners already in the City in relation to children and young peoples mental and emotional health - this can be done through correspondence starting soon, though you will need project management support to collate it (skilled business support or more senior support.
5. We should consider those who will be managing the project receiving some professional training in CAMHS / EFA / etc. and professional observation so they can benefit from carrying out some practice based observation of the environments in which the target age range experience services from day to day. This will improve their own practice and judgement in evaluating impact and performance.
6. We should consider modelling the division of the total resource between all young people in the age range with a view to trialling something like a personal budget approach for spending on "approved" activities and support. (Talk to Matt Harrison re parallels with the Short Breaks commissioning, and others about other parallels.)
7. We should consider some specific targeted programmes in relation to specific groups - e.g. Year 6 in run up to SATs year and transition to 2ndry school, Year 7s in relation to supported transition to secondary school, particularly if they are not accompanying peers.
8. Identify stakeholders and networks / organisations who can offer instant or very quick access to youth opinion.
9. Develop a supported proposal for a youth consultation structure to facilitate young people's voice on this programme (and maybe others) - and also a mapping exercise on what remains in respect of consultative forums for dialogue between services and children and young people.
10. Identify, scope ToR and create a core Project Overview Group and governance structure to provide overview and capacity to do the work commissioned through the programme, and the monitoring etc.
11. Develop and articulate a communications strategy for the programme and the governance arrangement - including getting information and dialogue going with service users and representative groups of children and young people.
12. Develop an engagement model that is demonstrably genuine, and inclusive in its involvement of a diverse range of CYP from across the City to avoid risk of "tokenistic" involvement or consultation.
13. Genuinely inclusive of the Voluntary Sector at both a strategic and provider level to ensure the contribution of this sector is maximised and not lost.
14. Ensure that we share and then extend to initial "map" of the services and assets available in the City to capture recognition of all those who can add value - youth support, vulnerable group specialist support etc.
15. Project leadership and planning should be inclusive and specifically representative of schools (primary, secondary and special (and FE))
16. When commissioning activities we should have a view as to how we expect the programme to be delivered, and its intended effects on complementary Southampton provision already in place. We should also be mindful of the potential of the programme resource to have a perverse impact upon existing provision and commissioning of these services in the City in thinking about what we see as success criteria. i.e. in thinking about success criteria we should try to minimise disruption of things already working well. Think Win Win.
17. In governance terms we need to secure buy in from all key partners, and key players within key partners.
18. We need to be inclusive of what the two universities, EPs and others with the relevant skills and

knowledge to offer qualitative evaluation of the programme and its different elements.

19. We also need to be open to the chance of things not working, but to trying them if there is a reason to think that they might - don't strangle innovations by looking to totally eliminate risk in what we expect from those putting forward ideas. Big Lottery want the national programme to be bold and experimental. We should make some specific allowance for more speculative innovations with less evidence - think about the example of the Solent University initiative - £8k investment has led to major opportunity for programme - ref Prof Longmore for details. This can show commitment to innovation and encourage further genuine creativity from the front line.
20. The programme should be inclusive of the widespread excellent work from the non statutory service providers in the City.
21. The project needs to be significantly built with children and young people, including interactive and face to face work.
22. We need to build what we want to do on some of the foundations of what we have in terms of services and assets - this should give faster access to a rough model.
23. The ongoing development of the programme should include technical input from CAMHS / BRS / EFA and other specialists in the field in Southampton
24. We need to ensure that the Southampton programme is also distinctive so we maximise our chances of making it to the extended 6 year programme.
25. We need to ensure that an early priority is a mapping exercise to fully capture our services, assets, needs and strengths, to get a really good sense of both the opportunity from the 1 year, and also from the longer programme.

**Other suggested considerations for the Southampton Partnership in its next steps**

To deliver a local framework with the flexibility and fleetness of foot we need we are looking at a commissioning framework in our overall use of resources that:

1. Incorporates the development of a specific / dedicated grants programme into which schools, and community and voluntary groups could bid with ideas for specific programmes and activities that they would like to make available as part of a response to service interventions and support that would be of use to Children aged 10-14 with MH problems at different levels.
2. Investing in some specific additional capacity that we might anticipate in year 1 through a variation of our S76 contract with Solent for more specialist CAMHS in anticipation of higher levels of input and treatment for 10-14 year olds.
3. Investing in some significant expansion of Emotional First Aid as a cornerstone of our Children's workforce development when seeking to improve the ability of front line professionals to identify, hold, support, respond to, and where necessary escalate for more specialist support correctly children and young people who most need it. Current shop window costs for Intensive EFA 5 day course are £1700 per delegate. We may be able to negotiate something preferential to that for a bulk order that guaranteed their trainers for the next year to support levels of EFA practitioner in schools and other settings at levels we aspire to in the City – Teacher / ELSA / SENCo / Pastoral lead / Social Worker / GPs / School Nurses and others to be able to support young people much earlier.
4. Investing in some bespoke allocated resource for all schools to use to support their staff in supporting teachers and pastoral support staff in signposting children.
5. Developing online and web resources to provide support and resources for children and young people to self help, and for professionals to be clear about the topography of local services and sources of help for the young people they are working with.

6. developing capacity in some services where preventative capacity to help is overwhelmed by demand – e.g. Bullying
7. Developing our internal capacity to manage and deliver and administer and performance manage the services that we commission through the programme.
8. Don't ignore the research and evidence bases we already have:
   a) on digital interaction, behaviour, implications and experiences of children and young people.
   b) in relation to local programmes already developed such as Emotional First Aid, ELSA programme and Nurture Groups
9. The Southampton partnership would benefit from some formal early review of the work already being done through EFA in Southampton schools. What is its reach? What is it achieving.

**Offers of help and support in developing next Stage Application**

1. No Limits
   a) engaging children and young people who are less resilient and in difficult personal situations to provide input into the project.
   b) provide information for the needs assessment from the consultation in Hampshire that has just closed on Emotional Wellbeing: including feedback from 800 8-19 year olds views.
   c) support in bid writing for the Big Lottery process - No Limits have lots of experience in writing successful bids
2. SVS – to host and facilitate a wider meeting with voluntary sector agencies and organisations to maximise awareness and opportunities for engaging in the success of HeadStart - talk to Phil Lee further.
3. Work with Saints Foundation to explore specific areas of shared interest and cross referral of organisations they can't fund but HeadStart may be able to and vice versa - talk to Jazz Bhatti further.
4. Work with Southampton Solent Uni to benefit from the "Life Journey" reflective practice materials and develop ideas for approaches that can potentially be branded once developed as part of a wider regional or national product of support to underpin long term sustainability of local expertise developed through the programme.
5. Jessica North (Communications, Southampton City Council) has offered to help in both support for the initial applications in a range of ways and in terms of the digital angles.
6. Debbie Chase (Public Health) – Help in developing, proof reading and contributing to further Stage applications.
7. Anne Hendon-John (Schools) – Help in facilitating access to Headteacher Partnership events and meetings in relation to Southampton Headstart Programme.

**5.2. Roles and responsibilities**

Tim Davis explained that the Southampton City Council/Clinical Commissioning Group's Integrated Commissioning Unit is co-ordinating the development of the initial stages of the Southampton HeadStart programme. This will include both the Stage 1 and Stage 2 applications, and the development of the Multi-Agency Partnership arrangements that will ensure that the Southampton HeadStart programme is collaborative and inclusive, and the development of mechanisms for ensuring the systematic engagement with, and involvement of children and young people in the development and ongoing evaluation of the Southampton programme, and the allocation of resources for the development of services under the programme.

Tim Davis confirmed that for the initial stages he will remain the key contact, particularly for the Stage 1 application which needs to have been articulated and submitted by 17 January. As mechanisms for involving young people and partners in the governance and development of the programme start to come online this may change. SCC invited volunteers from the partnership to come forward and lead on different streams to form a working group. This was extended to those at the Partnership, but would be extended once the Stage 1 application is submitted to specifically include representation from children and young people, and particular groups thought to be vulnerable to poor mental health and emotional wellbeing outcomes.

It was mentioned that whilst the day was a rich gathering but there were also people missing for the long term partnership: representatives of youth organisations, people from deprived backgrounds, guides and scouts, faith communities, children and young people, political representation. A participant offers to provide political representation with local political parties.

## 6. Next steps

1. 17 January: deadline for submission of stage one application

2. By 24 January: provide feedback to Stage 1 participants on the content of the Southampton Stage 1 application, and to wider potential partners, including inviting initial thoughts and suggestions on mechanisms for engaging children and young people at a range of levels in the development of the Southampton programme, for example through school councils, the Children in Care Council, Young Carer support networks and through mapping other forums for engaging specific communities of children and young people.

3. By end January: to have confirmed a date for further meeting with representative groups for different sectors to consider terms of reference for the Southampton HeadStart Partnership, and have developed an outline Communications Plan for the Stage 2 application process and the development of a year 1 programme based on what young people want and need, including of our key local partners.

4. By 7 February: formal confirmation by Big Lottery of their assessment of the Southampton Stage 1 application, clearing way for:
   - Allocation of specific resources from the development funding to confirm a programme of engagement, mapping and involvement to underpin the inclusive development of the Southampton HeadStart Year 1 programme as part of the City's Stage 2 application.
   - Implementation of an outline Communications Plan setting out how partners, children and young people will be involved, and kept informed about, the Southampton programme.

5. Early February: Southampton webinar to check in with the progress of developing the project proposal and report on progress in the formation of the partnership with local partners, Reos and Big Lottery.

6. Early March: second workshop

   - To provide partnerships with the opportunity to 'regroup' in a facilitated setting to consider their next steps in the transition from vision to the development of an initial project.
   - For partners to agree role and responsibilities within the partnership, including agreeing ways of working.
   - For partnerships to consider further their support and development needs to enable successful delivery of their plans and projects.
   - For partners within the emerging local partnership to test some of our initial ideas with children and young people attending the event, and reflect on other messages from children and young people in terms of their sense of priority in relation to the programme.

7. March to April: development of stage two application
   - Responding to feedback and priorities identified and agreed at the March Workshop.
   - Working with partners and volunteers through working groups under the Project Group.
   - Ensuring engagement with all key partners affected by emerging programmes and proposals

as to the implications of these if approved as part of the Year 1 programme.

- Management of regular communications messages to partner and children / young people audiences, in-keeping with the initial Communications Strategy for the programme and online resources relating to the Southampton HeadStart partnership and emerging programme.
- Developing the detailed content of a costed Year 1 Southampton programme, based upon the feedback received from children, young people and partners.
- Developing proposals for commissioning frameworks, grant programmes and other mechanisms that will facilitate the involvement of children and young people in service development, resource allocation with minimal delay in the implementation of approved programmes.

8. Around 10 April: Partnership meeting to consider draft Stage 2 application, and formal sign-off of support for Application and proposed year 1 programme through Council, Partner and partnership forums and decision making processes to confirm in-kind resources, governance and formal accountability for the programme to Big Lottery through democratic process.

9. 17 April: deadline for stage two application.

10. 24 April: communication with partners as to the detail of the Southampton HeadStart year 1 programme set out in the Stage 2 application.

11. End of June: deadline for Big Lottery to have evaluated and considered which aspects of the Southampton Stage 2 application they will approve for implementation.

12. End of July: delivery of the Southampton HeadStart programme starts.

## 7. Contact information

**Southampton partnership coordinator / lead**
For inquiries relating to the Southampton HeadStart partnership, please contact:

Tim Davis
Senior Commissioner – Healthy Lives
Integrated Commissioning Unit
tim.davis@southampton.gov.uk
Tel: 023 8083 3738

**Big Lottery Fund contact**
For enquiries relating to the HeadStart investment process:

Andrew Hitches-Davies
Funding Manager (Investment)
HeadStart Team
andrew.hitches-davies@biglotteryfund.org.uk
Direct line: 0121 345 7870

# Appendix

## 1. Agenda

| | |
|---|---|
| 9.30 | Arrivals and registration |
| 10.00 | Welcome, agenda overview and introductions |
| 10.30 | HeadStart investment funding – introduction to the programme |
| 11.00 | 'Cynics and believers' exercise<br>*A short warm up exercise to surface our assumptions and preconceptions on the potential of this project to create a step change in young people's wellbeing in this area over the next five years* |
| 11.15 | Break |
| 11.30 | Community asset mapping exercise<br>*We will work together to build a shared understanding of different types of assets that can be of use in building young people's wellbeing in the area.* |
| 12.30 | Buffet lunch: *sharing success stories about young people's health and resilience* |
| 1.15 | Paired discussion: *short reflection in pairs on the discussion so far* |
| 1.30 | Big Ideas brainstorming exercise<br>*An exercise to explore our own individual and shared visions and ideas on possible projects to make a difference to the lives of young people in the area. Participants will group similar ideas and prioritise them.* |
| 2.50 | Big Lottery Fund explain the next steps for the HeadStart investment |
| 3.10 | Project planning exercise<br>*The goal of this session is to identify some of the specific, practical actions that need to be completed following the workshop and in the months ahead – and to clarify roles going forward.* |
| 3.45 | Final reflections |
| 4.00 | Close |

## 2. List of workshop participants

| | | |
|---|---|---|
| Ross McClean | Partnerships Manager | Active Nation |
| Carole Binns | Senior Commissioning Lead | Adult Mental Health Southampton CCG |
| Ezra Kanyimo | Senior Practitioner | Behaviour Resource Service |
| Ruth Evans | Headteacher | Cantell School |
| Liz Palmer | GP | Clinical Lead for Families South |
| Sarah Stringer | Public Health Commissioning Manager | NHS England |
| Annabel Hodgson | CEO | No Limits |
| Ian Golding | Headteacher | Oasis Academy Lord's Hill |
| Karen Dawkins | Head of Student Services | Oasis Mayfield |
| Anne Hendon-John | Headteacher | Polygon School |
| Sonia Piper | Senior Nurse | Solent NHS CAMHS Service / Emotional First Aid |
| Barbara Inkson | Head of Business Unit Paediatrics | Solent NHS Trust |
| Jackie Hall | Drug Action Team Manager /Commissioner | Southampton CCG |
| John Richards | Chief Executive | Southampton CCG |
| Tim Davis | Senior Commissioner, Public Health | Southampton CCG |
| Alicia Halton-Nathan | Trainee Educational Psychologist | Southampton City Council |
| Andrew Mortimore | Director of Public Health | Southampton City Council |
| Bryn Roberts | Vulnerable pupils lead | Southampton City Council |
| Chloe Allen | Educational Psychologist | Southampton City Council |
| Cllr Dave Shields | Cabinet Member for Health and Adult Social Care | Southampton City Council |
| David Thorpe | Anti Bullying Lead | Southampton City Council |
| Debbie Chase | Public Health Consultant | Southampton City Council |
| Graham Talbot | Head of Education | Southampton City Council |
| Jessica North | Corporate Communications Specialist, Public Health | Southampton City Council |
| Mike Harris | Head of Leisure and Culture | Southampton City Council |
| Sally Denley | Public Health | Southampton City Council |
| Theresa Leavy | Head of Service, Education | Southampton City Council |
| Jazz Bhatti | Projects Manager, Saints Foundation | Southampton Football Club |
| Mark Abrahams | Head of Saints Foundation | Southampton Football Club |
| Chris Dynn | Health Promotion Manager | Southampton Solent University |
| Paul Davis | Sports Partnerships Manager | Southampton Solent University |
| Professor Jane Longmore | Deputy Vice Chancellor | Southampton Solent University |
| Phil Lee | Deputy Chief Executive | Southampton Voluntary Services |
| Michelle Barry | | Star Project |

| | | |
|---|---|---|
| Matt Sambrook | Headteacher | Townhill Junior School |
| Dr Sue Dewhirst | Research Fellow in Public Health | University of Southampton |
| Barry Smith | Headteacher | Vermont School |

Also attending:

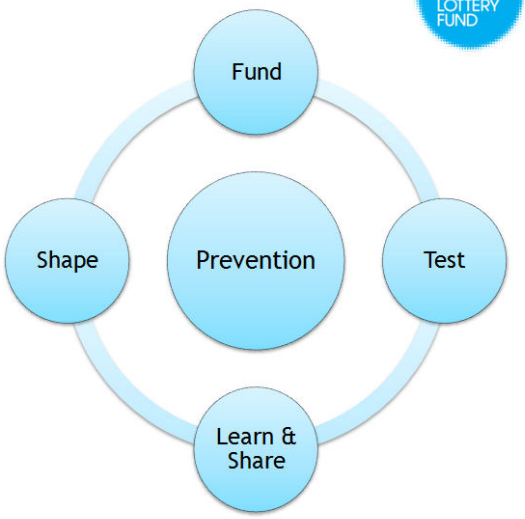
| | | |
|---|---|---|
| Claire Hodgkins | HeadStart Funding Manager | Big Lottery Fund |
| Gemma Bray | HeadStart Funding Officer | Big Lottery Fund |
| Mia Eisenstadt | Partner | Reos Partners |
| Zaid Hassan | Partner | Reos Partners |

## 3. Big Lottery presentation on HeadStart


## Our approach

BIG LOTTERY FUND

- At BIG, we're investing up to a **quarter of a billion pounds** in the wellbeing of children across England
- This presents a unique opportunity to make **not just the social case, but the economic case** for prevention
- We're committed to sharing this learning **beyond our funded areas** so we can achieve impact beyond the initial investments

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## The fundamental facts

BIG LOTTERY FUND


**One in 10 young people** - so three in every classroom - has a clinically diagnosable mental health problem (Young Minds).

**Rates of mental health problems increase during adolescence.** Among teenagers, rates of depression and anxiety have increased by 70% in the past 25 years.

Half of those with a lifetime mental illness first experience symptoms **by the age of 14.**

**Only 25% of young people** needing treatment actually receive it.

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## HeadStart

Our funding is intended to help equip young people to deal better with difficult circumstances in their lives, so as to prevent them experiencing common mental health problems.

This investment has been designed with young people in direct response to the mental health needs of adolescent young people in England

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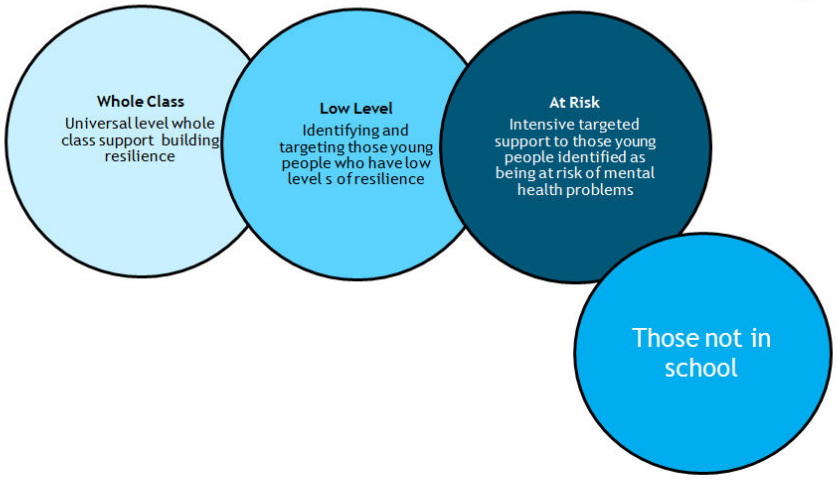
## Beneficiaries

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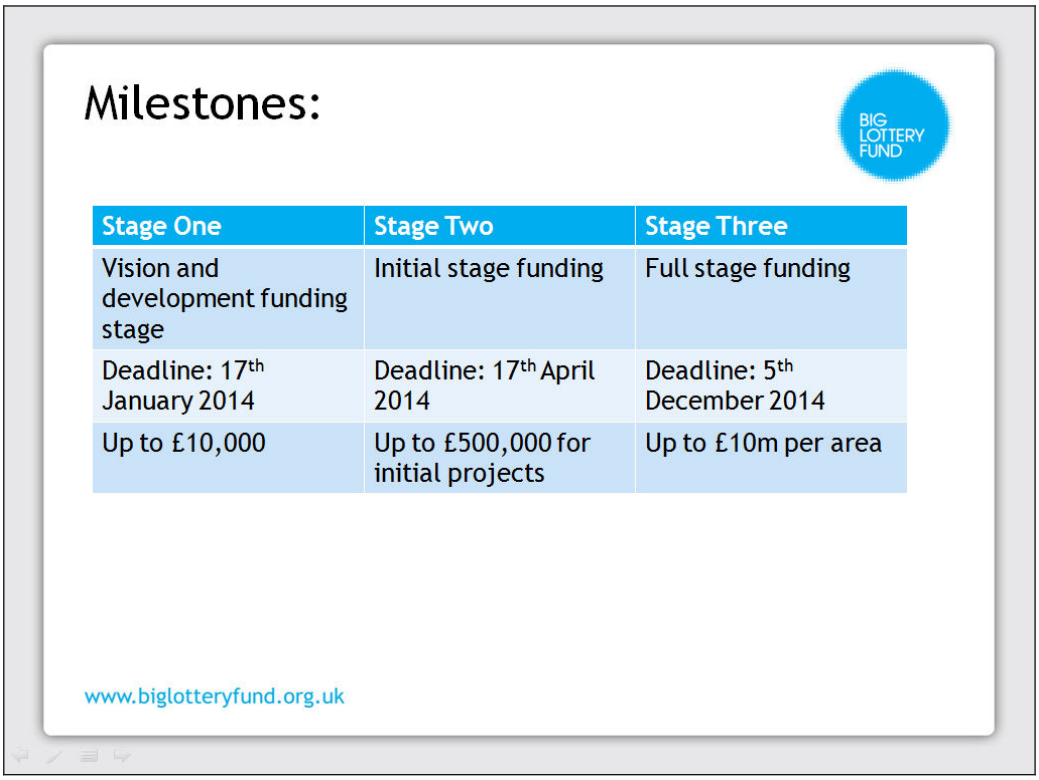
Milestones:
BIG LOTTERY FUND
Stage One
Stage Two
Stage Three
Vision and development funding stage
Initial stage funding
Full stage funding
Deadline: 17th January 2014
Deadline: 17th April 2014
Deadline: 5th December 2014
Up to £10,000
Up to £500,000 for initial projects
Up to £10m per area
www.biglotteryfund.org.uk

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