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Health and Wellbeing Board

Wednesday, 3rd December, 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 Chamberlain

Rob Kurn – Health Watch
Alison Elliott – Director, 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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BACKGROUND AND RELEVANT INFORMATION

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

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

Southampton City Council's Priorities:

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

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

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

Smoking policy – The Council operates a no-smoking policy in all civic buildings.

Mobile Telephones:- Please switch your mobile telephones to silent whilst in the meeting

Use of Social Media:- If, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting

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

Dates of Meetings: Municipal Year 2014/15

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

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED

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

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

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

DISCLOSURE OF INTERESTS

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

DISCLOSABLE PECUNIARY INTERESTS

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

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

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

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

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

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 PECUNIARY INTERESTS

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

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

3 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 1 October 2014 and to deal with any matters arising, attached.

5 HEALTH OVERVIEW AND SCRUTINY PANEL INQUIRY REPORT: THE IMPACT OF HOUSING AND HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE

Report of the Director of Public Health providing details of the Health Overview and Scrutiny Panel (HOSP) Inquiry into the "Impact of Homelessness on the Health of Single People" for information and comment, attached.

6 HEALTH INEQUALITIES IN SOUTHAMPTON

Report of the Director of Public Health providing details of the health inequalities that exist in the City for information and comment.

7 BETTER CARE SOUTHAMPTON UPDATE

Report of the Director of Quality and Integration, Integrated Commissioning Unit providing an update on the progress towards the implementation of Better Care Southampton, attached.

8 CARE ACT 2014

To receive a briefing from the Director, People on the Care Act 2014.

Tuesday, 25 November 2014 Head of Legal and Democratic Services

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 1 OCTOBER 2014

Present: Councillors Baillie, Lewzey, Shields (Chair), Jeffery (Minute No 17 and 20) and Chamberlain
Alison Elliott (Minute No 17 and 20), Andrew Mortimore, Dr Steve Townsend (Vice-Chair), Dr Stuart Ward and Rob Kurn

Also in Attendance: Mr P Burns – Primary Care Commissioning Consultants
Theresa Leavy – Interim Head of Service (Minute No 17 and 20)

12. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

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

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

13. **STATEMENT FROM THE CHAIR**

The Chair made a statement in accordance with accepted practice and informed members that SKONP (Southampton Keep our NHS Public) were organising a number of events during October 2014.

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

RESOLVED that the Minutes of the Meeting held on 30 July 2014 be approved and signed as a correct record, subject to the following amendment:-

Minute No 8 – Primary Care Development, Page 3 – the last bullet point to read “in Southampton there were six surgeries in crisis as a result of these issues; and”

15. **PHARMACEUTICAL NEEDS ASSESSMENT (PNA)**

The Board considered the report of the Director of Public Health seeking approval of the draft pre-consultation Pharmaceutical Needs Assessment (PNA). Mr P Burns, Primary Care Commissioning Consultants presented the draft PNA.

The Board noted the following:-

- that it was a statutory requirement of all Health and Wellbeing Boards to publish and keep up-to-date a statement of the needs for pharmaceutical services for the population in its area;
- that the draft PNA had considered the current provision of pharmaceutical services across Southampton and had established that there were no gaps in these services;

- a robust PNA would ensure that services were targeted to areas of health need and the risk of overprovision in areas of less need would be reduced; and
- that the document would change after consultation and the final PNA document would be adopted by the Board at its meeting on 25th March 2015, in time for publication on 31st March 2015.

RESOLVED:-

i. that the draft pre-consultation Pharmaceutical Needs Assessment be approved; and
ii. that following consultation with the Chair and Vice-Chair of the Health and Wellbeing Board, authority be delegated to the Director of Public Health to finalise the consultation draft of the Pharmaceutical Needs Assessment, incorporating comments made by the Health and Wellbeing Board and any other drafting changes or additional information as requested.

16. **DEVELOPING AN INTEGRATED DISCUSSION ON MENTAL HEALTH**

The Board considered the report of the Director of Public Health proposing that a mental health "round table" meeting be convened to enable discussions between key stakeholders and user representatives on the needs and key challenges facing the commissioning of mental health services.

The Board noted that:-

Mental Health Services were fragmented and commissioning responsibilities were divided;
- mental health was a major and complex health issue for the City and merited an in-depth discussion at a session dedicated to this single topic, involving organisations not represented on the Health and Wellbeing Board; and
- it would be appropriate for the Health and Wellbeing Board, as the strategic local system leader, to facilitate a "round table forum" to include members of other boards and partnerships, with the aim of developing a better understanding of the issues involved and scoping of future work.

RESOLVED that a mental health "round table" meeting be convened early in December 2014, to enable a discussion between key stakeholders and user representatives on the needs and key challenges facing the commissioning of Mental Health Services.

17. **SOUTHAMPTON LOCAL SAFEGUARDING CHILDREN BOARD - ANNUAL REPORT 2013/14 AND BUSINESS PLAN 2014/15**

The Board considered the report of the Chair, Southampton Local Safeguarding Children Board (SLSCB) presenting the Southampton Local Safeguarding Children Board Annual Report 2013/14 and Business Plan 2014/15 for information and comment. Theresa Leavy, Interim Head of Service presented the Annual Report and Business Plan.

The Board noted the following:-

- that the SLSCB had a new Chair and Manager and its role and function had been strengthened with the introduction of new systems for quality assurance and learning and development; at the recent Ofsted review it had been noted that there had been significant improvements;
- that there had been four Serious Case Reviews published during 2013-14. All agencies involved in the review process had co-operated fully which had ensured honest and transparent inquiries and many lessons had been learned;
- that the SLSCB was working to deliver a number of objectives in the Joint Health and Wellbeing Strategy which included a co-ordinated approach and response to safeguarding and improving outcomes for children looked-after;
- that the SLSCB supported the transformation of key services and in particular the launch of Southampton's Multi-Agency Safeguarding Hub (MASH) in March 2014. The MASH was now the single point of contact for all safeguarding concerns regarding children and young people in the City;
- that there were difficulties in monitoring situations involving children who were home-educated as concerns could only be raised if there was proof of safeguarding issues; and
- that child sexual exploitation, domestic violence and long-term neglect were areas of concern which were receiving high focus.

RESOLVED:-

i. that the Southampton Local Safeguarding Children Board Annual Report 2013/14 and the Business Plan 2014/15 be noted; and
ii. that the comments and observations identified by the Health and Wellbeing Board be reported back to the Southampton Local Safeguarding Children Board.

18. **HEALTHWATCH SOUTHAMPTON ANNUAL REPORT 2013/14**

The Board considered the report of the Healthwatch Manager presenting the Healthwatch Southampton Annual Report 2013/14 for information and comment.

The Board noted that:-

- Healthwatch was recognised as a legal and statutory element of Southampton's Health and Wellbeing Board and the Annual Report provided an overview of the development of Healthwatch Southampton and the activities undertaken in its first year;
- Healthwatch was in the process of investigating the quality of care in residential care homes and would be submitting its findings to the Health and Wellbeing Board; and
- Healthwatch Southampton, in conjunction with Healthwatch Wessex and NHS England were in the process of organising a strategy programme covering maternity services.

RESOLVED:-

i. that the Healthwatch Southampton Annual Report 2013/14 be noted; and
ii. that comments and observations identified by the Health and Wellbeing Board be reported back to Healthwatch Southampton.

19. **BETTER CARE SOUTHAMPTON SUBMISSION UPDATE**

The Board considered the report of the Director of Quality and Integration, Integrated Commissioning Unit providing an update on the status of Southampton's Better Care Plan which had been submitted on 19 September 2014.

The Board noted that:-

- the previous Payment for Performance framework had been revised in that the proportion linked to performance was dependent solely on setting a planned level of reduction in total emergency admissions, supported by evidence of robust finance, analytical modelling, and demonstrating strong provider and partner engagement;
- Southampton's vision for Better Care incorporated the assurance that people were at the centre of their care, the provision of the right care in the right place at the right time, optimum use of the health and care resources and early intervention; and
- the final steps towards implementation were as follows:-
  - from 22 September to 3 October a desktop review of plans would be undertaken nationally, focused on an overall review;
  - a moderation exercise would be completed by 10 October; and
  - the final presentation and recommendations would be submitted to Sir Bob Kerslake, Simon Stevens and Ministers on 17 October 2014.

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

20. **TRANSITION OF HEALTHY CHILD PROGRAMME 0-5 YEARS TO SOUTHAMPTON CITY COUNCIL**

The Board considered the report of the Director of Public Health detailing the Local Authority's Healthy Child Programme (0-5 years) and its new commissioning responsibility from October 2015.

The Board noted the following points:-

- responsibility for commissioning the Healthy Child Programme (5-19 years) had been transferred across with Public Health responsibilities in April 2013 and in October 2015, commissioning responsibilities for the Healthy Child Programme (0-5 years) would be transferred across to Local Authorities from NHS England. This would enable Local Government to integrate the commissioning for 0-5 year olds with the commissioning for 5-19 year olds, which would improve continuity for children and their families and align the outcomes to the overall Children's Services Transformation programme;

- transition arrangements would be overseen by the Integrated Commissioning Board on behalf of Southampton City Council; and
- health visitors would be employed by their current provider, Solent NHS Trust and funding would be required for the commissioning responsibility to be transferred to the Local Authority. The Department of Health would be negotiating a re-allocation with each Local Authority and the final allocation would be received in December 2014.

RESOLVED:-

i. that the new commissioning responsibility of the Local Authority's Healthy Child Programme (0-5 years), which would take effect from October 2015 be acknowledged and welcomed; and
ii. that consideration would be given to the Health and Wellbeing Board's role in ensuring the successful delivery of the 0-19 Strategy at a future meeting.

21. **SCREENING AND IMMUNISATION UPDATE**

The Board received and noted the report of the Consultant for Public Health, NHS England (Wessex) providing an update on the performance of screening and immunisation programmes in Southampton.

It was further noted that "hard-to-reach" population groups were not accessing the screening and immunisation programmes and these should be more prominently advertised in order to highlight the profile of the programmes.

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		HEALTH OVERVIEW AND SCRUTINY PANEL INQUIRY REPORT: THE IMPACT OF HOUSING AND HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE		
DATE OF DECISION:		3RD DECEMBER 2014		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Martin Day**	**Tel:**	**023 80917831**
	E-mail:	**Martin.day@southampton.gov.uk**		
Cabinet Member	**Name:**	**Councillor Dave Shields**	**Tel:**	**023 80833340**
	E-mail:	**Councillor.d.shields@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

The Health Overview and Scrutiny Panel (HOSP) undertook an Inquiry into the Impact of Homelessness on the Health of Single People between February and July 2014. During this time the Panel heard from a wide range of witnesses and visited a number of the homeless housing services. The final report of the inquiry, attached at Appendix 1, was agreed at the HOSP meeting on 25th September 2014 and submitted to the Cabinet on 21st October.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board notes the contents of the Health Overview and Scrutiny Panel Inquiry Report and identifies whether there are any issues where the Board might be in a position to assist the Executive in responding to the recommendations of the Health Overview and Scrutiny Inquiry Panel.

REASONS FOR REPORT RECOMMENDATIONS

1. As the body responsible for the strategic oversight of health issues in the city, the Health and Wellbeing Board may be in a position to assist the Cabinet Member for Health and Adult Social Care in responding to the recommendations of the scrutiny inquiry.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not to respond. This was rejected on the grounds that housing and homelessness are majority contributors to poor health and health inequalities which the Health and Wellbeing Board is keen to address.

DETAIL (Including consultation carried out)

3. The Impact of Homelessness on the Health of Single People Inquiry Terms of Reference and Inquiry was undertaken by the Health Overview and Scrutiny Panel (HOSP) with information presented to 5 meetings from February to May 2014.

4. The recommendations are grouped under the following key themes:

- A strategic city-wide approach to homelessness
- Raising awareness and recognition of homelessness issues and protecting valued services
- Improving service delivery
- Monitoring and reviewing critical services

5. The final report of the Inquiry is attached as Appendix 1. It contains 25 recommendations in total, summarised in Appendix 2, which if implemented the Panel believed would help to maintain balanced communities in Southampton.

6. Although the Inquiry's recommendations were all seen as important to maximise access and improved health outcomes for single homeless people, the Panel identified that the following issues should be considered a priority for long-term sustainable improvements for single homeless people in the City:

- Maximising the quality and availability of single units and shared accommodation for single people in the system through the Housing Strategy and working with landlords (Recommendations iii, xviii, xx, xxi)
- Continued transformation through early help, and improved outcomes for children who are looked after and care leavers (Recommendations xii, xiii)
- Review mental health support and services to ensure early intervention is a key focus and transition into adult services is integrated with substance misuse services (Recommendations xvi, xvii)
- Consider invest to save opportunities including a 'dry' hostel option and 'Housing First' model (Recommendations ii, xv).
- Increase awareness and expand the Homelessness partnership (Recommendation vi, vii, viii)

The related **recommendations*** have been highlighted throughout the report.

7. The report was presented to the Cabinet on 21st October to consider the Inquiry recommendations and to formally respond within two months of the date of receiving the final report. Its response is scheduled to be reported to a Cabinet meeting in January 2015 for approval.

8. The Health and Wellbeing Board has an interest in this topic, having

previously had debates on housing and mental health. The Board is now offered the opportunity to assist the Cabinet Member for Health and Adult Social Care to identify where members of the Board, and the organisations they represent may be able to respond to the issues raised in the scrutiny inquiry recommendations.

RESOURCE IMPLICATIONS

Capital/Revenue

9. Any future resource implications arising from this review will be dependent upon whether, and how, each of the individual recommendations within the Inquiry report are progressed by the Executive. More detailed work will need to be undertaken by the Executive in considering its response to each of the recommendations set out in the Inquiry report.

Property/Other

10. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11. The duty to undertake health overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000. The Health and Social Care Act 2012 required Health and Being Boards to act in the best interest of improving the health of an area.

Other Legal Implications:

12. None.

POLICY FRAMEWORK IMPLICATIONS

13. None.

KEY DECISION? /No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Final Report – The Impact of Homelessness on the Health of Single People Inquiry
2.	Summary of Recommendations

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.	

Health Overview and Scrutiny Panel

THE IMPACT OF HOUSING AND HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE

PANEL MEMBERSHIP

Councillor Stevens (Chair)
Councillor Matthew Claisse
Councillor Sarah Bogle
Councillor Sharon Mintoff
Councillor Brian Parnell
Councillor Sally Spicer
Councillor Ivan White

Improvement Manager – Dorota Goble
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Contents

INTRODUCTION

1. The model for homelessness prevention in Southampton has significantly reduced homelessness in the City over the last decade, reducing homeless applications and acceptances from the 1000s to around 200 in 2012/13. However, homelessness remains in the system with 520 people still on the Homeless Healthcare Team's register. Welfare Reforms and a heavy reliance on private sector rented properties, of which a high proportion is unaffordable to those on or below the average wage in the City, are making the cycle difficult to break for entrenched individuals with chaotic lives and complex needs. The way services are funded is also changing adding increasing pressures on these vital preventative public services.

2. For this Inquiry Homelessness was defined where an individual finds themselves sleeping rough, living in insecure or short-term accommodation or at risk of being evicted from their home.

3. The purpose of the Inquiry was to consider the impact of housing and homelessness on single people, a significant number of whom have complex needs, living unsettled and transient lives. The Panel examined the difficulties of delivering a preventative and planned approach to improve their health and wellbeing to reduce or minimise their health inequalities, supporting them to move into a settled and decent home. The Panel considered the quality and impact of housing that single homeless people are most likely to move on to.

4. The rationale to focus on single homeless people stems from the high demand for single person's accommodation in the City, with over half of the 15,000 people on the Housing Register in need of single units. Homeless families and older people over 65 are much more likely to be accepted as homeless due to a priority need.

5. The objectives of the Inquiry were:

   a. To understand how the current model for homelessness prevention supports and promotes better health outcomes for single people.
   b. To recognise what works well and what needs to improve locally, learning from best practice nationally.
   c. To identify if there are any gaps or blockages in homeless prevention and health interventions for single homeless people.
   d. To explore how the Houses in Multiple Occupation (HMO) Licensing scheme contributes to the health and wellbeing of tenants who have been homeless, or at risk of homelessness, and what opportunities there are to provide further support by working in partnership with others.
   e. To explore the adequacy of single person accommodation and the effectiveness of the support pathway that leads to settled accommodation for those who have been homeless, in line with any existing contract periods.
   f. To consider further collaboration or invest to save opportunities that would

prevent future increasing demand or reduce homelessness in the city, within existing budget constraints.

6. The Terms of Reference (TOR) and Inquiry Programme, agreed by the Panel, are shown in Annexe 1.

7. The Panel received extensive evidence from witnesses as the Inquiry meetings. A list of witnesses that provided evidence to the Inquiry is detailed in Annexe 2. Members of the Scrutiny Panel would like to thank all those who have assisted with the development of this review.

8. The findings and recommendations of the Inquiry have been divided into four key areas for improvement, for ease of understanding behind the Panel's rationale and where the recommendations within those sections were strongly inter-related to each other. The four main areas for improvement and recommendations identified by the Panel include:
   a) A strategic city-wide approach to homelessness
   b) Raising awareness and recognition of homelessness issues and protecting valued services
   c) Improving service delivery
   d) Monitoring and reviewing critical services

9. Recognising the current good practice alongside budget constraints and the challenges of the housing market, the Panel have identified 25 recommendations, which they feel are realistic and achievable through either a shift of current resources or by considering 'invest to save' opportunities. The recommendations related to each area for improvement are included at the end of each section.

10. Although the Inquiry's recommendations are all important to maximise access and improved health outcomes for single homeless people, the Panel identified that the following issues should be considered a priority for long-term sustainable improvements for single homeless people in the City:
    - Maximising the quality and availability of single units and shared accommodation for single people in the system through the Housing Strategy and working with landlords. (Recommendations iii, v, xviii, xx, xxi)
    - Continued transformation through early help, and improved outcomes for children who are looked after and care leavers. (Recommendations xii, xiii)
    - Review mental health support and services to ensure early intervention is a key focus and transition into adult services is aligned with substance misuse services. (Recommendations xvi, xvii)
    - Consider 'invest to save' opportunities including a 'dry' hostel option and 'Housing First' model. (Recommendations ii, xv)
    - Increase awareness and expand the Homelessness partnership. (Recommendations vi, vii, viii)

    The related **recommendations*** have been highlighted throughout the report.

11. The Panel recognised the difficulties of achieving a paradigm shift in the lifestyle choices of individuals and that a proportion of the remaining clients are entrenched in the system. Sustaining housing is the first and only outcome that can truly be achieved for a number of these individuals – any further transformation will ultimately only come when those individuals are ready to change which may take time and a great deal of resources to support this to happen.

CONSULTATION

12. The HOSP members undertook the Inquiry over six evidence gathering meetings between February 2014 and June 2014 and received evidence from a wide variety of organisations to meet the agreed objectives. The final Inquiry report and recommendations were agreed at the HOSP meeting on 25 September 2014.

13. During the Inquiry, many of the Panel members also visited a number of homeless providers to see the facilities and services first hand and talk directly to residents and staff about their experiences. The Chair of the Panel also attended the GP Forum and Southern Landlord Forum to obtain wider feedback on the issues and challenges being faced by homeless individuals and services. These visits were extremely insightful and highlighted the passion and commitment that exists to make a difference to homeless people. In addition, those who gave evidence were also invited to comment on the draft final report which received positive feedback from a number of contributors.

SUMMARY OF KEY FINDINGS AND ISSUES

14. The Inquiry concluded that the key findings and issues are:

- An excellent and effective Homelessness Prevention Strategy, team and Partnership have dramatically reduced homelessness over the last 10 years;
- The partnership has achieved significant outcomes within a framework of housing providers and support services with a common focus on prevention;
- However, a group of entrenched and high cost individuals remain in the homeless system who have complex needs and behaviours;
- Existing health inequalities and complex needs are exacerbated by difficulties in accessing the right services, especially mental health and substance misuse services which operate a high threshold due to limited resources and high demand;
- There is a legacy of care leavers or people who were missed by the system in the past. However, Children's Services transformation is underway with some improved outcomes emerging;
- The complex needs and comorbidity of many homeless individuals mean that it is often their immediate problem that is resolved rather than the whole person;
- Staff in homelessness provider services show a passion and commitment to

their clients but their views are not always heard by the professionals making decisions about their clients;

- GP practices requiring valid identification documents may prevent homeless individuals accessing the health services they need, thus potentially missing opportunities for earlier intervention and integration into community services;
- Homeless individuals are frequent users of hospital Emergency Departments, despite being registered and using the Homeless Healthcare Team or GPs;
- Access to emergency out of hours facilities, mental health and substance misuse services can be challenging, especially with referrals and transition into adult services for young people;
- The high demand for single unit council housing has led to a high reliance on the private rented sector and Houses in Multiple Occupation (HMOs);
- Housing is often unaffordable for single homeless people who are ready to move on, which means they are likely to live in poorer quality shared housing that they can afford;
- It is still too early to see the impact of the HMO Licensing scheme that aims to improve the condition of shared houses;
- The Housing Strategy focus on new affordable single units and increased dedicated student accommodation may eventually reduce pressures on the single rental market in the city;
- Social letting agencies are working with landlords to sign up to leasing schemes for homeless clients however there are perceived / potential barriers and few incentives to encourage landlords to take up these schemes.

KEY FINDINGS FROM THE INQUIRY

A A STRATEGIC CITY-WIDE APPROACH TO HOMELESSNESS

15. The Homelessness Act (2002) requires local authorities to carry out a review of homelessness every five years, and use the findings to develop a strategy for preventing homelessness locally. The Council has recently published its third Homelessness Prevention Strategy, which sets out the current context for homelessness provision, achievements since the previous strategy, trends and priority actions going forward. The strategy has been developed in partnership with stakeholders, who have made a joint commitment to deliver the plans set out in the strategy.

16. The Southampton Homelessness Prevention Model supports clear and distinct pathways for young people, adults and older people, focussing on prevention and early intervention. Its effectiveness relies on established relationships and strong partnerships.

17. The Panel heard from Homeless Link, the national membership charity for organizations working directly with homeless people in England, that

Southampton operates a best practice Homelessness Prevention Model. It ensures that Supporting People budgets, which are no longer ring-fenced, and homelessness prevention resources are being used to good effect. The Southampton Homelessness Services Model is attached at Annexe 3.

18. The Panel recognised that the partnership requires the current elements to be in place for the future to ensure the most effective and efficient use of resources. These include: early assessment, emergency provision, high/intensity support, case management approach (through the Street Homeless Prevention Team), young people's services and support for those with longer term needs.

19. The Panel acknowledged the progress achieved through the Homelessness Prevention Strategy and praised the dedication and commitment of the whole partnership. However, the Panel were particularly impressed by the following innovative projects, which have seen excellent results or provided exceptional support to vulnerable single homeless people:

- The needle exchange has reduced infections from blood-borne viruses
- The Naloxone programme (which can reverse the effects of a drug overdose) has saved the lives of overdose victims
- Two Saints introducing 'Psychologically Informed Environments' in hostels
- Breathing Space hospital discharge homelessness project providing medical support in a domestic setting
- End of life support to enable homeless people to die with dignity in partnership with the Homeless Health Care Team and Patrick House
- The Vulnerable Adult Support Team (VAST) set up in the Emergency Department of the University Hospital Southampton Trust to give extensive support, time and signposting to appropriate services to people who present at the Emergency Department with no fixed abode.

20. Southampton's Homelessness Prevention Model has been effective in dramatically reducing the number of homeless applications and acceptances and reduced the use of temporary accommodation in the City over the last 10 years, providing a clear route for many homeless people to move into and stay in settled accommodation.

21. Despite these best efforts and results an entrenched group of 'revolving door' clients remain who have complex needs and chaotic lifestyles who struggle to make progress or 'revolve' in and out of the system. These are primarily individuals who are expensive for public services often needing 24 hour care or supervision, frequent users of emergency services, lack a sense of personal care / space and are regularly involved in crime or anti-social behaviour.

22. It should be noted, however, that the Panel did not receive any evidence during the Inquiry from South Central Ambulance Services.

23. The Panel heard from Adult Social Care that it is difficult to find cost-effective solutions for these clients. A number of housing providers cited the 'Housing First' model, where homeless clients are housed first in their own home and then given intensive support, as achieving dramatic results in the USA and Camden. When targeted at their most chaotic clients they have seen

reductions in visits to the Emergency Department by a third, hospital admissions down by two thirds and nearly 75% were still in their own home after 2 years.

24. The Southampton Homeless Prevention Model, is delivering a form of Housing First. When someone is assessed as homeless, they are housed first within a hostel, whilst an appropriate support package is determined. The Panel recognised that generally this works for most single homeless people but they believed that consideration should be given to whether a more intensive Housing First model could provide a more effective route for the entrenched group of individuals who have not progressed significantly or move on over a long period of time. The Panel recognised that this model would require the allocation of single units and resources for this specific purpose. However, the potential benefits of reducing high costs of 'revolving door' clients may outweigh the investment required.

25. Pressure on single housing units in the City is extensive. The Panel noted that 50% of the council's housing waiting list are for single units, with the cost of buying a home prohibitive for around 50% of residents who would be unable to enter the market without help. The Welfare Reforms are adding to the pressure on the housing. Changes to the Local Housing Allowance are creating pressures at the lower price end of the private sector rented market. The City's heavy reliance on private sector rented accommodation is unlikely to diminish in the medium term and the Panel recognised the importance of continuing the Housing Strategy's emphasis on affordable single units. The Housing Strategy has reprioritised its focus to increase the number of single affordable units in developments.

26. The Panel heard a consistent message from witnesses that the main triggers for homelessness include the loss of a home, job or benefits, offending, a mental health episode or other significant crisis. Clearly not everyone who experiences these issues will become homeless. However, where someone does become, or is at risk of homelessness, the Panel supports the principle and evidence that early intervention and prevention are crucial to avoid an individual becoming entrenched in the system. Support mechanisms are in place to provide homeless clients access to skills and employment when they are ready, although many single homeless people will be the most removed from the work place and face significant barriers to entering employment.

27. Evidence to the Panel highlighted the desire that many homeless clients want to get (back) into work. The Panel recognised the importance of existing links for homelessness providers with employment and skills based projects in the City such as Adult Community Learning, City Limits and services to be provided under the new City Deal. These services concentrate on increasing individual skills and on getting long term unemployed young people, disadvantaged people or those with mental health issues into work. With seven out of ten homeless people having at least one mental health condition, which often makes it slower for them to progress and move on to paid employment. The Panel felt that further consideration should be given to ensure the connections are in place.

Enabling homeless clients to have good access to support into employment, will bring homeless clients closer to the work place, increases their life and health chances, and increase the likelihood of staying in their own home.

28. Although there are relatively few rough sleepers in the City, numbers have increased in recent years alongside national trends. A higher proportion of rough sleepers are from European Union Accession States with no recourse to public funds. However, although they may access services and support at Cranbury Avenue Day Centre they are fearful of the UK Border Agency and may avoid accessing essential support services as a result. The Panel heard that most want to stay in the country and find work. However, where these individuals have no recourse to public funds they may find themselves on the street or in other unsustainable situations. The Panel supported the work of the EU Welcome Project, which is funded to support migrants into work so that they do not spend a second night on the street.

A: Recommendations **(*HOSP agreed priorities)**

29. With this evidence in mind the Panel has recommended that:

i. The Homelessness Prevention Strategy continues to support city-wide commitment for continued funding of the existing flexible and innovative partnership model of homelessness in the city.

ii. Commissioners undertake a feasibility study including a cost/benefit analysis, with providers, to consider whether a more intensive 'Housing First' model could provide the relatively small number but high cost entrenched homeless clients a potential route into sustainable and settled accommodation.*

iii. The Housing Strategy continues to prioritise an increase in affordable single person accommodation across the City, including new developments.*

iv. Links are maintained and strengthened between homelessness prevention and employment projects such as City Limits and the new City Deal to increase the skills and employment opportunities for homeless and vulnerably housed individuals.

B RAISING AWARENESS AND RECOGNITION OF HOMELESSNESS ISSUES AND PROTECTING VALUED SERVICES

30. Southampton has historically had a high demand for shared private sector rented housing due to the number of students in the City. There is also a short supply of affordable single units. The average house price is out of reach for a higher than average level of low paid workers. In addition, as prices are cheaper in the City than surrounding areas this has added pressure on the demand for single units and shared housing. Welfare Reforms, including the changes to the Local Housing Allowance for private sector rented and the 'under occupation of social housing', is also adding to the strain on housing needs.

31. The South Hampshire Strategic Housing Market Assessment forecasts that an increase in dedicated student accommodation and higher targets for single affordable units may reduce the pressure on shared housing. But even if more affordable shared accommodation becomes available, many homeless clients may face additional barriers as they may be perceived as unreliable tenants due to their chaotic lifestyles and low or unstable incomes.

32. The Panel heard evidence from No Limits and Two Saints Real Lettings Agency who are working with landlords to offer a more stable package for homeless clients. They are brokering deals with landlords, offering pre-tenancy training with a period of support, leasing accommodation for longer periods, guaranteeing rents, and acting as a single point of contact for landlords if their tenants have any concerns or problems. This route is proving effective for single homeless people who are ready to move without support services such as a number of ex-offenders or those subject to a supervision order. The Panel believe this approach should be expanded; more social lettings would increase the housing options for single homeless people in the City.

33. Furthermore, the Panel felt that landlords have a social responsibility to view their tenancies as an ongoing relationship rather than a simple cash transaction. They acknowledged that a number of landlords already provide additional support to tenants, especially single tenants who are less likely to have a support network.

34. The Panel agreed it is important that the Homelessness service continues to build bridges with landlords to increase their awareness of the risks of becoming homeless and take a more long term approach to support tenants who have been homeless. A better mutual understanding of the barriers to social letting should ultimately lead to more stable tenancies for single homeless clients in future.

35. As highlighted above, the Homelessness Prevention Strategy and Partnership have achieved excellent results for homeless people in the City and provide exemplar services to support single homeless people into a settled home. However, a number of the witnesses highlighted the stigma that homeless people, and their case workers, experience accessing mainstream services.

36. The Panel noted the work that has been undertaken to promote the Homelessness Prevention Strategy, however, they felt that awareness and understanding of the excellent support services available was still patchy across public sector organisations. Understanding of the issues and potential positive impacts of early intervention through homelessness referral services was potentially not as strong amongst other public services.

37. Agencies who play an important part in the health and wellbeing of homeless people such as Jobcentre Plus, Police, GPs and hospital ward and A&E staff were not very aware of their role to support homeless people or the referral services available. Improving awareness and understanding of homelessness issues with these agencies would ensure better early

intervention and community responses through more effective referrals to the right services.

38. Homeless people can experience barriers to accessing services. Case workers reported that barriers are often increased where they are not always enabled to effectively advocate on behalf of individuals or they were not listened to, despite having permission from their clients. The Panel heard that many single homeless people have underlying health problems but they may fall below the threshold criteria or present well on assessment. Case workers will often have a more informed view of their clients. This may lead to missed opportunities for early diagnosis leading to exacerbated symptoms if clients do not receive help.

39. The Panel felt that case worker's opinions deserved greater recognition with health professionals. Increased awareness of homelessness issues and services and involvement of wider public services in the Homelessness Strategy Steering Group could lead to better understanding and wider support mechanisms for homeless people.

40. Due to the high prevalence of poor health issues, often with co-morbidity, for single homeless people, the support of appropriate and early intervention of health services is crucial for the individual to reduce or limit health inequalities.

41. The Panel heard that homelessness can be a cause or a consequence of mental health issues, with an estimated 60-70% of homeless people having some form of mental health problem. Patients often have a dual need or complex issues that may delay the management of recovery making the partnership between mental health and homelessness services essential to ensure adequate and ongoing support. Having a stable environment is critical for mental health patients and therefore the availability of adequate and safe housing when discharged from secondary care services is an important part of their recovery.

42. The Partnership in Southampton is well established with Southern Health's Mental Health Housing Coordinator and Mental Health Accommodation Panel considering appropriate options for move on. However despite this the proportion of patients in contact with mental health services in stable accommodation is very low at 28.5% for 2013/14, amongst the worst in the country.

43. The Panel also heard that mental health services are seeing more young people being admitted with accommodation issues. Young people's homelessness provider case workers highlighted they are finding it increasingly difficult to tackle the mental health issues of their clients, particularly where they are not receiving the mental health support they need whether due to the stigma of mental health illness or perception of mental health services. Mental health patients often fall out of the system whilst managing the transition to adult services.

44. The Panel recognised limited resources and a high demand for mental health services meant the threshold for treatment is set high and that others who need help do not access the services as early as they could. Support

and access to appropriate mental health services as early as possible, however, is crucial to prevent or minimise the impact of homelessness.

45. The Panel expressed serious concerns that the links between community support and acute mental health services are not as effective as they could be with a significant number of referrals being made through acute and urgent care services. Homeless patients are less likely to receive early intervention or treatment where relationships are not built with a GP. In addition, younger patients may be reluctant to access services, especially where transitioning to adult services.

46. The Panel was hopeful that the Better Care Southampton Plan will improve links for homeless people within communities through the GP clusters. However, in the meantime work needs to continue to reduce the stigma and raise awareness of the need for extensive support in the community for homeless mental health patients and where possible, reduce the demand for acute levels of care for those at risk of homelessness through earlier intervention.

47. Southampton's Substance Misuse Services are developed in partnership and coordinated through the City's Integrated Commissioning Unit through transferred funding from Public Health and the Police. It was reported to the Panel that people with substance also have a high risk of housing problems which in turn leads to a high risk of relapse.

48. The number of opiate users is increasing in the City and evidence suggests that stable accommodation can support their chances of successful treatment. Following a high number of overdoses in hostels, Naloxone (which is a special narcotic drug that reverses the effects of other narcotics) has successfully reduced harm and death. The Panel heard that for every pound invested in drug and alcohol treatment the public purse can save £2.50 and £5 respectively and supported the continued funding for substance misuse services, recognising the benefits this can bring to the life chances of homeless individuals.

49. The Panel acknowledged the central role of the Homeless Healthcare Team, delivered by Solent NHS Trust, in reducing health inequalities for homelessness people. It offers general health services alongside those more tailored to homelessness needs, operating from the Cranbury Avenue Day Centre. The co-location and effective partnership of these services has been critical in tackling the health needs of homeless people in the City, as well as providing essential outreach services to hostels. The Homeless Healthcare Team resources are limited however and with over 500 homeless patients on their register the service is overstretched.

50. GP registration can be difficult for homeless people who may not have valid identification papers where requested by GPs to avoid the risk of duplication and over-subscribing to patients. For many homeless individuals the cost of having, or risk of losing, a passport for example can be prohibitive or appear unnecessary. This issue prolongs the reliance on the Homeless Healthcare

Team rather than integration within community services when clients have moved on.

51. The Panel urged GPs and practice managers to recognise the benefits for the wider health system of enabling homeless patients. This is to register without ID and work to find alternative ways of checking the identification of individuals, particularly, homeless patients, to ensure they can continue to access healthcare in the community and avoid the risks of continued exposure to the drinking / drugs culture of homelessness services.

B: Recommendations **(*HOSP agreed priorities)**

52. To address the above issues the Panel recommend that the Homeless Strategy Steering Group work with partners to prioritise and deliver the below actions given current resources and capacity:

v. Continue to build relationships with landlords to raise awareness and common understanding of the issues and barriers of homeless tenancies and increase social letting with relevant support agencies. This includes bringing together the current range of city approaches for social lettings to the private sector housing rental market.*

vi. Raise awareness of good practice and successful outcomes in homelessness prevention services as a means of reducing the stigma for homeless clients and encourage wider partnership involvement of other agencies including the Police and National Health Services including GPs and the University Hospital Southampton Trust.*

vii. Expand the partnership to wider health services to reduce inequalities for homeless people services through delivering a comprehensive framework of preventative and integrated services.*

viii. Raise the awareness of healthcare professionals of the role of homeless healthcare provider case workers and the value of their support of the single homeless, particularly through advocacy.*

ix. Maintain an overview of the cost benefit of key valued services within the City's Homelessness model, including the Homeless Health Care Team and dedicated specialist services supporting substance misuse and mental health problems.

x. Consider outcomes from the Southampton Healthwatch review of GP registration and continue to work with GPs to improve access and integration to support homeless clients to move on from homeless health care to primary care services.

C IMPROVING SERVICE DELIVERY

53. The Panel heard from homeless service providers and the University of Southampton's Psychology Department that services can be driven by targets to move someone on within a given timescale. However, while this is the case in the City, there are adequate safeguards to ensure that people are not moved on too quickly. However, for homeless people, changing behaviours (e.g. incidences of antisocial behaviour, drug and alcohol use etc.) are the most tangible of outcomes for many homeless individuals.

54. Commissioning of services according to realistic and meaningful outcomes is essential. Service providers need to be clear what will change as a result of what they do. In this way, providers may be encouraged to think creatively about their areas of expertise in delivering tangible and measurable change. Monitoring these outcomes could contribute to a culture of evidence-based commissioning, where services are clear with commissioners about expected outcomes, and commissioners then hold the services to that contract.

55. The Panel supports an evidence-based approach to homelessness provision as this enables a mixed economy of housing providers to sustain additional projects to support vulnerable homeless people alongside council funded services.

56. The Panel noted that research at the University of Southampton identified that a key factor of homelessness links to childhood neglect and abuse. This can lead to difficulties in managing emotions, and partly explains the high level of mental health problems and addictive behaviours of homeless people. Housing support services for young people reflected that their support workers are not trained to provide support for mental health needs of their clients and are finding it increasingly difficult to meet their needs.

57. The Panel also heard that Southampton homelessness services have seen increasing numbers of a younger aged clients, although they tend to sofa surf rather than sleep rough. There are clear separate pathways established to avoid young people entering adult services where possible.

58. Historically, the proportion of care leavers in suitable accommodation and employment has been low but following a priority focus to address this performance has improved, through signing up to the Care Leavers Charter and Staying Put arrangements but the position needs to continue to improve. The Panel recognised the benefits of increased support to care leavers up to the age of 24 and support the continued priority to improve outcomes and life chances for care leavers to break the cycle of homelessness and ensure they are better prepared for independent life.

59. The Panel, however, were concerned about vulnerable children and young people under the radar now, and in the future, who need to be prevented from escalating into the homeless system later in life due to a lack of support network, increasing risks of poor mental health or substance misuse.

60. The Panel noted that Children and Families Services are going through substantial improvement and transformation and through the establishment of Early Help Team and the new Multi-Agency Safeguarding Hub (MASH). The Panel recognised these services aim to provide an effective team and expertise, connecting to both public sector and voluntary services, in a timely and effective manner to ensure that children do not fall through the system

or that dangerous individuals are not hidden. The Panel will continue to monitor the progress of these new services to ensure that they achieve the desired outcomes for future generations of vulnerable children.

61. The Panel heard from Hampshire Probation Services that access to stable accommodation can be a significant barrier to avoid repeat offending. However, Homelessness Prevention Services often find release dates are on a Friday which means their accommodation needs are difficult to resolve. They have also been working to secure better health outcomes for ex-offenders and in considering the general wellbeing of clients alongside access to accommodation and benefits they have already seen successful outcomes.

62. Although drinking and drugs are monitored and managed in hostels, the Panel were concerned that a lack of a 'dry house' in the system can cause problems for homelessness people who want to detox. All the Southampton hostels allow alcohol consumption on the premises and although residents can exercise their own free will, it can often be too much of a temptation for someone with an addiction, especially if coupled with mental health problems. Dry houses have proved effective in the Integrated Offender Management Scheme and the commissioners should learn the lessons from these services and consider if an alternative similar option is currently feasible within adult homelessness services, to reduce the harm to those homeless clients who want to be sober.

63. The Panel heard repeatedly from witnesses of the problems experienced by homelessness clients accessing mental health services either due to long waiting lists for services, especially Cognitive Behaviour Therapy (CBT). They will often fall below the threshold criteria for services, present well on assessment or are refused treatment whilst under the influence of alcohol or drugs due to potential conditions such as Korsakoff's Syndrome.

64. The University of Southampton have undertaken extensive research over the last 8 years with the Society of St James, Two Saints and the Booth Centre (Salvation Army) to evaluate effective psychological interventions to treat their clients' issues. Their research has found that behaviour therapies that take a skills approach to the treatment of emotion management can be very effective in increasing functioning of people experiencing complex mental health difficulties. These interventions have enabled them to operate better in a structured 'hostel' environment and move on in a more sustainable way.

65. They found that with training, housing providers can enable hostel staff to establish 'psychologically informed environments' where they can better understand and support behaviours more effectively, enabling the process of real change. Although it is recognised that these outcomes take time to embed, Two Saints, who have been working to establish this within Patrick House, are already seeing positive results with their clients.

66. Despite this potential improved support for the mental health of homelessness clients the Panel remained concerned about the overall capacity of the current Mental Health provision to deal with the growing mental health needs of the City. There was particular concern for young

people accessing mental health services, where early signs of mental health issues are most likely to occur and services have the best chance of responding effectively to intervention.

67. Where homeless people remain untreated it is clear that their mental health can deteriorate, often with increasing psychotic episodes. If this pattern of poor access to mental health services is being replicated across the City, given that Southampton has one of the highest anti-depressant prescription rates, there is clearly an underlying issue for mental health commissioning that needs to be addressed.

68. The Panel therefore supports a fundamental review of mental health services in the City to identify better ways to manage current demand and provide earlier help to avoid escalating health problems in the future, which may need a more acute response.

69. The Panel also remained concerned that the support available for young people with mental health problems was not meeting the demand, given that problems are most likely to occur at this stage and treatment is most effective through early intervention. The Panel heard that the transition into adult mental health services can be very difficult for young people, with many not progressing into the system but resurfacing later with more acute mental health problems and often at high risk of homelessness. To reduce this escalation of need for mental health support, and ultimately homeless prevention services, the Panel would like to see the age threshold for mental health services raised in line with the Integrated Substance Misuse Service and Staying Put model for care leavers. This would provide a more effective and consistent early intervention model for young people to a later age of at least 24 years.

70. The chair of HOSP and two social letting agencies attended to the Southern Landlord's Forum to gauge the interest in expanding opportunities for social letting in the City. Although there was an enthusiastic response to the opportunities for increased social letting, landlords raised some concerns about the legality of signing up to long term leases and that the limits of the HMO Licensing Scheme might restrict opportunities in certain areas. The Panel, however, were optimistic that social letting could expand if the barriers could be removed or incentives provided in the scheme to enable more private sector tenancies and HMOs to be used as social letting for specific vulnerable groups such as single homeless people.

C: Recommendations **(*HOSP agreed priorities)**

71. To address the above issues the Panel have recommended that:

xi. The Homelessness Strategy Steering Group continue to support commissioners as they progress towards an evidence-based and outcome-focussed commissioning model so that the case for changes in policy and practice can be evidenced.

xii. **Children and Family Services continue to prioritise the Multi-Agency Safeguarding Hub (MASH) and Early Help Team to ensure children in need are not falling through the gaps.***

xiii. **Children in Care continue to be a priority, particularly in preparing those in care to lead an independent life and that care leavers have access to suitable accommodation and maximise opportunities for employment, education and training.***

xiv. Homelessness Services work with National Probation Trust and the Hampshire Community Rehabilitation to support more pre-release planning to ensure emergency bed spaces are being used appropriately and to include looking at possibility of avoiding Friday prison releases.

xv. **Commissioners of Homelessness services should consider the option of providing a 'dry' environment within the homelessness prevention model in the City to support those who want to become or stay sober.***

xvi. **Homelessness providers and commissioners should work towards developing 'psychologically informed environments' in hostels and develop a staff training programme as appropriate. Partnerships between the psychological support from the University of Southampton and local housing providers are essential to achieving this.***

xvii. **Undertake a fundamental review of Mental Health services for the City, specifically including improving access to behaviour therapies for homeless clients and considering raising the age for transition for young people into adult services to 24 years in line with the thresholds for the Integrated Substance Misuse Service. Early intervention should be prioritised alongside improving access to services from primary to acute care to ultimately reduce and better manage demand.***

xviii. **Investigate opportunities to reduce barriers and provide incentives for Houses in Multiple Occupation (HMOs) to be used for homeless clients.***

xix. Expand training on homelessness services / welfare services to community first responders and primary care services e.g. Hampshire Police, Ambulance Services, GPs and community nurses.

D MONITORING AND REVIEWING CRITICAL SERVICES

72. The Panel heard repeated evidence of the clear link between good housing and good health. Regulatory Services undertook a Stock Condition Survey in 2008 which identified that 38% of the 25,000 private homes in the City did not meet the Decent Homes Standard, primarily due to overcrowding or inadequate facilities. The service also investigates complaints and carries out risk based inspections to ensure that private housing in the City is safe, warm and secure.

73. The Stock Condition Survey is now six years old, and concerns were raised, by the Panel and landlords, over the reliability of this data. The Panel felt that the timing was right to undertake a new Stock Condition Survey, and to renew the survey at least every 6 years. The Panel acknowledged the resources implications of undertaking this survey, however, they felt that

reliable information on the quality of the City's housing stock was crucial, given the reliance on the private sector market in the City.

74. 7% of the City's homes are estimated to be Houses in Multiple Occupation (HMOs), which is 5 times the national average. HMOs are usually shared houses of 4 or more people averaging between 16 and 34 years old. With the high reliance on HMOs for moving homeless clients on and given changes to the Local Housing Allowance, the Panel accepted that people who have been homeless are more likely to rent at the lower end of the market and experience poorer quality housing, exacerbating any existing poor health conditions they may already have. The Panel recognised that there are good and bad landlords, however, they were concerned that tenants in lower quality housing are less likely to report issues for fear of the landlord increasing the rent or ending the tenancy.

75. The Panel heard that the HMO Licensing Scheme aims to work with landlords to improve overall conditions, management and basic health and safety for shared homes in the City. The scheme is currently being rolled out to 4 wards in the City (Portswood, Swaythling, Bevois and Bargate), where it is estimated that there are 4,500 HMO properties. To date just over a third of these properties have applied for a licence voluntarily; with the enforcement stage commencing in 2014/15 the service continue to gain a better understanding of the quality and compliance issues in these areas.

76. A number of witnesses highlighted the poor conditions that many ex-homeless people were living in and the Panel heard that the HMO Licensing Scheme would identify and deal with non-compliant landlords who let properties in a poor or dangerous condition or who have poor management arrangements. The Panel acknowledged that there may be merit in expanding the scheme across the City, to ensure all shared houses are of an acceptable quality. However, the Panel felt that how and when this expansion takes place should be based on the evidence and outcomes from HMO Licencing in the first four wards and supported by an up to date Stock Condition Survey.

77. Given the high level of substance misuse and dependency by single homeless people the Panel were encouraged to see the new Integrated Drug and Alcohol Substance Misuse Service is planned for 1 December 2014. Hostels were particularly concerned that they were not receiving as much outreach support and were sometimes finding it difficult to cope with the addiction of their clients and associated behaviours. The Panel believed that the new integrated service would enable resources to be placed more effectively. They were keen to see how it will offer better support to homelessness services in future, including outreach services and raising the age for young people to transfer to adult services.

78. The Panel recognised that monitoring systems were well established for the Homelessness Prevention Strategy. However, evidence to the Panel suggested that the full impacts of the Welfare Reforms may not have materialised yet in the City, particularly around changes to the Local Housing Allowance (LHA) and the under occupation of social housing. The Panel heard that homeless individuals, with complex needs and chaotic lifestyles,

were more likely to fail to comply with their claimant commitment resulting in an increased risk of having their benefits sanctioned. This is likely to have a devastating impact on their ability to cope. Further Welfare Reforms expected in the next 2 years, including the continued transition from Disability Living Allowance (DLA) to Personal Independence Payments (PIP) and the roll out of Universal Credit (UC), will have serious implications for homeless individuals.

79. Monitoring of the impacts of Welfare Reforms is underway with key agencies through the Welfare Reforms Monitoring Group. However, with major changes still to come housing providers and the Homelessness Prevention Team need to ensure that they are continuing to assess, record and share the impacts on their clients and services. This will ensure that the Local Welfare Provision can respond to these changes and provide an evidence-based response to commissioners, the Jobcentre Plus and Department of Work and Pensions.

80. Although access to homelessness assessments and referrals is relatively straight forward and well understood during the week, some referral agencies found it difficult to access beds for discharge from hospital out of hours. This can cause significant problems for single homeless people who will have limited support mechanisms to turn to.

81. The Panel also heard that there can be a concentration of Prison Service releases on Friday. If there is no pre-release liaison, the individual is less likely to settle and will be more likely to reoffend over the weekend where access to the services they need can be difficult. Conversely, an emergency bed may be reserved in a hostel for an ex-offender which does not get used, blocking it from other potential clients. The emergency bed situation was cited as particularly difficult for young people services, where bed spaces are more limited. The Panel felt that the availability of emergency bed spaces needed to be reviewed with referral partners. A better understanding of the issues being faced by all services and increased planning with offenders in advance of their release would ensure a more effective 'out of hours' service can be provided and used.

82. The Panel heard that a number of best practice services have time limited funding or are under threat of funding being withdrawn. However, it was clear that these services are making a tangible difference to the lives of homeless people. These services include:

- The Vulnerable Adult Support Team in the hospital Emergency Department who have reduced frequent attendance and supported over 200 patients to homelessness services that would otherwise have been back on the streets. Short term funding was agreed by the University Hospital Southampton NHS Trust but is due to end in September 2014.
- The Breathing Space Project was established through funding from the Department of Health and works with the University Hospital Trust to provide medical support in a domestic setting. The project has seen dramatic life changes with entrenched homeless individuals who have

been given time to recover in a safe environment. This funding is due to end in October 2014.

- The Cranbury Avenue Day Centre, run by Two Saints provides an established and effective central homeless hub for the City. The Homeless Link transition funding and Council funding ends in March 2015.

83. The Panel felt that a city wide review should be undertaken to identify the cost benefit of these services to key public agencies to ensure that a sustainable funding plan is developed to keep them operating. This may include the need for short-term funding while this is being evaluated.

D: Recommendations **(*HOSP agreed priorities)**

84. To address the above issues the Panel have recommended that:

xx. Regulatory Services undertake an evidence based review of the effectiveness of the HMO licensing scheme to ensure that standards of quality are maintained for all private sector tenants in the City and to support the decision making process for whether to expand the scheme to other wards in the city. It should be recognised that those who have been homeless will be moving on into the lower cost / quality end of the market where risks to their health remain high.*

xxi. Regulatory Services consider options to undertake a new stock condition survey to gain a better understanding of the quality of the City's private housing stock and establish mechanisms and resources to secure an up to date survey at least every 6 years.*

xxii. Integrated Drug and Alcohol Substance misuse service to report to the Health Overview and Scrutiny Panel on how changes to service delivery will support homeless people more effectively, particularly in relation to raising the age of transition into adult services.

xxiii. Continue to monitor homelessness trends and impacts of Welfare Reforms on homeless people to enable an evidence based response to adapt the Local Welfare Provision where necessary and report the impacts of Welfare Reforms to commissioners, the Jobcentre Plus and the Department of Work and Pensions.

xxiv. The Homelessness Strategy Steering Group review the number, use and awareness of emergency weekend bed schedule for adults and especially for young homeless referrals and discharge from hospital or custody.

xxv. Homelessness commissioners undertake a city-wide review of valued services which may come under threat due to lack of funding. Immediate consideration should be given to determine their value to the city's Homelessness Model and health outcomes for individuals for The Two Saints Day Centre and 'Breathing Space' project and the Vulnerable Adult Support Team in the University Hospital Southampton NHS Trust's Emergency Department.

CONCLUSION

85. There is an established and effective Homeless Prevention Strategy with a strong Partnership delivering good services for the City. This Partnership, however, needs to expand to wider health services and other agencies working with homeless people such as the Hospital, Police, the National Probation Trust and the Hampshire Community Rehabilitation and Prison Release Service to be more effective.

86. There are many excellent services in operation across the City but single homeless individuals continue to suffer health inequalities and remain amongst the most marginalised residents, suffering many barriers to accessing the services. Increasing the understanding and awareness of other agencies who refer and deal with single homeless people should lead to more effective support and signposting and referral for individuals. Dealing with the mental health and substance abuse of homeless individuals, especially with earlier intervention for young people, is critical to them moving on. In addition, the lack of any 'dry' houses in the City can limit the options and willpower of those who want to be sober.

87. A large proportion of homeless clients have been through the care system or suffered abuse or neglect at a young age, which will impact on their behaviour and emotions. Work underway to transform the life chances of care leavers and multi-agency approach to providing early help will hopefully reduce the homelessness of future generations of children in need through early intervention.

88. There remains an entrenched group of individuals in the system who are hard to move on or relapse frequently who due to their complex needs and behaviours. These clients are expensive to the public purse and consideration should be given to whether more intensive Housing First model would make a difference for these individuals.

89. The Panel recognises the difficulties of achieving a paradigm shift in the lifestyle choices of individuals. The Homelessness Prevention Model in operation enables many homeless people to move on but for many move on from homeless services needs time and access to the right support mechanisms and treatment. Sustaining housing is the first and only outcome we can truly achieve for a number of these individuals – any further transformation will ultimately only come when they are ready to change.

ANNEXE 1

INQUIRY TERMS OF REFERENCE AND PROGRAMME

1. **Scrutiny Panel:**
   Health Overview and Scrutiny Panel

2. **Membership:**
   a. Councillor Matthew Stevens (Chair)
   b. Councillor Matthew Claisse
   c. Councillor Carol Cunio
   d. Councillor Georgina Laming
   e. Councillor Brian Parnell
   f. Councillor Sally Spicer

3. **Purpose:**
   To consider the impact of housing and homelessness on the health of single people, a significant number of whom have complex needs, live unsettled and transient lifestyles, and to examine the difficulties that their everyday life presents to deliver a preventative and planned approach to improve their health and wellbeing and access to a settled and decent home.

5. **Background:**

4.1 This Inquiry will focus on the health of homeless single people. The definition of homelessness for this Inquiry will be those who are sleeping rough, living in insecure accommodation such as a squat or sofa-surfing, in short-term accommodation such as a hostel or recently moved into to private rented accommodation for the first time after a period of homelessness. It will also examine the quality and impact of accommodation that homeless people move on to, which is likely to be either a shared home or a single unit.

4.2 The rationale to focus on single homeless people stems from the high demand for single person's accommodation, with over half of the 15,000 people on the housing register are in need of single units. Evidence suggests that a high proportion of homeless individuals having complex health needs, requiring significant and intensive support from specialist services. The Southampton experience, through the 2013 Homelessness Strategy Review identified homeless single people are:

- More likely to be marginalised or isolated, with limited support networks
- Less likely to be in priority need for the council to house them but likely to have aggregate needs that will make their life more chaotic
- Experience barriers to accessing mainstream primary care
- More likely to have no recourse to public funds
- Significantly affected by the Welfare Reforms, particularly changes to the local housing allowance, migrant benefits rights and Universal Credit

4.3 Homeless families and older people over 65 are much more likely to be accepted as homeless due to a priority need and are the key focus for other current initiatives such as the Families Matter and the Better Care (Integrated Transformation Fund) programmes. Therefore these groups will not be included as part of this Inquiry.

4.4 The model for homelessness prevention in Southampton is delivered and commissioned by a wide range of public and third sector providers and has a strong history of collaboration and good practice through the Homeless Prevention Strategy. Despite preventing a large number of single households from becoming homeless in 2012/13 there were still 520 people on the Homeless Health Team's register. However, increasing trends of homelessness are adding pressures on services for homeless people.

4.5 The national picture of funding these services is also changing with financial pressures in the public sector. Nationally, the ring-fence for Supporting People grants has been removed and across the country councils are reducing spend on Supporting People services. Additional budget pressures also prevalent in the public and third sector are placing further pressures on the services that support homeless people.

4.6 There is much evidence published that homelessness and poor quality housing can have a significant and negative impact on an individual's health and wellbeing. Those who are who have slept rough have significantly higher levels of premature mortality. Homeless Link undertook a national audit of over 700 homeless people which demonstrated the inequality in the health needs of homeless people:

- **Mental Health** – 7 out of 10 homeless people have one or more mental health needs, although they may not be diagnosed, it is estimated that 30% of the general population experience some form of mental distress; over a third of homeless clients said they would like more support. It is estimated mental health costs £9.7 million in Southampton, with £1.3 million worth of anti-depressants prescribed in 2011/12.
- **Substance misuse** – Over half of clients in the audit use one or more types of illegal drug, with around a quarter engaged is some form of treatment or support. 3 out of 4 clients consume alcohol regularly, with 1 in 5 drinking harmful levels. Alcohol misuse in hospital admissions and primary care treatment is estimated to cost £12 million per annum in Southampton.
- **Physical health** – 8 out of 10 homeless people had one or more physical health needs including:

Condition	**Homeless People**	**General Population**
Musculoskeletal problems	38%	10%
Respiratory problems	32%	5%
Eye complaints	25%	1%

- **Tuberculosis** – TB rates have doubled in the UK in the last 10 years. The homeless population is particularly vulnerable to the disease, and more likely to present with advanced forms. However, even if diagnosed and being treated a homeless patient is also more likely to discontinue treatment given their chaotic lifestyle.

4.7 Primary care is the first point of contact for health services to respond to an individual's health needs. However, evidence in the national audit suggests that homeless people are more likely to access healthcare through emergency services, with their stay likely to be longer. Their lifestyles may also mean that they are more likely to seek medical help when their condition has significantly deteriorated. The review will examine the picture of homelessness access to health care service in the city.

4.8 Historically, single homeless people have predominantly been males over 30, anecdotally these are often people who have had traumatic or troubled life experiences including service men, care leavers and offenders; however, in recent years the trend has changed to reflect a larger proportion of women with the age profile getting younger. The interventions to support homeless people are generally split into those for young people, aged 16-25 and adults.

4.9 The pathway from rough sleeping to settled and suitable accommodation can be a long one and requires intensive support to help an individual to move on. It is estimated that it takes 7 attempts for an individual to make a real difference to their lives through intervention, equating to approximately 2 years for individuals with intensive support to turn things around. The panel will need to recognise the long term support needed to make a difference to these individuals and will examine the challenges and opportunities for the current homelessness support and health services delivery.

6. Objectives:

a. To understand the current model for homelessness prevention supports and how it promotes better health outcomes for single people
b. To recognise what works well and what needs to improve locally, learning from best practice nationally.
c. To identify if there are any gaps or blockages in homeless prevention and health interventions for single homeless people
d. To explore how the Houses in Multiple Occupation (HMO) Licensing scheme contributes to the health and wellbeing of tenants who have been homeless, or at risk of homelessness, and what opportunities there are to provide further support by working in partnership with others.
e. To explore the adequacy of single accommodation and the effectiveness of the support pathway that leads to settled accommodation for those who have been homeless, in line with any existing contract periods.
f. To consider further collaboration or 'invest to save' opportunities that would prevent future increasing demand or reduce homelessness in the city, within existing budget constraints.

7. **Methodology:**
    a. Outline of current national policy and local activity including:
        - The service model for homelessness prevention and Supporting People
        - National and local data on health inequalities for single homelessness
    b. Engage commissioners, public sector and third sector providers
    c. Visit facilities to understand service provision and talk face to face with clients and frontline staff
    d. Understand client needs through direct contact with service users alongside case studies
    e. National and local health audit results and key data for Southampton
    f. Identify and consider best practice and options for future delivery:
        - National best practice examples
        - Local success stories

8. **Proposed Timetable:**
    Five meetings February 2014 – May 2014

ANNEXE 2

SUMMARY OF WITNESSES TO THE INQUIRY

MEETING 1: 20 FEBRUARY 2014
SETTING THE NATIONAL AND LOCAL SCENE

Sarah Gorton, South East Regional Manager Homeless Link
Liz Slater - Housing Needs Manager
Matthew Waters - Commissioner Supporting People and Adult Care Services
Pam Campbell - Consultant Nurse, Homeless Healthcare Team

The agenda papers for the Panel meeting can be found here:
http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=477&MId=2826&Ver=4

MEETING 2: 20 MARCH 2014
SERVICE AND HEALTH PROVIDERS PERSPECTIVE

PART A: Accommodation and support services through the voluntary sector
Liz Slater - Housing Needs Manager
Guy Malcolm - Operations Director, Society of St James,
James McDermot - Regional Director, Two Saints
Alison Ward - Project Manager, No Limits
Tina Hill - Service manager, Chapter 1

PART B: Access to and discharge from health services
Pam Campbell - Consultant Nurse, Homeless Healthcare Team
Jackie Hall - Substance Misuse Commissioner, SCC Integrated commissioning Unit
Dr Shanaya Rathod - Director of Research & Development, Southern Health

The agenda papers for the Panel meeting on 20th March can be found here:
http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=477&MId=2536&Ver=4

SITE VISITS IN MARCH
Two Saints – Cranbury Avenue Day Centre, Patrick House, Breathing Space
Homeless Healthcare Team
Salvation Army – Booth Centre
Society of St James – Southampton Street
Chapter 1 – Alma Road

MEETING 3: 2 APRIL 2014
ACCESS TO AND SUSTAINING LONG TERM ACCOMMODATION

PART A: Access to suitable long term accommodation for single homeless people

Sherree Stanley - Manager- Housing Delivery & Renewal
Mitch Sanders - Head of Regulatory Services and **Janet Hawkins**, Team Leader
Fred Knight - Southern Landlords Association South Hampshire Branch
Alison Ward - Project Manager, No Limits
Dominic Thompson - Real Lettings South, Two Saints

PART B Supporting people into sustaining long term accommodation:
Peter Walton - Booth Centre, Salvation Army, Operations Manager
Steve Curtis - Family Mosaic, Regional Manager

The agenda papers for the Panel meeting on 20th March can be found here:
http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=477&MId=2828&Ver=4

MEETING 4: 29 APRIL 2014: TACKLING COMPLEX HEALTH AND OTHER NEEDS ASSOCIATED WITH HOMELESSNESS

PART A: Children and Adult Safeguarding.
Fiona Mackirdy & Mary Hardy - Children safeguarding Children Looked After
Carol Judge - SSAB Board Manager Adult safeguarding
Matthew Waters – Commissioner, Supporting People and Adult Care Services

PART B: Police and Probation - identification and support of homeless people
The Police perspective – Inspector **Sharman Wicks**, Portswood HQ
Probation Services - **Robbie Turkington,** Operations Manager, Southampton Probation

PART C Impacts of Welfare Reforms, migration and No Recourse to Public Funds
Sara Crawford - SCC Improvement Manager - Welfare Reforms
Liz Slater - Housing Needs Manager
Dave Adcock - Project Manager EU Welcome - Homelessness in Migrant workers

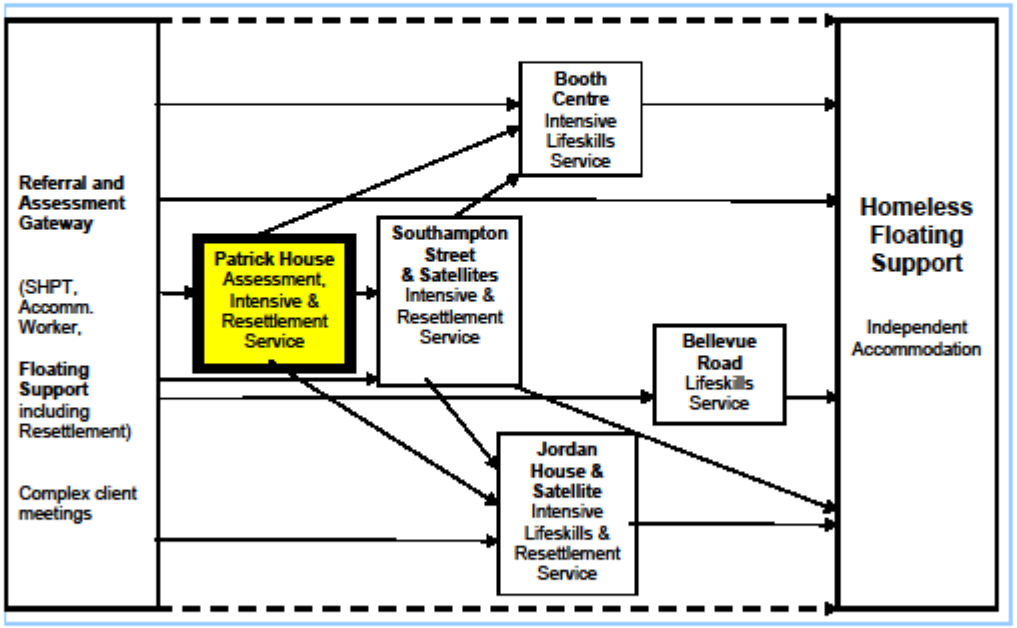
PART D Primary care and services connected with the hospital
Sara Charters - Consultant Nurse Emergency Care, UHS Emergency Department Vulnerable Adult Support Team (VAST)
Meriel Chamberlain, UHS Integrated Discharge Bureau
Nick Maguire – Senior Lecturer Clinical Psychology, University of Southampton
Dr Steve Townsend, Chair, Southampton CCG
Annabel Hodgson, Healthwatch Southampton HOSP representative

The agenda papers for the Panel meeting on 20th March can be found here:
http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=477&MId=2829&Ver=4

MEETING 5: 15th MAY
Considering the key issues and potential recommendations

ANNEXE 3

Southampton Homelessness Services – Model of Provision and Services



*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
A: A strategic city-wide approach to homelessness				
i. The Homelessness Prevention Strategy continues to support city-wide commitment for continued funding of the existing flexible and innovative partnership model of homelessness in the city.			Homelessness Strategy Steering Group	
ii. Commissioners undertake a feasibility study including a cost/benefit analysis, with providers, to consider whether a more intensive 'Housing First' model could provide the relatively small number but high cost entrenched homeless clients a potential route into sustainable and settled accommodation.*			Southampton Integrated Commissioning Group (ICU)	
iii. The Housing Strategy continues to prioritise an increase in affordable			Development, Economy and Housing Renewal	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
single person accommodation across the City, including new developments.				
iv. Links are maintained and strengthened between homelessness prevention and employment projects such as City Limits and the new City Deal to increase the skills and employment opportunities for homeless and vulnerably housed individuals.			Housing Needs / Skills and Regeneration	
B: <u>Raising awareness and recognition of homelessness issues and protecting valued services</u>				
v. Continue to build relationships with landlords to raise awareness and common understanding of the issues and barriers of homeless tenancies and increase social letting with relevant support agencies. This includes bringing together the current range of city			Homelessness Strategy Steering Group	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
approaches for social lettings to the private sector housing rental market.*				
vi. Raise awareness of good practice and successful outcomes in homelessness prevention services as a means of reducing the stigma for homeless clients and encourage wider partnership involvement of other agencies including the Police and National Health Services including GPs and the University Hospital Southampton Trust.*			Homelessness Strategy Steering Group	
vii. Expand the partnership to wider health services to reduce inequalities for homeless people services through delivering a comprehensive framework of preventative and integrated services.*			Homelessness Strategy Steering Group	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
viii. Raise the awareness of healthcare professionals of the role of homeless healthcare provider case workers and the value of their support of the single homeless, particularly through advocacy.*			Homelessness Strategy Steering Group	
ix. Maintain an overview of the cost benefit of key valued services within the City's Homelessness model, including the Homeless Health Care Team and dedicated specialist services supporting substance misuse and mental health problems.			Southampton ICU / Clinical Commissioning Group	
x. Consider outcomes from the Southampton Healthwatch review of GP registration and continue to work with GPs to improve access and integration to support homeless clients to			Healthwatch	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
move on from homeless health care to primary care services.				
C: <u>Improving service delivery</u>				
xi. The Homelessness Strategy Steering Group continue to support commissioners as they progress towards an evidence-based and outcome-focussed commissioning model so that the case for changes in policy and practice can be evidenced.			Southampton ICU	
xii. Children and Family Services continue to prioritise the Multi-Agency Safeguarding Hub (MASH) and Early Help Team to ensure children in need are not falling through the gaps.*			Children and Families	
xiii. Children in Care continue to be a priority,			Children and Families	

*HOSP's Priority Recommendations are shown in bold
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Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
particularly in preparing those in care to lead an independent life and that care leavers have access to suitable accommodation and maximise opportunities for employment, education and training.*				
xiv. Homelessness Services work with National Probation Trust and the Hampshire Community Rehabilitation to support more pre-release planning to ensure emergency bed spaces are being used appropriately and to include looking at possibility of avoiding Friday prison releases.			Homelessness Strategy Steering Group	
xv. **Commissioners of Homelessness services should consider the option of providing a 'dry' environment within the homelessness prevention model in the City to support those**			Southampton ICU	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
who want to become or stay sober.*				
xvi. Homelessness providers and commissioners should work towards developing 'psychologically informed environments' in hostels and develop a staff training programme as appropriate. Partnerships between the psychological support from the University of Southampton and local housing providers are essential to achieving this.*			Southampton ICU	
xvii. Undertake a fundamental review of Mental Health services for the City, specifically including improving access to behaviour therapies for homeless clients and considering			Southampton ICU	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
raising the age for transition for young people into adult services to 24 years in line with the thresholds for the Integrated Substance Misuse Service. Early intervention should be prioritised alongside improving access to services from primary to acute care to ultimately reduce and better manage demand.*				
xviii. Investigate opportunities to reduce barriers and provide incentives for Houses in Multiple Occupation (HMOs) to be used for homeless clients.*			Regulatory Services	
xix. Expand training on homelessness services / welfare services to community first responders and primary care services e.g. Hampshire Police,			Public Health	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
Ambulance Services, GPs and community nurses				
D: <u>Monitoring and reviewing critical services and issues</u>				
xx. Regulatory Services undertake an evidence based review of the effectiveness of the HMO licensing scheme to ensure that standards of quality are maintained for all private sector tenants in the City and to support the decision making process for whether to expand the scheme to other wards in the city. It should be recognised that those who have been homeless will be moving on into the lower cost / quality end of the market where risks to their health remain high.*			Regulatory Services	
xxi. Regulatory Services			Regulatory Services	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
consider options to undertake a new stock condition survey to gain a better understanding of the quality of the City's private housing stock and establish mechanisms and resources to secure an up to date survey at least every 6 years.*				
xxii. Integrated Drug and Alcohol Substance misuse service to report to the Health Overview and Scrutiny Panel on how changes to service delivery will support homeless people more effectively, particularly in relation to raising the age of transition into adult services.			Southampton ICU	
xxiii. Continue to monitor homelessness trends and impacts of Welfare Reforms on homeless			Skills and Regeneration, Local Welfare Provision	

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
people to enable an evidence based response to adapt the Local Welfare Provision where necessary and report the impacts of Welfare Reforms to commissioners, the Jobcentre Plus and the Department of Work and Pensions.				
xxiv. The Homelessness Strategy Steering Group review the number, use and awareness of emergency weekend bed schedule for adults and especially for young homeless referrals and discharge from hospital or custody.			Homelessness Strategy Steering Group	
xxv. Homelessness commissioners undertake a city-wide review of valued services which may come under threat due to lack of funding.				

*HOSP's Priority Recommendations are shown in bold
KEY: Y – Accepted; AIP - Accepted in part; R - Rejected

Recommendation	Accepted, In part or rejected	Outline of work in progress or future plans (denote which)	Lead organisation or group	Key Partners
Immediate consideration should be given to determine their value to the city's Homelessness Model and health outcomes for individuals for The Two Saints Day Centre and 'Breathing Space' project and the Vulnerable Adult Support Team in the University Hospital Southampton NHS Trust's Emergency Department.				

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		HEALTH INEQUALITIES IN SOUTHAMPTON		
DATE OF DECISION:		3RD DECEMBER 2014		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Martin Day**	**Tel:**	**023 809187831**
	E-mail:	**Martin.day@southampton.gov.uk**		
Director	**Name:**	**Dr Andrew Mortimore**	**Tel:**	**023 80**
	E-mail:	**Andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report provides an opportunity for the Health and Wellbeing Board to reflect on the health inequalities that exist in the city, to explore the wider determinants that impact on health inequalities, and develop a view as to whether other partners and stakeholders may have a more significant role to play in the long-run in securing a reduction in health inequalities.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board considers whether a wider range of organisations and agencies can be engaged in addressing health inequalities.

(ii) That if specific health inequality topics are identified for further investigation, a working party be established and report its finding back to the Health and Wellbeing Board at a future date.

REASONS FOR REPORT RECOMMENDATIONS

1. To create wider opportunities to address health inequalities in the city.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. Addressing health inequalities is a key priority for the Health and Wellbeing Board.

DETAIL (Including consultation carried out)

3. The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to produce a Joint Strategic Needs Assessment which utilises information and intelligence to describe the health of the city and identify health inequalities. The Act then goes on to state that Boards should then use the information set out in the JSNA to prioritise actions and set these out in the Joint Health and Wellbeing Strategy (JHWS) to improve the health of the city and reduce health inequalities.

4. In common with many other Health and Wellbeing Boards, Southampton's JHWS reflected what are referred to as the "Marmot principles". This relates to a major national report produced by Professor Sir Michael Marmot at the Institute of Health Equity at University College, London. In November 2008 Professor Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. Entitled "Fair Society, Healthy Lives", this landmark study produced in 2010 presented a large volume of evidence which demonstrated that people with higher socioeconomic position in society have better health than those with a lower socio-economic status.

5. Following a thorough analysis of a very high volume of evidence the Marmot team identified the following key messages:

1. Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
2. There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
3. Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.
5. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
6. Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.
7. Delivering policy objectives to reduce health inequalities will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.
8. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

6. The report identified 6 key policy objectives to reduce health inequalities:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

These policy objectives are integrated throughout the Southampton Joint Health and Wellbeing Strategy.

7. Recognising how important and valuable the work of Professor Marmot and his team at UCL is, Public Health England commissioned the Institute of Health Equity to produce a series of briefing papers specifically geared towards assisting Health and Wellbeing Boards to address health inequalities. The first block of health equity briefings has recently been published. These briefings relate to the first five policy objectives set out in the above paragraph, and cover the following topics:

Early intervention	• Good quality parenting programmes • Improving the home to school transition
Education	• Building children and young people's resilience in schools • Reducing the number of young people not in employment, education or training (NEET) • Adult learning services
Employment	• Working interventions to improve health and wellbeing • Working with local employers to promote good quality work • Increasing employment opportunities and retention for people with a long-term health condition or disability • Increasing employment opportunities and retention for older people
Ensuring a health living standard for all	• Health inequalities and the living wage
Healthy environment	• Fuel poverty and cold-home relate health problems • Improving access to green spaces

The health equity briefings have already been supplied to members of the Health and Wellbeing Board. They can be accessed via the following link: https://www.gov.uk/government/publications/local-action-on-health-inequalities-evidence-papers

The briefing papers are backed up by more detailed evidence reviews.

8. The forthcoming Director of Public Health's Annual Report will analyse local health inequalities, many of which will already be familiar to members of the Board. Local headline information includes the following:

- Life expectancy for men is 6.7 years lower for those living in the 20% most deprived areas of the city compared to those living in the 20% least deprived areas and the gap is widening.
- Life expectancy for women is 3.2 years lower for those living in the 20% most deprived areas of the city compared to those living in the 20% least deprived areas and the gap is widening.
- Premature mortality (under 75s) is 95.4% higher in the 20% most deprived areas of the city compared to the 20% least deprived areas.
- Premature circulatory disease mortality (under 75s) is 120.1% higher in the 20% most deprived areas of the city compared to the 20% least deprived areas, although there is some evidence that the gap is narrowing.
- Premature cancer mortality (under 75s) is 56.9% higher in the 20% most deprived areas of the city compared to the 20% least deprived areas, and there is no evidence that the gap is narrowing.
- Mortality from COPD is 124.9% higher in the 20% most deprived areas of the city compared to the 20% least deprived areas, although there is some evidence that the gap is narrowing.

9. Taking account of the issues set out in the PHE/IHE documents, in conjunction with local data, the Health and Wellbeing Board may wish to consider the following questions:

- Where does responsibility for reducing health inequalities lie?
- What is the level of understanding of the levels and the consequences of health inequalities?
- How do the plans and strategies of other partnerships and agencies link with the work of the Health and Wellbeing Board on reducing health inequalities within the city and the city region
- How can the Health and Wellbeing Board effectively engage with other sectors and communities not represented on the Board in a meaningful discussion on health inequalities?
- What other support is required from the health and care community to address these issues?
- What can other sectors offer to the solution, and what is in it for them if they can be effectively engaged?

10. Representatives from a variety of sectors have been invited to the meeting and will have the opportunity to present views and comments from their organisational and professional perspectives.

11. Ideas and comments generated in discussion can be captured and recorded. Some may be useful to include when work begins to review the Joint Health and Wellbeing Strategy in 2016. Alternatively, the Board may wish to identify mechanisms if, as a result of these conversations, more detailed work and analysis needs to be undertaken before work begins on refreshing the Joint Health and Wellbeing Strategy.

RESOURCE IMPLICATIONS

Capital/Revenue

12. None.

Property/Other

13. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to ensure that a Joint Strategic Needs Assessment is to describe the health of the city and identify health inequalities. The Act then goes on to state that Boards should then use the information set out in the JSNA to prioritise actions and set these out in the Joint Health and Wellbeing Strategy (JHWS) to improve the health of the city and reduce health inequalities.

Other Legal Implications:

15. None

POLICY FRAMEWORK IMPLICATIONS

16. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	Public Health England / Institute of Health Equity briefing papers: Local action on health inequalities.

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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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		BETTER CARE SOUTHAMPTON UPDATE		
DATE OF DECISION:		3RD DECEMBER 2014		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION, INTEGRATED COMMISSIONING UNIT		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 8029 6941**
	E-mail:	**Stephanie.ramsey@southampton.gov.uk**		
Director	**Name:**	**Alison Elliott, Director of People** **John Richards, Chief Executive**	**Tel:**	**023 8083 2602** **023 8029 6923**
	E-mail:	**Alison.Elliott@southampton.gov.uk** **John.richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

Southampton submitted its initial Better Care Fund (BCF) local plan on 4 April 2014. Since then there have been some changes to the national policy framework underpinning Better Care and further national guidance has been issued by the Local Government Association and NHS England. Health and Wellbeing Boards were required to submit revised plans by 19 September 2014.

NHS England confirmed on 29th October 2014 that the Southampton Better Care Fund (BCF) local plan was "Approved with Support". This report outlines the implications of this and provides progress update on the implementation of the plan. As part of Better Care there is a requirement to develop a pooled fund which needs to be in place to be in place from April 15 and the timeline for the approval of this is also included within the report.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board notes the approval of Southampton's Better Care Plan, following the Nationally Consistent Assurance Review (NCAR) process.

(ii) That the Health and Wellbeing Board notes the progress made towards the implementation of Better Care Southampton.

(iii) That the Health and Wellbeing Board approves the Section 75 pooled fund agreement at the 28 January 2015 meeting.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of comprehensive spending review 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 was 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. It should be noted that this is not new money; the funding will be top sliced from existing budgets. Local authorities and the clinical commissioning group (CCGs) were 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 would be met.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

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

DETAIL (Including consultation carried out)

3 **Summary of Southampton's Better Care Fund Plan**

3.1 Better Care Southampton plan was approved by the Health and Wellbeing Board in March 2014, with strong stakeholder support. The re-submission followed the same direction of travel.

3.2 The vision for Better Care is to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, fully engaged and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention.

3.3 Our overall aims 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 to stay in their own homes for as long as possible
- 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

3.4 There are 6 main schemes:

- **Local person centred coordinated care** - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7 day working – this will impact on those people most at risk who will benefit from case and disease management, roughly 5% of our population (around 12,000 people), but also support those at more moderate risk (35,500 people) who would benefit from supported self-care. The majority of this target group will be older people (65+) and those with multiple long term conditions.

- **Long Term Conditions pathways** – key areas of focus are COPD, given the high proportion of respiratory admissions, and diabetes.

- **Integrated discharge, reablement and rehabilitation** service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home, in the community, intervening quickly where required to prevent deterioration, as well as supporting people's recovery and reablement following a period of illness. The scheme will particularly focus on reducing long term admissions to residential and nursing homes and preventing delayed transfers of care.

- **Community development** – this scheme is aimed at developing local community assets and supporting people and families to find their own solutions. This is key to the overall development of our local person centred coordinated care model.

- **Supporting carers** – this scheme recognises the important role that carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care. This will support the new eligibility framework within the Care Act where, for the first time, councils will be under a duty to provide support for carers who have eligible needs.

- **Developing the market for placements and packages** – this includes work to develop the market to provide greater opportunity and choice, encourage a recovery/reablement focus and support people to remain as independent as they can be in their own homes.

4. **Plan approval**

4.1 Southampton's Better Care Plan has been approved with support following the Nationally Consistent Assurance Review (NCAR) process. The confirmation letter, Appendix A, states that there are no areas of high risk in the plan and as we should progress with plans for implementation. Although the areas of support the review identified are essential to successful delivery in the medium term NHS England do not consider them as material at this stage.

4.2 Ninety-seven per cent of areas across the country are approved (about 30 per cent with some conditionality) and only five are not approved.

4.3 Ongoing support and oversight of the BCF plan will be led by NHS England Regional/Area Team along with Local Government Regional peer rather than the BCF Taskforce from this point onwards. An update on the outstanding actions had to be submitted by 14th November and further feedback is awaited.

5 Section 75 development – pooled fund

5.1 Local areas are required to set up a single pooled budget and for Southampton City the minimum value of the pooled fund is £15.325m. None of this is new money. Approximately £7m will be the existing Carers, Reablement and Social Care Transfer Grants, £908k will be the Disabilities Facilities Grant, £618k the Social Care Capital Grant and the remaining million will come from existing CCG commissioning budgets.

5.2 However, local areas had local discretion to agree how much funding to allocate and encouraged to use this opportunity to achieve transformational change. Southampton intends to take a holistic approach to out of hospital health and social care and fund and commission it in that way. Our ambition is to encompass all services that fit within the scope of the Better Care model and current modelling suggests a total pooled fund of £131,060m. The split between the forecast contributions are currently 57% CCG and 43% LA.

5.3 Work is currently underway to develop a Section 75 with both local authority and health legal and finance expertise. The work is being overseen by the Integrated Commissioning Board. This will require sign off by Health and Wellbeing Board, Cabinet and CCG Governing Body in January 2015.

5.4 The pooled fund agreement will cover governance and technical aspects including accountability, financial reporting, how overspends, underspends and savings requirements will be handled. Partners need to ensure they have an agreed risk management strategy at the outset for how risks will be managed.

5.5 It is proposed a phased approach is adopted, whereby pooled funds are established within the S75 Partnership Agreement as and when schemes have been fully worked up. The schemes are as outlined in 3.7 above. This would mean that from 1 April 2015 the full £131,060m is not pooled but the amount of funding pooled is incrementally increased over the lifetime of the Agreement. (This approach would need to be mindful of the budgets that are mandated to be included from 1 April 2015.)

6. Progress

6.1 There is already significant momentum in delivering the Better Care programme.

- The 6 local cluster areas, based around GP practice populations, through which integrated care will be delivered are progressing with cluster leadership teams in place
- Pilot of elderly care nurse role to support primary care in work with patients over 75 years of age
- Purchase of additional reablement and domiciliary care for the remainder of 2014
- BCF newsletter being sent to all stakeholders
- Work underway with Community navigator role
- New geriatric fracture clinic will start to see patients over 75 years old with a fracture – early Dec

- Partnership development between Age UK, Solent and Active Options to provide exercise classes and Southampton City Council housing
- Significant work has been done across the system on reviewing discharge processes. The trusted assessor model is being rolled out with inreach coordinators and discharge facilitators being trained to assess, restart and set up simple packages. Discharge to assess is also being implemented with 12 beds commissioned in the nursing home sector to support this.
- A concept paper for a more integrated model of rehabilitation and reablement is currently being consulted on.
- The domiciliary care tender is progressing with a new framework due to go live in February 2015.

6.2 As well as being the key programme for strategic change in our local health and social care system, the Better Care plan is also pivotal to operational resilience this winter and improving ED performance. With this in mind, Southampton received a visit on 30 October from the Cabinet Office Implementation Team, which provides confidential advice to ministers. The visit was highly successful and a copy of our presentation is attached at Appendix 2. It describes the broad range of initiatives underway or starting soon and their intended impact.

6.3 Key performance indicators progress:

- On track - Permanent admissions of older people (65 and over), to residential and nursing care homes by 100,000 population, although costs are not reducing
- Slippage - Delayed Transfers of Care (delayed days) from hospital per 100,000 population (average per month
    - Non Elective Admissions (Rate per 100,000)
    - Local Priority: Injuries due to falls in people 65 and over

RESOURCE IMPLICATIONS

Capital/Revenue

7. Southampton intends to take a holistic approach to out of hospital health and social care and fund and commission it in that way. Our ambition is to encompass all services that fit within the scope of the Better Care model.

   Current modelling suggests a total pooled fund of £131.060m. The split between the forecast contributions are currently 57% CCG and 43% LA.

8. A draft Section 75 agreement is being complied. The finalised pooled fund agreement will progress through appropriate organisational approval. The fund will be developed in a phased approach

Property/Other

9. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

10. NHS England Publications Gateway Ref. No.00314 and Ref.No, 02396

Other Legal Implications:

11. None.

POLICY FRAMEWORK IMPLICATIONS

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

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	NHS England assurance letter - Publications Gateway Ref. No. 02396
2.	Briefing on Better Care for Cabinet Office Implementation Team

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	

NHS England

Publications Gateway Ref. No. 02396

Quarry House
Quarry Hill
Leeds
LS2 7UE

E-mail: england.coo@nhs.net

To:
Southampton Health and Wellbeing Board
NHS Southampton CCG

Copy to:
Southampton City Council

29th October 2014

Dear colleague,

Thank you for submitting your revised Better Care Fund (BCF) plan. We know that the BCF is an ambitious programme and preparing the plans at pace has proved an immensely challenging task. However, your plan is now part of an ongoing process to transform local services and improve the lives of people in your community.

It is clear that your team and partners have worked very hard over the summer, testing out ways of working and finding innovative solutions to some of the challenges our services face in order to improve people's care.

NHS England is able to finally approve plans once the 2015/16 Mandate is published. I am pleased to let you know that, following the Nationally Consistent Assurance Review (NCAR) process, provided there is no material change in circumstance and the 15/16 Mandate is published as expected, your plan will be classified as **'Approved with Support'** once the 15/16 Mandate has been published. This recognises that whilst your plan is strong the review process identified a number of areas for improvement which once addressed will enable you to move to a fully approved status. This category means that your plan will be approved and your BCF funding will be made available to you subject to the following standard conditions which apply to all BCF plans:

- That you complete the agreed actions from the NCAR in the timescales agreed with NHS England;
- The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released

into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

The conditions are being imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

Appended to this letter is your NCAR Outcome Report which documents the agreed actions. Please work with your Area Team Lead Felicity Cox (Felicity.cox1@nhs.net) to agree a timetable for when you will submit the additional information/evidence required on the back of the NCAR report.

We are confident that there were no areas of high risk in your plan and as such you should progress with your plans for implementation. Although the areas of support the review identified are essential to successful delivery in the medium term we do not consider them as material at this stage.

Any ongoing support and oversight with your BCF plan will be led by NHS England Regional/Area Team along with your Local Government Regional peer rather than the BCF Taskforce from this point onwards.

Non-elective (general and acute) admissions reductions ambition

As there is a considerable amount of time between the submission of BCF plans and their implementation from April 2015, we recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Once again, thank you for your work and we look forward to the next stage.

Yours sincerely,

Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

SOUTHAMPTON CITY COUNCIL

NHS
Southampton City
Clinical Commissioning Group

Better Care Fund

Reducing Demand for Hospital Care over Winter 2014/15

Thursday 30th October 2014

Agenda

Introduction to Southampton

Our Plans for Winter

- Better Care Fund -
&
- Operational Resilience & Capacity Plan -

Our Targets & Impact Over Winter

Introduction to Southampton

- Southampton's Population is **c.265,000**
- Our spend on acute activity is **54%** and growing
- A higher proportion of older people in Southampton rely on **input from social services** than is the case nationally (**5.2%** compared with 3.8%)
- Around **86,000 people** in Southampton are estimated to be living with **long-term health conditions**
- The **over 65s** population is set to increase by **11%** between 2012 and 2019
- A review of **non-elective hospital admissions** for 2013/14 showed that **38%** (10,260) were **over the age of 65**

Our Better Care programme is therefore focussing on older people and those with multiple long-term conditions

Introduction to Southampton

Southampton City Council

NHS Southampton City Clinical Commissioning Group

Our vision for Better Care is to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as **locally** as possible and **person centred**.

Southampton's Health and Wellbeing Board's priority is 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.

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.

OUR VISION

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

Our Plans for Winter

The **Better Care Fund** is our key strategic goal to **shift the balance of care**. Our core interventions include:

- Person Centred Coordinated Local Care
- Better Discharge and Reablement
- Engaged & Resilient Communities

Our **Operational Resilience & Capacity Plan** describes how the system will operationally **work together** to deliver our Better Care Programme.

This plan will:

- ✓ **Accelerate** the implementation of our **Better Care Fund** strategy over the winter
- ✓ **Reduce elective and non elective** demand for hospital care over the winter

South West Operational System Resilience

Urgent Care Pathways

Southampton City Clinical Commissioning Group

Self-Help, Primary Care, Social Care

NHS 111

GP

Pharmacy

Dentist

Patient has an urgent problem that can't be managed through self-help, primary care or social care.

NHS 999

Urgent Care

Minor Injuries Unit

Eye Casualty

First Responder

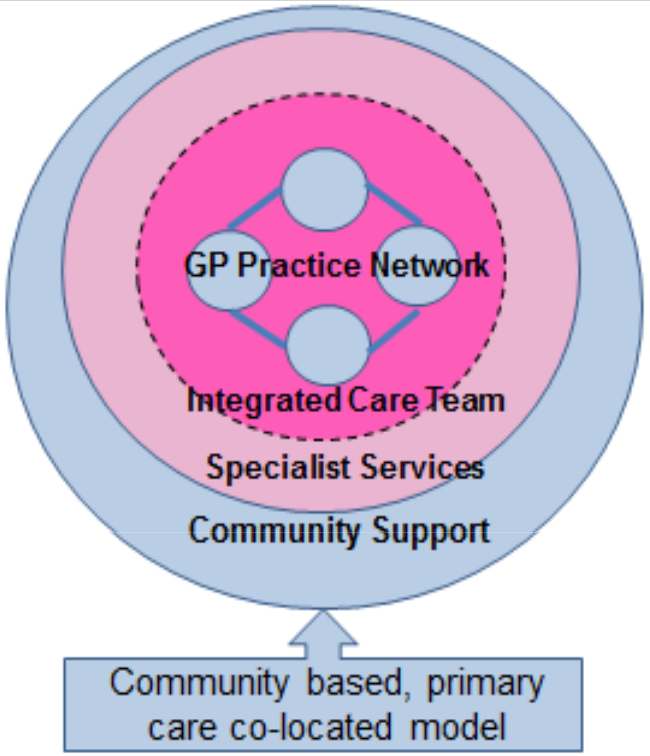
ED

A&E

Ambulance

Elective outsourcing to relieve pressure and avoid cancellations

Better Care Fund



Our approach:

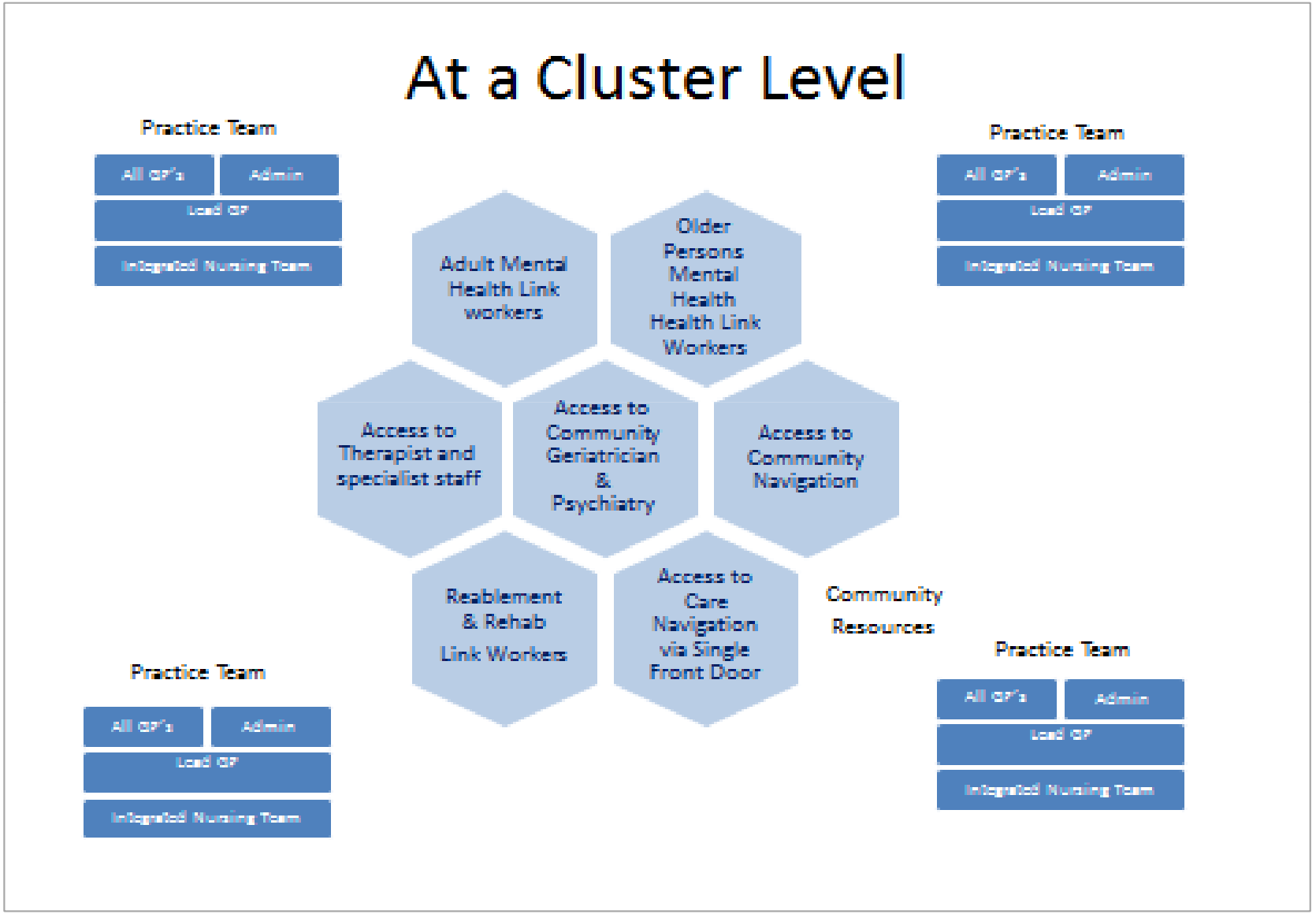
- Reconfiguration of health into integrated cluster based teams, based on GP practice populations, with strong links to social care
- Teams to include community nurses, therapists, geriatricians, MH nurses, primary care, housing and voluntary sector
- 7 day working within teams
- Development of a personalised care promoting workforce across all services
- Introduction of a common trusted assessment and planning tool and accountable professional role
- Full integration of mental health into the integrated care model
- Introduction of a single point of access for integrated care

Southampton City wide services
(more specialist service or where economies of scale require a city wide model)

Cluster team Based around practices | Cluster team Based around practices | Cluster team Based around practices | Cluster team Based around practices | Cluster team Based around practices | Cluster team Based around practices

Wrap around Community Support

Better Care Fund



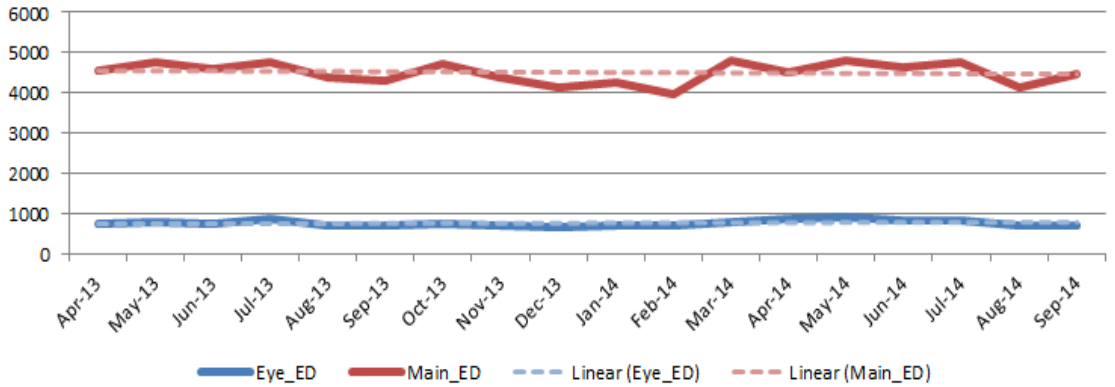
Southampton Performance

NHS Southampton City Clinical Commissioning Group

A&E Attendances

(Apr 2013 - Sep 2014)

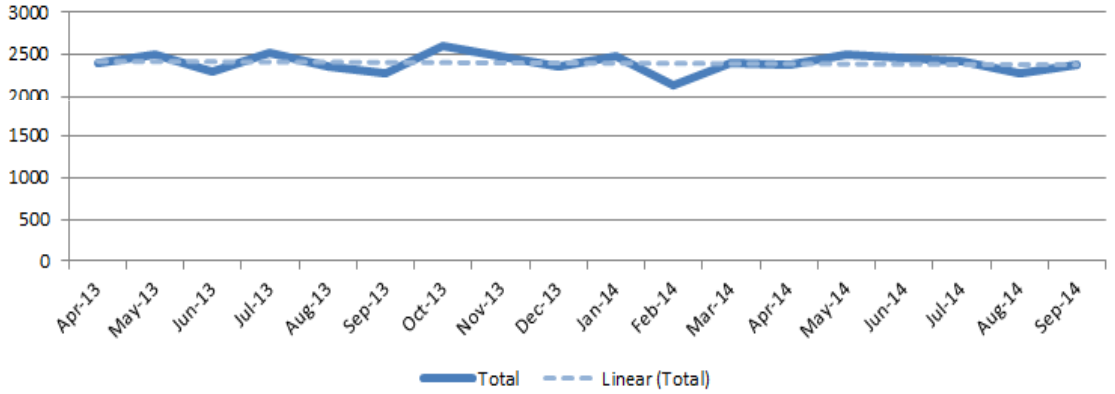
Source: SUS Data



Non-Elective Inpatient Admissions

(Apr 2013 - Sep 2014)

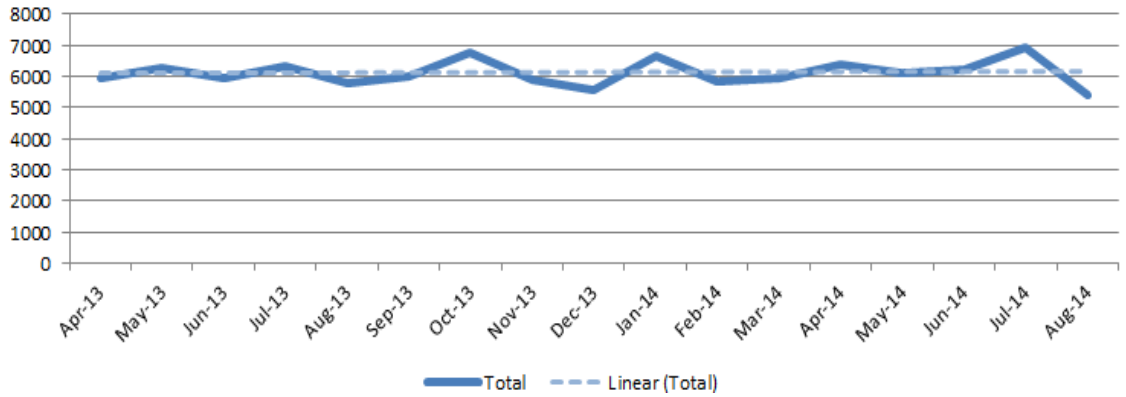
Source: SUS Data



Referrals

(Apr 2013 - Aug 2014)

Source: C3 Report



Our Plans for Winter

Southampton City Clinical Commissioning Group

Our Better Care Fund and Operational Resilience & Capacity plans will focus on **3 key areas** over the winter:

- **ED Front Door**
- **Back Door**
- **Managing Long-Term Care in the Community**

Implementation of our plans will also help to accelerate the delivery of our **Better Care Fund outcomes**:

Better Care Fund Outcomes

- *Non Elective Admissions*
- *Delayed Transfers of Care*
- *Older people staying at home longer after discharge*
- *Injuries due to Falls*
- *Permanent Admissions of Older People to Residential & Nursing Homes*
- *Patient experience*

SOUTHAMPTON CITY COUNCIL

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Southampton City
Clinical Commissioning Group

ED Front Door

ED Front Door

SOUTHAMPTON CITY COUNCIL

NHS Southampton City Clinical Commissioning Group

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Additional GP Out of Hours *7 day working*  ✓ **324 additional GP appointments out of hours** in the evenings and at weekends ✓ Target population is patients with **long term conditions** ✓ This is a **key risk group** for non elective admissions outside of core GP opening hours	Accident and Emergency • Reduction in **A&E attendances and non elective admissions**, by providing patients with more GP appointments. NHS Minor Injuries unit • **Reduction in utilisation WIC and MIU** by improving access to services in the community.	**December 2014**
In-Hospital Therapy *7 day working*  ✓ **Additional therapy staff** on the front door, **across 7 days** ✓ Focus on **pulling patients out of ED/AMU** and into the **Medicine for Older Persons wards** and providing acute **rehab** during their hospital stay.	 • Reduction in patient **length of stay**  • Reduction in **wait for rehab** beds as some patients will be able to go directly home  • Reduction of **ED breaches**	**Mid November 2014**

ED Front Door

NHS Southampton City Clinical Commissioning Group

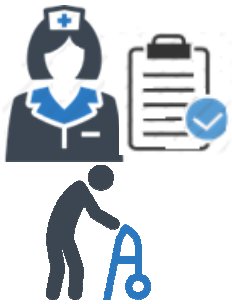
What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Mental Health Support in A&E *7 day working*   ✓ **Additional Mental Health practitioners** at the front door, during the **night, weekends and bank holidays (7 day working)** ✓ This will support the assessment and treatment of patients who present with mental health needs and **improve the throughput in ED**	Accident and Emergency • Preventing unnecessary **non elective admissions** by arranging appropriate community care  • Improved **response times** and fewer breaches	**In Progress**
✓ **Vulnerable Adult Support Team** (VAST) undertaking psychological interventions ✓ Ensures that **underlying mental health problems are addressed**, in addition to urgent physical health needs.	Accident and Emergency • Reduction in **non elective admissions**  • Reduced **length of stay in ED**  • **Reduced risk of repeat attenders**	**In Place**

ED Front Door

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
ED Front Door Transfer Team *ED Flow* 	✓ **New front door transfer team** to reduce the delays around **patient moves** to downstream wards.	 • Reduction in current **transfer times** by 2 hours.  • Reduction in **length of stay** in ED and AMU  • Releases **AMU capacity** to support ED admissions	**November 2014**
ED 'Pit-Stop' Service Model *ED Flow* 	✓ Implementation of an **additional 2 assessment areas** to implement front door early assessment and treatment, called 'pit stop' ✓ **Diagnostics and assessments are carried out at the front door**, rather than waiting until the patient is in majors.	 • Improved **patient flow** in ED  • Reduction in **length of stay** in ED	**Start October 2014**

ED Front Door

Southampton City Clinical Commissioning Group

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Frailty Rapid Assessment Service 	✓ **Additional staff** at the front door to carry out **comprehensive geriatric assessments** of patients in ED ✓ If appropriate, pull patients into the **ambulatory care** pathway.	Accident and Emergency • Reduction in **non elective admissions** for over 80's patients.  • Reduction in **ED length of stay** for over 80's patients.  • Reinforce links across older persons pathway (**Cluster Teams** & acute care)	**End October 2014**
Personalised Care for over 75's *£5 per head* 	✓ **20 additional senior practice based nurses** across Southampton, funded by the £5 per head scheme ✓ Right skills and experience to meet the needs of the **over 75 population** and to work **collaboratively** in primary and secondary care, together with **social care and local community groups.**	Accident and Emergency • Reduction in **non elective admissions** for over 75's  • Reduced **length of stay** for over 75's  • Reduction in **urgent GP appointments** for over 75's	**Phased Approach** 10% additional nurses now in place 30% in place in Nov 60% in place in Dec

SOUTHAMPTON CITY COUNCIL

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Southampton City
Clinical Commissioning Group

Back Door

Back Door

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
In-Reach Coordinators *7 day working* 	✓ **Extension of in-reach coordinator roles** for AMU, Medicine for Older People (MOP) and Trauma & Orthopaedic wards ✓ In reach coordinators **identify and navigate the transitions of care** across health and social care ✓ Focus on trauma cases 65yrs+ ✓ Focus on orthopaedic & MOP cases 80yrs+	• Reduction in **length of stay, excess bed days and delayed transfers of care** • Reduction in **readmission** rates • Reduction in **patients on IDB list** • Reduction in **waiting for community beds**	**In-Reach Coordinators in place** **Extension in Nov-Dec**
Integrated Discharge Bureau Manager 	✓ Appointment of an **Integrated Discharge Bureau Manager** to lead the delivery of discharge across the city	• **Improved flow** from hospital into the community • Reduction in **length of stay/excess bed days**	**January 2015**

Back Door

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Responsive Discharge & Reablement 	✓ **12 additional beds** from the nursing home sector for **CHC and other complex patients (discharge to assess)**	• Reduction in **length of stay, excess bed days and delayed transfers of care**	**12 CHC beds in place**
	✓ Additional integrated **rehabilitation & reablement capacity**	• Reduction in time from **checklist to discharge**	**Dom Care from February 2015**
	✓ Recommissioning **domiciliary care** provision	• Additional capacity to **discharge to assess 12 additional CHC patients a month**	
Trusted Assessors 	✓ **Social care training** for In-Reach Coordinators and Hospital Discharge Facilitators, enabling them to be competent at **restarting pre-existing care packages**	• Reduction in **length of stay** • Reduction in **waiting for discharge**	**Early November 2014**

SOUTHAMPTON CITY COUNCIL

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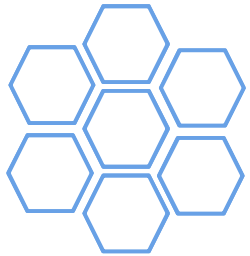
Southampton City
Clinical Commissioning Group

Managing Long-Term Care in the Community

Long-Term Care in the Community

Southampton City Clinical Commissioning Group

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Cluster Teams Integrated Working *7 day working*  ✓ Work proactively with the most **complex client group** towards meeting their future needs ✓ Promotion of **self-management** ✓ Early **intervention & prevention** ✓ Signposting to community resources within local area ✓ Delivering **health improvement plans** for the Cluster population	• Working with the In-Reach Coordinators to enable a **pull approach to discharge** • More **robust long-term care** • Development of **person-centred plans** and promoting use of personal budgets and direct payments	**In Progress**
Community Navigators *Building Community Capacity* ✓ Development of **community solutions** (co-production) ✓ Development of our **Community Navigator** role, embedded within 3rd sector partners	• Patients who require low-level support to move towards managing own care will have **access to additional services**	**January to March 2015**

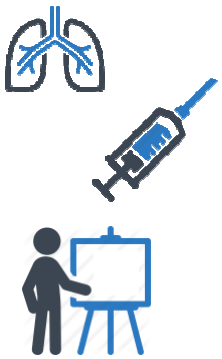
Long-Term Care in the Community

Southampton City Clinical Commissioning Group

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Personalised Care for Over 75's 	✓ Community nursing for over 75's, working in **partnership with Cluster Teams**	Accident and Emergency • Reduction in **non elective admissions** for falls or medication related incidences  • Increase in the number of patients **self-managing**  • Shift in balance of care from institutional to **home-based care**	**In Progress**
Risk Stratification *Earlier Intervention* 	✓ Development of a **proactive multi-agency risk stratification** tool ✓ Bringing together a breadth of information to **identify those people most at risk** of deterioration and intervene earlier, maintaining and promoting independence. ✓ Target group is **older people (65+)** and those with multiple **long-term conditions**	 • Greater number of anticipatory care plans developed following risk stratification Accident and Emergency • Reduction in **non-elective admissions**	**In Progress**

Long-Term Care in the Community

Southampton City Clinical Commissioning Group

What's being implemented?	How will this reduce demand for hospital care over winter?	When will it happen?
Increasing Capacity of Primary Care & Community Nursing 	✓ Increasing the **community nursing capacity** across the city to support primary care	Accident and Emergency • Reduction in **non elective admissions**	**In Progress**
	✓ Placing **advanced nurse practitioners** into a small number of GP practices	 • **Care plans** for patients with long-term conditions	
Long-Term Conditions Community Management *COPD & Diabetes* 	✓ **Integrated pathway** for adults with Chronic Obstructive Pulmonary Disease (COPD), providing both community based consultant and nurse led clinics and home visits	Accident and Emergency • Reduction in **non elective admissions**	**In place or In Progress**
	✓ Implementation of **primary care Diabetes Accreditation Scheme** to enhance quality of care	 • Reduction in **excess bed days**	
	✓ Implementation of **diabetes integrated model of care**, with stronger focus on self management & professional education		
	✓ Influenza and Pneumonia **vaccinations**		

Our Targets & Impact Over Winter

Reduce Non-Elective Admissions	**2% Reduction** next year, starting Q4 14/15
Reduce Delayed Transfers of Care (DTOC)	DTOCs are high in Southampton and we have seen significant growth during the start of 2014/15. Our target over winter is to **hold this growth**, with a reduction planned in 2015/16
Reduce Permanent Admissions to Residential & Nursing Homes	**5% Reduction** next year, starting Q4 14/15
Reduce Injuries due to Falls	**12.5% Reduction** next year, starting Q4 14/15

Our System Wide Governance Structure