Appendix 1

Progress against priority outcomes

Priority	Actions	Anticipated Outcomes	Investment £	Progress September 2013
Continuation of schemes with contractual agreements in place				
Peer support – to develop focus on self management and reduce incidence of relapse	Peer Support services commissioned Timebanking development	Decreased risk of relapse Decreased symptoms Increased self esteem Reduced stigma Increased control over their future Increased community involvement Improved quality of life Increased social support and networks Increased independence Feeling safe in the community	50,000 15,000	Peer support has led to an increase in an individual's wellbeing and independence, reducing their need for support and input from other services. As at June 2013 there were 200 Timebanking members who had exchanged more than 1800 hours activity with each other
Increasing access to psychological therapies	Additional investment within current IAPT contract to widen focus to support people with Long term conditions The future plan	Increase in people feeling supported to manage their condition Improving functional ability in people with long term conditions - employment of people with long terms conditions Reducing time spent in hospital by people with long	170,000	The project has limited outcomes to date; this is not unexpected due to the stage the project is currently at. There is an evolving research base to support the inclusion of psychological support in the treatment of patients with Long term health conditions (LTHC) Outcomes that have been demonstrated in

	is to focus on a particular LTHC, diabetes, as this has demonstrated best outcomes in the national pilots in reducing cost to health and social acre and reducing need for intensive treatments/ encouraging adherence to treatment. Fits with IPCC Meets following strategic criteria - Helping individuals and communities to work together and help themselves", Theme 1 of the H& WB	term conditions - unplanned hospitalisation for chronic ambulatory care sensitive conditions Enhance quality of life for carers - health related quality of life for carers Increased quality of life, ability to self care, compliance with treatment and satisfaction with services received Decreased service utilisation, resulting in potential cost saving		other pilots include: Significant improvement in general psychological measures; PHQ, GAD and WSAS. Significant improvement in diabetes specific psychological measures; self-caring activities, general diet, specific diet and foot care. Significant improvement in blood markers from pre-intervention to 3 month post intervention. Reduction in healthcare cost, Primary Care and Secondary Care utilisation. There is some evidence of outcome in - Staff changes in knowledge, skills, confidence and understanding – through training evaluation Increase in detection of common mental health problems Additional audit for end of scheme includes - Patient changes including; physical health outcomes, mental health outcomes, quality of life indicators, patient's satisfaction, patient confidence in managing self-care and feedback from carers. Qualitative and quantitative information will be included.

	Strategy, “Building resilience and using preventative measures to achieve better health and wellbeing.”. Supports roll out of self-care.			Audit of changes to referral rates to the Steps to Wellbeing IAPT service and the outcome of patients involved with this service.
Alcohol prevention and early treatment	Tender for Tier 1 and 2 service provision	Tier 1 and Tier 2 - Individual outcomes (via accredited monitoring tool outcome we or star) Tier 1 and Tier 2 - Service outcomes (via accredited monitoring tool outcome we or star) Increase in number of screening and BI undertaken, based on agreed penetration, and year on year improved rate across drinking population Achievement of standard of 1 in 8 people reducing alcohol consumption as a result of BI Increase in % of people who	95,200	Increase in number of screening and Brief Interventions I undertaken, In Quarter 1 of 2013/14 the provider is achieving well above the target rate for initial screening and Brief Interventions in telephone, face to face and BIT contacts. Currently approximately 1 in 10 people in contact with the service reduce their alcohol consumption to recommended levels Increase in % of people who reduce their alcohol consumption to recommended levels - The first year’s activity indicates that 10% of people in contact with the service reduce their alcohol consumption. This will become the benchmark for

		reduce their alcohol consumption to recommended levels Improved efficiency , reduction in DNA, increased volume at Tier 1 Service take-up reflects population profile of Southampton and demonstrates equality of access (including age, gender, ethnicity, city ward, GP practice)		improvement in the next 12 months.
Initiatives to support increase uptake and use of direct payments	The Pilot is targeted to support the City Plan social priority of "increasing take up of clients receiving self-directed support" and contribute to the One Council priority of transformation.	Increase in direct payments The purpose of the ISF Pilot is to help identify:- (i) the specific benefits(or dis-benefits) of an ISF for customers, carers, providers and the Council; (ii) Customer demand for an ISF; (iii) the costs of delivering an ISF An Evaluation Report is scheduled for April 2014, and will include the impact of ISF on:- • Customer choice and control	37,400	The Pilot is at the mid-stage now and an interim evaluation has been completed by each Provider. Findings include:- i) A positive customer demand for ISF. E.g. the Pilot is not only exploring how customers on an SCC "managed account" can transfer to an ISF, but also attracting customers in the Shared Lives service, and a customer who's "suitable person" is no longer able to mange the DP on their behalf; (ii) An increase in customer and carer satisfaction. E.g. "Carers have been willing to be involved and have viewed ISF as a way of their relative having more control and choice over services";

		over services; • Customer and carers satisfaction; • The Transition process • Culture change in relationships between customers, provider and the LA; • Service costs; • Progression to a Personal Budget being taken as a Direct Payment (DP). The two Providers will produce a joint “How to - ISF” Guide at the end of the Pilot to inform other providers.		(iii) An emerging interest in considering taking a DP at the end of the Pilot. (iv) An innovative change in PARIS to record the ISF, which also has SCC savings potential on all DP accounts and is a step-change from “time and task” support plans. (v) New and effective partnership working relationships which have improved parent engagement e.g. between Spectrum, SEND Inspector and parent. (vi)The negative impact on stakeholders of the complex records/finance processes and systems within SCC, and inefficiencies.
Vulnerable Adult team in ED		Safeguarding vulnerable children, young people and adults. Improving people’s health by helping them to make better lifestyle choices Creating easy referral pathways from secondary to community care Increasing opportunities for self-resilience. Reducing health inequalities	55,000	On average, the Vulnerable Adult Support Workers intervene in the care of 110 patients per month. They are a key referring team to a multitude of community agencies, often identifying and referring patients who are not being identified through other pathways Data provided by key partners suggest the following engagement rates for Southampton City patients (post codes SO14-19): • 80% engagement with the

		amongst those who come from the most deprived populations within the City Promoting better access to services, particularly for those who find it difficult to engage Working in productive partnerships with patients and other health and social care providers Care that is integrated with community services and designed around individual need Review of weekly assault data and multi-agency risk assessment conference (MARAC) lists demonstrate that the VAST are significantly reducing individual patient and organisational risk relating to domestic homicide, due to their comprehensive interventions. VAST plays an important role for the Safe City Partnership by providing weekly data on assaults, as well as impact data about large drinking events.		Independent Domestic Violence Advocacy Service for high risk domestic abuse cases (n = 8/10) from mid July-Dec 12. 75% engagement for standard / medium risk cases referred to Southampton Women's Aid (n=4/6) from mid July-Dec 12. • 54% of referrals to the Quitters service were interested in smoking cessation when contacted post ED attendance ie, booked to clinic, given telephone support or referred to local service (18% not interested; 28% uncontactable). With a UHS average quit rate of 65%, it is estimated that 53 patients referred by ED from May-Dec 12 will have given up smoking for four weeks or more. • Of 81 patients referred to Options/CRI, 35% (n= 28/81) engaged with assessment and 9 patients (11% of total) were referred on to New Road for alcohol treatment. • Of 61 patients referred to the New Road Frequent Attendee Service by VAST and/or the UHS Alcohol Specialist Nurse Service, 83% have engaged with the New Road team. • 58% of referrals to the Drug

				Outreach Team (n = 7/12) from Jul-Dec 12 accessed drug treatment at The Bridge or New Road. The team are playing a major role in meeting the requirements of CQUIN 2013/14 for high intensity users. Evaluation of the alcohol related frequent attendee programme, of which the Vulnerable Adult Support Service plays a major role (through identification and referral of frequent attendees) has demonstrated an average saving per quarter per client of just over £1000. Over a 35-day period, the Vulnerable Adult Support Workers spent 60% (155 out of 262.5 hours) of their time in face-to-face, and other direct clinical activity. If the Vulnerable Adult Support Workers were not available much of this work would either be undertaken by clinical staff or would not be undertaken at all.
Minimise assessment waits and targeted reviews	Increased care management capacity x3		130,600	
Social workers/care managers hospital discharge team to further			346,100	

improve assessments and planning from when date of discharge set				
Newly identified schemes that meet the criteria				
Reablement – specific initiatives to support speedier implementation including medicines management Increase access to equipment, including further development of telecare	0.5wte Telecare technician Telecare project manager OT specialist support	Increase widely held professional awareness of the use of telecare Reduction in care packages due to use of telecare Reduce delayed transfer of care from hospital, attributable to equipment shortage/availability Increase proportion of people who were offered telecare services following discharge Increased number of clients enabled to stay in their place of choice Reduction in admissions to residential and nursing care homes Increased proportion of community to bed based funded packages of care Reduce emergency readmissions within 30 days of discharge	61,500	Increased uptake of telecare opportunities
Prevention/ raising quality in	Quality assessor team	Appropriately skilled workforce across commissioned sector	351,700	Implementation of quality reviews of provider organisations

residential and nursing homes	x 4.5wte	Improved quality standards across commissioned sector Evidence of more personalised care within care homes More choice being exercised by residents Improved activity programmes within residential homes Fewer medication related incidents Reduce avoidable and/or inappropriate ambulance conveyances. Reduce avoidable and/or inappropriate A&E activity Reduce avoidable and/or inappropriate acute admissions		Programme of care funding calculator reviews
Support to carers and focus on self-management	Advocacy support to parents with a Learning disability i therapy for LD clients Independent visitors	Reduced loneliness and isolation Improving health and wellbeing Improving education skills Increasing community spirit	87,900	

Improving hospital discharge	3 x Care manager posts Hospital Discharge admin officer Hospital Discharge weekend worker	Implementation of 7 day discharge service from acute hospital (unsure if this has been achieved) Increased proportion of older people who were offered rehabilitation services following discharge from acute or community hospital Increased proportion of older people 65+ who were still at home 91 days after discharge from hospital into reablement/rehabilitation services Reduce delayed transfer of care from hospital Reduce emergency readmissions within 30 days of discharge	198,300	Contribution to overall reduction 40% of complex patients now being discharged within 2 days, lower in comparison to neighbouring LA's Support available over weekend
Development of extra care services for those with dementia and complex health needs	Specialist adaptations to Graylings to ensure accommodation suitable for those with dementia	Improved levels of independence Admission avoidance improved Reduced isolation Reduction in emergency admissions for acute conditions that should not usually require hospital	89,000	Complete and Graylings about to start providing accommodation for individuals with dementia

		admissions		
It infrastructure			48,600	
Project management			14,000	
Schemes to support maintaining eligibility criteria (funding to support existing adult social care services)			2,380,000	
Outturn 2012/13			**3,495,167**	

2013/14 SCT Allocation	3,970,700
2012/13 Carry forward	147,100
2013/14 less funding for Maintaining Eligibility	-2,380,000
2013/14 Funding Available	1,737,800
2013/14 SCT Funding Requirement / Spending Plan	1,737,100
Surplus / (Deficit)	**700**