Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 28th January 2016
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor Furnell
Councillor Houghton
Councillor Noon
Councillor Parnell
Councillor Tucker
Councillor White (Vice-Chair)

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have six scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the Health Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview and Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

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

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

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

Use of Social Media: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting

COUNCIL'S PRIORITIES:

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

CONDUCT OF MEETING

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

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

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

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

DISCLOSURE OF INTERESTS

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

DISCLOSABLE PECUNIARY INTERESTS

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

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

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

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or

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

Other Interests

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

Any body to which they have been appointed or nominated by Southampton City Council
Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

Dates of Meetings: Municipal Year 2014/2015

2015	2016
23 July 2015	28 January 2016
1 October 2015	24 March 2016
26 November 2015	28 April 2016

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

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

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

3 DECLARATIONS OF SCRUTINY INTEREST

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

4 DECLARATION OF PARTY POLITICAL WHIP

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

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

(Pages 1 - 4)

To approve and sign as a correct record the minutes of the meeting held on 26th November 2015 and to deal with any matters arising, attached.

7 EMERGENCY DEPARTMENT PERFORMANCE

(Pages 5 - 10)

Report of the Chief Executive of University Hospital Southampton NHS Foundation Trust updating the Panel on the performance of the Emergency Department, attached.

8 UPDATE ON DISCHARGES FROM UNIVERSITY HOSPITAL SOUTHAMPTON

(Pages 11 - 24)

Report of the Chief Executive of University Hospital Southampton NHS Foundation Trust and the Acting Director of Adult Social Care, outlining progress being made reducing complex discharges in the Hospital, attached.

9 ADULT SOCIAL CARE: KEY PERFORMANCE INDICATORS
(Pages 25 - 30)

Report of the Acting Director of Adult Social Care outlining performance in Adult Social Care between April and December 2015, attached.

10 PUBLIC HEALTH GRANT REDUCTIONS
(Pages 31 - 40)

Report of the Director of Public Health outlining the approach that the Council is taking in response to reductions in the Public Health grant, attached.

11 UPDATE ON "GETTING THE BALANCE RIGHT IN COMMUNITY-BASED HEALTH SERVICES"
(Pages 41 - 64)

Report of the Director of System Delivery, NHS Southampton City CCG, providing the Panel with an update on the progress decommissioning the Bitterne Walk-In Services, attached.

12 IMPLEMENTATION OF A NICE COMPLIANT FOOT CARE PATHWAY
(Pages 65 - 88)

Report from NHS Southampton City Clinical Commissioning Group informing the Panel of plans to implement a National Institute for Health and Care Excellence (NICE) compliant Foot Care Pathway, attached.

13 MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE
(Pages 89 - 92)

Report of the Head of Legal and Democratic Services monitoring progress of the recommendations of the Panel, attached.

Wednesday, 20 January 2016 HEAD OF LEGAL AND DEMOCRATIC SERVICES

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 26 NOVEMBER 2015

Present: Councillors Bogle (Chair), Furnell, Houghton, Noon (Except Minute 18) and White (Vice-Chair)

Apologies: Councillors Parnell and Tucker

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

RESOLVED: that the minutes for the Panel meeting held on 1st October 2015 be approved and signed as a correct record.

14. **CARE QUALITY COMMISSION COMPREHENSIVE INSPECTION ACTION PLAN PROGRESS UPDATE**

The Panel considered the report of the Director of Medical Services updating the Panel on progress made against the CQC Action Plan submitted by Southern Health NHS Foundation Trust following the comprehensive inspection of the Trust in October 2014.

Katrina Percy, Chief Executive, and Chris Ash, Director of Integrated Services, Southern Health NHS Foundation Trust updated the Panel on progress with the Action Plan against the 129 recommendations highlighted in the 18 inspection reports received. In addition, John Richards - Chief Officer NHS Southampton City CCG, Joe Hannigan, Fairness Commission and Rob Kurn, Healthwatch Southampton were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel noted that overall, good progress has been made against the Action Plan. However, it was acknowledged that mental health services in the City were not at the level the Trust would hope for, although improvements had been significant in comparison with last year.

The Panel discussed the improvements made and how they had been achieved. It was reported that pathways to services had been simplified whilst partnership working was improving with better access to services. It was reported that services at Southampton General Hospital now covered seven days a week. There was improved provision for feedback from staff and service users and the improved levels of engagement with the Trust were welcomed by Healthwatch Southampton. It was noted that the results of the University of Southampton research commissioned by Healthwatch Southampton could be provided to the HOSP when available.

RESOLVED

(i) that an update on the progress by the NHS Foundation Trust on implementing the CQC Action Plan, be brought to a meeting of the Panel in Autumn 2016;
(ii) that the Panel give consideration to the parity of esteem when discussing the Integrated Commissioning Unit led 'Mental Health Matters' review; and
(iii) that the research commissioned by Healthwatch Southampton from the University of Southampton be circulated to the Panel when published.

15. **UPDATE ON THE DEVELOPMENT OF NEW CARE MODELS IN SOUTHERN HAMPSHIRE**

The Panel considered the report of the Director of Integrated Services (MCP West) Southern Health, updating the Panel on progress being made in developing the new model of care ('Better Local Care") to transform out of hospital care in Hampshire.

Chris Ash, Director of Integrated Services (MCP West), and Alex Whitfield - Chief Operating Officer Southern Health NHS Foundation Trust were in attendance and, with the consent of the Chair, addressed the meeting. In addition, at the invitation of the Chair, representations were heard from Joe Hannigan, Fairness Commission and John Richards - Chief Officer NHS Southampton City CCG.

The Panel heard that in Hampshire the approach to the Multi-specialty Community Provider (MCP) care model was based around GP surgeries and their registered patients, with a strong focus on self-management and prevention. There was also a commitment to simplify and shorten the pathway to specialist support even to the point of resolution at the first point of contact.

Progress in the year was outlined and it was reported that Southern Health NHS Foundation Trust were keen for South Hampshire vanguard programme monies to be used on programmes tailored for the City.

RESOLVED that the report be noted and a further report be brought back to the Panel as part of the wider picture of changes to services in the City.

16. **UPDATE ON "GETTING THE BALANCE RIGHT IN COMMUNITY-BASED HEALTH SERVICES"**

The Panel considered the report of the Director of System Delivery, NHS Southampton City CCG, providing the Panel with an update on the progress decommissioning the Bitterne Walk-In Services.

Peter Horne - Director of Systems Integration CCG, John Richards - Chief Officer NHS Southampton City CCG, and Dawn Buck - Head of Stakeholder Relations and Engagement, CCG were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel were provided with a verbal update on the outcome of the CCG board meeting of 25 November 2015 and the steps undertaken since the closure of the Bitterne Walk-In Service.

When questioned by the Panel about feedback received since the closure - it was reported that no complaints had been received and that groups involved in the formal consultation had supported the alternative services. Members enquired about getting specific feedback on the 111 service and progress on transport.

The Panel also considered the revised communications and engagement plan as circulated at the meeting.

RESOLVED that updates on the following issues be included in the report on this item at the meeting of the Panel on the 28th January 2016:

(i) transport issues; and
(ii) the impact of the closure of the Walk-In Service, including the impact on GP Practices.

17. **PROGRESS REPORT - THE IMPACT OF HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE**

The Panel received and noted the report of the Head of Legal and Democratic Services outlining progress made with implementing the recommendations approved by Cabinet from the HOSP inquiry into the impact of homelessness on the health of single people.

The Panel were given a detailed overview regarding the progress made against individual HOSP recommendations by Matthew Waters – Senior Commissioner ICU.

It was reported that the Street Homeless Prevention Team (SHPT) were effectively working to the Housing First model, although not by name, in achieving a housing first focus especially for very vulnerable and chaotic individuals where it was recognised sustaining housing was likely to be the only outcome that might be achieved for high cost entrenched homeless individuals.

The Panel noted and welcomed the successes reported in tackling issues around homelessness in the City, including:

- integrating employment and mental health services in order to produce a more flexible way of working with some individuals,
- provision of greater access to accommodation for young people and care leavers, including the Bellevue Road unit housing young parents,
- the Healthwatch work with GPs project to reduce the stigma of homelessness, the new guidance being issued to GPs had been picked up as a national issue by the British Medical Association,
- supporting homeless individuals to work as carers in the domiciliary care market,
- successes with the “dry house / dry unit environment” where greater flexibility allowed for better management of “slip ups”,
- achievement of positive outcomes for individuals despite the challenging financial climate and high proportion of benefit sanctions.

Overall, the Panel’s perception was one of improvement and the Panel agreed not to make any further recommendations.

18. **HEALTH AND ADULT SOCIAL CARE PORTFOLIO - 2016/17 BUDGET PROPOSAL HASC 8**

The Panel considered the report of the Chair of the Health Overview and Scrutiny Panel requesting that the Panel consider the 2016/17 Health and Adult Social Care Budget Proposal, HASC 8, the Setting of Personal Budgets to meet unmet eligible social care needs; together with the information contained in the Equality and Safety Impact Assessment (ESIA) relating to the proposal.

Paul Juan, Service Manager from Adult Social Care was present and at the invitation of the Chair responded to questions from the Panel.

It was highlighted that whilst the number of individuals involved was relatively small, the impact for them could be significant. The intention was to work with individuals to support their unmet eligible social care needs in the most cost effective way. Options included: extra care housing, residential or nursing care placement or individuals topping up their Personal Budget with their own resources to remain living independently at home.

The Panel overall, having heard how assessment and reviews of Personal Budgets might be carried out, felt that whilst the proposal could produce positive outcomes for the individuals currently affected, the process needed to be carefully managed to ensure positive outcomes.

RESOLVED that feedback from the budget proposal consultation be circulated to the Panel.

NOTE: Councillor Noon declared an interest and withdrew from the meeting for the consideration of this item.

19. **MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE**

The Panel received and noted the report of the Head of Legal and Democratic Services setting out progress on recommendations made at previous meetings.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		EMERGENCY DEPARTMENT PERFORMANCE		
DATE OF DECISION:		28 JANUARY 2016		
REPORT OF:		CHIEF EXECUTIVE, UNIVERSITY HOSPITAL SOUTHAMPTON		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Jane Hayward**	**Tel:**	**023 8120 6060**
	E-mail:	**Jane.Hayward@uhs.nhs.uk**		
Director	**Name:**	**Fiona Dalton, Chief Executive UHS**	**Tel:**	**023 8120 6060**
	E-mail:	**fiona.dalton@uhs.nhs.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY
The University Hospital Southampton Foundation Trust and system partners will update the Health Overview and Scrutiny Panel (HOSP) on the latest Emergency Department performance.

RECOMMENDATIONS:		
	(i)	That the Panel notes the report and following discussions agree any issues that may need to be brought forward to a future HOSP meeting.

REASONS FOR REPORT RECOMMENDATIONS	
1.	At the request of the Chair of the Panel.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None.
DETAIL (Including consultation carried out)	
3.	Attached as Appendix 1 is an update on emergency flow within University Hospital Southampton. The Panel are requested to note the good progress that has been made within the hospital and that, with the exception of August 2015, performance in 2015/16 has improved on 2014/15 in every month to date. However, the Trust is yet to meet the target of 95%.
RESOURCE IMPLICATIONS	
Capital/Revenue	
4.	N/A
Property/Other	
5.	N/A

LEGAL IMPLICATIONS			
Statutory power to undertake proposals in the report:			
6.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.		
Other Legal Implications:			
7.	N/A		
POLICY FRAMEWORK IMPLICATIONS			
8.	N/A		
KEY DECISION	N/A		
WARDS/COMMUNITIES AFFECTED:	N/A		
SUPPORTING DOCUMENTATION			
Appendices			
1.	Update on Emergency Flow in University Hospital Southampton		
Documents In Members' Rooms			
1.	None		
Equality Impact Assessment			
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No	
Privacy Impact Assessment			
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No	
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**			
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		

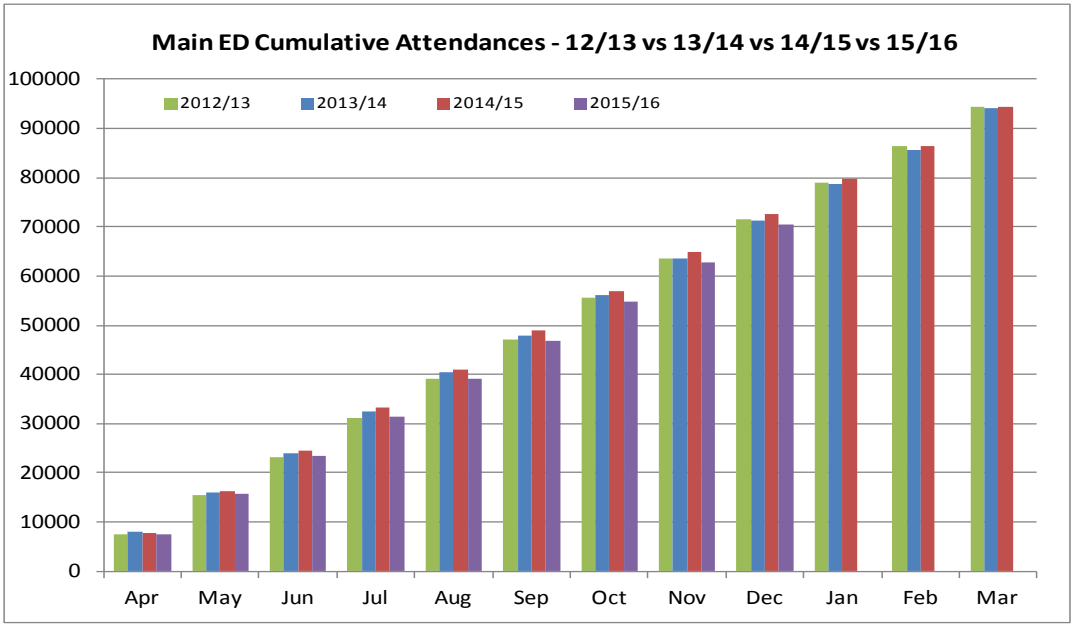
University Hospital Southampton FT

Update on Emergency Flow in University Hospital Southampton

This is an update to the papers previously provided to the Panel.

Activity

The table below shows the demand for Main ED (ie excluding MIU and Eye Casualty) over the current and previous 3 financial years:



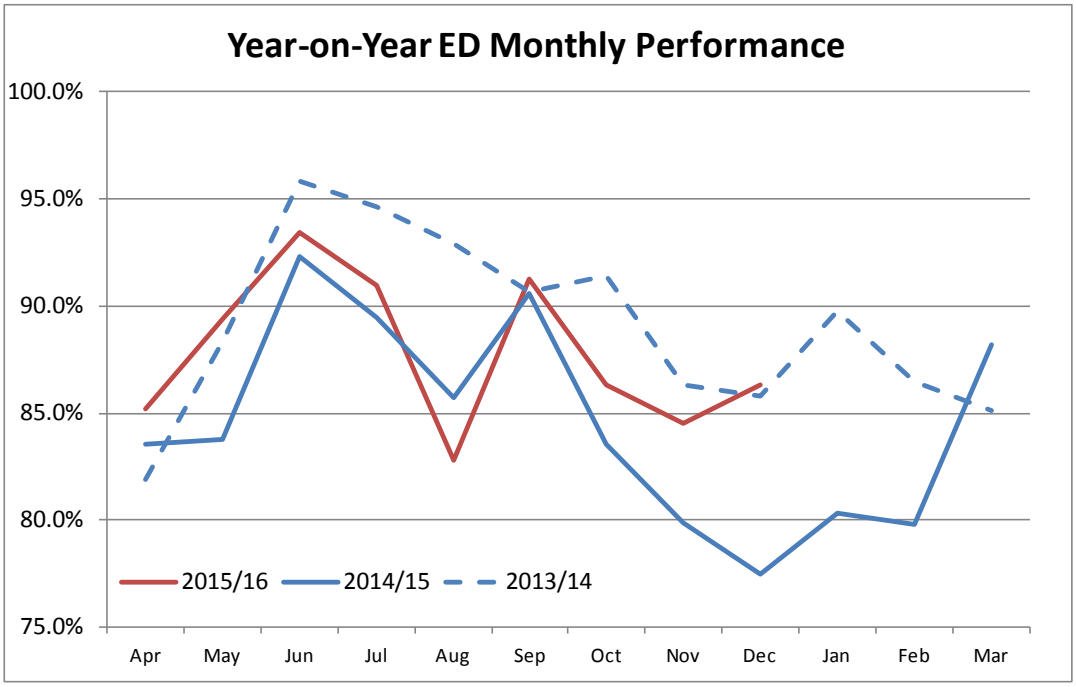
Year-on-year monthly ED attendances are down for each month from January to October 2015. However, a rise was seen in both November and December 2015 compared to the same months in 2014, with an extra 268 attendances recorded in across these months, equating to a 1.7% increase. Overall, attendances to main ED remain down by 2.7% (1,970 attendances) in 2015/16 compared to the previous year. However, it is also important to acknowledge the activity seen by Eye Casualty has increased. The table in Appendix 1 shows the same data but for Eye Casualty.

Performance

The performance by Main ED against the 95% target for can be seen on the table below, along with the 95th centile, mean and median waits:

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance: Main ED	2014/15	83.5%	83.7%	92.3%	89.5%	85.8%	90.6%	83.5%	79.9%	77.4%	80.3%	79.8%	88.2%
	2015/16	85.2%	89.4%	93.4%	91.0%	82.8%	91.3%	86.3%	84.5%	86.3%			
Performance: Main & Eye ED Combined	2014/15	86.8%	86.9%	93.7%	91.4%	88.3%	92.2%	86.5%	83.4%	81.4%	84.0%	83.7%	90.4%
	2015/16	87.6%	91.0%	94.5%	92.5%	85.6%	92.7%	88.5%	86.9%	88.4%			
Wait: 95th Centile (Main ED)	2014/15	07:51	07:11	05:10	05:56	06:35	05:53	07:41	08:12	09:54	09:14	09:48	06:31
	2015/16	07:28	06:11	04:55	05:33	07:13	05:29	06:20	06:40	06:18			
Wait: Mean (Main ED)	2014/15	03:31	03:25	03:01	03:10	03:22	03:05	03:25	03:37	03:50	03:39	03:43	03:12
	2015/16	03:21	03:11	02:58	03:04	03:27	03:07	03:17	03:23	03:18			
Wait: Median (Main ED)	2014/15	03:21	03:21	03:06	03:12	03:24	03:05	03:14	03:23	03:28	03:17	03:13	03:10
	2015/16	03:11	03:11	03:03	03:09	03:22	03:12	03:19	03:24	03:21			

With the exception of August 2015, performance in 2015/16 has improved on 2014/15 in every month to date, while April, September and December were also improvements on 2013/14



1. Next Steps

The ED remains subject to a formal RAP.

Most importantly a number of the actions in the plan are in place:

- the new 24/7 cover has started within ED (maximum of 4 nights per week)
- The ward reopened at the end of October
- The new Psychiatric service is in place and on site cover is available until 11pm
- Southampton performance on delayed discharges remains extremely good. This has not been mirrored in Hampshire.
- The new pitstop bays, in the ED extension, opened at the end of November
- There is a Winter bed plan

ED themselves are focusing on the quality of care within the ED environment and developing care pathways for admission. They also plan to visit other Trusts to share ideas.

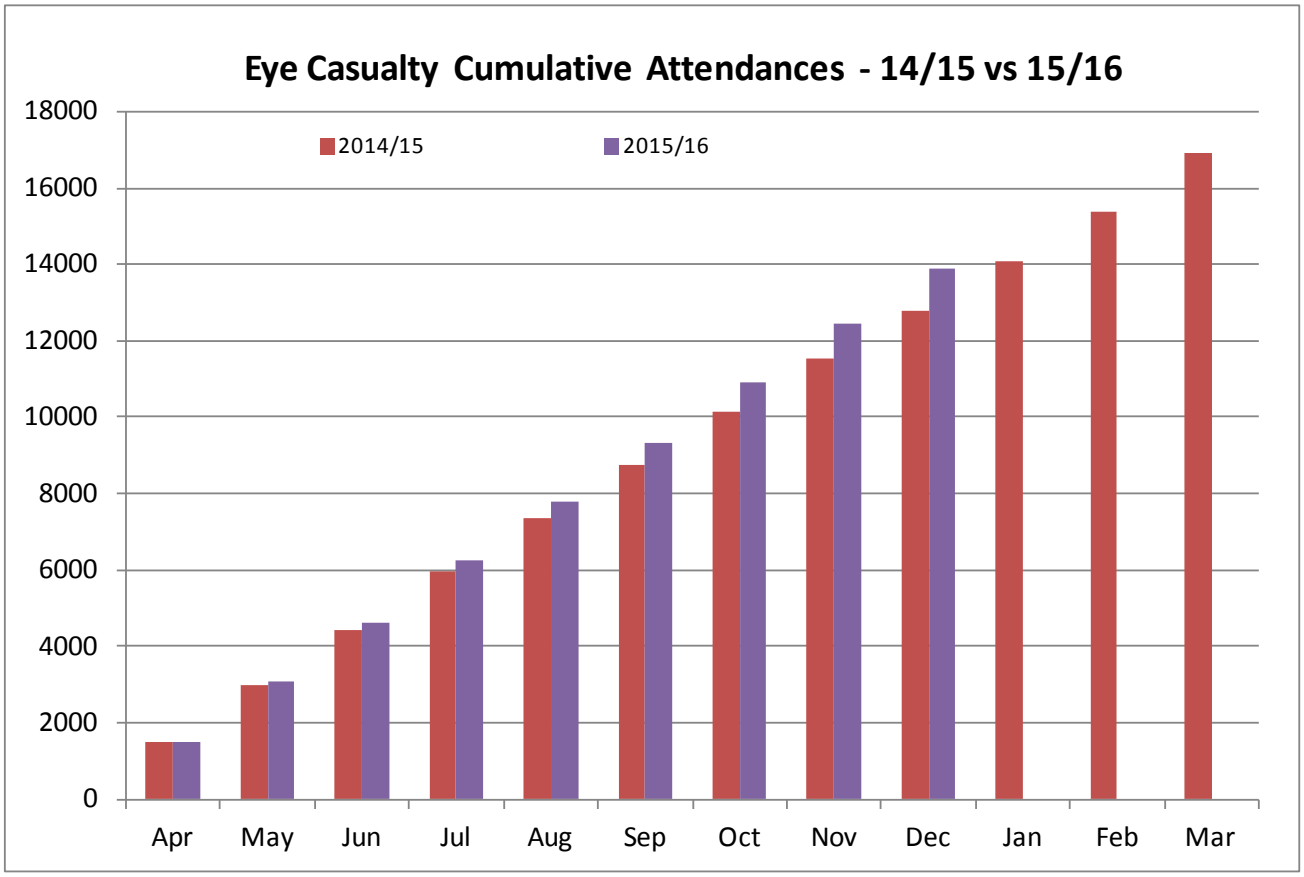
Conclusions

In 8 of the past 9 months, ED performance has improved on performance for the same months in the previous year. However the Trust is yet to meet the target of 95%. The ED remains subject to a formal remedial action plan.

ANNEX 1

1 Emergency pathway metrics

1.1 Eye Casualty Attendances



Activity in Eye ED has risen by 8.4% (1078 attendances) in 2015/16 compared to 2014/15.

NB: In April 2015, a change was made in the way in which Eye ED attendances are counted and was applied retrospectively to 2014/15 data to aid with trend monitoring. This resulted in a reduction in the total number of attendances reported and had an impact of approximately 0.5% to the Trust's combined overall ED performance. Data is not presented in this chart for years prior to 2014/15 as it would not be comparable.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON DISCHARGES FROM UNIVERSITY HOSPITAL SOUTHAMPTON		
DATE OF DECISION:		28 JANUARY 2016		
REPORT OF:		CHIEF EXECUTIVE, UNIVERSITY HOSPITAL SOUTHAMPTON AND THE ACTING DIRECTOR OF ADULT SOCIAL CARE, SOUTHAMPTON CITY COUNCIL		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Jane Hayward** **Mark Howell**	**Tel:**	**023 8079 6241** **023 8083 2743**
	E-mail:	**Jane.Hayward@uhs.nhs.uk** **Mark.howell@southampton.gov.uk**		
Director	**Name:**	**Mark Howell, Acting Director of Adult Social Care, SCC** **Fiona Dalton, Chief Executive, UHS**	**Tel:**	**023 8083 2743** **023 8077 7222**
	E-mail:	**fiona.dalton@uhs.nhs.uk**		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
The University Hospital Southampton Foundation Trust and representatives from Adult Social Care at Southampton City Council will update the committee on progress being made reducing complex discharges in the Hospital.		
RECOMMENDATIONS:		
	(i)	The Panel is asked to note the positive work which has been undertaken across the system since HOSP last considered this matter and the improvements which have been made.
	(ii)	The Panel is asked to note the specific issues of large packages of care and increasing funding pressures.
	(iii)	The Panel is asked to review progress against the action plan in three months' time.
REASONS FOR REPORT RECOMMENDATIONS		
1.	At the request of the Panel.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None	

DETAIL (Including consultation carried out)	
3.	Following discussion at the 1 October 2015 meeting of the HOSP the Panel requested an update on discharges from University Hospital Southampton at the January 2016 meeting.
4.	Attached as Appendix 1 is an update on discharges from University Hospital Southampton that identifies the current position and the steps that are being taken to improve performance across the system.
RESOURCE IMPLICATIONS	
Capital/Revenue	
5.	Not applicable
Property/Other	
6.	Not applicable
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
8.	Not applicable
POLICY FRAMEWORK IMPLICATIONS	
9.	None

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	Update on discharges from University Hospital Southampton
Documents In Members' Rooms	
1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	No
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	No
Other Background Documents **Equality Impact Assessment and Other Background documents available for**	

inspection at:		
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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Update on Discharges from University Hospital Southampton – January 2016

Southampton City Council Health Overview and Scrutiny Panel

Introduction

Since our last update in October 2015 a considerable body of work has been undertaken internally within the Trust and externally in collaboration with commissioners, community providers and the councils in relation to discharge. This has been centred on the following pathways (*Figure 1*) which involve the wider multidisciplinary teams (doctors, nurses, therapists, social work) working in collaboration with patients and their relatives; the associated decision making processes may be straightforward or very complicated.

If the health and social care systems can continue to make the same strides towards improving flow and discharge it will make a real difference to patient care. Not only to the patients who are transferring to other care settings but to the patients who cannot be admitted for their elective surgery and for the patients waiting for admission in the emergency department. The Hospital runs at over 98% occupancy so every extra patient that transfers really counts.

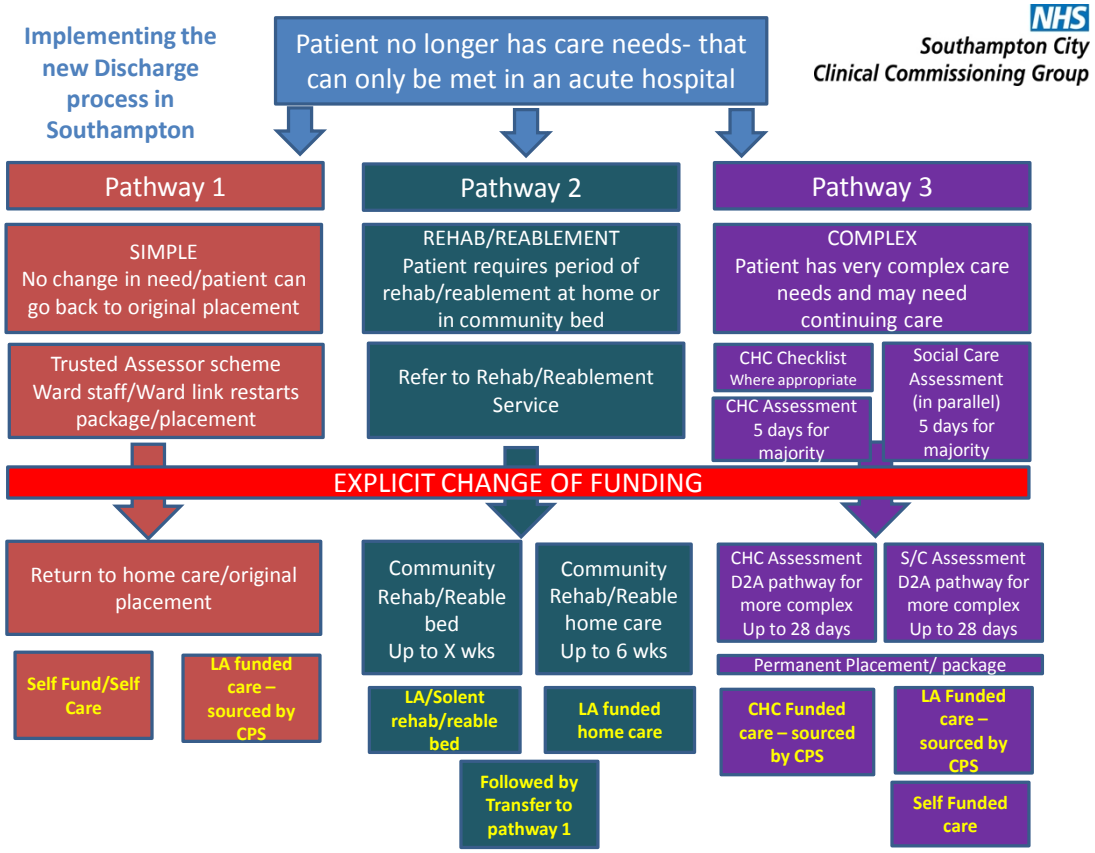


Figure 1: discharge pathways out of hospital

Details of work undertaken / ongoing

Work to improve flow of patients through these pathways across the system has continued over the autumn and winter months. This has previously been divided into four parts – the below section summarises progress in each of the categories.

a) Break down the barriers between Health and Social Care to create one service to reduce duplication of services

- Appointment of Integrated Discharge Bureau Operational Manager role, who commenced in November 2015. This post holder has operational responsibility for staff from all partner organisations within the IDB at UHS and is charged with bringing the organisations together under one operational framework.

- Restructure of the UHS IDB team including introduction of Discharge Officer roles to be the main liaison between the wards and the staff in the IDB. This team is almost fully recruited to and feedback so far from ward staff and IDB staff has been positive.

- Complete revision of the complex discharge process driven by the Care Act 2014, developed in the IDB and focussing on front loading the discharge process to start planning for discharge earlier in the admission. Supported by a redeveloped single IT workflow management system.

- Progress towards creating a merged health and social care provision for patients who need reablement services. Southampton City Council (SCC) and Solent Health Care Trust have worked together and recruited a new integrated Management team for a combined Rehabilitation and Reablement Team. The co-location of seven front line services will start to take place from mid-February 2016 and a final report recommending adoption of the wider integration plan will be taken to Cabinet in the February cycle.

- The Trusted Assessment principles are agreed across the local system, with good progress towards an agreed competency framework and training programme. This is aimed to increase the number of people who can complete work across health and social care.

- Ward link system is starting to embed and relationships building between staff and their ward link colleagues. The SCC team within the IDB are constant and stable, enabling team relationships to build and be sustained. This offers an enhanced service over seven days. We have increased our staff ratio over the weekend. This includes, in E.D, AMU and the discharge bureau itself. All new SCC employees recruited into the Hospital Discharge Team (HDT) are employed using a contract which makes provision for seven day working to help facilitate timely discharge.

b) Increase care for patients at home to reduce the chance of an admission to Hospital

- Creation of teams of health and social care staff who work in localities within Southampton to ensure good, joined up, health and social care on an everyday basis and increased care when the patient is more unwell working,

- Anticipatory care planning with shared IT records to navigate through the health and social care and present Hospital admission

c) Encourage people to maintain their independence through targeted interventions

- Progress towards creating a merged health and social care provision for patients who need reablement services as described elsewhere in this report.

- The Hospital has extended its discharge to assess pathway pilot in Medicine for Older People – using our own domiciliary care provider to discharge patients home with a care package to meet immediate needs, and assessing the patients ongoing needs in their own environment. So far this has been very successful in reducing patient length of stay, and reducing the overall size of the care package required at the point of discharge from the service. It receives positive feedback from patients.

- UHS and SCC have also worked closely with our partners at Solent to review the inpatient rehabilitation pathway.

d) Following Hospital admission ensure the care needs assessment and placement processes are as simple and clear as possible and capacity is available to ensure the patient is home as soon as possible

- The Managing Complex Discharge Policy has been further strengthened and agreed at a system wide level. The policy sets out clear expectations and acceptable timescales for patients and families on the choice of future care, starting from admission and going as far as compulsory discharge from the Trust. There have now been a small number of test cases where using the later stages of the policy has been effective in facilitating discharge from the Trust.

- UHS has also overhauled it continuing healthcare (CHC) assessment process and assembled a new team to lead continued improvement. We are now working much more closely with our CCG partners to manage the process, and as a result we are now able to put far fewer patients through the process unnecessarily. This not only reducing the length of time that a patient has to stay in hospital for the full assessment process to take place, but reduces workload on the ward staff and the IDB team. Social services provide a vital input to this assessment process and SCC has been responsive to the changing timescales. The time to complete the process has reduced from 6 weeks to around 10 days on average.

- Improved and quicker access to Domiciliary Care Packages, including complex packages. The new domiciliary care framework is increasing the coordination and availability of carers with

a reduction from 7.4 days for a care package to start to 3.9 days in July 2015. There is still more to do in this area especially for residents who need the most complex care packages. The ongoing partnership working which is part of the Cities better care fund (BCF) activities will seek to improve performance in this area even further. The Integrated Commissioning Unit (ICU's) Care Placement Team (CPT) continues to make securing timely packages of care its top priority. In the longer term SCC will be developing a new Extra Care Housing Strategy designed to help individual remain independent at home for longer thus reducing the pressure on UHS.

Despite the significant financial pressures faced by the Council, through the work of the HDT, SCC continues to carry out needs based assessments which are designed to facilitate timely. This ensures that the Council continues to ensure that the availability of funding is not a barrier to discharge.

- The integration of services increase social services and health's ability to respond to patients who need short term support (rehabilitation and reablement) through the proposed integration of services. As the integration agenda moves forward it is envisaged that this will see an increase in the availability of rehabilitation services through increased use of the new Domiciliary Care contracts.

- We continue to use bridging services - both the Hospital and Council provide these services until the domiciliary care provider is available to pick up that care. The need to make use of this sort of service will diminish as the new approach to Domiciliary Care continues to deliver benefits for the whole system.

26 per day target (13 for Southampton)

In our last paper we reported that approximately 10% of patients that are discharged from University Hospitals Southampton need some kind of further support to enable them to go home – this translated into about 20 per week day. In an effort to reduce the overall numbers of patients waiting for discharge to be arranged the Hampshire and Southampton health and social care systems have and ongoing commitment increase the number of these discharges from 20 to 26 per week day (13 per weekday for Southampton residents).

26 discharges per weekday equates to 130 per week. In line with the national direction of travel we need to ensure that complex discharge is also delivered over the weekends – if we adjust the target over 7 days, this would mean we would need to be discharging 18.6 patients per day on average (9 per day for Southampton residents).

Performance against this target over the last 6 months has been improving and is approaching 9 per day within the Southampton system:

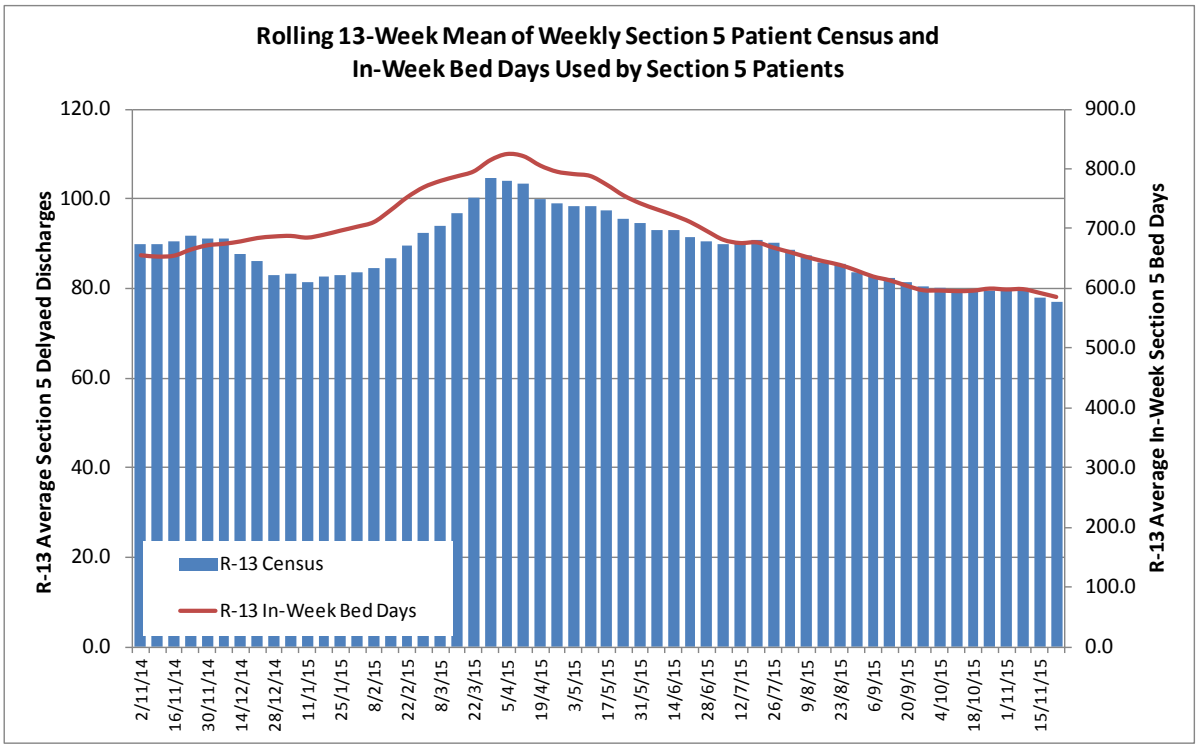
	Jul	Aug	Sep	Oct	Nov	Dec†
Average Complex Discharges per day	**13.9**	**12.5**	**14.3**	**14.2**	**14.8**	**16.4**
Southampton system	7.8	6.8	7.4	7.6	8.0	8.4
Hampshire system	5.7	5.3	6.6	6.2	6.3	7.3

Weekend Days	8	10	8	9	9	6
Week Days	23	21	22	22	21	18

(Data taken from daily manual count of complex discharges – un-validated; †up to 24/12/15)

Parity does not exist between the Southampton and Hampshire systems due to different processes and commissioning arrangements.

The number of lost bed days due to delays for Southampton patients are shown below. It appears we are making good progress towards reducing the number of lost bed days since the peak in April this year, and the trend continues downwards. .



Improved flow and discharge contributes to our hospital alert status and, therefore, our ability to provide higher quality care; a summary is shown below:

Cancellation Month	Number of cancelled operations	Alert status			
		Black Alert	Red Alert	Amber Alert	Green Alert
Sep-14	65		38	22	
Sep-15	75		39	21	
Difference	***10***	***0***	***1***	***-1***	***0***
Oct-14	115	1	60	1	
Oct-15	57		43	19	
Difference	***-58***	***-1***	***-17***	***18***	***0***
Nov-14	76		60		
Nov-15	47		23	26	11
Difference	***-29***	***0***	***-37***	***26***	***11***
Dec-14	90	32	25		5
Dec-15	tbc		8	19	35
Difference		***-32***	***-17***	***19***	***30***
Total Difference	***-77***	***-33***	***-70***	***62***	***41***

September status was almost identical when comparing 2014 and 2015, but since October (when a number of changes were made) our alert status and cancelled operations has been significantly improved each month.

Continuing healthcare processes

It is important that we get continued healthcare right. This means identifying the people who are eligible for healthcare funding in the community but not delaying discharge by performing too many assessments, unnecessarily, in hospital.

It is locally and nationally recognised that the threshold of the CHC checklist is set at a low level of tolerance. For this reason many people will "check in" for a full application to be put together, but in reality a very low percentage of these people will be eligible for CHC funding at the end of the process. This process of pulling together a full application has historically been lengthy and resource intensive, and may mislead patients and families into thinking they are eligible for funding.

UHS has worked with our local partner CCG's and local authority to introduce a simplified decision tool / process at the ward level, in an effort to reduce the number of patients we are "checking in" for a full assessment where it is very unlikely that they will be eligible for funding at the end. This has been largely successful in reducing the overall number of assessments completed and improving the conversion rate for those assessments into funding eligibility.

This new process ensures that those we do checklist are those that are likely to be eligible for funding, thereby puts less patients through the process unnecessarily. For Southampton, we have been supplied the data which suggests that the number of patients being agreed as positive has gone up slightly over the last 6 months. The % agreed as eligible of the total applications put forward (both yes and no ratifications) has also increased from 8 to 29% over the same time frame.

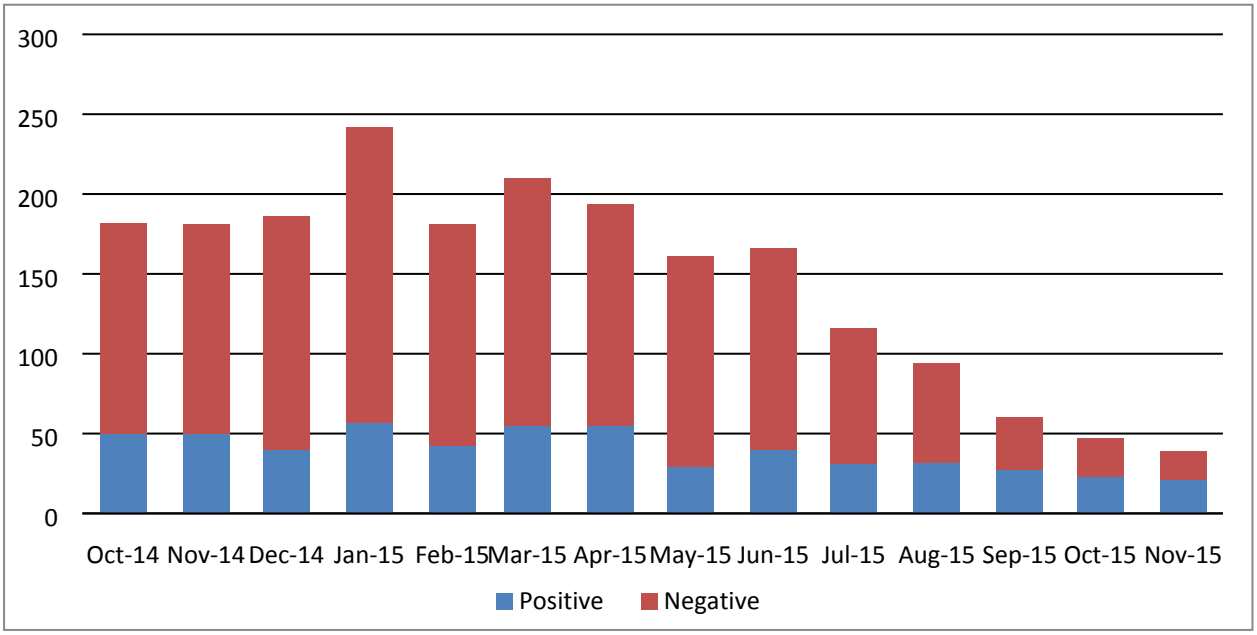


Figure 2: Number of CHC checklists undertaken broken down by outcomes

Time to wait for domiciliary care

It is really important that domiciliary care in the community is arranged in a timely manner to avoid unnecessary hospital delays. We have seen considerable improvements within the Southampton system over 2015 although more work and a demonstration of sustainability is still needed. Larger packages of care remain challenging to source. As highlighted elsewhere in this report this sourcing is a priority for the Councils CPT.

To illustrate this we have chosen a random day – Wednesday 19th November 2015 – and looked at the snapshot data for that day. Please note that this is data taken from our Complex Discharge Database and is only as good as the data entered. We are currently completing a joint review of patients discharged over the last 6 months to 4 times a day double up packages of care, to look at key timescales. ASC teams and in particular the HDT are participating fully in this review.

	Hampshire	**Southampton**
Number of patients awaiting a Social Services funded care package	13 – 7 inpatients, 6 on UHS@Home	7 – all inpatients, 0 on UHS@Home
Range of length of wait (from date of Section 5 to date of census)	3 - 189 days	5 – 22 days
Average wait (from date of section 5 to date of census)*	28 days	9 days

* Data ratification required by SCC.

Time to wait for rehabilitation beds

Flow into rehabilitation beds is also important and working well within the Southampton system. Again, for illustration purposes, we have chosen a random day – Wednesday 19th November 2015 – and looked at the snapshot data for that day. Please caveat that this is data taken from our Complex Discharge Database and is only as good as the data entered.

	Hampshire	**Southampton**
Number of patients awaiting a Rehab Assessment	19	3
Range of length of wait (from date of Section 5 to date of census)	1-19 days	1-2 days
Average wait (from date of section 5 to date of census)	8 days	1 day

Conclusion

Good progress has been made in many areas towards improving safe and timely discharge from hospital - the joint work we have put in is starting to show its results in terms of the increasing numbers of discharges and improved operational position at the hospital. We continue to develop the system complex discharge action plan in response to challenges as they arise. The Southampton system appears to be performing better than the Hampshire system.

The Panel should be aware that there are still significant risks and challenges as we move forward.

Capacity within domiciliary care agencies to support large package of care continues to be an issue which delays discharge for a number of patients. Partnership work to address this is ongoing and all stakeholders across the system continue to work to fully establish the three pathways described on page two of this report.

In the short term it is important to note that the Council's Social Care budget is currently projected to be overspent by £ 3.4 m which, amongst other factors, is being driven in meeting the needs of the older population. Additionally, the Hospital is overspent by a predicted £9.6m and is failing to reduce the length of stay for patients. Moving to 13 per day would help reduce this impact as more beds would be released.

In the long term the population being looked after is ageing data analysed by the Hospital Discharge team for instance suggests that - On average, patients are two years older now before nursing home/ social services care is required) and becoming more dependent; the strategy of keeping increasingly dependent older people at home, whilst supported, is likely to result in increased hospital readmissions and a frailer hospital population needing recurrent social input. This dependency means we have to design care services that are able to meet the needs of patients which especially includes ensuring the availability of complex care packages at home (2 carers visiting four times per day and overnight care) and ensuring the availability of nursing home placements which are able to fully meet the very complex needs of the population who eventually cannot be managed at home; including those with challenging dementia, and respiratory needs plus 1:1 care.

There is also a significant workforce risk in the short and medium term. Care workers and Nursing staff are in short supply. Southampton has been better than other areas in Hampshire at recruiting staff but this may not last. It is therefore vitally important that we continue to focus on making every contact count (reducing unnecessary overlap and duplication) and making these roles as attractive and as rewarding as possible.

Recommendations

1. The Panel is asked to note the positive work which has been undertaken across the system since HOSP last considered this matter and the improvements which have been made.

2. The Panel is asked to note the specific issues of large packages of care and increasing funding pressures.

3. The Panel is asked to review progress against the action plan in three months time.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		ADULT SOCIAL CARE: KEY PERFORMANCE INDICATORS		
DATE OF DECISION:		28 JANUARY 2016		
REPORT OF:		ACTING DIRECTOR OF ADULT SOCIAL CARE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Paul Juan**	**Tel:**	**023 8083 2530**
	E-mail:	**paul.juan@southampton.gov.uk**		
Director	**Name:**	**Mark Howell**	**Tel:**	**023 8083 2743**
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STATEMENT OF CONFIDENTIALITY

None.

BRIEF SUMMARY

This report outlines performance in Adult Social Care during the third quarter of 2015/16, using the twelve key indicators previously agreed by the Health Overview and Scrutiny Panel.

RECOMMENDATIONS:

	(i)	To note performance during the third quarter of 2015/16 against the twelve key indicators for Adult Social Care.
	(ii)	To consider and agree whether there are any recommendations that the Panel wishes to make in respect of matters arising from this report.

REASONS FOR REPORT RECOMMENDATIONS

1.	The Health Overview and Scrutiny Panel agreed on 26 March 2015 that it would receive performance updates from Adult Social Care.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	Not applicable.

DETAIL (Including consultation carried out)

3.	Performance against the twelve key indicators for Adult Social Care for April to December 2015 is set out in Appendix 1. Performance figures for each quarter are given, with a Red, Amber or Green rating based on the latest available data.
4.	A key objective for Adult Social Care is to enable individuals to live independently with the appropriate care and support and this has been consistently achieved for almost 80% of people, exceeding the target of 70%.
5.	An action plan is in place to further increase the percentage of individuals receiving a direct payment, a key priority for 2015/16.
6.	Changes implemented in the Single Point of Access (SPA) Team have resulted in the number of Adult Social Care enquires resolved at first contact exceeding the target of 70% for the first time this year.

7.	Although Adult Social Care's performance in ensuring that all individuals receiving a package of care and support receive a timely review of their needs has improved, additional work is underway with the Transformation Team to further improve performance.
8.	A restructure of two social work teams to ensure closer alignment with local health and social care clusters has been completed and the launch of the integrated reablement and rehabilitation team in February 2016 will maintain the focus on supporting people to maximise their independence and reduce the need for ongoing care and support (number 2).
9.	The safeguarding indicators (numbers 10 and 11) link to the work of the Local Safeguarding Adults Board.
10	A full update on transfers of care (number 12) is a separate item on the agenda.
RESOURCE IMPLICATIONS	
Capital/Revenue	
11.	None.
Property/Other	
12.	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
13.	Not applicable.
Other Legal Implications:	
14.	Not applicable.
POLICY FRAMEWORK IMPLICATIONS	
15.	These performance indicators are aligned to the following priorities set out in the Council Strategy 2014-2017: • Prevention and early intervention • Protecting vulnerable people • A sustainable Council.
KEY DECISION	No.
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report.

SUPPORTING DOCUMENTATION			
Appendices			
1.	Adult Social Care, key performance indicators – April to December 2015		
Documents In Members' Rooms			
1.	None		
Equality Impact Assessment			
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.			No
Privacy Impact Assessment			
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.			No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**			
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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Adult Social Care, key performance indicators - April-December 2015

No	Indicator	Target 2015/16	Q1	Q2	Q3	RAG
1	Percentage of people with eligible social care needs supported to live independently	≥70%	79.9	79.4	79.5	Green
2	Percentage of people not requiring on-going care and support after receiving reablement	≥50%	46.4	58.6	47.9	Amber
3	Number of permanent admissions of older people (over 65) to residential/nursing care homes (monthly average)	≤21	29	20	21	Green
4	Percentage of people re-referred to the Hospital Discharge Team after referral within the previous 91 days	≤60%	13.4	13.3	18.6	Green
5	Percentage of SID self-assessment forms not passed onto SPA (individuals receive information or are signposted)	≥80%		89.5	97.0	Green
6	Percentage of Adult Social Care enquiries resolved at first contact	≥70%	67.8	69.8	72.1	Green
7	Direct payments as a percentage of all eligible service users (ADASS definition)	≥25%	16.9	18.2	18.5	Amber
8	Percentage of people who use our services who find it easy to obtain info. about services that meet their needs	>70%		67.6	68.6	Amber
9	Percentage of people receiving long term care and support who have received a review during the past year	≥50%		61.0	63.7	Green
10	Number of Adult safeguarding enquiries received	No target	267	311	196	-
11	Percentage of people with three or more safeguarding enquiries in a year	No target	10.9	10.6	3.3	-
12	Number of Delayed Transfers of Care per month, where the delay is more than 72 hours - social care patients only	No target	26	9	13	-

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		PUBLIC HEALTH GRANT REDUCTIONS		
DATE OF DECISION:		28 JANUARY 2016		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dr Andrew Mortimore**	**Tel:**	**023 80833204**
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	E-mail:	**Andrew.mortimore@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY

BRIEF SUMMARY
This paper sets out the approach that the Council is taking to respond to the 2015/16 in-year Public Health grant cut, and the reduction in grant funding that will continue to 2020/21. A range of options were considered, and proposals for additional in-year savings have been identified. The budget for 2016/17 will include reduced expenditure on commissioned services, and a plan is being developed to respond to what will be a 25% reduction in the purchasing power of the Public Health grant over the next five years.

RECOMMENDATIONS:		
	(i)	HOSP is asked to consider the approach being adopted and contribute views on how the Council and wider system responds to the funding situation described in the report.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Council is the local lead for public health, and has responsibilities to protect local people from threats to their health and to improve the health of the population.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	The Council is continuing to work on longer term plans to meet its public health responsibilities with reduced grant income, and a range of options are still under active consideration.

DETAIL (Including consultation carried out)	
	Background - 2015/16 "in-year" cut
3.	A £200 million cut in the 2015/16 PH grant allocation to local authorities was announced by the Chancellor in June 2015. In the consultation on the cut, the majority of local authorities favoured an option in which more was taken from those currently funded above their target allocation. Despite this, the Government has announced that it is proceeding with its preferred option – an "equal share" cut. This means that the Council's £15.05M 2015/16 Public Health grant has been reduced by £1.06M. £2.10M has been added to cover six months funding for 0-5 year's public health services (health visiting and

Family Nurse Partnership) that transferred to local authority responsibility on 1st October 2015:

Public Health Allocations to local authorities: Total in-year savings in 2015/16 include 0-5 children's budget (£'000s)					
ONS LA Name	Total PH allocation for 15/16 (£'000s)	0-5 allocation transferred in October 15 (£'000s)	Overall PH allocation for 15/16 (£'000s)	LA share of the £200m savings	15/16 allocation after reduction
Southampton	15,048,535	2,103,000	17,151,535	1,061,608	16,089,926

4. In-year savings over a five month period (Quarter 3 and Quarter 4) will be very difficult to find and fully deliver, because the remaining budget controlled by Public Health is almost all in commissioned services that need a 12 month notice period, or in staff costs.

5. The original 2015/16 Public Health (PH) budget headings were:

	2015/16 working budget
Health improvement	£2.77M
Health protection and surveillance	£8.83M
Population healthcare	£3.90M
Public health management, overheads and recharges	£1.98M
Total planned expenditure	**£17.48M**

6. At the start of 2015/16, the PH grant funded £2.26M of services that were provided by the Council prior to it receiving the PH grant. This figure includes an additional £0.40M in 2015/16 following an approved saving in February 2015. This was taken on the assumption of an inflation uplift which was not received, and so has been an additional pressure for the service in the light of the new cut.

Future funding cuts

7. Following the spending review, the CEO of Public Health England sent out on 27th November 2015 the following information to local authority CEOs and Directors of Public Health (DsPH):

"The Chancellor talked about savings in the Public Health grant, which will be an average real terms saving of 3.9% each year to 2020/21. This translates into a further cash reduction of 9.6% in addition to the £200 million of savings that were announced earlier this year. From the baseline of £3,461m (which includes 0-5 commissioning and takes account of the £200m savings) the savings will be phased in at 2.2% in 16/17, 2.5% in 17/18, 2.6% in each of the two following years, and flat cash in 20/21".

8. For Southampton City Council this is an approximate additional cash reduction of £400-500K each year over the next four years which will have a very significant impact on the commissioned public health services (see

below). The impact could be halved if we were moved to be funded according to the target allocation, but the formula is under review and there is no indication of future "pace of change". The current working assumption is that there will be no significant movement towards fairer funding. The confirmed grant allocation will be announced before the end of January 2016.

9. Working estimate of grant reduction as at 30 November 2015:

	£
Baseline indicative 2015/16 PH Grant:	18,194,400

Financial Year	PH Cut %	PH Cut £	Revised PH Grant Allocation £
2016/17	2.20%	400,277	17,794,123
2017/18	2.50%	454,860	17,339,263
2018/19	2.60%	473,054	16,866,209
2019/20	2.60%	473,054	16,393,154
2020/21	0.00%	0	16,393,154
Total	9.90%	1,801,246	

10. The "in-year" grant reduction has largely been mitigated through a range of measures, including holding vacancies, cutting planned public health initiatives and eliminating non-essential expenditure, but there is a residual pressure of £300K for which additional measures are being considered. Most savings have been of a "one off" nature and do not assist the 2016/17 position, for which there is a forecast pressure of £117K before the grant cuts are factored in.

Approach to managing budget reductions

11. When the in-year cut was announced, it was agreed by the Council Management Team (CMT) that this "challenge" would be one for the whole Council to address and could not be met from the residual grant controlled by Public Health alone.

12. The Public Health grant has been re-distributed over the last three years, so that in 2015/16 £2.26M funds existing Council "Internal Services". This does not include any additional services chosen to be purchased from other Council departments by Public Health or the recharges for corporate overheads.

13. The grant from the Department of Health is to enable the Council to deliver the responsibilities that transferred in April 2013. These include a set of "mandated" services, reflecting the fact that local authorities are part of the national public health service for England:

- Appropriate access to sexual health services
- Steps to be taken to protect the health of the population, in particular, giving the Director of Public Health a duty to ensure there are plans in place to protect the health of the population
- Ensuring NHS commissioners receive the public health advice they need

	• The National Child Measurement Programme • NHS Health Check assessment • Elements of the Healthy Child Programme.
14.	The other responsibilities are: • Tobacco control • Alcohol and drug misuse services • Obesity and community nutrition initiatives • Increasing levels of physical activity in the local population • Assessment and lifestyle interventions as part of the NHS Health Check Programme • Public mental health services • Dental public health services • Accidental injury prevention • Population level interventions to reduce and prevent birth defects • Behavioural and lifestyle campaigns to prevent cancer and long term conditions • Local initiatives on workplace health • Supporting, reviewing and challenging delivery of key Public Health funded and NHS delivered services such as immunisation programmes • Comprehensive sexual health services • Local initiatives to reduce excess deaths as a result of seasonal mortality • Role in dealing with health protection incidents and emergencies • Promotion of community safety, violence prevention and response • Local initiatives to tackle social exclusion.
15.	Included amongst these are “demand-led” services, largely commissioned from NHS providers. The Council is responsible for ensuring these service are provided and meet national quality standards. These include sexual health services (and the treatment of sexually acquired infections), drugs and alcohol treatment, school nursing and health visiting.
16.	It will be challenging to reduce the cost of meeting these needs as the number of service users will increase, and the scope for delivering the service at lower costs will be limited. This means that all aspects of the Council’s funded public health programmes are now under review in order to propose a balanced budget for 2016/17 and a realistic plan for the subsequent four years of cuts.
	Process and progress
17.	All non-essential expenditure ceased after the announcement in June 2015, and other central controls have applied. The Public Health team is now a third the size it was at the point of transfer three years ago. All public health contracts have been moved to the management of the Integrated Commissioning Unit (ICU) and are under review so that the appropriate level of investment can be achieved in 2016/17, balancing protecting the public’s health with achieving better health outcomes through prioritised, high value interventions. At the same time, the public health programmes will need to be geared to supporting the delivery of the Council’s priorities. This will involve

	doing things differently and doing different things.
18.	If the reduction in grant is translated into an “equal shares” cut to all services there is likely to be a greater impact on health outcomes and future costs than if a more targeted programme of cuts is developed. The Public Health team and the Integrated Commissioning Unit are using the available evidence on return on investment (ROI) from public health preventative measures to refine the approach to delivering savings. All recommissioning will look at delivering the maximum return on investment and net savings to the Council, while improving health outcomes. Principles and priorities for achieving this are summarised in Appendix 1.
19.	The level of corporate overheads charged to Public Health is being reviewed, and other directorates benefitting from the re-allocation of the Public Health grant are considering ways of profiling their future spend with reduced grant support.
20.	The running costs of the small in-house Public Health team will continue to be kept as low as possible while ensuring that the Council is able to meet all its statutory responsibilities. Working as part of a Hampshire and Isle of Wight network has enabled some joint initiatives and avoided duplication of efforts. As plans for a devolved authority progress there will be further opportunities to develop cost-efficient ways of delivering the public health function and commissioning services.
21.	The major opportunities for contract saving lie with Solent NHS Trust, who have contracts for most of the major public health services. Discussions have begun to identify potential contract variations that would allow savings to SCC and avoid redundancy costs and other costs passed on by the provider. Anything agreed by the Council will have implications for the rest of the block contract that the CCG has with Solent NHS Trust, and all three organisations will need to work together to ensure sustainability of the provider’s services.
22.	For the longer term, major service re-commissioning exercises will look to take out costs to the Council, and will be brought forward if possible in the ICU work programme so that these are achieved sooner rather than later. These have the potential to contribute to the delivery of a sustainable financial plan.
23.	The details of the changes to services in 2016/17 are still to be finalised and agreed. Options under consideration include suspending the NHS Health Check programme and chlamydia screening as these services are considered to be less cost-effective than other PH programmes, but the contractual implications are significant, and the cost is likely to be more than the saving in both 2015/16 and 2016/17, based on experience elsewhere.
	Conclusion
24.	The huge cuts to the Public Health grant will present a major challenge to the Council over the next five years. However, these are not the only resources available to the Council, as it has previously delivered a wide range of services that have a positive impact on the public’s health. The NHS, other partners and wider society will have contributions and assets to bring as the prevention and Public Health “offer” to the City is redesigned. The role of the Health and Wellbeing Board will be crucial in ensuring that a sustainable system is built, that progress in improving health outcomes does not stagnate (or reverse) and that longstanding and unacceptable inequalities are reduced.

	Engagement of citizens and communities will be equally important, enabling people to have a voice and to get involved in making change happen at both an individual and community level.
RESOURCE IMPLICATIONS	
Capital/Revenue	
25.	The reduced Public Health Grant income will result in a reduction in the Health and Adult Social Care budget that without corresponding savings will create a pressure.
26.	Information within this report outlines the approach being taken to meet this challenge to reduce the recurring spend on public health services both in year, (2015/16) and on an ongoing basis.
Property/Other	
27.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
28.	Public Health responsibilities of the Authority are set out in the Health and Social Care Act 2012.
Other Legal Implications:	
29.	N/A
POLICY FRAMEWORK IMPLICATIONS	
30.	The City's Health and Well-being Strategy is being reviewed and re-written, and its plans to improve health outcomes and reduce health inequalities will need to recognise the Council's reduced grant income

KEY DECISION?	Yes/No
WARDS/COMMUNITIES AFFECTED:	
SUPPORTING DOCUMENTATION	
Appendices	
1.	Return on Public Health Investment Summary
Documents In Members' Rooms	
1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	Yes
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	No

Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
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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Return on Public Health Investment Summary

2017/18 and beyond will require recommissioning PH services so that there is an explicit, evidence-based increased return on investment, with reduced costs to the Council and its partners. This will be based on the best evidence for the return on investment (Kings Fund etc, summarised below) and experience gained elsewhere, recognising that other local authorities have invested more and achieved greater savings than we have in Southampton.

To contribute to a net saving in **Adult Services**, the public health effort will shift to focus more on alcohol misuse prevention, more effective drug treatment programmes, befriending services (grants programme), falls prevention, reducing obesity, improving air quality and smoking cessation. For example, current and ex-smokers who require care in later life as a result of smoking related illnesses cost the Council an additional £2.4m each year.

To contribute to a net saving in **Children's Services**, the public health effort will shift to focus more on parenting support, including the Family Nurse Partnership programme, interventions to reduce bullying, prevention of conduct disorder through school-based social and emotional learning programmes, prevention of domestic violence, alcohol harm reduction (parents), prevention of teenage pregnancy and school based smoking cessation.

To contribute to the Council's priority of **economic growth**, public health will prioritise employee wellness programmes, including uptake of the SCC funded NHS Health Check (mandated service), work-based mental health promotion, and programmes to get disadvantaged groups back into work.

To contribute to the Council's priority of **clean and attractive streets**, smoking cessation will remain a priority - non-biodegradable smoking waste produces 29 tonnes of landfill each year, including 7 tonnes of cigarette waste discarded as street litter that must be collected by street cleaning services.

Engagement with individual, families and communities is essential for public health programmes to be successful and deliver maximal benefits and saving. Cross-Council community engagement effort will need to be well coordinated and appropriate resources identified.

Assessment: Number of pounds saved for each pound spent

Intervention	££s saved	Notes
Reduction of obesity	£2	Over 5 years
Alcohol treatment	£4	Reduced public sector costs
Screening and brief interventions in primary care for alcohol misuse	£12	
Drugs treatment	£5	Reduced NHs and social care costs and reduced crime
Domestic violence prevention	£2.9	
Family Nurse Partnership (young parents-to-be)	£5	
School-based interventions to reduce bullying	£14	
Parenting programmes to prevent conduct disorder	£8	Over 6 years –savings to NHS, education and criminal justice system
Prevention of conduct disorder through school-based social and emotional learning programmes	£84	
Befriending services	£3.75	Reduced MH services costs
Motivational interviewing and developing supportive networks for people with alcohol and drug addiction	£5	Reduced health care, social care and criminal justice costs
Employee wellness programmes	£2-10	
Work-based mental health promotion	£10	After one year
Prevention of teenage pregnancy	£11	
Smoking cessation and tobacco control measures	£5	Over 5 years
School based smoking prevention	£15	
Be Active, including free use of leisure centres (Birmingham)	£23	Reduced NHS use, and better Quality of Life
Housing intervention to keep people safe and free form cold and damp	£70	Saving to NHS over 10 years
Falls prevention and bone health saves £5 for every £2 spent, through saving lives and maintaining independence	£2.5	Saving lives and maintaining independence
Programmes to get disadvantaged groups back into work	£3	Reduced costs of homelessness, crime, benefits and NHS care
Improving air quality	£6	(Eg Kensington and Chelsea)

Sources: Kings Fund, Joint Commissioning Panel for Mental Health

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON "GETTING THE BALANCE RIGHT IN COMMUNITY-BASED HEALTH SERVICES"		
DATE OF DECISION:		28 JANUARY 2016		
REPORT OF:		DIRECTOR OF SYSTEM DELIVERY - NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dawn Buck**	**Tel:**	**023 80296932**
	E-mail:	**Dawn.buck@southamptoncityccg.nhs.uk**		
Director	**Name:**	**Peter Horne**	**Tel:**	**023 80725660**
	E-mail:	**Peter.horne@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

This report provides an update on progress of the decommissioning of the Bitterne Walk-In Service (BWIS) and the actions that were agreed at the CCG Governing Body and HOSP.

The CCG board will meet on 27 January 2016 to consider the progress. A verbal report will be made to the Panel on 28 January 2016 to inform them of the outcome of the CCG Board meeting.

RECOMMENDATIONS: That the Panel:

	(i)	Note the progress on decommissioning of the BWIS.
	(ii)	Consider the proposed approach to monitoring the impact of the closure over the next six months.

REASONS FOR REPORT RECOMMENDATIONS

1.	The Health Overview and Scrutiny Panel has requested regular updates on the impact and implementation of the closure of the Walk-In Service.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	Not applicable.

DETAIL (Including consultation carried out)

	Overview
3.	Following a public consultation in the summer, the CCG decommissioned the Walk-in Service at Bitterne Health Centre on 31 October 2015.
4.	Subsequent to the decision by the Governing Body, Southampton City Health Overview and Scrutiny Panel (HOSP) accepted the decision and made the following monitoring recommendations: • That the draft Urgent and Emergency Communication Plan is circulated to the Panel for comment. • That response times and key performance information relating to the

	NHS 111 and GP Out of Hours services are circulated to the Panel. • That the proposal for a community hub on the east side of Southampton is considered at a future meeting of the Panel if the scheme progresses. • That the Panel scrutinise the impact and implementation of the closure of the Walk-In Service at each HOSP meeting until the Panel informs the CCG that the information is no longer required.
	Communications and Engagement
5.	The initial focus for communications works was aimed at ensuring people were aware of the closure of the walk-in service and the alternative services in place to support people when they become unwell. Following the closure of the service, attention has turned to building confidence in urgent care services across the City. The plan was presented to the Panel in November 2015.
6.	Communications and engagement has continued apace over the last two months with particular emphasis on supporting local people to manage common winter conditions such as coughs and colds. Messaging included top tips to treat symptoms along with the promotion of the relevant services.
7.	A separate work stream to help improve access to GPs is now being implemented. Details of activities are in the attached paper.
	Monitoring the Impact
8.	The CCG continues to monitor the impact of the closure using both qualitative and quantitative information. • **Quantitative info**. The BWIS closure impact monitoring data pack for January (based mainly on M8 data) can be found at Appendix 2. There have not been any substantial activity changes, in particular relating to East locality patients, which are unexpected or raise significant concern. The CCG has added some monthly data on capacity in community nursing. • **Qualitative info**. The qualitative impact is monitored through the CCGs normal monitoring mechanism. The main activities related to this have been: gathering feedback from service users; a stall in Bitterne market and a survey that is being run at present. There are no issues to report.
9.	Members are asked to consider the information presented at the meeting and following discussions comment on the report.
RESOURCE IMPLICATIONS	
Capital/Revenue	
10.	None.
Property/Other	
11.	None.
LEGAL IMPLICATIONS	

Statutory power to undertake proposals in the report:			
12.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.		
Other Legal Implications:			
13.	None.		
POLICY FRAMEWORK IMPLICATIONS			
14.	None.		
KEY DECISION	No.		
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report.		
SUPPORTING DOCUMENTATION			
Appendices			
1.	Southampton CCG Board Paper: Getting the Balance Right in Community Based Health Services		
2.	BWIS closure impact monitoring – data at January 2016 (mainly M8)		
Documents In Members' Rooms			
1.	None		
Equality Impact Assessment			
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No	
Privacy Impact Assessment			
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No	
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**			
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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NHS
Southampton City
Clinical Commissioning Group

Southampton City Clinical Commissioning Group Board

Date of meeting	27 January 2016
Agenda Item	**6**

Topic Area	Getting the Balance Right in Community Based Health Services
Proposal	To update the Governing Body on the actions that were agreed at Governing Body and HOSP following the decommissioning of the Bitterne Walk-in Service (BWIS)
Background information	The CCG decommissioned the Walk-in service at Bitterne Health Centre on 31st October 2015. As part of the decision making, the following actions were identified by the Governing Body: • Develop a clear plan with the GP federation and other primary care providers to improve GP access. This will also inform the Primary Care Strategy • Increase public awareness on urgent and emergency care • Develop and implement a detailed communication plan • Provide a detailed report reviewing both quantitative and qualitative impact of closing the service
Key issues to be considered	• The actions around communications and engagement are now part of routine CCG work as is the monitoring of impact • A communications plan to improve access to primary care is in place and will complement the broader strategic plan for primary care which is part of Better Care Southampton.
Please indicate which meetings this document has already been to, plus outcomes	None

Principal risk(s) relating to this paper (Assurance Framework/Strategic Risk Register reference if appropriate)	• SC004: Delivery of ED performance • SC009: Implementation of the Better Care Southampton plan
HR Implications (if any)	Nil
Financial Implications (if any)	Nil
Public involvement – activity taken or planned	Nil
Equality Impact Assessment required / undertaken	N/A
Report Author **Contact details**	Peter Horne, Director of System Delivery
Board Sponsor	Peter Horne
Date of paper	21st January 2016
Actions requested /Recommendation	The Governing Body is requested to: • Note the progress on the actions that were directed as part of the decommissioning of the BWIS. • Note that subsequent actions are now part of the routine work within the CCG. • Agree that further progress can be incorporated into routine reporting mechanisms.

Getting the Balance Right in Community Based Health Services

Introduction

1. Following a public consultation in the summer 2015, the CCG decommissioned the Walk-in service at Bitterne Health Centre (BWIS), provided by Solent NHS Trust, on 31st October 2015. Funding for the service has remained with Solent and transferred to the community nursing service line, as set out in the case for change.

2. As part of the decision making of the Governing Body, the following actions were identified:

   - Develop a clear plan with the GP federation and other primary care providers to improve GP access. This will also inform the Primary Care Strategy.

   - Increase public awareness on urgent and emergency care services as a priority

   - Develop and implement a detailed communication plan

   - Develop and implement reporting mechanisms to review both quantitative and qualitative impacts of closing the service

3. Subsequent to the decision by the Governing Body, Southampton City Health Overview and Scrutiny Panel (HOSP) accepted the decision and made the following monitoring recommendations:

   - Circulate the draft Urgent and Emergency Communication Plan to the Panel for comment. This action is complete.

   - Circulate response times and key performance information relating to the NHS 111 and GP Out of Hours services to the Panel. This action is complete.

   - Consider the proposal for a community hub on the east side of Southampton at a future meeting of the Panel, if the scheme progresses. The Governing Body should note that this action lies with Southampton City Council.

   - Provide data reports for the Panel to scrutinise the impact and implementation of the closure of the BWIS at each HOSP meeting until the Panel informs the CCG that the information is no longer required. This action is in progress.

Aim

4. The aim of this paper is to report on the progress of the actions taken following the decommissioning of the BWIS and the early indications on any impact of the closure on urgent care services and East locality residents.

Scope

5. The paper will cover the following:

   - Update on the communications and engagement plan, including increasing public awareness on urgent and emergency care

- Impact monitoring.

- Summary and recommendations

Communications and engagement plan.

6. Communications and engagement has continued apace over the last two months with particular emphasis on supporting local people to manage common winter conditions such as coughs and colds. Messaging included top tips to treat symptoms along with the promotion of the relevant services. Information was disseminated via:

   - social media, being shared by a number of our partners and reaching around 70,000 people

   - press releases, articles regarding pharmacies and online access to GP practices including repeat prescription ordering were covered by the Daily Echo

   - ongoing radio advertising aimed at 15-40 year olds

   - Solent NHS Trust and Southern Health NHS Foundation Trust who have provided all their front line staff with a supply of NHS 111 wallet cards to hand out during patient consultations

   - posters advertising NHS 111, pharmacies and online services were distributed to practices throughout the city

   - BBC Radio Solent's Big Cuppa event at the Guildhall to reduce isolation

   - public engagement events at community centres, children's centres and Sikh and Hindu temples

   - community groups such as Black Heritage and Priory Road Luncheon Club

   The urgent and emergency communications plan now forms part of the CCG's business as usual.

7. A separate communications plan has been developed to improve access to GPs. This is intended to provide a firm platform for the delivery of the overarching strategy for primary care which is part of Better Care Southampton plan. The communications plan will be supported by both the CCG and NHS England and will involve practices advertising the service on their websites, in their newsletters, via social media and on a face to face basis. In conjunction with this the CCG has committed to:

   - providing practices with a comprehensive communications and marketing pack.

   - disseminating messages throughout our wide ranging network of schools, nurseries, major employers, community and voluntary groups via a variety of channels.

   - working with local media to promote the benefits of online access.

- attending local community events to encourage people to register.

8. Baseline data has been recorded on a per practice basis and we will measure ongoing progress.

Impact monitoring

9. **Quantitative Impact**. The BWIS closure impact monitoring data pack for January (based mainly on M8 data) can be found at annex A. For this first month post BWIS closure there have not been any substantial activity changes, in particular relating to East locality patients, which are unexpected or raise significant concern.

10. The data for the community nursing service is also monitored monthly. The profile of alert status for the community nurses is shown below. This reporting will be incorporated into the data pack at Annex A from February 2016 onwards.

DATE	JUN	JUL	AUG	SEP	OCT	NOV
Black	15%	70%	63%	70%	68%	20%
Red	34%	6.3%	23%	2%	9%	14%
Amber	26%	2%	2%	2%	4%	8%
Green	9%	0%	0%	1%	3%	5%
Data not available	5%	19%	11%	23%	15%	22%

11. These metrics will continue to be reviewed monthly for at least 6 months in order to ensure that trends can be identified. It is proposed that the metrics will be included in the CCG performance reporting packs as part of normal monitoring.

12. **Qualitative impact**. The qualitative impact is monitored through the CCGs normal monitoring mechanism. The main activities related to this have been: gathering feedback from service users; a stall in Bitterne market and a survey that is being run at present. There are no issues to report.

Summary

13. Good progress has been made on all actions that the Governing Body and the HOSP directed the CCG to complete as part of the decommissioning of the BWIS

14. The communications and engagement work has been embedded into routine reporting within the CCG.

15. Impact monitoring will also be embedded into the routine reporting of the CCG.

Recommendations

16. The Governing Body is requested to:

- Note the progress on the actions that were directed as part of the decommissioning of the BWIS.
- Note that subsequent actions are now part of the routine work within the CCG.
- Agree that further progress can be incorporated into routine reporting mechanisms.

Annexes:

Annex	Description	Document
A	BWIS closure impact monitoring – data at January 2016 (mainly M8)	

BWIS closure impact monitoring – data at January 2016 (mainly M8)

Contents

January update report for monitoring of SCCCG and East GP registered patients' activity within the urgent care system

Impact monitoring and reporting timeline

Month	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16
Report	Baseline	1	2	3	4	5	6	7	8	9	10	11	12
CPT	28th	11th	2nd	6th	3rd	9th							
SMT	29th	12th	3rd	7th	4th	10th							
CEG		18th	9th	13th	10th	16th							
GB (*pub		25th *		27th *	24th	23rd *							
HOSP		26th		28th		24th							
Check points	Baseline			1st impact review		Add dates for 16/14	2nd impact review			3rd impact review			Final impact review
Notes	All baseline data to be received by 30/10	First reports received and reporting format approved	Reports timely and working	Follow up GP survey		Confirm reports will continue into 16/17		Follow up GP survey				Follow up GP survey	
NB:	Data will be mainly M5 (Aug)	Data will be mainly M6 (Sept)	Data will be mainly M7 (Oct)	Data will be mainly M8 (Nov)	Data will be mainly M9 (Dec)	Data will be mainly 10 (Jan)	Data will be mainly M11 (Feb)	Data will be mainly M12 (Mar)	Data will be mainly M1 (Apr)	Data will be mainly M2 (May)	Data will be mainly M3 (June)	Data will be mainly M4 (July)	Data will be mainly M5 (Aug)

BWIS closure impact monitoring – data at January 2016 (M9)

Pharmacy First minor ailments scheme utilisation

GP registered pratice	Average weekly activity			% of total utilisation		
	East	West	Central	East	West	Central
Baseline	4	4	7	28%	24%	48%
Nov-15	3	2	12	15%	14%	71%
Dec-15	7	3	7	45%	15%	40%

Pharmacy accessed	Average weekly activity			% of total utilisation		
	East	West	Central	East	West	Central
Baseline	3	3	9	22%	17%	61%
Nov-15	2	2	12	12%	14%	74%
Dec-15	7	2	8	42%	12%	46%

Would otherwise have attended	Weekly feedback			
	GP	WIC	ED	Other
Baseline	85%	4%	0%	11%
Nov-15	91%	3%	0%	6%
Dec-15	89%	6%	0%	5%

- Increase in activity from patients registered with an East practice GP
- Increase in activity at accredited pharmacies in the East locality
  - including a 100hr pharmacy and 2 in close proximity to Bitterne Health Centre
- Small increase in patients who say they would otherwise have gone to the BWIS

BWIS closure impact monitoring – data at January 2016

GP access and patient experience

Question	SCCCG	National	East locality practice notes
Overall, how would you describe your experience of your GP surgery?	84% good	85% good	6/10 practices at or above national average
Generally, how easy is it to get through to someone at your GP surgery on the phone?	68% easy	71% easy	5/10 practices at or above national average
How helpful do you find the receptionist at your surgery?	87% helpful	87% helpful	7/10 practices at or above national average
The last time you wanted to see or speak to a GP or nurse, were you able to get an appointment to see or speak to someone?	84% yes	85% yes	4/10 practices at or above national average
How convenient was the appointment you were able to get?	90% convenient	92% convenient	4/10 practices at or above national average
Overall, how would you describe your experience of making an appointment?	72% good	73% good	4/10 practices at or above national average
How do you feel about how long you normally have to wait to be seen?	51% don't wait too long	58% don't wait too long	2/10 practices at or above national average
Did you have confidence and trust in the GP you saw or spoke to?	91% yes	92% yes	5/10 practices at or above national average
Did you have confidence and trust in the nurse you saw or spoke to?	84% yes	85% yes	8/10 practices at or above national average
How satisfied are you with the hours that your GP surgery is open?	76% satisfied	75% satisfied	4/10 practices at or above national average

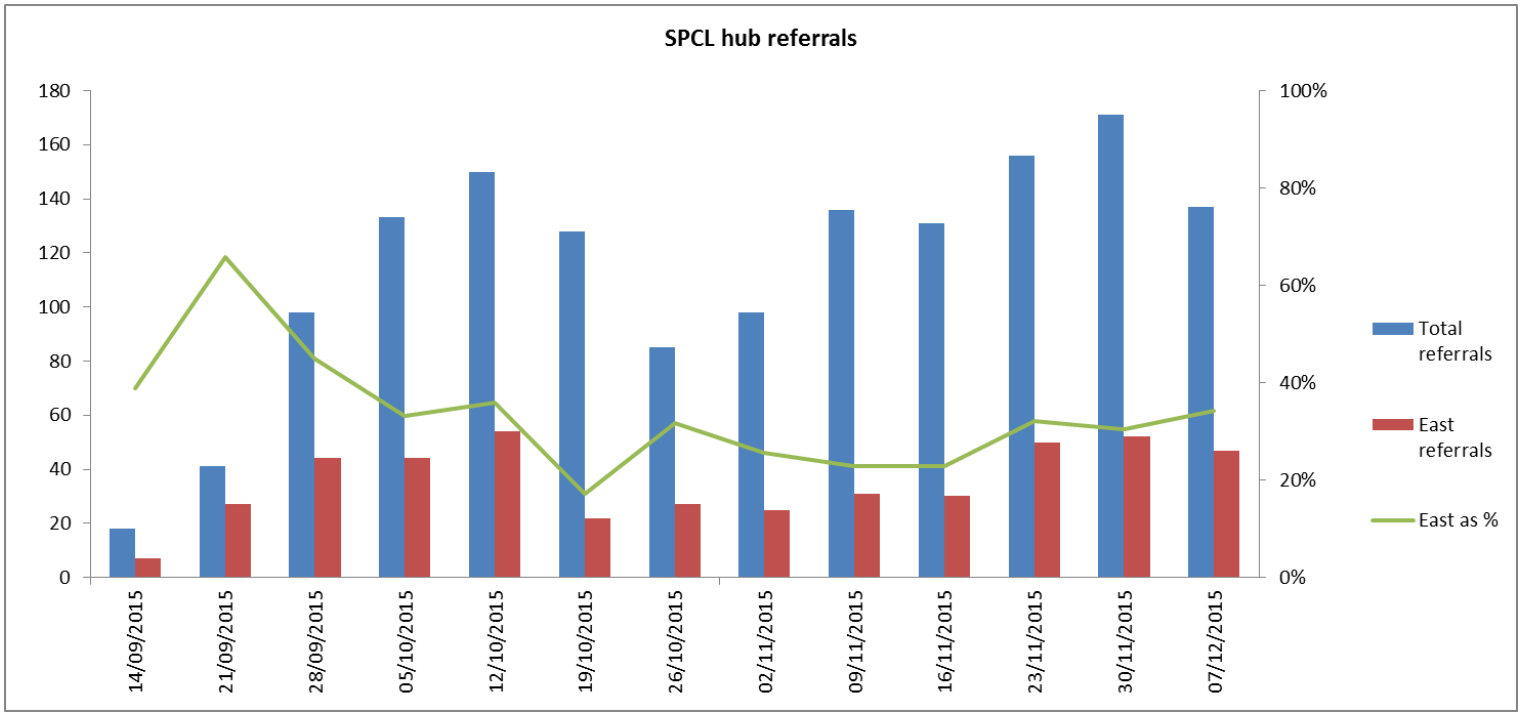
Baseline data: GP patient survey – NHS SCCCG published July 2015 (Data July – September 2014 and January – March 2015)

- Patient complaints, issues and feedback will be collated on a monthly basis and form part of the qualitative reporting
- Next surveys due in January and July 2016

Note GP feedback and experience will be reported in the qualitative impact monitoring

BWIS closure impact monitoring – data at January 2016 (to w/c 7/12/15)

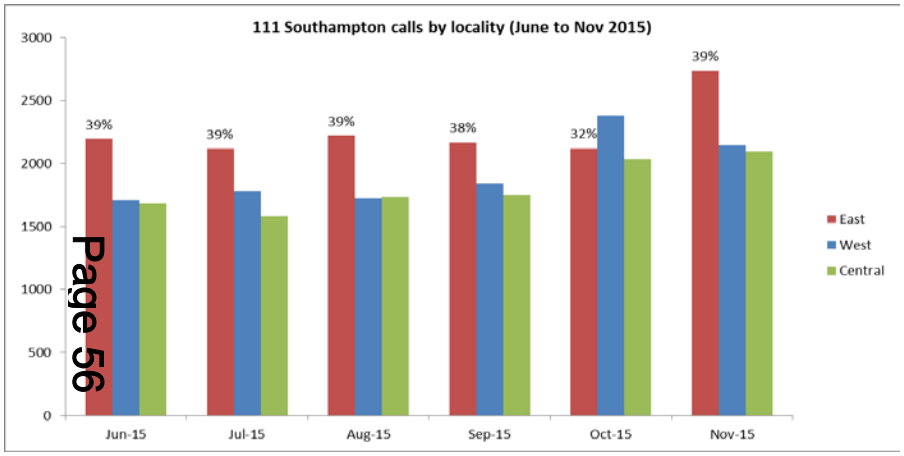
Referrals to SPCL hub



- 3 hubs in city (1 in each locality, East went live first)
- East locality practices averaging 28% of all hub activity since BWIS closure
- Expecting to see activity increase further when hubs on 111 DoS

BWIS closure impact monitoring – data at January 2016 (to M8)

Calls to 111



111 calls	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Total calls answered	37945	38115	40722	38611	43024	46610
Calls answered within 60 seconds (≥95%)	98%	96%	97%	95%	93%	92%
Calls abandoned before answered (<5%)	0.2%	0.4%	0.7%	0.5%	0.8%	0.9%
Southampton patient call volume	5582	5480	5687	5753	6539	6981
Southampton as % of all	15%	14%	14%	15%	15%	15%
East	2193	2117	2221	2167	2121	2737
West	1707	1782	1727	1840	2379	2145
Central	1682	1581	1739	1746	2039	2099

Southampton 111 calls by East practice	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Bath Lodge (registered population 12351)	208	231	259	238	230	280
Bath Lodge as % of East calls	*9%*	*11%*	*12%*	*11%*	*11%*	*10%*
Bitterne Park (registered population 8979)	185	148	139	166	157	176
Bitterne Park as % of East calls	*8%*	*7%*	*6%*	*8%*	*7%*	*6%*
Chessel (registered population 12758)	331	280	343	320	373	342
Chessel as % of East calls	*15%*	*13%*	*15%*	*15%*	*18%*	*12%*
Ladies Walk (registered population 8223)	133	154	138	136	150	165
Ladies Walk as % of East calls	*6%*	*7%*	*6%*	*6%*	*7%*	*6%*
Old Fire Station (registered population 8605)	157	138	112	127	150	204
Old Fire Station as % of East calls	*7%*	*7%*	*5%*	*6%*	*7%*	*7%*
St Peter's (registered population 5223)	103	98	75	82	98	135
St Peter's as % of East calls	*5%*	*5%*	*3%*	*4%*	*5%*	*5%*
Townhill (regisistered population 5465)	109	98	108	90	94	127
Townhill as % of East calls	*5%*	*5%*	*5%*	*4%*	*4%*	*5%*
West End Road (registered population 11627)	244	206	231	213	234	287
West End Road as % of East calls	*11%*	*10%*	*10%*	*10%*	*11%*	*10%*
Weston Lane (registered population 9369)	193	210	211	213	244	249
Weston Lane as % of East calls	*9%*	*10%*	*10%*	*10%*	*12%*	*9%*
Woolston Lodge (registered population 13749)	229	248	271	260	270	317
Woolston Lodge as % of East calls	*10%*	*12%*	*12%*	*12%*	*13%*	*12%*
SO18/19 no GP recorded	301	306	334	322	379	455
SO18/19 no GP recorded as % of East calls	*14%*	*14%*	*15%*	*15%*	*18%*	*17%*

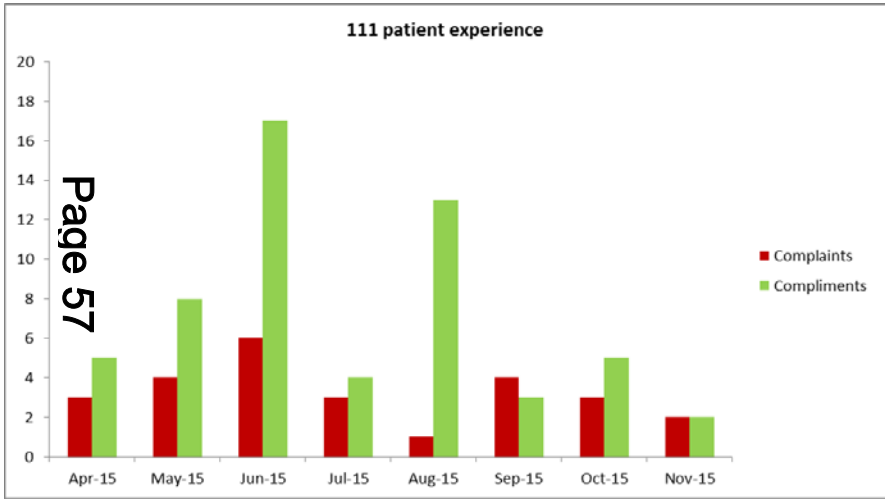
- Calls from Southampton GP registered patients represent ~15% of all calls to the local 111 service
- Across the city, East locality patients are the highest user of the service (averaging 39% of Southampton calls at baseline)
- Although numbers have increased (seasonal trend) the proportion of East patients remains consistent in the first month post BWIS closure

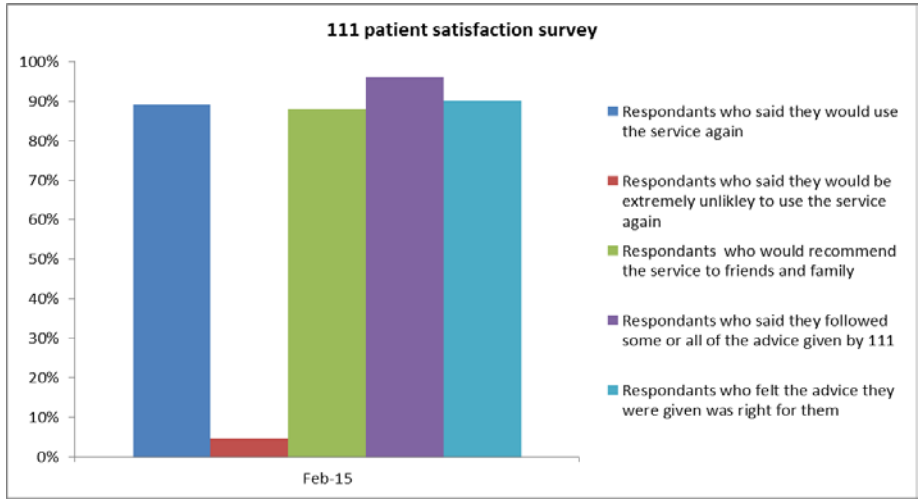
BWIS closure impact monitoring – data at January 2016 (to M8)

111 patient experience

111 patient expereince (SHIP)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Complaints	3	4	6	3	1	4	3	2
Compliments	5	8	17	4	13	3	5	2

Patient satisfaction survery 6 monthly (SHIP - contract level)	Feb-15
Respondants who said they would use the service again	89%
Respondants who said they would be extremely unlikley to use the service again	4.6%
Respondants who would recommend the service to friends and family	88%
Respondants who said they followed some or all of the advice given by 111	96%
Respondants who felt the advice they were given was right for them	90%

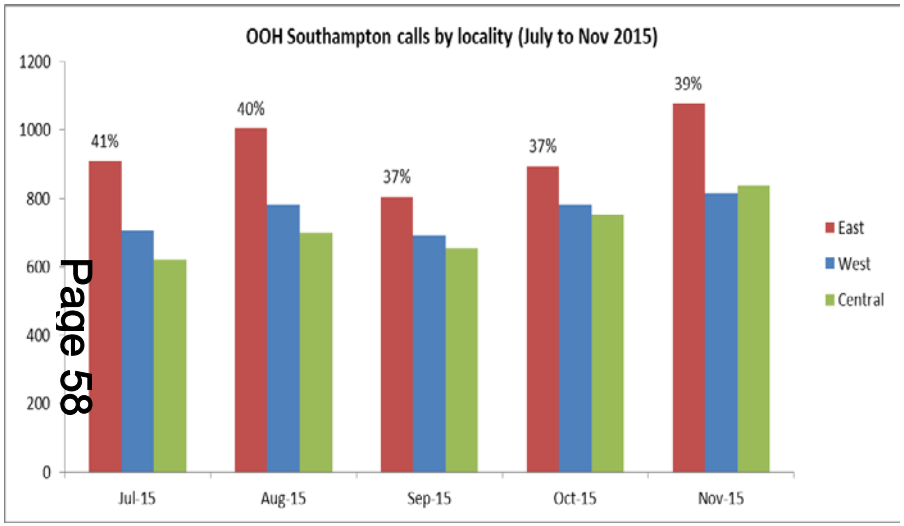




- next patient satisfaction survey results expected next month
- Feb 15 patient satisfaction shows almost 90% of respondents would recommend the service and use it again, with the majority feeling the advice given was both appropriate and applied
- the service generally receives more compliments from patients than complaints

BWIS closure impact monitoring – data at January 2016 (to M8)

Calls to GP OOH



OOH calls	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Total patient call volume (SHIP)	13329	15351	12812	14654	15760
Southampton patient call volume	2237	2485	2150	2427	2729
Southampton as % of all	17%	16%	17%	17%	17%
East	909	1005	804	893	1077
West	706	781	692	782	814
Central	622	699	654	752	838

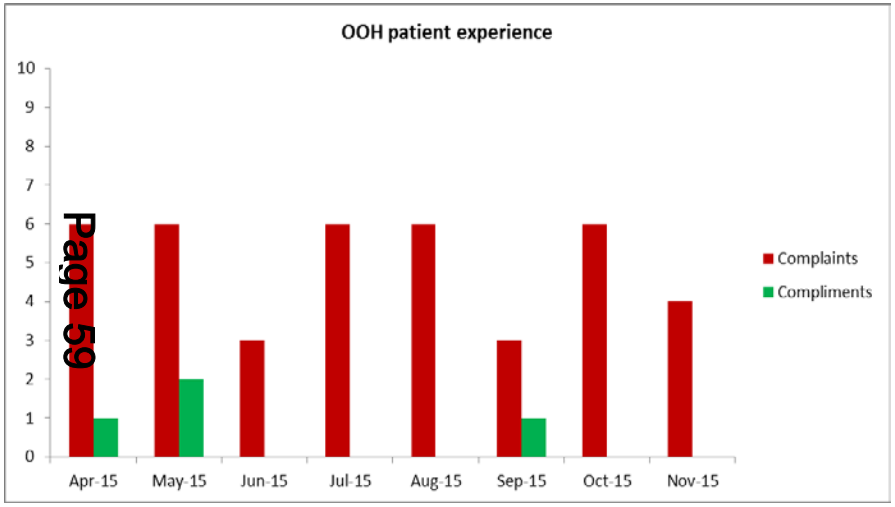
Southampton OOH calls by East practice	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Bath Lodge (registered population 12351)	112	140	126	98	143
Bath Lodge as % of East calls	*12%*	*14%*	*16%*	*11%*	*13%*
Bitterne Park (registered population 8979)	55	80	72	65	93
Bitterne Park as % of East calls	*6%*	*8%*	*9%*	*7%*	*9%*
Chessel (registered population 12758)	151	188	124	179	164
Chessel as % of East calls	*17%*	*19%*	*15%*	*20%*	*15%*
Ladies Walk (registered population 8223)	81	81	63	69	77
Ladies Walk as % of East calls	*9%*	*8%*	*8%*	*8%*	*7%*
Old Fire Station (registered population 8605)	66	58	50	65	91
Old Fire Station as % of East calls	*7%*	*6%*	*6%*	*7%*	*8%*
St Peter's (registered population 5223)	54	41	30	46	59
St Peter's as % of East calls	*6%*	*4%*	*4%*	*5%*	*5%*
Townhill (regisistered population 5465)	32	56	48	44	60
Townhill as % of East calls	*4%*	*6%*	*6%*	*5%*	*6%*
West End Road (registered population 11627)	112	100	89	93	126
West End Road as % of East calls	*12%*	*10%*	*11%*	*10%*	*12%*
Weston Lane (registered population 9369)	109	118	85	108	123
Weston Lane as % of East calls	*12%*	*12%*	*11%*	*12%*	*11%*
Woolston Lodge (registered population 13749)	137	143	117	126	141
Woolston Lodge as % of East calls	*15%*	*14%*	*15%*	*14%*	*13%*

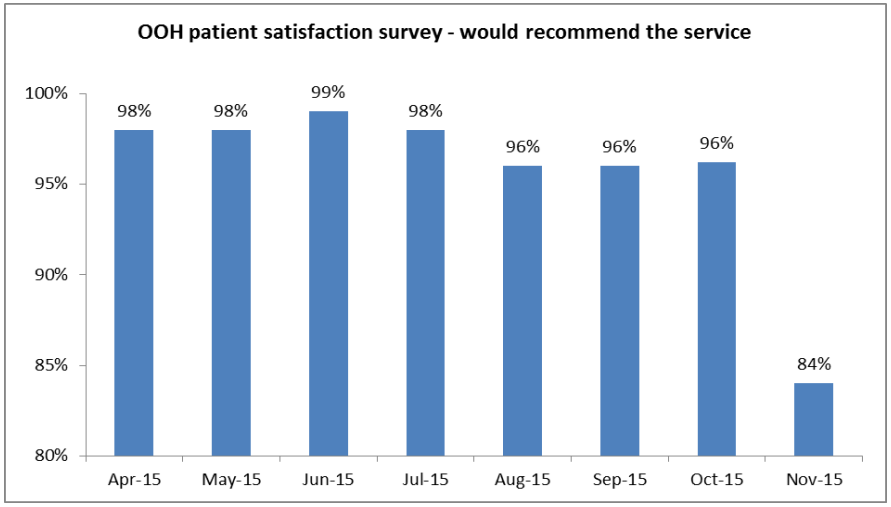
- Calls from Southampton GP registered patients represent ~17% of all calls to the local OOH service
- Across the city, East locality patients are the highest user of the service (averaging 39% of Southampton calls at baseline)
- Although numbers have increased (seasonal trend) the proportion of East patients remains consistent in the first month post BWIS closure

BWIS closure impact monitoring – data at January 2016 (to M8)

OOH patient experience

Patient satisfaction with OOH (SHIP)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Total patient call volume	16791	17960	13078	13329	15351	12812	14654	15760
% respondents who say they would recommend the service	98%	98%	99%	98%	96%	96%	96%	84%
Complaints	6	6	3	6	6	3	6	4
Compliments	1	2	0	N/A	N/A	1	N/A	N/A



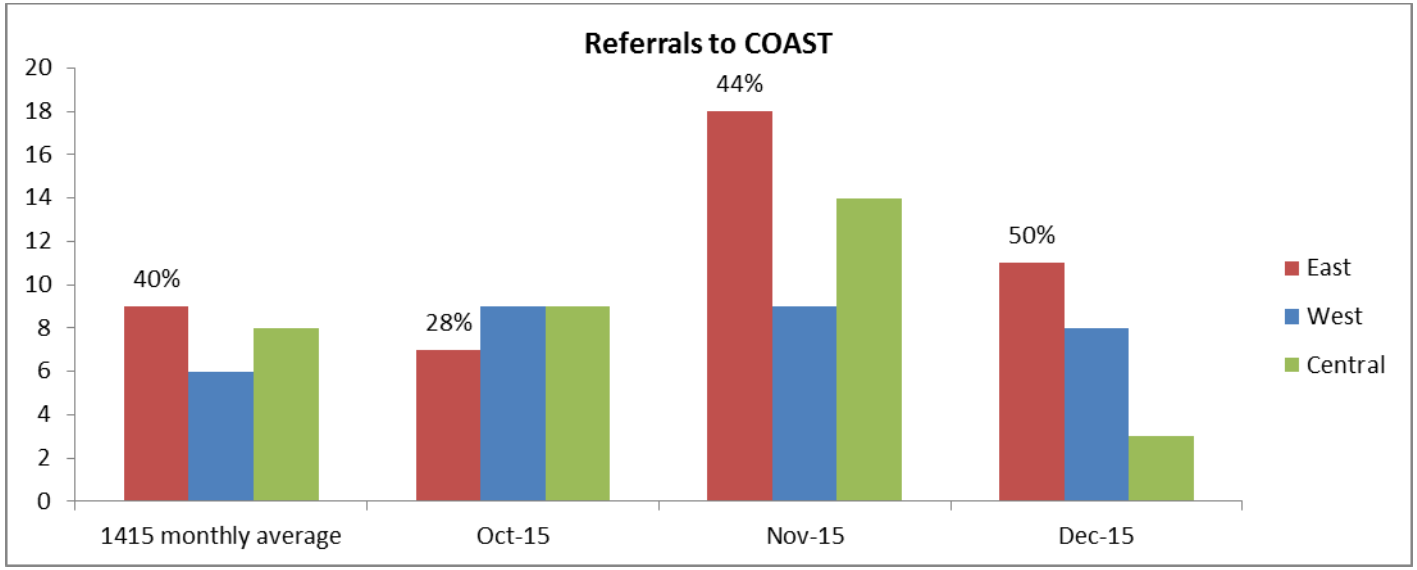


- % of respondents saying they would recommend the service to family and friends dipped in November, this will be monitored
- complaints exceed compliments, but in relation to the total call volume, complaint rate averages at 0.03%

BWIS closure impact monitoring – data at January 2016 (to M8)

Utilisation of COAST

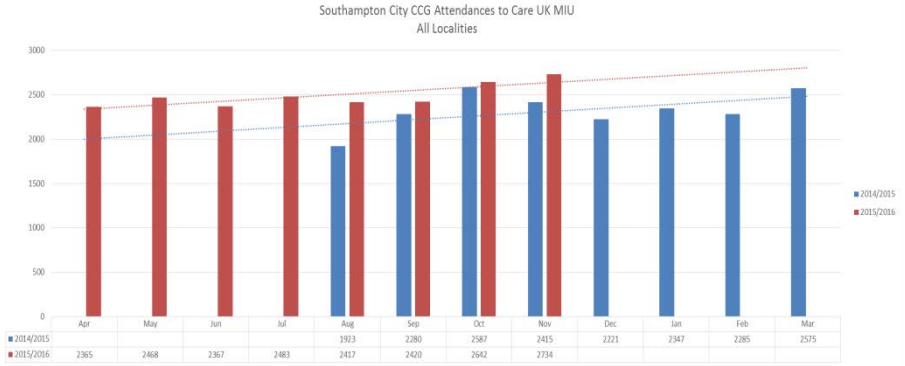
Referrals to COAST	1415 monthly average	Oct-15	Nov-15	Dec-15
East	9	7	18	11
West	6	9	9	8
Central	8	9	14	3



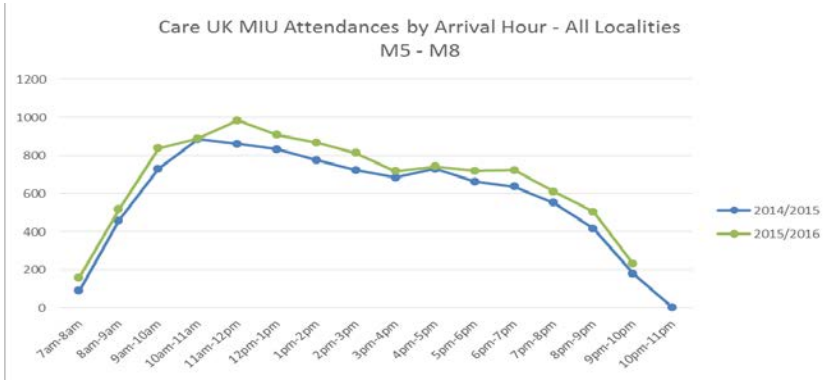
- East practice referrals to COAST have increased post BWIS closure, with activity mostly from one practice in November (West End Road referred 11) and one practice in December (Bath Lodge referred 6)
- Compared to the same time period last year, East practice non-elective short stay admissions have increased by 8% (+6) but note this is significantly lower than West practices (increased by 48% (+29)), while central practices are the same as previous year

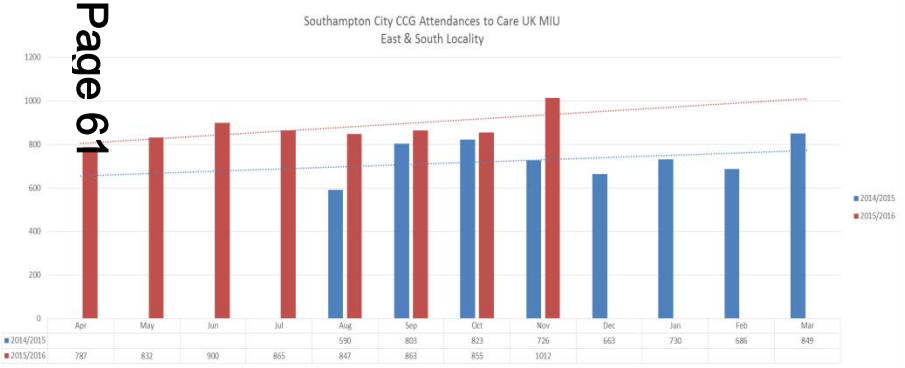
BWIS closure impact monitoring – data at January 2016 (to M8)

MIU attendances



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/2015					1923	2280	2587	2415	2221	2347	2285	2575
2015/2016	2365	2468	2367	2483	2417	2420	2642	2734				





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/2015					590	803	823	726	663	730	686	849
2015/2016	787	832	900	865	847	863	855	1012				

East locality activity M5 to M8

Sum of Activity	Column La	
Row Labels	2014/2015	2015/2016
J82040 - West End Road Surgery	266	346
J82076 - Woolston Lodge Surgery	460	510
J82101 - Chessel Practice	387	535
J82128 - Old Fire Station Surgery	260	312
J82141 - Bath Lodge Practice	362	419
J82171 - Bitterne Park Surgery	312	367
J82180 - Townhill Surgery	171	187
J82187 - Weston Lane Surgery	293	349
J82208 - St.Peters Surgery	172	213
J82622 - Ladies Walk Practice	259	339
Grand Total	**2942**	**3577**

KEY:

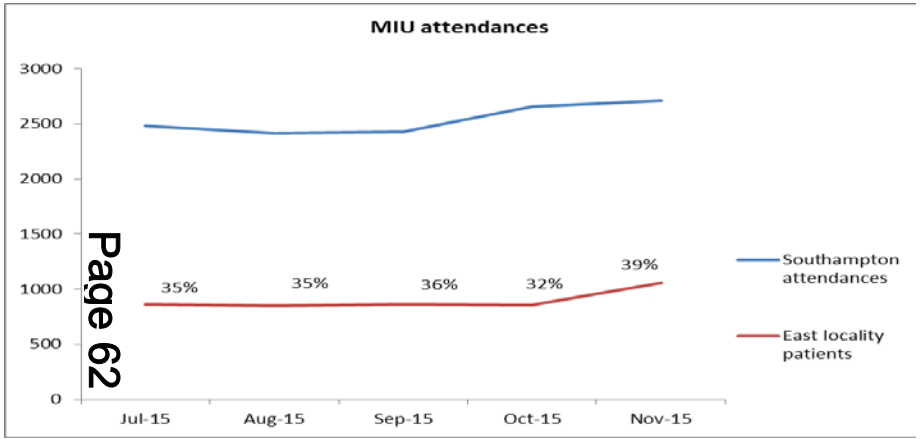
Activity is higher than last year, but less than 10%

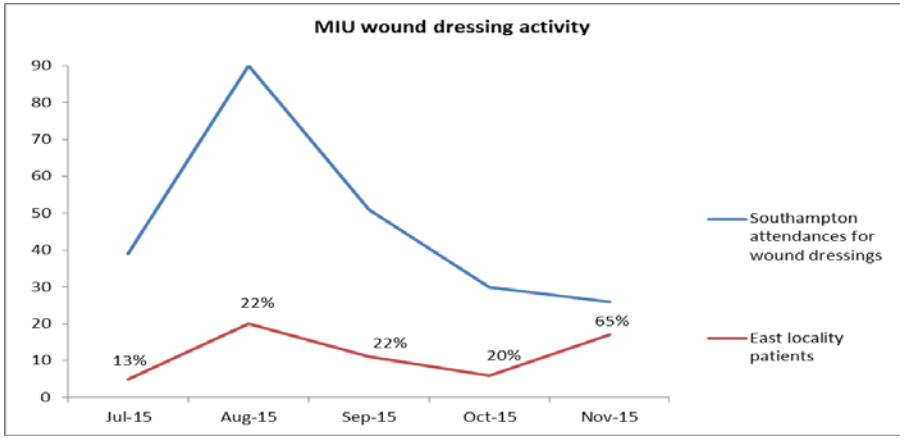
Activity is more than 10% higher than last year

- MIU attendances increased in general in November, compared to previous months and same period last year
- Proportion of East locality patient attendance increased slightly post BWIS closure – expected and will monitor
- Activity for all bar one East practice has increased by over 10% compared to same time period last year (trend mirrored by most Southampton practices)
- East locality patient attendance activity across the day follows the same pattern to rest of the city

BWIS closure impact monitoring – data at January 2016 (to M8)

MIU attendances





Minor illness presentations	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Southampton attendances	2483	2417	2426	2659	2708
% Southampton attendances with minor illness	28%	30%	28%	33%	40%
East locality patients	865	847	863	855	1060
East as % of Southampton	35%	35%	36%	32%	39%

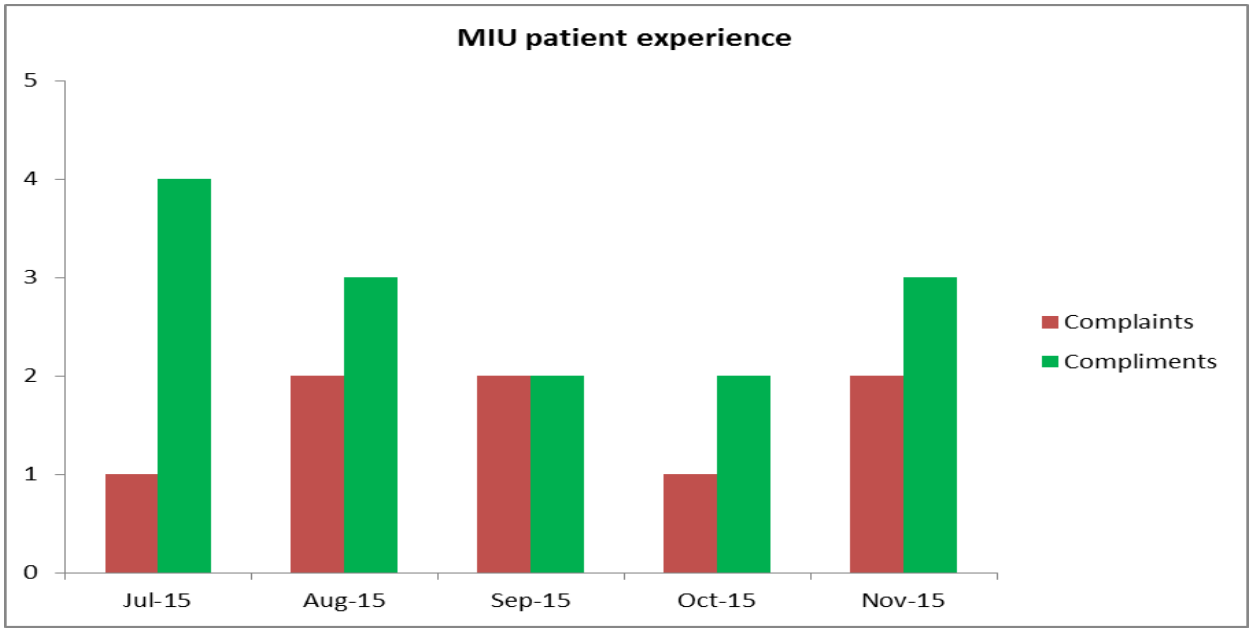
Wound dressings	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Southampton attendances for wound dressings	39	90	51	30	26
East locality patients	5	20	11	6	17
West & central	34	70	40	24	9
% East locality patients for wound dressings	13%	22%	22%	20%	65%

- Proportion of East locality patient attendance increased slightly in the first month post BWIS closure – expected and will monitor
- Minor illness presentations have increased in the first month post BWIS closure – seasonal trend, expected and will monitor (93% of minor illness patients received 'choose well advice' in November and MIU are promoting Pharmacy First)
- Proportion of East locality patient attendance for wound dressings has increased in the first month post BWIS closure, although numbers are smaller – will monitor and target practices as required. SPCL hubs can offer this service out of hours

BWIS closure impact monitoring – data at January 2016 (to M8)

MIU patient experience

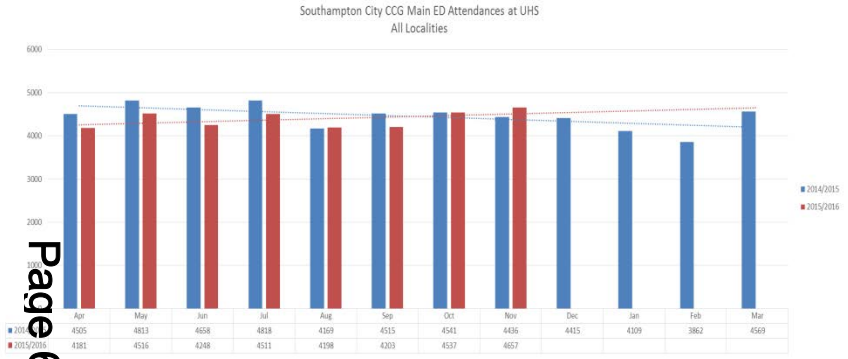
Patient experinece	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Complaints	1	2	2	1	2
Compliments	4	3	2	2	3

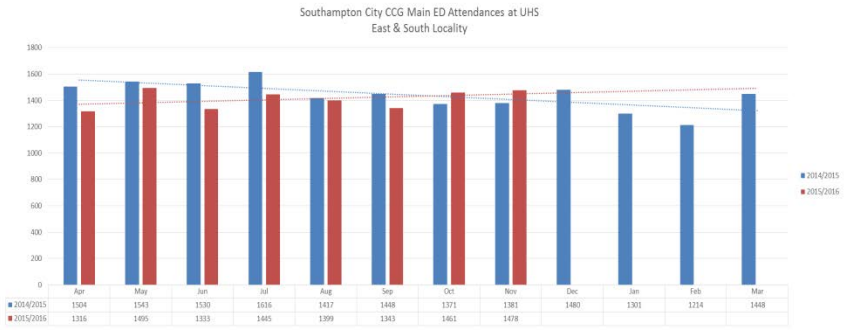


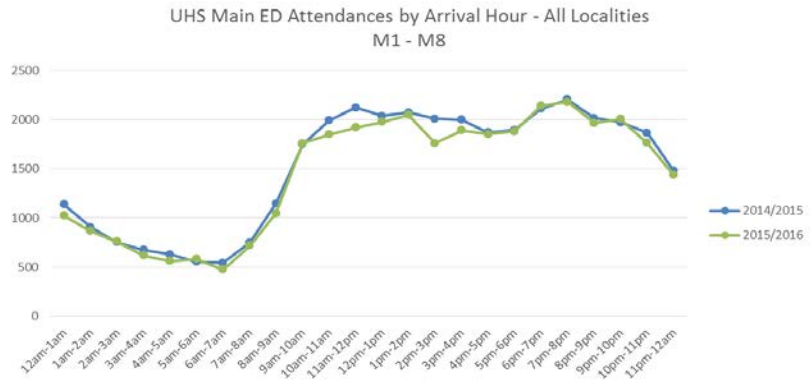
- Friends and family test at November 2015 shows 98% of patients would be extremely/very likely to recommend service
- Generally the service is receiving more compliments than complaints

BWIS closure impact monitoring – data at January 2016 (to M8)

ED attendances







ED attendances East locality M1 to M8

Sum of Activity	Column Label	
Row Labels	2014/2015	2015/2016
J82040 - West End Road Surgery	1491	1489
J82076 - Woolston Lodge Surgery	1651	1534
J82101 - Chessel Practice	1683	1537
J82128 - Old Fire Station Surgery	887	904
J82141 - Bath Lodge Practice	1520	1404
J82171 - Bitterne Park Surgery	999	1121
J82180 - Townhill Surgery	583	566
J82187 - Weston Lane Surgery	1356	1228
J82208 - St.Peters Surgery	591	581
J82622 - Ladies Walk Practice	1049	906
Grand Total	**11810**	**11270**

KEY:

- Activity has decreased by 10% or higher than last year
- Activity has decreased from last year, but less than 10%
- Activity is equal to last year
- Activity is higher than last year, but less than 10%
- Activity is more than 10% higher than last year

- East practice ED attendances in November are have increased slightly compared to previous months and same time period last year – in line with the rest of the city
- Year to date, activity for all bar two East practices has decreased compared to same time period last year
- Attendances by time of day for East locality patients mirrors that of the rest of the city

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		IMPLEMENTATION OF A NICE COMPLIANT FOOT CARE PATHWAY		
DATE OF DECISION:		28 JANUARY 2016		
REPORT OF:		NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Georgina Cunningham**	**Tel:**	**023 8072 5607**
	E-mail:	**Georgina.Cunningham@southamptoncityccg.nhs.uk**		
Director	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 8029 6941**
	E-mail:	**Stephanie.ramsey@southamptoncityccg.nhs.uk**		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

Diabetes is a priority for NHS Southampton City CCG. A three year plan has been developed to improve the outcomes for patients with diabetes who live in the City. Key areas identified as key to tackling diabetes quality issues have been developed by GP localities as part of the overall diabetes programme of work. These are: patient education, professional education and foot care for people with diabetes.

This paper provides an outline of the priority area "foot care" and describes the case for change and the new model of service delivery.

RECOMMENDATIONS:

	(i)	That progress towards implementation of a NICE compliant foot care pathway be noted.
	(ii)	The Panel identifies any issues it may require further information/updates on.

REASONS FOR REPORT RECOMMENDATIONS

1.	To enable the Health Overview and Scrutiny Panel to examine key health issues.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)

	The case for change
3.	NHS Southampton City CCG does not currently commission a fully NICE (National Institute for Health and Care Excellence) compliant pathway for foot care for patients with diabetes. The NICE NG 19 *Diabetic foot problems: prevention and management* published in 2015 (replaces GC10 published in 2004) recommends effective management of those who are: • At low risk • At increased / medium risk • At high risk • Those who have acute or active foot disease.

4.	Changes are needed in diabetes care in the City as there are poor outcomes in amputation rates, making Southampton an outlier nationally when compared to cities with similar population and demographics. Two of the significant complications related to diabetes are peripheral vascular disease, the damage caused by raised glucose levels to large blood vessels supplying lower limbs and the damage or degeneration of nerves called neuropathy which leads to the loss of sensation in the feet. Both of these can predispose people with diabetes to the development of ulcers and this can result in amputation.
5.	Table one shows the amputation rates for Southampton City that were published in 2014 and 2015: **Table One**

Extracted data from PHE Diabetes Foot Care Profile	Hospital foot care activity (April '10 to Mar '13) Published March 2014		Hospital foot care activity (April '11 to Mar '14) Published June 2015	
	SCCCG	England avg.	SCCCG	England avg.
Amputations per 1,000 people aged 17+ with diabetes	4.2% (137)	2.6%	4.3% (148)	2.6%
Major amputations per 1,000 people aged 17+ with diabetes	1.0% (32)	0.9%	0.8% (28)	0.8%
Minor amputations per 1,000 people aged 17+ with diabetes	3.2% (105)	1.7%	3.5% (120)	1.8%

6.	Key observations are: • Major amputations are similar to the national average for England • Minor amputations are significantly higher than the national average for England. It is important when reviewing the headlines about amputations to understand the context, for example the numbers of amputations undertaken, identified by the numbers in the brackets, over the period of time.
7.	Whilst there has been some progress with the improvements within Podiatry over the past two years with the use of Patient Group Directives to all our podiatrists to prescribe antibiotics and direct access to x-ray which has reduced the delays in patients being able to access treatment. Southampton is far from providing a level and quality of service that is sufficient to address the poor outcomes identified above and there remains a high level of dissatisfaction within Primary Care and from those patients who have diabetes.
8.	The case for change is clear in terms of improvement of patient quality of care and is one which the CCG has committed to. Implementation of a NICE

	compliant Foot Care Pathway to meet national guidelines does require significant change across primary, community and secondary care to ultimately improve outcomes.
	NICE Compliant Foot care pathway - What does this mean?
9.	Every patient with diabetes has an annual review undertaken at their GP surgery, most commonly by the practice nurse. As part of this annual review, the feet of each patient are examined and assessed. By doing this, the foot risk is identified and will be discussed with the patient. There are three levels of risk: • Low risk – managed in Primary Care • Increased / moderate risk – referred to NHS Solent Podiatry • High Risk – referred to NHS Solent Podiatry.
10.	All parties have been working towards a phased implementation of the NICE compliant Foot care pathway, initially commencing with the re-modelling of NHS Solent Trust Podiatry service followed by the creation of a new combined clinic to be held at University Hospital Southampton (UHS) for patients with acute active foot disease and ulceration, delivered collaboratively between UHS and NHS Solent.
11.	The new pathway will offer integrated and co-ordinated care, rooted in primary care and community based. It will be easily accessible, and provide seamless transfer of patients between hospital care and the community. It will meet the needs of those at low risk, medium risk and those with acute foot disease and ulceration, with the implementation of a community Diabetes Foot Protection Team (DFPT) and Combined Foot Care Clinics and Multi-Disciplinary team (MDT) delivered at the hospital.
	Benefits – what will improve?
12.	The implementation of the NICE compliant Foot care pathway will lead to: • Improved management in primary care to support patients who are at low risk to self-manage better and maintain their low risk status • Improved access to more responsive and timely care, greater patient satisfaction (Through the implementation of the DFPT) • Prevention of foot disease and improved management of ulceration to prevent further complication • Improved access to expert assessment and intervention through MDT and Combined Foot Care clinics • Reduction in major and minor amputations over the next 3 years • Improved outcomes for the City. Further information on expected benefits is shown in Appendix 1.
	What will change?
13.	The NHS Solent Podiatry service works under a block contract, to provide foot care services for those with diabetes and for non-diabetic patients. To enable enough capacity for the DFPT to see those patients who present with acute foot disease, who are referred as being at increased moderate risk and high risk, there has to be a review of the present caseload.
14.	This will mean that patients who are assessed by podiatry as being at low risk of foot disease and complication will be discharged from the Podiatry

	service. These patients will no longer be eligible to have care provided by the NHS Solent Podiatry service. In addition, NHS Solent Podiatry service will no longer take referrals for low risk patients. The management of low risk patients is within primary care, very few podiatry services across the country accept referrals for this group of patients. Low risk patient referrals are not accepted by the Podiatry service in Portsmouth or other neighbouring areas.
15.	These low risk patients will be signposted for their foot care, supported by self-help education, to providers such as Age UK and private Healthcare Professions Council (HCPC) Registered Podiatrists.
16.	The CCG, NHS Solent and UHS are committed to improving outcomes and preventing foot disease for those patients with diabetes that are identified as being at increased risk; high risk or with acute foot disease.
	How have we engaged?
17.	**Diabetes Patient Survey - 2013:** As part of the wider programme of Diabetes work, a Diabetes Patient Survey was undertaken in 2013. 97% of those who responded to the questions relating to foot care said that they were aware of the problems they might have with their feet, 66% said that they check their feet every day and 75% said that they had their feet checked by a health care professional annually or more frequently.
18.	**Foot Care engagement – 2015:** Engagement specifically on foot care provision has been undertaken at the Diabetes UK Tesco's Big Event and the Diabetes Research and Wellness Foundation event, held in June 2015. The following provides a summary of our findings:

Question:	Responses from Diabetes UK 13th / 14th June	Responses from DRWF 27th June
1. Which of the following foot care services do you feel are the most important to be funded by the NHS?	Top 3 in order: Infection/ulceration treatment Annual Foot Check Drop-in service for treatment	Top 3 in order Annual foot check Drop-in service for treatment Health Education to prevent complications
2. If you thought you had a problem with your feet who are you most likely to see?	Top 3 in order: GP or Practice Nurse Podiatrist drop in service Pharmacist	Top 3 in order GP or Practice Nurse Podiatrist drop in service Minor injury unit
3. Do you have Diabetes? - if so, do you know your Diabetic foot risk? If yes who told you this in the last 12 months?	Clear majority said that GP or practice nurse told them their risk score	Majority said that GP or practice nurse told them their risk score. A significant number said they did not know their risk score
4. If you have Diabetes, at your last annual foot check: - list of areas provided that should be covered in the annual foot check	Low response rate for those who had their footwear examined to check it was not causing problems	Low response rate for those who had their footwear examined to check it was not causing problems.

19.	**Diabetes UK:** Since May 2013 a Diabetes UK representative has been a member of the Diabetes Project Group and of the Diabetes Development. Clinical leads have also presented at the local Diabetes Patient Group.

20.	On the 1st October 2015, Diabetes UK held a 'Putting Feet First Campaign' in Southampton City centre. Later that day, the CCG met with local 'Diabetes Voices' to discuss the plans to improve foot care in the City.
21.	More recently commissioners have met with the Diabetes UK South East Regional Manager; following this they also attended the Diabetes Development Group meeting in November 15 to outline how Diabetes UK can help to support local plans to implement a new foot care pathway. These include a patient education event in April 2016 and a professional education event later in the year.
22.	Diabetes UK has also kindly provided the following statement to support this report: *'Diabetes UK is pleased to see the development of a Foot Protection Service and the introduction of a Multi-Disciplinary Foot care Team (MDfT). There is evidence from areas that have introduced such teams that amputation rates have decreased. We understand both will start in April 2016 and we very much hope this timescale is adhered to. However, we note that the MDfT will only operate twice a week and the healthcare professional team involved is rather more limited than is recommended, and would like to see assurances that the proposals will be fully NICE compliant. If the service will not be NICE compliant from April we would like to see plans and timescales for when compliance will be achieved.'*
	Communications
23.	Since the plans for the new foot care pathway were approved the CCG has been actively sharing the plan and the impact of the changes. These include a meeting with the Chair of HOSP and a meeting with the Chair of Health Watch. Supported by Lead Podiatrist at NHS Solent Podiatry service presentations have been made at the CCG Patient Forum and the Consult and Challenge Group. Presentations are planned at the CCG Communications and Engagement Reference group on 6th January and the Diabetes UK patient group meeting on 26th January 2016.
24.	To date, the plan to introduce the new pathway has been well received and the impact on the current low risk caseload has not met with any challenge. A Communications and Engagement Plan has been drafted and agreed between the CCG and NHS Solent.
	Timescales
25.	NHS Solent Podiatry service will begin the review of its present caseload and the process of moving towards a DFPT in January 2016. The combined clinic at University Hospital Southampton will begin in April 2016. To support all these changes, NHS Solent Podiatry service will move from a 5 day a week to a 6 day a week service from 1st April 2016.
26.	Having a NICE compliant DFPT will improve outcomes such as a reduction in foot ulcer rates within the City, which will then impact on the amputation rate. Evidence shows that 95% of all diabetes related amputations start with at least one foot ulcer.
27.	In summary it is an integrated co-ordinated foot care pathway that covers primary care, community and secondary care. It is critical to get all areas of the pathway working together to produce success and improve outcomes for patients with diabetes.

28.	Effectiveness will be monitored quarterly using the service specification quality indicators and an annual review of improved outcomes as reported nationally in the Public Health England Diabetes Foot care activity profile.
RESOURCE IMPLICATIONS	
Capital/Revenue	
29.	N/A
Property/Other	
30.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
31.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
32.	N/A
POLICY FRAMEWORK IMPLICATIONS	
33.	N/A
KEY DECISION	N/A
WARDS/COMMUNITIES AFFECTED:	N/A

SUPPORTING DOCUMENTATION			
Appendices			
1.	SCCCG NICE Compliant Foot Care Pathway		
2.	Equality Impact Assessment		
Documents In Members' Rooms			
1.	None		
Equality Impact Assessment			
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.			Yes
Privacy Impact Assessment			
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.			No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**			
Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None		

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Southampton City CCG – NICE Foot Care Pathway – November 2015 V1

Key Principles: 7 day working - Single point of access -Seamless integrated service where patients can transfer between levels, as needs escalate/de-escalate -Clear single set of quality standards and outcome measures

Level of risk Total pop. 11,854	Setting of Care	Planned improvement	Benefits
Low risk 70% of the diabetes population (Approx. 8,000)	Primary Care	• Improved quality of annual foot check • Consistent foot care scoring of risk • Better provision of education leaflets to raise awareness • Improved signposting to services in the community	• Better patient awareness and improved self-management for those at low risk to maintain status to prevent developing complications • Improved management in primary care, through education, training
Medium to high risk **Medium risk 20%** (Approx. 2,500) **High risk 5%** (Approx. 500)	Community Diabetes Foot Protection team (DFPT) within Podiatry service	• Improved management of those at medium to high risk by the DFPT with regular review, assessment and management. • Onward referral to new MDT and combined foot care clinics • Improved advice and guidance to primary care • Better focus on education for patients	• Improved access, more responsive and timely care • Improved patient satisfaction • Prevention of foot disease • Improved management of ulceration by the foot protection team to prevent further complications
Acute (active) Foot Disease and Ulceration 5% of the diabetes population (Approx. 600)	Acute Multi-disciplinary team (MDT and Combined clinics) With access to podiatrists, diabetologist, vascular surgery, tissue viability nursing, orthopaedic surgery, orthotics, diabetic specialist nursing, radiology, microbiology)	• Dedicated specialist provision for those with active foot disease • Joint working with community DFPT • More effective use of resources • Improved care and management for active foot disease	• Improved access to MDT and Combined Foot Care clinics to provide expert assessment and intervention. • Reduction in unplanned and emergency admissions • A move towards improved patient experience and outcomes through more planned admissions • Reduction in major and minor amputations over the next 3 years • Improved outcomes for the city to align with similar cities Please note: Improved outcomes will start taking effect from 2016/17 but the aim to align the city's outcomes with its neighbours, especially for the reduction in amputation rates, will not be realised until 2018/19

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EQUALITY IMPACT ANALYSIS (EIA) FORM

Policy/Project/Function	**Diabetes Foot Care Pathway – new NICE recommended pathway**
Date of Analysis	**February 2015 – updated December 2015 (all up-dates in blue)**
Analysis completed by: **Name and Department** **Email and contact details**	**Dawn Buck**
What are the aims or intended outcomes of the Policy/Project or Function?	**To implement a NICE compliant Foot Care Pathway for those with diabetes who are at low risk, medium and high risk and those with active foot disease. To improve patient satisfaction and reduce delays of accessing treatment through improvement awareness and understanding and better management in primary care for those at low risk, introduction of a dedicated foot protection team and new provision of combined foot clinics and MDT. Overall this will help, in time, to reduce amputation rates and non-elective admissions.**
Are there any other policies related to this as part of the analysis?	**Proposed new model of the foot care pathway/ Diabetes Strategy – revised November 15 pathway added – this improved pathway has been used to further engage local patients about the plans to implement a new pathway**  Foot Care Pathway Dec 14.docx  Diabetes Strategy for Southampton City  SCCCG NICE Compliant FC Pathwa

1. SCREENING

Protected Characteristic	Will this policy have a positive effect? Yes or No	Will this policy have a negative effect? Yes or No	What is the evidence?
Age	**Yes**	Following the review of the current podiatry caseload in July and August 2015. A significant number were low risk patients. To build the capacity to deliver the proposed Foot Protection team the service will need to discharge 1,762 patients who will be sign-posted to alternative provision in the city to manage corns, callous, nail care and generalised foot pain. However of the 23,000 contacts per year provided by the service the overall impact will still be positive for the majority of service uses who will benefit from reduced waiting times and a more responsive service to reduce further complications	**See full assessment page 11**
Disability	**Yes**		
Marital status/ Civil Partnership	**Yes**		
Pregnancy and Maternity	**Yes**		
Race	**Yes**		
Religion or Belief	**Yes**		
Sex	**Yes**		
Sexual Orientation	**Yes**		
Transgender people	**Yes**		

Retain this information for evidence

2. LOCAL POPULATION PROFILE/DEMOGRAPHY

<table>
<tr><td>Overall Population Of Southampton</td><td>239,428</td></tr>
<tr><td>Age Profile</td><td>
<table>
<tr><th></th><th>Total</th><th>Percentage</th></tr>
<tr><td>All ages</td><td>239,428</td><td></td></tr>
<tr><td>0-4</td><td>15,910</td><td>6.6</td></tr>
<tr><td>5-15</td><td>26,169</td><td>10.9</td></tr>
<tr><td>16-17</td><td>4,974</td><td>2.1</td></tr>
<tr><td>18-24</td><td>40,783</td><td>17.0</td></tr>
<tr><td>25-34</td><td>40,246</td><td>16.8</td></tr>
<tr><td>35-44</td><td>30,068</td><td>12.6</td></tr>
<tr><td>45-54</td><td>27,971</td><td>11.7</td></tr>
<tr><td>55-64</td><td>21,586</td><td>9.0</td></tr>
<tr><td>65-74</td><td>16,310</td><td>6.8</td></tr>
<tr><td>75-84</td><td>10,643</td><td>4.4</td></tr>
<tr><td>85-89</td><td>3,062</td><td>1.3</td></tr>
<tr><td>90+</td><td>1,706</td><td>0.7</td></tr>
</table>
</td></tr>
<tr><td>Disability Profile</td><td>38,399</td></tr>
</table>

Marital /Civil Partnership Status profile

Marital Status	Number	Percentage
Single (never married or never registered a same-sex civil partnership)	88,491	45.3
Married	72,324	37.0
In a registered same-sex civil partnership	416	0.2
Separated (but still legally married or still legally in a same-sex civil partnership)	5,141	2.6
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	17,827	9.1
Source: Office for National Statistics, 2011 Census		

Pregnancy/Maternity Profile

In 2011 there were 3,520 maternities to Southampton females resulting in 3,550 live births.
In 2011/12 47.2% of babies were being fully or partially breastfed at their 6-8 week check.

Race Profile

Ethnic Group	Number	Percentage
All people	236,882	
White (English/Welsh/Scottish/Northern Irish/British)	183,980	77.7
White (Irish)	1,746	0.7
White (Gypsy/Irish Traveller)	341	0.1
White (Other)	17,461	7.4
Mixed (White and Black Caribbean)	1,678	0.7
Mixed (White and Black African)	941	0.4
Mixed (White and Asian)	1,796	0.8
Mixed (Other Mixed)	1,263	0.5
Asian/Asian British (Indian)	6,742	2.8
Asian/Asian British (Pakistani)	3,019	1.3
Asian/Asian British (Bangladeshi)	1,401	0.6
Asian/Asian British (Chinese)	3,449	1.5
Asian/Asian British (Other Asian)	5,281	2.2
Black/Black British (African)	3,508	1.5
Black/Black British (Caribbean)	1,132	0.5
Black/Black British (Other Black)	427	0.2
Other Ethnic Group (Arab)	1,312	0.6
Other Ethnic Group (Other)	1,405	0.6

Source: Office of National Statistics 2011 Census

Religion/Belief Profile

Religion	Number of people	Percentage
Christian	122,018	51.5
Buddhist	1,331	0.6
Hindu	2,482	1.0
Jewish	254	0.1
Muslim	9,903	4.2
Sikh	3,476	1.5
Other religions	1,329	0.6
No religion	79,379	33.5
Religion not stated	16,710	7.1
Source: Office for National Statistics, 2011 Census		

Sex Profile

Male 121,234
Female 118,195

Sexual Orientation Profile

Data from the Integrated Household Survey in 2010/11 found 1% of adults surveyed identified themselves as gay or lesbian and a further 0.5% identified themselves as bisexual. In Southampton this would equate to 1,970 gay or lesbian adults and 990 bisexual adults. The survey found a larger proportion of men stating they were gay (1.3%) compared to women (0.6%).

Transgender Profile

There are no official statistics nationally or regionally regarding transgender populations, however, GIRES (Gender Identity Research and Education Society) estimated that, in 2007, the prevalence of people who had sought medical care for gender variance was 20 per 100,000. This equates to an estimated 50 people in Southampton

3. AVAILABLE EQUALITY DATA AND INFORMATION

Is Equality Information/Data available in relation to the implementation of this Policy/Project/Function? This is internal or external information/data which may indicate how the different Equality Groups may be affected by this policy/project /function	Please Tick; **Yes ✓** **No** Diabetes Patient Survey 2013 Foot Care Engagement Summary Report 2015
List any Consultations which have been undertaken with Service Users, Carers, Public, Employees, Unions in the development and implementation of this Policy/Project/Function	A programme of engagement started in December 2012 and has continued to seek patient views on current provision and areas for improvement. Foot Care was identified as an area for improvement. Diabetes Uk continues to challenge the CCG on its performance against the national measures for foot care management. It advocates the implementation of the NICE guidelines for Foot Care. The proposed changes would require education of both primary care and local people with diabetes whose expectation of the podiatry service needs to be managed appropriately. In 2013-14 343 people self-referred to the podiatry service, 8% of all referrals to the service. If this proposal is approved communications and engagement, as part of the overall implementation plan will need to be delivered to ensure that the proposal for improvement to the foot care pathway gains local support. Initial plans include 'Myth Buster' leaflet, presentations by the podiatry team lead with support from LTC commissioning manager at local Diabetes Uk meeting, CCG Comms and Engagement Group and Patient Forum. The proposal for the implementation of a NICE Compliant Foot Care pathway was approved in October 2015. Further public engagement was undertaken in June 2015 – feedback from these events was included in the final paper to the Clinical Executive Group.

	Since October a programme of engagement has started to share the plans to implement the new pathway to ensure full support of the planned changes. To date the plan to introduce the new pathway has been well received and the impact on the current low risk caseload has not met with any challenge. The Communications and Engagement plan has been approved.
Promoting Inclusion and Cohesion: How does this Policy/Project/Function contribute towards the organisations aims to promote Equality, Diversity and Human Rights and Elimination of Discrimination?	One of our strategic goals it Making it Fairer – tackling inequalities. As a CCG we have developed a systematic and embedded approach to insight gathering and engagement and involvement work via our You said we did framework.

4. ASSESSMENT

What impact will the implementation of this Policy/Project/Function have on the Equality Groups as defined by the Equality Act 2010?

Equality Groups	No Impact	Positive Impact	Negative Impact	Evidence of impact and /or justification for a *Genuine De*termining *Reason* exists
Age		✓		**This project will support those adults with diabetes in the city approximately 11, 545. It aims to improve outcomes for all patients who are low risk, medium to high risk and those with active foot disease.**
Disability Mental or Physical or Sensory		✓		**This project will improve outcomes for all those with diabetes including those with a disability**
Marital or Civil Partnership Status		✓		**This project will improve outcomes for all those with diabetes**
Pregnancy and Maternity		✓		**This project will improve outcomes for all those with diabetes**
Race All racial groups		✓		**This project will improve outcomes for all those with diabetes**

Religion or Belief All faiths or no faith		✓		**This project will improve outcomes for all those with diabetes**
Sex Women and Men		✓		**This project will improve outcomes for all those with diabetes**
Sexual Orientation		✓		**This project will improve outcomes for all those with diabetes**
Trans-gender		✓		**This project will improve outcomes for all those with diabetes**

5. ACTION PLANNING

As a result of the assessment what actions are proposed to reduce or remove any risks of adverse/negative outcomes identified for service users, carers, public, employees who share the 9 protected Characteristics of the Equality Act 2010?

Identified Risk	Action Recommended	Completion Date	Review Date	Responsible Manager + Contact details
In the Diabetes Patient Survey 2013 – 97% of those who responded to the questions relating to foot care said that they were aware of the problems they might have with their feet, 66% said that they check their feet every day and 75% said that they had their feet checked annually or more frequently. In Primary Care 83% those with diabetes have a record of a foot care check annually. Despite these positive examples of good foot care management amputation rates within the city have continued to rise and we see a high number of NEL admissions. Key to the success of this project is to ensure improved quality of provision particularly in primary care and to ensure that those with diabetes and the general population are aware of the need for good self-management.	1. Improved management in Primary Care – 12 month programme of engagement, education & training and in reach support from podiatry team. 2. Improved patient awareness – 12 month programme of engagement, promotion and awareness building – linked to provider provision 3. Diabetes Uk foot care event to be held in April 2016, supported by local community Diabetes and Podiatry teams to help promote good foot care self-management	March 2016	6 month review on progress September 2016 Final review / evaluation June 2016 On the day participant evaluation	LTC Senior Commissioner / Head of Communications / Head of Stakeholder and relations engagement

The risk is therefore that we fail to reach those who would benefit most from increased awareness and education.				

6. RATING of FINDINGS

Analysis Rating			**Green**	

7. Summary

Brief Summary/Any Comments:

The EIA has been undertaken by Dawn Buck, Head of Stakeholder Engagement and the Commissioner for LTC.

The EIA found that there would be no negative impact on people protected under the equality act (2010)

One key risk has been identified together with an action plan which it is considered will address the risk.

The up-date undertaking in December 2015 also concludes that although patients who are at low risk will need to access care, with support, outside of the podiatry service, the overall impact is positive.

Responsible Manager

Name	Job Title	E-Mail/ Telephone	Date
Dawn Buck	Head of Stakeholder Engagement & Patient Experience	Dawn.buck@southamptoncityccg.nhs.uk	10th Feb 2015
Dawn Buck	Head of Stakeholder Engagement & Patient Experience	Dawn.buck@southamptoncityccg.nhs.uk	Up-date December 2015

Approval and Sign Off

Name	Job Title	E-Mail/ Telephone	Date
John Richards	Chief Executive		

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE		
DATE OF DECISION:		28 JANUARY 2016		
REPORT OF:		HEAD OF LEGAL AND DEMOCRATIC SERVICES		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**Mark.pirnie@southampton.gov.uk**		
Director	**Name:**	**Dawn Baxendale**	**Tel:**	**023 8083 2966**
	E-mail:	**Dawn.baxendale@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None.

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

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

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

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None.

DETAIL (Including consultation carried out)	
3.	Appendix 1 of the report sets out the recommendations made at previous meetings of the Health Overview and Scrutiny Panel. It also contains summaries of any action taken in response to the recommendations.
4.	The progress status for each recommendation is indicated and if the Health Overview and Scrutiny Panel confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Panel does not accept the matter has been adequately completed, it will be kept on the list and reported back to the next meeting. It will remain on the list until such time as the Panel accepts the recommendation as completed. Rejected recommendations will only be removed from the list after being reported to the Health Overview and Scrutiny Panel.

RESOURCE IMPLICATIONS	
Capital/Revenue	
5.	None.

Property/Other			
6.	None.		
LEGAL IMPLICATIONS			
Statutory power to undertake proposals in the report:			
7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.		
Other Legal Implications:			
8.	None		
POLICY FRAMEWORK IMPLICATIONS			
9.	None		
KEY DECISION	No		
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report		
SUPPORTING DOCUMENTATION			
Appendices			
1.	Monitoring Scrutiny Recommendations – 28th January 2016		
Documents In Members' Rooms			
1.	None		
Equality Impact Assessment			
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	No		
Privacy Impact Assessment			
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	No		
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**			
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: Monitoring Recommendations

Scrutiny Monitoring – 28th January 2016

Date	Title	Action proposed	Action Taken	Progress Status
26/11/15	CQC Inspection Action Plan – Southern Health NHS Foundation Trust	1) That an update on the progress made by the NHS Foundation Trust implementing the CQC action plan is brought to a meeting of the Panel in Autumn 2016. The report should include specific reference to the improvements to the environment within Antelope House	A briefing paper outlining improvements to the environment at Antelope House was circulated to the Panel on 23/12/15.	
		2) That the Panel consider parity of esteem when discussing the Integrated Commissioning Unit led Mental Health Matters review.	Agreed	
		3) That the research commissioned by Healthwatch Southampton from the University of Southampton is circulated to the Panel when published.	Agreed	
26/11/15	Update on 'Getting the Balance Right in Community Based Health Services'	1) That the following issues are included in the report on this item at the 28 January 2016 Panel meeting: • Update on transport issues • Update on the impact of the Walk-In Service closure, including the impact on GP Practices.	Agreed	
26/11/15	Health & Adult Social Care Budget Proposal – HASC 8	1) That feedback from the budget proposal consultation be circulated to the Panel.	Update on the proposal to be provided.	

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