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Health and Wellbeing Board

Wednesday, 30th September, 2015
at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Shields - Chair
Councillor Jeffery
Councillor White
Councillor Lewzey
Councillor Chamberlain

Rob Kurn – Healthwatch
Hilary Brooks – Interim Head of Service
Dr A Mortimore – Director of Public Health
Dr S Robinson – Clinical Commissioning Group – Vice-Chair
Dr E Mearns – NHS England Wessex Local Area Team

Contacts
Judy Cordell
Senior Democratic Support Officer
Tel: 023 8083 2766
Email: judy.cordell@southampton.gov.uk

BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

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

Responsibilities

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

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

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

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

Southampton City Council's Priorities:

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

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.

Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take

Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Dates of Meetings: Municipal Year 2015/16

2015	2016
29 July	27 January
30 September	23 March
4 November	

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

PROCEDURE / 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.

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

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

DISCLOSURE OF INTERESTS

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

DISCLOSABLE PECUNIARY INTERESTS

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

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

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

Other Interests

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

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

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

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

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 STATEMENT FROM THE CHAIR

3 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.

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 29th July, 2015 and to deal with any matters arising, attached.

5 FAIRNESS COMMISSION RECOMMENDATIONS

Report of the Fairness Commission Independent Chair detailing the Fairness Commission Recommendations, attached.

6 LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT

Report of the Independent Chair of the Local Safeguarding Adults Board detailing the Annual Report, attached.

7 HEALTH AND WELLBEING STRATEGY PRIORITIES

To receive a verbal update from the Assistant Chief Executive on the Health and Well Being Strategy Priorities and Timetable for approval.

8 INTEGRATED COMMISSIONING UPDATE

Report of the Director of Quality and Integration detailing the Integrated Commissioning Update, attached.

9 BETTER CARE SOUTHAMPTON IMPLEMENTATION

Report of the Director of Quality and Integration detailing the Better Care Southampton Implementation, attached.

Tuesday, 22 September 2015 Head of Legal and Democratic Services

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 29 JULY 2015

Present:	Councillors Chamberlain, Jeffery, Lewzey, Shields and White Andrew Mortimore, Rob Kurn, Dr Elizabeth Mearns, Hilary Brooks, Mark Howell and Dr Sue Robinson – Clinical Commissioning Group Chair
Also in attendance	Councillor Payne – Cabinet Member for Housing and Sustainability John Richards – Chief Officer, NHS Southampton City CCG

1. **ELECTION OF CHAIR AND VICE-CHAIR**

RESOLVED that Councillor Shields be elected as Chair and Dr Robinson be elected as Vice-Chair for the 2015/2016 Municipal Year.

COUNCILLOR SHIELDS IN THE CHAIR

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

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

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

Councillor White declared that he was an appointed Member of the Health Overview and Scrutiny Panel and that in addition held a position of trustee at the Hampshire Autism Trust and remained in the meeting and took part in the consideration and determination of items on the agenda.

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

Councillor Jeffery declared that he was and employee of University Hospitals Southampton and took part in the consideration and determination of items on the agenda.

3. **STATEMENT FROM THE CHAIR**

The Chair made a statement in accordance with accepted practice and informed members:-

- that following this year Central Government Budget there was now a potential delay in the implementation of funding caps set out in the Social Care Act 2014;
- that it was hoped the Children and Adolescent Mental Health Service would receive some additional funding allocated to it from NHS England;
- that governance arrangements for the Board where being reviewed; and

- that in order to ensure that the Board stayed fit for purpose there would be a review of the governance arrangements.

In addition the Vice-Chair advised the Members that the CCG was continuing to review the provision of GPs within the City and was working to ensure greater sustainability of service.

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

RESOLVED: that the minutes for the Board meeting on 25th March 2015 be approved and signed as a correct record.

5. **HOUSING AND HEALTH IN SOUTHAMPTON**

The Board considered the report of the Director of Public Health detailing the health impact and opportunities to improve health through joined up housing related approaches

The Board noted the following:

- the excess winter death rate in the City;
- the potential effects of poor quality housing on an individual's health;
- the need to improve the quality of private housing stock;
- the Council's extension of the Houses of Multiple Occupancy (HMO) Licensing scheme scheduled for October 2015;
- the need for the alignment of the strategic intent of the Council to improve the quality of housing within the City and the effects of the Council's policies on improvement to the City's housing stock, especially within the private rented sector;
- local schemes designed to improve the quality of housing.

RESOLVED that the Board acknowledged the broad range of housing and social care related services currently operating in the City and supported the recommendations set out in Appendix 1 the paper namely:

- the alignment of strategic intentions for housing and health under Health and Wellbeing Board and ensuring a strategic approach to provision of housing services for those who are most vulnerable i.e. needs based rather than self-referral.
- the protection housing initiatives that are working well, where possible, seek to evaluate the impact of local existing and new approaches on health and social care resource use and well-being.
- supporting the Health Overview and Scrutiny Panel recommendations on homelessness.
- extending the Houses of Multiple Occupation (HMO) licensing scheme to all HMOs across the City to ensure conditions in the private rented sector are improved.
- supporting strategies to encourage behaviour change and early intervention to reduce demand for social housing and adaptations.
- exploration of the use of Social Return on Investment approaches to determine future health and well-being priorities for the City.
- supporting the Southampton Warmth for All Partnership to ensure City wide partnership working on this agenda, especially in the development of bids for future funding.

- aligning the work of Southampton Warmth for All Partnership with the Better Care Programme Framework and engage the Integrated Care Board on fuel poverty agenda and potential for developing a warmth on prescription scheme.

6. **DRAFT HEALTH INEQUALITIES FRAMEWORK**

The Board considered the report of the Director of Public Health detailing the draft Health Inequalities Framework

The Board noted the following:

- The 8 key principles, detailed within the paper, that underpinned the framework:
  a) Take evidence – informed action:
  b) Use a life course approach:
  c) Apply proportionate universalism
  d) Work with local communities:
  e) Aim for health equity in all activities:
  f) Inter-sectoral Collaboration
  g) Ensure impact and learn from successes and failures
  h) Aim for continuity and sustainability:
- The Cores 6 main themes, detailed within the report, that would be developed to support and focus action on health inequalities in the City:
  a) Early Life Interventions – Give every child the best start;
  b) Skills Development – enable all children, young people and adults to maximize capabilities;
  c) Employment and Work – create access to fair employment, good work for all and promote the living wage;
  d) Healthy Environment – create and develop healthy and sustainable places and communities;
  e) Ill Health Prevention – strengthening the role and impact of ill health prevention; and
  f) Resilient Communities – building resilient communities, tackling loneliness and social isolation.
- The preliminary High Impact Actions set out within the report and the potential for these actions to reduce health inequalities in the City

RESOLVED that the Health and Wellbeing Board agreed the following recommendations in order to support the further development of the Health Inequalities Framework namely the:

(i) Development of a Consultation and Engagement Process as part of Health and Wellbeing Strategy Development;
(ii) Assigning accountability of an action and the development an implementation plan for high impact actions;
(iii) Development of a Community Resilience Theme; and
(iv) Ensuring that action was taken across Health and Wellbeing Board partner agencies to make both the commissioning and policy development were “Health Equality Proofed”

7. **INTEGRATED COMMISSIONING WORK PROGRAMME 2015/16**

The Board considered the report of Director of Quality and Integration detailing the Integrated Commissioning Work Programme 2015/16.

The Board noted the following:

- The depth and scope of the key commissioning themes of work for the Integrated Commissioning Unit (ICU), detailed with the paper, including:
    - Early Intervention and prevention – developing an integrated early intervention and prevention offer for adults and young people, children and families
    - Improving outcomes for people with Learning disabilities
    - Improving outcomes for people with Mental health problems
    - Improving outcomes for children and young people
    - Delivering Integrated Care (Better Care)
- Opportunities for the work programme to align with the national priorities;
- That the quality element of the ICU's work programme was unique but, was core to the standards and requirements of any commissioning;
- The potential integration of the Children's centres across the City as a base for health services;
- The timetable for the projects across the City; and
- The percentage value the targeted savings across the budgets as a whole.

RESOLVED that the Board welcomed the priorities for Integrated Commissioning for 2015/16 and noted that consideration would be given on how the Health and Wellbeing Board will engage with areas of strategic importance to its own work programme.

8. **BETTER CARE SOUTHAMPTON PROGRESS AND PERFORMANCE**

The Board considered the report of Director of Quality and Integration detailing progress and performance of Better Care Southampton

The Board noted the following;

- The 3 key building blocks, detailed within a presentation, for performance of Better Care :
    - Person centred local co-ordinated care;
    - Responsive discharge and reablement- supporting timely discharge and recovery; and
    - Building capacity.
- There were different priorities set by each of the 6 clusters/ locality teams and Citywide objectives that over arched the teams;
- Progress to date on the 3 key buildings blocks;
- The key risks and issues in relation to the delivery and the mitigating factors
- Future plans for improvement including the:
    - establishment of a Single point of access across the system;
    - automated shared care plans; and
    - roll out to other client groups, e.g. people with learning disabilities, mental health problems, children.
- National reporting requirements; and
- Southampton City Better Care Logic Model.

RESOLVED that Board noted the progress with implementation and performance of the Better Care Southampton programme.

9. **PERFORMANCE UPDATE**

The Committee considered the report the Chair of the Health and Wellbeing Board detailing a performance update.

The Board noted the introduction of a Health and Wellbeing Performance Scorecard in order to enable the Board to assess the outcomes for key health priorities across the City and address areas requiring further action.

It was noted that the scorecard would be developed over time and marked the progress against commitments set out in the Health and Wellbeing Strategy 2013 – 16. Members were requested to assess the effectiveness of the measures and direct any potential additional measures towards the Chair.

RESOLVED that Board:

(i) noted the progress against the commitments in the Health and Wellbeing Strategy 2013 – 2016;

(ii) that further actions be taken to progress the commitments detailed within the Health and Wellbeing Strategy 2013 - 2016, with a particular focus on the actions that are significantly off target (red); and

(iii) agreed the format of the Health and Wellbeing Scorecard and recommended that any changes to the measures required be brought to the Board and agreed the future reporting mechanisms; and

(iv) agreed that any Members would direct any potential additional measures or changes to the Scorecard towards the Chair.

10. **SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP (SCCCG) QUALITY PREMIUM**

The Board considered the report of the Southampton City Clinical Commissioning Group GP Board Representative, detailing the Southampton City CCGs Quality Premium.

The Board noted the achievement of the targets set by the quality premium would result in additional funding.

It was explained that as part of the planning process for 2015/16, The Clinical Commissioning Groups (CCGs) had needed the approval of both the local Health and Wellbeing Boards and NHS England for a number of measures that the CCG would be held accountable for in the coming year. It was noted that as the deadline for submission of these plans was by 14th May 2015 and it had not been possible to ratify these at a meeting. Approval was given by the Chair and Vice- Chair and the Board and the Board were ask formally to ratify the Southampton City CCGs Quality Premium.

RESOLVED that the Health and Wellbeing Board considered the Southampton City CCGs Quality Premium and approved the proposals for the 2015/16 targets to be structured as follows:

- Urgent and Emergency Care would have an overall worth 30% of quality premium;
- Mental Health would have an overall worth 30% of quality premium; and
- Local priority measures would have an overall worth of 10% each of quality premium

- Maternal smoking at delivery;
- Total health gain as assessed by patients for elective groin hernia procedures.

DECISION-MAKER:		**Health and Wellbeing Board**		
SUBJECT:		FAIRNESS COMMISSION RECOMENDATIONS		
DATE OF DECISION:		30 September 2015		
REPORT OF:		The Fairness Commission Independent Chair		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Sara Crawford**	**Tel:**	**023 8083 2673**
	E-mail:	**Sara.crawford@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

This report sets out the Fairness Commission process and recommendations to be launched in November. Alex Whitfield, one of the commissioners and also the Chief Operating Officer for Solent NHS Foundation Trust, will present the key issues for the Health and Wellbeing Board to consider their response to the recommendations given their duty to promote health and wellbeing and reduce inequalities in health.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board consider the Fairness Commission recommendations and, following discussion, agree the Board's role for the recommendations from the Commission.

REASONS FOR REPORT RECOMMENDATIONS

1. The Health and Social Care Act 2012 sets out the Health and Wellbeing Board's duty to promote health and wellbeing and reduce inequalities in health in their area. The Fairness Commission's key role was to look into how to make the city a fairer and more equal place to live and work, including reducing health inequalities. Their recommendations are therefore relevant to the strategic development and work programme of the Board.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

Background

3. The Southampton Fairness Commission is an independent and entirely voluntary body. It was set up in late 2013, against a backdrop of impressive economic growth for the city that is somewhat negated by the poverty and deprivation experienced by a significant proportion of its citizens.

The Commissioners

4. The Southampton Fairness Commission comprises representatives from the public, private, and voluntary sectors. The Commissioners are unpaid volunteers and were appointed as a Task and Finish Group on the basis of their

professional expertise and commitment to fairness and social justice. They have shaped and promoted the work of the Southampton Fairness Commission, and worked together to identify practical ways of making the city a fairer place.

5. The Commission is chaired by Jonathan Cheshire OBE, a leading developer of charities and voluntary agencies with particular expertise in youth and young people's issues, employment and training, regeneration, and outdoor education. The Vice Chair is Dr Darren Paffey, a former Labour councillor for Southampton City Council and a lecturer in Spanish and Linguistics at Southampton University.
6. The Commissioners are:
    - Dave Adcock
    - Jo Ash
    - Annette Davis
    - David Gilani
    - Geoff Glover
    - Joe Hannigan
    - Ian Loynes
    - Ahmed Sasso MBE
    - Jojar Singh
    - Alex Whitfield
7. The Southampton Fairness Commission believe that:
    - Inequality is bad for everybody, not just those at the lower end of the socio-economic scale. Numerous recent studies by leading economists bear this out.
    - Inequality is growing in the UK and has been growing for the last ten years, accelerating after the 2008 economic crash and recession.
    - Concerted local action is required and likely to be the only effective way forward. Disadvantaged people in Southampton and other similar communities are unlikely to receive any significant help from public agencies over the next few years because of policy constraints in central government and resource constraints in local government.
    - Southampton has the potential to be one of the best places in the world to live and work.
8. The Commission agreed the following principles of fairness:
    - Everyone in Southampton should have the opportunity to do well in life, regardless of their beginnings or where they live.
    - A commitment to greater equality in health outcomes, wellbeing, social relationships, learning and life opportunities, is a worthwhile investment for all, reducing costs and multiplying social and economic benefits long term.
    - Consensus and innovation among Southampton's public, private and voluntary sectors should bring about lasting solutions to inequality.
    - Prevention of inequalities and removing any barriers to fairness through appropriate policy and practice are more effective than later attempts to correct unfairness.
    - People are empowered more when solutions are found by them in consultation with others, not just for them.

- Resources should be prioritised where the most benefit can be provided for those in greatest need.
- Southampton must reflect, represent and cherish our community diversity, value those from different backgrounds and identities, and protect and encourage vulnerable people.

Consultation and gathering evidence for the recommendations

9. The Commission has undertaken a wide programme of consultation and engagement during 2014/2015. This has included a 'call for evidence', an online survey, questionnaires, public meetings on key 'fairness' themes, visits to groups and communities, engagement with local agencies working with some of our most disadvantaged residents and dialogue with politicians and business leaders.

10. Themed public meetings were held between June 2014 and January 2015. These included discussions with experts and local communities of interest on:
    - Employment
    - Income
    - Health
    - Housing
    - Transport
    - Growing Older
    - Growing Up

11. The feedback and findings from this work, alongside additional local and national research, have enabled the Commission to understand more deeply, some of the underlying issues and barriers to achieving a fairer City. In response, the Commissioners have developed a set of key recommendations which they have identified as being realistic and achievable by local agencies with a minimum of reliance on central government. These recommendations are based on the expectation that all the current work to reduce inequalities will continue.

The recommendations:

12. The Fairness Commission recommendations are based on three key themes:
    - Fairer employment
    - Fairer living
    - Fairer organisation and communities

Fairer employment

13.
1. Create a 'Great Place to Work' city with commitment from employers, including the promotion of the Living Wage[1] and recognise achievements at an annual award ceremony.
2. Establish a comprehensive support service designed to help people deal with involuntary self-employment, fairly and safely - e.g. dealing successfully with HM Revenue and Customs (HMRC), insurance, cash

[1] Living Wage in this report refers to the level recommended jointly by the Joseph Rowntree Foundation and the Resolution Foundation, which may be higher than the Living Wage in the Chancellor's Summer Budget 2015.

flow, credit control and VAT.

3. Establish a tactical fund to address urgent skills shortages in the local labour market; to be allocated by a representative group of employers, and financed by pooled contributions from strategic funders – Skills Funding Agency (SFA), Solent Local Enterprise Partnership (LEP), Department for Work and Pensions (DWP) and their contracted providers.

Fairer living

14.

4. Increase the availability of affordable and good quality housing by using alternative funding mechanisms outside public sector constraints to build new homes and exploit under-used resources such as empty properties, self-build and container conversions. This should also provide local employment opportunities.
5. Encourage our citizens to take individual responsibility for healthier lifestyles and all agencies to take collective action to support this through citywide campaigns to reduce smoking, drinking and obesity.
6. All health and social care commissioners should ensure that contracts with providers require them to demonstrate that they have taken action to achieve equity of outcomes. The Health and Wellbeing Board must monitor inequalities and take actions to address them.
7. Improve access to, and awareness of financial services for all by building capacity in community finance institutions and initiatives e.g. Credit Unions and user-friendly local banking.
8. Improve the ability of people to manage money better by:
    a. Promoting and providing learning modules for debt and money management in schools and colleges.
    b. Developing and implementing a programme to increase awareness of and fair access to welfare entitlements, particularly linked to key life-transition points.
9. Improve accessibility to integrated transport by actively:
    a. Supporting social enterprise solutions to improve local transport, particularly in non-commercial routes.
    b. Taking a more strategic approach to market failures in transport, particularly bus routes and frequency of key bus services.

Fairer organisations and communities

15. The delivery of the recommendations under ‘fairer employment’ and ‘fairer living’ needs to be supported by:

10. Organisations, in procuring goods and services, should maximise local economic and social outcomes through improved application of the Social Value Act to:
    a. Increase employment and skills of local residents.
    b. Use local supply chains to develop capacity in local organisations with a long term commitment to the city.
11. Promote zero tolerance of bullying, hate crime and discrimination, by increasing awareness in the city of reporting mechanisms and organisations improving their responses and support for victims.
12. Support individuals and communities to take responsibility for improving the quality of their lives and their environment through funding of small

community-run preventative projects to reduce inequality.

13. Set up a ‘Southampton Fairness Fund’, an ‘employee giving’ scheme matched by employers and allocated in a transparent and democratic

Next Steps:

16. The Southampton Fairness Commission will be publishing its final report and recommendations shortly. This will be followed by a public/stakeholder event to present the findings and recommendations later in the year.

17. The Health and Wellbeing Board is requested to consider the Fairness Commission recommendations and, following discussion with the Chief Operating Officer for Solent NHS Foundation Trust, agree its response to the Commission’s recommendations as part of its duty to promote health and wellbeing and reduce health inequalities in the local population.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None. The Fairness Commission recommendations should be achievable through a shift or rethinking of existing resources.

Property/Other

7. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. None.

Other Legal Implications:

9. None.

POLICY FRAMEWORK IMPLICATIONS

10. None.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	

Equality Impact Assessment

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

DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**LOCAL SAFEGUARDING ADULTS BOARD'S ANNUAL REPORT**		
DATE OF DECISION:		**30 SEPTEMBER 2015**		
REPORT OF:		**INDEPENDENT CHAIR, LSAB**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Fiona Bateman**	**Tel:**	**023 8083 4608**
	E-mail:	**Fiona.bateman@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY
This report introduces the 2014/15 Local Safeguarding Adults Board's (LSAB) annual report.

RECOMMENDATION:		
	(i)	That the Health and Wellbeing Adults Board's (LSAB) Annual Report be noted in respect of the following:
		• The LSAB was peer reviewed in 2014/15 which concluded its structure and membership ensured it would comply with the new legal duties introduced by the Care Act 2014. The reviewers also praised the good multi-agency ownership at senior level, found partners were being held to account by LSAB and that partners '*contribute equally and fully participated'* and were '*driven to improve and modernise services.*
		• The substantial increase in concerns this year and the changing nature of the types of abuse being reported.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Department of Health's (DoH) Care and Support Guidance requires that the LSAB have core responsibility for strategies for the prevention or abuse and neglect and, as part of their oversight, understand how this work ties in with the Health and Wellbeing Board (HWBB) approach locally. [pg. 14.111]. The HWBB are therefore asked to consider where there may be opportunities for the HWBB and LSAB to work more closely together, particularly in relation to corresponding functions of both board's e.g. to hold partners to account and gain assurance of the effectiveness of their arrangements and on strategies to reduce incidents of abuse and neglect for adults at risk in Southampton.

DETAIL (Including consultation carried out)	
2.	The LSAB meets six times a year in order to share learning in relation to pertinent practice issues, examine the effectiveness of each agency's actions in preventing harm to adults at risk and evaluate their ability to identify and address risks when these arise. Outside of these meetings partners work within their own organisations or within the LSAB subgroups to undertake the core statutory functions of the LSAB.

3.	In 2014-15 the LSAB's Case Review sub group received 10 referrals for a safeguarding adults review. The LSAB must undertake a review when an adult at risk has died or suffered serious harm and there is reasonable cause for concern about how partners have worked together to safeguard them from harm [s.44 Care Act]. Having reviewed the cases the group made recommendations to the LSAB or, where there was evidence of a single agency failing, sought assurance that the matter would be referred to the appropriate regulatory service and commissioners of services to pursue.
4.	Following the case review group's recommendation the LSAB commissioned a partnership review in one case which, although it did not meet the threshold for a Safeguarding Adults Review, the partnership felt important lessons could be learnt from the case. In addition, the LSAB is working with MAPPA colleagues to review another case where a vulnerable adult died. Both reviews are yet to be concluded and so will be reported in next year's annual report, but the learning from these will inform the work of the Board and partner agencies as soon as it is available.
5.	LSAB's Monitoring and Evaluation sub group play an essential role in collating the multi-agency data for safeguarding activities undertaken by the partners, cross referencing information and identifying trends or spikes throughout the year. In addition the sub group has a detailed programme of qualitative audits to conduct to ensure that the LSAB partners are able to make well informed, evidence based strategic decisions on how best to use resources to prevent or intervene to stop adults at risk from experiencing abuse and neglect.
6.	The LSAB shares the Community Engagement and Awareness sub group and Learning and Development Group with the LSCB, these are recently established and has already led in coordination of awareness campaigns and training opportunities that are promoting a 'think family approach' to interventions. The group is developing a full multi agency safeguarding delivery plan based on the principles agreed in the Workforce Development Strategy for the 4LSAB area. It has also begun its role to quality assure local single agency training as well as mapping what is available for staff in Southampton currently.
7.	In 2014-15 there were 1,363 concerns (previously known as 'alerts') made in relation to adults at risk of abuse or neglect. This is a significant increase of 237% from 2013-14. There were 282 completed enquiries (previously known as referrals or investigations) which is a reduction from the previous year. There is still a high number of repeated concerns (27%) which the LSAB continue to monitor because this may be an indication that screening or early interventions are not as effective as they could be. Concerns were, in the main, raised by professionals working in partner agencies.
8.	It is reassuring that professionals, and particularly those from health services, are increasingly more confident to raise safeguarding concerns, but noteworthy that only 5% of concerns were raised by service users, carers or family members. The LSAB believes this demonstrates much more needs to be done urgently to raise awareness with members of the public about the risks of neglect or abuse and how to report this. A public campaign is a key priority for 2015 and the LSAB will continue to monitor the source of concerns as a measure the impact of these campaigns.

9.	There has been a number of significant changes in the types of abuse being reported. For example, there was an increase in enquiries resulting from physical abuse (up to 48% from 29% last year, which was consistent with national figures). The SAT report that professionals (when either raising concerns or conducting safeguarding investigations) are more confident to identify physical abuse which reflects the impact of the awareness campaigns, led by the LSCB, on zero tolerance of domestic violence within the city. It is also noteworthy that SHFT report that 25% of concerns for their client group relate to physical abuse. The LSAB will work to ensure partners recognises the increased risk of harm posed to vulnerable groups and ensure that partners respond effectively to allegations, including Disability Hate Crime, so that we can demonstrate we are tackling this form of abuse and people feel safer in the city.
10.	There was also a substantial reduction in allegations of neglect and acts of omission (only 8% of all enquiries in 2014-15, against 16% in 2013-14 and much lower than national comparative data of 30%). It also corresponds with a reduction in cases of alleged abuse occurring in care homes (15% in 2014-15 down from 20% for 2013-14 and against 36% nationally) and community social care settings (4% in 2014-15, down from 11% last year). Furthermore, there were no enquiries which identified institutional abuse within Southampton last year, an improvement on the 5 cases investigated the year before. This is as a result of the significant work, detailed within the full report, undertaken by the Integrated Commissioning Unit to monitor and improve provision within the social care sector in the city.
11.	The data also reveals a reduction in financial abuse enquiries from 28% last year to 22% in 2014-15. This is still higher than the national comparator of 18%, but it is also fair to say that this does not reflect the true extent of work undertaken by the partnership to manage the risk of financial abuse and support those who have experienced it. The LSAB, in recognition of the complexity in tackling financial abuse after the event, proposes instead to address this area of risk through a preventative campaign in 2015-16.
RESOURCE IMPLICATIONS	
Capital/Revenue	
12.	The LSAB has agreed a budget for 2014-15 which is funded by the City Council, Southampton City Clinical Commissioning Group and Hampshire Constabulary, all of whom are statutory partners of the LSAB. As this report is for information only, there are no resource implications.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
13.	The Care Act 2014 requires Southampton City Council to establish a LSAB and provides for accountability of the Independent Chair to the Chief Executive of the Local Authority. The DoH's Care and Support Guidance recommends the LSAB work in partnership with the HWBB and this report is to inform HWBB members about the work of the LSAB to assist with this.
POLICY FRAMEWORK IMPLICATIONS None	

KEY DECISION?	No		
WARDS/COMMUNITIES AFFECTED:	All		
SUPPORTING DOCUMENTATION			
Appendices			
1.	LSAB Annual Report 2014-15		
2.	LSAB Strategic Plan 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
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.	DoH Care and Support Guidance	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf	

LSAB
Southampton
Local Safeguarding
Adults Board

Annual Report

2014-2015

Tel 02380 832995

lsab@southampton.gov.uk
www.southamptonlsab.org.uk

Contents

"In recognition that 2014-15 would be a demanding year for the LSAB, given the significant changes to safeguarding practices and LSAB's statutory responsibilities introduced by the Care Act 2014, last year's annual report set out an ambitious work plan."

"The LSAB recognise more needs to be done to demonstrate how the partnership is supporting and driving forward a preventative agenda and embedding the 'making safeguarding personal' principles into practice".

Message from Fiona Bateman, Independent Chair

This report is produced by Southampton Local Safeguarding Adults Board (LSAB) in accordance with the Care Act 2014 which requires the LSAB to publish an annual report detailing what each member and the LSAB has done collectively during the year to achieve its main objective and implement its strategic plan. The report must also set out the findings of any Safeguarding Adults Reviews and subsequent action taken to implement the recommendations arising from those.

Within this part of the report I will therefore address progress made by the LSAB and its core partners from the period April 2014 to March 2015 against the priorities identified in the last annual report before going on to detail who we look to protect from abuse and neglect; what types of harm are more prevalent within Southampton and what the partnership has done in 2014-15 to address the needs identified during the year.

In recognition that 2014-15 would be a demanding year for the LSAB, given the significant changes to safeguarding practices and LSAB's statutory responsibilities introduced by the Care Act 2014, last year's annual report set out an ambitious work plan for the year. The LSAB continued to meet six times a year in order to share learning in relation to pertinent practice issues, examine the effectiveness of each agency's actions in preventing harm to adults at risk and their ability to identify and address risks when these arise.

Outside of those meetings partners also agreed focus on:

- Further developing links with key strategic forums within Southampton including Healthwatch, Southampton Local Safeguarding Children Board (LSCB), Southampton Safe City Partnership (SCP), Southampton Connect and LSABs in neighbouring areas;
- Ensuring that the partnership was equipped to meet the new statutory responsibilities introduced by the Care Act 2014;
- Re-energising the sub groups with committed membership, clear work streams and reporting frameworks so that they had the skills and resources to scrutinise and inform the work of the main board;
- Prepare and consult on the implementation of the Southampton LSAB's Strategic Plan 2015-16.

During 2014 I attended, as the LSAB Independent Chair, each of the strategic forums, or met with their Chairs to establish regular reporting arrangements on the work of the Board.

In December 2014 the Local Authority established a joint Safeguarding Boards Team to support the work of both the LSAB and LSCB. The team, made up of a Board manager, Board Coordinators and Safeguarding Assistant ensure effective support to advance the work of the Board, reducing duplication or discrepancy between the LSCB and LSAB and identifying common areas of concern and/or gaps in safeguarding work across the city so that safeguarding does now embrace the 'think family' agenda and work is coordinated to address the needs of adults, children and young people at risk of exploitation, abuse or neglect.

The LSAB set up a Task and Finish group made up of senior representatives of the Local Authority, CCG, Police, our voluntary sector representative, as well as the Independent Chair, Democratic services and Board team to review the current governance arrangements and the structure of the Board. The group drew up a new Constitution, membership handbook and framework for quality assurance and case review work for the LSAB which were adopted by the partners and formally recognised by Southampton City Council Executive in March 2015. These documents are available to view at http://www.southampton.gov.uk/health-social-care/contact-social-care/safeguarding-adults-board.aspx.

In addition the Safeguarding Board team and partners have been actively involved alongside colleagues in Hampshire, the Isle of Wight and Portsmouth in the review of the Pan Hampshire multi-agency safeguarding Policy, Guidance and Toolkit, so as to ensure a consistent approach to safeguarding work for partners working across Hampshire. In addition, the review of membership at both Board and sub group level has encouraged wider participation from statutory and voluntary sector practitioners working in the frontline. Each sub group has reviewed their terms of reference and each member has signed up to undertake responsibilities in line with expectations set out within the handbook.

In March 2015 the effectiveness of the LSAB was considered by an external peer review, led by the Association of Directors of Adult Social Services (ADASS) in the South East. Peer reviews are intended to support the partnership to improve services and performance and in Southampton looked at 4 key topics to test the effectiveness of the LSAB. The review then offered some guidance on what could make the LSAB more effective in engaging with adults at risk, their carers/ support networks and communities, meet the learning needs of the workforce and thereby ensure adults at risk are protected. The feedback from the reviewers was positive; they praised the good multi-agency ownership at a senior level, found partners were being held to account by LSAB and that partners '*contribute equally and fully participated"* and were "*driven to improve and modernise services*."

The LSAB recognise more needs to be done to demonstrate how the partnership is supporting and driving forward a preventative agenda and embedding the 'making safeguarding personal' principles into practice. Overall the review team were impressed by the amount of

energy and commitment to ensuring that the LSAB have sufficient information to provide assurance that systems were working for adults at risk in Southampton. This report was used to help inform the 2015-16 Strategic plan. The full plan can be viewed online here and was developed by the LSAB through consultation with partners including Healthwatch. The LSAB sub groups have subsequently agreed a work plan for each key area to reflect the priorities identified. Progress on the plan is monitored in every LSAB meeting.

I would like to take this opportunity to thank all those who have contributed to the work this year, thank members who have moved on to new opportunities outside the city and wish them well for the future. Moreover, I am grateful to the Safeguarding Boards Team whose energy, commitment and enthusiasm has enabled the Board to maintain the momentum necessary for this vital work.

The LSAB recognised that there will always be more to do to improve safeguarding practices within the city. In line with national guidance the LSAB continue to work towards embedding core safeguarding values across the community, namely that people should be able to live a life free from harm, forming a culture that doesn't tolerate abuse, but that encourages communities to work together to prevent abuse and that everyone know how to respond effectively to protect a child, young person or adult at risk when abuse happens.

Fiona Bateman
Independent Chair of Southampton LSAB

Who are adults at risk in Southampton and how well are we supporting them?

It is everyone's responsibility to keep ourselves safe and report abuse when we see it, but statutory duties to investigate safeguarding concerns arise in relation to adults in need of care and support who are experiencing, or at risk of experiencing, abuse or neglect and are unable to protect themselves as a result of their needs.

Notification of possible safeguarding concerns are received first to the Council's Single Point of Access ['SPA'] Team who are expected to address any simple enquiries by offering advice and information or signposting the enquirer to alternative, more suitable support. The SPA team will usually refer any ongoing safeguarding concerns [previously known as 'alerts' or 'referrals'] to the Safeguarding Adults Team ['SAT'] unless the adult at risk has a social care worker already allocated to their case or they are receiving treatment in University Hospital Southampton. In these instances the case is referred for a response to be coordinated by their allocated worker or, in the latter case, by Southampton City Council's ['SCC's'] Hospital Discharge Team to assess and support. In those cases the SAT is available to provide any necessary guidance and assistance to the teams.

The Board recognises that focusing on reported Safeguarding concerns investigated by these teams underrepresents the true extent of safeguarding activity carried out across the city. For example, it does not reflect the work carried out by partners, particularly those who campaign and support adults at risk, those who have regulatory or commissioning obligations to prevent abuse and neglect before any concerns arise or those who have responsibilities to provide care and do so in a way that responds to actual or perceived safeguarding risk so that harm is averted. That said, the data provides a useful measure of the level, source and types of harm suffered. In addition, their work is benchmarked locally against our area profile and nationally so that the Board are able to identify further ways to improve practices and safeguarding adults throughout Southampton.

Southampton City Council received 1363 concerns in 2014-15, a significant increase of 237% from 2013-14. Of those concerns raised, there was 282 completed enquiries during that period. This is a reduction against last year, continuing a trend in Southampton which, since 2010, has seen an 11% reduction in completed enquiries. This is in contrast to the national picture of a 7% increase in the same period. Less than 20% of concerns resulted in concluded enquiries, the team later received further concerns [previously known as 'repeat alerts'] on 27% of cases during the same period. During 2014-15 8.5% of all enquiries related to individuals who had, in the same period, already been the subject of a safeguarding enquiry. Whilst data in relation to repeat concerns and enquiries is no longer collected nationally, the LSAB recognises that this is an important indicator of the effectiveness of any screening

process or safeguarding intervention and therefore is apprehensive that this rate remains high (it was 8.5% in 2013-14 and 4.2% in 2012-13). The LSAB have received assurance that the rise may in part be explained by more consistent practices, in that previously the rate of repeat concerns might have been unrecorded. Furthermore, the SAT report that included within this figure are numerous cases where the adult is initially unwilling to accept support, but often through longer term or repeat interventions the team are able to build up a rapport and subsequently provide effective support to reduce or remove the safeguarding risk. Nevertheless the LSAB has asked for a review of the operational thresholds used by the SAT to screen notifications and continues to audit case work to ensure decision making is robust. We have also identified, as a priority for 2015-16, the establishment of clear referral pathways between services so that we can be assured that cases which don't meet the threshold for a safeguarding enquiry under s42 Care Act, but require the provision of information, advice or care and support or some other service are signposted effectively. New operational guidance has been issued for April 2015 and the LSAB will work with the SAT and continue to monitor this to ensure adults at risk are safeguarded at the earliest opportunity.

The safeguarding data also identifies, by category, who raised the concern. This demonstrates that professionals, and particularly those from health services, are increasingly more confident to raise safeguarding concerns. However, it is noteworthy that only 5% of concerns were raised by service users, carers or family members. Problems in the way this is recorded endure, the SPA team and partners have been advised to record notifications raised by members of the public as such but often systems record these as being made by professionals because of the need to refer on to the secondary response teams, namely the SAT and Adult Social Care assessment and support planning teams. This issue was identified last year and this therefore doesn't explain why the figure is lower than the figure for 2013-14. The LSAB believes this demonstrates much more needs to be done urgently to raise awareness with members of the public about the risks of neglect or abuse and how to report this. A public campaign is a key priority for 2015 and the LSAB will continue to monitor the source of concerns as a measure the impact of these campaigns

Southampton is a vibrant city with a diverse population. This brings huge benefits and richness in culture to the city which is rightly celebrated and embraced. The black and minority ethnic (BME) population of Southampton is recorded as 14.2% with 22.4% of the population reported as non-white British. Recent estimates suggest the figure is more likely to be 18%. The highest proportion of the BME population is Asian British. The data however demonstrates that the proportion of enquiries completed during 2014-15 again underrepresents the diversity in our community with only 3% relating to Asian or Asian British adults. 88% of concluded enquiries related to white adults. Whilst this is in line with national comparator figures, it is significantly lower than what should be expected given our demographic profile. The Community Engagement and Awareness sub group is working

through established links to faith and community groups so that we are able to ensure all our communities feel confident to report concerns when they arise.

The 2011 Census reports the proportion of Southampton's population aged over 65 is reducing (13% compared with 14.5% in 2001 and a 2011 England average of 16.3%). The number of safeguarding enquiries raised in respect of this age group has dramatically fallen this year from 62% in 2013-14 (which was in line with national comparators) to 37% this year. This group, however, does still appear to be disproportionately at risk of abuse and neglect as such the LSAB believe they would benefit from targeted preventative campaigns. In addition, more needs to be understood about the significant spike in concerns relating to younger people with mental health issues or learning disabilities over the last year and the LSAB has already identified raising awareness of the risks to younger adults as a key priority for the coming year.

It is relevant to safeguarding to recognize the economic and environmental factors that impact on risk of abuse and neglect. Southampton is ranked 81st out of all 326 LA's in England in the overall Index of Multiple Deprivation 2010 (where one is the most deprived). Southampton has the 41st highest level of child poverty in England out of 326 local authorities with 27.5% of children in the city living in poverty. It is also relevant that partners take into account how people's own sense of wellbeing can impact on safeguarding. 78.6% of residents in receipt of social care report that they have control over their daily life, 65.3% who use services say they feel safe and only 43% (cared for people) and 49.5% (carers) feel they have as much social contact as they would like.

Of the concluded safeguarding enquiries in 2014-15 24% had a physical disability or sensory impairment. This is a dramatic reduction from previous years, since 2010 this client group has accounted for approximately 50% of all enquiries and quite different from the national comparator (reported as 51%). Conversely there has been a marked rise in the percentage of referrals relating to those whose primary support need is a learning disability (28%), previously it had been noted that concerns in relation to this client group had dramatically fallen from 19.01.% in 2012-13 to 5.2% in 2013-14 (compared with the national comparator of 18%). As we will see below national campaigns and targeted interventions for those with learning disabilities may explain, in part, the spike in enquiries. In addition the reconfiguration of care management teams within SCC's ASC department has improved practice so that safeguarding risks are identified more frequently and addressed through safeguarding processes rather than as part of a social care package. This should ensure individuals are better able to protect themselves in the future and do not become reliant on overly protective statutory interventions.

Mental health was recorded as the primary support need for 41% of enquiries (against national comparator of 24%). Though this includes 36 enquiries (12.8%, 10.7% nationally) where the primary support reason was memory or cognitive impairments. Southern Health Foundation Trust ['SHFT'], who provide integrated health and social care functions to those with enduring and/or severe mental health needs now report separately to the LSAB on the number of concerns they raise and the type of abuse identified for their client group. This should ensure that the Board is well informed to coordinate appropriate responses to this vulnerable client group. It is also noteworthy, given that safeguarding interventions must now focus on 'Making Safeguarding Personal' to the adult at risk that that over half of all cases where concerns were raised by SHFT the adult was involved in the decision to raise the concern.

Substance misuse is recorded as the primary support reason for 5% of all safeguarding enquiries, which is consistent with previous local and national figures. It should be noted, however, that this figure doesn't truly reflect the risk of exploitation, neglect and harm experienced by this client group or the fact that substance misuse if a contributing factor (for the service user and/or alleged perpetrator) in many other enquiries. The complexities of managing risk for adults with substance misuse problems require significant professional input across policing, health and social care. Despite the considerable skilled intervention that will be employed to provide protection where professionals are made aware of concerns, it is this group who experience poor outcomes or report that the risk of exploitation, abuse or neglect remains even after any safeguarding enquiry. The LSAB will work with all partnerships in the city to highlight the particular needs of this vulnerable group.

It is likely that some of the differences can be explained by data collection issues and the LSAB will be working closely with partners to ensure the availability of reliable data. In addition the LSAB's Monitoring and Evaluation sub group will play an essential role in collating the multi-agency dataset for safeguarding activities undertaken by the partners, cross referencing information and identifying trends or spikes throughout the year. In addition the sub group has a detailed programme of qualitative audits to conduct so as to ensure that the LSAB partners are able to make well informed, evidence based strategic decisions on how best to use resources to prevent or intervene to stop adults at risk from experiencing abuse and neglect.

What type of harm are adults most at risk of in Southampton?

Care and Support Statutory Guidance issued by the Department of Health in October 2014 and the Pan Hampshire Policy and Guidance here sets out the types and patterns of abuse and neglect that may take place. It is, of course, imperative that frontline staff and communities remain alert to all types of harm that individuals, particularly those with additional vulnerabilities, might face. The LSAB collect statistics which reflect the primary risk identified in each case, recognising that whilst this is an imperfect measure, it does give the LSAB a picture of need within the local area which assists the partners to work together more effectively to address local need.

The Safeguarding Adults return shows a huge increase in enquiries resulting from physical abuse (up to 48% from 29% last year, which was consistent with national figures). The SAT report that professionals (when either raising concerns or conducting safeguarding investigations) are more confident to identify physical abuse. This may in part be explained by differences in classification but is more likely to reflect the changing nature of the focus of the SAT enquiries and the impact of the awareness campaigns, led by the LSCB, on zero tolerance of domestic violence within the city. It is also noteworthy that SHFT report that 25% of concerns for their client group relate to physical abuse. The LSAB will work to ensure partners recognises the increased risk of harm posed to this vulnerable group and ensure that partners respond effectively to allegations, including Disability Hate Crime, so that we can demonstrate we are tackling this form of abuse and people feel safer in the city.

Neglect and acts of omission accounted for 8% of all enquiries in 2014-15. This is a dramatic reduction from last year (16%) and much lower than national comparative data (30%). It also corresponds with a reduction in cases of alleged abuse occurring in care homes (15% in 2014-15 down from 20% for 2013-14 and against 36% nationally) and community social care settings (4% in 2014-15, down from 11% last year). Furthermore, there were no enquiries which identified institutional abuse within Southampton last year, an improvement on the 5 cases investigated the year before. This is as a result of the significant work, detailed in the next section, undertaken by the Integrated Commissioning Unit to monitor and improve provision within the social care sector in the city.

It is noteworthy that SHFT identify emotional abuse more regularly than any other agency, which accounts for 17% of all enquiries. Perhaps this it is to be expected given the nature of their involvement with adults at risk in the area. The LSAB and partners can benefit from SHFT's staff' skills so that all agencies have a greater awareness and gain confidence in identifying risk in this area. This is of increasing importance because of the focus under the Care Act on emotional wellbeing.

The data also reveals a reduction in financial abuse enquiries from 28% last year to 22% in 2014-15. This is still higher than the national comparator of 18%, but it is also fair to say that this does not reflect the true extent of work undertaken by the partnership to manage the risk of financial abuse and support those who have experienced it. The LSAB, in recognition of the complexity in tackling financial abuse after the event, proposes instead to address this area of risk through a preventative campaign in 2015-16.

This will build on the success of work already undertaken by partners. For example, Solent NHS trust identify and raise concerns on a high number of cases involving financial abuse. There are clear opportunities for the LSAB to use the skilled workforce across partner agencies to ensure individuals are better informed about steps they can take to protect themselves from risk of financial abuse and exploitation.

SCC's Regulatory services also continue to support the whole community through their 'Buy with Confidence' and specifically those in need of health and/or social care through the 'Support with Confidence' schemes. In addition the service carried out over 50 investigations into allegations of miss-selling or organised financial abuse. The approach adopted by the enforcement teams demonstrate a true commitment to protecting adults at risk of exploitation and abuse in a manner that makes safeguarding personal.

Case Study – Mrs A

Mrs A was referred to Adult Services and Trading Standards via police because of concerns that she had been the victim of financial abuse. She had been groomed initially over the internet into believing she was in direct communication with the governor of the Bank of Nigeria and was to receive a large sum of money from Nigeria. Over a period of time, she had sent away sums of money in excess of £150,000 in 'fees', using untraceable money transfer facilities. The money included an inheritance, pension funds and a lifetime of savings. Once capital had been exhausted, Mrs A had taken out a number of loans which could not be repaid. Passport, birth certificates, bank account details and other personal details had been revealed. Once Mrs A's money had run out, fraudsters began to use her bank account for money laundering.

As soon as money laundering was detected, the bank closed Mrs A's account and standing orders and direct debits ceased. The money paid in by the criminals was seized. The fraudsters were by now telephoning Mrs A throughout the day and night threatening murder, blaming her for the money being seized. As a result of this a multi-agency plan was agreed and actions were taken to protect her. Mrs A was offered support and reassured they had been defrauded and were not in trouble. A number of practical measures were taken including changing the telephone number and adding a call block. In addition their computer and lap-top were taken away for clearing and security measures put in place. Email addresses changed and agreement reached that there would be one email address for the house-hold and partner would check any emails from outside the family/friend circle.

Regulatory services offered Mrs A classes in safe use of a computer, arranged for her debts were put on hold and for some to be written off. Money management classes were also arranged and their partner opened a simple bank account into which pensions could be paid and bills settled. Meeting with bank manager was arranged so safeguards could be put in place to detect any unusual activity.

Further plans were drawn up with Mrs A to arrange for Carers Together to assist in making a successful claim for disability benefits, easing some financial worries. Mrs A appeared disorientated at times so Adult Services arranged for her to be seen by a doctor and was diagnosed with early stage dementia as a result she was referred to the Memory Clinic and day-time respite weekly. Mrs A did later reengaging with the criminals because she was promised compensation so work continued with Adult Services, Mrs A and her partner to find solutions.

How does the LSAB protect adults at risk?

- **Intervening early and protecting against predictable safeguarding risks**

LSAB partners work to tackle safeguarding risk both collectively and as individual organisations in line with their statutory duties. Whilst the LSAB are looking in 2015-16 to develop a coordinated prevention and early intervention strategy, partners have demonstrated they already cooperate in order to reduce risks. For instance Hampshire Fire and Rescue Service ['HFRS'] have developed a tool (the Home Safety Referral Pathway) for member agencies' staff to use to identify a fire risk and report this to the service so that suitable interventions are offered. For adults in need of care and support at high risk HFRS offer homes safety visits within 72 hours and can provide a range of equipment and advice to reduce the risk of harm. In 2014-15 their Community Safety Officer team facilitated Fire Risk Conferences for numerous individuals following home safety visit where the team have not been able to reduce fire risks. These conferences enable the adult at risk and professionals (social workers, housing officers, care providers, GP'S etc.) to agree an action plan to manage this risk to an acceptable level and identify where further intervention is required. The 'adult at risk' is always at the heart of the process and their wishes respected. They are encouraged to participate in the conferences either through self-representation, through the support of a family member or through an advocate.

- **Provision of independent advocacy support to those who are unable to protect themselves and without family/friends to assist**

If a person lacks capacity to decide how they wish to be supported in a safeguarding enquiry and does not have support from friends or family the local authority should appoint an independent advocate to help them. Of the concluded investigations in 2014-15 51 people appeared to lack capacity and, of those, 86% were supported by a family member, friend or independent advocate. However, in 46 cases the person's mental capacity was recorded as unknown (this accounts for 18%). Whilst this is in line with the national comparator, the LSAB intend to monitor this figure to assess the impact of mental capacity training. So that we can better safeguard those without capacity or who have substantial difficulty understanding safeguarding processes, the LSAB expects to see a reduction in this figure. We will set an aspirational target to see this percentage reduce to 10% in 2015-16.

- **Effective investigations**

In 2013-14 337 investigations were concluded, this year this figure has dropped to 282. In 37% of the enquiries subject to investigation by the SAT or SCC adult social care teams the allegation were substantiated. This is similar to outcomes nationally where 32% of cases are substantiate. It is worth noting that the burden of proof the SAT are required to apply in these

investigations is different to that which the Police and Courts apply in criminal matters as it is a civil investigation. As such the team must be satisfied that the abuse or neglect was more likely than not to have occurred. Slightly more cases are partially substantiate in Southampton than nationally (19.8% against comparator of 11%). Whilst 23% of all safeguarding allegations investigated by the SAT are unsubstantiated.

We know that for adults at risk, their families and carers it is important that any safeguarding intervention provides a clear outcome. It will, of course, not always be possible to conclude with certainty whether abuse or neglect has occurred, but given the lower burden of proof, it is of concern that 17.4% of enquiries undertaken by the SAT in 2014-15 resulted in inconclusive findings. Whilst this is in line with national statistics, it is noticeable that last year this figure was lower (14.5%). Even so the LSAB identified then this was too high so we will continue to monitor this as a key performance indicator of effective investigations and will work with the SAT and all agencies carrying out investigations under s42 Care Act to reduce this.

- **Working with the adult at risk to reduce or remove the risk**

The guidance issued by the Department of Health setting out how partners should meet their new safeguarding duties under the Care Act place great importance on the need to ensure that the adult at risk was at the centre of any process, that interventions were designed with the adult and that any protection plan should set out what steps should be taken, whether support is required and if so by whom and by when. In many cases this might be achieved with the provision of advice to the adult about actions they can take to protect themselves from abuse, exploitation or neglect.

The measure of any protection plan must be that they are effective at reducing or removing the risk and whilst the new duties apply only from April 2015, the SAT have reported that for the concluded enquiries undertaken in 2014-15 45% of protection plans reduced the risk and in a further 15% of cases risk was removed. 30% of cases were reported as requiring no further action and for 10% of cases the SAT believed that the risk remained.

It is worth remembering that a high proportion of concerns that were assessed as not meeting the threshold for an enquiry and enquiries which were stopped at the request of the adult at risk are not included within these figures. As such, whilst it is important to recognise that it will not always be possible to ensure protection from all risk, particularly where the individual has a right to expect services respect their wishes not to intervene, more must be done to ensure those conducting investigations and responsible for implementing protection plans have the skills, resources and confidence to balance the competing legal obligations

owed to the adult at risk, family members and professional and voluntary carers in a way that empowers the individual and minimises risk of future abuse and neglect.

- **Ensuring Partners actively quality assure care and support services commissioned by them.**

The commissioning functions for both Southampton City Clinical Commissioning Group and Southampton City Council are carried out jointly by the Integrated Commissioning Unit ['ICU'], who along with the Care Quality Commission ['CQC'] reported regularly to the LSAB during this period on the quality of care provided in registered residential and nursing homes and domiciliary care providers settings. During 2014-15 the ICU were able to report a substantial improvement in the quality of care with a number of providers, who had previously been subject to cautions or suspensions on new placements. This has been achieved by working collaboratively to address action plans with providers and regulators to support providers in demonstrating sustainable improvements in the quality of services. The ICU also developed a peer support network for nursing home managers and commissioned an innovative leadership programme aimed at nursing home registered managers and their deputies to support continued improvement in quality of care in the sector. This has supported the skills based training programme provided by SCC's Learning and Development team and the provider forums already in place. Additionally work has taken place to support providers in accessing training from other sources such as City College.

In addition, the Public Health team devised an Infection control protocol and ran a face to face training programme for all nursing homes in Southampton to strengthen control of infection so as to reduce incidence of viral and bacterial outbreaks among this vulnerable client group.

In December the Health and Wellbeing Board held a round table event to begin discussions about a local coordinated response to the Mental Health Crisis Concordat. The LSAB and relevant local stakeholders attended at this event and remain committed to work closely with the Health and Wellbeing Board to ensure that they are able to take forward this important work and effect change for those facing mental health difficulties.

- **Changing practice and policy**

A key challenge this year for LSABs and partners nationally has been a very significant rise in activity relating to protection against unlawful deprivation of liberty for adults at risk. The Mental Capacity Act 2005 provides a framework for making decisions on behalf of people who don't have the mental capacity to do so for themselves. Where someone's care requires constant supervision and they would not be free to leave the placement legal safeguards

exist, the Deprivation of Liberty Safeguards ['DoLS'] so they are not unfairly deprived of liberty. The procedure is designed to protect adults who can't make decisions about treatment or care, but need to be cared for in a restrictive way. The DoLS procedure applies to care provided in a hospital, residential care or nursing home provision. Applications to the Court of Protection must be made to authorise care within any other type of accommodation that limits personal freedom. This would also only be authorised if that level and type of care is necessary to protect a person from harm and the proposed restrictions are proportionate. This ensures that care is arranged in a way that promotes the best interests of the person. Under the DoLS procedure Best Interest Assessors '[BIAs'] assess people to find out whether a deprivation of liberty is in the best interests of the person. If the authorisation is to be granted, the BIA ensures the least restrictive option is in place. They act independently from those responsible for deciding and funding the care required for an adult who needs care and support.

Southampton DoLS Authorisations 2014-15

In 2014-15 Southampton City Council, who act as Supervisory Body under the DoLS procedure, were asked to authorise 727 applications. This is a 594% increase in referrals against the same period last year (97). The majority of applications related to individuals known to social care; residing in residential care facilities [89%]. University Hospital Southampton NHS Foundation Trust ['UHS'] submitted applications in relation to 80 patients in Hospital during this period, all of whom were Southampton residents so will be included within the data below. Of the applications received from UHS 58 were authorised, 13 were refused because it was either not in the person's best interests (3 applications) or, for the remaining 10 cases, it was determined that the person had capacity to make decisions regarding their hospital stay and treatment. Solent NHS Trust also reported submitting applications in respect of 9 patients which were subsequently authorised as requiring restrictive care, but reported that in each of these cases timescales for completing the assessments were breached.

The significant increase in referrals has put a considerable pressure nationally to ensure sufficient numbers of qualified BIAs are available to carry out assessments within the DoLS procedures' very tight timescales. LSAB partners have responded to this by funding an additional 13 individuals to receive BIA training. Which brought the total number of BIAs available to carry out the assessments in Southampton to 29 by March 2015. Though it should be noted that BIA obligations are undertaken in addition to the assessor's core duties. Referrals are triaged daily by a dedicated DoLS lead practitioner who prioritizes cases according to the ADASS task force approved risk matrix. Where cases are deemed high priority they are allocated immediately, this includes applications from providers where current or recent concerns have been raised regarding quality of care provision.

In addition, SHFT and UHS ensure each application is tracked and appropriate action taken in a timely manner. UHS lead manager has set up a monthly meeting with SCC's DoLS team to raise outstanding assessments and to facilitate improved communication, expedite assessments and receive confirmation about outcomes.

A DoLS audit, undertaken by the Supervisory body in November 2014, noted that only a relatively small number of registered care home providers in Southampton had submitted applications. Of those who did make applications many took the view that they would refer all with a diagnosed cognitive impairment, resulting in numerous unnecessary referrals. As a result substantial support was offered by SCC to raise awareness across the voluntary and private sector providers including Registered Social Landlords. In addition, DoLS awareness training was targeted at hospital staff and SCCCCG staff who conduct care planning and reviews functions to ensure they are putting in place plans which follow the Mental Capacity Act principles of least restrictive intervention and making appropriate referrals when care does require a deprivation of liberty.

Those who are subject to privately arranged care are just as likely to lack capacity and require restrictions to safeguard them. This group make up a significant proportion (28%) of the long term care home population in Southampton. However they are significantly underrepresented within the referrals received. Also, it is estimated that 183 people who reside in supported living or extra care facilities may require an assessment. It was also noted that applications relating to short-term or respite placements were also underrepresented within the referrals received. In total it is estimated that up to 800 applications should be received each year. Much work still needs to be done to ensure that the Local Authority, as the supervisory body, is able to complete assessments in a timely, appropriate manner and that care is provided in the least restrictive manner, but SCC should be commended on their proactive approach to raising awareness of the change in the law despite the considerable strain this has had on available staff to conduct assessments.

The LSAB will continue to monitor this and will also actively support legislative changes to ensure that mechanisms continue to provide safeguards against arbitrary deprivation of liberty, but that these are implemented in a way that it sustainable for statutory partners at a time of unprecedented pressures of resources. The LSAB will, in 2015, host a regional consultation event run by the Law Commission so that all agencies have the opportunity to understand the proposed legal reforms and input into the discussions.

- **Improved multi-agency communication and cooperation.**

The review of membership both at Board and sub group level has re-energised the board and ensured regular attendance from named professionals which in turn facilitated the development of closer relationships between practitioners at every level of member organisations. In addition, most partner agencies during the year identified a lead safeguarding officer or Designated Safeguarding Adult Manager ['DASM'] which will feed into a network across Hampshire to ensure effective information sharing on good practice, but also intelligence gathered in respect of individuals who may pose known safeguarding risks.

Agencies are also looking to either join or developing links with the Southampton Multi Agency Safeguarding Hub (MASH). For instance, HFRS report their aim in doing so is to provide a regular HFRS presence at the MASH, enabling participation with in strategy discussions to assist other agencies in action planning, to ensure the immediate safety for individuals at highest of risk of harm from fire at the earliest opportunity.

Another key priority for the LSAB in 2014-15 was to improve communication between health practitioners in the community and the SAT. The rise in health practitioner raising concerns was noted earlier within this report, but more detailed scrutiny of the 2014-15 data identified that 45% of all concerns raised by South Central Ambulance Service ['SCAS'] identified neglect as the primary safeguarding risk. As almost 80% of concerns do not meet the criteria for a safeguarding enquiry but are signposted for alternative support (usually a social care assessments) SCAS and SAT worked together to devise a referral form which provides more accurate information on the nature of need at the point of referral so that staff resources are used appropriately and the needs are met without delay or duplication.

In addition partners worked together to improve communication between health practitioners in community and hospital settings so as to ensure appropriate and safe care. UHS, working closely with SCC and SCCCCG, developed and introduced a Health Passport for people with Learning Disabilities. This document highlights important information about the individual to staff caring for them such as communication needs likes and dislikes and aids communication between health practitioners in the community and hospital settings so as to ensure appropriate and safe care. The improved service provision has a direct impact on individuals, who receive better quality care. It also reduces any need for safeguarding concerns or interventions as is demonstrated in the case study below.

Case Study - Mr M

Case Study: Mr M

Mr M is a 38 year old gentleman with Learning Disabilities & Autism who finds a change of environment very difficult. His carers reported that his previous hospital admission was distressing for him due to the difficulties inserting a cannula. On this occasion Mr M's appointment for treatment was delayed following his arrival at the hospital and he had become very anxious by the time the staff attempted to place a cannula in his arm. This resulted in his carers having to hold his hands tightly in order to insert the cannula and they were worried that the distress Mr M had experienced previously would impinge on the admission experience. Mr M also found it difficult to understand the importance of keeping his wound clean and therefore consequently picked at his dressings post operatively.

To optimise the success of his treatment and promote a person centred care pathway for a positive patient experience a planning meeting was convened which outlined key actions to ensure the best possible care. Recommendations included a 'Best Interest Meeting' which identified person centred reasonable adjustments. This information was discussed in advance with the admitting ward area, including possible antecedents to behaviours that may challenge. Alternative methods to help with the healing process were sought and given (wound sprays and barrier creams were available at home straight after the procedure).

The liaison team worked with both the CLDN and the local LD Intensive Support Team to produce practical guidelines for his carers to follow post operatively. Mr M was admitted and discharged in a timely way following successful surgery. The work undertaken prior to admission ensured a positive experience for Mr M and his carers.

- **Coordinating and monitoring training opportunities for the workforce**

The LSAB shares a Learning and Development Group with the LSCB, this is recently established and has already led in coordination of training and awareness opportunities that are promoting a 'think family approach' to interventions. The group is developing a full multi agency safeguarding delivery plan based on the principles agreed in the Workforce Development Strategy for the 4LSAB area. It has also begun its role to quality assure local single agency training as well as mapping what is available currently.

Partners continue to provide training opportunities to staff and colleagues across the partnership, in many cases, safeguarding and mental capacity training is mandatory for staff

and volunteers. The LSAB also provided multi-agency workshops during the year, including on the changing nature of safeguarding responsibilities under the Care Act. These were well received, with partners commenting that it was particularly useful that the audience was made up from practitioners working across the different services.

Southampton Voluntary Services continued to provide a much valued mailing service to ensure voluntary sector colleagues were informed of changes to safeguarding policy and practice. They also hosted numerous forums during 2014-15 to ensure providers and support networks from the voluntary sector were well informed on Safeguarding duties and policy developments in the area. They continue to advise voluntary sector agencies on the development of safeguarding policies and contribute directly to the work of the LSAB by providing a venue for the board to meet as well as hosting multi-agency mental capacity training.

In 2014-15 SHFT set up a quarterly safeguarding summit for staff at all levels of the organisation to meet together to consider issues in safeguarding from practice development, learning and improvement, one meeting benefitted from attendance from an inpatient unit who gave an example of innovative practice to support service users at risk, and another meeting included a presentation by a Local Authority Safeguarding Coordinator on Making Safeguarding Personal. UHS record and monitor attendance on all mandatory training, including safeguarding and mental capacity awareness. They collect and make available case studies demonstrating good practice. This approached has helped to ensure, as reported in March 2015 by during the CQC inspection, that "*safeguarding processes to protect vulnerable adults were embedded*" throughout the Trust.

- **Learning lessons from local and national cases with poor outcomes**

Partners have programmes in place to review any cases known to them where death or serious incidents arise. For example, UHS has, since September 2014, reviewed all deaths which occur in the hospital on a daily basis to identify whether the patient was an adult at risk, identify any areas of concern and decides if a referral to the Case Review Group or Coroner is required. This practice facilitates the sharing of learning and early identification of any issues that require further investigation and is reported to have already improved practice.

Where, as part of the review, partners identify an adult at risk has died or suffered serious harm and they have reasonable cause for concern about how partners have worked together to safeguard then referrals are made to the LSAB's Case Review sub group to consider in line with s44 of the Care Act. During 2014-15 the Case Review group received 10 referrals. Information was sought from all agencies involved in the individual case and considered against the criteria for a Safeguarding Adults Review. Where the group had concerns of single agency failings assurance were sought that the matter would be referred to the appropriate regulatory service

and commissioners of services. In 2014-15 the Safeguarding Adults Board commissioned a partnership review in one case which, although it did not meet the threshold for a Safeguarding Adults Review the partnership felt important lessons could be learnt from the case. . In addition, the LSAB is working with MAPPA colleagues to review another case where a vulnerable adult died. Both reviews are yet to be concluded and so will be reported in next year's annual report, but the learning from these will inform the work of the Board and partner agencies as soon as it is available.

In addition, the Public Health Team conducts detailed audits into deaths resulting from substance misuse or suicide. The audit work will provide the basis for a well-informed strategy to better meet the risks posed by those with complex and/or multiple needs and enable improvement in the recognition of risk, targeted and effective early intervention and sustainable, responsive services. Suicide rates, which are higher in Southampton than the national comparator, remain a key concern as they are a marker of the levels of severe distress affecting our communities, families and individuals. Reducing the level of suicides in Southampton remains a key priority for the LSAB and Health and Wellbeing Board who will work constructively together to identify and implement measures to address this issue.

The Board has also responded to issues arising from national concerns and serious case reviews, especially:

- **Winterbourne View:**

The Board continued to receive regular reports from the Local Authority and CCG to ensure that the care needs and welfare of learning disabled patients placed in-patient facility out of Southampton was reviewed regularly. Currently there are two clients in in-patient facilities, both have discharge plans in place which should see them move to residential / community placements by the end of August 2015.

- **PREVENT**

PREVENT aims to reduce the risk of terrorism by stopping people becoming terrorists or supporting terrorism. PREVENT focuses on working with adults at risk who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist related activity. The key challenge for partnership staff is to ensure that where there are signs that someone has been, or is being, drawn into terrorism staff can interpret those signs correctly, are aware of the support that is available and are confident in referring the person for further support.
SCC's Regulatory services, alongside Hampshire Constabulary, leads for the Safer City Partnership ['SCP'] on tackling extremism and anti-social behaviour. It is well recognised that often those most vulnerable within our community are specifically targeted by extremists and

also more likely to be the victims of hate crime so the LSAB continues to monitor interventions by partners and work closely with SCP to support their work.

- **Awareness raising campaigns**

In response to the significant changes introduced by the Care Act 2014 to the safeguarding responsibilities and care and support functions Southampton City Council delivered a range of activities to ensure its Care Act compliance including specific leaflets and campaign materials to ensure local carers, community members and service users were aware of the new legislation and the changes that take place as a result.

What Next?

The LSAB has set out in its Strategic Plan the work plan for 2015-16. The focus for the year will be to evidence improvements in practice and ensure that partners are compliant with the new safeguarding duties set out in the Care Act.

In particular, the Board will continue to drive change to tackle areas which remain of concern within Southampton as detailed above. We will also be working more closely with other partnership both within the city and across Hampshire to address new areas of mutual concern. For instance safeguarding risks to young adults at risk of exploitation or sexual harm or domestic violence.

Contact Information

Southampton Local Adults Safeguarding Board

Tel 02380 832995

Email lsab@southampton.gov.uk

www.southamptonlsab.org.uk

LSAB
Southampton
Local Safeguarding
Adults Board

Strategic Plan 2015-16

Introduction

Safeguarding is everyone's business, and it is important that organisations work together to protect people who need help and support. One of the biggest challenges is how to bring together the huge number of teams and organisations involved in keeping people safe. The Care Act 2014 requires local authorities to set up a Local Safeguarding Adults Board (LSAB) in their area, giving these boards a clear basis in law for the first time. The Act says that the LSAB must:

- include the local authority, the NHS and the police, who should meet regularly to discuss and act upon local safeguarding issues
- develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations
- Publish this safeguarding plan and report to the public annually on its progress, so that different organisations can make sure they are working together in the best way.

This Strategic Plan outlines the work to be undertaken by Southampton Local Safeguarding Adult Board during 2015-16, it is a shared plan by the organisations represented on the LSAB. It details how the Board will engage with local people to ensure that their views influence how adults in vulnerable situations, those 'at risk' of harm will be protected.

The plan details this in 5 key themes and priority areas which are detailed below. These areas will complement the LSAB and its key member's core safeguarding business. The Care Act 2014 and Supporting Guidance from the Department of Health details what this business entails.

The Southampton LSAB also works within the '4LSAB' area of Southampton, Portsmouth, Hampshire and Isle of Wight. The 4 areas share common safeguarding policies, procedures and guidance for staff to work to. They share a working group with all chairs of LSAB's and managers of the Boards working together with Health, Police and Local Authorities to achieve consistency across the areas.

Business As Usual for the LSAB:

This plan gives detail of the key priorities for the LSAB beyond its 'business as usual' which is broadly set out below. Other key LSAB documents alongside recently agreed 4LSAB Policy and Procedures should be reviewed for details of this:

Safeguarding Adult Reviews: When there is any failure in safeguarding, the results can be severe and tragic and therefore demand a strong response. The LSAB will carry out Safeguarding Adults Review in some circumstances – for instance, if an adult with care and support needs dies as a result of abuse or neglect and there is concern about how one of the members of the LSAB acted. The Reviews are about learning lessons for the future. They will make sure SABs get the full picture of what went wrong, so that all organisations involved can improve as a result. The LSAB will deliver these according to a *Learning*

and Review Framework for Southampton based on that agreed by the 4LSAB's of Southampton, Portsmouth, Hampshire and the Isle of Wight, and will also agree to review cases that do not meet the threshold for a SAR but where learning could be gained. This work is led by the LSAB's Case Review Group.

Quality Assurance: as detailed in its *Quality Assurance Framework* the LSAB will carry out a range of activities to be assured of local practice in keeping people safe, the LSAB will also collate service level information and data regarding local safeguarding services and report this regularly to the LSAB via the Monitoring and Evaluation Group.

Community Engagement: as detailed in the *Community Engagement and Awareness Strategy and Plan* which is shared with the Local Safeguarding Children Board (LSCB) and identified in Priority 4 below. This work is led by the Community Engagement and Awareness Group

Learning and Development: this work is led by the Learning and Development Sub Group which is shared with the Local Safeguarding Children Board (LSCB). The group will develop a local implementation plan to work within the framework of a *4LSAB Workforce Development Strategy for Safeguarding*. The LSAB will focus on multi agency safeguarding training for professionals and seek assurance of single agency plans for this area.

Monitoring of Success:

Progress against this plan will be reviewed and monitored by the LSAB, with Chairs of the relevant sub committees reporting on progress against their actions regularly to the Board. Where necessary and appropriate the Chairs of each sub group will highlight areas of concern and good practice to the full board meetings for further action.

Key to abbreviations:

Board / LSAB:	The full board of the Local Safeguarding Adult Board
L&D:	Learning and Development Group
M&E:	Monitoring & Evaluation Group
CEA:	Community Engagement & Awareness Group
4LSAB:	Hampshire, Isle of Wight, Portsmouth & Southampton
HWBB:	Health & Wellbeing Board
DVA:	Domestic Violence and Abuse
HBV:	'Honour' Based Violence
FGM:	Female Genital Mutilation
FM:	Forced Marriage

Summary of Key Priority Issues for 2014-15:

1.	**Make Safeguarding a whole city theme** – reinforcing that it is 'everybody's business until the person is safe' across partnerships.	LSAB CEA
2.	**Make Safeguarding Personal (MSP)** – to ensure that the principles are embedded in service provision.	L&D
3.	**Manage and monitor the impact of changes to services** – seek assurance to ensure that austerity measures and changes to strategic and operational service provision are not impacting negatively on adults at risk of harm.	LSAB M&E
4.	**Increase community engagement and awareness** - to ensure service user's views influence services and that community's awareness of safeguarding is high.	CEA
5.	**Make best use of local data and information** – using service data and intelligence to inform our work and measure success.	M&E

Priority 1: Make Safeguarding a whole city theme – reinforcing it is 'everybody's business until the person is safe'.					
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**RESOURCE REQUIRED (£)**	**HOW WILL WE MEASURE SUCCESS?**
Adults at risk are safeguarded at the earliest opportunity due to higher awareness of risk indicators and through coordinated action to respond to concerns.	Seek assurance from the Local Authority and its partners that pathway is in place for; • Receiving alerts and concerns – i.e. a 'front door' • Assessing and managing risk levels • Clear thresholds for appropriate interventions and section 42 enquiries • Out of hour's provision.	*LSAB*	*September 2015*	*Nil*	*Reports to LSAB and challenges made demonstrate timeliness of responses and improved safety of adults at risk of harm.*
	Ensure links to other key partnerships: • Health and Wellbeing Board • Safe City Partnership • Local Safeguarding Children Board	*Safeguarding Boards Team*	*September 2015*	*Nil*	
	Ensure learning from serious case reviews, safeguarding adult reviews and domestic homicide reviews is presented to the LSAB and learning is shared across partnerships.	*LSAB*		*Cost of SAR's*	
	Work with identified partnership leads to seek assurance of progress on work to address cross cutting issues such as: Domestic Violence Honour Based Violence Trafficking FGM Forced Marriage	*Safeguarding Boards Team*	*September 2015*	*Nil*	

Priority 1: Make Safeguarding a whole city theme – reinforcing it is 'everybody's business until the person is safe'.					
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**RESOURCE REQUIRED (£)**	**HOW WILL WE MEASURE SUCCESS?**
	Coordinate development of business plans and objectives across partnerships 6 monthly meeting of chairs & those managing relevant partnerships. Co – reporting of Annual Reports to each partnership / board.	*Safeguarding Boards Team* *Safeguarding Boards Team* *Safeguarding boards Team*	*September 2015* *July 2015* *September 2015*	*Nil* *Nil* *Nil*	

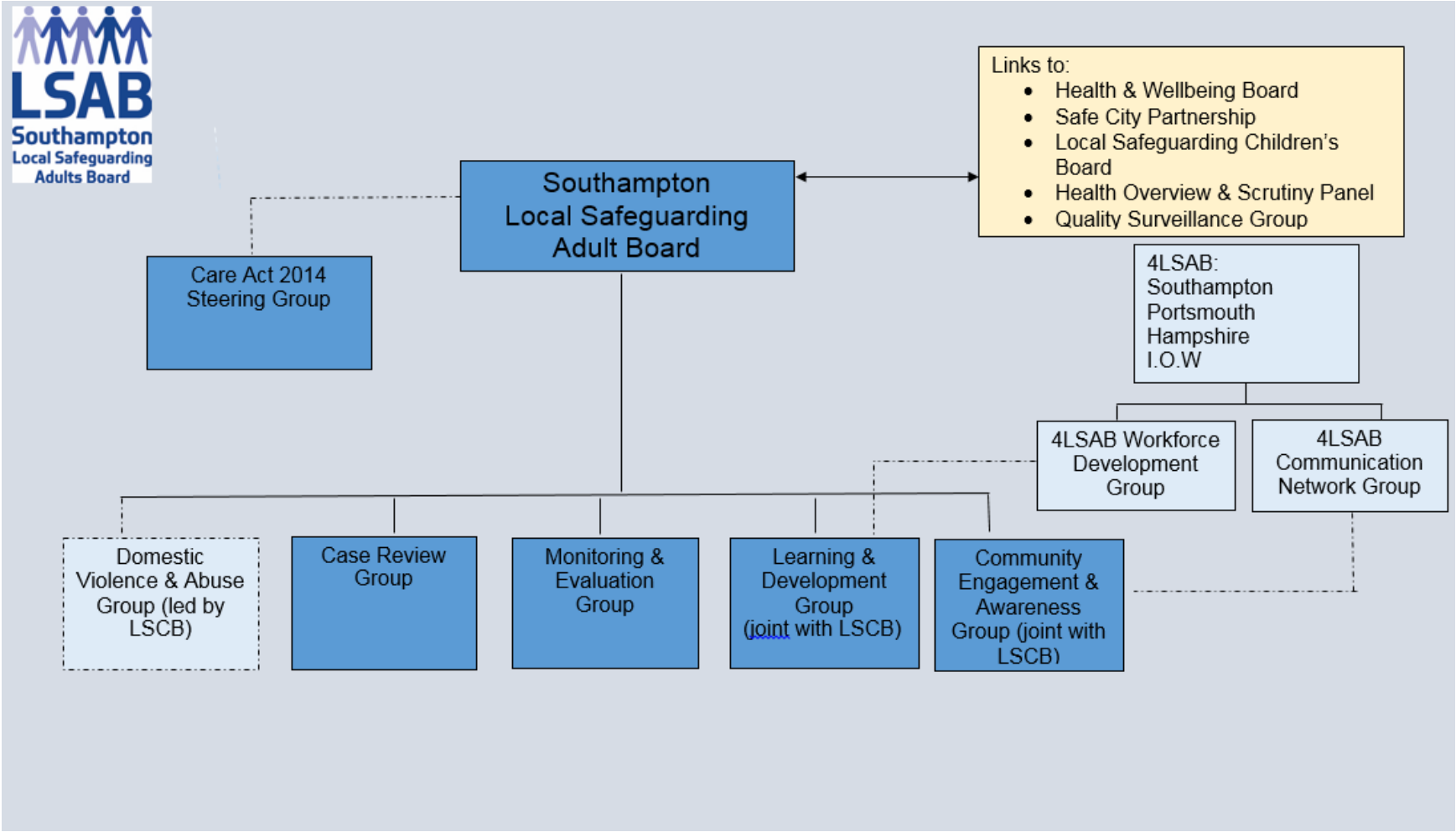
Priority 2: Make Safeguarding Personal (MSP) – to ensure that the principles are embedded in service provision.					
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**RESOURCE REQUIRED (£)**	**HOW WILL WE MEASURE SUCCESS?**
Adults at risk are safeguarded through interventions which are person centred and reflective of their views and needs.	Seek assurance through the LSAB quality assurance work that board partners are involving: • Clients • Family and friends where appropriate, safe, & at the agreement of the client In the process of safeguarding adults at risk.	*M&E Group*	*October 2015*	*Nil*	*Responses to I questions demonstrate increase in satisfaction with and success of interventions.*
	Ensure the principals of MSP are reflected in all 'levels' of learning and development work.	*L&D Group*	*June 2015*	*L&D Costs*	
	Deliver workshops to promote 'MSP' principals to workers in Southampton.		*September 2015*	*Venue cost Trainer cost*	
	Develop toolkit for multi-agency professionals to enable a person centred / MSP approach to safeguarding interventions, including: • Providing written information in appropriate and accessible formats, including community languages • Using BSL and community language interpreters appropriately • Identifying and responding to issues of capacity and mental health needs • Identifying and responding to advocacy needs • Encouraging (where safe and appropriate) friends, family and carer involvement.	*L&D Group* *L&D Group*	*December 2015*	*£2,000 for production and launch*	
	Deliver a campaign which will utilise MSP principles in prevention of financial abuse	*CEA Group*	*December 2015*	*As above includes materials*	
	Develop 'I' questions to be multi agency and person centred in design, and explore effective ways of collating responses.	*CEA Group*	*September 2015*	*Nil*	

Priority 3: Manage and monitor the impact of changes to services – seek assurance to ensure that austerity measures and changes to strategic and operational service provision are not impacting negatively on adults at risk of harm.					
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**RESOURCE REQUIRED (£)**	**HOW WILL WE MEASURE SUCCESS?**
Increased safety of adults at risk of harm, earlier in their experience through improved and clear information regarding services that provide preventative information and support.	Seek assurance that there are clear routes to information and advice services from across member agencies	*LSAB*	*Sep 15*	*Nil*	*Data showing success of interventions and levels of alerts / referrals for adults at risk.*
	Initiate a local campaign to advertise to the public when and how to raise alerts	*CEA*	*Dec 15*	*£1500 as above for MSP*	
	Seek assurance that informal carers have access to appropriate assessment, support and training to carry out caring tasks safely	*LSAB*	*Aug 15*		
	Seek assurance from member agencies undertaking operational redesigns in response to austerity measures, including: • Protective measures are in place where targets to reduce costs will result in increased use of less regulated provision, & that the LSAB is advised if any adverse impact. • Ensuring accessibility of services, specially Out of Hours (OOH) and crisis intervention	*LSAB*	*From June 15*	*Nil*	
	Request full details to main LSAB meetings of: • Deprivation of Liberty Safeguards (DOLS) activity • Availability of BIA across social and health care providers	*LSAB*	*From June 15*	*Nil*	
	Identify and develop a self-neglect tool kit to assist practitioners recognise and respond to neglect/ poor care, including self-care and map pathways for appropriate interventions.	*L&D*	*April 16*	*£1500 for materials and launch*	
	Request 6 monthly reports from the Clinical Commissioning Group and Integrated Commissioning Unit (CCG- ICU) alongside the Care Quality Commission (CQC) regarding work undertaken with health and social care providers regarding neglect	*LSAB*	*From Sep 15*	*Nil*	
	Request 6 monthly report from Acute Hospital Trusts to report on safe discharge practices.	*LSAB*		*Nil*	

Priority 4: Increase community engagement and awareness - to ensure service user's views influence services and that community's awareness of safeguarding is high.					
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**RESOURCE REQUIRED**	**HOW WILL WE MEASURE SUCCESS?**
Adults at risk are safeguarded at the earliest opportunity due to higher awareness of risk indicators and through coordinated action to respond to concerns.	Agree an annual multi agency community engagement and awareness plan Increase awareness of what constitutes 'adults at risk' of harm, include a focus on: • Younger adults • Local communication as well as national campaigns • Link to local sources of information (e.g. Southampton Information Directory – SID) • Use local radio shows and community links such as Unity 101 to regularly promote safeguarding issues and highlight 'what to do' if you are worried about someone. Utilise learning and development opportunities to promote key messages regarding 'safeguarding is everybody's business' as well as identifying and responding to adults at risk of harm. Engage with the local voluntary sector to deliver messages including; • Faith and community groups • Voluntary groups Agree an annual joint conference with LSCB / LSAB to focus on a cross adults and children's safeguarding issue/s Consult on this strategic plan with local service users and community groups.	*LSAB* *CEA* *L&D* *CEA* *Safeguarding boards Team* *LSAB*	*April 2015* *December 2015* *September 2015* *Nil* *December 2015*	*Nil* *Link to Priority 3.* *TBA proposals in development for L&D* *TBC*	*Responses to I questions shows increase in satisfaction with interventions* *LSAB is able to use community views to influence developments in provision.*

Priority 5: Make best use of local data and information – using service data and intelligence to inform our work and measure success.					
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**RESOURCE REQUIRED (£)**	**HOW WILL WE MEASURE SUCCESS?**
The LSAB understands the 'story' of local safeguarding services and makes informed improvements to enhance provision and ensure safety of Southampton residents.	Agree a quality assurance framework for the LSAB in Southampton that enables: • Information and data to be gathered in a systematic way • Data to compliment qualitative information submitted to the Board. Regularly analyse multi agency Safeguarding Adults data from all key board members. Continuously review data collection systems and develop these to effectively deliver data and performance information analysis as required. Ensure that statistical information is presented regularly to the LSAB main board in a meaningful and clear way to understand trends, quality and the performance of local safeguarding practice and inform developments and improvements. Ensure there is consistency in the use of terminology and language across the partnership (terms such as; alert, referral, concerns and enquiries). Identify issues for younger adults at risk – particularly through the transition from Children's Services to Adult Services. Identify links to University's in Southampton with a view to assisting the LSAB in evaluating its work and progress.	*LSAB* *LSAB / Safeguarding Boards Team* *M&E* *"* *"* *M&E* *M&E*	*April 2015* *From April 2015* *"* *"* *"* *September 2015* *December 2015*	*Nil*	*Data shows clear trends* *Clarity across partnership of terminology* *Data shows increase in safety* *Data shows improved timeliness of responses*

Southampton Local Safeguarding Adult Board (LSAB) Structure 2015-16



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DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**INTEGRATED COMMISSIONING UPDATE**		
DATE OF DECISION:		**30 SEPTEMBER 2015**		
REPORT OF:		**STEPHANIE RAMSEY, DIRECTOR OF QUALITY AND INTEGRATION**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296004**
	E-mail:	**Stephanie. Ramsey @southamptoncityccg.nhs.uk**		
Director	**Name:**	**Dawn Baxendale** **John Richards**	**Tel:**	**023 8029 6923**
	E-mail:	**Dawn.Baxendale@southampton.gov.uk** **john.richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The Council and Southampton City Clinical Commissioning group have committed to Integrated Commissioning and this is being achieved through the Integrated Commissioning unit (ICU). This was further strengthened through the establishment of a pooled budget for Better Care in April 2015.

The priorities for 2015/16 for the ICU are based on Health and Wellbeing Strategy and national targets required of Council and Southampton City Clinical Commissioning group. Key commissioning themes of work for the ICU are:

- Early intervention and prevention – adults and young people, children and families
- Improving outcomes for those with learning disabilities
- Improving outcomes for those with mental health
- Integrated care (Better Care)

Progress on a number of key priorities are outlined within this report.

RECOMMENDATIONS :

(i) To note progress with the priorities for integrated commissioning and identify how the Board want to be engaged in future integration.

REASONS FOR REPORT RECOMMENDATIONS

1. Priorities identified are based on Health and Wellbeing Strategy and national targets required of Council and Southampton City Clinical Commissioning group.
2. From 1 April 2015 Local Authorities and CCGs were required to establish a pooled fund under Section 75 of the NHS Act 2006 for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authority. Southampton City has taken a more

holistic approach to health and social care and is pooling funds and commissioning in that way. The ambition is to encompass all services that fit within the scope of the Better Care model, eventually bringing together approximately £132m into the pooled fund. Approval to proceed with the pooled fund was given by Health and Wellbeing Board, Full Council and Clinical Commissioning group Governing body

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. A range of transformation initiatives and savings were considered. Priorities have been identified based on strategic need, impact and cost effectiveness

DETAIL (Including consultation carried out)

Background

4. The Integrated Commissioning unit (ICU) was established in December 2013 to:
    - Pool capabilities and purchasing power across the Council and CCG, so that both organisations can exercise much greater control over what we need, buy, at what price and at the right level of quality.
    - Realigning spend to outcomes required – take a whole SCC/CCG perspective, regardless of the current budget arrangement
    - Commission so everything "works together" – achieve better outcomes for identified groups of people through joint working during the whole commissioning cycle and therefore providing a more joined-up service for these groups
    - Provide a mechanism for influencing the market at scale across health and social care
    - Deliver against national targets and new legislation requirements
5. Key drivers for this were to address need and improve outcomes, including reducing health inequalities and improving life expectancy. The aim is to be able to develop services to intervene earlier, be more proactive and to shift balance of care from acute to community settings. To support the development of integrated provision and to promote independence by improving the numbers of people living independently and using self-management approaches. All of this being achieved with a focus on managing within reducing resources and ensuring delivery of high quality care and support to a diverse population
6. **Mental Health Review**
Engagement on Mental Health Matters has commenced using a wide range of approaches including discussions with users and carers, survey monkey, attendance at existing forums and meetings. Engagement documents are also available via SCC and CCG websites. Key themes are already emerging, in line with national and local priorities, we are looking to ensure services are recovery orientated and that people have maximum choice and control of their own care and treatment. There has, and will continue to be, an emphasis on people accessing services in community settings and on employment being the norm for people with mental health conditions who are of working age.
7. The review will involve all services and is not age specific. We will be looking at how to align mental health services with other priority areas including Better Care, researching best practice and learning from others, consulting with a wide range of agencies and service users and carers and undertaking financial modelling to

design a model within the resource we can afford.

8. **Transfer Public Health Nursing (Health Visiting)**

   Work is on track for the transfer of the Public Health 0-4 nursing contract to the City Council on 1 October 2015.An exemption has been granted to extend the contract to 31 March 2017. The first phase of development commences this summer with the establishment of enhanced early childhood leadership teams comprising maternity, health visiting and children's centres. The teams will work together on creating local priorities and business plans against citywide templates. Support for families will be enhanced by combining and aligning assessment processes including:

   - Revision of the universal Family Health Assessment used by health visiting in the antenatal and early postnatal period so that it can be accessed and used by children's centre staff and
   - Implementing an integrated approach to the early years assessment carried out by Health visitors and Early Years providers at 2-3 years.

9. Second and subsequent phases of development are intended to include integrated locality management structures and co-location of services 0-19 years across health visiting, children's centres, school nursing and Early Help teams. These phases will take account of the recommendations from an Early Help review which is currently underway. Work is also underway to develop integrated care pathways using the national evidence base.

10. This is a key element of developing an integrated service offer for children and young people. The aim is to develop:
    - Child & Family centred local integrated services
    - Integrated specialist support - new model of service for integrating health and social care (0-18) in the 0-25 SEND service offer agreed. Implementation underway and due to be fully completed by November 2015

    Build community capacity to support prevention and early intervention

11. **Integrated rehabilitation and reablement consultation**

    On August 18th Cabinet agreed for consultation to commence on integration of resources that facilitate rapid crisis response, timely hospital discharge and preventative and recovery focused rehabilitation and reablement. This will be achieved through working alongside families/carers and community clusters to:
    - undertake community rehabilitation and falls prevention activity.
    - assess and coordinate safe discharge of people from hospital back into their communities
    - collectively intervene early and rapidly responding to crisis situations in a coordinated and flexible manner thus helping to avoid unnecessary acute hospital, residential and nursing home care or complex home packages.

12. A series of Stakeholder Workshops were to develop a Business Case on a potential preferred Option for a new service model. The consultation will be undertaken in two phases which will be completed by early December 2015. Phase One will be on a proposed service model which will bring together those functions associated with crisis response, rehabilitation, reablement and, at a later date hospital discharge, delivered by the City Council and Solent NHS Trust to provide a seamless response for the service user. This will be achieved through a single integrated team approach, with a single integrated management structure that better supports people in their communities and maximises their potential for independence. This Phase One is a re-structure of staffing resources and does not impact on the type, service delivery location or total range of services available to clients.
13. Phase Two is a reconfiguration of rehabilitation and reablement beds, to achieve a more appropriate and cost effective balance of bed based and domiciliary care that meets needs of clients and would deliver better outcomes, and represents a better value use of resources. This is a key strand of Better Care.
14. **Domiciliary Care retender**
As part of a joint commissioning exercise a new domiciliary care framework has been put in place following a tender process that concluded in February 2015. This framework will last for four years, and provides a platform for the delivery of domiciliary care and reablement services for adult and children services in Southampton City Council (SCC) and Continuing Health Care for Southampton City CCG (SCCCG). It will eventually provide the care arrangements for approximately 1,810 people in any given week.
15. The programme of implementing the new framework, and reducing the number of providers from 75 to the 31 on the framework has been on-going since April. During the transfers most agencies have worked positively with one another, smoothing the process and ensuring individuals are both kept informed of progress and have not seen a dramatic change in their care or carers.
16. The savings target set for SCC domiciliary care services of £420K in 2015/16 has been met, and once the mini-competitions for supported living are concluded, these savings could be higher. The saving to the CCG is lower due to a number of factors, including smaller differential in rates and the complexity of arrangements
17. All agencies on the framework have reported good responses to recruitment since the results were announced and this has increased capacity in the sector. This recruitment has led to improvements in waiting times for the start of care delivery which have been reducing steadily since April. Agencies are already considering the long term implications of being on the framework for four years and are committed to increasing the number of staff on fixed hours contracts – and therefore to reduce the numbers on zero-hours contracts.
18. Greater control of referrals to agencies and capacity issues has been provided by the development of the Care Placements Service. This service manages all domiciliary care referrals to agencies on the framework. Relationship development is positive, and agencies have a single point of contact regarding domiciliary care capacity and requirements. The Care Placements Service are able to provide information on each provider, their capacity, access routes and times and are an invaluable new resource in enabling Southampton to manage the market.

19. The framework sets clear expectations regarding the quality, continuity and consistency of care delivery in the city. A new process for contract monitoring is in place, which from October will enable individual agency performance to be mapped, and for this to be aggregated across all providers. Quality Audits are being rolled out across providers, with timings for reviews focused on risk management criteria and flexible enough to be used if concerns are raised and need investigating at any time.

20.. **Market Position Statement**

Southampton's first market position statement focussing on housing solutions for people with care and support needs has been finalised. Significant transformation is expected of the health and social care market in the next few years.

21. Recommendations within the statement are that SCC and SCCCG want to :

- work with residential and nursing providers to create more flexible service provision such as respite and other short-term placement types.
- support LD residential providers explore the benefits of deregistration and conversion into alternative accommodation models.
- work with local nursing providers to explore developing specialist provision for clients presenting within challenging behaviour needs.
- increase the local supply and mix of appropriate housing solutions for care leavers and homeless 16 & 17 year olds.

22. The report sets out key work strands to deliver the recommendations proposed. Work has started in advance of publishing the MPS and includes market engagement to explore alternative options to day service closure, sourcing of domiciliary care supply in preparation of winter pressure period, working with strategic council partners to develop tailored programmes to increasing workforce profile and supply, working with provider developing proposals in response to current challenges.

23. **Governance**

The detailed work of the ICU is overseen by the Commissioning Partnership Board which has Chief Officer, Director, Cabinet member, clinical and lay member representation. Formal decisions remain with SCC and CCG governance routes

RESOURCE IMPLICATIONS

Capital/Revenue

24. Current targeted savings to be achieved by the ICU for 2015/16 are £6,992m, approximately 50/50 split across SCC and CCG

25. The minimum requirement for the Better Care Fund in 2015/16 is £15.325M Revenue and £1.526M Capital. The majority is existing funding sources included within either the Council or CCG 2014/15 budget. Pooled budget for 2015/16 is £61m. It should be noted that it is the commissioning budgets for services that are being pooled and that the services themselves and the associated staff will remain managed and employed as they are currently are.

Property/Other

24. The proposal should not have any property implications as it relates to commissioning functions. Any changes made to any service funded through the pooled fund which may have property implications will be subject to a separate

report.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

25. Section 75 of the National Health Service Act 2006

Other Legal Implications:

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

POLICY FRAMEWORK IMPLICATIONS

27. The priorities identified are wholly consistent with the Council's Health and Wellbeing Strategy and other policy framework strategies and plans.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

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

Other Background Documents

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

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

DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**BETTER CARE SOUTHAMPTON IMPLEMENTATION**		
DATE OF DECISION:		**30 SEPTEMBER 2015**		
REPORT OF:		**STEPHANIE RAMSEY, DIRECTOR OF QUALITY AND INTEGRATION**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman** **Stephanie Ramsey**	**Tel:**	**023 80296004**
	E-mail:	**Stephanie. Ramsey@southampton.gov.uk** **Donna.chapman@southamptoncityccg.nhs.uk**		
Director	**Name:**	**Dawn Baxendale** **John Richards**	**Tel:**	**023 80834428** **023 80296923**
	E-mail:	**John.richards@southamptoncityccg.nhs.uk** **Dawn.baxendale@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

Extensive work has been undertaken by the City Council working in partnership with Southampton City CCG and other stakeholders to develop Southampton's Better Care Plan, under the leadership of the Health and Wellbeing Board. The final plan was signed off by the Health and Wellbeing Board, Chief Executive of the City Council and Chief Operating Officer of the CCG on 19 September 2014 and submitted to Ministers. This was approved following the Nationally Consistent Assurance Review which identified no areas of high risk within the plan and so Southampton is now progressing with full implementation of its plan.

As part of implementation regular reporting has to be made to NHS England and the national Better Care Support Team. The Quarterly returns form part of the overall accountability framework for the BCF as set out in the national guidance (Guidance for the Operationalisation of the BCF in 2015-16) issued in March 2015

This report summarises some of the progress towards implementation of Better Care Southampton and the details of the Quarter 1 2015/16 BCF national return.

RECOMMENDATIONS :

(i) To note the progress with implementation of Better Care Southampton.

(ii) To sign off the Quarter 1 2015/16 BCF national return which was

approved by the Commissioning Partnership Board (CPB) prior to submission to NHS England and the national Better Care team by 28 August 2015.

REASONS FOR REPORT RECOMMENDATIONS

1. From 1 April 2015 Local Authorities and CCGs are required to establish a pooled fund under Section 75 of the NHS Act 2006 for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authority.

2. National guidance (Guidance for the Operationalisation of the BCF in 2015-16) issued in March 2015 sets out overall accountability framework for the Better Care Fund and requires quarterly returns as part of this that Health and Wellbeing board have approved.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None applicable.

DETAIL (Including consultation carried out)

Background

4. Southampton's vision for Better Care is to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred. Better Care has the following overarching aims:
   - **To put Individuals at the heart of their own care**
   - **To focus on prevention and early intervention**.
   - **To build community capacity**
   - **To help people to retain and regain their independence**

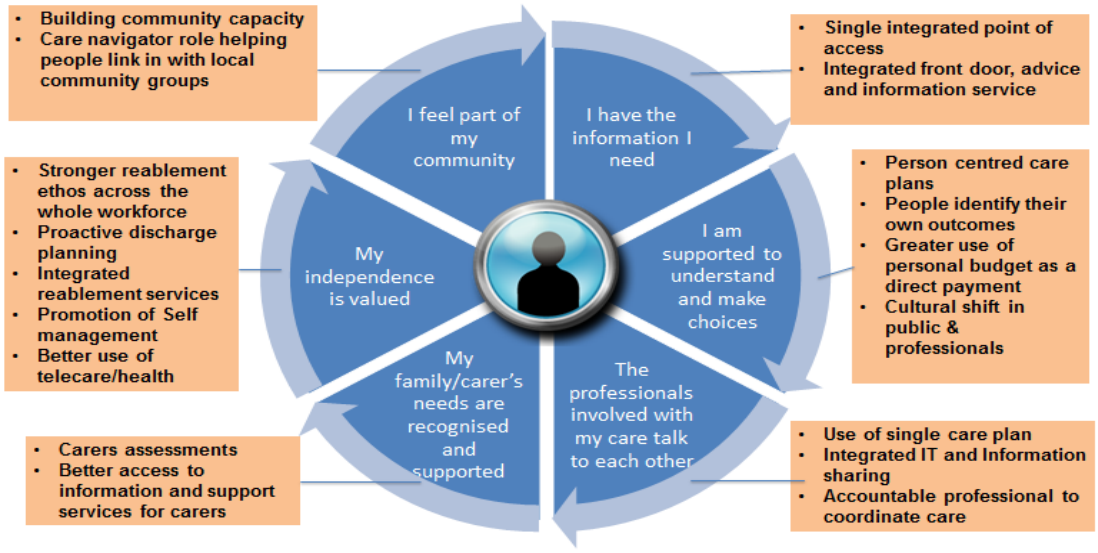
   The key principles are:
   - **Efficient and consistent** - care planning and assessment may be undertaken by any agency using a common trusted tool
   - **Integrated and seamless** - services will be delivered in an integrated way at all levels wherever possible with a focus on local care
   - **Round the clock** - out of hospital care will be a 7-days-a-week service and will be consistent both in and out of hours
   - **Community-led** – the vast majority of people's needs will be managed in the community by the local cluster teams. Community services will be the first port of call for people seeking help for themselves or others

5. Southampton's Phase 1 Better Care plan has the following main schemes and work is in progress with each:
   1. Local person centred coordinated care (clusters) - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7 day working.
   2. Integrated discharge, reablement and rehabilitation service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home in the community,

intervening quickly where required to prevent deterioration, as well as supporting people's recovery and reablement following a period of illness

3. Community solutions and prevention - this scheme is aimed at building on and developing local community assets and supporting people and families to find their own solutions.
4. Supporting carers – this scheme recognises the important role that carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care.
5. Developing the market for placements and packages and further integrating approaches – this includes work to develop the market to provide greater opportunity and choice, encourage a recovery/ reablement focus and support people to remain as independent as they can be in their own homes.

6. The diagram below illustrates what the system will look like from the perspective of an individual and the work in progress to achieve this:



7. **Implementation of Better Care Southampton Cluster Development**

Leadership groups are now working in all clusters, formed from community health providers, adult social care, supported housing and voluntary sector organisations and working on cluster specific implementation plan, resulting in six plans now being in place to underpin the city wide approach. Work has continued on engaging with a wider group of services, including domiciliary care providers. GP practices developing collaborative care plans with patients and the cluster multi-disciplinary team.

8. **Integrated rehabilitation and reablement**

Cabinet approved the commencement of consultation on proposals for an Integrated Service for Crisis Response, Rehabilitation, Reablement and Hospital Discharge on 18th August 2015. The vision is to achieve significant benefits across the system including:

- an improved client experience that is person-centred, seamless and integrated
- a clear and effective pathway for clients to promote recovery and independence
- improved efficiencies by reducing service duplication, providing co- ordinated care and a more tailored use of bed-based resources
- reducing spend across the health and social care system by reducing the future demand for services as the population gets older e.g. spend on avoidable hospital admission rates, length of hospital stay and need for ongoing complex packages of care.

9. Consultation is in two phases. Initially on a proposed service model which will bring together those functions associated with crisis response, rehabilitation, reablement and, at a later date hospital discharge, delivered by the City Council and Solent NHS Trust to provide a seamless response for the service user. This will be achieved through a single integrated team approach, with a single integrated management structure that better supports people in their communities and maximises their potential for independence. Phase two is consulting on a reconfiguration of rehabilitation and reablement beds, to achieve a more appropriate and cost effective balance of bed based and domiciliary care services that meets needs of clients and would deliver better outcomes, and represents a better value use of resources.

10. **Community solutions and prevention**

The Community Solutions group oversees and coordinates the delivery of increased community involvement to support the Better Care agenda. The mapping community resources at a cluster level against identified needs continues and being uploaded on Placebook, SID (Southampton Information Directory) or the Knowledge Hub. Community Navigation pilots have commenced and Age UK is starting to lead the work linking into a small number of GP practices. Southampton is involved in a national pilot scheme designed to change the way services are commissioned and delivered, with the involvement of local residents. The Our Place scheme which is underway in the Shirley and Freemantle area has started to engage the community to understand their concerns and priorities. One of the key areas identified is the need to improve the health and wellbeing of older people in the community.

11 **Market Development**

New domiciliary care contracts will came into place on the 1st April 2015 increasing reliability and quality of these packages of care. For example there has been an improvement of nearly 50% in the waiting time for start of care delivery which has been reducing steadily since the framework commenced.

The first market position statement has been developed focussing on housing solutions for people with care and support needs. This involved close work with providers and will be available on SCC and CCG websites.

Discussions continue about the development of Multi-speciality Community

Provider which includes opportunities for greater integration and exploration of appropriate contractual infrastructure.

12 **Developing an integrated service offer for children and young people**

Phase 2 of Better Care implementation is to extend the model to incorporate an integrated service offer for children and young people. For children, young people and family services, the Better Care approach can be broadly translated under 3 major headings: Child & Family centred local integrated services, Responsive Integrated Specialist Support delivered in partnership and Building Capacity – see below.

13 **Child & Family centred local integrated services**

At the universal and targeted level, work is in progress to integrate services organised around 3 localities (East, West, Central Southampton), each aligned to 2 Better Care clusters. The 3 integrated teams will work closely with partners including schools and primary care services in each locality. The first phase of development commences this summer with the establishment of enhanced early childhood leadership teams comprising maternity, health visiting and children's centres. The teams will work together on creating local priorities and business plans against citywide templates. Support for families will be enhanced by combining and aligning assessment processes.

14 **Integrated specialist support**

Work is also in progress to integrate systems and processes (and in some cases teams) that focus on meeting statutory requirements and more specialist needs to deliver a more coordinated service to children, young people and families which meets their needs in the round. In particular, this includes:

- Statutory processes for looked after children - the City Council looked after children services and Solent looked after children health team have been working together over the last 12 months to improve communication and join up processes to improve performance against statutory response times for new

into care assessments and reviews.

- Family assessment and intervention services which include the Behaviour Resource Service which is an existing joint health and social care assessment and support service under joint management and joint funding arrangements (supported through Section 113, 76 and 256 agreements).
- The MASH which acts as the city's single front door for all safeguarding concerns.
- Development of an integrated 0-25 SEND offer across Education, Health and Social Care which includes the statutory assessment and plan pathway as one amongst a range of options that enable families to meet the needs of their child, young person or young adult. There are clear parallels between the SEND development and Better Care developments for adults and older people, in particular:
  - the focus on early identification of needs and intervention that embeds support at the earliest opportunity
  - the development of personalisation approaches promoting independence and co-production

The next focus of the work is on developing the post 16 SEND offer and transition pathways into adult services, in addition to strengthening links to the locality 0-19 services described above to support children and young people with SEND in their local communities.

15 **Building community capacity to support prevention and early intervention**

Key to improving outcomes for children, young people and their families is the development of engaged, informed, supportive and thriving communities (neighbourhood and school communities) able to find innovative, creative solutions that recognise and harness the strengths and energies of children, young people and families working together. This includes seeking out and developing opportunities for attracting new money and resources into the city and will require statutory services to develop a new equitable relationship with the voluntary and community sectors that results in the growth of trust and co-operation and includes the sharing of data and priorities. Key areas that have been identified for development with the voluntary and community sector include:

- Initiatives that promote parent-child bonding and speech, language and communication skills in the first 2 years of life
- Initiatives that reduce isolation and promote confidence such as Parent and Toddler Groups, befriending and mentoring schemes and evidenced based parenting courses - a Parenting Offer has been developed for the city.
- Sufficient accessible play schemes during the holiday periods and positive activities for young people all year round, particularly open-access activities which have the support available to include young people with additional needs.
- Support for parents with low aspirations for themselves and their children.
- Support for parents to learn functional English, embrace citizenship and contribute to as well as access services in the city.
- Effective support for children and families to adopt healthy lifestyles and maintain a healthy weight.

Delivery of a clearly defined youth offer to ensure young people's engagement in a wide

range of positive activities that build aspirations, resilience and inspire young people to achieve and improve their outcomes

16 National Reporting requirements

The Quarter 1 2015/16 BCF national return was presented to the Commissioning Partnership Board (CPB) for approval prior to sign off by the Health & Wellbeing Board (HWBB) and submission. The return, in Appendix 2, was submitted to NHS England and the national Better Care Support Team on 28 August 2015.

The Quarterly returns form part of the overall accountability framework for the BCF as set out in the national guidance (Guidance for the Operationalisation of the BCF in 2015-16) issued in March 2015.

The Q1 return specifically focuses on:

- whether the pooled fund is in place under a S75 Partnership Agreement
- achievement of the 6 national conditions
- the payment for performance element linked to non-elective (NEL) admissions
- income and expenditure and any deviation from plan
- achievement of the local metric (falls) and locally defined patient experience metric (% of people who feel supported to manage their long term condition)
- our local support needs

The deadline for submitting the returns are as follows:

- 28 August 2015 – for the period April to June 2015
- 27 November 2015 – for the period July to September 15
- 26 February 2016 – for the period October – December 15
- 27 May 2016 – for the period January – March 2016

In addition to the national reporting template, a local performance monitoring return has also been developed in line with the terms of the S75 Pooled Fund agreement to track spend and progress specific to each Scheme/pooled fund. The local returns, Appendix 3, provide greater detail at an individual scheme level on income and expenditure, opportunities for savings, predicted cost pressures, delivery against aims and any risks/issues.

17 Areas of risk identified

Current areas of risk include:

- Slippage on implementation of integrated rehab/reablement model which is impacting on delivery of delayed transfers of care and residential/nursing home admission targets and associated savings. This is a cost pressure for both the CCG and SCC who have savings associated with this scheme in 15/16 savings plans.
- As at Q1 the following activity metrics are all off target: permanent admissions to residential/nursing homes, delayed transfers of care and falls. This position is particularly concerning in relation to residential/nursing home admissions as this is the first quarter since we have been tracking BCF performance (since April 2014) that this target has been missed. It should also be noted that, whilst the number of admissions in previous quarters has been reduced, the overall costs have been increasing, owing to increasing complexity and a proportionate increase in nursing home admissions relative to residential home admissions. An audit of residential and nursing home admissions is being planned to gain a better understanding of this activity and where to target future work, particularly with regard to the focus of the Rehab and Reablement Service. A similar audit is being undertaken for delayed transfers and is due to report shortly. Work is also underway with Solent (as part of a CQUIN scheme) to work with residential homes to better manage patient need and prevent crisis and escalation but is not likely to have an impact until Q3.

RESOURCE IMPLICATIONS

Capital/Revenue

18 The minimum requirement for the Better Care Fund in 2015/16 is £15.325M Revenue and £1.526M Capital. The majority is existing funding sources included within either the Council or CCG 2014/15 budget. This funding is not new to the Health and Social Care system. However, under the conditions of the Better Care Fund, additional funding of £600,000 from within the pool will be provided to help meet the new responsibilities of the Council required by the Care Act 2014. This funding will come from the existing NHS resource and will therefore be a pressure to the CCG.

19. Three of the five schemes have been placed into the pool from 1st April 2015. These schemes will incorporate approximately a further £45m of funding from the Council and the CCG bringing the total pool for 2015/16 to £61m. £3.4m of the additional £45m was within existing joint funding arrangements between SCC and SCCCG under a S75, S76 or S256 agreement. The funding for the first three schemes entering into a pooled fund arrangement are Council £5.3m, (9%) and CCG £55.5m (91%). It should be noted that all figures in this report are based on 2014/15 budgeted levels for both the Council and CCG.

20. It should be noted that it is the commissioning budgets for services that have been pooled and that the services themselves and the associated staff will remain managed and employed as they are currently.

Property/Other

21. The proposal should not have any property implications as it relates to commissioning functions. Any changes made to any service funded through the pooled fund which may have property implications will be subject to a separate report.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

22. Section 75 of the National Health Service Act 2006

The pooled fund agreement will cover governance and technical aspects including accountability, financial reporting and the handling of overspends, underspends and savings requirements.

Other Legal Implications:

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

Guidance for the Operationalisation of the BCF in 2015-16

POLICY FRAMEWORK IMPLICATIONS

24. The decision sought is wholly consistent with the Council's Health and Wellbeing Strategy and other policy framework strategies and plans.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Q1 BCF return
2.	Q1 local BCF monitoring for schemes in Pooled Fund

Documents In Members' Rooms

1.	None

Equality Impact Assessment

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

Other Background Documents

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

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

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Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 28th August 2015

This Excel data collection template for Q1 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on local metrics. It also presents an opportunity for Health and Wellbeing Boards to register interest in support. Details on future data collection requirements and mechanisms will be announced ahead of the Q2 2015/16 data collection.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an explanation of any material variances against planned performance trajectories as part of a wider overview of progress with the delivery of plans for better care.

Content

The data collection template consists of 9 sheets:

Validations - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements- this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Local metrics - this tracks performance against the locally set metric and locally defined patient experience metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) Narrative - this allows space for the description of overall progress on plan delivery and performance against key indicators.

Validations

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 8 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the 2014-15 Q4 submission and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously you can selection 'Not Applicable' this time.
If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4. Three figures are required and one question needs to be answered:
Input actual Q1 2015-16 Non-Elective performance (i.e. number of NELs for that period) - Cell L12
Input actual value of P4P payment agreed locally - Cell D23
If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box
Input actual value of unreleased funds agreed locally

This section also requires indication of the area of spend that unreleased funds have been spent on for Q4 and Q1 using a drop-down list. If no funds were left unreleased then 'Not Applicable' should be selected.

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:
Planned and forecast income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1
Planned and forecast expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure into the pooled fund in Q1

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan.

6) Local metrics

This tab tracks performance against the locally set metric and locally defined patient experience metric submitted in approved BCF plans. In both cases the metric is set out as defined in the approved plan for the HWB and **the following information is required for each metric:**

Confirmation that this is the same metric that you wish to continue tracking locally

Confirmation of planned performance for each quarter of 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)

Confirmation of actual performance for Q1 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)

Commentary on progress against the metric and details of any changes to the metric including reference to reasons for changing

7) Understanding Support Needs

This asks what the key barrier to integration is locally and what support might be required in delivering the six key aspects of integration set out previously. This section builds upon the information collected through the BCF Readiness Survey in March 2015. HWBs are asked to:

Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan

Confirm against each of the six themes whether they would welcome any support and if so what form they would prefer support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help

8) Narrative

In this section HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q1 2015/16

Data collection Question Completion Validations

Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Comments	Any unreleased funds were used for: Q4 14/15	Any unreleased funds were used for: Q1 15/16
Yes	Yes	Yes	Yes	Yes

I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the total yearly plan and the pooled fund
Income to	Plan	Yes	Yes	Yes	Yes	Yes
	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
Expenditure From	Plan	Yes	Yes	Yes	Yes	Yes
Expenditure From	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
	Commentary	Yes				

Local Metrics

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local performance metric plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local patient experience plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

Understanding Support Needs

Area of integration greatest challenge
Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

Narrative

Brief Narrative
Yes

Cover and Basic Details
Q1 2015/16

Health and Well Being Board	Southampton
completed by:	Donna Chapman
E-Mail:	donna.chapman@southamptoncityccg.nhs.uk
Contact Number:	023 80 29 6004
Who has signed off the report on behalf of the Health and Well Being Board:	Councillor David Shields

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	21
6. Local metrics	18
7. Understanding Support Needs	13
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Southampton

Data Submission Period:

Q1 2015/16

Budget arrangements

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	<Please Select>
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q4 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board:

Southampton

Data Submission Period:

Q1 2015/16

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Comment			
1) Are the plans still jointly agreed?	Yes			1	1	1
2) Are Social Care Services (not spending) being protected?	Yes			1	1	1
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	01/01/2016	Hospital discharge team have increased their weekend working to support timely discharge on a 7 day basis. This is showing an impact on discharges; Social care and community nursing staff already supporting 7 day discharges; Aiming to have integrated Rehab/Reablement/Discharge service in place with 7 day access from later in	1	1	1
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes			1	1	1
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes			1	1	1
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes			1	1	1
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes			1	1	1
6) Is agreement on the consequential impact of changes in the acute sector in place?	Yes			1	1	1

Please select
Yes
No
No - In Progress

National Conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Southampton

	Baseline				Plan				Actual				% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance	Total Performance Fund Available	Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment				Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16				Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16			
D. REVALIDATED: HWB version of plans to be used for future monitoring.	6,943	7,190	6,994	7,253	6,801	6,953	6,937	7,213	6,864	6,944			1.7%	476	£709,240	142	379	436	476	£211,580	£353,130	£84,930	£59,600	79	246			£117,710	£366,540			£709,240	£4,429,000	£0

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify	
Cost per non-elective activity	£1,490		

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Quarterly payment taken from above	£117,710	£366,540		
Actual payment locally agreed	£0	£0		

If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box (max 750 characters)	Southampton has gone at risk and invested the totality of its BCF financial committment upfront into the pooled fund. This includes the element relating to the payment for performance fund. This money has been invested in a project to provide additional Over 75s nurses to work in a preventative capacity with primary care to keep people out of hospital and expedite discharge; which in turn forms part of the Cluster Scheme.

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggest amount of unreleased funds	£93,870	-£13,410		
Actual amount of locally agreed unreleased funds	£211,580	£353,130		

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	community car	community car		

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as at 10am on 6th August 2015. Please note that the data has not been cleaned and limited validation has been undertaken.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Southampton

Income

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£14,497,000	£14,497,000	£14,497,000	£14,497,000	£57,988,000	£132,718,000
	Forecast	£14,368,000	£14,540,000	£14,540,000	£14,540,000		
	Actual*	£14,368,000					

Please comment if there is a difference between the total yearly plan and the pooled fund	Southampton has taken the decision to pool over time the majority of health and social care resources on community services bringing the total BCF to £132,718,000. This is higher than the nationally required minimum contribution of £15.325m revenue funds plus £1.526m capital. It has always been the intention to increase the pooled fund on a phased basis, starting first in 15/16 with 3 of the schemes which make up the 5 schemes described in our BCF Plan. The total value in year 1 (1/4/2015 - 31/3/2016) is £57,988,000.

Expenditure

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£14,497,000	£14,497,000	£14,497,000	£14,497,000	£57,988,000	£132,718,000
	Forecast	£14,368,000	£14,540,000	£14,540,000	£14,540,000		
	Actual*	£14,368,000					

Please comment if there is a difference between the total yearly plan and the pooled fund	Southampton has taken the decision to pool over time the majority of health and social care resources on community services bringing the total BCF to £132,718,000. This is higher than the nationally required minimum contribution of £15.325m revenue funds plus £1.526m capital. It has always been the intention to increase the pooled fund on a phased basis, starting first in 15/16 with 3 of the schemes which make up the 5 schemes described in our BCF Plan. The total value in year 1 (1/4/2015 - 31/3/2016) is £57,988,000.

Commentary on progress against financial plan:	There is a slight (0.9%) underspend YTD which will recover by year end.

Footnote:

Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a Q4 collection previously filled in by the HWB.

Local performance metric and local defined patient experience metric

Selected Health and Well Being Board: Southampton

Local performance metric as described in your approved BCF plan	Injuries due to falls in people aged 65 and over
Is this still the local performance metric that you wish to use to track the impact of your BCF	Yes
If the answer is no to the above question please give details of the local performance metric being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local performance metric plan and actual	234	231	225	233	264	258		

Please provide commentary on progress / changes:	The data above relates to actual falls as opposed to a rate. Reducing the numbers of injuries due to falls remains challenging for a number of reasons: 1. Introducing falls exercise has an evidenced based lag effect of at leats 6 months as individuals need to build core stability strength and maintain this over time. On a population basis significant numbers of individuals need to have improved and maintained their core stability and strength and avoided falls over time to impact on the

Local defined patient experience metric as described in your approved BCF plan	Percentage of people who feel supported to manage their Long Term Conditions
Is this still the local defined patient experience metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local defined patient experience metric now being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local defined patient experience metric plan and actual:	1	1	1	1	1	0		

Please provide commentary on progress / changes:	This indicator is measured via a patient survey undertaken by local providers and the CCG has received a report annually. Currently this information is not available on a quarterly basis but the CCG is discussing with providers whether a quarterly return could be produced. It should also be noted that the indicator relates to a percentage. This has been entered into the table above but the formatting does not allow this to be shown as such.

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board: Southampton

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	4.Aligning systems and sharing benefits and risks

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	No	[redacted]	
2. Delivering excellent on the ground care centred around the individual	No		
3. Developing underpinning integrated datasets and information systems	Yes	Workshops or other face to face learning opportunities	
4. Aligning systems and sharing benefits and risks	Yes	Workshops or other face to face learning opportunities	Suppport/advice around benefit and risk sharing linked to alternative contracting models in both NHS and Social Care
5. Measuring success	Yes	Peers to peer learning / challenge opportunities	
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Peers to peer learning / challenge opportunities	

Narrative

Selected Health and Well Being Board:

Southampton

Data Submission Period:

Q1 2015/16

Narrative	Remaining Characters	30,066

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time with reference to the information provided within this return where appropriate.

Southampton established its BCF pooled fund under a S75 Partnership Agreement on 1 April 2015, initially pooling 3 schemes: supporting carers (£1.334m), cluster teams (£30.634m) and Rehab/Reablement and supported discharge (£26.015m). As mentioned earlier, these schemes bring together a total pooled resource of £57.99m which exceeds the national minimum requirement of £16.85m and reflects Southampton's ambition to integrate at scale. Ultimately Southampton is seeking to pool the totality of community based health and social care resources to achieve a total pooled fund of over £132m. The Southampton Commissioning Partnership Board oversees the performance of the BCF, reporting to the HWBB and is receiving detailed reports on each of the schemes.

With regard to carers, an assessment service has been procured from the voluntary sector and recently went live (June 15). We are already seeing a signifiant increase in numbers of carers identified.

With regard to Rehab, Reablement and supported discharge, an integrated health and social care service is being developed and is about to go out to formal consultation (Aug - November). This will formally integrate staff teams, systems and processes (e.g. assessment, care planning) and management structures to provide a streamlined redesigned service capable of better responding to crisis and supporting timely discharge, with a greater focus on promoting and maintaining independence in people's own homes to reduce hospital admissions and admissions to residential and nursing homes.

Under the clusters scheme, we now have agreed operational policies for integrated working and established Cluster Leadership groups in each of the 6 localities. 4486 Care plans have been up-loaded on to the Hampshire Health Record and cluster performance dashboards have been developed to measure change and target future interventions. We are currently trialling a model of Community Navigation, working with a voluntary sector partner, in 2 cluster areas as part of our strategy to build community capacity and target need earlier to prevent pressure on specialist services and protect social services.

In terms of performance, as at Q1 we are successfully delivering on our target to reduce NEL admissions. Reducing falls is proving more challenging, despite the significant progress which has been made in redesigning services to create a falls liaison function (in place since Jan 15) and establish a falls exercise programme with voluntary sector partners (went live Jul 15); however impact is known to take time.

Monitoring systems are in place for all other BCF indicators and being regularly reported to the Integration Board and HWB.

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Southampton City Better Care Partnership Agreement 2015/16

Quarterly Performance Report

Scheme	**CLUSTERS**
Host	**Southampton City CCG**
Report Author	**Adrian Littlemore, Senior Commissioner ICU**
Reporting Period	**Q1 2015/16**
Report Date	**17 August 2015**

Overall Financial Performance

Annual value	£30.634m CCG = £30.483m SCC = £151k
Year to date budget	£7.659m
Year to date spend	£7.658m
Variance	£0.001m
Reasons for Over/Underspends: N/A	
Actions being taken to address Over/Underspends: Not applicable	
Opportunities for Savings: None identified at present	
Predicted Cost Pressures: None identified at present	

Associated Contracts

Contract	Duration	Annual Value	Any Over/Under spend to date	Summary of Performance to date	Further Comments
Solent NHS Trust Block NHS Contract – community nursing services, including continence, services for people with LTC and podiatry	1 year rolling contract	£9.684m	n/a – block contract	Additional investment in community nursing services and associated additional capacity being closely monitored as service still reporting workload pressures.	

Contract	Duration	Annual Value	Any Over/Under spend to date	Summary of Performance to date	Further Comments
Southern Health Block NHS Contract – OPMH community teams and AMH assessment and community support	1 year rolling contract	£11.750m	As above		
IAPT Service commissioned from Dorset Health Care	1 year rolling contract	£1.993m	As above		
Personalised care for over 75's (GP £5 per head) commissioned from: Solent NHS Trust SMS Central practices	 18 months 18 months 18 months	 £0.403m £0.515m £0.295m	 As above	All teams now in place; embedding of model with GP practices being monitored closely	Evaluation planned for end of calendar year to determine plans for 16/17

Overall Delivery

Original Aims and anticipated Outcomes	• A more integrated approach to service delivery to address system wide problems which cannot be tackled by one agency alone o Through focussing spending on system need rather than agency need. o Through supporting integrated strategic development, mutual responsibility and joint outcome measurement. o Through creating more opportunity for cross skilling of staff. o Through bringing together generic and specialist resources in a more integrated way that supports people's needs holistically but at the same time enables the person and/or the professionals involved in the person's care to access specialist resources for input/advice/support on specific conditions. • Fewer unscheduled admissions to hospital o Through proactive multiagency risk stratification tools which bring together a breadth of information to identify those people most at risk of deterioration and intervene earlier, maintaining and promoting independence o Through better use of case management and shared care planning to better manage people at home o Through a stronger focus on prevention, including falls

	prevention • Fewer admissions to long term care, eg. residential or nursing homes o Through better case management and shared care planning o Through a stronger reablement ethos o Through more proactive discharge planning, ensuring that people are only in hospital for as long as they clinically need to be and that their independence is promoted • Better service user experience o Through supporting people to manage their own health and wellbeing and have a single lead professional who will coordinate their health and social care. o Through providing accessible services in a timely streamlined fashion that will seek to help them to be as independent as possible. o Through providing consistency and reducing duplication through single processes such as single assessment, lead professionals and shared recording and communication systems. • Improved joint working with local communities and voluntary sector o Through development of community navigator role to signpost people to community resources o Through better understanding and knowledge of local area		
Evidence of delivery against original aims and outcomes and how this supports overall BCF targets	• Agreed operational policy developed for integrated working in clusters. Cluster Leadership groups established and meeting on a monthly basis. • High risk patients being identified by multi-disciplinary team. Care plans developed and up-loaded on to the Hampshire Health Record (4486 patient plans). • Cluster performance dashboards developed to measure change and target future interventions. • Work commenced to align other adult or specialist services to deliver through the integrated cluster model. • Options appraisal and seeking commitment to develop a Single Point of Access to services, under development. • Workforce developments progressing with a focus on making "every contact count". • Emerging estates strategy to support integrated working. • Community Navigation being trialled in 2 cluster areas. • Cluster community plans being developed involving health, social care, housing, voluntary and faith groups and local business representatives to bring organisations together to more strongly focus on the needs of the community. • Falls prevention plan developed with system wide implementation. Falls exercise classes and fragility fracture clinics operational. • CQUIN established with Solent NHS Trust as part of contract specifically focussed on working with residential homes to improve management of residents and reduce hospital and nursing home admissions • Over 75 nursing schemes fully operational – due to be evaluated at end of calendar year.		
Performance	Indicator	Plan to date	Actual to date

Indicators	• To significantly reduce permanent admissions to residential and nursing homes	69	83
	• To increase the percentage of older people still at home 91 days post discharge into reablement services	Data still unavailable from SCC	Data still unavailable from SCC
	• To significantly reduce delayed transfers of care	2296	2727
	✓ To reduce avoidable emergency admissions	6953	6944
	• To reduce injuries due to falls	231	258
Summary of Risks and Issues & Mitigating actions	• Reducing the numbers of injuries due to falls remains challenging for a number of reasons: ○ Introducing falls exercise has an evidence based lag effect of at least 6 months as individuals need to build core stability strength and maintain this over time. On a population basis significant numbers of individuals need to have improved and maintained their core stability strength and avoided falls over time to impact on the trajectory. ○ The model for delivery of falls exercise developed previously was based on the assumption that students from Solent University would deliver the sessions as part of their undergraduate degree and individuals being charged for venue and coordination costs. Solent University have now indicated that this is no longer feasible. Work is underway to explore the potential of stimulating existing exercise providers in the City to provide appropriate services. It is highly likely that these potential providers will require financial support to develop and maintain a required service as the full costs cannot be transferred to individuals. ○ Patients who are prescribed bone density medication benefit from taking the medication after many months. On a population basis Fracture Liaison Services (FLS) are known to take 18 months before a population impact is seen. • Admissions to residential and nursing care – the target reduction is a composite target and may not necessarily have a financial benefit if the reduction is mainly focussed on residential admissions. This has been illustrated in the previous year, where although the actual number of permanent admissions reduced, the actual cost increased. An audit of recent residential care admissions is being planned to provide greater understanding of the increasing need of individuals and the interventions that are likely to have the greatest impact on reducing admissions and costs. • Development of IT interoperability - The development the Hampshire Health Record to provide care plan interoperability is challenging. There is a lack of pan Hampshire alignment and shared vision which is impacting on progress. This has been escalated by the CCG and a meeting is scheduled shortly with CSU to discuss. Other delaying		

	factors are the achievement of a data extract from TPP (GP data) and from Paris (social care data). • Community Nursing - The community nursing service is reporting consistently very high levels of demand, which limits the responsiveness of the service. This is despite additional investment in staff resource and in the continence service to undertake routine reviews of patients, releasing community nurses for other duties. The position is being closely monitored through monthly performance review meetings and Solent are undertaking a detailed caseload audit to provide greater transparency.

Summary

Any proposed Changes/ Recommendations for consideration by CPB and HWBB	None at present
Priorities for forthcoming period	• Greater alignment of other adult and specialist services to cluster working. • Review of the Community Nursing specification and demand management strategies, with greater alignment to primary care teams. • Workforce development plans for "every contact counts" rolled out. • Agreed estates strategy and principles • Evaluation of Fragility fracture clinics • Proposals for the provision of falls exercise classes for 2016-17. • Community plans developed with each cluster and proposals for external grant funding supporting community and faith group delivery.

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Southampton City Better Care Partnership Agreement 2015/16

Quarterly Performance Report

Scheme	**INTEGRATED REHAB/REABLEMENT AND SUPPORTED DISCHARGE**
Host	**Southampton City CCG**
Report Author	**Jamie Schofield, Senior Commissioner ICU**
Reporting Period	**Q1 2015/16**
Report Date	**17 August 2015**

Overall Financial Performance

Annual value	£26.015m CCG = £23.882m SCC = £2.133m
Year to date budget	£6.504m
Year to date spend	£6.378m
Variance	-£0.126m
Reasons for Over/Underspends: SCC – Underspends on Brownhill and HDT which will recover by year end	
Actions being taken to address Over/Underspends: N/A	
Opportunities for Savings: This scheme includes the integrated Rehab and Reablement service proposal for which there is a separate Business Case outlining savings opportunities. The intention is to bring together health and social care community and bed based rehab and reablement (and ultimately discharge facilitation) services under a single management structure to create efficiencies and savings that can be reinvested in the integrated provision in order to deliver wider system savings. The efficiency savings of bringing the teams together are linked to streamlining of management structure, a reduction in bed based reablement (shifting more reablement activity to people's own homes) and some externalisation of dom care reablement onto the Dom Care Framework. The proposal is to reinvest a significant proportion of these efficiency savings to create additional capacity to deliver wider system change and in particular reduce hospital admissions and permanent admissions to residential and nursing homes There is an indicative net saving in the region of £825,380 linked to this scheme to be realised by 2020 if the proposals (currently going through Cabinet for approval to consult) are taken forward. This saving is against budgets that sit outside of this scheme, ie. residential and nursing home admissions, NEL admissions and excess bed days. **It should be noted that a decision is still to be made about the share of the benefits and risks between the CCG and SCC. This will need to be agreed by end November 2015 in time for the next Cabinet report in early 2016.** Cabinet approval to consult is expected 18 August.	
Predicted Cost Pressures: See individual lines in section below.	

Associated Contracts

Contract	Duration	Annual Value	Any Over/Under spend to date	Summary of Performance to date	Further Comments
Solent NHS Trust Block NHS Contract - Rehab/reablement services	1 year rolling contract	£4.7m	n/a block contract 0.229m cost pressure relating to 15/16 CCG QIPP saving on Rehab/Reable not being achieved due to slippage.	Ongoing issues around LOS and DTOC in RSH wards	
SCC Inhouse provision - rehab/reablement services (including previous S256s for Social Care Transfer, Reablement, Care Manager posts)		£1.033m	£0.4 m cost pressure relating to 15/16 SCC saving on Rehab/Reable not being achieved due to slippage.		
Southern Health Block NHS Contract - Adult and OP inpatient and Rehab services	1 year rolling contract	£13.545m	£0.043m overspend – being managed by CCG		Overspend is due to contract value increasing after signing of S75
EC09/01/1987 - JES Contract with Millbrook Healthcare	2013 – 2020	£1.6m	£0.06m underspend	Measures have been taken to reduce spend in year – further report to CPB due Sept 15	Predicted underspend at year end of c£100k
Disabilities Facilities Grant		£0.908m			SCC held capital grant
Social Capital Fund		£0.618m			SCC held capital grant
Wheelchair Contract with Millbrook Healthcare	5 years commencing Apr 2014	£0.216m	£121k cost pressure relating to high levels of demand	There are significant demand pressures on this contract relating to backlog activity	

Contract	Duration	Annual Value	Any Over/Under spend to date	Summary of Performance to date	Further Comments
				at point of contract transfer and ongoing referral rates. For SCCCG, this equates to £62,639 NR backlog clearance and £121,192 pa recurring uplift.	
Home Oxygen Contract with Dolby Vivisol	Regional contract coming up for re-tender				
Orthotics contract with Peacocks	No contract at present	£0.104m	n/a		

Overall Delivery

Original Aims and anticipated Outcomes	The following aims and anticipated outcomes related specifically to the integrated rehab and reablement proposal and the associated service redesign: • Economies of scale through shared management structures, reduced overhead costs and a reduction in duplication of functions and roles. • Focussing of spend on system need rather than agency need. • The development of a diverse holistic provision that aids person centred practice. • Single processes such as single assessment, lead professionals and shared recording and communication systems that support higher levels of consistency and reduce duplication. • Opportunities for the workforce to cross skill and develop wider knowledge and experience that supports them to deliver person centred care across agency boundaries. • Avoidance of duplication and unnecessary "hand offs" in the system. • Integrated patient pathways to improve timeliness and efficiency. • Improved accessibility through the development of single points of access, shared processes and 24/7 service delivery. • Improved coordination of hospital discharge processes through standardisation of approaches such as "Discharge to Assess", "Trusted Assessment" and "Early Supported Discharge".
Evidence of delivery against original aims and outcomes and how this supports overall BCF targets	• A joint City Council/Solent NHS transformation manager has been employed to implement the integrated rehab and reablement service • A Cabinet Paper has been produced requesting permission to consult with staff on Phase 1 of the project and with staff and the public on Phase 2. Cabinet decision expected 18 August 2015. • Provider services have developed a draft management structure that reduces the number of managers working across the newly integrated

	team. • Draft plans are underway to integrate systems reducing duplication including introducing a lead professional approach, integrated planning and recording, co-location and greater flexibility in the use of resources including administration weekly workshops. • A S75 legal partnership agreement for integrated provision is currently being drafted by SCC and Solent. • The integrated Rehabilitation and Reablement Service has direct links to the rest of the pathway at cluster level through the delivery of Community Rehabilitation, falls work, Risk Stratification, Supported Self Managing Planning, Integrated Person Centred Plans, expanding opportunities to "step up" into reablement with rapid response to crisis. All of these elements are currently within the design of the service. • There are both strategic and operational project boards with direct oversight of the programme collectively determining the service structure, outcome measures and legal framework.		
Performance Indicators	Indicator	Plan to date	Actual to date
	• To significantly reduce permanent admissions to residential and nursing homes	69	83
	• To increase the percentage of older people still at home 91 days post discharge into reablement services	Data still unavailable from SCC	Data still unavailable from SCC
	• To significantly reduce delayed transfers of care	2296	2727
	✓ To reduce avoidable emergency admissions	6953	6944
	• To reduce injuries due to falls	231	258
Summary of Risks and Issues & Mitigating actions	• Timescales for delivery of the integrated Rehab and Reablement service proposal and associated savings have slipped significantly and are dependent on Cabinet approval to consult (due 18 August) and the outcome of the consultation. Political sensitivities have the potential to result in further delay. • Savings attached to the project are primarily generated through reinvesting resources freed up through integrating management structures, reducing bed based reablement and externalising some domiciliary care to create the additional capacity needed to really impact on admissions to hospital, residential and nursing home care. There is the risk that, having reinvested these savings, the service fails to have the desired impact and these wider system savings are not realised. However, this will be mitigated through a phased approach to reinvestment with a robust monitoring framework for tracking the impact of investment. This will mean that investment in additional capacity will only be made where there is evidence that previous investment has achieved the outcomes to help deliver the long term		

	reductions. • Co-location would support the service to develop faster; there is a risk that both the estate and IT systems will not be available in the short term to facilitate this change. In mitigation there are other aspects of the programme that providers can and are working on to move the project forward.

Summary

Any proposed Changes/ Recommendations for consideration by CPB and HWBB	None
Priorities for forthcoming period	• Commence consultations for the integrated Rehab and Reablement proposals (subject to Cabinet decision) • Implement initial integration of the staff teams and processes under an integrated management structure (subject to outcome of consultation)

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Southampton City Better Care Partnership Agreement 2015/16

Quarterly Performance Report

Scheme	Supporting Carers
Host	Southampton City Council
Report Author	Sandy Jerrim, Senior Commissioner ICU
Reporting Period	Q1 2015/16
Report Date	17 August 2015

Overall Financial Performance

Annual value	£1.334m CCG = £600k Care Act contribution + £600k Carers contribution SCC = £134k Care packages
Year to date budget	£0.334m
Year to date spend	£0.332m
Variance	£0.002m
Reasons for Over/Underspends[1]: • Carer Training E Licence is only being paid every 3 years but Care Act funding is supporting a new Carer Assessment Service. Any underspend may be needed to support the new service (training, licences etc.)	
Actions being taken to address Over/Underspends: N/A	
Opportunities for Savings: • No savings anticipated at this stage of the developments.	
Predicted Cost Pressures: • The provision of carer assessments is expected to increase. The cost of providing carer assessments and related packages of support to both the carer and cared for is expected to place a cost pressure on the available resources. • These have been included in the forecast and currently not expected to generate any additional pressures.	

[1] For year one the Care Act implementation of £600,000 shall be a straight pass through cost regardless of Council spend. Any overspend in respect of the Care Act implementation shall be funded by the Council.
The £400,000 Financial Contribution by the CCG in relation to CHC respite for carers will be a fixed charge and billed as such. The CCG will be liable for any overspend and receive any underspend in relation to this.
Any remaining overspend/underspend will be incurred by the partners proportionate to their contributions to the pool

Associated Contracts

Contract	Duration	Annual Value	Any Over/Under spend to date	Summary of Performance to date	Further Comments
EC09/01/2160A – Carers Info Advice & Support Services – Adults	September 2014 – August 2017	£251k	n/a	232 carers are on CiS's database which is an increase of 114 from the previous quarter. The increase in number of carers 'reached' i.e. the number of people the service has been advertised to, spoken to or come into contact with is 874 (with a total of 3,684 since Sept '14). It doesn't include the numbers of when the service is on the radio, advertised through newspapers or website. The website has 1,436 visits by individuals (the IP address of the computer is recorded once so multiple visits by the same user are counted as 1).	CiS receive an additional: £17,000 from LDDF for a Family Link worker for people with LD; £1,412 per month for Carers Assessment co-ordination work; an additional sum which is dependent on the quantity and type of assessments they undertake.
EC09/01/2160B – Young Carers	September 2014 – August 2017	£91k	n/a	142 young carers are currently engaged with the young carer's service. This is a decrease from previous years due to a change in entry criteria in the 2014 contract: 2011 – 13 numbers were between 170 – 200 young carers. At the last monitoring meeting (21/07) it was agreed the project would accept young carers with moderate needs to bring engagement up to capacity.	SVS have committed to additionally spending £69,000 over 3 years to employ a Volunteer Officer to recruit, train and support volunteers for the project; there are presently 19 volunteers of which 5 are befrienders.
CHC respite for carers (part of CCG Carers contribution)	Ongoing	£400k	n/a		
Care Act contribution to Carers implementation	Ongoing	£600k	n/a	New Carer Assessment service commenced 1st June with soft launch. New online tool will be ready 1st September.	Ongoing discussions about parent carer assessments which are a potential cost pressure
Vitalise	Ongoing	£7,700	£0		Will be subject to a wider review of respite services in 2015-16
Carers Week	Ongoing	£11,000	£0	Includes funding for E-Licences	
Carer Strategy	Ongoing	£3,600	£0	Series of events have taken place, with engagement of a range of key stakeholders	

Overall Delivery

Original Aims and anticipated Outcomes	• To identify a significant number of Adult and Young Carers and provide them with relevant, accessible and meaningful information and advice. • To provide access for Carers to proportionate assessment and support services in their local communities. • To involve Carers in service planning and development. • To provide Carers with choice and control though personal budgets and direct payments. • To support Carers to remain healthy and maintain their own wellbeing both physically and mentally.		
Evidence of delivery against original aims and outcomes and how this supports overall BCF targets	• New carer assessment service developed within the universal carer information and advice service, supporting access to a proportionate assessment and support in local communities. • Inviting up to 3 carers to become carer representatives on the Carer Assessment partnership group. In addition, providers are also represented on the Carer Assessment partnership group, enabling an engaged and informed development around the new service • Few carers take up the offer of direct payments. This will be addressed as the service is developed. Currently developing appropriate support groups, pathways and information for carers about taking direct payments.		

Performance Indicators	<u>Indicator</u>
	• Number of adult and young carers identified
	• Number of adult and young carers provided with assessment
	• Number of adult and young cares with an appropriate support plan (all carers not just eligible carers)
	• Number of carers accessing support
	  ○ From local community
	  ○ Through packages of care.
	  ○ Through other commissioned services (e.g mental health services)
	• Number of carers accessing direct payments
		<u>Plan to date</u>
		
		See table below
			<u>Actual to date</u>
			
			See table below

Summary of Risks and Issues & Mitigating actions	Take up of carer assessments remains low reflecting the developmental nature of the service. Once fully active we anticipate an increase in referrals as agencies inform their networks of carers about the service. Close working with providers is mitigating any sudden demand for carer assessments.		

	Actual numbers			Planned numbers	
	Adult carers		Young carers	Adult carers	Young carers
Number of adult and young carers identified			Over 200 identified but only 142 provided with a service – please see above.		Service provided to 200 young carers
	Total	last Quarter		Spec Target	
Learning Disability	200	68		250	
Physical Disability					
Sensory Impairment					
Acquiried Brain Injury	10	7			
Substance Misuse	136	60		150	
Mental Health					
Older Adults	96	56		250	
Eastern European	24	18			
Black, Ethinic Minority	53	34		60	
End of Life					
Health Issues	38	35			
Number of adult and young carers provided with assessment	61 referrals received with 16 assessments completed		0	*Please see Section 13 of the Carers Assessment Service Specification below.	0
Number of adult and young cares with an appropriate support plan (all carers not just eligible carers)	1		All have completed an Outcomes Star which also plans how they are going to meet their objectives.		0
Number of carers accessing support, through their support plan, from					
local community	1		0		0
financial packages	0 (7 packages have been allocated through the RAS)		0		0
other commissioned services (e.g mental health services)	0		0		0
Number of carers accessing direct payments	0		0		0

Service volumes

In preparing for the Care Act a local modelling exercise was undertaken. This identified that there could be an additional 1800 requests for a carer assessment. The modelling also proposes that around 230 of those assessed will be eligible for support from the Local Authority. SCC has undertaken 250 - 300 carer assessments in 2014-2015. This demand will start to move to the Carer's Assessment Service during 2015-2016. This will include new requests for carer assessments made to SCC as well as scheduled annual carer reviews.

In the absence of any quantifiable demand provider(s) need to provide a flexible and adaptable method for meeting a varied and potentially intermittent level of demand. The first year will be used to establish demand and patterns of demand.

Summary

Any proposed Changes/ Recommendations for consideration by CPB and HWBB	None
Priorities for forthcoming period	Development of Carer Assessment Service.

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