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Health and Wellbeing Board

Wednesday, 30th November, 2016
at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Lewzey
Councillor Payne
Councillor Paffey
Councillor Shields (Chair)
Councillor Taggart

Rob Kurn – Healthwatch
Hilary Brooks – Interim Service Director, Children and Families Services
Paul Juan – Acting Service Director, Adults, Housing and Communities
Dr B Coates – Acting Director of Public Health
Dr S Robinson – Clinical Commissioning Group
Dr J Duffy – NHS England Wessex Local Area Team

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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

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

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

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.

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. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.

Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.

Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Dates of Meetings: Municipal Year 2016/17

2016	2017
27 July	25 January
28 September	29 March
30 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

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 28th September 2016 and to deal with any matters arising, attached.

5 CAMHS TRANSFORMATION PLAN

Report of the Director of Quality and Integration updating on the progression of Child and Adolescent Mental Health Services Transformation Plan, attached.

6 0-19 PREVENTION AND EARLY HELP

Report of the Director of Children and Family Services updating on the development of 0-19 Prevention and Early Help, attached.

7 BETTER CARE FUND UPDATE

Report of the Director of Quality and Integration providing an update on the Better Care Fund, attached.

8 SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH TRANSFORMING CARE PARTNERSHIP PLAN UPDATE

Report of the Director of Quality and Integration updating on the development of plans to improve services for people with learning disabilities, attached.

9 DRAFT ALCOHOL STRATEGY

Report of the Interim Director of Public Health proposing a draft Alcohol Strategy for the City, attached.

10 PRIMARY CARE MODEL REVIEW

Report of the Director of Quality and Integration relating to the delivery of Primary Care locally, attached.

Tuesday, 22 November 2016 Service Director, Legal and Governance

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 28 SEPTEMBER 2016

Present: Councillors Lewzey, Payne and Shields (Chair)
Dr Sue Robinson, Bob Coates, Rob Kurn, Paul Juan and Dr John Duffy

Apologies: Councillors Dr Paffey and Taggart.
Kim Drake

10. **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 determinations 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 determinations of items on the agenda.

Councillor Payne 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 determinations of items on the agenda.

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

RESOLVED: that the minutes of the meeting held on 23rd March 2016 be approved and signed as a correct record.

Matters Arising – Minute 5 – Mental Health and Suicide Prevention Update
The Committee noted that a Mental Health Conference jointly run by Southampton City Council and Hampshire County Council had taken place which had been very well received with 130 delegates in attendance. The Committee noted that the national organisation “Time to Change” had also attended the conference and commitment had been made for Southampton City Council to work with them.

The Committee also noted that World Mental Health Day was 10th October 2016 and events were being organised to mark the day.

12. **HEALTHWATCH ANNUAL REPORT 2015/16**

The Committee received and noted the Healthwatch Annual Report for 2015/16 together with the Strategic Priorities set for 2016/17. In particular the Committee noted the success and continuing work with GP registration barriers which culminated in the BME and CCG re-issuing guidance which enabled patients to register with a GP who did not have correct identification methods. Other successes included resources into community engagement and the securing of a 2 year extension on the Healthwatch contract to work in the City despite a 10% reduction in funding.

The Committee noted that priorities for 2016/17 included social care, mental health services and maintaining a focus on primary care. Next steps in delivering the priorities would be the development and delivery of work plans.

The Committee also received a demonstration of the online Healthwatch Southampton Public Feedback Centre which went live at the end of August 2016 and would receive a high profile launch in November. It was noted that anyone in the City could leave feedback, ratings and a review. The system also afforded providers to respond to reviews and provided the ability to categorise data, track and identify trend analysis.

13. CHILDREN AND YOUNG PEOPLE STRATEGY

The Committee noted that this item had been withdrawn from the meeting due to staff sickness. It was noted that the strategy would be circulated electronically to Board Members for comment as part of the consultation process ahead of the forthcoming Cabinet decision.

14. SUSTAINABILITY AND TRANSFORMATION PLAN 2016

The Committee considered the report of the Chief Officer, Southampton City Clinical Commissioning Group (CCG) outlining the aim of the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP).

John Richards, Chief Officer, Southampton CCG reported that NHS England had issued further guidance within the last week which indicated that operating models and contracts would need to be in place by Christmas 2016 which provided conflict with the original consultation process. For Hampshire and the Isle of Wight it was noted that proposals were not controversial and there had been reasonable local engagement and involvement across sectors.

It was noted that the recently published guidance provided some indication that financial pressures/deficits were likely to remain in the next financial year and as such locally there was a notion that a “local change fund” may be of benefit given past experience therefore there was a need for potential conversations around shared priorities, mitigation of risk within systems and providing significant change.

The Committee noted that the STP’s current position was that of draft and would not be available for circulation for another week. Key milestones over the forthcoming month were noted which included an informal H&WBB to consider the draft plan on 12th October, Full Council consideration of the plan on 19th October with submission to NHS England by 21st October 2016.

RESOLVED:

(i) that the proposal to form a joint committee of the four Health and Wellbeing Boards across Hampshire and the Isle of Wight to provide strategic governance and oversight of the STP and to ensure the principle of subsidiarity was maintained be supported;

(ii) that draft terms of reference for the proposed joint committee as detailed above be submitted to the Board for consideration and ratification;

(iii) that the Board make a clear commitment to debate specific issues from the STP in due course, in public and in line with public consultation requirements and good governance; and

(iv) that authority be delegated to the Chair of the Health and Wellbeing Board to approve the final version of the STP to be submitted by 21st October 2016 following discussions at informal Health and Wellbeing Board on 12th October and Full Council on 19th October 2016.

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DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		CAMHS Transformation Plan		
DATE OF DECISION:		30th November 2016		
REPORT OF:		CAMHS Transformation Plan		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Katy Bartolomeo**	**Tel:**	**02380 834162**
	E-mail:	**Katy.bartolomeo@southampton.gov.uk**		
Director	**Name:**	**Stephanie Ramsey**	**Tel:**	
	E-mail:	**Stephanie.ramsey@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

Following the publication of Southampton's CAMHS Transformation plan in 2015 the plan has been refreshed to provide a shorter summary document and to reflect changes in line with the outcomes from the Mental Health Matters review.

The attached CAMHS Transformation Plan should be read in conjunction with the Mental Health Matters consultation feedback and the Integrated Commissioning Units Transforming mental health care and services for the residents of Southampton which outlines all of the national and local targets for mental health.

The CAMHS Transformation Plan, consultation feedback and transforming mental health services document will be published on the CCG mental health matters website page and will be regularly updated to provide updates to the mental health matters project.

RECOMMENDATIONS:

(i) Review CAMHS Transformation Plan and support the identified priorities and plan.

REASONS FOR REPORT RECOMMENDATIONS

1. The CAMHS transformation plan has been written following national recommendations and targets and extensive engagement and consultation in Southampton with young people, parents and carers and key stakeholders

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. Mental Health Matters engagement (Autumn 2015) and consultation (February May 2016)

RESOURCE IMPLICATIONS

Capital/Revenue

4. Investment in CAMHS Transformation as outlined in the attached document.

Property/Other

5. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

6. NHS England requirement for HWBB sign off of the CAMHS Transformatio Plans

Other Legal Implications:

7. None

POLICY FRAMEWORK IMPLICATIONS

8. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	CAMHS Transformation Plan update
2.	Mental Health Matters consultation feedback
3.	ICU Transforming mental health care and services
4	Equality Impact Assessment

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	

Operational Plan and FYFV- MH | Targets | Funding FYFV-MH CCG baselines

Num	Area	Target	2016/17	17/18	18/19	19/20	20/21		16/17	17/18	18/19	19/20	20/21
1	CAMHS	CYP in treatment	Baseline		32%			Total	£ 555,034	£ 652,981	£ 792,906	£ 886,189	£ 998,128
								Increase	£ 555,034	£ 97,947	£ 139,925	£ 93,283	£ 111,940
2	CAMHS	YP IAPT	No	2018	Yes			Total	As above	As above	As above	As above	As above
								Increase					
3	CAMHS	Eating Disorder - 4 weeks routine, 1 week urgent	Baseline	95%				Total	£ 140,000	£ 140,000	£ 140,000	£ 140,000	£ 140,000
								Increase	£ 140,000	£ -	£ -	£ -	£ -
4	CAMHS/AMH	EIP	50%	50%	53%	56%	60%	Total		£ 48,780	£ 88,780	£ 139,925	£ 326,491
								Increase	£ -	£ 48,780	£ 40,000	£ 51,145	£ 186,566
4.1	CAMHS/AMH	EIP - NICE grades	Baseline	Level 2	Level 3	Level 3	Level 3	Total		As above	As above	As above	As above
								Increase					
5	AMH	Perinatal						Total				£ 342,815	£ 457,087
								Increase				£ 342,815	£ 114,272
6	AMH	Individual Placement Support - increase		Baseline	25% increase	60%	100%	Total					
								Increase					
7	AMH	CRHT - NICE concordant						Total		£ 189,268	£ 396,097	£ 652,981	£ 680,966
								Increase		£ 189,268	£ 206,829	£ 256,884	£ 27,985
8	AMH	SMI having physical health check						Total		£ 180,488	£ 364,878	£ 387,124	£ 387,124
								Increase		£ 180,488	£ 184,390	£ 22,246	£ -
9	AMH	Armed forces						Total	£ 23,321	£ 23,321	£ 23,321	£ 23,321	£ 23,321
								Increase	£ 23,321	£ -	£ -	£ -	£ -
10	AMH/OPMH	IAPT - Access	15%	17%	19%	22%	25%	Total			£ 707,000	£ 1,086,747	£ 1,436,558
								Increase			£ 707,000	£ 379,747	£ 349,811
11	AMH/OPMH	Increase baseline spend on mental health						Total					
								Increase					
12	AMH/OPMH	Eliminate out of area Acute and PICU					0	Total					
								Increase					
13	AMH/OPMH	Secure pathway						Total					£ 270,521
								Increase					£ 270,521
14	OPMH	Dementia	66%	66%				Total					
								Increase					
14	OPMH	Dementia post diagnostic care and support						Total					
								Increase					
15	All	Suicide prevention	baseline	10% less				Total			£ 23,321	£ 46,642	£ 46,642
								Increase			£ 23,321	£ 23,321	£ -
16	All	Psychiatric Liaison					24/7			As 7	As 7	As 7	As 7
								Total					
								Total	£ 718,355	£ 1,234,838	£ 2,536,302	£ 3,705,743	£ 4,766,837
								Total yearly increase	£ 718,355	£ 516,483	£ 1,301,464	£ 1,169,441	£ 1,061,094
								Total yearly increase excluding *	£ 695,034	£ 516,483	£ 1,301,464	£ 826,626	£ 676,302
									16/17	17/18	18/19	19/20	20/21

Operational Plan
FYFV-MH

* Secure pathway, armed forces, perinatal

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Southampton City Integrated Commissioning Unit (ICU) - Transforming mental health care and services for the residents of Southampton City

We told you in our recent mental health consultation report how you have helped us to shape mental health care and services in the city, and we told you that we would keep you updated on our progress, this document provides the first update as at November 2016.

NHS Southampton City Clinical Commissioning Group

SOUTHAMPTON CITY COUNCIL

Programme Number	Programme Area	Transformation Programme Target (definition where available)	Target Source*				FYFV-MH Investment	Target by Financial Year					Commissioner Outcomes and Performance Indicators	November 2016 - Overall Delivery Confidence (RAG status)
			MHM	FYFV-MH	LTP	OP		2016/17	2017/18	2018/19	2019/20	2020/21		
1	CAMHS	**Increase number of CYP in treatment** (% of CYP with a diagnosable MH condition receiving treatment from an NHS-funded community MH service) (baseline 2014/15 prevalence, to be reviewed 2018)	✓	✓		✓	Yes	28%	30%	32%	34%	35%	1. Number of new CYP aged 0-18 receiving treatment from NHS funded community services 2. Number of 'individual' CYP aged 0-18 receiving treatment from NHS funded community services	G
2	CAMHS	**Develop YP IAPT** (services working within CYP IAPT programme)	✓	✓		✓	Yes			YP IAPT service in place			1. CYP IAPT workforce capability programme, staff released for training 2. Staff accreditation status	G
3	CAMHS	**Evidenced-based community eating disorder services for CYP** (% of CYP receiving treatment within 4 weeks routine, 1 week urgent)		✓		✓	Yes	baseline	local trajectory	local trajectory	local trajectory	95%	1. Number of CYP (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral 2. Number of CYP (urgent cases) referred with a suspected ED that start treatment within 1 week of referral 3. Membership of national quality improvement and accreditation network for community ED that will monitor improvements and demonstrate quality of service delivery	G
4	CAMHS	**Develop services and support to access early intervention and prevention**	✓		✓		Yes						1. Continue to develop workforce model 2. Develop service specification 3. Development of service performance indicators, and outcomes measures	G
5	CAMHS	**Reduce waiting times for CAMHS services** (waiting time standard for routine access)	✓		✓		Yes	18 weeks	16 weeks	12 weeks	10 weeks	7 weeks	1. Average length of time from referral to assessment/treatment for routine access 2. Maximum length of time from referral to assessment/treatment for routine access 3. Action plan in place to address non-compliance with wait time trajectory, including regular review and updates 4. Detail of any CYP was waited in excess of 18 weeks 5. Develop measures to monitor secondary waits	G
6	CAMHS	**Improved access to crisis services which are appropriate for CYP**			✓		Yes						Work to commence summer 2017 1. Identification of services that are appropriate for CYP 2. Include CYP section to Mental Health Crisis Care Concordat 3. Development of service performance indicators, and outcome measures	N
7	CAMHS/AMH	**Develop a 0-25 years' transition service**			✓								Work to commence spring 2017 1. Plan and deliver pathway development workshop 2. Establish and test assumption for demand and capacity 3. Development of service specification 4. Development of service performance indicators, and outcome measures 5. Implementation plan	N
8	CAMHS/AMH	**Develop developmental disorders pathway for CYP and adults**	✓		✓								Work to commence winter 2016 1. Plan and deliver pathway development workshop 2. Establish and test assumption for demand and capacity 3. Development of service specification 4. Development of service performance indicators, and outcome measures 5. Implementation plan	G
9	CAMHS/AMH	**Early Intervention in Psychosis (EIP)** (% of people receiving treatment within 2 weeks)		✓		✓	Yes	50%	50%	53%	56%	60%	1. Number of people experiencing a first episode of psychosis start treatment within 2 weeks of referral with a NICE recommended package of care	G
10	CAMHS/AMH	**Early Intervention in Psychosis (EIP)** (specialist EIP provision in line with NICE recommendations)		✓		✓	Yes	Baseline	Graded at level 2	Graded at level 3	Graded at level 3	Graded at level 3	1. CCQI provider self-assessment rating of 'good' (graded level 3) by 2018/19 across all domains	
11	AMH	**Perinatal mental health services** (increase to baseline of woman accessing evidence-based specialist perinatal mental health treatment)		✓			NHS England						1. Continue to work with NHS England and local community providers to develop a comprehensive service	N
12	AMH	**Increase the number of people accessing individual placement support (IPS)** (increase the number of people accessing IPS)	✓	✓				Baseline audit of IPS provision	STP areas selected for targeted funding	25% increase in access	60% increase in access	100% increase in access	Work to commence spring 2017 1. Evaluate impact of employment advisors embedded into each of the three Community Mental Health Team (CMHT) 2. NHSE national baseline audit for IPS services completion in Q3/4 2016 3. Plan developed to improve access to IPS employment support for people with SMI 4. If invited, bid for transformation funding in autumn 2017, submission December 2017	N
13	AMH	**Crisis pathways**	✓	✓			Yes	Review					FYFV-MH	

Programme Number	Programme Area	Transformation Programme Target (definition where available)	Target Source*				FYFV-MH Investment	Target by Financial Year					Commissioner Outcomes and Performance Indicators	November 2016 - Overall Delivery Confidence (RAG status)
			MHM	FYFV-MH	LTP	OP		2016/17	2017/18	2018/19	2019/20	2020/21		
		(crisis resolution and home treatment teams, effective and properly resourced service models delivering best practice standards as described in the CORE fidelity criteria)						current provision against CORE					1. CCQI provider self-assessment tool completion 2. Plans in place to address gaps identified MHM 1. Continue pathway development work (inc. 'Arrivals and discharge lounge' & s136) 2. Establish and test assumption for demand and capacity 3. Development of service specification 4. Development of service performance indicators, and outcome measures 5. Implementation plan	G
14	AMH	**Physical health checks for people with severe mental illness (SMI)** (% of people on SMI register who receive NICE-recommended screening and access to physical care interventions)		✓			Yes		30%	60%			Work to commence spring 2017 1. Review QOF planning guidance for 2017/18 when released 2. Co-produce an improvement action plan with primary care and mental health secondary care providers to increase uptake of routine screening initiative to equivalent or greater than the general population national average 3. Implementation of action plan 4. Comparison of screening rates of SMI register to general population national average	N
15	AMH	**Develop services and support to access early intervention and prevention**	✓										Work to commence spring 2017 1. Plan and deliver pathway development workshop 2. Establish and test assumption for demand and capacity including evaluating existing projects 3. Development of service specification 4. Development of service performance indicators, and outcome measures 5. Implementation plan	N
16	AMH/OPMH	**Increase access to psychological therapies (IAPT)** (% of people with common MH conditions accessing psychological therapies each year)		✓		✓	Yes	15%	17%	19%	22%	25%	1. Workforce planning, number of therapists needed and training places secured 2. Number of people receiving treatment 3. Number of therapists co-located in general practice (as per NHSE planning guidance)	G
17	AMH	**Develop Personality Disorder pathways**	✓										Work to commence winter 2017 1. Plan and deliver pathway development workshop 2. Establish and test assumption for demand and capacity 3. Development of service specification 4. Development of service performance indicators, and outcome measures 5. Implementation plan	G
18	AMH	**Redesign rehabilitation pathway**	✓										Work to commence winter 2016 1. Complete service review, including options appraisal 2. Engagement and consultation with stakeholders, including; service users, experts by experience, carers, clinicians and voluntary sector organisations 3. Development of service specification 4. Development of service performance indicators, and outcome measures 5. Implementation plan	N
19	AMH/OPMH	**Eliminate (inappropriate) use of acute out of area (OOA) placements** (number of patients in acute OOA placements)	✓	✓		✓						Zero	1. Data collection and monitoring of adult mental health OOA placements including bed type, placement provider, placement reason, duration and cost	N
20	AMH/OPMH	**Secure care pathway**		✓									Work to commence summer 2017	N
21	OPMH	**Dementia diagnosis rate** (% of prevalence with diagnosis of dementia +65 years)		✓				66.7%	66.7%				1. Number of people diagnosed (65+) 2. Referral to treatment times	G
22	OPMH	**Dementia post diagnostic care and support**		✓									1. CCQI provider self-assessment tool completion 2. Number of care plan reviews undertaken in primary care using QOF data	N
23	All	**Suicide prevention** (reduction of 10% from baseline by 2020/21)		✓		✓		Baseline				10% reduction	1. Local multi-agency suicide prevention plan, following the latest evidence and PHE guidance completed 2. Published suicide rates, using ONS statistics	G
24	All	**Mental Health Liaison** (acute hospitals with an all-age service achieving 'Core 24' service standard)	✓	✓		✓	Yes						1. Completion of annual workforce survey to monitor compliance with workforce elements of the 'core 24' standard 2. Access and waiting times monitored through CCQI	N

RAG status definitions - overall delivery confidence	
Successful delivery of the programme appears to be unachievable. There are major issues on the programme definition, schedule, budget required, quality or benefits delivery, which at this stage do not appear to be manageable or resolvable. The programme may need re-basing and/or overall viability re-assessed	R
Successful delivery appears feasible but significant issues already exist, requiring management attention. These appear resolvable at this stage and if addressed promptly, should not present a cost/schedule overrun	A

Programme Number	Programme Area	Transformation Programme Target (definition where available)	Target Source*				FYFV-MH Investment	Target by Financial Year					Commissioner Outcomes and Performance Indicators	November 2016 - Overall Delivery Confidence (RAG status)
			MHM	FYFV-MH	LTP	OP		2016/17	2017/18	2018/19	2019/20	2020/21		

Successful delivery of the programme to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten deliver significantly	G
Programme is delivered	C
Programme of work not yet started	N

Glossary of unfamiliar words, abbreviations and further information
Adult mental health (AMH) - service for adults aged 18-65
Child and adolescent mental health services (CAMHS) - service for children and young people under the age of 18 who experience a mental health problem
Children and young people (CYP)
Developmental disorders - includes ADHD, high functioning autism and Asperger's
Five Year Forward View for Mental Health (*FYFV-MH) - An independent report of the Mental Health Taskforce set out the start of a ten year journey for transformation, the report made a set of recommendations for NHS bodies to achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people. It also set out recommendations where wider action is needed, for example, as well as access to good quality mental health care wherever they are seen in the NHS, people want a decent place to live, a job or good quality relationships in their local communities. Finally, the report places focus on tackling inequalities. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. The recommendations of the Five Year Forward View for Mental Health have been accepted by the NHS, and plans for their delivery over the coming years to 2020/21 are consistent with Southampton Mental Health Matters plans
Individual placement support (IPS) provides help to people with mental illness find and keep competitive employment
Local Transformation Plans for Children and Young People's Mental Health and Wellbeing (*LTP) - The document provides guidance for local areas - CCGs, working closely with their Health and Wellbeing Boards and partners from across the NHS (including NHS England Specialised Commissioning), Public Health, Local Authority, Youth Justice and Education sectors to support improvements in children and young people's mental health and wellbeing. The guidance should be read alongside Future in Mind (a report of the Children and Young People's Mental Health Taskforce Future in Mind, jointly chaired by NHS England and the Department of Health establishes a clear direction and some key principles about how to make it easier for children and young people to access high). quality mental health care when they need it
Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis
Mental Health Matters (*MHM) - A Mental Health Matters event took place in late 2014 which sought to hear the views of stakeholders in relation to mental health services and support in the city. The main feedback from this event was that people wanted an opportunity to be part of the review of mental health provision, and have a 'blank page' approach. This was followed by an engagement period during the Autumn of 2015 on the Mental Health Matters initiative that informed and contributed to the development of the proposals for the future of all age mental health services in the city. The next step was to undertake a period of public consultation, which ran from 5th February 2016 to 2nd May 2016. The proposals set out in the consultation were developed following feedback from service users, carers, GPs and other interested parties as a result of the engagement work during the Autumn 2015
NHS Operational Planning and Contracting Guidance 2017 – 2019 (*OP) - NHS England and NHS Improvement publish operational and contracting planning guidance that provides local NHS organisations with an update on the national priorities. The plan sets out the requirement for local areas to develop plans to deliver in full the implementation plan for the FYFV-MH and summarises the key deliverables for mental health transformation
Older persons mental health (OPMH) - service for older adults aged over 65
Perinatal mental health services provide support for women who are at risk of developing mental health problems during pregnancy and the first year post pregnancy, as well as those considering becoming pregnant
RAG status reporting is used when project managers are asked to indicate, how well a project is doing using the series traffic lights. A red traffic light indicates problems, amber then everything is okay, and green things are going well
The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. It rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services
The RCPsych College Centre for Quality Improvement (CCQI) aims to raise the standard of care that people with emotional or mental health needs receive by helping providers, users and commissioners of services to assess and increase the quality of care they provide. More than 90% of Trusts in the UK who provide mental health services participate in the work of the CCQI

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SOUTHAMPTON CITY COUNCIL

NHS Southampton City Clinical Commissioning Group

Mental Health Matters

Consultation Feedback and Analysis

August 2016

Contents

Time to Change – ending mental health discrimination
The NHS and the Council in Southampton support Time to Change, a national campaign led by Mind and Rethink aimed at ending the discrimination faced by people who experience mental health problems. For more information, please visit www.time-to-change.org.uk

1. Executive summary

A Mental Health Matters event took place in late 2014 which sought to hear the views of stakeholders in relation to mental health services and support in the city. The main feedback from this event was that people wanted an opportunity to be part of the review of mental health provision, and have a 'blank page' approach.

This was followed by an engagement period during the Autumn of 2015 on the Mental Health Matters initiative that informed and contributed to the development of the proposals for the future of all age mental health services in the city.

The next step was to undertake a period of public consultation, which ran from 5th February 2016 to 2nd May 2016. The proposals set out in the consultation were developed following feedback from service users, carers, GPs and other interested parties as a result of the engagement work during the Autumn 2015.

A wide variety of communication methods and networks were used in order that the Mental Health Matters consultation reached as wide an audience as possible within the city, details of these have been provided in Appendix 1.

In addition to these activities, feedback was actively sought via the NHS Southampton City CCG website, Southampton City Council website news, Healthy Southampton social media and e-bulletin, email correspondence, online surveys, attendance at existing forums and face to face interviews.

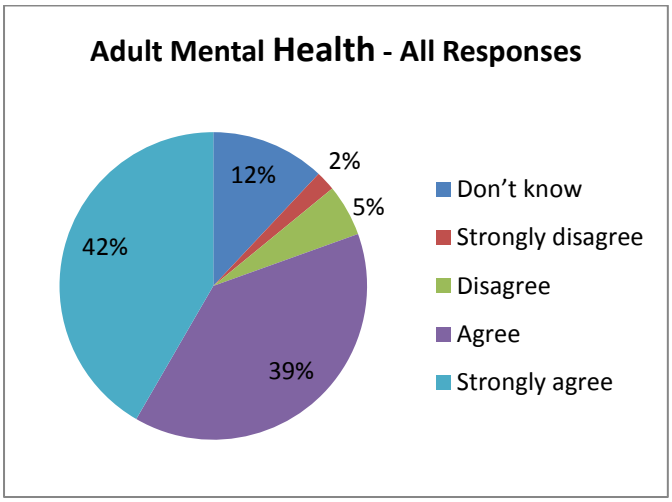
During the consultation period, a number of forums and settings were attended. The Mental Health Matters webpage was visited 1,852 times and the engagement document being viewed 568 times. Service user and carer feedback represented 56% of feedback received from the online survey and paper copy questionnaires completed.

The consultation report presents a summary of the responses received, and feedback was clear. The majority of stakeholders, and via all means of communication, indicated that they agreed with the proposals and a new model of care for Southampton.

It should also be acknowledged that a proportion of responses indicated that they 'don't know' to a small number of the consultation proposals, 'some resources should be shifted from secondary care mental health services', 'the proposals will improve services' and 'the proposals focus on the right things'. Additional comments received suggested that people did not feel they had enough information in order to make an informed choice.

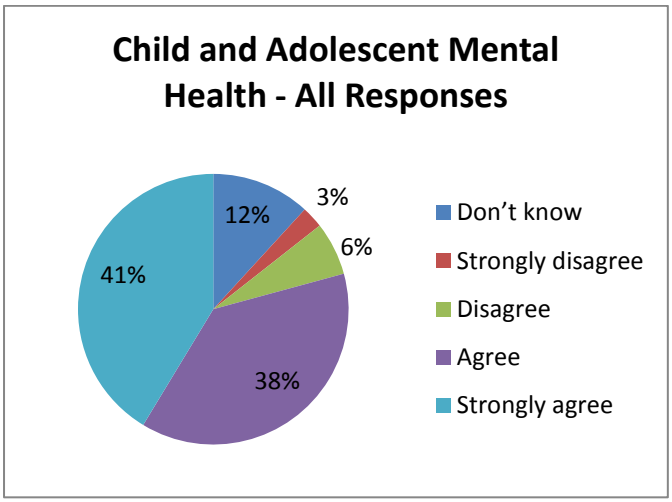
The charts on the next page provide an overall summary of the responses that we received to all of the proposals set out in the consultation document. This has been broken down into the three different areas; adult mental health, child and adolescent mental health, and child and adolescent mental health adapted survey.

Do you agree with the proposals set out for adult mental health services

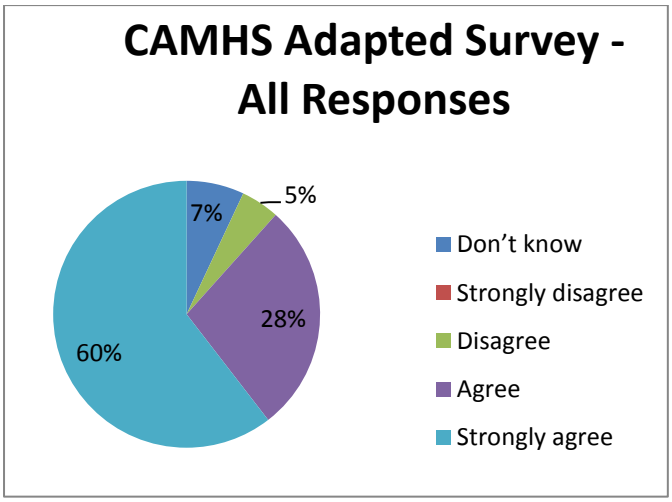


- **strongly agree or agree** to the proposals 81%
- **strongly disagree or disagree** to the proposals 7%
- **don't know** 12%

Do you agree with the proposals set out for child and adolescent mental health services



- **strongly agree or agree** to the proposals 79%
- **strongly disagree or disagree** to the proposals 9%
- **don't know** 12%



- **strongly agree or agree** to the proposals 88%
- **strongly disagree or disagree** to the proposals 5%
- **don't know** 7%

2. Introduction

This report outlines the methods used to capture feedback and presents the results of the feedback received following the period of consultation completed by the Integrated Commissioning Unit (ICU) on behalf of NHS Southampton City Clinical Commissioning Group (CCG) and Southampton City Council (SCC). With notable thanks to stakeholders who assisted with service user engagement.

Mental Health Matters, the initiative that sets out proposals for the future of all age mental health services in the city, detailed how service users, experts by experience, carers, clinicians, voluntary sector organisations could help us to redesign services, by taking a 'blank page' approach to care pathways.

The public consultation ran from 5th February 2016 to 2nd May 2016, the proposals set out in the consultation were developed using feedback received from the engagement that was undertaken during the Autumn 2015.

Although all were considered, it does not report on every comment received and in the interests of being concise and focussed it reduces the significant amounts of repetition of comparable comments into summary form. Therefore the length of any given section should not be used as a measure of the volume or strength of the views expressed.

It is assumed that the reader has read and understood the proposals in the consultation document Mental Health Matters (available at http://southamptoncityccg.nhs.uk/news/mental-health-matters-in-southampton-help-shape-future-services--770/)

3. Consultation methods

A wide variety of communication methods and networks were used in order that the Mental Health Matters public consultation reached as wide an audience as possible within the city, details of these have been provided in Appendix 1.

In addition to these activities, feedback was actively sought via the NHS Southampton City CCG website, Southampton City Council website news, Healthy Southampton social media and e-bulletin, email correspondence, online surveys, attendance at existing forums and face to face interviews.

The Autumn 2015 engagement identified a lower response rate from SO18 postcode areas within the east of the city, and mainly within cluster 6 (Bitterne park, Harefield and Bitterne), it recommended that additional focus was necessary during the consultation to ensure that residents from these areas have an opportunity to provide feedback. The additional focus resulted in an increase from 3% to 12% from SO18 postcode areas of those responding to the consultation.

Additionally further work was recommended from the engagement analysis and report to ensure that the consultation phase reaches a wider representation from black and minority ethnic (BME) communities. As a result, there was a BME engagement plan in place to raise awareness of the consultation ensuring that people were aware of the consultation, and had an opportunity to share their views on the proposals. This resulted in an increase to the response rate from 9.6% to 11.9% from BME communities.

The consultation facilitated a bespoke and targeted approach to reach the following groups:

- Users of children and adolescent mental health services in Southampton (CAMHS)
- Users of adult mental health services in Southampton
- Carers supporting people who use mental health services in Southampton
- Community and voluntary organisations
- Members of the Southampton Equality and Diversity Group
- Members of the Black and Minority Ethnic (BME) communities and their representatives
- GPs across the city
- Current service providers, both managers and clinicians/practitioners
- Allied services and domains including staff from
    - acute hospitals and the urgent care commissioners and clinicians including A&E
    - the criminal justice system (police and probation services)
    - substance misuse services
    - homelessness services
    - learning disability services
    - housing services – inducing supporting people providers
    - employment support agencies
    - student health services
    - schools and education

- Southampton Health and Wellbeing Board, including elected members
- Southampton Local Safeguarding Adult Board
- Southampton Local Safeguarding Children Board

Notes were taken at each forum / setting attended; these were returned to a central point for collation and analysis.

In addition to the above, an online survey was established inviting responses to the questions set out in Mental Health Matters. For those who could not access the online survey, hard copy, paper-based surveys were widely circulated, a copy is provided in Appendix 5. Details of how people could respond were also widely circulated in the consultation literature.

An adapted and simplified version of the online survey was produced by No Limits to facilitate engagement with young people.

The breakdown of responses from all these activities is as follows.

Activity
Mental Health Matters page on the CCG Website visited 1,852 times the engagement document was viewed 568 times, and the published frequently asked questions page was viewed 50 times
Social Media posts throughout the engagement period, messages were seen 16,325 times, this excludes the reach of any retweets or shares

Activity	
Number of forums /settings attended	9
Online surveys completed	120
Hard copy questionnaires completed	54
Online survey adapted for young people completed	43
Emails with feedback received	11
Telephone feedback received	2
Letter feedback received	1

During the consultation period a frequently asked question section was added to NHS Southampton City CCG website, and this was updated regularly. A copy of the questions and responses is provided in Appendix 3.

A mid consultation meeting took place involving the Head of Stakeholder Relations and Engagement in order to review progress, and to consider if any changes were needed to the consultation methods.

Full analysis was undertaken after the completion of the consultation period, the results of the feedback is captured in the next section of this report.

4. Consultation feedback and analysis

The consultation looked to receive feedback and comments on the proposals for the future of adult mental health, and child and adolescent mental health services.

Against each proposal, people had an opportunity to say if they;

- strongly agree
- agree
- disagree
- strongly disagree, or
- didn't know

Adult mental health proposals

- Mental health services should be aligned to Better Care Southampton clusters, and should be provided closer to my home in a local setting within the cluster
- There should be more services that support me outside of secondary care mental health services, such as in primary care or in ordinary community services
- Community navigators should be developed in all settings to help me access a range of services that will allow me to maintain my own health and wellbeing
- There should be improved access to local community resources, including the development of more peer support groups, and should be part of my care plan
- Services should adopt an 'ageless' approach, and my care should be based on my needs and not my age alone
- Perinatal mental health which provides support for women who are at risk of developing mental health problems during pregnancy and the first year post pregnancy, as well as those considering becoming pregnant should be improved
- Services should be established for adults of working age for developmental disorders, such as ADHD, high functioning autism and Asperger's
- Helping me get employment should be part of my care plan
- Carers should have improved access to support and education in their caring role, this will be achieved through community navigators and community solutions
- Service user networks and alliances should be developed and they should play an active role in improving services

Responses across the ten areas listed above were consistent; with the percentage of those saying that they:

strongly agree or agree to the proposals ranging from **78% to 90%** with an average of 86%
strongly disagree or disagree ranging from **3% to 16%** with an average of 6%
don't know ranging between **4% and 11%** with an average of 8%

The one area within the proposals that was an outlier was 'helping me get employment should be part of my care plan' - **16% of respondents strongly disagree or disagree** with this proposal.

The remaining three areas that were not consistent to the averages detailed above, due to a higher number of respondents ticking the 'don't know' option, were;

- 'Some resources should be shifted from secondary care mental health services into services such as community navigators, peer support groups' - **17% of respondents strongly disagree or disagree, 62% strongly agree or agree and 22% don't know**
- 'The proposals will improve services' - **10% of respondents strongly disagree or disagree, 63% strongly agree or agree and 29% don't know**
- 'The proposals focus on the right things' - **11% of respondents strongly disagree or disagree, 67% strongly agree or agree and 23% don't know**

Additional comments suggested that people did not feel they had enough information in order to make an informed decision, and raised concerns about affordability and shifting resources from secondary care services at a time when demand for services is increasing.

The conclusion reached from the analysis of responses received from the vast majority of stakeholders, and via all means of communication, was overwhelmingly positive for the proposals set out for adult mental health services.

We have included in section 6 of this document our response to a number of points raised that we wish to either be more explicitly clear upon or amend prior to any implementation phase.

Child and Adolescent proposals

- Child and adolescent mental health services should cover 0-25 years
- Young persons' improving access to psychological therapies service (IAPT), and community eating disorder services for young people should be developed
- Perinatal mental health support for women should be improved
- Services should be established for adults of working age for developmental disorders, such as ADHD, high functioning autism and Asperger's
- Mental health services shall be aligned to Better Care Southampton clusters, with care provided closer to my home
- There should be more services that support me outside of secondary care mental health services, such as in primary care or in ordinary community services
- Community navigators should be developed in all settings to help me access a range of services that will allow me to maintain my own health and wellbeing
- There should be improved access to local community resources, including the development of more peer support groups, and should be part of my care plan

- Carers should have improved access to support and education in their caring role, this will be achieved through community navigators and community solutions
- Service user networks and alliances should be developed and they should play an active role in improving services

Responses across the ten areas as listed above were consistent, with the percentage of those saying that they:

strongly agree or agree to the proposals ranging from **76% to 95%** with an average of 86%
strongly disagree or disagree ranging from **2% to 20%** with an average of 12%
don't know ranging between **3% and 14%** with an average of 8%.

The one area within the proposals that was an outlier was 'child and adolescent mental health services should cover 0-25 years' - **20% of respondents strongly disagree or disagree** with this proposal.

The remaining three areas that were not consistent to the averages detailed above, due to a higher number of people responding 'don't know', were;

- 'Some resources should be shifted from secondary care mental health services into services such as community navigators, peer support groups' - **22% of respondents strongly disagree or disagree, 55% strongly agree or agree and 23% don't know**
- 'The proposals will improve services' - **9% of respondents strongly disagree or disagree, 63% strongly agree or agree and 29% don't know**
- 'The proposals focus on the right things' - **14% of respondents strongly disagree or disagree, 60% strongly agree or agree and 25% don't know**

The conclusion reached from the analysis of responses received from the vast majority of stakeholders, and via all means of communication, was positive for the proposals set out for child and adolescent mental health services.

We acknowledge the concerns raised in the feedback about the capacity of current child and adolescent mental health services, and how this would be further impacted by increasing the age eligibility from 18 to 25 years. Our response to this point, and others have been included in section 6 of this document.

No Limits adapted survey

To ensure that the consultation was accessible to young people, the Integrated Commissioning Unit were supported by No Limits who summarised the proposed changes from the original document, using language and terminology that would be more familiar to this group.

Against each proposal, people had an opportunity to say if they;

- strongly agree
- agree
- disagree
- strongly disagree, or
- didn't know

- Child and adolescent mental health services should cover 0-25
- Services for children and young people should include the development of talking therapies (similar to counselling) and an eating disorder service that offers advice, help and support either within service users own homes, health centres or GP surgeries
- There should be more mental health support for woman who are planning on getting pregnant, ae pregnant, or have recently had a baby
- Support for people with autism, ADHD and similar disorders should be available across all ages
- I should be able to access mental health support close to where I live
- It should be easier to access mental health support via my GP, local community based services, No Limits etc.
- Community Navigators will work in community venues such as GP surgeries to assess individuals non-medical support needs and help them access groups, services and activities that can broadly improve their health and wellbeing
- Peer support groups should be easily accessible in the community and not require GP / CAMHS referral
- Young carers should have access to improved support and not be disadvantaged due to their caring role
- Children and young people should play an active role in the design, development, delivery and improvement of mental health services

Responses across the ten areas listed above were consistent, with the percentage of those saying that they:

strongly agree or agree to the proposals ranging from **84% to 98%** with an average of 91%
strongly disagree or disagree ranging from **0% to 7%** with an average of 3%
don't know ranging between **2% and 19%** with an average of 6%.

There were two areas that were not consistent, this was indicated by an increased number of young people answering 'don't know' in their response. A possible explanation for the increase in people choosing 'don't know' could be due to the use of unfamiliar words, and understanding of the community navigators and peer support concept.

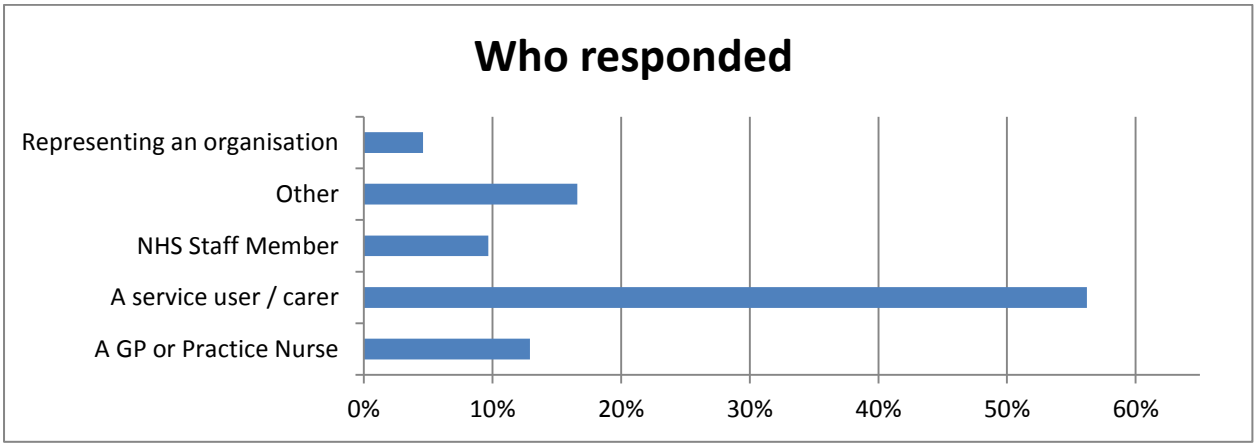
- 'Community Navigators will work in community venues such as GP surgeries to assess individuals non-medical support needs and help them access groups, services and activities that can broadly improve their health and wellbeing' – **don't know 19%**

- 'Peer support groups should be easily accessible in the community and not require GP / CAMHS referral' - **don't know 12%**

5. Who has responded to the consultation

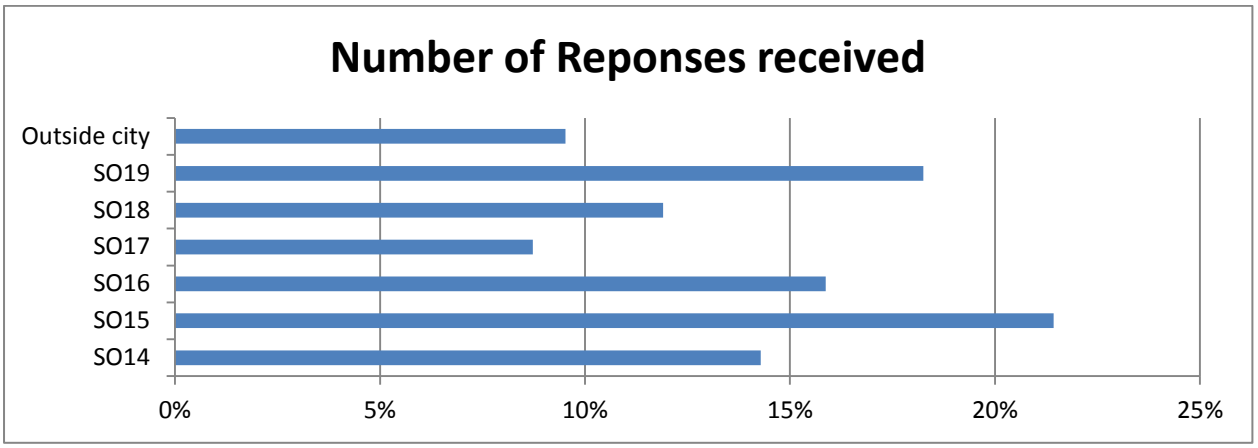
Based on the responses received from the online survey, including the No Limits adapted survey and paper copy questionnaires, the following analysis has been completed.

Service user and carer feedback was supported by a number of agencies, this resulted in good response rates from those who use mental health services and their families - proportion of those responding to the consultation who identified themselves as a service user or carer was 56%.

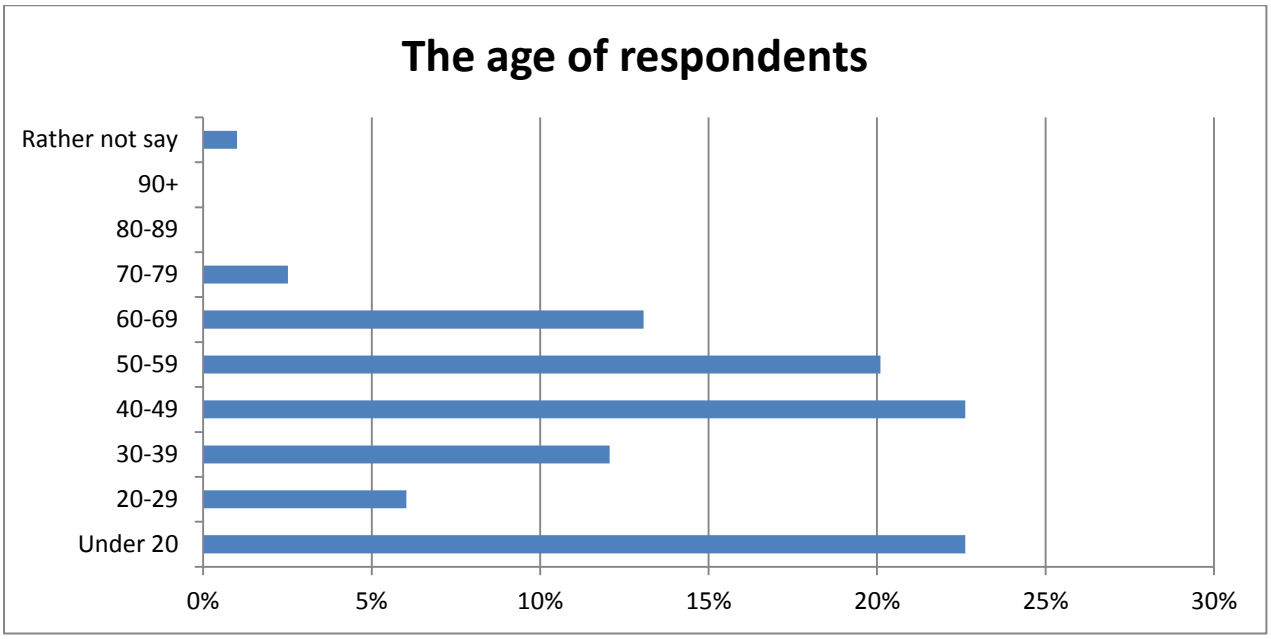


All four main providers of health services in the city provided a response/s to the consultation, Dorset University NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust, Solent NHS Trust and Southern Health NHS Foundation Trust. Wide representation from other organisations included, Southampton Youth Offending Services, No Limits, Southampton City Council, GP practices, Dental practices, schools and education, Family Mosaic, Solent Mind Services, City Limits employment, Creative Options community project, Living with Harmony and Transition Southampton.

The previous engagement report identified a lower response rate from SO18 postcode areas within the east of the city, and mainly within cluster 6 (Bitterne park, Harefield and Bitterne). Additional focus was made during the consultation to ensure that residents from these areas had an opportunity to provide feedback, this resulted in an improved response rate from 3% to 12% from this postcode area.



A wide range of ages were represented, this includes the 43 responses that were received from the adapted version of the online survey to facilitate consultation with young people; it has been assumed that the respondents to this survey fall into the under 20 category.



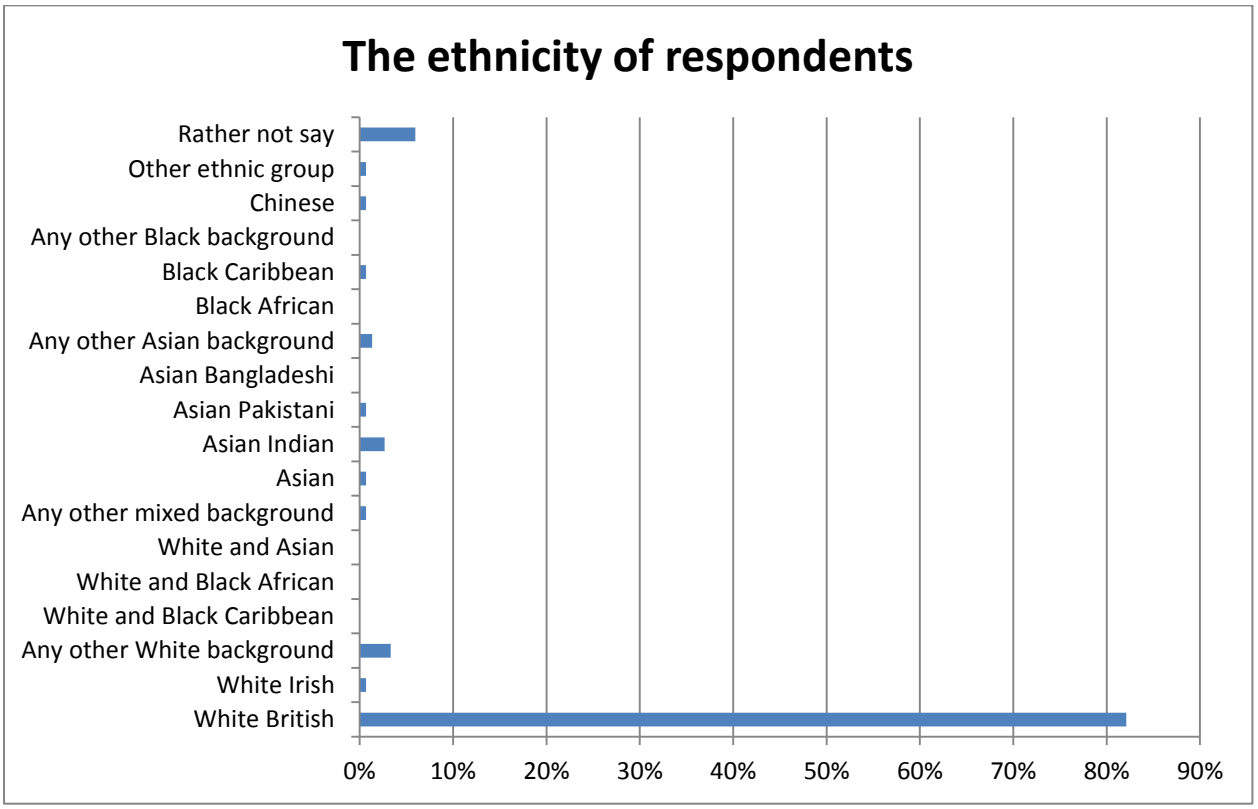
The gender of respondents was recorded as; male 34%, female 65%, and 1 % preferring not to say.

BME prevalence in Southampton is 18.2%, and white British 81.8%. We received responses from the following ethnicities: BME 11.9%, and white British 82.1%, with 6.0% opting not to provide information.

The engagement period highlighted that further work would be needed to ensure that the consultation phase reached wider representation from BME communities. As a result the consultation plan was supported by the community engagement officer to ensure that the consultation was accessible in a wide range of cultural and community venues, with attendance at

a number of community events. This resulted in an increase to the response rate from 9.6% to 11.9% from BME communities.

The notable change was a reduction from 14% to 6% of respondents who indicated 'rather not say' when asked to provide their ethnic group, and increases to the number and proportion who indicated their ethnic group to be 'any other white background', 'Asian', 'Asian Pakistani', 'any other Asian background' and 'other ethnic group'.



Details of all the forums and settings attended can be found in Appendix 2.

6. The changes we propose to make in response to the feedback

The overall proposals were welcomed and accepted by the full range of stakeholders, there were a number of points raised that we wish to either be more explicitly clear upon or amend prior to any implementation phase.

CAMHS Feedback	Response
Will the proposals be affordable	National investment in CAMHS is available to support the proposals, this additional investment has been protected for Mental Health.
We are concerned about extending CAMHS to the age of 25 due to the current wait times, and the significant student population. How will the proposals reduce long waiting times for CAMHS, improve access to treatment, whilst also providing a responsive service to support the student population when they are in crisis, developing acute psychosis, or suicidal	○ National non-recurrent investment has been made available to reduce current waiting times within CAMHS ○ The 0-25 model will enable an individuals' need to be best met, resulting in care and support being provided based on need and not age alone so patients could be seen by CAMHS or AMH services ○ In practice this will mean that referrals will be jointly screened, and assessments will take place to ensure that the right practitioner and therapy is offered, including the consideration of patient choice ○ We will ensure that there are appropriate systems in place to monitor waiting times
There is concern about the role of navigators ○ They will struggle to navigate complex systems ○ What happens once a client is signposted to a service and the service declines input, or the client fails to contact the service	○ Linked to Better Care Southampton, the navigation will be system wide and so will draw on expertise across the system ○ The new model will create capacity in the right areas, this will mean that there will be better support services for everybody. It will be linked to peer support networks that can help support people to access services, where there is an identified need for extra support. ○ An example of a navigator role includes a mechanism for the navigator to follow-up to discuss progress
We would like to see early intervention and provision for 'low' level mental health issues	Locality based CAMHS Primary Mental Health teams will work with schools and GPs (doctors) to meet the needs of 'low' level mental health issues, alongside the development of

	community resources.
The decommissioning of CAMHS Saucepans left a gap in Tier 2 provision	Please see response above - locality based CAMHS Primary Mental Health teams will identify children and young people earlier and provide early intervention to prevent the progression to more complex mental health problems.
We wish to see greater awareness of mental health within schools	CAMHS primary mental health workers will work with school nurses and emotional wellbeing workers in schools to continue to increase the awareness of mental health within schools.
Why was there no mention of children with intellectual disability, and the role of education and SEND within the consultation	There are mental health practitioners within the SEND teams, no specific changes are proposed to this team and they will continue to work closely together throughout the CAMHS transformation.
How will mental health services work better with young people who are using substances, this is usually a symptom of their poor mental health, not the cause	CAMHS and No Limits (who provide drug and alcohol services to young people) already work jointly, this will be further strengthened by exploring how workers from both organisations can be embedded within each team.

AMH Feedback	Response
We do not feel that the proposals adequately set out the final model, and therefore we have not had an opportunity to provide feedback	The end of Mental Health Matters consultation marks the start of the next phase in the programme; details of what this includes are set out in section 7.
Will the proposals be affordable	The proposals will be implemented on a phased approach, and plans will be based on affordability. It is expected that system wide changes within secondary care and some new investment, will release investment to support the proposals, e.g. a better range of therapeutic and recovery focused support, and access to local community resources, including the development of more peer support groups will help people to avoid episodes of crisis, and more intensive intervention.
Wish to see greater emphasis on peer support	The development of service specifications will include the requirement for all providers to promote peer support wherever possible within their service models; additionally we are exploring how peer support can be developed alongside the work that is underway in health and care services to provide support in the community.
We would like to see more social interventions	We will ensure that social interventions are considered within the development of service specifications. Employment services are already part of IAPT, and plans are progressing to integrate the provision of a mental health employment service into each of the community mental health teams. We will ensure that access to crisis support operates on social, rather than diagnosis criteria. The delivery of effective social support (as distinct from social care support) within the community will be accessible to people who have mental health problems: ○ peer support ○ carers support ○ behaviour change services (smoking, weight loss, exercise) ○ help to access employment, a volunteering role, or meaningful activities ○ safeguarding and criminal justice ○ other universal services – e.g. benefits, advocacy.

We believe there is a gap in services for people with personality disorders	We believe that all services should be accessible to, and support, people with personality disorders. However, we recognise the need to better meet the needs of people with complex personality disorders and will be looking at the patient pathway, ensuring that specialist personality disorder expertise is available.
How will the proposals address the needs of the population that "fall between the services" those that require more than the brief intervention that IAPT offer, but do not meet criteria for longer term intervention provided by secondary care services	IAPT and secondary mental health services are already exploring how they can improve joint working to support people that are currently falling between services. Primary care pilots are underway that will shape and inform the future development of a primary care mental health model.
Culture change is a key theme of this programme	Changing staff culture will be considered within the development of service specifications, we will consider with staff, service users, carers and other stakeholders how to define and measure cultural change.
We would like to see more work on reducing mental health stigma	The NHS and council support and actively promote Time to Change, a national campaign led by Mind and Rethink aimed at ending the discrimination faced by people who experience mental health problems. A citywide all age anti-stigma campaign was launched during the autumn of 2015, and continues into 2016.
How have the needs of veterans been considered in the proposals	We believe that all services should be accessible to, and support veterans. Additionally NHS England provides mental health services across England specifically for veterans. The Veterans and Reserves Mental Health programme (VRMHP) provides assessment and treatment advice for veterans.
Alongside carers support how will you ensure carers are engaged with, sometimes away from their loved ones	We are keen to further progress plans working with carers and providers to help develop methods of engaging with carers and helping to include them in the development of care plans where appropriate.

We would like to see that services are being provided equitably across the city, and that any future development considers equitable access	Services will be based on need and will be centred and developed around the three existing localities in the city; East, Central and West.
We would like to see a designated place where organisations could work together to provide a range of community services	With the development of the Better Care Southampton we are looking at ways that services can co-locate and provide hubs across the City for a range of health, social care and community services.
There is a lot about improving services for people with mental health problems but how will you ensure that services meet the mental health needs of those with physical illness	As part of the NHS England's Five Year Forward View for mental health we will be working towards increasing access to psychological therapies from 15% to 25%. Recommendations from NHS England are that the majority of this increase should come from people with physical health needs. We will be working across the physical health pathways to identify need and adapt pathways to include mental health support and information.
How will plans incorporate the five year forward view for mental health – report from the independent mental health taskforce to the NHS in England (February 2016)	We have assessed our plans against the five year forward view to ensure that our plans are consistent with the recommendations. We will be undertaking an assessment of how we will meet our commissioner responsibilities for investment in the following areas: ○ CYP mental health ○ eating disorders ○ specialist perinatal mental health ○ expansion of psychological therapies ○ crisis and acute care ○ early intervention in psychosis ○ physical health interventions ○ secure care pathway.
How will plans incorporate the learning and recommendations from Local Safeguarding Boards and Serious Incidents	We will continue to ensure that these areas are considered during the next phase of the programme; details of what this includes are set out in section 7.

7. Next steps

The conclusion of the Mental Health Matters consultation marks the start of the next phase in the programme. Some areas we have started to progress, with changes already underway, and some areas will continue to be progressed over the coming months. This will include establishing groups to further develop pathways, and these groups will include representation from experts by experience, carers, stakeholders and clinicians.

Changes and progress already underway

- Employment support officers embedded within each of the three community mental health teams (CMHT).
- Introduction of care navigation roles within the acute mental health team
- CAMHS; implementation of new community eating disorder team, recruitment to crisis workers underway, and embedding CAMHS practitioners within early intervention in psychosis (EIP) adult teams.
- Psychiatric intensive care (PICU) is currently being provided on another site due to difficulties in maintaining safe staffing levels at Antelope House. Commissioners are clear that this is not a sustainable or acceptable solution beyond the short term for our patients. It is essential that a local solution is delivered and we will be working in partnership to progress this through the STP mental health alliance (see below), and in parallel with taking forward the plans set out in Mental Health Matters.

Development of pathways

Engagement groups will include:

- acute mental health team including crisis support
- personality disorder pathway
- primary care mental health service
- community development inducing navigation and peer support
- CAMHS 0-25 development
- developmental disorder pathway (autism, ADHD)
- CAMHS transformation plan

Implementation

Phased implementation from summer 2016 onwards, each of the programme areas will progress and be completed to different timescales; this is in recognition of the diverse range and varying complexities of the service areas and pathways.

Progression of plans will be approved by Southampton City Clinical Commissioning Group, and our website will be updated regularly to reflect progress.

Additionally in December 2015, the NHS outlined a new approach to help ensure that health and care services are built around the needs of local populations. Every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years. Hampshire, Portsmouth, Southampton and the Isle of Wight have established a mental health alliance which includes membership from all sectors of health and care to support and enable the delivery of local 'place based' plans.

Rehabilitation pathway

We told you in our consultation document that a further formal review and public consultation on rehabilitation services would take place. The review of rehabilitation services will determine if the right residents are in the right place, receiving the right care at the right time, delivered by the right people. We anticipate that a public consultation will take place during winter 2016.

Senior Commissioner
Southampton Integrated Commissioning Unit

If you need further copies of this document or need it in a different format please contact Amanda.Luker@Southamptoncityccg.nhs.uk or telephone 023 8072 5568

Appendix 1 – Communication methods used for consultation

Southampton City Clinical Commissioning Group website and social media
Southampton City Clinical Commissioning Group staff newsletter, newsletter for GPs, practice managers and practice nurses
Southampton City Clinical Commissioning Group stakeholder newsletter - In Touch
Southampton City Clinical Commissioning Group TARGET delegate packs - GPs, practice nurses and HCA attendance
Southampton City Clinical Commissioning Group FYI Friday, GPs and other local clinical staff
SCC, your city your say distribution
SCC, Healthy Southampton bulletin and City news bulletin
SCC social media
Southampton Echo press release, article online and in evening paper
The Breeze radio station, news article
Mental health round table event participants
Southern Health NHS Foundation Trust Southampton teams, via management dissemination and via staff newsletter
Southern Health NHS Foundation Trust Southampton membership list
Solent NHS Trust Southampton teams, via management dissemination and via staff newsletter
Primary Care via GP portal, direct email from communications
Dorset University NHS Foundation Trust Southampton steps to wellbeing
Healthwatch
No Limits
The Wiltshire Trust
Solent Mind
Mental health partnership group
Natalie House
Supporting people housing providers
Substance misuse services
Southampton City Council housing needs manager
Carers in Southampton
Southampton City Council new deal employment project manager
Southampton City Clinical Commissioning Group website
Southampton City Council; Healthy Southampton Facebook, council website news, e-bulletin
0-19 Board
Headstart project group and providers

Children and adolescent mental health services (CAMHS) quarterly interface
Citywide anti-stigma circulation list
Solent and Southampton University Welfare Officers
Dementia partnership group & dementia support services community development grant programme
Mental health forum members
Street pastors
Southampton schools (Heads, deputy's, PSHE leads and all mental health leads identified through CAMHS transformation)
Youth options
No Limits adapted Mental Health Matters online survey
Ropewalk Community Centre
NHSE Wessex
Wessex Clinical Senate
Time to Change Equalities and Regional Co-Ordinator
Community BME volunteers who are members of various community groups
Leaflet 'please take part in our Mental Health Matters Public Consultation' distributed to community venues across the city
Frequently asked questions (FAQ) added to CCG website during consultation period

Appendix 2 – Calendar of consultation events

Primary Care TARGET
Natalie House
Supporting people providers
Solent Mind services
IAPT peer support group
Depression alliance group
Carers in Southampton
0-19 Board
Headstart project group and providers
Children and adolescent mental health services (CAMHS) quarterly interface
Dementia partnership group
Equality and diversity reference group
Consult and challenge group
Mental health partnership group
Mental health forum
Creative options group
Southampton drug and alcohol recovery service
Children and adolescent mental health services (CAMHS) - Brookvale waiting room
Children and adolescent mental health services (CAMHS) - Orchard waiting room
Antelope House peer support worker facilitated service user feedback
Solent mind service user forum
Adult mental health services - college keep waiting room
Children and adolescent mental health services (CAMHS) practitioners workshop
Communications and Engagement group
Southampton City Clinical Commissioning Group Patient Forum
Integrated Commissioning Unit 'Can Do' Group
University of Southampton Students Union
Southampton Safeguarding Children Board
Southampton Health Overview and Scrutiny Panel
Friends of St James Park Autism Social Group
St. Denys Activities Group launch - new mental health weekly drop in support service

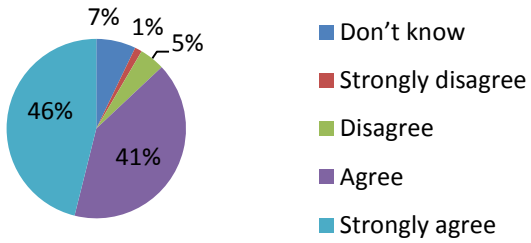
SO18 Big Local Health & Wellbeing Sub Committee
Vice Chair of Southampton Chinese Association - weekly drop in session at Northam Community Centre
Southampton Women's Forum
City of Sanctuary meeting
Mount Pleasant Junior School's Governor's meeting
Cultural & Community Agencies Exhibition
Spectrum to the 'Time 4 Tea' group
Sure Start Multi Agency Forum
Newtown Residents Association St. George's Day celebration

Appendix 3 – Frequently asked questions

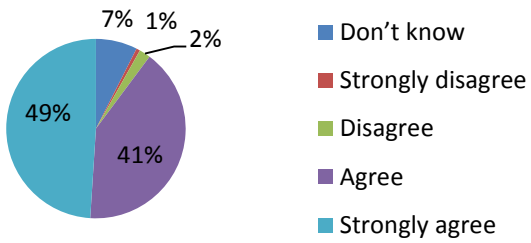
Question	Response
What is Better Care Southampton and how does this link to the consultation	Better Care Southampton is a joint project between NHS Southampton City Clinical Commissioning Group (CCG) and Southampton City Council. We are joining up health and social care services in the city together with local voluntary and community services and putting each individual patient's need at the centre of their care planning. You can find out more about Better Care on our website www.southamptoncityccg.nhs.uk/better-care-southampton
Why are you asking the same questions that were asked during the Mental Health Matters engagement period	The engagement period for Mental Health Matters took place during the autumn 2015; the feedback received during the engagement period included many valuable suggestions and things to consider. This feedback helped us to shape the plans set out in this public consultation and we are now checking that we have got these plans right before we implement them.
Why is my neighbourhood not included within appendix 3: Better Care Southampton - proposed closer organisation?	Unfortunately there is not enough room to include all of the city's neighbourhoods on the diagram but the whole city is included. Services will be delivered close to your community, and delivered around GP practice populations called clusters. The map at the end of this document shows which cluster you belong to base on where you live (your neighbourhood), and which GP practice you are registered with.
What is a Community Navigator?	Community Navigators are a key role in the Better Care programme. They are responsible for working with health services, social care, voluntary and community organisations and letting you know about the support available in your area.
Why is there no mention of dual diagnosis? (Dual diagnosis is the term used to describe patients with both severe mental illness and problematic drug and/or alcohol use)	Although we have not specifically made reference to dual diagnosis the same principles outlined in the proposals, changes and improvement section will apply if you need help with your mental health problem and also have concerns around drug and/or alcohol use.

Appendix 4 – Full analysis of feedback

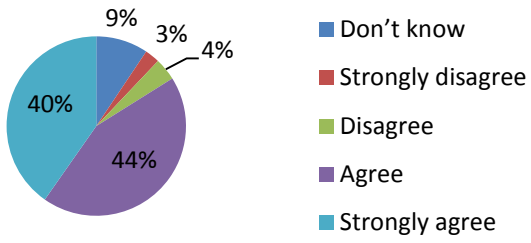
Mental health services should be aligned to Better Care Southampton clusters, and should be provided closer to my home in a local setting within the cluster



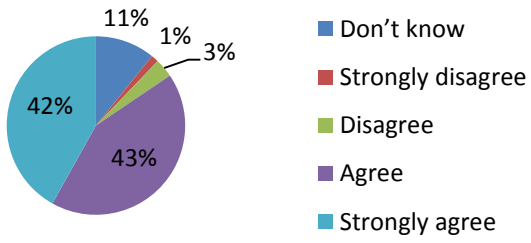
There should be more services that support me outside of secondary care mental health services, such as in primary care or in ordinary community services



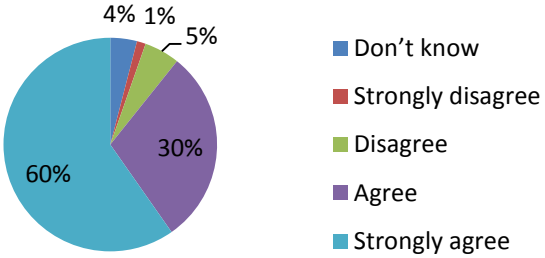
Community navigators should be developed in all settings to help me access a range of services that will allow me to maintain my own health and wellbeing



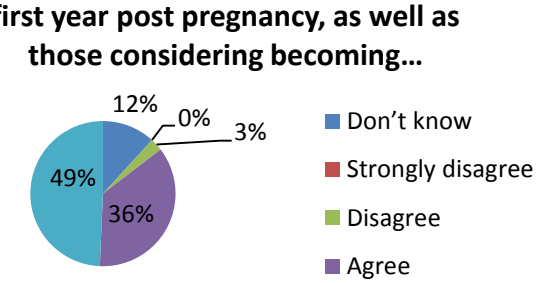
There should be improved access to local community resources, including the development of more peer support groups should be part of my care plan



Services should adopt an 'ageless' approach, and my care should be based on my needs and not my age alone



Perinatal mental health which provides support for women who are at risk of developing mental health problems during pregnancy and the first year post pregnancy, as well as those considering becoming…



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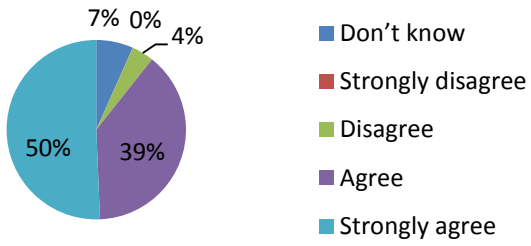
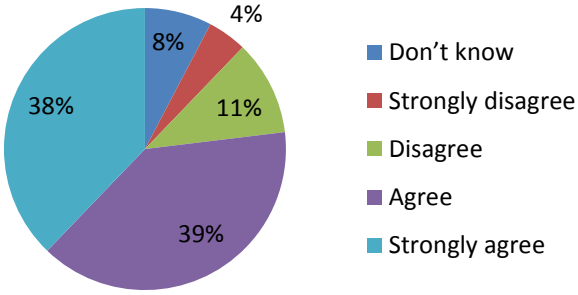
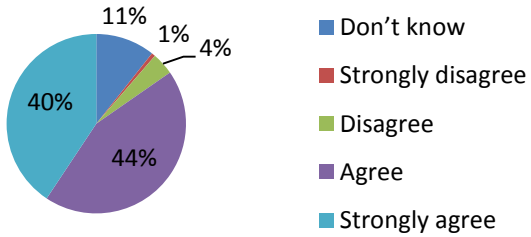


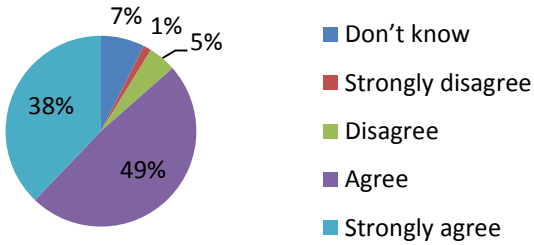
Helping me get employment should be part of my care plan



Carers should have improved access to support and access to education in their caring role, this will be achieved through community navigators and community solutions



Service user networks and alliances should be developed and they should play an active role in improving services



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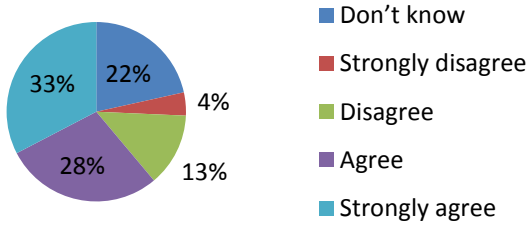
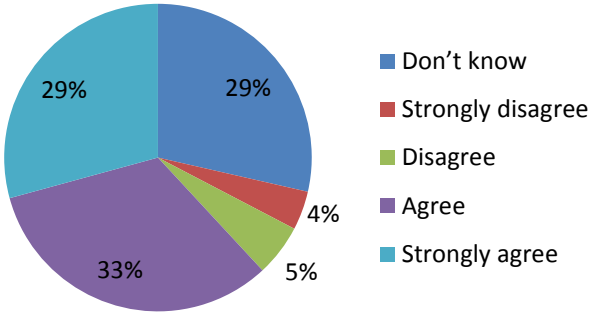
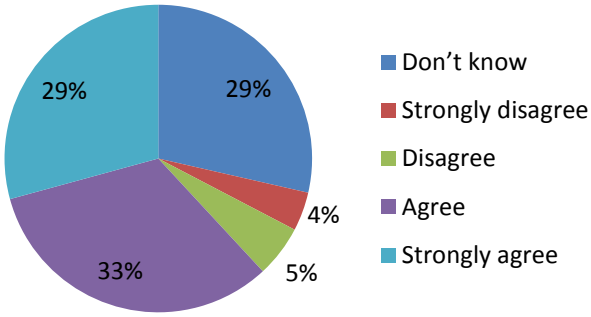


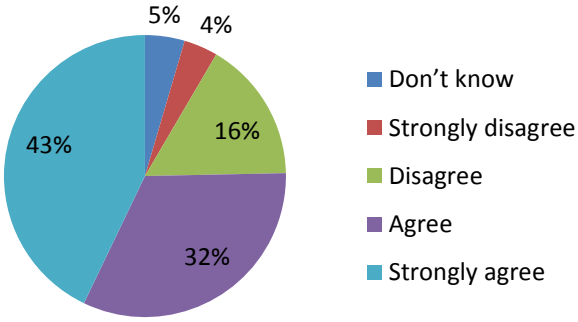
The proposals will improve services



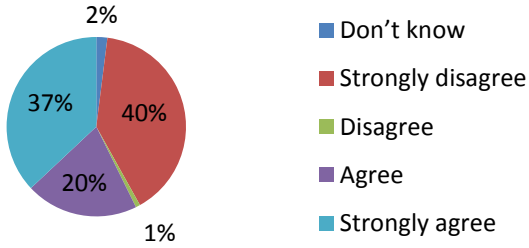
The proposals focus on the right things



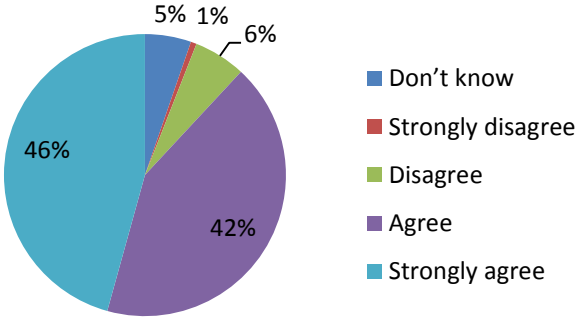
Child and adolescent mental health services should cover 0-25 years



Young persons' improving access to psychological therapies service (IAPT), and community eating disorder services for young people should be developed



Perinatal mental health support for women should be improved



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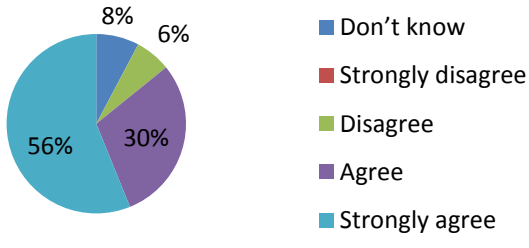
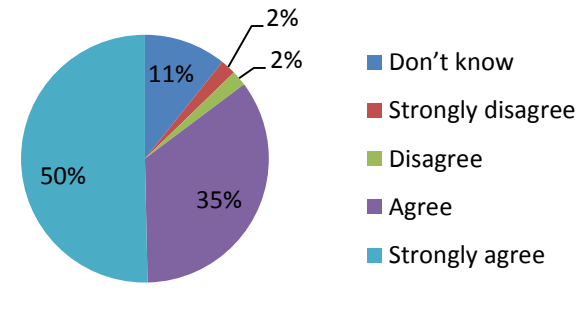


Mental health services shall be aligned to Better Care Southampton clusters, with care provided closer to my home



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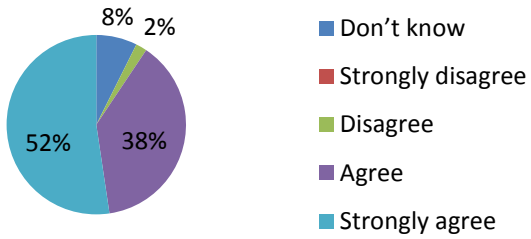

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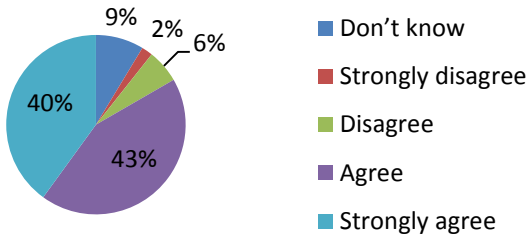

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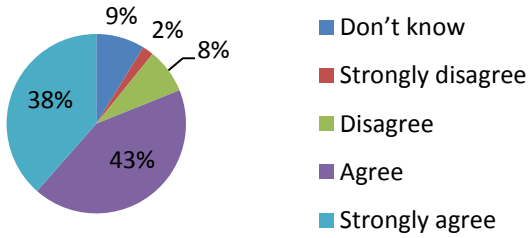

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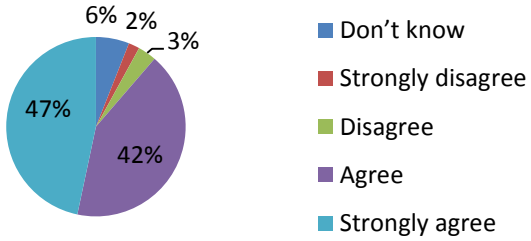

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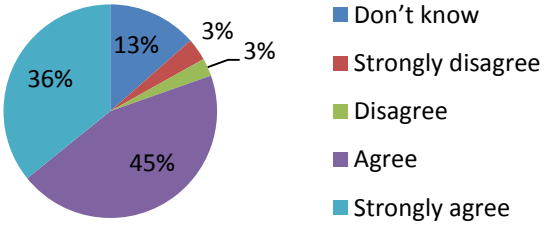

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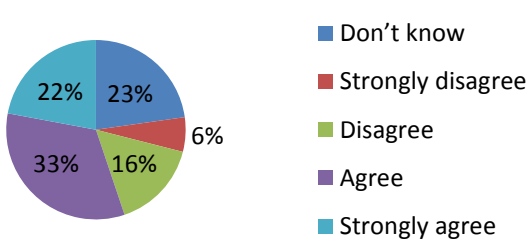
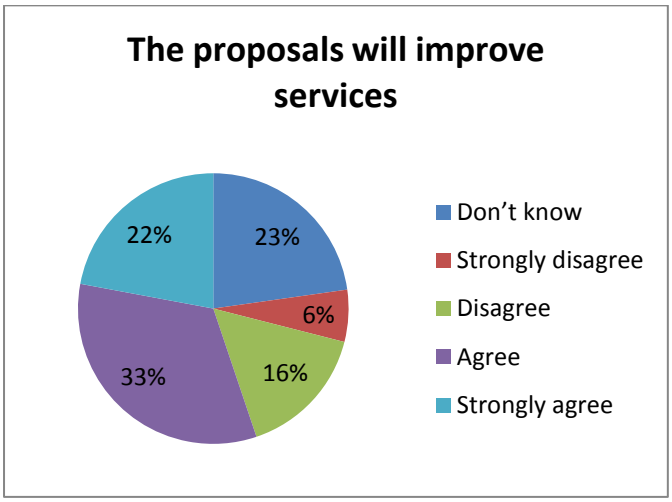
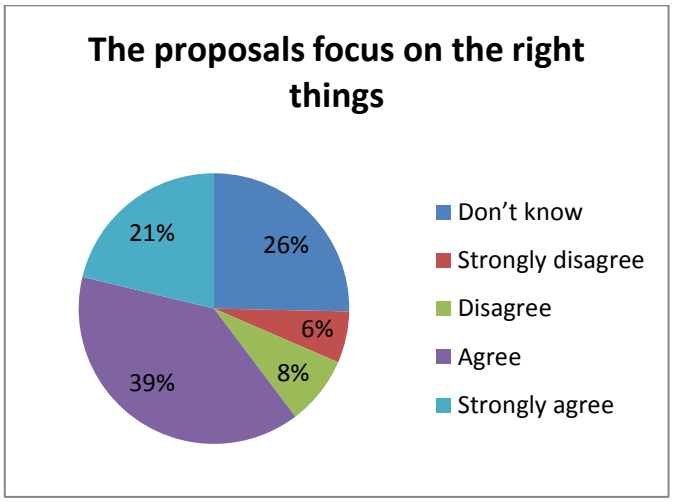
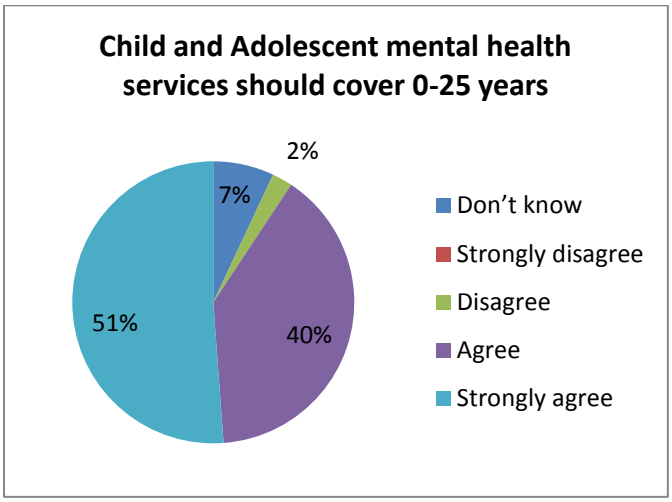
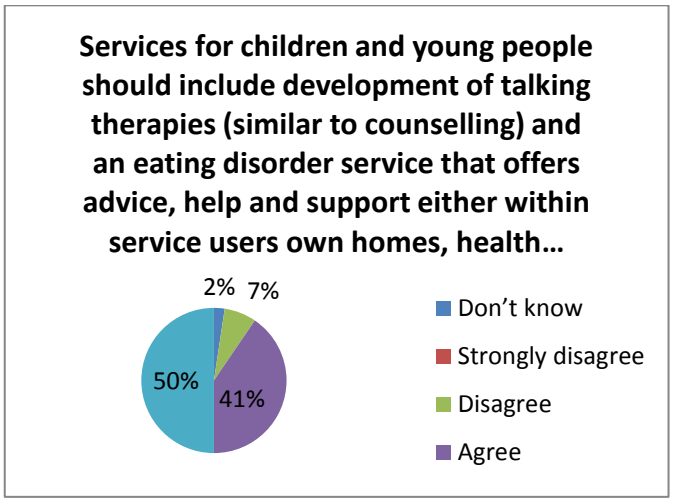


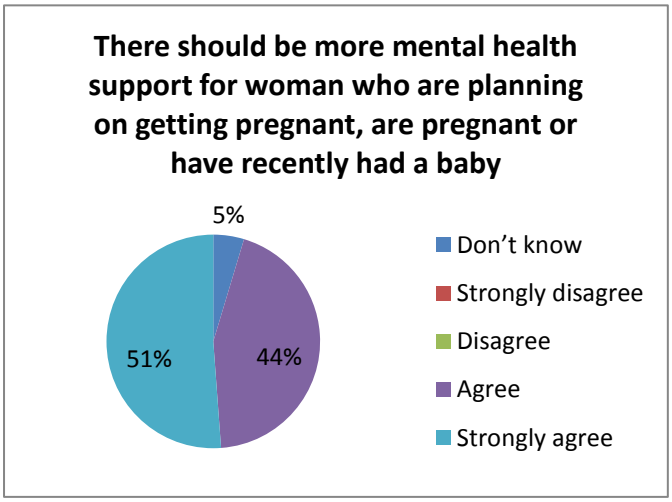


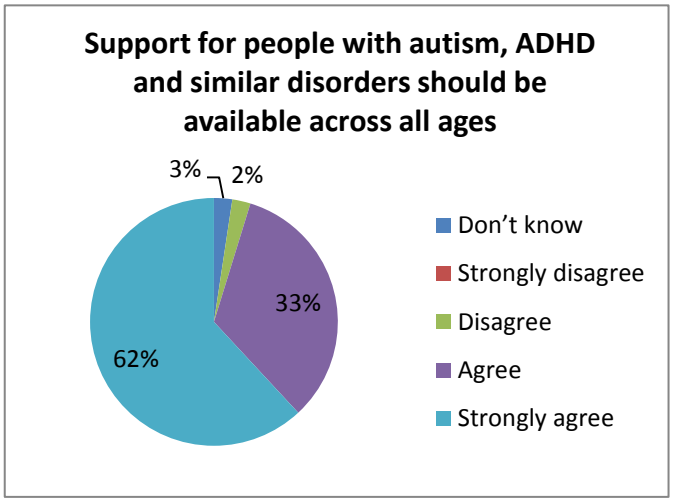


No Limits child and adolescent adapted survey feedback

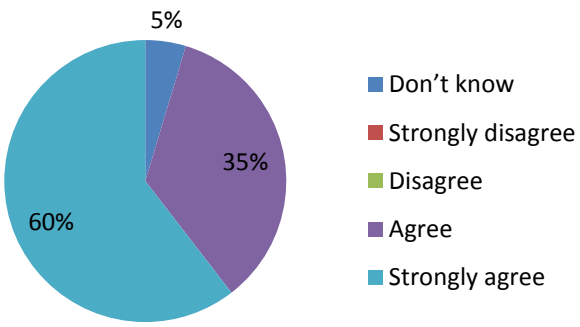




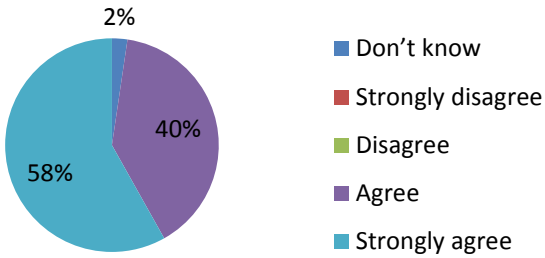




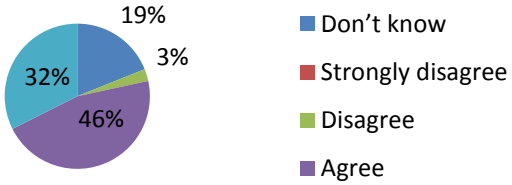
I should be able to access mental health support close to where I live



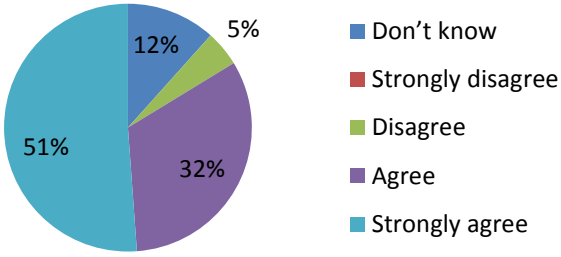
It should be easier to access mental health support via my GP, local community based services, No Limits etc.



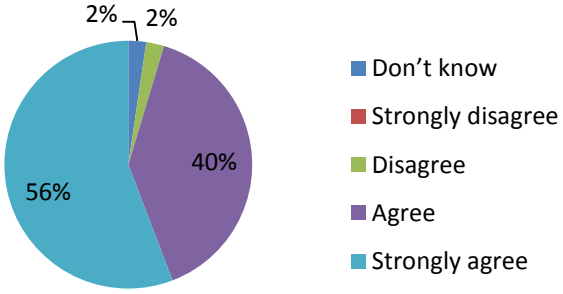
Community Navigators will work in community venues such as GP surgeries to access individuals' non-medical support needs and them access groups, services and activities that can broadly improve their…



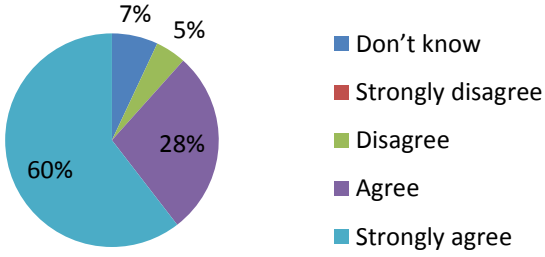
Peer support groups should be easily accessible in the community and not require GP / CAMHS referral



Young carers should have access to improved support and not be disadvantaged due to their caring role



Children and young people should play an active role in the design, development and improvement of mental health services



Appendix 5 – Online and paper based feedback form

Share your views

We are very interested in hearing your views; please take a few minutes to let us know what you think. You do not need to answer all of the questions; just those that you feel are **relevant to you**.

You do not have to provide your name.

To what extent do you agree or disagree with these comments?

Child and adolescent mental health services	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Child and adolescent mental health services should cover 0-25 years					
Young persons' improving access to psychological therapies service (IAPT), and community eating disorder services for young people should be developed					
Perinatal mental health which provides support for women who are at risk of developing mental health problems during pregnancy and the first year post pregnancy, as well as those considering becoming pregnant should be improved					
Services should be established for adults of working age for developmental disorders, such as ADHD, high functioning autism and Asperger's					
Mental health services shall be aligned to Better Care Southampton clusters, with care provided closer to my home					
There should be more services that support me outside of secondary care mental health services, such as in primary care or in ordinary community services					

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Community navigators should be developed in all settings to help me access a range of services that will allow me to maintain my own health and wellbeing					
There should be improved access to local community resources, including the development of more peer support groups should be part of my care plan					
Carers should have improved access to support and access to education in their caring role, this will be achieved through community navigators and community solutions					
Service user networks and alliances should be developed and they should play an active role in improving services					
Some resources should be shifted from secondary care mental health services into services such as community navigators, peer support groups					
The proposals will improve services					
The proposals focus on the right things					

Please tell us about any other options or ideas you would like us to think about in relation to child and adolescent mental health services for the future?

To what extent do you agree or disagree with these comments?

Adult mental health services	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Mental health services should be aligned to Better Care Southampton clusters, and should be provided closer to my home in a local setting within the cluster					
There should be more services that support me outside of secondary care mental health services, such as in primary care or in ordinary community services					
Community navigators should be developed in all settings to help me access a range of services that will allow me to maintain my own health and wellbeing					
There should be improved access to local community resources, including the development of more peer support groups should be part of my care plan					
Services should adopt an 'ageless' approach, and my care should be based on my needs and not my age alone					
Perinatal mental health which provides support for women who are at risk of developing mental health problems during pregnancy and the first year post pregnancy, as well as those considering becoming pregnant should be improved					
Services should be established for adults of working age for developmental disorders, such as ADHD, high functioning autism and Asperger's					
Helping me get employment should be part of my care plan					

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Carers should have improved access to support and access to education in their caring role, this will be achieved through community navigators and community solutions					
Service user networks and alliances should be developed and they should play an active role in improving services					
Some resources should be shifted from secondary care mental health services into services such as community navigators, peer support groups					
The proposals will improve services					
The proposals focus on the right things					

Please tell us about any other options or ideas you would like us to think about in relation to adult mental health services for the future?

Some details about you

We want to make sure that everyone has an opportunity to be part of the review and to contribute towards the design of mental health services in Southampton. To make sure we have reached a wide range of people, it would be helpful if you could provide us with a few confidential details about yourself to help us see who has responded.

Are you?

- ☐ A service user
- ☐ A carer
- ☐ A GP or Practice Nurse
- ☐ NHS Staff Member
- ☐ Other
- ☐ Representing an organisation

If you chose NHS staff member, which NHS organisation do you work for?

- ☐ Southern Health NHS Foundation Trust
- ☐ Solent NHS Trust
- ☐ University Hospital Southampton NHS Foundation Trust
- ☐ Dorset Healthcare University NHS Foundation Trust
- ☐ Other NHS organisation

What is your role?

If you chose representing an organisation, please state the organisation:

Please tell us your postcode (first four digits only)

Are you? ☐ Male ☐ Female ☐ Rather not say

What is your age?

- ☐ Under 20
- ☐ 20-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60-69
- ☐ 70-79
- ☐ 89-89
- ☐ 90+
- ☐ Rather not say

How would you describe your ethnic group?

White: ☐ British ☐ Irish ☐ Any other white background

Mixed: ☐ White and Black Caribbean ☐ White and black African ☐ White and Asian ☐ Any other mixed background

Asian or Asian British: ☐ Asian Indian ☐ Asian Pakistani ☐ Asian ☐ Bangladeshi ☐ Any other Asian background

Black or Black British: ☐ Black African ☐ Black Caribbean ☐ Any other Black background

Other ethnic groups: ☐ Chinese ☐ Other ethnic group ☐ Rather not say

Thank you for your feedback. The key themes compiled from all the responses will be one of the pieces of evidence that we will consider when making decisions about next steps.

Please return your form to:

Amanda Luker
Integrated Commissioning Unit
NHS Southampton City Clinical Commissioning Group and Southampton City Council
NHS Southampton HQ
Oakley Road
Southampton
SO16 4GX

Comments can also be emailed to: Amanda.Luker@Southamptoncityccg.nhs.uk
The deadline for feedback is 12:00 midday on Monday 2 May 2016.

Thank you for your comments.

Privacy
Any personal information you give to us will always be processed in accordance with the UK Data Protection Act 1998. We will only use the personal information you provide to deliver the services you have requested, or for our lawful, disclosed purposes.

We will not make your personal details available outside our organisation without your consent, unless obliged by law. Please be aware that any comments given on this form may be published in the report. However, Southampton Integrated Commissioning Unit will endeavour to remove any references that could identify individuals or organisations.

Appendix 4

NHS
Southampton City
Clinical Commissioning Group

Summary of Southampton's Transformation Plan for Children and Young People's Mental Health

October 2016

Contents

This summary document should be read in conjunction with the original transformation plan which contains much more depth and detailed plans, it should also be read in conjunction with the mental health matters consultation feedback. Links below to both documents

http://www.southamptoncityccg.nhs.uk/mental-health-services

http://www.southamptoncityccg.nhs.uk/news/decisions-made-on-the-future-of-mental-health-services-in-southampton-789/

Katy Bartolomeo

Senior Commissioner – mental health and substance misuse

Southampton Integrated Commissioning Unit

1. Introduction

1.1 Southampton City Clinical Commissioning Group, Southampton City Council and their partners from both the health and voluntary sector are committed to "promoting, protecting and improving our children and young people's (CYP) mental health and wellbeing". Whilst there are already areas of very high quality provision within the city we recognise that dramatic and significant changes and improvements are needed in order to ensure that all children and young people in Southampton, including those with particular vulnerabilities, can easily access high quality, outcome focussed, and evidence-based services appropriate to their need, when required.

1.2 This document is an updated summary of the full Transformation Plan and sets out how we will as a city, follow the national guidance set out in Future in Mind to develop services and an over-arching service model which responds to Southampton's specific needs and vulnerabilities and makes best use of its strengths.

1.3 Southampton City CCG was successful in a bid to NHS England (made in 2014) to lead and accelerate collaborative commissioning arrangements for CYP's mental health. This included work to build on the joint commissioning arrangements between Southampton City Council and Southampton City Clinical Commissioning Group further developing the work started by the formation of the Integrated Commissioning Unit (ICU). Key aims of the work were to improve joint commissioning across health, social care and education at Tier 2/3 and to also look at collaborative commissioning across the transition age span to 25. Following this piece of work and the release of Future in Mind, the CCG and City Council have completed 'Mental Health Matters' a review of mental health services across the City.

2. Mental Health Matters Southampton

2.1 In 2014 Southampton's Health and Wellbeing Board decided to instigate a full review of mental health services for all age groups, due to concerns being raised about current services and a wish to focus on early intervention and prevention services. As part of the review a mental health matters workshop event took place in December 2014. This event was attended by individuals from NHS, private and voluntary providers, service users, carers and public health. The main feedback from this event was that people wanted the opportunity to be part of the review and have a 'blank page' approach.

2.2 In August 2015 engagement officially started with the publishing of Mental Health Matters which set out proposals (offered as a first draft) for mental health services in the city and requested the views of all stakeholders to help us to shape it further. Great effort has been taken to ensure we have engaged with all stakeholders including CYP, parent/carers, schools and GP's and with hard to reach groups.

2.3 This review will help strengthen our transformation plan and provide a strategy that has been shaped by CYP and their families.

2.4 The engagement process ended on 16th October, the information and views collected have helped to design and inform new models across mental health for all ages. Formal consultation took place between December 2015 and April 2016. Final analysis of the consultation has now been undertaken and the final document published. This will enable implementation of new models.

3. Transformation Plan Investment

3.1 Due to the timelines for the Mental Health Review most of the initial year's Transformation Fund money was dedicated to 'system enabler' schemes that were designed to allow providers to be best placed to undertake the large scale change that is required to deliver on the vision of Better Care Southampton, the Mental Health Matters review and Future in Mind. Ongoing recurrent use of the Transformation Fund will focus on crisis care, one stop shops/community based treatment/early intervention and treatment, and the development of a 0-25 CAMHS team.

3.2 The local priority work streams identified for this year (2015/16) as shown below:

Work stream	Budget Allocation	Recurrent Investment	Details
1	£50,000.00	£50,000.00	**Navigators** - to support children, young People and their families to access the services most appropriate to their needs. This navigation function will also support professionals and 'hold' clients through periodic check-ins.
2	£65,000.00	£65,000.00	**Community solutions -** including a worker, peers support and grants/training
3	£50,000.00	£50,000.00	**EIP** - Supplement existing EIP team with CAMHS clinicians to become evidence compliant and to ensure that CYP are being seen within EIP teams and not remaining in CAMHS. MDT sessional input and pathway development to include CAMHS consultant psychiatrist sessions, mental health nurse and Systemic Family Therapy sessions.
4	£140,000.00	£140,000.00	**CYP ED Service** - Supplement of existing team to ensure compliant. Includes dietician, prescribing nurse, CBT-E therapist and occupational therapist, full details in chapter 6.
5	£120,000.00	£120,000.00	**Early Intervention** - Extend primary care mental health worker role to all schools in the city and develop a Schools Forum for primary schools. Introduction of engagement worker role within CAMHs to assist with these priorities and engagement including with hard to reach groups, some focussed work for training of public health nurses.
6	£80,000.00		**Community Group work** - Piloting of expanding existing Teen Safe House service (age bracket and scope of provision). Piloting of new community based support groups to support larger cohort of children and young people in the community. (Continuation of pump priming initiatives)
8	£152,500.00	£152,500.00	**Crisis Care Services** - Improvements to crisis care services for children and young people
8	£40,000.00	£40,000.00	**Counselling Provision** - Pilot options for expanding counselling provision including opportunities to develop digital streams and collaborative work with schools
9	£100,000.00		**Waiting times** -Supplement existing CAMHS teams to tackle current waiting times. Focus on Autism assessments and CBT which currently still have long waiting times. Pilot Saturday clinics and extension of working hours, evaluate patient feedback and take up of these services. (Continuation of pump priming initiatives)
10	£60,000.00	£60,000.00	**Commissioning** - supplement exiting commissioning resources to enable smooth implementation of transformation plans and continued commissioning capacity
11	£17,500.00	£17,500.00	**Mental Health Alliance –** Contribution to ageless alliance to bring together service users, carers and providers
	£875,000.00	£695,000.00	Total
	£695,000.00		Transformation budget
	£180,000.00		Other additional investment

3.3 The updated finance for 2016/17 is shown below for the increased budget allocation of £652,981:

Work stream	Budget Allocation	Recurrent Investment	Details
1	£50,000.00	£50,000.00	**Navigators** - to support children, young People and their families to access the services most appropriate to their needs. This navigation function will also support professionals and 'hold' clients through periodic check-ins.
2	£65,000.00	£65,000.00	**Community solutions -** including a worker, peers support and grants/training
3	£50,000.00	£50,000.00	**EIP** - Supplement existing EIP team with CAMHS clinicians to become evidence compliant and to ensure that CYP are being seen within EIP teams and not remaining in CAMHS. MDT sessional input and pathway development to include CAMHS consultant psychiatrist sessions, mental health nurse and Systemic Family Therapy sessions. Existing members of staff will be used and an increase in consultant psychiatrist time (3 sessions) has been recruited to.
4	£140,000.00	£147,156.00	**CYP ED Service** - Supplement of existing team to ensure compliant. Dietitian and prescribing nurse recruited to with CBT therapist and Occupational Therapist out to advert.
5	£202,678.00	£202,678.00	**Early Intervention** – Two early intervention workers recruited (Band 5) with a further one out to advert (Band 6). Extend primary care mental health worker role to all schools in the city and develop a Schools Forum for primary schools, recruitment of 3 primary support workers 17/18 and option to extend by a further 3 in 18/19 with further increase in CAMHS Transformation Funding.
6	£59,034.00	£59,034.00	**Crisis Care Services** – Crisis care lead recruited and will oversee further changes within crisis services
7	£40,000.00	£40,000.00	**Counselling Provision** – Extend existing counselling provision to include developing digital streams and collaborative work with schools
8	£36,800.00	£36,800.00	**Learning Disabilities** –Increase psychology and nurse input into learning disabilities team
9	£60,000.00	£60,000.00	**Commissioning** - supplement exiting commissioning resources to enable smooth implementation of transformation plans and continued commissioning capacity – service development officer recruited
10	£17,500.00	£17,500.00	**Southampton Mental Health Alliance** – Contribution to ageless alliance to bring together service users, carers and providers
11	£20,000.00	£20,000.00	**Peer Support –** Group work with embedded peer support development
12	£51,969.00		**Community Group Work –** Continuation of pilots to test market needs and inform future needs.
	£792,981.00	£748,168.00	Total
	£792,981.00		Transformation budget

4. Promoting resilience, prevention and early intervention

4.1 Southampton is a city committed to prevention and early intervention, our Primary Prevention and Early Help Joint Commissioning Strategy states that Southampton's vision is "An Early Intervention City with multiagency service provision that works to ensure children's needs are met at the earliest stage. Where possible, and children's welfare is assured, these needs will be met within their family and community resources."

4.2 The Southampton Healthy Ambition service replaced Southampton's school nursing service in April 2015. It delivers public health nursing, and leads delivery of the 5-19 year old elements of the Healthy Child Programme. One of the key priorities for the service is emotional wellbeing and mental health.

4.3 Better Care Southampton have developed a pilot to test out the role of Community/Family Navigators. The role of this navigation is to receive and make referrals from/to primary care and cluster teams and provide information about how to access and where necessary directly link people community resources. They will also provide the point of contact to access other universal services, provide active follow up to discover if the identified solution is working or if the person needs additional support to take action or other solutions. Furthermore to map community resources and local organisations, encourage people to up load information on to either the Southampton Information Directory (SID) or Placebook and identify through a process of coproduction gaps in community resources to improve health and wellbeing. The intention is that this will then be rolled out more extensively across Southampton and will cover mental health more fully.

Key Priorities

Current

1. Continue to develop whole school approaches to promoting mental health and well-being.	
1.1. On-going evaluation and development of Southampton's new Healthy Ambition service to ensure school nurses are leading and delivering the Healthy Child Programme 5-19 and working effectively at community, family and individual level and that the Emotional Health & Wellbeing workers are fully embedded in the service and linking to the CAMHS team.	G
1.2. Work with schools to ensure a more consistent use of counsellors and the Department for Education's guidance on evidenced-based school counselling across the city.	A
2. Develop prevention and early intervention services, including harnessing learning from the new 0-2 year old early intervention pilots.	A
3. Complete planning and execute a citywide anti-stigma event with Time to Change for the autumn to coincide with World Mental health day.	G
4. Develop whole family approach and whole family service offer available within the city.	A
5. Continue to explore opportunities to reduce incidence and impact or post-natal depression including monitoring and potential service development of, midwifery, health visiting and FNP services and the NHS commissioned specialist perinatal service.	A
6. Explore opportunities to better utilise links with PSHE networks to develop whole school approach the prevention and early intervention agenda.	A

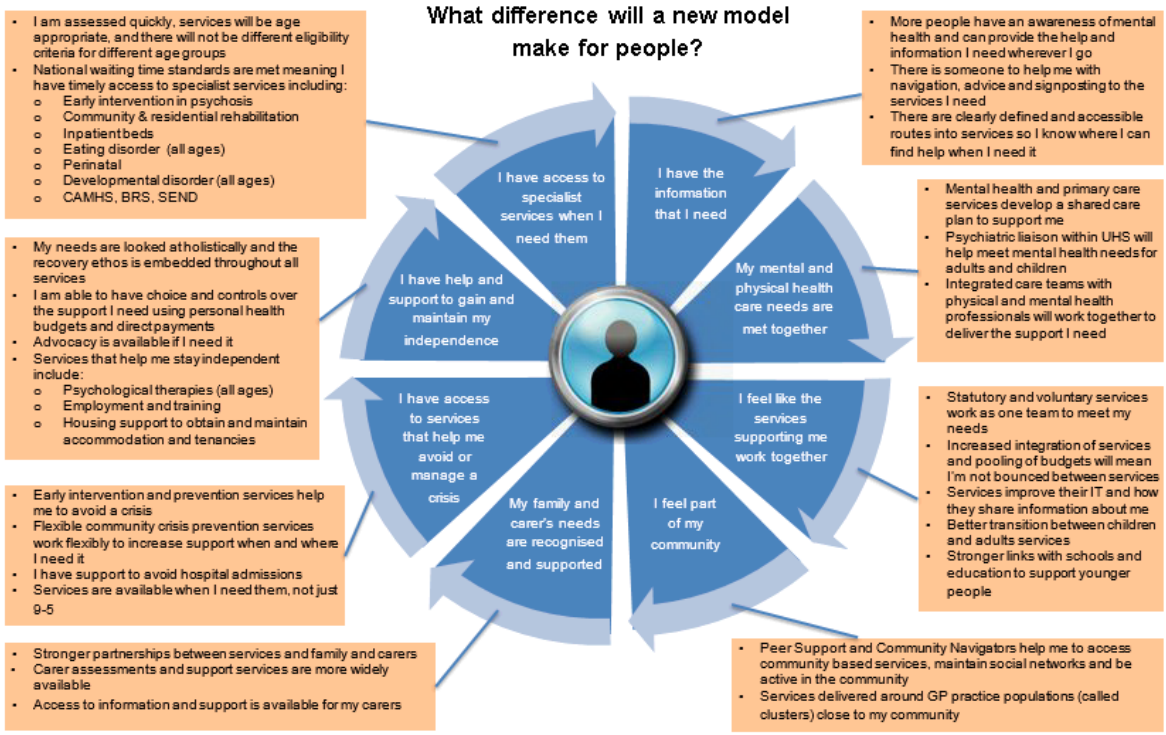
Future

1. Enhancing existing maternal, perinatal and early years health services and parenting programmes
    1.1. Prepare for potential waiting times standards in relation to pregnant and post-natal women accessing Mental Health services, including mental health supervision and training for health visitors, IAPT drop-in at children's centres and outreach from P8T groups
    1.2. 0-2 year old early intervention pilots
2. Incentivise development of new apps to support self-care
    2.1. Continued development of CAMHS app BASE
3. Evaluate Community Navigation role with specific regard to CYP and families and to further extend this model throughout the City.
4. Develop a 'Southampton' PSHE curriculum

5. Improving access to effective support – a system without tiers

5.1 Mental Health Matters, the review of all mental health services within Southampton which has already begun, along with national and local policy and strategy will guide the redesign of our current model. We have already begun moving away from the tiered model in several areas and our future model will create new and develop existing pathways of care which work across the continuum of need from universal support through to the most intensive and targeted interventions including specialist inpatient.

5.2 The diagram below shows how our model will work in practice for our population ensuring that there is easy access to the most effective support for each individual's needs.



5.3 Many mental health services including many of those for children and young people will join with other health and social care services to form integrated teams based around GP practice populations (called 'clusters') as part of Better Care Southampton, putting patients at the center of their own care planning and taking a more whole person approach to care. There is a focus on prevention and early intervention and building on the role of individuals in managing their own health and wellbeing.

5.4 No limits (Southampton's youth information advice and counselling provider) already has a 'one stop shop' service for under 26 year olds and from November 2015 Solent (Southampton's CAMHs provider) began a pilot of a single point of access (SPA) which incorporated the functions of initial telephone triage with families, choose and book system for appointments and telephone advice line.

5.5 A common theme that has been identified in Southampton is the need for all services to be identifying children that are living with parents with mental health problems and ensuring that all services work better to develop a whole family approach.

5.6 By undertaking a workforce review and developing a workforce strategy including training and development needs we will ensure that our future service model delivers a wide range of NICE compliant therapies including CBT and systematic Family therapy to meet our populations needs.

5.7 There is much on-going work engaging with hard to reach CYP in Southampton. We plan to re-evaluate learning and replicate some of the work done in 2013 by No Limits consulting with disadvantaged young children for the GP Champions Youth Health pilot which consulted with 43 young people who had multiple and complex issues.

5.8 Southampton has a significantly higher rate of mental health admissions than all of our statistical neighbours, this may at least in part be attributed to variations in admission policies between acute trusts but will need to be investigated further during our re-modelling.

5.9 Southampton also sees significant numbers of CYP self-harming and has recently analysed the numbers being seen by the DSH team in the emergency department but also those seen within the 'one stop shop' service provided by the voluntary organisation 'No Limits'. We plan to extend the DSH service within the city.

5.10 Developing stronger links between services for CYP with Learning Disabilities (LD) and mental health problems is also a priority for Southampton. The CYP disability service JIGSAW has recently been integrated within the 0-25 SEND service, there has been investment in this team and funds have been diverted to enhance both the CAMHS and SEND team. The addition of 3 sessions of CAMHS consultant time to support clinical supervision for the wider SEND team and also to deliver assessments, interventions and acting as a bridge for specialist/complex pathways such as autism and CYP with LD and complex mental health problems. There is also an LD nurse that works half their time in the SEND team and half within the CAMHS team. Developing a much clearer pathway between specialist SEND services and the new locality based Integrated Universal and Targeted services which are due to go live in April 2016 is a priority to ensure that these teams are much better supported to meet the needs of children with SEND in their local communities.

Key Priorities

Current

1. Expansion of deliberate self-harm service, increasing hours initially to six days a week but with an end goal of 7 day a week service.	A
2. Complete Southampton's comprehensive review of all mental health services and develop/re-model in-line with its conclusions and national and local strategy	G
2.1. Move away from tiered system to a more flexible needs based model based around seamless pathways of care and support.	A
2.2. Explore the expansion of one-stop shops from bases such as No Limits 3 centres within Southampton	A
2.3. Explore where and how CAMHS will fit within Better Care model in Southampton, multi-disciplinary teams, single points of access	A
2.4. Self-referrals in to all teams	R
2.5. Development and introduction of extended 0-25 CAMHs service.	A
3. Explore options to utilise work around school link pilot project – named points of contact within CAMHS, schools and GPs	A
4. Explore development of Joint training programme	G
5. Further develop and strengthen links between CAMHS and LD and SEND services including work around Care Treatment Review's.	A
6. Finish evaluating current peer support programmes and be led by service user engagement as to how this needs to be developed to more fully meet needs	G
7. Crisis Care Concordat local plans	G
8. Development of a Community Eating Disorder service	G
9. Evidenced based pathways for community based care	
9.1. Expansion of intensive home treatment teams	A

9.2. Develop clearer pathways including for step-down provision and discharge from inpatient care	A
10. Mental health and behavioural assessments in admission gateway for YP with LD/challenging behaviour	R

Future

1. Universal Local Offer
2. Waiting time standards for eating disorder service and early intervention in psychosis team
3. On-line information and support
4. Develop improved data around crisis/home treatment for under 18's and the use of section 136
5. Development of primary care mental health teams

6. Community Eating Disorder Service – Southampton, Portsmouth and the Isle of Wight

6.1 The children and young people's eating disorder access and waiting time standard was released in July 2015 and set the direction for improve access and waiting times and the evidenced based treatments offered. The model of care prescribed in the 'Access and waiting time's standard for children and young people with an eating disorder -Commissioning Guide, July 2015' is making recommendation for a viable evidence based eating disorder service which will engage with children young people their families and carers, delineating clear referral pathways, but also providing localised care, in a timely manner.

6.2 The recommended model requires a population footprint of at least 500,000. It is not currently possible to co-commission a Hampshire wide ageless eating disorder service due to the Hampshire CCGs being in the process of procuring a new provider of CAMHs services.

6.3 Portsmouth, Southampton and the Isle of Wight are therefore working together on a joint initiative that meets the criteria of minimum recommended population. The collaboration between Southampton and Portsmouth is further along due to sharing the same provider (Solent NHS Trust) and we are in the early stages of working with the Isle of Wight CCG. Due to obvious difficulties with the Isle of Wight being an island this will need a larger piece of work to consider how the services can work together to align current services. Our ambition in the longer term is to extend this collaboration further to include the rest of Hampshire and to develop a pan-Hampshire ageless service, which the Hampshire 5 CCGs are also committed to discussing further.

6.4 **Population Footprint of collaboration**

CCG	Weighted population
NHS Southampton CCG	245,755
NHS Portsmouth CCG	221,654
NHS Isle of Wight CCG	145,854
Total	**613,263**

6.5 The Eating Disorder money allocated to each CCG for 2016/17 is as follows:

- Portsmouth £110,000
- Southampton £140,000
- Isle of Wight £77,000

6.6 Current Service model in Southampton

6.6.1 Currently specialised CAMHS in Southampton provides assessment and treatment for children and young people and their families or carers, with eating disorders, drawing on the best available evidence. A comprehensive package as recommended by NICE is available and includes Cognitive Behavioural Therapy (brief CBT and CBT – enhanced), Cognitive Analytical Therapy (CAT), Family/Couple Therapy, Carer and family Support Group. There is a nursing team who can offer more intensive community support, extended hours and input to parents via the parent group. There are also close links to specialist inpatient teams both at the general hospital and the local inpatient adolescent unit.

6.6.2 There is a multi-disciplinary team working closely and flexibly with children and their families and others that are important to them. Links with primary care (GPs, to ensure safe management of the physical risks that often accompany an eating disorder) and secondary mental health services are in place, in order to provide a comprehensive package of care. The out-patient service is open Monday to Friday from 8.30am to 5.00pm excluding bank holidays. The intensive community support services are more flexible working more extended hours and currently offering a parent group in the evenings 6-8pm.

6.6.3 A typical outpatient treatment package for anorexia nervosa might last between 20 and 40 sessions. For bulimia nervosa, the typical treatment packages range from 10-20 sessions, although these can be extended depending on individual need. Programmes are available for those stepping down from in-patient care or for those wanting more intensive support than that provided in out-patient treatment alone. The intensive community programmes offer nursing nutritional input, supported mealtimes and a range of therapeutic groups, aimed at supporting individuals to address the psychological issues underlying their eating difficulties. The nutritional dietary recommendations are based on the (weight gaining) plan delivered at Leigh House Hospital, (Tier 4 inpatient provision). Moderations are made to the plan when children and young people reach a position of their optimal maintenance weight. This is also undertaken in negotiation with the primary care services. These programmes are currently run in Southampton five days a week. The structure of the treatment allows time practised and integrated into everyday life. The process of admission and discharge is also supported, for those needing an episode of in-patient care.

6.6.4 There is a confidence that the package offered matches recommendations in the NHS England paper 'Access and waiting time's standard for children and young people with an eating disorder -Commissioning Guide, July 2015'. Waiting time compliance is already within the recommended timeframes, however more work is needed to accurately collect this information and capture it. Working with children and young people with eating disorders is integral to specialist CAMHS, which results in a comprehensive assessment, management of risk and governance, keeping skills updated for all staff.

6.7 Outcome measures

6.7.1 The service currently uses objective outcome measures: CGAS, EAT Questionnaire, RCADS, (for common co-morbidities). They also use height/weight checks and CT scans for delayed menstrual status in girls. The teams offer a variety of ways for users and carers to give feedback about the service development.

6.7.2 The parent support group in Southampton is actively involved in giving carer feedback and have been involved in writing a care package brochure given to newly diagnosed families. As part of the on-going service evaluation feedback is asked for at discharge.

6.8 Number of Eating Disorder cases seen in Southampton – Please note data for 2016/17 currently being collated and 2015/16 investigated due to migration of computer system

2012/2013	2013/2014	2014/2015
49 cases	46 cases	35 cases

6.9 Current staffing levels in Southampton

Professional group	Whole time equivalents	Work undertaken
Consultant psychiatrist	2 sessions	offering case management + mental health assessment + consultation/ liaison with professionals
Community nurses	3 full time band 6	offering community working in the homes, meal supervision in homes and schools, liaison with GP, +

		nutritional advice to families and professionals
Family therapist	5 sessions	offering family therapy + couple work + parent group
Psychologists	4 sessions	offering CBT –E individual therapy, + Supervision
Psychotherapists	2 sessions	offering individual CAT + family parent groups + supervision
Paediatrics in local general hospital	As required	offering physical assessment and short term admission
Nurse- led groups	1 session from 2 band 6 nurses	Offering short term anxiety group.

6.10 Current Waiting Times in Southampton

An initial review of waiting times for eating disorder referrals into our CAMHS service for 14-18 year olds in 2014 has highlighted that 68.9% of CYP are seen within 4 weeks but as yet we are not able to link this to classification of need at time of referral (see table below). As discussed above current data subject to more investigation due to migration issues.

Time till assessment	Number	%
Within 24 hrs	0	0
1 week	7	24.1
4 weeks	13	44.8
Over 4 weeks	9	31
DNAs	5	
Referrals	34	

longest wait 14.3 weeks

6.11 Identified gaps in the service

6.11.1 Currently there is no access to a dietician, which is recognised in the model of care NHS England have recommended.

6.11.2 The teams would seek closer links to our primary care services and schools which would enable streamlined and earlier presentation to clinics leading to better outcomes for the children and young people their families and carers.

6.11.3 The services would also work towards extending the hours of working towards initially six days a week and then to seven day services.

6.12 **Proposal for the funding available in Southampton:**

6.12.1 Sessions of a Dietician (in each of the CCG areas) who would be available to primary care services as well as provide advice the specialist team on nutritional care. This is not available in the current model of service provision.

6.12.2 A full time Nurse Practitioner who would be available to build on the 'out of hours' services, supervising evening meals and visiting families in their homes, extending the working hours of the whole nursing team (from 8-8pm).

6.12.3 A liaison nurse who would work with the GPs, primary care workers and schools to increase education and knowledge, this would enable earlier presentation to clinics for children, young people, families and their carers.

6.12.4 A CBT-E therapist who would be able to provide sessional work over 2 days for young people to gain additional twilight sessions of therapy when college commitments and family life patterns prevent attendance at sessions during usual working hours.

6.12.5 Additional Staff Costing

Profession	Band Grade
Dietician - 0.2 WTE (Recruited)	Band 7
Prescribing Nurse -Full time (Recruited)	Band 6
Occupational Therapist 0.6 WTE (Out to advert)	Band 6
CBT-E Therapist – Full time (Out to advert)	Band 7
Total Cost £147,156.00	

6.13 Service KPI's

To record % of cases that received NICE concordant treatment within the standard's timeframes	69% seen within 4 weeks	75% seen within 4 weeks	Mar-16
To record % of cases that have outcomes data entered electronically on to the IT system	Not measured as new scheme	25% of active cases	Mar-16
To accurately record patient status as either routine, urgent and emergency in % of cases	Not measured as new scheme	95% of referrals	Mar-16

6.14 Progress to date

The funding is allowing the service to employ a dietician and increased Occupational Therapy time to work alongside those young people with an eating disorder. The extra nursing time allows for further meal planning and supervision to take place (over which the dietician will have an oversight). The extra staffing also means that a teaching package can be developed which would be presented to the wider CAMHS team to underpin existing knowledge and skill bases around this specific field of CAMHS intervention.

7. Care for the most vulnerable

7.1 There are groups of children and young people that we know are more at risk of poor mental health. In Southampton, there are high number of Looked After Children, children with Special educational Needs and Disabilities (SEND), young offenders, children and young people living in families experiencing domestic violence, under 18's admitted to hospital for alcohol specific reasons, and numbers of children living in poverty. All of these factors make children and young people more vulnerable.

7.2 Southampton's Multi-Agency Safeguarding Hub (MASH) and Early Help Teams are positive examples of creative integration designed to maximize the impact of diminishing public sector funding. They offer high quality evidence based support around which organizations from all sectors can align and develop additional services. There is a Solent NHS health navigator within the MASH team who can access any information on CYP held within the CAMHs service and also provide advice and on suitability of service referrals.

7.3 Hampshire Liaison and Diversion Service began operations on the 1st April 2015. There are two teams, one in Soutampton and one in Portsmouth. The Southampton team operates Monday to Sunday 9am-9pm and includes all vulnerable adults and children, people with mental illnes, substance misuse issues, learning disabilities, head injuries, autism or ADHD.

7.4 University Hospital of Southampton (UHS) provides a Paediatric psychiatric liaison service which is concerned with providing a bridge between acute paediatrics and psychiatric and psychosocial care for children and young people receiving treatment within the hospital where the presenting illness has a psychological component or where psychological distress is caused by the illness. While the hospital provides paediatric services for a larger population that Southampton city CCG and specialist services for the South West of

England there referral data included within Appendix P is useful in understanding the most common presenting issues in this vulnerable group of CYP.

Key Priorities

Current

1. Develop policies and practices which ensure that children and their families who do not attend appointments are not just discharged from service.	R
2. Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate bespoke care pathways	A
2.1. Continue work around links with Liaison and Diversion service. Further development of YOT multi-disciplinary team.	A
2.2. Explore the possibility of using some of the additional funding to progress unsuccessful school pilot extension bid which looked at developing specialist outreach teams to upskill school staff to be better equipped to support children dealing with trauma and to have mental health workers embedded within early help teams to work with families when children are on the edge of care.	A
2.3. On-going work with the BRS service which supports some of our most vulnerable children and families.	G
2.4. Further strengthening of mental health function within Families Matter and early help teams.	A
2.5. Continue work on pathways/referral processes and joint working between services including the City's CSE and Rape Crisis services	A
3. On-going development and expansion of multi-agency teams with flexible acceptance criteria for vulnerable children (need not diagnosis).	A
4. Working with lead officer for Childhood Sexual Exploitation within the city to ensure changing understanding and knowledge of need is met and clear and affective pathways are in place.	A
5. Work with SARC and NHS England specialist commissioner to ensure necessary links and pathways are working effectively.	A
6. On-going review of MASH and function of mental health staff within the team.	A
7. Development and expansion of Lead professional approach for the most vulnerable CYP with multiple and complex needs.	A

Future

1. Working with professional bodies to improve skills of professionals working with children & young people with mental health problems
2. Pilot – teams specialising in supporting vulnerable CYP
3. Development of tierless services with SPA and no referrals rejected but always signposted/aligned with an appropriate service.

8. Accountability and transparency

8.1 Southampton's Integrated Commissioning Unit went live in December 2013, and merged commissioning teams from Southampton City Clinical Commissioning Group, Southampton City Council Adult services and Southampton City Council Children's services. This integration has not only seen the introduction of lead commissioners for service areas across health and social care but has enabled much easier pooling of funds and co-ordinated strategic planning.

8.2 Southampton's Health and Wellbeing Board are responsible for driving forward improvements in mental health in the City and have strong links to all aspects of the Mental Health Matters review.

8.3 Southampton is committed to working with all partners to ensure that the most effective and integrated services are commissioned for the local populations specific needs. We will continue to work with colleagues from NHS England as well as neighbouring CCG's and local authorities, pooling resources where sensible to do so to ensure that services commissioned provide a seamless and holistic service provision which mitigates the risks of service users slipping through gaps, avoid duplication and offer the best outcomes for our residents.

The table below shows the spend for specialist commissioning for Southampton (original table 2014/15)

Hub Region	Provider Name	NHS Southampton CCG	Grand Total
London	East London NHS Foundation Trust	£40,592	£40,592
	Ellern Mede Centre for Eating Disorders	£157,668	£157,668
London Total		**£198,260**	£198,260
	Cygnet Health care Limited	£39,762	£39,762
	Dorset Healthcare University Foundation Trust	£7,286	£7,286
	Priory Group Limited	£353,347	£353,347
	Southern Health NHS Foundation Trust	£246,223	£246,223
South Total		**£646,618**	£646,618
Grand Total		**£844,877**	£844,877

Contract Title	Total Investment (NHS England, City Councils, Police and Crime Commissioners)
Liaison and diversion scheme (SE and SW Hampshire)	£1,045,647

8.4 Current CAMHS activity and waiting times (please note that 15/16 waiting times has been excluded due to the migration of data to a new operating system and the poor data quality for that year).

2014/15 CAMHs Waiting times		
<4 weeks	382	22.37%
4-11 weeks	620	36.30%
11-18 weeks	482	28.22%
>18 weeks	224	13.11%
Total	1708	100.00%

2016/17 Apr-Jul CAMHs Waiting times		
<4 weeks	198	56.25%
4-11 weeks	72	20.45%
11-18 weeks	12	3.41%
>18 weeks	70	19.89%
Total	352	100.00%

Referrals 2014/15

Accepted 1,351
Rejected 324 (24%)

Referrals 2015/16

Accepted 1,474
Rejected (data inaccuracies)

Referrals 2016/17 to date (Apr- Jul)

Accepted 395
Rejected 129 (32%)

Referrals 2015/16		
Month of Referral	**Referrals Received**	**Referrals Accepted**
Apr-15		133
May-15		136
Jun-15		138
Jul-15		154
Aug-15		97
Sep-15		119
Oct-15		138
Nov-15		148
Dec-15		101
Jan-16		101
Feb-16		130
Mar-16		79
2016 YTD		**1474**

Referrals 2016/17		
Month of Referral	**Referrals Received**	**Referrals Accepted**
Apr-16	116	90
May-16	139	111
Jun-16	132	100
Jul-16	137	94
2016 YTD	**524**	**395**

With the continued recruitment to the early intervention and prevention team it is anticipated that rejected referrals will reduce significantly over 2017/18.

Contacts

The tables below illustrates the new and follow up contacts throughout 2015/16 and 2016/17 to date. It should be noted that a significant amount of the CAMHS Transformation money in 2015/16 was spent on initiatives that were system enablers and schemes to reduce waiting times, alongside the migration to a new information system means that the data found in the table below should be viewed with caution.

Contacts 2015/16		
Row Labels	**Sum of new**	**Sum of Follow_Up**
Apr-15	536	754
May-15	347	963
Jun-15	317	1323
Jul-15	265	1236
Aug-15	141	882
Sep-15	207	964
Oct-15	148	481
Nov-15	164	814
Dec-15	87	671
Jan-16	130	787
Feb-16	154	876
Mar-16	72	856
2016 YTD	**2568**	**10607**

Contacts 2016/17		
Month	**Sum of new**	**Sum of Follow_Up**
Apr-16	90	786
May-16	102	822
Jun-16	82	845
Jul-16	78	840
Grand Total	**352**	**3293**

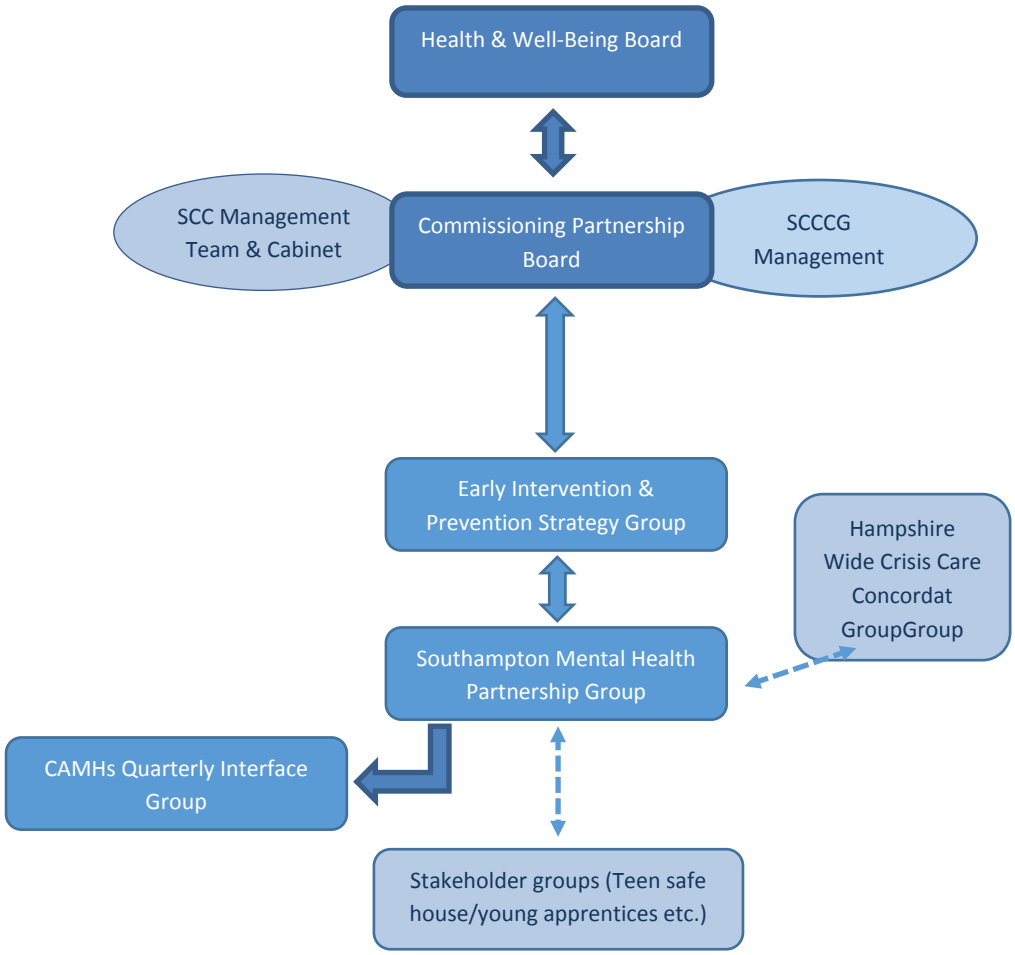
Number in treatment

Number of children in treatment as at 31/03/2016	1,634
Number of children in treatment as at 30/09/2016	1,670

2016/17 will provide the baseline for meeting the 2018/19 target to increase the number of children and young people in treatment by 32%. Southampton's focus on early intervention and prevention will play a significant role in achieving this ambition. Currently 32% of referrals were rejected as they were either inappropriate or did not meet the current CAMHS Tier 3 criteria. With the development of the early intervention and prevention team it is anticipated that many of those currently rejected would meet the criteria for our teams.

Work is continuing to address not only overall waiting times but also to tackle the secondary waiting times that occur after an initial assessment has occurred. In addition to the money announced by NHS England this year to help reduce waiting times the Integrated Commissioning Unit have invested in reducing the CBT, autism diagnosis and counselling waiting times.

8.5 The diagram below illustrates the governance structure which will be applicable for decisions made in relation to this transformation



8.6 Throughout the Mental Health Matters review CYP, families and key stakeholders formed a huge part of both the engagement process and then the formal consultation with 56% of feedback received from service users and carers.

Key Priorities

Current

1. Continuation of consultation and engagement with CYP (including hard to reach groups), family and other relevant stakeholders whilst developing the transformation plan and Mental Health Matters review	G
2. Explore new opportunities and build upon existing co-commissioning arrangements with NHS England	A
3. Ensure NICE quality standards continue to inform and shape commissioning decisions	G
4. Increase in level of local benchmarking/monitoring data collected and reported on.	A
5. Waiting time standards for early intervention in psychosis and Community eating disorder service.	A
6. Monitoring access and wait measurement against pathway standards	A
7. Financial investment transparency	G

Future

1. Data collection and analysis
   1.1. CAMHS minimum dataset
   1.2. Routine outcome data collection
2. Prevalence survey

9. Developing the workforce

9.1 Current CAMHS workforce and skills – CAMHS currently has a multi-disciplinary team that offer a variety of NICE recommended and evidence based interventions. The Mental Health Matters review aims to work with the CAMHS provider and CYP their families and other key stakeholders to re-design the way current services are configured.

Specialist CAMHS workforce as at 31st March 2016:

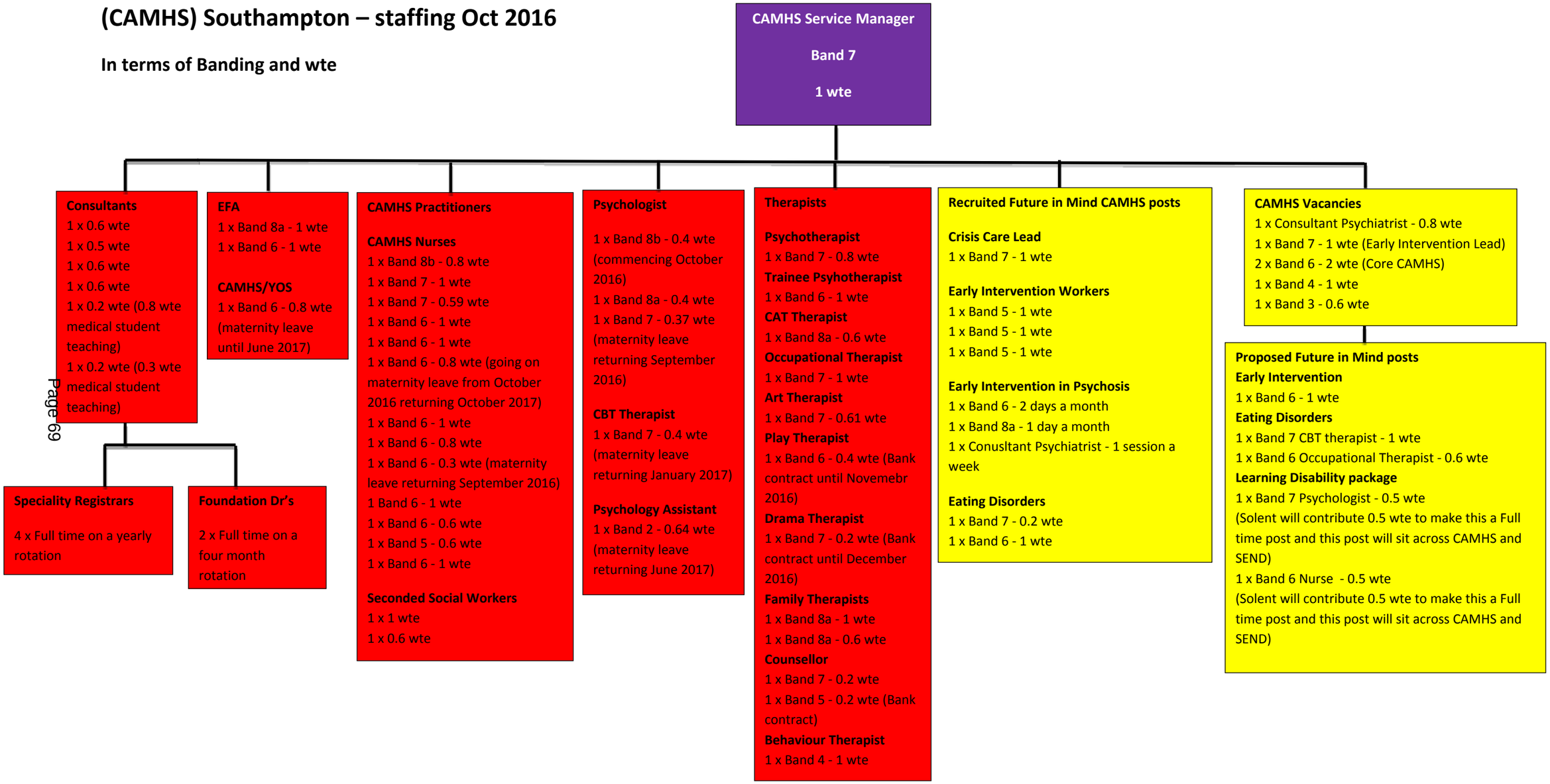
Profession	WTE	Skills	
Staff Nurse	8.1	Individual CBT	
Specialty Registrar	4.9		
Specialist Registrar (Closed)	1.4		
Specialist Nurse Practitioner	3.5		
Psychotherapist	1.5	Psychodynamic Psychotherapy	
Nurse Manager	0.8		
Occupational Therapy Specialist Practitioner	1.6	Psychodynamic Psychotherapy	
Multi Therapist	2		
Healthcare Assistant	0.6		
Health Care Support Worker	0.8		
Consultant	4.1		
Clinical Psychologist	4.3	CBT Therapist (PGDip)	CBT Supervisor (PGDip)
Clerical Worker	7.9		
Assistant Psychologist	1.4		
Total	**43.0**		

Workforce BRS (Behavioural Resource Service)

Profession	WTE	Skills
Clinical Psychologist	4.3	CBT therapist (PGDip), Interpersonal therapy, CBT Supervisor (PGDip), Family therapy
Specialist Nurse Practitioner	3.4	Individual non-directive supportive therapy, Interpersonal therapy, psychodynamic psychotherapy, family therapy
Total	**7.7**	

Child Adolescent Mental Health Services (CAMHS) Southampton – staffing Oct 2016

In terms of Banding and wte



9.2 A comparison of the staffing at March 2016 to October 2016 illustrates that once all vacancies are recruited to there will be a real time increase of 12.71WTE within the CAMHS team. This is from the addition of new posts and as a result of workforce development and changes to the skill mix of the team following vacancies. This figure excludes admin, temporary posts and medical student teaching. It also excludes the BRS team.

9.3 CY-IAPT transformation programme – Southampton has joined a CYP-IAPT collaborative and is currently working with the collaborative to begin identifying staff with appropriate experience and qualifications are being invited to participate in training courses. Discussions have commenced with Solent NHS Trust and the Voluntary sector provider of our counselling services to look at future models. This is in response to the national guidance that by 2018 CAMHS develops a choice of evidence based interventions, adopting routine outcome monitoring and feedback to guide service design, working collaboratively with children and young people.

9.4 We will also work with the workforce development team within Southampton City Council to ensure that mental health training remains prominent within the programme of training offered to all practitioners within the city and look to develop this with them in conjunction with our CAMHs provider.

9.5 We will commission a robust and detailed workforce strategy which will include identifying any risks around not securing sufficient clinical CAMHS and mental health experienced clinicians. Southampton University and our CAMHS provider are a training centre for medics and succession planning is a priority at both undergraduate and post graduate levels – with dedicated personnel funded for this agenda. Solent NHS Trust are working closely with colleagues in learning and development and the university to ensure the programmes are fit for practice and will deliver against service needs.

Key Priorities

Current

1. Targeting training and continued professional development (CPD) of health and social care professionals to create workforce with appropriate skills, knowledge a values	A
2. National mental health commissioning capability development programme	A
3. CYP IAPT – joining programme, training	A
4. Develop comprehensive workforce strategy	G
5. Continue to develop this transformation plan in response to findings, outcome of mental health matters etc.	G

Future

1. CYP IAPT – joint programme, training
2. Develop comprehensive workforce strategy

DECISION-MAKER:		**Health and Wellbeing Board**		
SUBJECT:		0-19 Prevention and Early Help		
DATE OF DECISION:		30th November 2016		
REPORT OF:		Director of Quality and Integration		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman**	**Tel:**	**023 8029 6004**
	E-mail:	**Donna.chapman@southampton.gov.uk**		
Director	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 8029 6923**
	E-mail:	**Stephanie.ramsey@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

The Integrated Commissioning Unit are investigating how to achieve a more integrated offer of prevention and early help services for children 0-19 and their families.

RECOMMENDATIONS:

	(i)	Health & Wellbeing Board to note the progress made so far investigating the main options to improve this service.

REASONS FOR REPORT RECOMMENDATIONS

1.	The 0-19 prevention and early help service offer is aimed at improving the health and wellbeing of people using these services in the city. The Health and Wellbeing Board is therefore recognised as a key partner in the development and delivery of the service.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	NONE

DETAIL (Including consultation carried out)

3.	The aim of the 0-19 prevention and early help service offer is to bring together a range of health and local authority services to deliver a strengthened prevention and early help offer based around localities, schools and communities. By so doing, it is intended to provide families with a seamless journey of support (where they get the right information, the right help and the right challenge by the right person at the right time) that enables them to manage independently, thereby increasing family resilience, promoting the protective factors for children and young people and reducing the need to resort to expensive specialist or statutory intervention.
4.	These services include a range of services some of which are delivered in house (Children's Centres and Families Matter) whilst others are commissioned through contracts (Public Health Nursing, Oral Health Promotion, Breastfeeding support and healthy settings promotion and awards).
5.	Options for integrating this offer: i. Continued alignment of all the services in scope (no formal integration) ii. Integration of Public Health Nursing services only (to form a 0-19 public health

	nursing service) to align with remaining services in the offer iii. Fully integrated offer achieved through procurement iv. Fully integrated offer achieved through integrated provider arrangements (no procurement) v. Joint procurement with Portsmouth – for option 2 A verbal update will be given at the meeting.
RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	NOT APPLICABLE
Property/Other	
7.	NOT APPLICABLE
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	NOT APPLICABLE
Other Legal Implications:	
9.	NOT APPLICABLE
POLICY FRAMEWORK IMPLICATIONS	
10.	None

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	

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
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	No

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

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

1.	None	

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DECISION-MAKER:		**REPORT TO HEALTH AND WELLBEING BOARD**		
SUBJECT:		UPDATE ON BETTER CARE		
DATE OF DECISION:		30 November 2016		
REPORT OF:		Director Of Quality and Integration		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman**	**Tel:**	**023 8029 6004**
	E-mail:	**Donna.chapman@southamptoncityccg.nhs.uk**		
Director	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 8029 6941**
	E-mail:	**Stephanie.ramsey@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
NOT APPLICABLE		
BRIEF SUMMARY		
This report provides a summary of the 2016/17 Better Care programme and key schemes as at the end of Quarter 2.		
RECOMMENDATIONS:		
	(i)	To note progress and performance.
	(ii)	To note and comment on priorities for 2017/18 and beyond.
REASONS FOR REPORT RECOMMENDATIONS		
1.	Nationally Health and Wellbeing Boards are responsible for signing off the Better Care Plan for their area and providing high level oversight, ensuring that partnership arrangements are effective and that plans are robust, ambitious and realistic in their aspiration. In Southampton, the Integration Board which has broad partnership representation has the role of driving delivery of the Better Care plan and receives monthly reports on performance. The Integration Board in turn reports to the Health and Wellbeing Board.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	NOT APPLICABLE	
DETAIL (Including consultation carried out)		
	Background	
3	Planning guidance was published in February 2016 for 2016/17 Better Care Fund (BCF) plans. The policy guidance also highlighted the importance that BCF plans are aligned to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of 7 day services.	
4	Southampton city's plan was signed off by the Health and Wellbeing Board on 20 April 2016 and by the Commissioning Partnership Board of the CCG and Council on 14 April 2016, prior to submission to NHS England on 3 May 2016. It was developed with strong engagement from health and social care partners,	

	the voluntary sector and housing through the Integration board.
5	Plans for 16/17 specifically included: • ***Further development of clusters*** – extension to working age adults, impacting on high users of health care; closer alignment of social care staffing. • ***Supporting carers*** – continuing to increase numbers identified and supported. • ***Rehabilitation/reablement and supported discharge*** – consolidating the integration and focus on discharge. • ***Telehealthcare*** – developing the vision, cultures and preparing for a wider expansion of use within health and social care settings. ***Prevention and early intervention*** – building on the 2015/16 Community Solutions work and recommissioning services in the following areas to redirect resources to key priorities: Information and advice services; Developing community resilience; Behaviour change and Housing related support.
6	**Progress to date (Quarter 2).**
	Further development of Clusters (total value of pooled fund = £34,086,000 - split 96% funding from CCG / 4% funding from SCC)
	Key areas of development include: • Introduction of working age adult facing services to the integrated cluster working model, including adult mental health services, with a particular focus on targeting those with more complex needs, multi-morbidities and challenging social circumstances which can trigger high usage of health and social care • Exploration of Children's cluster development in 3 of the 6 clusters. • Development of Cluster leadership which is being strengthened through admin support and development of a leadership team model (with identified management, clinical/professional, commissioner and community leads). • Introduction of a self-assessment and peer approach to evaluation, focussed on identifying the extent to which the key characteristics of integrated working are embedded in each cluster (e.g. key worker role, risk stratification, multidisciplinary team delivery). Self-assessment by each cluster will take place over November to December 2016 with a view to completing the peer review in Quarter 4 of the year. This process will provide improved assurance that cultural and system changes to integrated working are being implemented. • Specific developments in individual clusters include: o Cluster 5 – new approach to practice multidisciplinary team meetings and leading for the system on developing a single anticipatory (crisis) care planning process/model. o Clusters 3 and 4 – undertaking complex care discussions within cluster meetings. o Clusters 1 and 2 are modelling an approach to promote joint working between mental and physical health services

	○ Cluster 1 is developing an approach to piloting a closer relationship between primary/community and acute care for paediatric patients. • Programme of redesign for community nursing to reshape/integrate nursing resources in the community (including aligning practice nursing). • Building on the learning from the 18 month pilot, recommissioning of the Over 75 nurses to deliver a Community Wellbeing Service for adults of all ages which will commence 1 April 2017. The service has been expanded to include individuals in the full adult age group who would benefit from a proactive approach to care planning and their care, targeting those people who are not in receipt of core community service provision. • Local Solutions Group commencing (Cluster 5) to map in detail neighbourhood resources. • Building on the learning from the Community Navigation pilot in two clusters and rolling this out to the rest of the city, with plans being developed to recommission the service for 2017/18. • Review and enhancement of cluster performance dashboard. • Linking communication within clusters with Domiciliary Care provision • Establishment of a development plan for SCC Long Term Care Teams for further integrated working at cluster level, including agreement on performance reporting.
7.	Priorities for the next 3-6 months include: ○ Continued embedding of cluster leadership teams ○ Embedding the working age adults involvement ○ Developing the children's facing offer ○ Refresh strategy to devolve more of the care and support for people with long term conditions to cluster teams with the specialist services taking on more of an advisory, supporting role, providing training and consultation and, where appropriate, shared care
8.	***Rehabilitation and Reablement and supported discharge (total value of pooled fund = £29,178,000 split 80% funding from CCG / 20% funding from SCC)***
	The integrated service went live from 1 April 2016 and is still bedding down, although making good progress in key areas: - 95% of referrals for crisis response will be responded to within 2 hours of referral – target being met. - 100% of patients/clients to have an identified lead professional from their home cluster or from the integrated service – target being met. - 95% clients receiving reablement to have an initial review by rehabilitation/ reablement service within 2 weeks of commencing their reablement package – achieving 91% . - 70% of agreed reablement goals achieved or partially achieved – achieving 76%. The key areas of challenge have been: • The capacity in the domiciliary care market, particularly long term care

placements, to enable clients to move out of rehabilitation and reablement at the end of their episode of care. This has impacted on flow and therefore capacity. An action plan has been put in place to address the issues around domiciliary care and some progress has been made in bringing in additional capacity from providers both on and off the SCC Domiciliary Care Framework and tightening up assessment and review processes. Some improvement has been seen recently (e.g. 50% reduction in the numbers of client awaiting move on care); however shortages in domiciliary care are a national issue for which there are no "quick fixes". Additionally, a block contract is being negotiated with one of the Lot 5 Reablement providers on the domiciliary care framework and this is expected to provide additional reablement capacity towards the end of November 2016.

- The pace of structural integration within the service, particularly in relation to budgets (health and social care budgets are still separately managed and accounted for) and IT systems, has impacted on the pace of cultural integration and the ability to fully realise the opportunities of an integrated service.

9. Priorities for the next 3-6 months include:

- Development of the discharge to assess function of the integrated rehabilitation and reablement service to support the 3 discharge pathways that are being rolled out as part of improvements to discharge processes for 2017/18. This will enable people to have their future care needs assessed out of an acute hospital setting.
- Development of the Hospital Discharge Team to support the new discharge pathways.
- Ongoing work as described above to improve capacity and flow for long term care.

10. ***Supporting Carers (total value of pooled fund = £1,389,000 split 89% funding from CCG / 11% funding from SCC)***

This scheme relates to the provision of carer assessments and is showing a significant increase in the numbers of carers being identified and assessed, as demonstrated in the table below.

	Year 1 6 months 1 Sept '14– 31 March '15	Year 2 12 months 1 April 15– 31 Mar'16	Year 3 6 months 1 April '16 – 30 Sept '16
Carers contacting service	200	842	931
Carers on database	227	961	432
Reach through marketing*	Not recorded	6,239	6,894
Carers assessments completed	n/a	222	112
Nº personal budgets awarded	n/a	111	73

- All adult carers who receive an assessment are also contacted by Carers in Southampton to offer support that is relevant to their identified needs, including signposting to other agencies as appropriate. The majority of

<table>
<tr><td></td><td>assessments are via telephone and then face to face, where necessary.
• Although there has been a lack of resources to process carer's direct payments in a timely way, all carers that were assessed before the end of this quarter have now started receiving their payments. The support plans show that they are exercising choice in how they anticipate spending their personal budgets, and the majority have elected to take a direct payment.</td></tr>
<tr><td>11.</td><td>Whilst the scheme is broadly within budget, there is however an anticipated rise in cost for increased assessments and an Options Paper is being prepared for consideration at the end of 2016 on how carers assessments will be provided in future.</td></tr>
<tr><td>12.</td><td>Priorities for the next 3-6 months include:
• Full implementation of online carer assessments and development of the service in accordance with the option chosen through the Options Paper.
• Develop practices within adult social care and children's services to deliver a whole family approach to children's and adults' care.</td></tr>
<tr><td>13.</td><td>Development of the visions and culture for telehealthcare (total value of pooled fund = £258k - 100% funding from SCC in 16/17, following investment from CCG in 15/16)</td></tr>
<tr><td>14.</td><td>The purpose of this scheme was to:
• Develop a clear vision and strategy for telehealthcare in Southampton
• Deliver the culture change and engagement required to prepare the Adult Services workforce to make even more high quality referrals
• Broaden the telecare service and pathway into health to deliver better outcomes for patients
• Robustly measure the financial and non-financial benefits of enhanced telecare
• Configure a commercial model to reward service performance and development
There has been progress across all these areas and positive take up is being seen across Adult Social Care and engagement within health settings.
<table>
<tr><th>Target</th><th>Plan to date</th><th>Actual to date</th></tr>
<tr><td>1. 720 ASC clients who are new, or new to receiving care technology</td><td>652</td><td>177*</td></tr>
<tr><td>2. 105 telecare referrals (health setting)</td><td>25</td><td>0</td></tr>
<tr><td>3. % of ASC staff trained</td><td>100%</td><td>98%</td></tr>
<tr><td colspan="3">*These are confirmed installations to date. Referrals have been increasing with a rise from 8 in April to 42 in September (5 in May, 28 in June, 40 in July, 44 in August)
Net savings are pending the Benefits tracking process being implemented. From referral source (not validation) it shows
• 61% of referrals are likely to avoid an immediate increase in costs
• 30% of care packages were expected to increase in coming months if telecare not provided</td></tr>
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	• 9% were already high cost packages that are expected to reduce as a result of telecare
15.	Priorities for the next 3-6 months include: • Finalise the strategy for care technology in Southampton through the Independent Living Board. • Explore and progress options for delivering the strategy.
16	**Performance against targets**
	Despite good progress within each of the schemes, performance against the national targets has been challenging this year, particularly with regard to delayed transfers of care (DTOC) but also for non-elective admissions. The table below presents performance as at the end of month 6.

OFFICIAL PERFORMANCE METRICS		Apr	May	Jun	Jul	Aug	Sep	YTD Plan & Actual	Difference	% Difference (Actual vs. Plan)	% Difference (Actual vs. Last Yr)
Permanent admissions to residential & nursing homes (65yrs+)	16/17 Target	26	26	29	27	25	24	157	-31	-20%	-28%
	16/17 Actual	23	23	25	17	20	18	126			
Delayed transfers of care from hospital (DToC) (18yrs+)	16/17 Target	909	1188	1299	1266	1190	1078	6,930	1477	21%	17%
	16/17 Actual	1,041	1,418	1,348	1,693	1,415	1,492	8,407			
NEL admissions (all ages)	16/17 Target	2206	2339	2237	2282	2169	2235	13,468	417	3%	1%
	16/17 Actual	2,281	2,307	2,393	2,343	2,267	2,294	13,885			
Injuries due to falls (65yrs +)	16/17 Target	75	79	80	72	77	74	458	88	19%	6%
	16/17 Actual	89	84	102	70	105	96	546			

NEL Admissions by Age Group		Apr	May	Jun	Jul	Aug	Sep	YTD	Difference	% Difference (Actual vs. Last Yr)
Children (0-17 yrs)	15/16 Actual	297	301	304	290	238	346	1,776	8	0%
	16/17 Actual	313	326	299	296	237	313	1,784		
Working Age Adults (18-64 yrs)	15/16 Actual	1229	1388	1344	1440	1272	1310	7,983	107	1%
	16/17 Actual	1,287	1,318	1,412	1,385	1,353	1,335	8,090		
Older People (65+ yrs)	15/16 Actual	783	792	765	728	754	782	4,604	389	8%
	16/17 Actual	843	811	857	840	795	847	4,993		

The only metric that is performing well to date is the number of ***permanent admissions to residential and nursing homes*** which have significantly reduced and are 20% lower than plan. This data has been checked and confirmed that it is accurate. Whilst this may appear positive on the surface, it is worth noting that one of the main reasons for delayed discharge this year is delay in nursing home placements.

Delayed transfers of care (DTOC) are the greatest area of concern and at month 6 are 21% higher than plan and 10% higher than the same period last year. The main reasons for delay are understood from the data to be the

	following: • The pressures in the domiciliary care market which are as a result of a combination of increased demand and complexity (there has been a 24% increase in double up packages compared to last year) and difficulties in recruitment. As highlighted above, an action plan is in place to improve domiciliary care capacity and includes short to medium term actions such as improving assessment and review systems, working with providers to increase capacity and reducing 15 minute calls, through to longer term actions such as workforce development. This action plan is overseen by the Independent Living Board and reviewed weekly. • Growing delays in access to nursing homes, partly associated with delays in assessment and partly due to the ability to source placements, particularly for those people with higher level needs, e.g. people with dementia and challenging behaviour. An action plan to address nursing home delays is currently being developed. ***Non elective admissions*** are 3% above plan. This is largely being driven by an 8% increase in admissions in the over 65s age group, reversing the downward trend seen in the previous year. Admissions due to falls injuries are also increasing (9% over plan), although the numbers are small and therefore year on year comparisons can be misleading. ***A key focus going forward needs to be on strengthening cluster leadership to enable devolution of more responsibility for decision making to a cluster level, along with the accountability for achieving the city wide reductions in each cluster, based on a clear multiagency understanding of the local issues and agreed multiagency action plan to address them.***
17.	**Priorities for 2017/18 and Beyond**
	At the time of writing this report, national Better Care guidance for 2017 - 19 has still to be published but is expected towards the end of November 2016. The deadline for 2017-19 Better Care plans is likely to be 12 January 2017.
18.	As a city, Southampton will be continuing to roll out its vision of transforming the delivery of care so that it is better integrated, delivered as locally as possible and person centred. This will mean further delivering against the 6 key priorities outlined below: • Delivery of the integration agenda across the full life-course, to include children and families as well as adults and older people. • A strong focus on prevention and early intervention. • A greater proportion of care delivered out of hospital and in the community. • Developing a vibrant community and voluntary sector - to support people in their communities by building resilience, promoting independence and access to community resources. • New organisational models which better support the delivery of integrated care and support, joined up patient/client record systems, joint use of estates and greater use of technology solutions to drive efficiencies • New contractual and commissioning models which enable and incentivise the new ways of working described above

19.	Key areas of focus for the 17 - 19 Better Care plan are therefore likely to be: • Further strengthening cluster leadership to drive forward the necessary changes in culture, embed the characteristics of integration and deliver the city's performance targets at a cluster level. • Developing place based commissioning to support this approach. • Exploring new contractual and payment structures to better support our vision of integrated, place based local care. • Developing primary care in line with the city's primary care strategy as the bed rock to our vision. • Embedding delivery of 7 day services. • Rolling out discharge pathways and processes, underpinned by discharge to assess and trusted assessment principles. • Developing community services to support the management of higher levels of acuity in the community. • Support to develop the community and voluntary sector as equal partners in achieving our vision. To include specific developments such as: o Roll out of care navigation o Development of our "older person's offer" o Development of advice, information and guidance
RESOURCE IMPLICATIONS	
Capital/Revenue	
20.	NOT APPLICABLE TO THIS REPORT
Property/Other	
21.	NOT APPLICABLE
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
22.	NOT APPLICABLE TO THIS REPORT
Other Legal Implications:	
23.	NOT APPLICABLE
POLICY FRAMEWORK IMPLICATIONS	
24.	NOT APPLICABLE
KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	
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
Privacy Impact Assessment			
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.			No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**			
Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None		

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DECISION-MAKER:		**Health and Wellbeing Board**		
SUBJECT:		Southampton, Hampshire, IOW and Portsmouth (SHIP) Transforming Care Partnership Plan Update		
DATE OF DECISION:		30th November 2016		
REPORT OF:		Director Quality and Integration Southampton City CCG / Southampton City Council		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Matthew Harrison**	**Tel:**	**023 80834830**
	E-mail:	**Matthew.harrison@southampton.gov.uk**		
Director	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296293**
	E-mail:	**Stephanie.ramsey@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY
This report provides an update on progress of implementing the Transforming Care Plan for people with learning disabilities and autism. Southampton City Council and Southampton City Clinical Commissioning Group are working in partnership with local authorities and CCG's in Hampshire, the Isle of Wight and Portsmouth to implement the regional plan.

RECOMMENDATIONS:		
	(i)	Health & Wellbeing Board to note the Transforming Care Plan and the progress made so far on the main areas of work within the plan.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Transforming Care Plan includes actions aimed at improving the health and wellbeing of people with learning disabilities in the city. The Health and Wellbeing Board is therefore recognised as a key partner in the development and delivery of the plan.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None. NHS England require all local authorities and CCG's to be part of a Transforming Care region.

DETAIL (Including consultation carried out)	
3.	The Department of Health and NHS England set up the Transforming Care programme to strengthen the improvement work following the exposure of abuse of people with learning disabilities and autism at Winterbourne View in 2011. They require local authorities and CCG's to work in partnership with other local stakeholders to put together and implement a plan to transform care and support for children, young people and adults with learning

	disabilities and autism. One of the main aims of the programme is to facilitate the appropriate discharge of people with learning disabilities and autism in specialist in-patient units and to reduce, as far as possible, the number of people being admitted to these units. NHS England have set the national expectation that 45-55% of inpatients are discharged by 2019 and unnecessary inpatient beds will be closed at the same time. Historically the north of England has had much higher inpatient numbers than the south so their percentage reduction required is much higher.
4.	Southampton, Hampshire, the Isle of Wight and Portsmouth (hereafter called 'SHIP') have joined together to form one of the 48 Transforming Care partnerships in England. The SHIP Transforming Care Plan was submitted to NHS England in March 2016 and is a three year plan aiming to reduce the inpatient numbers to 30-40 beds per million population. There are currently 68 inpatients from the SHIP area of whom 25 are funded by local CCG's and 43 by NHS England specialised commissioning. The aim is for this to reduce to 53 inpatients by 2019. There are currently three inpatients from Southampton.
5.	Due to the low inpatient numbers, efforts to facilitate discharge are happening on an individual basis with joint work between case managers and commissioners to ensure that there is appropriate housing, care and wider community support available.
6.	Alongside the work to facilitate the appropriate discharge of current inpatients, there is also a focus on preventing future admissions to inpatient units and more broadly improving services for all people with learning disabilities and autism. The main work areas of the plan are: • Development of Community Services • Developing the Workforce • Developing a Regional Approach to Housing Development The following sections provide an update on progress for each of these work areas.
7.	**Developing Community Services** The overall aim of this workstream is to improve the services available in the community so that individuals can be appropriately supported in their own homes and local areas. The progress so far has been: • Development of a community forensic service which began taking referrals in September 2016. They will work with individuals with learning disabilities and autism who have been in contact with the criminal justice system and provide training to support agencies. • Continuation of the Learning Disability Acute Liaison Nurse role within the hospital (UHS). The Liaison nurse can support colleagues in the hospital to make reasonable adjustments so that any individuals with learning disabilities and autism are supported appropriately during their stay. • A pilot is due to start in early 2017 with a number of GP practices to

	make then 'Learning Disability Friendly' by for example providing accessible easy-read information. Findings from this pilot will then be built on and good practice spread more widely. • A strong focus on increasing the availability, uptake and quality of Annual Health Checks for people with learning disabilities and autism. This involves working with GPs, support providers and individuals to ensure the process of being invited for a health check, actual attendance and the resultant actions are clearly understood by all involved. • Local areas are developing 'At Risk' registers so that individuals who are at risk of being admitted to inpatient units are known about and appropriate support is in place from all organisations.
8.	**Developing the Workforce** The aim of this workstream is to have a skilled and stable workforce to support individuals with learning disabilities and autism. This is across clinical specialties such as Learning Disability Nurses and within the domiciliary care/support sector as well. • Mapping of the current health and social care workforce is taking place to understand where there are gaps and how these can be addressed. • Use of support approaches such as 'Positive Behaviour Support' is being expanded and there will be an expectation that all support providers include these approaches within their staff training. Providers themselves are involved in this workstream through a sub-group.
9.	**Developing a Regional Approach to Housing Development** The availability of appropriate housing for individuals is a high priority as is the need to have a range of housing options. • Housing workshops have taken place for people with lived experience and professionals to understand what is missing and what individuals want to see in terms of high quality housing. • Development of five bespoke flats across the SHIP area which inpatients or those at risk of becoming inpatients can use with specialist support. • Engagement with housing associations and other stakeholders to hear their views and identify opportunities for collaborative working. • Development of more supported living accommodation, including bespoke properties which enable individuals living in residential placements a long way from the city to move back to be close to their families and local communities. • Deregistration of some residential homes to supported living which gives individuals stronger legal rights to continue living within their own home, the ability to receive a wider range of benefits (if eligible) and to have greater choice over their home and their lives through accessing a personal budget.
10.	All of the work areas have been developed in co-production with service

	users and their families. There is direct involvement of people with lived experience in the steering group and regular updates will be provided to Learning Disability Partnership Boards. An easy read version of the Transforming Care Plan has been written and given to stakeholders.
RESOURCE IMPLICATIONS	
Capital/Revenue	
11.	Capital funding has been awarded to the SHIP partnership from NHS England to develop the five specialist forensic flats. The procurement and commissioning of this is being led by Hampshire.
Property/Other	
12.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
13.	None
Other Legal Implications:	
14.	None
POLICY FRAMEWORK IMPLICATIONS	
15.	None
KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	People with Learning Disabilities and their families will be affected.
SUPPORTING DOCUMENTATION	
Appendices	
1.	SHIP Transforming Care Plan June 2016
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
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	No
Other Background Documents **Equality Impact Assessment and Other Background documents available for**	

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

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Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) Transforming Care Partnership Plan

June 2016



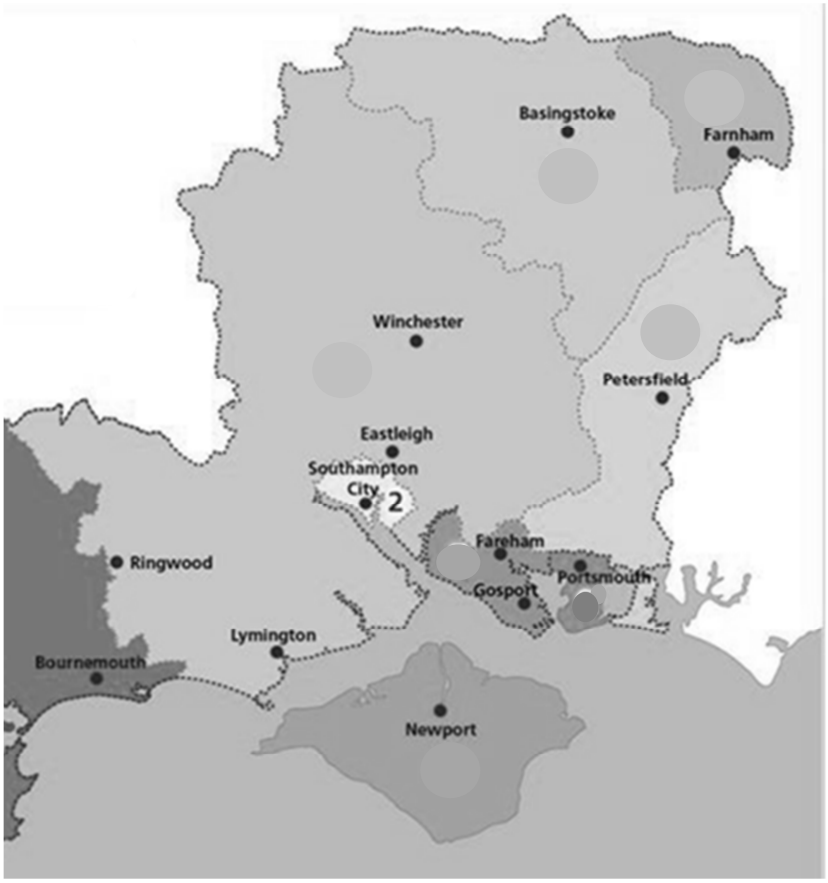



Table of Contents

Embedded Documents include;

Document Section	Description
Mobilising Communities 1.2 - Governance & Assurance	• Multi-agency risk management framework
1.5 – Transforming Care Partnership Board	Example Job Descriptions; • Senior Responsible Officer • Deputy Chair Programme Manager
1.7 – Co-production of Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP)	• Co-production self-assessment framework tool • Co-production 'how are we doing' self-assessment tool
Implementation Planning: 4.4 - What existing services will change or operate in a different way?	Draft Risk Register and Protocol
Delivery: 5.1 What are the programmes of change/work streams needed to implement this plan?	Project Briefs; • Early Intervention & Prevention • Developing Community Services • Increasing the Offer and Uptake of Personal Budgets
5.4 What are the risks, assumption, issues and dependencies	• SHIP TCP Risk Register

Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) Transforming Care Partnership Plan

Executive Summary

The draft plan for the Hampshire & Isle of Wight Transforming Care Partnership (TCP) has been developed with the NHS England and the Clinical Commissioning Groups (CCGs) and local authorities from Southampton, Hampshire, Isle of Wight and Portsmouth. It was agreed at the inaugural Board Meeting that this TCP will be referred to as SHIP to represent the four geographic areas.

Our Vision is ***"To Build on a Child, Young Person's or Adult's unique strengths and abilities, getting it right for the person first time through ensuring there is the right care in the right place at the right time that is consistent across the SHIP TCP"***

Timescales for this first draft plan has prevented the SHIP TCP from consulting with the individual Learning Disability Partnership Boards (LDPBs) properly in time for submission, however it is intended to work with the local LDPBs, Advocacy and other established task/working groups with whom local areas have strong and established links these include; 'My Life, My Way' (IPC), 'My Life, a Full Life (IOW), Peer Advocacy, Parent Carer Networks, Local Involvement Groups, IPC (Portsmouth). Underpinning the TCP plan is the ethos of co-production and truly working in partnership with people with lived experience in reviewing and shaping the plans. This plan supports the principles as described in 'Building the Right Support' and supports the new service model.

SHIP TCP wants to prevent the 'revolving door syndrome' trying to fit people into a traditional solution that does not meet the person's needs that results in regular placement breakdown and more restrictive regimes being put in place. This plan aims to build on the person's unique strengths and abilities, not seeing them as a problem and get it right for the person first time. Complex people and those in crisis are often managed through reactive strategies rather having proactive strategies agreed and in place in the event of requiring intensive support, avoiding a hospital admission.

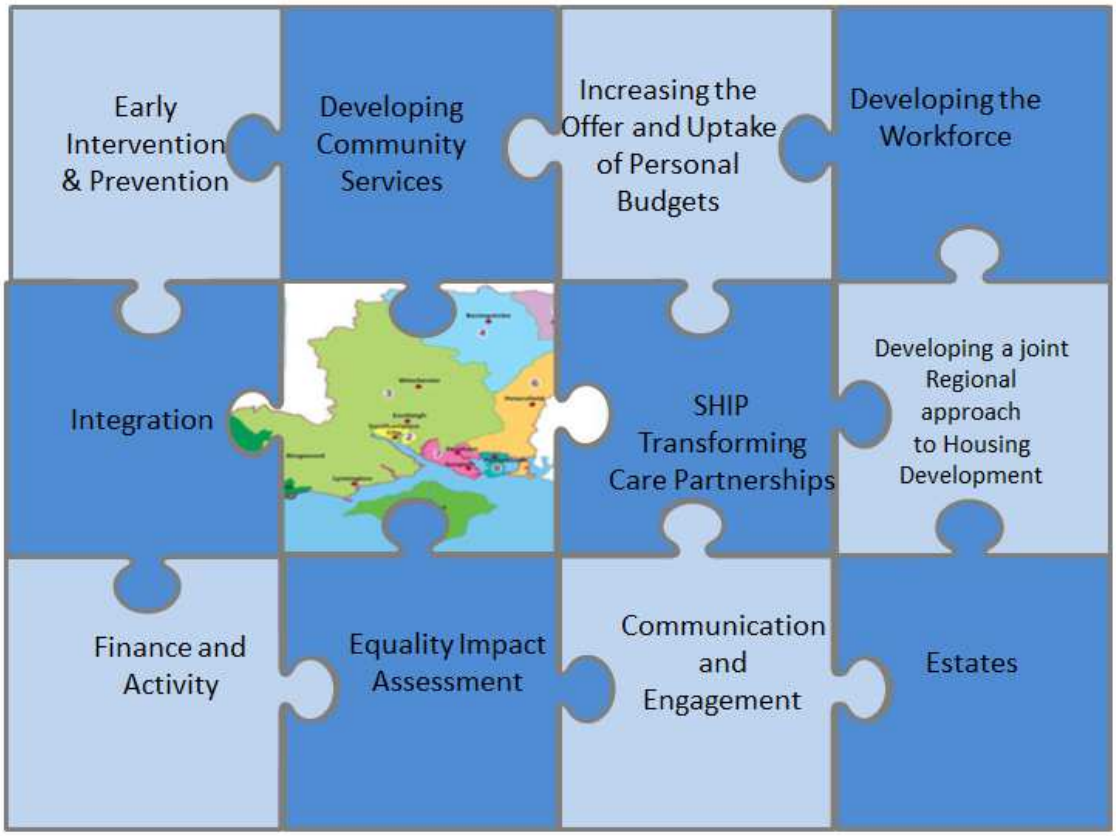
This plan focuses on Children, Young People and Adults with a Learning Disability and/or autism and includes;

- Young people in transition to adults
- Individuals at risk of admission to hospital
- Patients already in specialist learning disability hospitals
- People requiring adapted behaviour treatment programmes
- Those who are currently living in long 'unsettled' accommodation e.g. Residential Care, 38/52 week Education based placements
- People wanting to have a Personal budget (Blended from Health, Social Care and Education)

The SHIP TCP Plan identifies key areas of work required to meet the needs of Children, Young People and Adults with a learning disability and/or autism, the future model will focus on;

- Early intervention and prevention to avoid people being admitted to hospital, this includes supporting good physical health as well as mental health and having 'learning disability friendly GP practices'
- Reducing the number of inpatients in specialist learning disability units
- Reducing the Length of Stay for those individuals requiring assessment, diagnosis and treatment
- Training and development for support staff
- Increasing the offer and uptake of personal budgets
- Increasing the number of personal assistants available in the TCP region
- Working with providers in the use of Positive Behavioural Support
- Having robust care planning with relapse prevention strategies agreed with pre-agreed funding in place either directly funded or via personal budgets to help keep people well
- Establishing a TCP community forensic rehabilitation service
- Developing a joint Regional approach to Housing Development and a portfolio of housing options for individuals

SHIP Transforming Care Partnerships Workstreams



Currently the local health and social care economy spend circa £153.8 million; this figure includes people who are in specialist learning disability hospitals. As the work outlined above is progressed over the next 2 to 3 years, this will enable people to be supported within the local community and enable a reduction in the number of NHS England and CCG commissioned in-patient beds in specialist learning disability units.

The plan describes the current finance/activity and how CCG funding invested in community services will support people; however there is no information available to identify the alignment of NHSE budgets with the SHIP TCP plan.

The Key Targets/Milestones for the project are attached in **Appendix V** of this plan. In summary;

- **By end 2016** all patients who have been in hospital for more than 3 years will be discharged to local community services
- The SHIP TCP will reduce the reliance on in-patient services between now and the end of 2019 from 55 beds to 44 beds;
  - 4 Less **by end March 2017**
  - 5 less **by end March 2018**
  - 2 less **by end March 2019**
- Existing Community Learning Disability Health and Social Care Teams reconfigured to support Early Intervention and Prevention of people with investment aligned to support the function **by End March 2017**
- A new community forensic rehabilitation / relapse prevention service to be **established by end March 2017**
- The number of people with a 'Personal Budget' (Health, Social Care or Education Funded or those in receipt of blended funding) will increase from circa 5,135 individuals to 6,635 **by end March 2019**

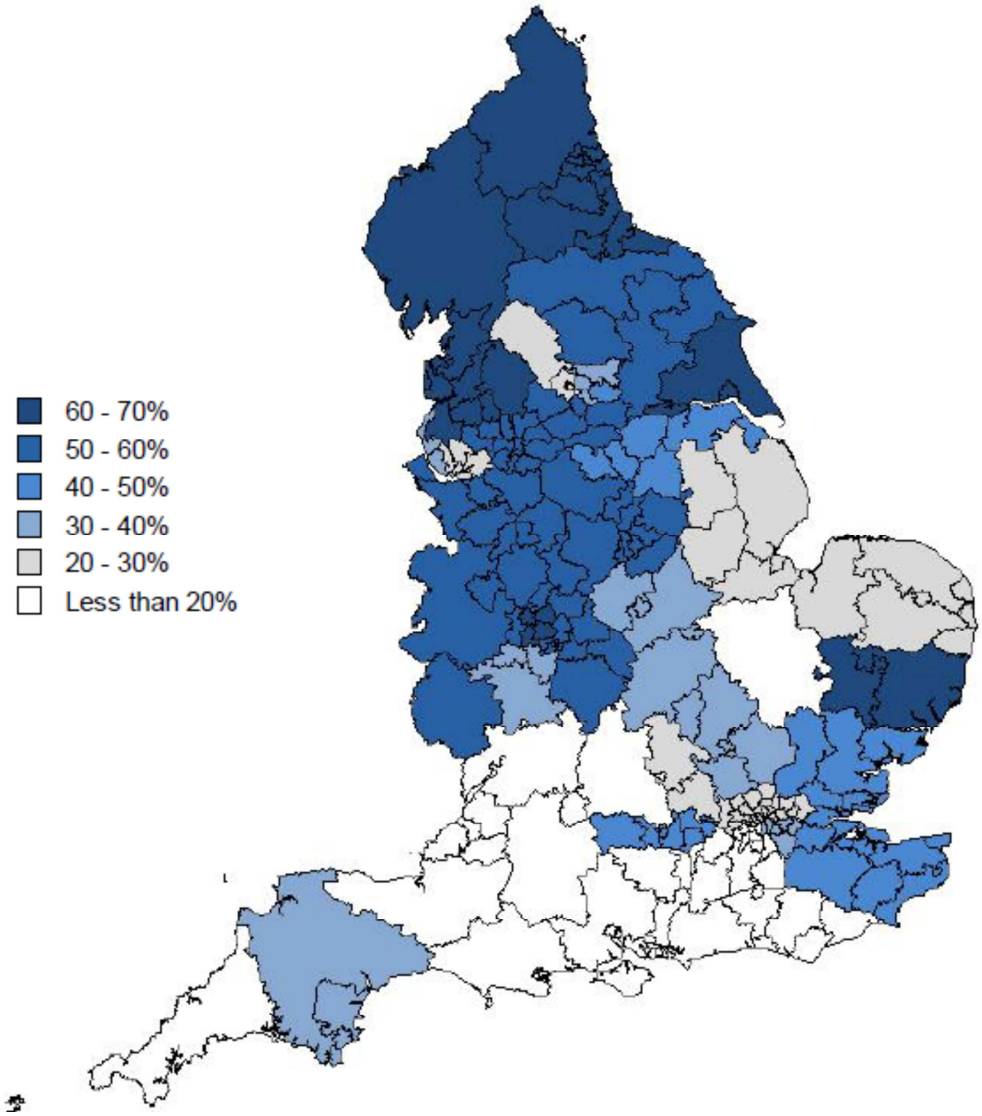
Background and National Context

In May 2011 BBC Panorama transmitted "Undercover Care: the Abuse Exposed", which showed Winterbourne view hospital staff mistreating and assaulting adults with learning disabilities. In December 2012 the Department of Health published its final report on the abuse that took place at the Winterbourne View Hospital. The report identified 63 actions to be completed by health and social care in relation to the findings of the investigation. The Winterbourne View Joint Improvement Programme was established to monitor progress by Clinical Commissioning Groups, Local Authorities and NHS England Specialist Commissioning in implementing the recommendations from the report. This programme of work is now known as Transforming Care Programme and requires Local Authorities, Clinical Commissioning Groups and NHS England to come together to build local community provision and to develop whole pathways through the establishment of Transforming Care Partnerships of which there are 49 in England. In Wessex Region there are two; Dorset and Hampshire & Isle of Wight, from hence referred to as SHIP.

Proposed Transforming Care Partnerships

Local Transforming Care Partnerships will be asked to consider the financial envelope they spend as a whole health and social care system on people with a learning disability and/or autism, and to use that money in a different way to achieve better results. This requires the aligning and pooling of budgets either across the TCP or within individual CCG areas. This will entail whole system redesign and transformation. This will include NHS England's Specialised Commissioning budget for learning disabilities and autism services. This will support the discharge of people with learning disabilities from in-patient units and the closure of all unnecessary beds in England by March 2019 35-50% of both secure and non-secure. Local planning assumptions indicate local areas will have no more than 10-15 beds per one million population CCG commissioned capacity and 20-25 inpatient beds per one million population for NHSE Commissioned beds. The map below shows the % reduction of inpatient numbers based on the mid-point between upper and lower rates for each Transforming Care Partnership. Locally SHIP TCP are on track to achieve this target.

Figure 10: Reduction in bed usage (%) implied by national planning assumptions, by proposed transforming care partnerships[14]



The planning methodology for the SHIP Transforming Care Planning Template is based on six key stages;

Local Context

The SHIP TCP Plan will contribute to the delivery of the Five Year Health and Social Care Vision of person-centred, co-ordinated health and social care and support and will enable;

- A new way of working which aims to ensure the systems health and social care provision is sustainable within the resources available despite increasing demand.
- Services to be people centred and delivered in a way which meets their individual need
- Health and social care outcomes for people to be improved and will ensure that this is being delivered through careful monitoring and evaluation of our plan
- Services to be provided in an integrated way across health, social care and the independent and voluntary sector
- Commissioners to understand their service model now and in the future using the Principles outlined in 'Building the Right Support' Plan;

1. Mobilise Communities

1.1 Local Work Underway to support the Transforming Care Partnership Plan

Southampton, Hampshire, Isle of Wight and Portsmouth health and social care teams are already undertaking a number of work programmes to support the delivery of the Transforming Care Partnership Plan;

Early Intervention & Prevention

- Blue Light Meetings / Pre-Admission Care and Treatment Reviews (CTRs)
- Care & Treatment Reviews (CTRs)
- Developing 'At Risk' Registers
- LD Annual Health Checks
- Intensive Support / Early Intervention – an proactive and early response for people with a learning disability at a time when their specialist health needs challenge the capacity of existing community LD health services
- Developing the transition process between Children and Adults

Winterbourne View Joint Improvement Programme

- Repatriation of individuals back to local community services
- Reducing length of stay for individuals with a learning disability requiring an inpatient stay
- Developing the interface between NHS England commissioned services and CCG / Local Authorities

The Right Support for Individuals

- Upskilling of staff in the use of Positive Behaviour Support (PBS)
- Developing the provider market in terms of accommodation provided
- Quality assurance monitoring of providers
- Personal Health Budgets
- SEN Reforms and the introduction of Educational Health Care Plans (EHCPs)
- Integrated Personal Commissioning (Hampshire & Portsmouth)

Mobilising Communities : Transforming Local Work into Action;

In addition to the above, there are a number of local projects/initiatives within the individual areas which support the TCP Plan and through feedback learning it is intended to share learning from these across the TCP to improve services for people with a learning disability and having flexibility of how they are supported through the use of personal budgets;

In addition the new Care Bill introduced in 2015, is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. It requires local authorities, CCGs, health and housing services, as well as other service providers, to deliver an integrated approach to the provision of care and support to ensure the best outcomes are achieved for the individual. There are also new areas of responsibility, such as social care in prisons, carer's needs being put on a statutory footing, adult safeguarding becoming a statutory function, having a statutory responsibility for providing information and advice as well as Personal Budgets, including Personal Health Budgets, being included within a legislative framework for the first time.

In July 2014, Simon Stevens announced the launch of the Integrated Personal Commissioning Programme (IPC) described as a "radical new option in which individuals could control their combined health and social care support". This involves developing a new approach to deliver integration at an individual level that is person centred for key groups at scale, with innovation around payment approaches to support this. Service users, carers, the voluntary sector, providers and commissioners will come together to provide leadership for a new integrated and personalised commissioning approach for people with complex needs. Hampshire and Portsmouth were selected as 2 of the 9 demonstrator sites in England. The IPC projects support the Principles of 'Building the Right Support' as outlined the New Service Model.

Hampshire – The IPC project renamed locally as 'My Life, My Way' and will build upon the work undertaken to date, sharing of the lessons learnt across the Transforming Care Partnership and aims to;

- Remove the 'cliff edge' for young people and their families going through transition to adulthood
- Shift power to people with a learning disability and their families by offering personal budgets to more people with a learning disability
- Reduce the number of crises leading to placement breakdown and hospital admission
- Reduce length of stay in learning disability inpatient units
- Reduce the use of institutional care and increase the use of supported living through joint housing strategies across health and social care

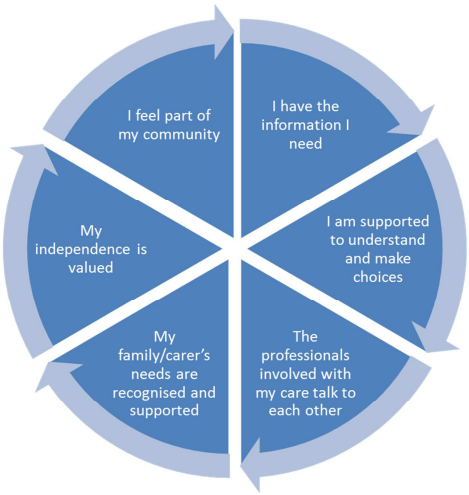
The Hampshire IPC project focuses on;

- People with a learning disability and or Autism aged 14 years and older who are;
    - In receipt of health and/or social care services
    - Registered with a disability with a Hampshire GP
    - People who are inpatients in either Assessment & Treatment Units or Forensic Rehab Units
    -

Southampton has been working with communities and providers through the Better Care programme to develop a plan which not only joins up care and support but also enables people to live well within their communities and the city as a whole.
Southampton's vision for the future of health and social care in the city is summarised as:

'I can plan my care with people who work together to understand me and my carer/family, empower me to take control and bring together services to achieve the outcomes important to me'

The key drivers behind the plan are the 'I' statements below.



Person centred care will be at the heart of everything we do. In support of this, the overall aims for integrated care in Southampton are:

- Intervening earlier and building resilience in order to secure better outcomes by providing more coordinated, proactive services
- Putting people and families at the centre of their care and support, meeting needs in a holistic way
- Providing the right care, in the right place, at the right time, and enabling people and families to be independent and self-resilient wherever possible
- Making optimum use of the health and care resources available in the community
    - Reducing duplication and closing gaps, doing things once wherever appropriate
    - Improving health, social and educational outcomes for children whilst identifying and responding proactivity to early signs of difficulty and preventing escalation

The Southampton model has a shared principle of moving from service delivery as a group of organisations to that of an integrated system or pathway organised around the 6 clusters identified in the city which are based around GP practice populations and natural neighbourhoods. These will have the following characteristics:

- Single core teams sitting in a matrix of specialist services
- Shared IT and information
- Shared estates – office hubs and front line service user hubs

- Locality/cluster focus across the whole system of care and support
- Community and voluntary sector as part of the team

One of the key aims of integrated cluster working is to promote integrated offering across both core and specialist services (including learning disability and autism).

The **Portsmouth** IPC projects overall goals are to:

Enable people with complex needs and their carers to have a better quality of life
And achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and individual circumstances.
Prevent crises in people's lives that lead to unplanned hospital and institutional care by keeping them well and supporting self-management as measured by tools such as 'patient activation' – so ensuring better value for money.
Ensure better integration and quality of care, including better user and family experience of care.

Portsmouth have developed a project to create an integrated care pathway, based around integrated locality teams, where a single personalised care plan approach, owned and understood by the individual, is developed. This existing project will be used as the initial basis for the Integrated Personal Commissioning programme, building on the work already in place, but expanding it to include the development of personal budgets and a supporting financial model using a capitation based approach. This will build on the existing work around Personal Social Care budgets and Personal Health budgets for Continuing Care and SEND Reforms.
The aim initially is to improve quality of care for older people in Portsmouth with multiple long-term conditions at most risk of avoidable hospital admissions, but for 16/17 and 17/18 Portsmouth will establish plans to develop personalised care for:

- **Children's services**: Building on the work of developing integrated health educational and care plans (as part of SEND reforms), develop the market place, engage families and stakeholders and offer a personal budget;

- **Learning Disabilities**: Implement person centered planning and an integrated approach to care and health needs for people with learning disabilities, develop the market place, engage service users and carers, and offer a personal budget;

- **Adult Mental Health**: As part of transforming Adult Mental Health, initiate an approach to recovery focused integrated care and health planning for people with mental health conditions, with a view to potentially offer personal budgets.

Isle of Wight - The joint aim of the Island's health and social care organisations is to promote longer, healthier and more independent lives for the people of the Isle of Wight. Primary, secondary and social care all have individual contributions to make to this, but we recognise our overall effectiveness and efficiency is dependent upon developing a highly integrated model of care. The people we serve need to be at the heart of all our decisions and be the

ultimate judge of everything we do.

We are committed to making our vision of person-centred, co-ordinated health and social care and support a reality on the Island. We want to improve the outcomes and experiences of people, families and carers which will be achieved by doing things differently, to collaboratively harness the capacity of organisations, people and communities to think creatively to help us build a sustainable health, social and community economy, fit for now and for future generations.

Putting the person at the centre of everything we do is key to the success of our vision. Using the "I" statements developed by National Voices and Making it Real as a basis for development by local people, we have defined what good will look like for our residents and communities:

- I will no longer be a patient or a client; I'll be a person
- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community
- I feel valued for the contribution I make to my community
- I have access to easy to understand information about health, wellbeing, care and support which is consistent, accessible and up to date
- I am able to get skilled advice to plan my care and support
- I can plan ahead and keep control at times of crisis
- I have considerate support delivered by competent people

It is also recognised that as organisations, we need to respond differently to how we support people. The organisational "We" statements below, developed as a response to the local "I" statements, will be how we now prioritise and respond to people we work with on the Island:

- We will enable people to promote their own health and wellbeing supported by self-care and self-management
- We will see people as people and deliver co-ordinated support to individuals, their families and carers
- We will support people at times of crisis to have the right support as soon as possible, to enable people to return home and to their communities
- We will develop the infrastructure to deliver truly co-ordinated care and support
- We will support people with long term conditions and the elderly frail locally, based around GP practices

A key element of our future vision is to design and deliver a progressive prevention strategy which will support people to look holistically at their care and support needs at an early stage, finding the low intensity support that will help to prevent the deterioration of those needs. It will include a community information hub (Isle Help) which will bring together all third sector advice services within one service, providing a broad range of information and advice to enable people to be as informed as possible. Sitting alongside this will be an on-line community directory which will take a holistic approach to providing up-to-date information around key areas of people's lives, rather than focussing merely on conditions or presenting

need. It will provide details on the wide range of services and support groups that are available, including peer support, and will be easy to access and navigate.

The Island's User Led Organisation, People Matter, will play a key role in our prevention strategy. It will be a key player within the community information hub, providing specialist advice around personal budgets and employing Personal [care] Assistants (PAs). It also has an Independent Living Centre which enables people to look at aids and adaptations before purchasing any equipment. Uniquely, the centre provides OT support to those who do not meet the national eligibility criteria or do not want statutory service intervention. They also facilitate and support the IOW LDPG.

To support those people who have a greater level of need or who are in crisis, we have created an integrated Urgent Care Hub which has brought together a team of professionals who are able to communicate clearly and respond quickly and effectively to the health and social care needs of Island residents.

Critically, the relationship between Primary Care and services provided in the community will be the key to ensuring that case management is embedded in practice and communication between key professionals is enabled to the benefit of the most vulnerable people in our community and good risk stratification tools are used to identify those residents most at risk of hospital admission or A&E attendances.

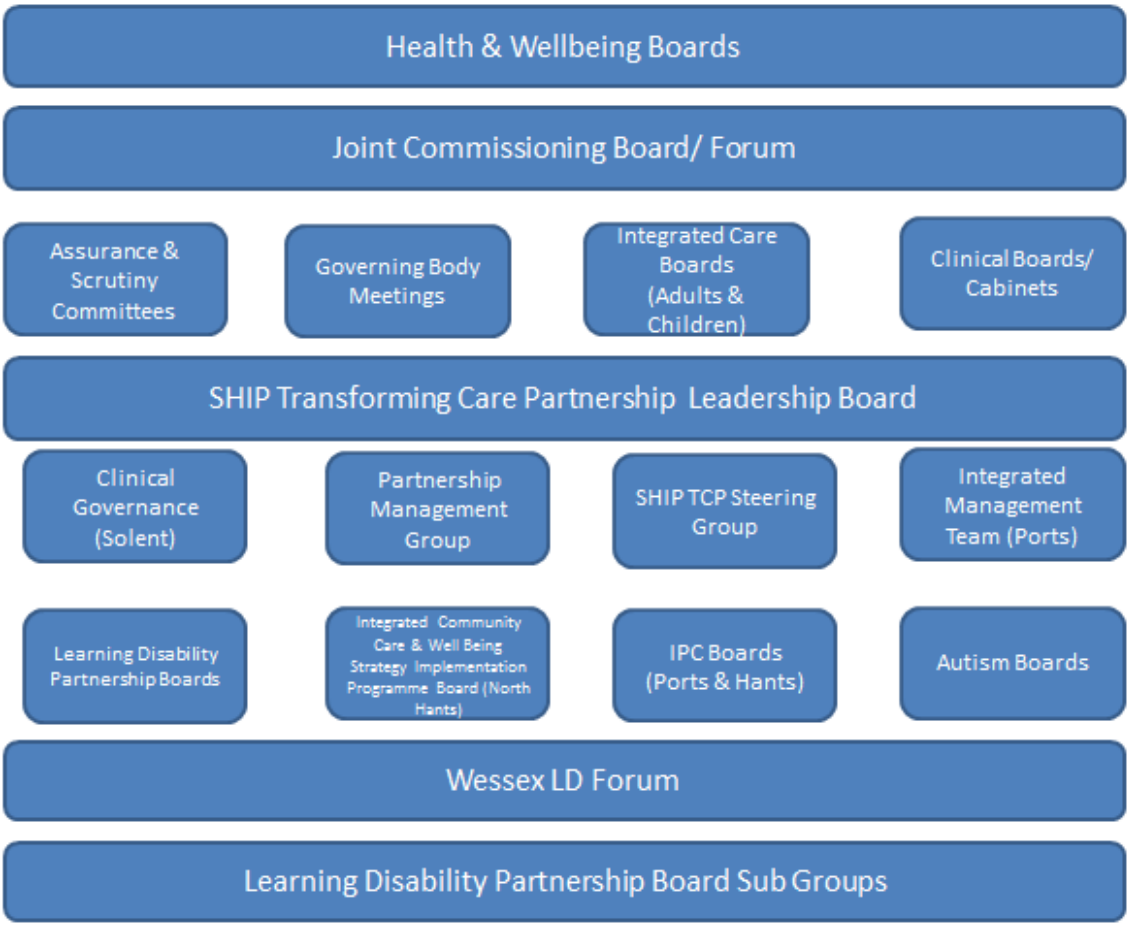
We have developed a joint Carers Strategy which has been developed through extensive consultation with a wide range of carers across the Isle of Wight. It identifies what's important to carers and how those priorities will be delivered. We have made the commitment that carers will be:

- respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role
- able to have a life of their own alongside their caring role
- supported so that they are not forced into financial hardship by their caring role
- supported to stay mentally and physically well and treated with dignity
- children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters outcomes

Fundamental to the delivery of our vision is the need to ensure that people are safe. This requires a robust approach to safeguarding, whilst ensuring that the individual has a personalised experience that is outcomes focussed. We need to ensure that we work on a partnership basis, ensuring that people are fully engaged in the process and feel listened to. Alongside our desire to deliver an integrated approach to safeguarding vulnerable people, we will work with partner agencies, included CQC, to ensure that there is a level of quality assurance which provides reassurance that services and organisations offer quality care and support.

1.2 Governance & Assurance

Within the SHIP Transforming Care area there are already established governance arrangements such as Health & Wellbeing Boards, Assurance & Scrutiny Committees, Clinical Boards, Integrated Care Boards, and Learning Disability Partnership Boards. The SHIP TCP will report updates and progress against the plan to their local governing boards and to NHS England (Wessex) which has an established Learning Disability Forum for the Wessex Area.



The four Safeguarding Adults Boards in SHIP have produced a multi-agency framework and a Memorandum of Understanding (MOU) relating to information sharing. The Framework provides guidance on managing cases relating to Adults where there is a high level risk but the circumstances may sit outside the safeguarding framework but for which a multi-agency approach may be beneficial. This aims to provide an effective, coordinated and multi-agency response to these 'critical few' cases in order to facilitate;

- Timely information sharing around risk
- Identification and holistic assessment of risk
- Development of shared risk management plans
- Shared decision making and responsibility
- The adult's involvement and engagement in the process
- Improved outcomes for the adult at risk

Multi-Agency-Risk-Management-Framewo

1.3 Health and Care economy covered by the plan;

Local Demographics;

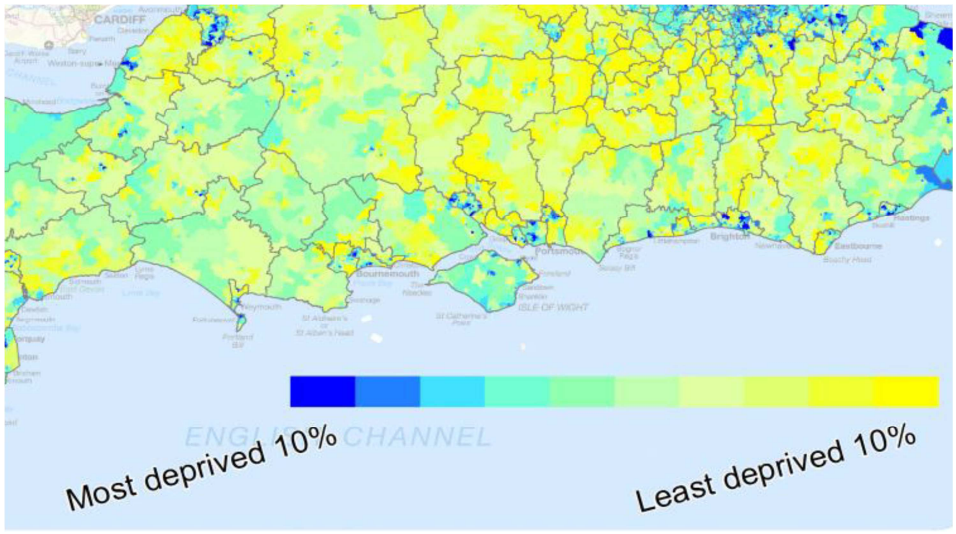
The Hampshire and Isle of Wight (SHIP) Transforming Care Partnership (TCP) geographical region has a wide range of communities from sparsely populated rural areas to high density city areas and is unusual in that this includes the Isle of Wight which is not connected by road to the mainland and travel is via Ferry/Hovercraft links and has a total estimated population of just over 1.9 million;

NHS Southampton CCG	241,895
5 Hampshire CCGs	1,339,011
NHS Isle of Wight CCG	139,105
NHS Portsmouth CCG	207,945
TOTAL	1,927,956

Population forecasts are estimated to rise to 2,039,981 in 2021, an increase of approximately 5.81% across the SHIP TCP.

Portsmouth has the highest density of population outside of London. The Indices of Deprivation published 2015 (based on tax year 2012/13) identify areas within the TCP as being the 'Most Deprived' as well as having a larger number of 'Least Deprived' areas. Assessment is measured against seven domains of deprivation plus two supplementary indices; the Income Deprivation Affecting Children Index and the Income Deprivation Affecting Older People Index.

- Income Deprivation
- Employment Deprivation
- Education, Skills and Training Deprivation
- Health Deprivation and Disability
- Crime
- Barriers to Housing and Services
- Living Environment Deprivation



Distribution of the Index of Multiple Deprivation 2015

The Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) Transforming Care Partnership comprises;

1x County Council;
- Hampshire
- With links to Surrey CC for the North East Hants & Farnham Area

3x Unitary authorities;
- Southampton
- Isle of Wight
- Portsmouth

11x District & Borough Councils;
- Basingstoke & Deane Borough Council
- East Hampshire District Council
- Eastleigh Borough Council
- Fareham Borough Council
- Gosport Borough Council
- Hart District Council
- Havant Borough Council
- New Forest District Council
- Rushmoor Borough Council
- Test Valley Borough Council
- Winchester City Council

- 8 Clinical Commissioning Groups;
  - Isle of Wight CCG - 17 GP Practices
  - Portsmouth CCG - 23 GP Practices
  - Southampton CCG - 44 GP Practices
  - Fareham & Gosport CCG - 21 GP Practices
  - North Hampshire CCG - 25 GP Practices
  - North East Hampshire & Farnham CCG - 24 GP Practices
  - South East Hampshire CCG - 26 GP Practices
  - West Hampshire CCG - 51 GP Practices

- 1 NHS England Area Team - Wessex

Within the SHIP TCP there are 8,453 people with a learning disability registered with GP practices between ages of 0 to 65 and over. (Further GP data provided in **Appendix I**)

Population Data	SHIP Area			
	Southampton	Hampshire	Isle of Wight	Portsmouth
How many people have a learning disability?				
Aged 0-13	184	195	41	37
Aged 14-17	134	189	45	25
Aged 18-34	792	1,664	313	139
Aged 35-64	1046	2,238	430	302
Aged 65 & Over	170	371	77	61
Total	**2,326**	**4,657**	**906**	**564**
	Data extracted from GP clinical systems using the Read codes as stated in the technical guidance for the LD enhance service scheme	**Taken from GP QOF registers via Hampshire Health Record**		**Data provided by 15 out of 24 practices in Portsmouth**

The majority are within the 35 to 64 age range. This age range also has the highest recorded number at 57% of people with a learning disability with an Autistic Spectrum Disorder. (See Diagrams 1 and 2 below)

Diagram 1

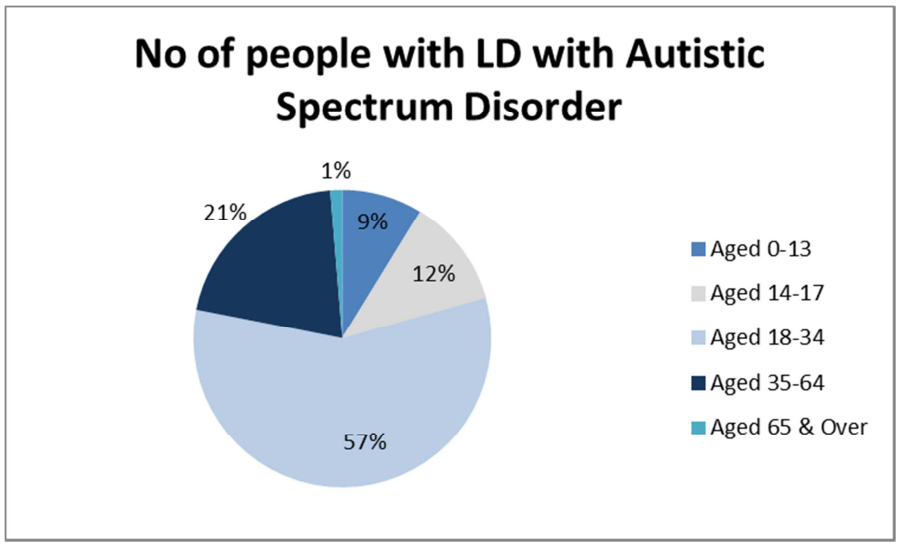


Diagram 2

Current care economy;

The SHIP TCP is a nett importer of people with a learning disability. A review of Residential Care commissioned beds identified less than 50% of available capacity was purchased by local Health and Social Care Commissioners with the remainder from out of area teams such as London Boroughs and neighbouring counties. Portsmouth is a nett importer of people with a learning disability plus a nett exporter of in-patients as there are no beds on Portsea island. This is a similar picture in the Southampton area. The Isle of Wight has locked rehab, low or medium secure provision, it has one assessment treatment bed on Osborne Ward, Sevenacres.

For some time support outside of the family home has predominantly been within residential care homes whereby people have little flexibility over how they wish to be supported. The closure of the Local Based Hospital Units (LBHU) and Campus re-provision programme enabled individuals through Department of Health (NHS) capital funding to move from long term 'in-patient' status to more bespoke models of support within their own homes either on a single occupancy basis or sharing with a small number of people. Unfortunately since this time new service provision has been market led by providers seeing predominantly residential care homes being established with one or two small annexes attached to these services. This has led to very little choice for people in where they choose to live, who they live with and who supports them. This is a particular issue for young people coming through Transition from aged 14 and impacts on long term life planning for individuals.

> *"I want to be able to make housing choices and be in control of my own life."*
>
> *Feedback on Hampshire LD Plan - The Right Place To Live*

Individuals receive a wide range of support mainly from commissioned services, however it is important to recognise the support provided to people by families, friends, third sector organisations. The types of support are summarised below; **Support Status**
At Home with Family
At Home no Support
At Home with support; - Domiciliary Care - Supported Living (including nursing) - Live in carers - Extra care housing
Shared Lives; - Living with Shared Lives carers on permanent basis
Residential Care; - In main residence - In annexe on site - With core support staff - With core support staff and additional 1:1 / 2:1
Day Services; - Local Authority Managed - Independent Centres
Education Facilities; - School placement up to 19 - Specialist Units 19-25
Foster Carers
Children's Homes for looked after children
Secure Children's units
Hospitals; - Non-Secure (ATU) - Forensic Rehab - Low secure - Med secure - CAMHS (tier 4)
Replacement Care (respite care) - Short Breaks - Shared Lives - Children & Young People's Respite e.g. (Jack's Place / Naomi House)

Feedback from stakeholders indicate a lack of suitable housing provides limited choices to people, often resulting in placements for people within residential care which may not enable the flexibility of support to participate in activities outside of the home at a time that is suitable to them or having to accompany other residents on activities which may not be at their choosing.

Increasing the application and take up of personal budgets is also restricted by the lack of suitably trained staff/personal assistants and the willingness of staff to work for an individual in receipt of a personal budget rather than a larger domiciliary/supported living support provider.

"I am a person. I have my own feelings and thoughts. I want these to be respected and followed through. I want to live my life my own way, not just have my care needs met. You would be amazed at what I can achieve. But I need you to support me and give me the confidence I need to do it. With you beside me I can really go places that might have seemed impossible."

Feedback from Hampshire LD Plan - Marcia

Supported People;

Provides housing related support to vulnerable people including:

- People with mental health problems
- Young people at risk

In 2010 the ring-fence for the supported people budget was removed and this budget is now within the general formula settlement for local authorities (general social care).

Autism;

The national strategy 'Fulfilling and Rewarding Lives' and subsequent update 'Think Autism' (2014) represent a shared approach towards a common goal i.e. a society that not only accepts and understands autism, but also provides real opportunities for people with autism to live fulfilling and rewarding lives".

The Department for Education (DfE) provided funding resource during 2013-15 for;

- 'Ambitious about Autism' to work with the Association of Colleges and a number of FE Colleges on transition into further education for young people with autism
- Autism Education trust to provide tiered training across early years schools and further education

There is joint working by CCGs/Local Authorities with a number of key stakeholders within the TCP in relation to raising awareness of Autism, diagnosis and support to individuals these include; Autism Hampshire, Local Parent Voice Networks, , Surrey & Borders, Hampshire Constabulary, voluntary sector organisations, parents/carers and local schools/colleges. This aims to provide better co-ordination between agencies and to work in partnership with the child or young person with autism and their family/carers.

Estimated Number of People with Autism				
	Southampton	**Hampshire**	**Isle of Wight**	**Portsmouth**
Total Number	2,453	10,020		2,359

Mobilising Communities : Transforming Local Work into Action;

Hampshire has an established Autism Partnership Board (HABP) is currently undertaking a public consultation in relation to services for people with autism and are working with the third sector to gather views via the sounding board.
http://actionhampshire.org/communities/soundingboard

Diagnostic assessment and post diagnostic support for adults with suspected autism under the statutory guidance associated with the Autism Act 2009 and offering diagnostic assessment and post diagnostic support for adults with suspected ADHD, formalising and enhancing current shared care arrangement with GP's, for a minimum period three years from October 2016-2019

Table 1: Estimated number of adults with autism by Clinical Commissioning Group (CCG) area (numbers are rounded to nearest 10)

CCG Area	Males with autism (1.8% population)	Females with autism (0.2% population)	Total number of people who have autism
North Hampshire	1,410	160	1,570
Fareham and Gosport	1,340	160	1,500
South Eastern Hampshire	1,430	170	1,600
North East Hampshire and Farnham[4]	1,140	130	1,270
West Hampshire	3,650	430	4,080
Hampshire County Council area	**8,970**	**1,050**	**10,020**

Supporting map of CCG's boundaries seen in Appendix 1

If this accurately reflects prevalence, local data shows that only a very small proportion of people with autism in Hampshire are known to local services.

[2] The Office for National Statistics: http://www.ons.gov.uk/ons/rel/npp/national-population-projections/2010-based-projections/stb-2010-based-npp-principal-and-key-variants.html
[3] Aged 19 years or above
[4] Farnham is in Surrey - its population is not included in the statistics shown

Portsmouth is currently working with a number of key stakeholders including Autism Hants, Portsmouth Parent Voice and Surrey & Borders to plan the new Strategy Plan for Portsmouth 2016-2020, building on the recent consultation work around priorities for Portsmouth people with Autism. A new Portsmouth Autism Community Forum to be launched in a few months will undertake much of the consultation work

Estimated number of people with autism-spectrum conditions Portsmouth, 2012 to 2035						
Age band	2012	2015	2020	2025	2030	2035
0-14	384	405	432	435	421	415
15-19	160	153	148	167	183	181
20-64	1,483	1,482	1,476	1,461	1,472	1,499
65+	302	319	343	377	419	455
Total	**2,331**	**2,359**	**2,397**	**2,440**	**2,495**	**2,551**

Southampton's Autism Strategy Group meets quarterly. They have recently signed off the new strategy, ensuring Think Autism is being progressed.
Southampton's 2014 ONS mid-year population estimate was 245,290. Based on a raw prevalence of 1% approx. 2,453 people in the city will have an ASD. As detailed in the table below:

Estimated Number of people with Autism	
0-14 years	413
15-24 years	492
Over 25 years	1,548

Isle of Wight has an established Autism strategy implementation group who meet bi-monthly to oversee the implementation of the strategy. Membership includes:

- People Matter (the IOW user lead organisation)
- Parents
- Voluntary Sector
- Autism Hampshire
- Local National Autistic Society Branch
- Commissioning from both health and social care
- Representation from Autism Inclusion Matters

Children & Young People;

The formation of a Children's Trust and the production of a Children and Young People Plan (CYPP) were statutory requirements under the Children Act 2004. Whilst some of the statutory guidance on the Children's Trust have since changed the 'duty to co-operate' and the requirement for each local authority to have a children's trust board remain in place. The CYPPs have been developed through consultation with children and young people via Care Ambassadors, Youth Voice Meetings etc. The SHIP area

Children's Trusts each have a shared commitment to improve the lives of children and young people and identifying as early as possible whether a child or family need support, enhancing parental capacity, helping them to access services.
There are a number of maintained / academy schools within the SHIP TCP, most of whom cater for children with a learning disability / statement of Special Education Need (SEN). In addition there are a number of schools with a resourced provision for children with needs arising from a diagnosis of Autism Spectrum Condition. In Hampshire there 26 Special Schools.

In 2015 the SEN Reforms brought about the introduction of Educational Health Care Plans (EHCPs) requiring joint working across Education, Health and Adult Services for those aged 0 to 25 to develop with individuals, central to this process is the involvement from parents/carers and the young person themselves in 'my story'. There are established Transition teams within the TCP areas.

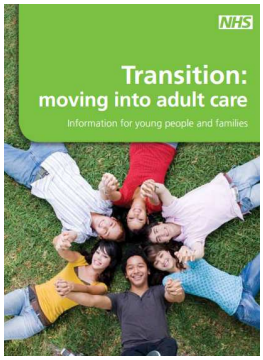
In July 2013, a strategic legal agreement was entered into by Hampshire County Council and the Isle of Wight Council for a 5 year period working with Children's Social Services and Education. This joint working is also seeing closer alignment and standardisation of the EHCP processes which supports the principles of 'Building the Right Support'.

> *"The five –year strategic partnership between the Isle of Wight and Hampshire county Council is providing essential stability and is driving demonstrable improvements across children's services and on the island"*
>
> *Ofsted Report (September 2014)*

SHIP also have a number of specialist Independent Education centres for either 38 or 52 week placements for young people and Independent Day provision which are also commissioned by other commissioners from out of the area. This is also a problem for SHIP commissioners for young people in transition who are in out of County educational placements as often these continue as there are limited alternatives/opportunities available in the local area.

Transition;

Across SHIP local areas have their own transition plans:



The transition from children's services to adult services is a crucial period in a person's lifetime care pathway.
For people to be supported effectively through transition we need to ensure that the process has the following elements:

- Planning. A young person's pathway should be planned from birth, but it is particularly important that detailed planning for adulthood starts early, around age 14. Where a person will want to live and how they will receive support should be considered when people start residential college, not when they leave.

- Early provider engagement. The SHIP area have will work with providers to ensure further engagement with families and Social Services to develop services which are ready to come on-stream when people leave college. Specific locations can be targeted, accommodation can be tailored and more readily adapted and staff can be recruited with specific skills.

- Transitional services. People who leave residential colleges are not always fully prepared or skilled to face the challenges of adulthood. We will explore the short break services to enable continuity of planning when people leave residential college and five-day college placements to ease transition.

- Joint working. The work of children's and adult services must be joined up.

- Process management and accountability. Transition sometimes lacks clear processes or accountability, both of which are essential.

- Information. The quality of information and how it is shared is critical to transition. We must capture accurately who is coming through the system and ensure that information about support and services is shared effectively with people, families and other stakeholders.

- Brokerage. Brokerage must function effectively to link people who need services with those who provide it. One possible initiative is that the provider community could undertake their own brokerage to ensure that voids are filled and need met.

- Advocacy. People need to be able to access good advocacy support through transition. This is particularly important for people who do not benefit from family support.

Mobilising Communities : Transforming Local Work into Action;

Hampshire - There are circa 30,000 children in receipt of a statement of SEN need of which circa 6,500 have an Educational Health Care Plan. 782 children are open to the Disabled Children's Teams. Within these numbers currently circa 7000 children access the short breaks service (further information is available via the link http://www3.hants.gov.uk/shortbreaks -
Hampshire also promote the use of the Gateway Card scheme in Hampshire, which is free and will give access to activities, play schemes and buddy schemes available through our short breaks programme. People can register for a Gateway Card at: http://www3.hants.gov.uk/gatewaycard

In addition there are three local authority run respite units that provide overnight breaks for young people with disabilities as well as independent respite centres such as Naomi House/Jack's Place.

Portsmouth are developing a joint commissioning strategy with education to provide co-ordinated support for children and young people with disabilities and special educational needs, including:

- Cognition and learning,
- Communication and interaction difficulties (including speech language and communication difficulties and autism)
- Sensory and physical difficulties,
- Social emotional and mental health difficulties

Isle of Wight have developed a draft transition protocol following a development workshop on 28th September 2015 and taking into consideration the views shared during the workshop from parents/carers and professionals to clarify the role of each agency to simplify and promote better understanding of the processes involved in accessing support leading up to and during transition from Children to Adult Services. This is currently being consulted on;

https://www.iwight.com/Residents/Care-Support-and-Housing/Adults-Services/Adult-Social-Care-Preparation-for-Adulthood/Transitions-Protocol-Consultation

Isle of Wight Clinical Commissioning Group, Isle of Wight Council and their partners from both the health and voluntary sector are committed to "promoting, protecting and improving our children and young people's mental health and wellbeing". Whilst there are already areas of very high quality provision on the Island it is recognised that dramatic and significant changes and improvements are needed in order to ensure that all children and young people on the Isle of Wight, including those with particular vulnerabilities such as

learning disability and autism, can easily access high quality, outcome focussed, evidence-based services appropriate to their need, when required.

Over the next five years children and young people, residing on the Isle of Wight will be supported in having good mental health and to build emotional resilience, in order to help them fulfil their goals and ambitions and to make a positive contribution to society. The work that needs to be done will fit in with the 'My Life a Full Life Programme' (MLAFL) and is reflected in the Isle of Wight Local Transformation Plan for Children & Young People's Mental Health & Wellbeing which can be accessed via the following link: Isle of Wight Transformation Plan for Children and Young People's Mental Health (2015-2020).

The MLAFL programme will fundamentally change and improve the lives of people on the Island. MLAFL is about organisations working together in partnership with the voluntary and private sector, the Isle of Wight Clinical Commissioning Group (CCG), the Isle of Wight Council (IWC), the Isle of Wight NHS Trust (IW NHS Trust) and One Wight Health (a GP membership organisation) providing for people's individual needs to enable them to take control of their lives and plan for their future health and social care needs. This work is based on the partners five year vision for integrated health and social care on the Island.

Southampton – are currently working with the educational sector to ensure that there is more provision within the city for Residential and non-residential educational placements, with a stronger focus on preparing for adulthood outcomes.

Child and Adolescent Mental Health Services;

Within the SHIP TCP there local CAMHS services are commissioned to support children and young people up to the age of 18. Types of problems CAMHS can help with include; depression, eating difficulties, low self-esteem, anxiety, obsessions or compulsions, sleep problems, self-harming and the effects of abuse or traumatic events. CAMHS can also diagnose and treat serious mental health problems such as bipolar disorder and schizophrenia.

The Transforming Care work programme has expanded the work of the Winterbourne Joint Improvement Programme to include Children and Young and has a project for 'C&YP with Learning Disabilities and / or Autism – CAMHS LD' this has four main elements for completion by April 2016 these include;

- Ensuring that Care and Treatment Reviews (CTRs) are implemented for children & young people who have a mental health condition or behaviours that challenge either at risk of admission to hospital or who have been admitted to hospital (including Assessment and Treatment Units (ATUs), CAMHS and secure services)
- Identification of young people with learning disabilities and autism in 52 week residential schools, in particular those young people leaving their school in 2016. Ensuring there is appropriate transition planning in place (through effective health engagement in the Education health and Care Planning Process)
- Development of a community pathway for children and young people which will outline how children, young people and families should be supported, based on best practice, on what young

people and their families say works, and wherever possible make sure they are supported before things become too difficult

- The roll out of a grant programme to support innovative projects that provide early support and intervention for children and young people with learning disabilities and/or autism and their families

It is intended the four main elements of the above project will be met through existing work in relation to the CTR programme (including 'Blue Light Meetings' and Pre-admission' CTRs) and developing local risk registers. The development of community pathways and support provision will include expanding the number of young people being offered a personal budget to enable greater flexibility of support to meet an individual's needs.

Mobilising Communities : Transforming Local Work into Action;

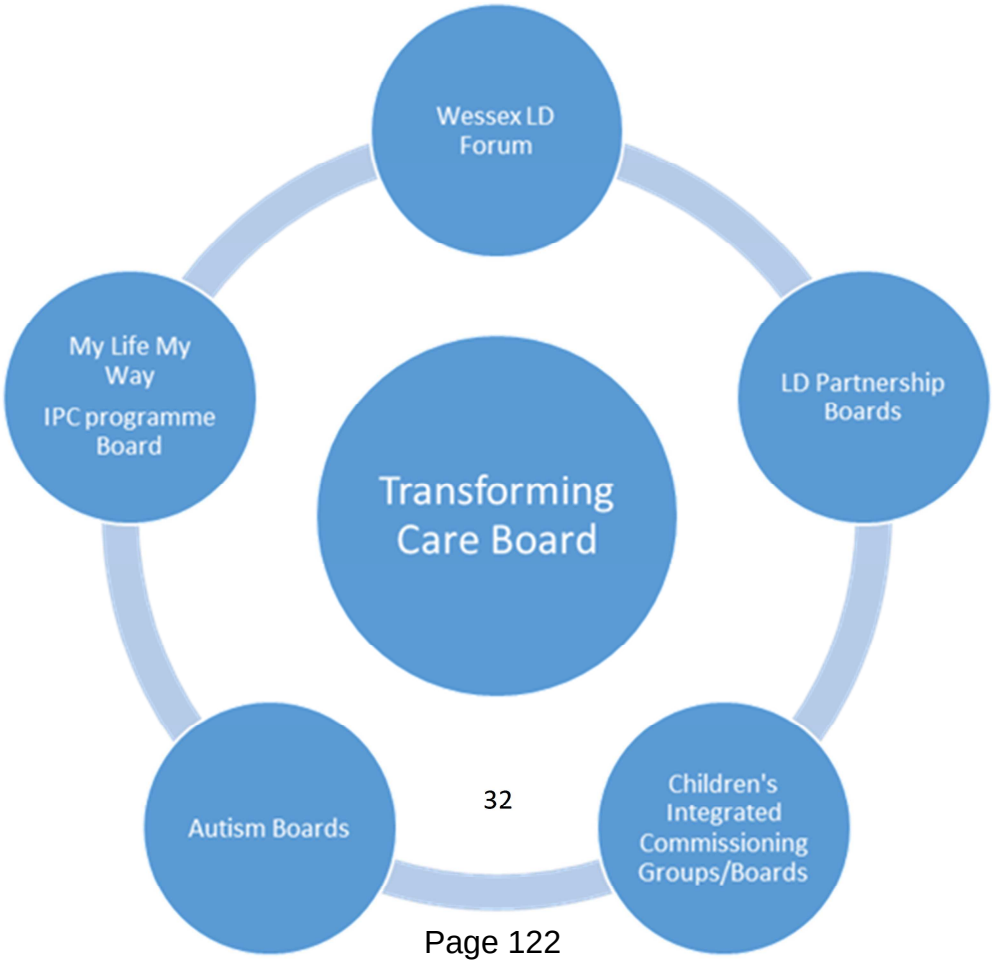
NHS England uses the 'My Shared Pathway' Recovery and Outcomes model putting individuals at the heart of their recovery. There are key steps;

- Where am I now? – a full assessment of current life situation
- Where do I want to get to? – identifies goals and objectives outline destinations for the recovery journey
- How do I get there? – focusing on the development of care and support plans and ways to help individuals achieve their goals
- How can I tell how I'm doing? – monitors progress and looks at how this is measured and assessed

1.4 Governance arrangements for this transformation programme

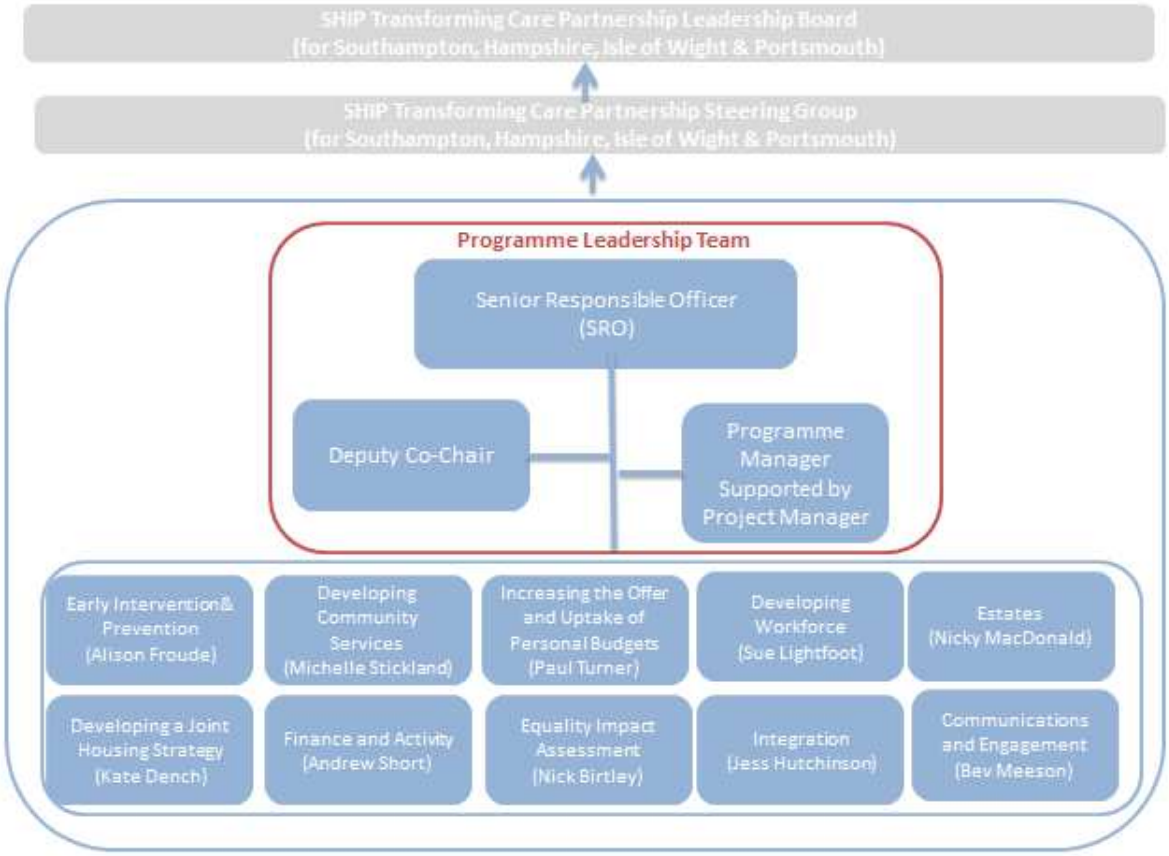
Southampton, Hampshire, Isle of Wight and Portsmouth's collaborative arrangements are detailed in the diagram below. Key features of this include:

- A multi-agency Transforming Care Board to provide a single place for collaborative decision-making by commissioners, clinicians and relevant professionals and experts
- The representation of parents and carers to ensure service user/carer involvement and participation
- Work stream Sub groups via the IPC programmes to drive and manage progress in developing and implementing this plan



1.5 Transforming Care Governance

The SHIP TCP has senior multi-agency leadership from commissioners and people with lived experience. Following consultation with the eight local CCCGs (SHIP 8), Heather Hauschild has been appointed as the Senior Responsible Officer and this project will be hosted by West Hampshire CCG. The Transforming Care Governance structure is as below; The Leadership Board will have oversight of the plan to ensure effectiveness of systems/proposals; quality and assurance check control and escalation for decision making. The Steering Group will provide assurance to the Leadership Board and will ensure operational delivery of the plan.



The draft job descriptions provided to Transforming Care Partnership Boards for individual roles and are provided below;

Senior Responsible Officer (SRO)

2) Transforming Care Example Job Descript

Deputy Chair

2) Transforming Care Example Job Descript

Programme Manager

2) Transforming Care Example Job Descript

Terms of Reference

The following Terms of Reference documents have been provided for The Leadership Board and The Steering Group


SHIP LD
Transforming Care Pa


SHIP LD
Transforming Care Pa

Project Manager

- The Project Manager is given the responsibility and the authority to manage the project on a day to day basis on behalf of the Project Board within the constraints laid down by the Board
- The Project Manager's prime responsibility is to ensure that the project produces the required products, to the required standard of quality and within the specific constraints of time and cost. The Project Manager is also responsible for the project producing a result that is capable of achieving the benefits defined in the TCP Plan

Core Project Team

The core project team represents the key service leads from different perspectives and as such the Senior Users within the project. Their role is:

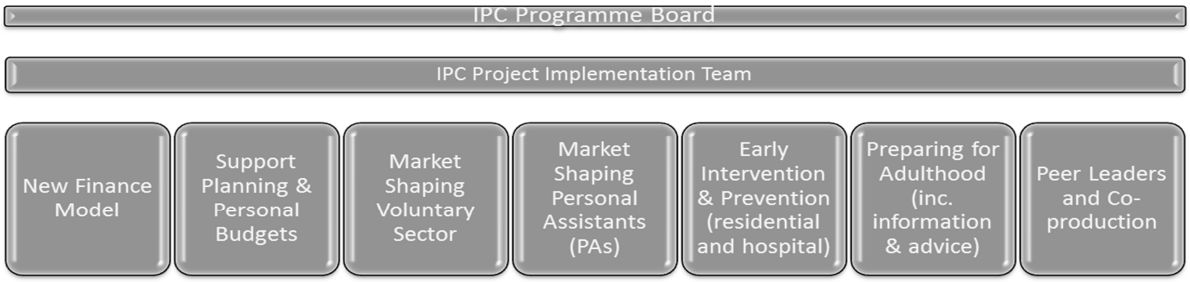
- To help shape the project
- To direct and facilitate the completion of work in their area within the time, quality and cost requirement of the project
- To communicate broader messages about the SHIP Transforming Care Partnership Plan within their respective organisations/services
- To be responsible for specifying the needs and benefits required of those who will use the projects products
- To be responsible for liaison within the core, wider project team and support services as necessary to ensure the products can be delivered and timescales met
- To monitor the solution to ensure it meets the requirements of the user and broader IPC and other local strategy requirements
- Where resource constraints exist they will be required to facilitate these to meet the requirements of the project, or raise an issue to be escalated through the Change Board for resolution
- Project Support
- This role supports the Project Manager and is key in co-ordinating all documentation for the

review, scheduling meetings, providing assistance to the Project Manager and general administrative support, such as setting up and maintaining project files and maintaining standards throughout the project lifecycle

Other Key Stakeholders;

In addition to those listed, other key stakeholders who will be consulted on changes to the SHIP TCP Plan include but are not limited to; Police, Probation, MAPPA, Youth Offending Teams, Looked after Children Team, District Housing Departments, Colleges, SEN Schools, Surrey & Borders NHS Trust, Care & Support Providers.

To deliver the work streams the local transforming care partnership aims to interface with the local Hampshire IPC Programme 'My Life, My Way', this has an established Programme Board, Project Implementation Team and individual work streams as illustrated below;

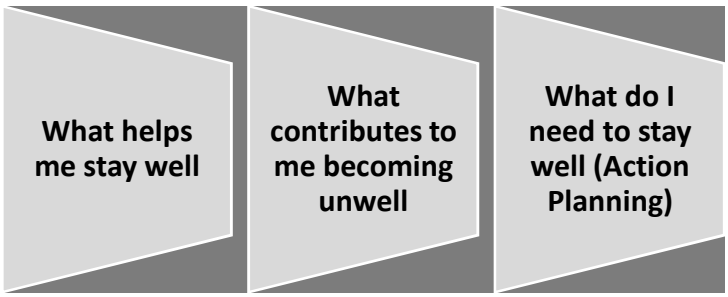


1.6 Stakeholder engagement arrangements

Timescales for this first draft plan has prevented the SHIP TCP from consulting with the individual Learning Disability Partnership Boards (LDPBs) properly in time for submission, however it is intended to work with the local LDPBs, Advocacy and other established task/working groups with whom local areas have strong and established links these include; 'My Life, My Way' (IPC), 'My Life, a Full Life (IOW), Peer Advocacy, Parent Carer Networks, Local Involvement Groups, IPC (Portsmouth). Members from the TCP Board will attend each LD Partnership Boards on a regular basis and a suite of briefing documents will be developed to ensure consistency of information provided and that the approach for co-producing local services is the same.

Underpinning the TCP plan is the ethos of co-production and truly working in partnership with people with lived experience in reviewing and shaping the plans. This supports principles 2 and 3 of the 'Building the Right Support' support model.
The SHIP TCP truly values the input from people with lived experience and recognises the difficulties in being able to manage caring roles to attend meetings. In order to support participation it is intended to follow the NHS England guidance 'Working with our Patient and Public Voice Partners: reimbursing out of pocket expenses and involvement payments' whereby out of pocket expenses will be covered for costs incurred relating to travel, accommodation and carer support and those involved as Patient and Public Voice Adviser roles.

To help us to understand what helps a person stay well and not be at risk of a hospital admission, person centred thinking will be used and will include asking;



It is important that people with lived experience are engaged with developing the SHIP TCP plan and people who are currently in specialist learning disability hospitals will be included through attending patient council meetings and specific events at each of the hospital sites within the SHIP area. Stakeholder engagement will also be with people who have previously been in hospital as well as their families/carers. True co-production is about people who use services, carers and professionals working together as equals.

An Indicative map of SHIP Stakeholders is provided below:

Mobilising Communities : Transforming Local Work into Action;

The **Hampshire** 'My Life, My Way' has parent/carers who are equal partners on the Project Board and truly help shape local service design. In addition the project has funded 5 young peer leaders from the Self Advocacy Youth (SAY) group, who in turn are setting up groups in schools in Hampshire in order to really engage directly with young people.

Isle of Wight – This was taken to LDPG last week to start the conversation. This has also been too Been to Joint Adult Care Board (JACB), CCG Executive Board, CCG Governing Body and going to Health and Wellbeing Board.

1.7 Co-production of the SHIP Plan

The SHIP TCP have a strong and vibrant advocacy movement which co-produces Commissioning Plans with the Learning Disability Partnership Boards in relation to; Health, Transition, Transforming Care, The Right Support, My Day, Where I live are some of the areas of work with local involvement / delivery groups across the region. This plan is about people who use services and will be developed with people who have lived experience and families/carers as equal partners.

The Hampshire 'My Life, My Way' programme has developed a 'Co-production Agreement' (see **Appendix II**) and have a commitment to follow 5 Steps to Co-production 2010/12. It is proposed to adapt this agreement for the TCP Plan.

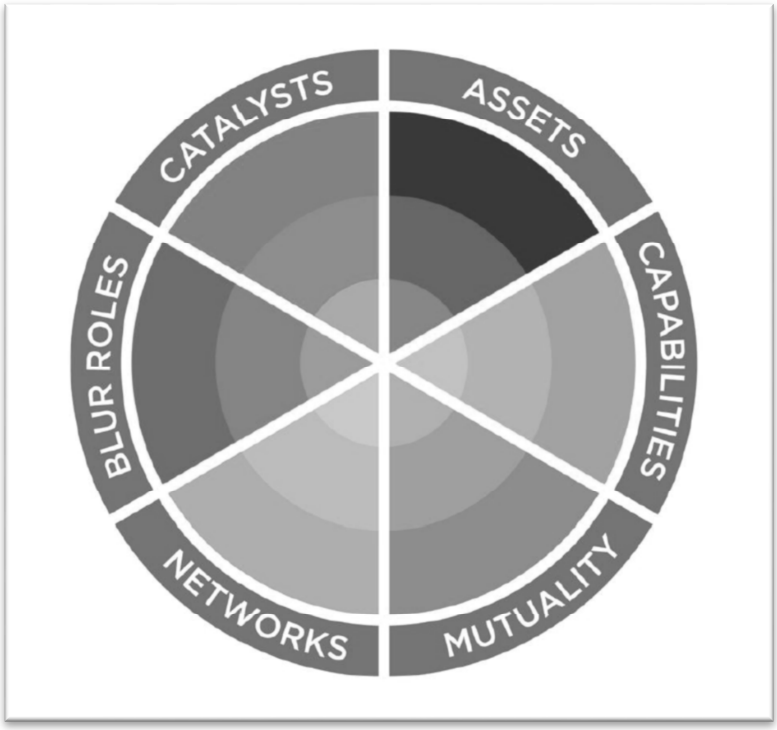
> *Co-production is about people who use services, carers and professionals working together as equals. Being equal means nobody is more important than anyone else.*
>
> *SCIE Co-production in social care*
>
> *A way of working, whereby everyone works together on an equal basis to create a service or come to a decision which works for them all*
>
> *National Co-production Advisory Group and Think Local Act Personal*

To ensure this plan represents true co-production, self-assessment will be undertaken during the project using tools from 'Think Local Act Personal' such as the Inclusion North and Tricia Nicoll Consulting's co-production self-assessment tool. This provides four areas to be considered;

- treating people as assets and using the skills and strengths they have to design and run services - using the gifts and skills people have to offer
- Valuing work differently – making sure people are not just seen as, treated as or expected to behave as 'people who need help'. Support that works to build on people's assets and building self-esteem to identify how people can support others enabling them to feel needed and valued
- promoting reciprocity or 'give and get' so that people who use services have a chance to 'give' as well as 'get' support
- Building social networks so that people get more connected - remembering that people build and sustain communities and you have to be present to be included. Services supporting people to become or stay part of their local communities NOT cut them off from any but paid contact.

The Co-production Self-assessment Framework: A working reflection tool for practitioners by New Economics enables evaluation of how a current service or project works and the way the broader system operates in relation to the following key components of co-production;

1. **Assets:** transforming the perception of people from passive recipients of services and burdens on the system into one where they are equal partners in designing and delivering services
2. **Capacity:** altering the delivery model of public services from a deficit approach to one that recognises and grow people's capabilities and actively supports them to put them to use at an individual and community level
3. **Mutuality**: offering people a range of incentives to engage which enable us to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations
4. **Networks:** engaging peer and personal networks alongside professionals as the best way of transferring knowledge inside and outside of 'services
5. **Shared roles:** removing tightly defined boundaries between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered



In order for us to measure co-production we have locally developed the attached templates.

Co-production Self-assessment Fran

Co-Production how are you doing Self ref

Mobilising Communities : Transforming Local Work into Action;

Co-production and engagement with people with a learning disability, advocacy groups and families /carers is established practice within the SHIP TCP region enabling new models of care and support to be truly developed with 'experts by experience' and meeting local need. This ethos of co-production underpins the TCP Plan. Current citizen based partnership working/development include;

Southampton – The Learning Disability Partnership Board have had two sessions regarding the national model on 30th November 2015 then again on 25th January 2016. Busy People (Southampton's Self Advocacy group) and Southampton Mencap Carers sit on the board, and are fully engaged in plans .The LDPB have agreed to six priority areas which encompass the national model and also overlay with the Preparing for Adulthood outcomes. Those are;

- Person centred approaches and quality
- Carers
- Health
- Employment
- Community Inclusion
- Independence

The four main action plans in relation to the LD Health and Social Care Assessment Framework, Autism, Challenging Behaviour and SEND reforms for Southampton are being reviewed to ensure they are aligned and consolidate key actions.

In order to refresh the local strategy, two consultation workshop events were held to find out from service users, families, carers, advocates, professionals and wider stakeholders how the City is progressing in respect to its approach to supporting people that have (or may have) autistic spectrum conditions. The workshops were themed around the 15 Priority Challengers for Action which were detailed in 'Think Autism – Fulfilling and Rewarding Lives, the strategy for adults with autism in England: an updated (April 2014) and gave attendees the opportunity to comment on the priority challenges in respect of Southampton. The feedback was put into a document which was circulated widely to various networks in order to obtain more views in order to inform the Strategy refresh.

Hampshire launched the new LD Plan in July 2014 which co-produced by people with a learning disability for people with a learning disability including people who were in-patients. The Partnership Board monitors progress against the plan for Adults to ensure that people with a learning disability receive the same opportunities as everyone else and the right support to live their life the way they choose not matter how complex their needs.

Funding for the Hampshire 'My Life, My Way' programme has been used to set up Self Advocacy / Peer groups for young people in order that they can participate in co-producing new ways of working / local plans and these were established by the local Regional Advocacy Group. This programme looked at where to start to make the greatest benefit for people and to change hearts and minds. The solution to start small but think big! This involved starting with a small number of young people and their families using the planning model as the foundation stone, families were offered an independent facilitator over two informal gatherings using the Think Local Act Personal (TLAP) approach to care and support planning and planning live i.e. planning in real time together, in the same room, supporting and sharing with each other and creating individual care and support plans.

> *"..it is uplifting to take part in a process which engages with my child in a proactive and creative way, thinking about the things he can do rather than the things he can't do, and identifying real aspirations and positive outcomes that offer a route to true, active progression. In our view by identifying what is most useful now, we also identify ways to improve outcomes, increase independence, stay safe, and save money in the longer term."*
>
> *Feedback from whole life planning sessions by Wendy*

The need has been recognised to strengthen the young person's and adult's network in Hampshire. Hampshire Advocacy Regional Group (HARG)has been funded as part of the IPC project to establish a network to enable young people and adults with disabilities to have a voice and enable them to direct key elements of the 'My Life, My Way' project.

8 groups will be identified across the county, representing all groups of children and young people with a disability and aged between 13 and 25. HARG will co-produce and deliver this work with peer expert co-workers, from groups facilitated by HARG organisations. They will recruit new peer expert co-workers from the network as it develops. There will be an offer of working together with children and young people at the groups to provide;

- Opportunities to develop self-advocacy skills
- Information about policy and service developments.
- Opportunities to take part in consultations
- Opportunities to take part in co-production activities i.e. IPC programme
- Develop links to the Hampshire Youth Council
- Reports to other organisations about the views of group members

The network will also have the opportunity to meet together and share information with each other and other participation networks, i.e. Hampshire Youth Council,

The FACES (Friendship, Assertiveness, Choice, Empowerment and Social Skills) programme in Hampshire won the Putting People First category in the Great South East Care Awards. FACES trains staff to help people with a learning disability to develop life and social skills, helping them voice what is important to them. Over 50 people are currently supported under this project. This has been extended to people with high support needs. FACES gives people with learning disabilities the skills and confidence to make their thoughts, feelings and choices known. FACES are part of Hampshire's approach to helping people to live more independently, with greater choice and control over their lives and the care and support that they receive.

Hampshire is currently undertaking a public consultation in relation to services for people with Autism and are working with the third sector to gather views via the sounding board. http://actionhampshire.org/communities/soundingboard this includes resources in easyread.

The **Isle of Wight** undertook a full public consultation to identify the needs and aspirations of people with autism and mental health and are currently ensuring the co-production of the Isle of Wight transition policy.

People with Autism and family carers have been involved in writing the Autism Strategy and developing the action plan. Most of Autism Implementation Matters (AIM) attends the Autism Strategy Implementation Group and acts as the link between both groups. The Autism Strategy Implementation Group also has membership from third sector organisations, CCG's, healthwatch and Parents/Carers of adults and children with Autism.

"Together we will open doors to a world where all people can keep on learning and growing"
To make this happen, we will:
- Listen and involve people with a learning disability,
- Encourage, enable and help people to have a voice and take risks.
- With training and support, enable people to reach and take responsibility for their chosen dreams, needs and hopes,
- Shape our services to create new opportunities. *IOW LD Partnership Board*

In addition on the Isle of Wight a new way of working across health and social care is underway. The 'My Life A Full Life' programme is collaboration between the CCG, NHS Trust and Local Authority. This new initiative works in partnership with local people, voluntary organisations and the private sector to deliver a more co-ordinated approach to the delivery of health and social care initially for older people and those with long terms conditions, however as this develops it is considering other areas of delivery which could benefit from this approach to improve individuals' experience of health and social care support services on the Island.

Portsmouth have a well-established parent/carers' co-production group and a young people's co-production group, 'Dynamite' which meet regularly and work in partnership with professionals to identify gaps in provision, good practice and to shape provision for children and young people with disabilities and special educational needs going forward.

Portsmouth has recently re-established their Partnership Board. Feedback from a workshop on 4th November identifies 'What we can Change' and includes;

- assistive technology to help independence
- flexible hours
- the right to support workers – young / autism / older – different needs
- creative practice led by choice not need
- funding for an evening facilitator and weekend life
- communication
- raise aspirations – staff, service users
- robust recruitment
- good support plans

> *"We should be treated equally and our views respected, and we should be helped to live the lives we choose. You need to make sure we are safe in services if we need support or care"*
>
> *Portsmouth LD Partnership Board*

Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership

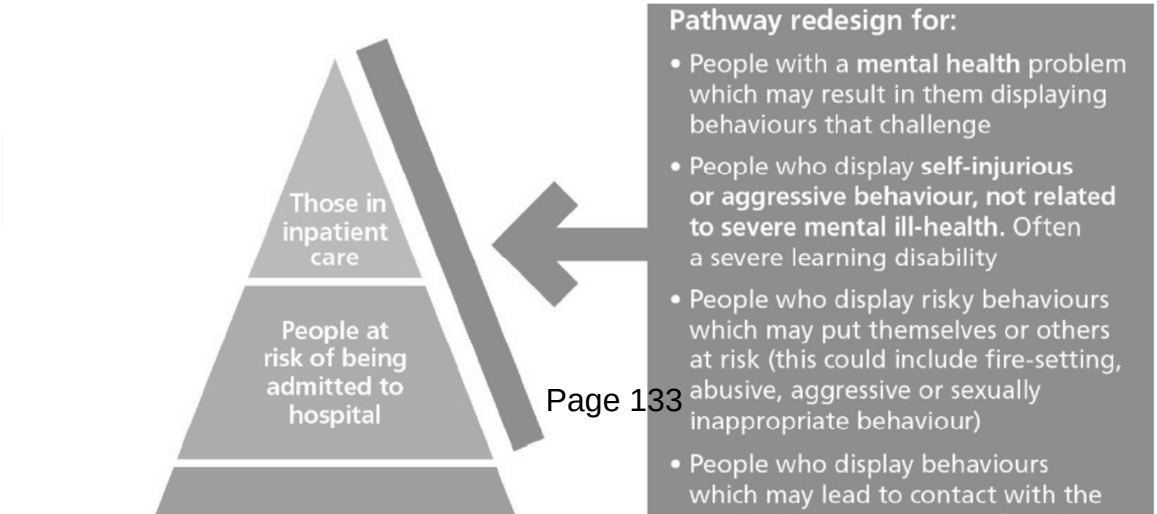
This plan covers the SHIP Transforming Care Partnership and covers the following CCGs;

- Isle of Wight CCG
- Portsmouth CCG
- Southampton CCG
- Fareham & Gosport CCG
- North Hampshire CCG
- North East Hampshire & Farnham CCG
- South East Hampshire CCG
- West Hampshire CCG

2.Understanding the Status Quo

2.1 Population / Demographics;

Children, Young People and Adults with a learning disability and/or autism who display behaviour that challenges are a diverse group of people each having widely dissimilar needs and are described as being a highly heterogeneous group. The pathway redesign requires TCPs to consider the various elements and components of services for this group of individuals and identify five needs groupings;



NHS Southampton CCG*	241,895	2,326	237 (based on diagnosis)
5 Hampshire CCGs*	1,339,011	4,657	Circa 3,500
NHS Isle of Wight CCG	138,392	906	593 open to services 540 in receipt of direct services
NHS Portsmouth CCG*	207,945	564	
TOTAL	**1,927,243**	**8,453**	

In order to serve and meet the needs of Children, Young People and Adults with a learning disability and/or autism transformation is required and co-production has to be the foundation for developing robust services, expanding the offer of personal budgets to individuals and collaboration across Health, Social Care, Children's Services, Education, Hospitals, Housing Departments and the Criminal Justice System.

The SHIP TCP Plan identifies key areas of work required; early intervention and prevention to avoid people being admitted to hospital, upskilling of support staff, increasing the number of personal assistants available in the TCP region, working with providers in the use of Positive Behavioural Support and having robust care planning with relapse prevention strategies agreed with pre-agreed funding in place either directly funded or via personal budgets to help keep people well.

Services will meet the needs of Children, Young People and Adults with a learning disability and/or autism who are supported from local community based services and out of area e.g. within residential schools, care homes, hospitals and secure children centres and who;

- Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neuro-developmental syndrome where there may be an increased likelihood of developing behaviour that challenges
- Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour)
- Often have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges including behaviours which may lead to contact with the criminal justice system

– It will also continue with the work undertaken to date to discharge people from specialist learning disability hospitals and build upon the joint working between NHS England and the Ministry of Justice to facilitate discharge of patients subject to restriction orders

Within the SHIP TCP there are 8,453 people with a learning disability known to services, an overview is provided in the table below. (See **Appendix I** for breakdown of population data).

CCG	Total population	LD/autism population in area*	LD/autism known to services
NHS Southampton CCG*	241,895	318 C&YP 2,008 Adults **Total - 2,326**	237
5 Hampshire CCGs*	1,339,011	384 C&YP 4,273 Adults **Total - 4,657**	Circa 3,500
NHS Isle of Wight CCG	138,392	86 C&YP 820 Adults **Total - 906**	593 open to services 540 in receipt of direct services
NHS Portsmouth CCG*	207,945	62 502 **Total - 564**	889
TOTAL	**1,927,243**	**8,453**	
	*Source: Hampshire County Environment Department's 2014 based Small Area Population Forecasts **Source IOW JSNA 2013	Based on JHSCAF data as at 31st March 2014	Based on numbers known to either Health and/or Social Care Teams

Due to the timescales to produce the first draft plan it has not been possible to review commissioned services across Children, Young People and Adults with a learning disability and/or autism. To develop this plan it is necessary to work with local stakeholders to gather information and lived experience to identify how people are currently supported, where they are supported, how they would like to be supported and if there are services in the local area to enable people to have personal budgets. This will also include understanding why breakdown in placements have occurred. This will enable the TCP Project Board to;

- Identify people 'at risk' of hospital admission or to long term institutional type care (residential)
- Develop a risk stratification to enable health, education and social services to meet the local population need
- Develop a local learning disability early intervention and prevention charter
- Ensure service gaps are addressed
- Work with providers to identify and understand their education/workforce development needs including relating to positive behavioural support
- Develop a joint Regional approach to Housing Development for the TCP area

Understanding the Status Quo : Transforming Local Work into Action;

Hampshire - 782 children open to Disabled Children's teams in HCC, vast majority of whom will have a learning disability. 89 are looked after and 176 receive an overnight short break in a residential setting/home and circa 50 CYP have overnight breaks in 'Family Link' foster placement / fostering respite in addition there are 47 in external high cost 38 or 52 week placements provision – external placements and may be within the county (TCP boundary)

2.2 Analysis of inpatient usage by people from Transforming Care Partnership

Local in-patient bed availability for Learning Disabilities

The Hampshire and Isle of Wight Transforming Care Partnership area is a nett importer of in-patients (Adults) into Assessment and Treatment units and Forensic Rehab and low secure services. There are currently only two providers Southern Health NHS Foundation Trust (SHFT) and Partnerships in Care (PiC). In February 2015 the low secure ward at Mildmay Oaks (formerly Vista Healthcare) was closed and following extensive refurbishment work this has re-opened and NHSE have indicated they will commission 6 beds within this unit. Currently there are 81 beds within the SHIP area. An overview of the in-patient bed capacity within the area is provided below;

Provider Name	Unit Name	Location	No of Beds	M or F	Type	Commissioned by
Local In-patient Beds						
SHFT	Woodhaven - Ashford	Tatchbury	6	M	Low Secure	NHSE
SHFT	Woodhaven - Cypress	Tatchbury	6	M	Forensic Rehab	CCG
SHFT	Willow	Moorgreen	6	M/F	ATU	CCG
PiC	Mildmay Oaks - Bramshill	Winchfield	14	M	Low Secure	NHSE (5 commissioned)
PiC	Mildmay Oaks - Eversley	Winchfield	8	M	ASD	CCG
PiC	Mildmay Oaks - Heckfield	Winchfield	8	F	Locked Rehab	CCG
PiC	Mildmay Oaks - Winchfield	Winchfield	18	M	Low Secure	NHSE
PiC	Knightsbridge House	Fareham	13	M	ATU	CCG
IOW NHS	Sevenacres	Isle of Wight	1	M/F	ATU	CCG
CAMHS	Leigh House	Winchester	1	M/F	CAMHS	NHSE
Total Number of Beds			**81**			
SHFT	*Evenlode*	*Oxford*	*10*	*M*	*Low Secure*	*NHSE*

Use of in-patient beds by TCP CCGs

Hampshire and Isle of Wight CCGs commissioners endeavour to commission in-patient placements within the local area, however this is not always possible where capacity is full or whether individuals do not meet the criteria for local services e.g. physical health and being at risk of harm from other patients or the complexity of presentation and the compatibility with existing patients.

The introduction of Care and Treatment Reviews (CTRs) has enabled CCGs to review the care and treatment for patients and discharge plans. This has been complemented by the new Pre-Admission CTR where there is a planned admission to an in-patient service e.g. in the event of a radical medication reduction plan as well as the 'Blue Light Meetings' to respond to people who are in crisis and at risk of going into hospital. These are recorded and reported to NHSE on a weekly basis together with current patient numbers and planned discharge dates.

In-patients beds within specialist learning disability hospitals are commissioned on both a block and spot basis based on a bed day rate with additional support e.g. 1:1 charged separately. For some individuals community day opportunities are funded to provide work based skills training either at local colleges or vocational training centres e.g. car mechanics, computer maintenance etc. There are no in-patient services in Portsmouth or Southampton. Current patient numbers for the area are provided in the table below;

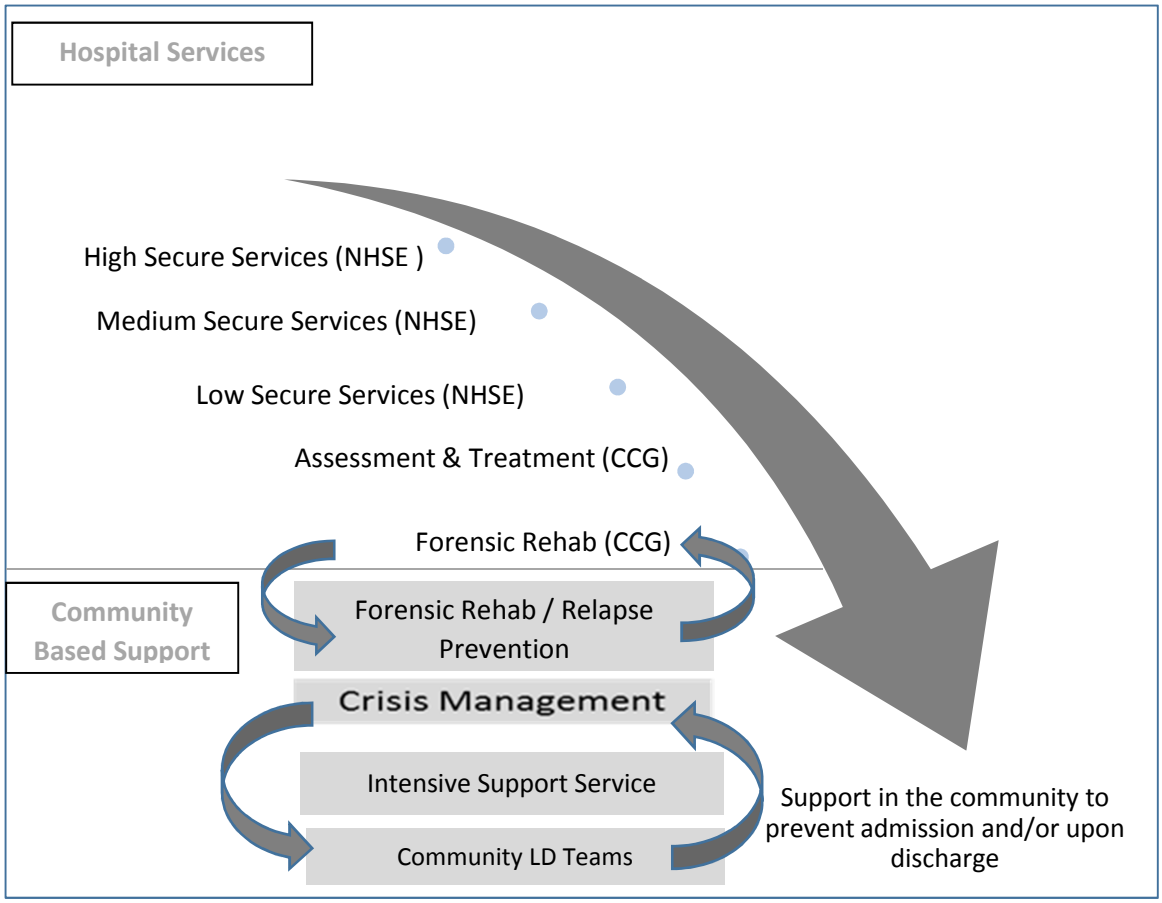
In-patient Statistics	Southampton	Hampshire	Isle of Wight	Portsmouth	NHSE
Current No of In-patients					
Adults	1	14	0	1	
CAMHS					3
NHSE Secure Beds - Adults	5	18	7	5	40
No of patients in NHS in-patient services					
Adults	0	7	0	0	
No of patients in Independent in-patient services					
Adults	0	7	0	0	
No of patients in the Hampshire & IOW area					
Adults	0	11	0	0	
No of patients in out of area hospitals					
Adults	0	3 Newcastle Buckinghamshire Devon (moving to Lincolnshire)	0	0	43
Totals	**1**	**14**	**0**	**1**	**43**
Overall Total	**54**				

As well as the SHIP TCP being a nett importer of people with a learning disability into Assessment and Treatment units and Forensic Rehab and low secure services, the area is also a nett importer into residential care homes with less than 50% of available capacity being commissioned by local health and social care teams. A recent admission was following a failed placement commissioned in Hampshire from an out of area local authority and due to 'Responsible Commissioner' guidance the CCG in which they

were registered with a GP becomes responsible for funding. There is a suggested protocol for commissioners to inform local health teams when they place people out of their home area, however this is not always followed.

Discharge from specialist in-patient learning disability services is also impacting on commissioning decisions due to funding responsibility under Section 117 aftercare. Who Pays? Determining responsibility for payments to providers (August 2013) states "it is then the responsibility of the CCG in the area where the patient moves to pay for their aftercare under section 117 of the Act 21 as agreed with the appropriate local social services authority". This has a detrimental effect of those individuals being discharged as Case Management/Care Co-ordination is then transferred to a new team who may not know the person thus providing a lack of consistency. This issue will be addressed within Early Intervention and Prevention work within this plan and developing the 'At Risk' register and will build upon the joint working between NHS England and the Ministry of Justice to facilitate discharge of patients subject to restriction orders.

CCG and NHS England Commissioners with partners from the Criminal Justice System aim to develop one model of care whereby individual needs are considered holistically through identification of those at risk of offending and who may present with other needs e.g. mental health issues, substance misuse, financial and relationship problems. Often when a person with a learning disability offends they may not link the consequence of their behaviour and therefore an adapted behaviour programme is required as part of the treatment programme.



2.3 Overview of Current Commissioned Health & Care Services

Community Learning Disability Health Team Activity

CCGs commission Community Learning Disability Team from local mental health trusts i.e. Isle of Wight NHS Trust, Solent NHS Trust and Southern Health NHS Trust, in addition there is some investment into Surrey and Borders Partnership Trust who serve the North East Hampshire and Surrey area. An overview of the local CLDT activity is provided below;

Community Activity	Southampton	Hampshire	Isle of Wight	Portsmouth
CLDTs Face to Face Contacts	5,649 Per annum	19,794 Per annum	To be confirmed	3,600 per (300 per month)
Community Health Teams – Community Nurses	361 Per annum			3,600 per annum (300 per month)
Intensive Support Team	377 Per annum	548 Per annum		1,200 per annum (100 per month)
LD Enhanced Team	373 Per annum	N/A		N/A
LD Outpatients	6,298 Per annum	1,645 Per annum		N/A
LD Autism & ADHD	£ investment into service	N/A		N/A
Totals	**6,760**	**23,086**		**8,400 per annum (700 per month)**

Health Facilitation is included within CLDT contracts, this provides support to GP practices for how to make reasonable adjustments for people with a learning disability and/or autism and to enable people to be offered a LD annual health check and to have a health action plan to enable good physical health.
An overview of the current care economy is provided in section 1.3 of this plan and this describes services provided for Children, Young People and Adults with a learning disability and/or autism who;

- Have a mental health condition which may result in them displaying behaviour that challenges
- Display self-injurious or aggressive behaviour
- Display risky behaviours which may put themselves or others at risk
- May not traditionally be known to health and social care services

SHIP TCP wants to prevent the 'revolving door syndrome' trying to fit people into a traditional solution that does not meet the person's needs that results in regular placement breakdown and more restrictive regimes being put in place. This plan aims to build on the person's unique strengths and abilities, not seeing them as a problem and get it right for the person first time. Complex people and those in crisis are often managed through reactive strategies rather having proactive strategies agreed and in place in the event of requiring intensive support, avoiding a hospital admission.
Current commissioning arrangements with residential care require changes to when a provider can serve

notice on a placement, often these are 28 days, 7 days or in rare instances 24 hours. This exacerbates situations for individuals as not only are they experiencing either a deterioration in their mental health and presenting with challenging behaviour they are moved out of what may have been their home for a long time to somewhere unfamiliar to them and then possibly moved again to longer term accommodation to admitted to a hospital setting.
Young people in transition often continue within an out of County educational setting as there are limited alternatives available and usually planning has commenced too late to develop bespoke services for individuals.

CCGs and NHS England commission services for people with a learning disability following the committing of an offence. They are given a hospital order by the courts to an LD Forensic inpatient service (secure or non-secure) for treatment under an adapted behaviour programme which are usually for a period of one year but tend to commence at specific times within the calendar year e.g. if you are admitted in October you may not commence your treatment programme until January the following year. Currently there is no community forensic service provision which could commence whilst an inpatient and continue once discharged to the community thus enabling the individual to access progressive independence enhancing life skills. An illustration of the proposed CCG/NHSE forensic pathway is provided in section 2.2 of this plan.

Due to the timescales to produce the first draft plan it has not been possible to review the provider base for commissioned services across Children, Young People and Adults with a learning disability and/or autism. To develop this plan and we will work with local stakeholders to gather information and lived experience to understand what the challenges are, gaps and how people can be supported and to have a personal budget that helps to keep them well.

National Outcome Measures;

Local Authorities and CCGs are required to undertake a Joint Health and Social Care Assessment for people with a learning disability and a further assessment for those with Autism. The assessment framework identifies areas for improvement in relation to learning disabilities (see diagram 3 below). The main area is increasing the provision of annual health checks and resulting health action plans to above the assessed rate of 50%. The only area within the TCP meeting this measure is the Isle of Wight. Hampshire is the only area for which there are is no designated learning disability liaison function in one or more acute provider trusts, this has been identified as an area for improvement/development within 2.5 of this plan 'The Case for Change'. Analysis of the full assessment is provided in **Appendix III**.

Joint Health and Social Care Assessment Framework 2014;

Areas for Improvement RAG rated as Red on the JHSCAF	CCG Areas			
	Southampton	Hampshire	Isle of Wight	Portsmouth
Staying Healthy – Health Action Plans (Q.4): Fewer than 50% of Annual Health Checks generate specific health improvement targets (Health Action Plan)	X	X		X
Staying Healthy – Primary / Secondary Care Communication (Q6): There is no local area team/clinical commissioning group wide system for ensuring LD status and suggested reasonable adjustments are included in the referral		X		
Staying Healthy – Acute LD Liaison Function (Q7): No designated learning disability liaison function or equivalent process in place in one or more acute provider trusts per site.		X		
Staying Healthy – Reasonable Adjustments in primary care (Q8): Considering NHS commissioned primary care services- dentistry, optometry, community pharmacy and podiatry		X		
Staying Healthy – Offender Health and the Criminal Justice System (Q9): There is no systematic collection of data about the number of people with LD in the criminal justice system. There is no systematic learning disability awareness training for staff within the criminal justice system. The local offender health team does not yet have informed representation of the views and needs of people with learning disability.		X		
Keeping Safe (Q.1): Less than 90% of all care packages including personal budgets reviewed within the 12 months covered by this self-assessment			X	

Keeping Safe (Q.2): Less than 90% of health and social care commissioned services for people with learning disability 1) have had full scheduled annual contract reviews 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance			X	X

Diagram 3

Results from the Autism assessment framework identifies areas for improvement in relation to autism awareness training, reasonable adjustments ensuring local housing strategies recognise the need of people with Autism. An overview of the key areas for improvement is provided in Diagram 4 below. Analysis of the full assessment is provided in **Appendix IV.**

Autism Self-Assessment Framework 2014

Areas for Improvement RAG rated as Red on the ASAF	CCG Areas			
	Southampton	Hampshire	Isle of Wight	Portsmouth
Planning (Q4) : Does your local JSNA specifically consider the needs of children and young people with autism?			X	
Planning (Q6) : Do you collect data on the total number of people currently known to social care services with a diagnosis of autism (whether new or long-standing) meeting eligibility criteria for social care (irrespective of whether they receive any)?				X
Planning - Reasonable Adjustments (Q10): Have reasonable adjustments been made to general council services to improve access and support for people with autism – Red: Only anecdotal examples	X		X	
Training (Q4) : Do CCGs ensure that all primary and secondary healthcare providers include autism training as part of their ongoing workforce development?	X	X		X
Training (Q6): Criminal Justice Services. Do staff in the local court services engage in autism awareness training?	X	X	X	
Training (Q7) : Criminal Justice Services. Do staff in the local probation service engage in autism awareness training?			X	
Diagnosis (Q9) : In your local diagnostic pathway does a diagnosis of autism automatically trigger an offer of a Community Care Assessment (or re-assessment) if the person has already had a current community care assessment?	X			X

Housing & Accommodation (Q1): Does the local housing strategy specifically identify autism?			X	X
Housing & Accommodation (Q2): Do you have a policy of ensuring that local housing offices all have at least one staff member who has training in autism to help people make applications and fill in necessary forms?		X		X

Diagram 4

2.4 Overview of Current Housing, Accommodation & Estate

Over the past number of years there have been a variety of schemes to move people out of long stay hospitals e.g. LBHU & Campus re-provision. This resulted in people moving into their own accommodation with individual support in their own homes or sharing with other people. For the majority of individuals this has been a positive experience, however for some they have had to move due to compatibility issues with people they lived with. For these houses the NHS hold legal charges with Registered Social Landlords (RSL) either at the full market value of the property regardless of the capital granted or at a fixed capital sum.

Local NHS Foundation Trusts have a number of properties within their portfolios which have been used as Registered care homes or hospitals. Upkeep of these is managed by the local Foundation Trust. Any change in use or disposal is between the Foundation Trust and NHS Property Services however there have been occasions whereby the Foundation Trust has given notice to the RSL and then vacated the property. This has raised difficulties in being able to release the Foundation Trust from legal agreements as they are no longer fit for purpose due to changes in the NHS from Primary Care Trusts to CCGs. Locally Hampshire is working with NHS Property Services to seek authorisation to dissolve agreements and to recycle the capital monies back to the local area for the learning disability population.

Local commissioners are working with residential care providers to de-register and provide supported living accommodation thus providing assurance of tenure to individuals rather than being at risk of a provider giving very short notice e.g. 7 days to leave a property. This results in temporary moves to alternative accommodation which is unsettling to a person which has resulted in deterioration in mental health and being sectioned under the Mental Health Act requiring a hospital admission.

To develop a portfolio of housing options for individuals the SHIP TCP working with local housing departments, will develop a joint Regional approach to Housing Development. This will include working with the Housing and Support Alliance http://www.housingandsupport.org.uk/home who have launched a programme of support for commissioners and providers which helps people to move from specialist learning disability hospital units and how people can be supported to remain in their communities with the housing and support that works for them. This work will support Principle 5 of 'Building the Right Support'.

"How can Hampshire make sure people with complex needs are involved in planning housing?"

Feedback Hampshire LD Plan – The Right Place to Live

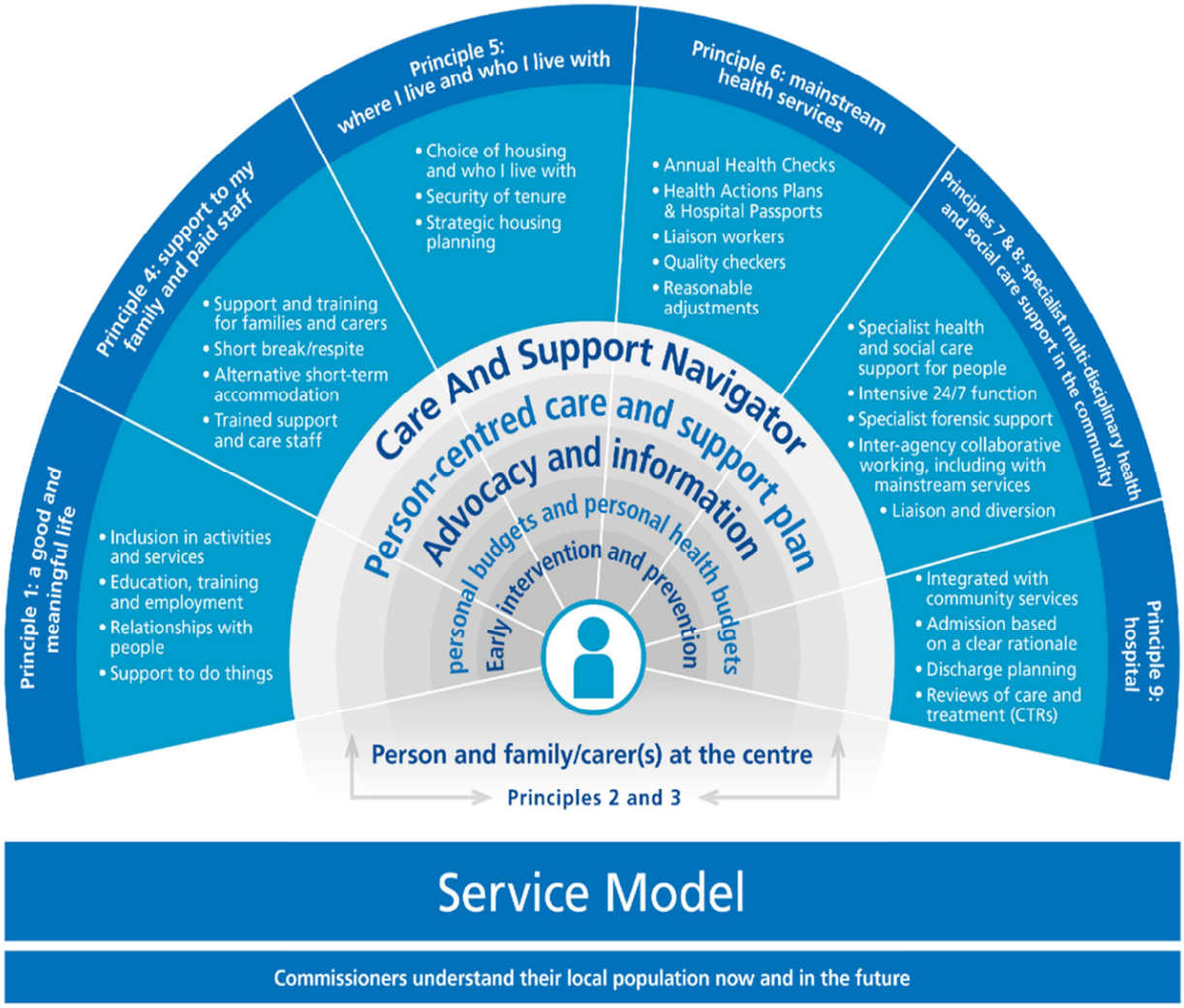
2.4 Case for Change for the SHIP Transforming Care Partnership

The SHIP TCP care model for the delivery of support planning and personal budgets strives for co-production, truly working with families and people with a learning disability in an open way, designing new ways of working and helping drive cultural change. This is based on the New Service Model as outlined in 'Building The Right Support'. The benefits envisaged for this plan include;

- Reduced number of people with learning disabilities being admitted to inpatient beds through the development of more flexible, local and person centred alternatives e.g. crisis support, short term accommodation etc.
- Reduced length of stay for those requiring an in-patient admission
- People with a learning disability and their family to have a better quality of life and achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and circumstances
- Building carers and family resilience reducing the need for formal care
- Services involving and being guided by people with lived experience
- Giving a focus for Adult Services, Children's Services, SEN, CCGs and NHS England to plan earlier and more collaboratively for people with complex needs, minimising inconsistencies in provision for people through the use of personal budgets.
- Changing commission patterns with improved outcomes as well as improved financial management of young people and adults with complex needs, through the creation of a greater range of support options that maximise shared support and social capital with greater and longer engagement with families
- Identifying and promoting different routes in employment
- Better co-ordination of activities that help young people develop independent living and life skills
- Developing joint commissioning and aligning/pooling budgets
- Multi agency early intervention and prevention offer to people to complement self-management and innovative contingency planning

The SHIP TCP will undertake local workshops with families, people who use services, voluntary sector and statutory partners to identify;

- Existing pathways in each of the four areas; Southampton, Hampshire Isle of Wight and Portsmouth to identify the interaction points with different partners/organisations
- Identify the 'hotspots' (potential barriers) that require targeted work
- Identify the value and non-value areas of the pathway and recommend proposed changes
- Develop the future pathways and undertake testing new areas of working
- A co-produced charter across local services developed with stakeholders that is based on best practice and meets the needs of the local population



The Hampshire 'My life, My Way' with the Portsmouth IPC and Isle of Wight, 'My Life, A Full Life' projects will form a key part of the Transforming Care Partnership Plan for Hampshire with people with a learning disability and supports the delivery and outcomes for people based on the principles of the new Service Model;

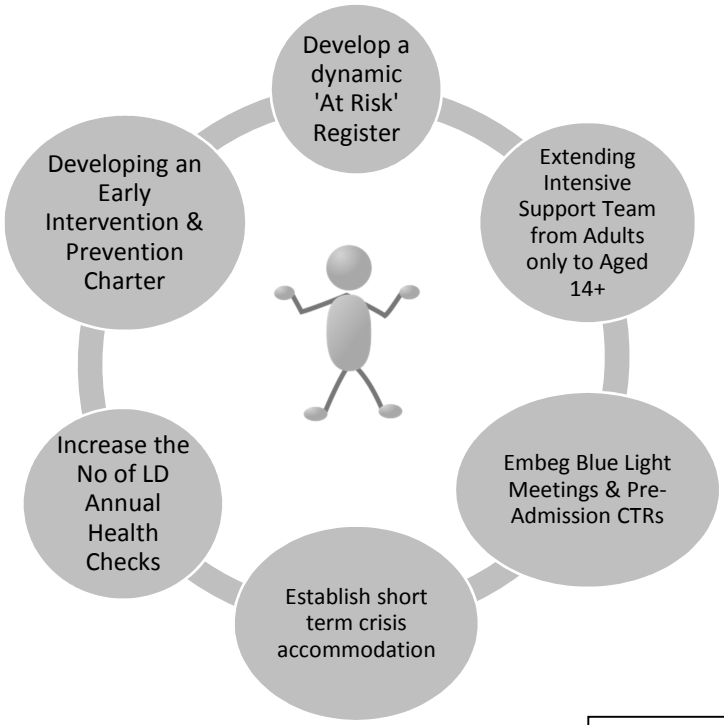
- Principle 1 – **A good and meaningful life** – People are supported to participate in activities that meet their goals and aspirations and have control over what activities their budgets are spent on
- Principle 2 – **person-centred, planned, proactive and coordinated** - through Personalised care & support planning e.g. 'whole life planning'
- Principle 3 – **Choice and Control** - for people by being in control of their budgets and being able use these flexibly to meet needs
- Principle 4 – **Support from and for their families/carers as well as paid support and care staff** - Building carers and family resilience reducing the need for formal care and developing the local workforce for 'Personal Assistant' by working with Skills for Health and Health Education England
- Principle 5 – **Housing** – Enabling people to choose where they live and who they live with. Transforming Care Plans ask local Partnerships to describe how local estate/housing bases need to change?
- Principle 6 – **Mainstream NHS Services** – IPC will enable early intervention and prevention planning to form part of a support package to enable proactive strategies and funding to be agreed and in place to support someone if it is predicted they are likely to go into crisis using the 'At Risk' register criteria.
- Principle 7 – **Specialist health and Social Care support in the Community** – Individualised support planning will include how people can be supported to receive annual health checks, work with their Health Action Plans and completing Health passports and can include interventions for an individual that provide a therapeutic benefit e.g. attending trampolining to enable an individual to maintain fitness, deep muscle tone and wellbeing resulting in a reduction in challenging behaviour and the need for additional support.
- Principle 8 – **Support to stay out of trouble** – People who are subject to S.117 under the Mental Health Act can use a personal budget to support them either with tenancy support or with buying relapse prevention support.
- Principle 9 – **Hospital** – The Transforming Care Partnerships asks Local Authorities, CCCGs, NHS England & other key stakeholders to come together to building local community provision to develop whole pathways reducing the use of inpatient services. TCPs are required to produce TC Plans that demonstrate how people will be managed in the community through Early Intervention and Prevention work to crisis support and where a hospital admission is required that this is appropriate and agreed by all agencies using the Blue-Light Meeting and Care & Treatment Review process.

The key areas identified by the SHIP TCP for development to enable people to be supported in their communities and to avoid inappropriate hospital admissions are grouped into five areas of work;

- Early Intervention and Prevention
- Developing Community Services
- Developing the Workforce
- Increasing the offer and update of Personal Budgets
- Housing

Early Intervention & Prevention;

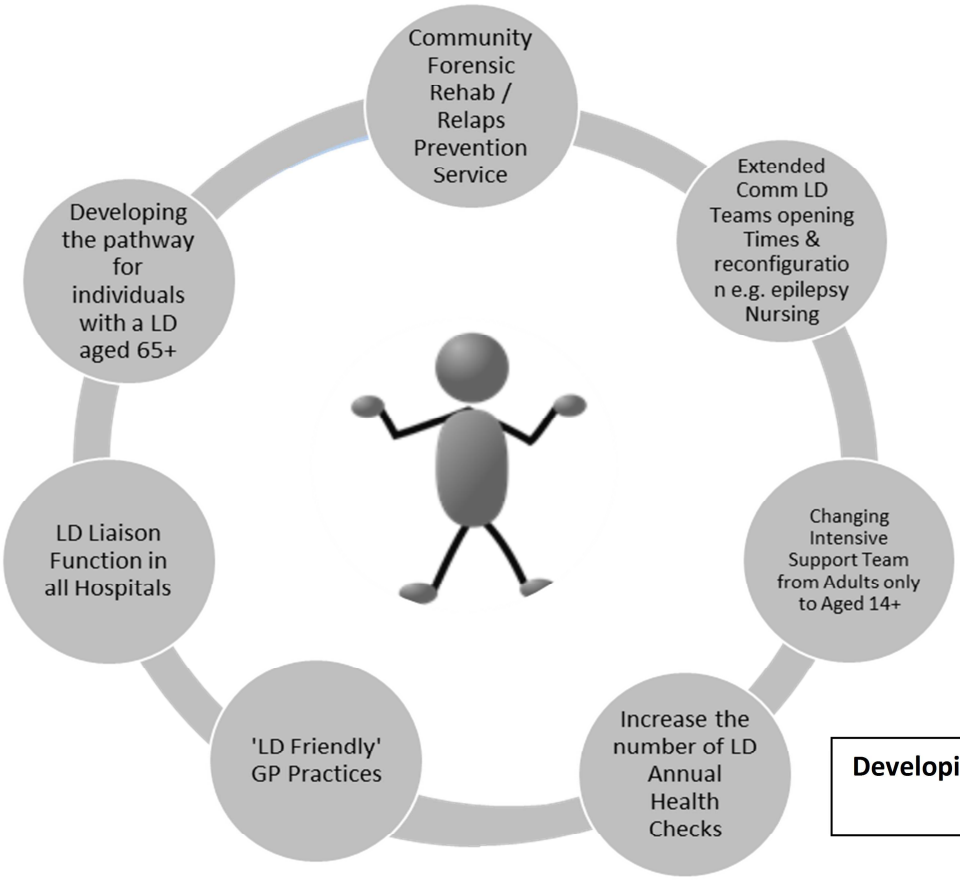
- Extending the scope of the Intensive Support Service from Adults only to all ages, providing services outside of normal working hours i.e. until 22:00 in the evenings 7 days a week
- Development of short term accommodation for those in crisis who cannot remain in existing housing.
- Active 'At Risk' Register Monitoring; establishing criteria for registers and developing proactive strategies for individuals, pooled/aligned monies to enable support to be provided which a person is in crisis.
- Early Intervention and Prevention Charter – developing a joint charter across the SHIP TCP
- Increasing the update of LD Annual Health Checks; working with GP practices to understand the barriers to providing annual health checks and how people can be supported to have Health Action Plans that are meaningful and help people to keep well.



Early Intervention & Prevention

Developing Community Services;

- SHIP wide Community Forensic Rehabilitation Service; working with local NHS Foundation Trusts and people who are / have been inpatients to develop the service whereby people receive care and treatment either in their own homes or in short term accommodation instead of having to go to hospital for adapted behaviour treatment programmes. Pooled/aligned budget across partners for the service.
- Extending the scope of the Intensive Support Service from Adults only to those aged 14 years and above, development of short term accommodation for those in crisis who cannot remain in existing housing.
- LD Acute Hospital Liaison function; ensuring this is provided in each acute trust in the TCP region
- Increasing the update of LD Annual Health Checks; working with GP practices to understand the barriers to providing annual health checks and how people can be supported to have Health Action Plans that are meaningful and help people to keep well.
- Developing the pathway for those aged 65+ with a learning disability; working with support providers to identify appropriate models of care, working with CQC and providers regarding registration of services
- Investment into local health and social care community teams for support planning, reviews for people in receipt of commissioned support or Personal Budgets
- Changing operating times of local community teams providing services outside of normal working hours i.e. until 22:00 in the evenings 7 days a week
- Reconfiguration of existing Epilepsy community nursing and/or investment for this function within CLDTs



Developing Community Services

Developing the Workforce;

- Training and development; for staff / personal assistants to build more robust support for people who are complex and whose behaviour is challenging and for families/carers
- Working with local agencies to promote caring/personal assistants as a career with continuous personal/professional development pathways.
- Extending the FACES (Friendship, Assertiveness, Choice, Empowerment and Social Skills) programme across the SHIP TCP
- Working with providers in the use of positive behaviour support rather than physical interventions
- Developing a career pathway for the Personal Assistant workforce
- Having 'Learning Disability Friendly' GP Practices

Increasing the offer and uptake of Personal Budgets;

- Increasing the uptake of personal budgets including; direct payments, personal health budgets, Educational Health Care Plans (EHCPs) and IPCs – one plan, one budget
- Support to increase the number of Personal Assistants
- Aligning/pooling commissioning budgets across health and social care and developing Section 75 agreements for local joint commissioning arrangements
- Training for support planning co-ordinators / trusted assessors
- Better Care planning; whole life planning for individuals and where appropriate whole families where there is more than one sibling with a learning disability.

Housing;

- Portfolio of housing options for individuals; this will require capital funding to enable the purchase and/or development of buildings that offer greater flexibility of how a person is supported.

Please complete the 2015/16 (current state) section of the 'Finance and Activity' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

	Southampton	Hampshire	Isle of Wight	Portsmouth
No of people with learning disabilities in receipt of Continuing Health Care (CHC)?	103	156	20	27
Section 117 – No of people with learning disabilities in receipt of care funded through an arrangement under Section 117 of the Mental Health Act?	12	35	7	5
Data extracted from JHSCAF 2014				

3.Develop your vision for the future

Vision, strategy and outcomes

3.1 SHIP Transforming Care Aspirations for 2018/19

SHIP TCP wants to prevent the 'revolving door syndrome' trying to fit people into a traditional solution that does not meet the person's needs that results in regular placement breakdown and more restrictive regimes being put in place. This plan aims to build on the person's unique strengths and abilities, not seeing them as a problem and get it right for the person first time. People with complex needs and those in crisis are often managed through reactive strategies rather having proactive strategies agreed and in place in the event of requiring intensive support, avoiding a hospital admission. Underpinning the TCP plan is the ethos of co-production and truly working in partnership with people with lived experience in reviewing and shaping the plans. This plan supports the principles as described in 'Building the Right Support' and the new service model and will enable improved quality of life, quality of care and reduced reliance on in-patient services. Aspirations for 2018/19 will see a reduction in the number of beds commissioned by CCGs and NHSE and people will be supported in the local community.

The Key Targets/Milestones for the project are attached in **Appendix V** of this plan. In summary;

- **By end 2016** all patients who have been in hospital for more than 3 years will be discharged to local community services
- The SHIP TCP will reduce the reliance on in-patient services between now and the end of 2019 from 55 beds to 44 beds;
- Less **by end March 2017**
- less **by end March 2018**
- 2 less **by end March 2019**
- Existing Community Learning Disability Health and Social Care Teams reconfigured to support Early Intervention and Prevention of people with investment aligned to support the function **by End March 2017**
- A new community forensic rehabilitation / relapse prevention service to be **established by end March 2017**
- The number of people with a 'Personal Budget' (Health, Social Care or Education Funded or those in receipt of blended funding) will increase from circa 5,135 individuals to 6,635 **by end March 2019**

Delivery of the above will enable;

Improved Quality of Life;

1) Through whole life planning there will be an understanding of what keeps people well and what is required when they become unwell
2) Personalised care and supported planning approach to encompass education, employment, health and social support and the whole family
3) Remove the 'cliff edge' for young people and their families going through the transition to adulthood
4) To shift power to people with a disability and their families
5) Enable people to be supported how they want to be supported and when to maximise what people do in their life
6) More provision in the region so that people can be closer to home
7) Market development and shaping to suit the needs of people with a learning disability and/or autism
8) Increase investment in non- institutional settings and pathways that are fit for purpose
9) Increased physical health will increase people's life expectancy

Improved Quality of Care;

10) Prevention and early intervention
11) Community forensic intervention rather than just a hospital based model of care
12) Seamless care across the pathway, no stopping and starting based on commissioner boundaries
13) Development of the workforce to implement the new model of care
14) Personal Budgets will put people in control of their support
15) Robust good quality care will prevent breakdown in support packages

Reduced reliance on inpatient services ;

16) Having robust early intervention and prevention strategies in place for people who are at risk of a hospital admission
17) Increase in more appropriate day services/daytime opportunities, respite offers and advocacy/self-advocacy that enables people to keep well
18) A joint housing plan between health and social care that begins to be implemented in year one to provide a greater range of housing for shared lives, independent living, domiciliary care , supported living,
19) Consistency and equity of provision across the TCP partnership

3.2 Measuring improvement against each of these domains

National Measures;

The SHIP TCP Plan will support delivery against all of the Principles as outlined in 'Building the Right Support' and 4 of the NHS Outcomes Framework Domains and indicators;

Domain 2 – Enhancing quality of life for people with long-term conditions

Doman 3 – Helping people to recover from episodes of ill-health or following injury

Domain 4 – Ensuring people have a positive experience of care

Domain 5 – Treating and caring for people in safe environment and protecting them from avoidable Harm

It will also support the Adult Social Care Outcomes Framework (ASCOF) which measures how well care and support services achieve the outcomes that matter most to people.
This plan will support local health and care systems when considering their transformation footprint for the Sustainability & Transformation Plans, required to deliver the NHS Five Year Forward View.

Local Measures;

Co-production will be measured using the two self-assessment tools as described in 1.7 of this plan to measure the involvement of people with a learning disability and/or autism in the development of the plan, work streams identified and evaluation process of the TCP Plan.

The TCP Plan will be evaluated utilising the Health Equality Framework (HEF), outcomes tool based on the determinants of health inequalities designed to help commissioners, providers, people with learning disabilities and their families understand the impact and effectiveness of services.

To demonstrate the effectiveness of change compared to how services are currently delivered, it is anticipated the Patient Outcomes Evaluation Tool (POET) will be used to evaluate the provision of Personal Budgets.

Measures will be developed with leads from local Better Care Fund and Vanguard sites across the SHIP region to improve the health of Children, Young People and Adults with a learning disability and/or autism to identify the wider determinants of poor health outcomes, improve the provision of early intervention and prevention and increasing the workforce capacity to deliver more robust care and support for people who wish to manage a Personal Budget.

The Plan will support local Health and Wellbeing Strategies as outlined below;

Southampton	Hampshire	Isle of Wight	Portsmouth
H&WB Strategy (2013-16) are grouped into three themes which are; **Building resilience and preventative measures to achieve better health and wellbeing:** Developing a focus on health improvement priorities to help people improve their lifestyles and to reduce suffering from many long-term conditions **Best start in life :** Good outcomes in the early years, childhood and adolescence are a strong predictor of the health and wellbeing experiences of individuals throughout their life **Living and Ageing Well:** Life expectancy continues to increase and more people are living longer with long-term conditions. It is important that people not only live longer but retain their health and independence for as long as possible. The evidence is that people who retain more control over their lives and remain as independent as they can be to stay healthier for longer.	H&WB Strategy 2013-18 This sets out four areas of work which are; **Starting well:** so every child can thrive **Living well:** empowering people to live healthier lives **Ageing well:** supporting people to remain independent have choice, control and timely access to high quality services **Healthier communities:** helping communities to be strong and support those who may need extra help	H&WB Strategy 2013-16. Our priorities and plans are; **Children and young people have the best possible start in life** **People are helped and supported to prepare for old age and to manage long-term physical and mental health conditions and disabilities.** **People make healthy choices for healthy lifestyles** **Sustainable economic growth for the Island supports improved employment opportunities** **The Isle of Wight is a better place to live and visit**	H&WB Strategy 2014-17 main vision is Improving and protecting the health and wellbeing of Portsmouth people. There are 5 work stream priorities which are: **Best start** - Improve outcomes for pre-birth to 5 age group, support effective learning; better understand emotional wellbeing. **Promoting prevention** - **Create sustainable healthy environments**; improve mental health & wellbeing; tackle smoking, alcohol and substance misuse. **Supporting independence** - developing lifestyle hubs; implementing high impact volunteering and Better Care Fund initiations for intervention and prevention. **Intervening earlier** - Safeguarding; delivering CCG priorities; improving dementia services. **Reducing inequality** - Tackling poverty; tackling health related barriers and sustaining employment; addressing issues in the Public Health Annual report.

3.3 Supporting people who display behaviour that challenges

"Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion".

(Challenging behaviour – a unified approach; RCPsych, BPS, RCSLT, 2007)

According to the Challenging Behaviour Foundation, "Challenging behaviour is often perceived as a 'problem' or 'illness' to be 'treated', 'cured' or 'stopped'. The problem is seen as being part of the person rather than focussing on what needs to change around the person, such as their environment or how people support them."

The SHIP TCP Plan aims to support people through the use of thorough person centred planning, involving their families/circle of support to fully understand them, how they communicate and how they can be supported using Positive Behaviour Support (PBS). People will also be offered Personal Budgets to enable greater flexibility in how they are supported, where and by whom. This plan supports 'The Challenging Behaviour Charter - Rights for All' which ensures people with behaviour that challenges have access to the same rights, opportunities and support as everyone else. including;

1) People will be supported to exercise their human rights (which are the same as everyone else's) to be healthy, full and valued members of their community with respect for their culture, ethnic origin, religion, age, gender, sexuality and disability.
2) All children who are at risk of presenting behavioural challenges have the right to have their needs identified at an early stage, leading to co-ordinated early intervention and support.
3) All families have the right to be supported to maintain the physical and emotional wellbeing of the family unit.
4) All individuals have the right to receive person centred support and services that are developed on the basis of a detailed understanding of their support needs including their communication needs. This will be individually-tailored, flexible, and responsive to changes in individual circumstances and delivered in the most appropriate local situation.
5) People have the right to a healthy life, and be given the appropriate support to achieve this.
6) People have the same rights as everyone else to a family and social life, relationships, housing, education, employment and leisure.
7) People have the right to supports and services that create capable environments. These should be developed on the principles of positive behavioural support and other evidence based approaches. They should also draw from additional specialist input as needed and respond to all the needs of the individual.
8) People have the right not to be hurt or damaged or humiliated in any way by interventions. Support and services must strive to achieve this.
9) People have the right to receive support and care based on good and up to date evidence.

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

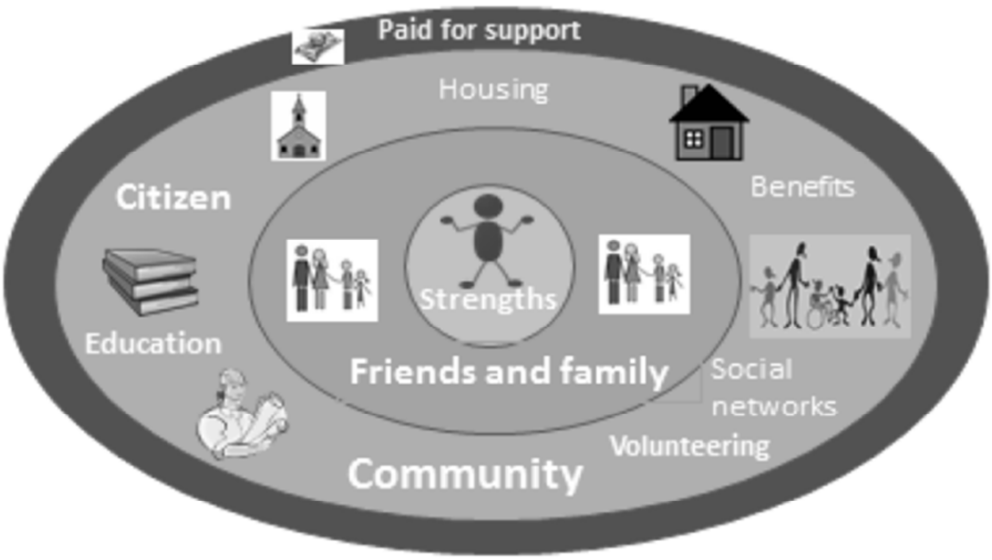
3.4 Any additional information

The plan describes the current finance/activity and how CCG funding invested in community services will support people; however there is no information available to identify the alignment of NHSE budgets with the SHIP TCP plan. This has been highlighted under 'Risks'.

4.1 Overview of the New SHIP TCP Model of Care

In Hampshire there is a cross agency initiative 'Think Differently' which is already changing the culture and barriers fostering collaborative working across statutory and voluntary sector partners. This initiative is a workforce development programme across the whole of the County across all care groups, changing culture and challenging mind sets, focusing on the citizenship model and recognising people as assets, strengthening the values and principles of person centred planning and personalisation. This initiative sees the shift in focus from what a person cannot do to what can a person do for themselves and their circle of support do thus promoting greater independence and control for the individual rather than the traditional model of 'over supporting' people. The illustration below illustrates how this will look for people, whereby support is developed from the person's strengths, their circle of support, the community as a resource base and then what support needs to be commissioned or paid for from a Personal Budget. This model is supported by the five key shifts that define Integrated Personal Commissioning;

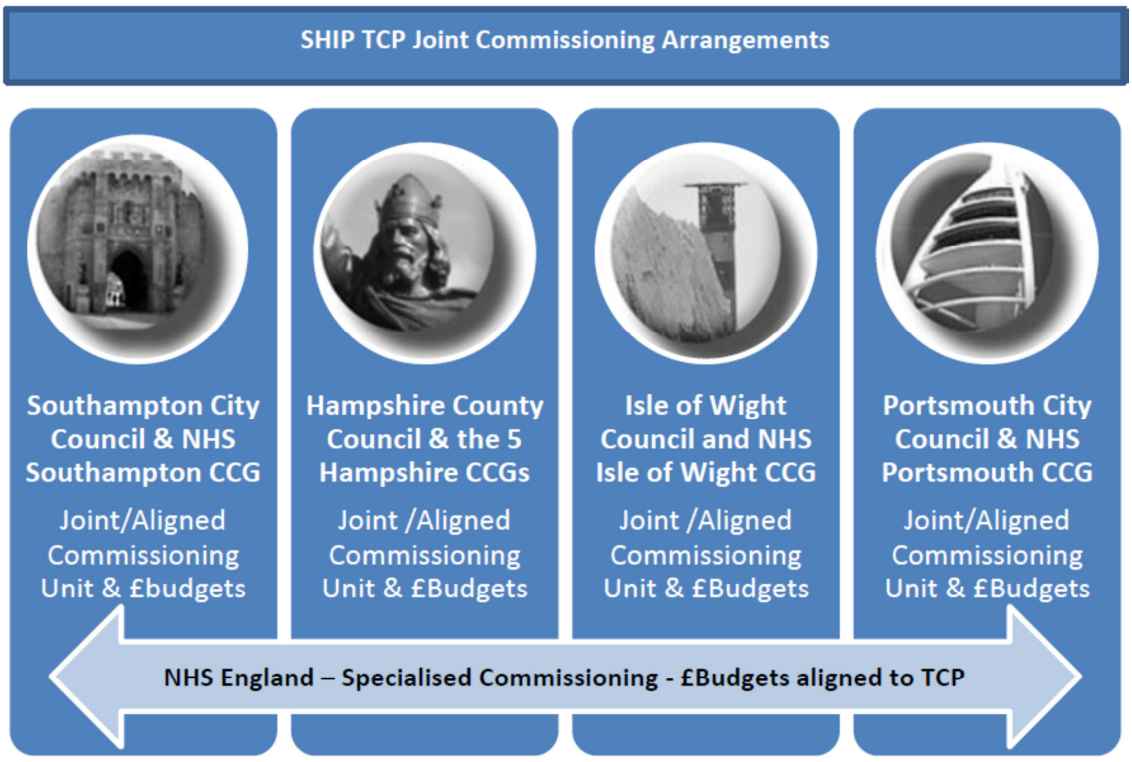
- A proactive approach to improving your experience of care and preventing crisis
- A different conversation with the people involved in your care focussed on what's important to you
- A shift in control over the resources available to you, your carers and family
- A community and peer focus to build your knowledge, confidence, and connections
- A wider range of care and support options tailored to your needs and preferences



To support people as described above, five key areas have been identified for development to enable people to be supported in their communities and to avoid inappropriate hospital admissions as described in 2.5 of this plan;

- Early Intervention and Prevention
- Developing Community Services
- Developing the Workforce
- Increasing the offer and uptake of Personal Budgets
- Housing

The SHIP TCP 'Integration' Project objectives aim to align pooled budgets under either formal Section 75 agreements or Lead Commissioning agreements.



4.2 What new services will be commissioned?

Community Services;

- Extending the scope of existing the Intensive Support Service from Adults only to all ages
- SHIP wide Community Forensic Rehabilitation Service; working with local NHS Foundation Trusts and people who are / have been inpatients to develop the service whereby people receive care and treatment either in their own homes or in short term accommodation instead of having to go to hospital for adapted behaviour treatment programmes. Pooled/aligned budget across partners for the service.
- LD Acute Hospital Liaison function; ensuring this is provided in each acute trust in the TCP region

- Developing the pathway for those aged 65+ with a learning disability
- Investment into local health and social care community teams for support planning, reviews for people in receipt of commissioned support or Personal Budgets
- Changing operating times of local community teams
- Reconfiguration of existing Epilepsy community nursing and/or investment for this function within CLDTs

Training & Development;

- For staff / personal assistants to build more robust support for people with complex needs and whose behaviour is challenging and for families/carers
- Extending the FACES (Friendship, Assertiveness, Choice, Empowerment and Social Skills) programme across the SHIP TCP
- Positive Behaviour Support Training for Providers, Personal Assistants and people with a Personal Budget
- Training and resources (stickers etc.) for 'Learning Disability Friendly' GP Practices
- Training for support planning co-ordinators / trusted assessors

In order to have real partnership working in local areas it will be necessary for local health and social care organisations to align/pool budgets and where appropriate to enter into Section 75 agreements.

4.3 What services will the TCP stop commissioning, or commission less of?

Through developing local community services, this will enable a reduction in the number of CCG and NHSE commissioned beds and a reduced length of stay for those individuals who require an in-patient admission.
There will also be a reduction in the number of residential care commissioned placements as services are de-registered to supported living models of support or where people are enabled to move to their own home with their own tenancy or have shared ownership.

4.4 What existing services will change or operate in a different way?

Early Intervention and Prevention

At the heart of this plan is the early intervention and prevention work stream. The Transforming Care Programme, require CCGs working with local authorities and Mental Health Trusts to manage 'At Risk' Registers. This will include identifying those factors which could indicate a placement breakdown was more likely. Research such as "Predicting Placement Breakdown: Individual and environmental factors associated with the success or failure of community residential placements for adults with intellectual disabilities (Phillips and Rose 2010) suggest these predictors include;

- Previous admission to psychiatric inpatient services or assessment and treatment services
- Anti-social behaviour such as 'tantrums' and verbal aggression
- Sexual delinquency
- Psychiatric diagnosis

- Mild LD and outward directed behaviour
- Senior staff attributing control to the service user
- Staff support levels being lower and culture in terms of supervision, training, leadership etc.

The SHIP TCP recognise that it is important to recognise the purpose of the 'At Risk Register' and what this means for individuals in terms of outcomes, this will include;

- Early Intervention and prevention – knowing individuals and ensuring that a crisis plan is in place, that people are aware of this and ensuring planning of clinical work to support the person (this may include clinical work or issues such as accommodation/environmental factors, provider support etc.)
- Reviewing/monitoring of support packages and the use of suitable standards to achieve this e.g. Periodic Service Reviews, framework contracts etc.
- Analysis – identifying service gaps
- Planning and developing resources e.g. training for support staff

To develop the 'At Risk' template three key criteria will be included; Systems, Individual and Behaviour ;

<u>Systems</u>

- Family factors e.g. social deprivation, mental health needs of family members, parents having a learning disability, schooling, being placed away from the home environment, being a looked after child, parental stress, parental/family cares age
- National factors and guidance e.g. decrease in use of antipsychotics and how local services are implementing this
- Funding streams regarding an individual e.g. CHC, being funded by external CCG/Local Authority in Hampshire, 117 (this may indicate complexity of need)
- Change of service provider
- Engagement by the service provider or family with statutory services
- Compatibility within current service provision
- Environment – deprivation, inappropriate provision to the identified needs of the individual, specific provider issues (e.g. overarching safeguarding concern)

<u>Individual</u>

- Motivation of individual to engage with health and social care professionals
- Safeguarding relating to the individual
- Diagnosis of individual (e.g. comorbidity, specific syndromes or diagnosis which may increase likelihood of the person presenting with challenging behaviour e.g. Prader Willi), personality disorder, autism)
- Change in physical or mental health within the individual (may include dementia), person lacking in sleep
- Deprivation of Liberty being in place(DOLs) and restrictive practices – use of physical intervention, use of medication and frequent prn, use of seclusion, polypharmacy
- Contact with Criminal Justice System or contact with the police

- Difficulties around communication
- Life limiting condition
- At point of being discharged from services e.g. health input being reduced
- Individual service user journey/pathway
- Complex epilepsy
- Life events and cyclical events (e.g. Christmas, parents aging/death, loss of a social role e.g. job)
- Use of physical intervention

Behaviour

- Increase in behaviour that challenges
- Aggression to others
- Severity of impact of any behaviour to others on to self
- Aggression to property
- Self-neglect
- Non-compliance with medication
- Loss of placement/tenancy, threats of eviction
- Number of placements an individual has experienced
- Contact with police/criminal justice system

To support risk management/contingency planning, there are processes already in place such as Care Programme Approach (CPA),Multi-Agency Public Protection Arrangements (MAPPA), Periodic Service Reviews (PSR) etc. (Please see document below for example of draft Risk Register and protocol).

Draft Risk Register and Protocol.pdf

'I have support workers that do keep me company but keep me lonely'

Feedback to the Hampshire LDPB

Developing Community Services;

- Community Learning Disability Teams providing services outside of normal working hours i.e. until 22:00 in the evenings 7 days a week, developing crisis support
- Intensive Support Services - extending the scope of the Intensive Support Service from Adults only to those aged 14 years and above
- SHIP wide Community Forensic Rehabilitation Service; working with local NHS Foundation Trusts and people who are / have been inpatients to develop the service whereby people receive care and treatment either in their own homes or in short term accommodation instead of having to go to hospital for adapted behaviour treatment programmes. Pooled/aligned budget across partners for the service.
- Adult Services and Community Health Teams will jointly manage the 'At Risk' Register MDT working
- Improved physical health care; Ensure LD Hospital Liaison available across all acute trusts within the SHIP TCP, increase provision and take up LD Annual Health Checks.
- Developing the pathway for those aged 65+ with a learning disability; working with support

providers to identify appropriate models of care, working with CQC and providers regarding registration of services. Work with local housing departments to include this cohort in their local housing plans.

Local TCPs are asked to consider the money they spend as a whole health and social care system on people with a learning disability and/or autism, and to use that total sum of money in a different way to achieve better results. This will require the aligning/pooling of budgets and where appropriate to enter into Section 75 agreements between health and social care commissioners.

The SHIP TCP will work with local children, young people and adults to determine what it is they wish to do during the day (activities). The current local offer will be expanded by working in partnership with local voluntary sector organisations to respond to the individual.

Activates will include:

- Education and training
- Day services
- Work based opportunities
- Volunteering
- Community access e.g. libraries, discovery centres, community cafes, community hubs.

4.5 Increasing the uptake of more personalised support packages

Due to the timescales to submit this plan it has not been possible to undertake a full review of PHBs, Direct Payments or Educational Health Care Plans. An overview of these is provided in the tables below, however it is intended the number of people with a 'Personal Budget' (Health, Social Care or Education Funded or those in receipt of blending funding) will increase from circa 5,135 individuals to 6,635 by end March 2019.

Personal Health Budgets	**Southampton**	**Hampshire**	**Isle of Wight**	**Portsmouth**
No of PWLD Offered a PHB	-	-	14	-
No of PWLD who have a PHB	6	17	13	25
Total No of PHBs		101		75
Type of Budget;				
Direct Payment	4 = part PHBs 2 = Full PHBs	101 PHBs; 81% direct payment 10% Notional & Direct 9% Notional 0% Third Party	4	9
3rd Party Budget			9	3

No of people in receipt of Direct Payments from the Local Authority	Southampton	Hampshire	Isle of Wight*	Portsmouth
Direct Payment Only	39		297	49
Part Direct Payment	41		17	34
Managed Personal Budget			22	0
No of people in receipt of a personal budget who have a personal assistant	-		121	11*
Notes			*figures from IOW SALT return 31.03.15 (relates to accommodation and employment status of LD clients)	*Those on prepaid card only

No of People in receipt of Education, Health & Care Plans (EHCPs)	Southampton	Hampshire	Isle of Wight	Portsmouth
No of EHCPs	790	Circa 3,500	95	190
No of pupils with statement of special education needs		30,000*	442	859
% of SEN Population	2.5%	-	0.6% of Total Education Numbers	3.1%
Notes	Southampton figures are from the January 2015 school census	*includes those with a statement/LDA and EHCP		

To support the offer and uptake of Personal Budgets the following actions will be taken within the local areas;

- Offer PHBs to more PWLD and to extend the offer to people who are not CHC eligible
- Decommissioning some elements of block contracts e.g. therapies, SALT etc.
- To bring the Personal Health Budget projects and IPC demonstrator site projects together and offer people the integrated personal commissioning approach e.g. 'blended budgets'
- To establish joint commissioning arrangements e.g. section 75 agreements and aligned/pooled budgets
- Joint commissioning approach for providers

The Personal Budget offer across the SHIP TCP will offer;

- A single joint assessment of need (whether Health , Social care , Education)
- Person centred life and support planning undertaken by the voluntary sector
- The personal budget being managed via:
  - A direct payment to the person or Responsible Person
  - A third party organisation
  - A statutory agency managing this budget on their behalf
  - An Individual Service fund
  - The local authority to purchase commissioned services

Provisional plans to increase Personal Health Budgets are indicated in the following table:

Plans for increase in PHB's	**Southampton**	**Hampshire**	**Isle of Wight**	**Portsmouth**
15/16	**6**	**17**	**13**	**25**
16/17	**20**	**100**	**20**	**75**
17/18	**25**	**200**	**10**	**75**
18/19	**20**	**200**	**10**	**50**
Totals	**71**	**517**	**53**	**225**

Implementation Planning : Transforming Local Work into Action;

Independent Lives has a 3 year contract with **Hampshire** County Council for Personal Planning and Direct Payments for Adults and Children & families with disabilities, they are using their expertise and experience to work with Hampshire Advocacy Regional Group, service users and carers and other stakeholders to co-produce a single personal centred life and support model centred life planning for people with complex needs and limited communication HARG.

Isle of Wight - PHB referrals are only currently considered for people who are already eligible for Continuing Healthcare Funding and are living at home with a care package.

J is 17 years old and currently lives at home with his mother and younger brother. He has a diagnosis of Athetoid Cerebral Palsy, is doubly incontinent, has asthma, is non-weight bearing, has a learning disability and displays autistic traits in nearly all aspects of daily living. He requires full 24 hr support at all times as he is at high risk of choking and requires very careful positioning and moving.

J leaves school next year and so a care plan was agreed under a personal health budget to enable him to remain at home with his family, access person centred day time activities and ensure regular respite breaks for his mother, who is his main carer. J requires the support of two for all personal care tasks and so the recruitment of a team of skilled carers who know him well and understand his needs was essential.

Time has been spent at this transition stage getting to know and understand J. Links were then made with Blue Sky Arts and a specialist local farm to devise a bespoke care package for him. His mother and school have been very involved in this and his mother now has the confidence in the carers employed and the outcomes from the activities he will be undertaking.

Isle of Wight CCG – PHB Team

T is 18 and has a diagnosis of Epilepsy, Autism, Learning Disability, Colitis and Hyperactive. There is an inter-relationship between his epilepsy and behaviours which is extremely complex and requires significant levels of support on a daily basis. He receives care for 20 hours per week from 2 carers, but his parents provide the bulk of his care. He receives animal therapy, and swimming sessions but the pool needs to be booked for him alone given his behaviours.

The PHB has enabled the provision of sensory cabin in his garden so that he will be able to have access at all times of the day and night, to help manage his unpredictable behaviours linked to his autism and seizure activity. Total cost was £30k, with part funding (£10K) from the LA Housing Department, offering a designed space that will give him the quiet and visual calm required, with him having more control over his environment as the home environment is unpredictable as others have to live there also.

The cabin will enable T to minimise his sensory overload - this will support his future development assisting him to be more socially interactive and communicate his needs/feelings or emotions more.

Isle of Wight CCG

4.6 Future SHIP TCP Care Pathways

The vision of the SHIP TCP Plan is to have equity of service provision across the area focusing on;

- Early Intervention and Prevention
- Achieving better health outcomes
- Local service planning
- Improved physical health
- Inclusion in service monitoring & evaluation
- Access to appropriate opportunities for life-long learning
- A more inclusive society with 'learning disability friendly' places e.g. GP practices
- Robust Community Services for both commissioned health and social care support and services available to people who have a Personal Budget
- A skilled local workforce whereby Positive Behavioural Support is enabled as a way of life for individuals and not as a means of managing behaviour that challenges
- People no longer being managed inappropriately in the criminal justice system
- A joint Regional approach to Housing Development that offers people a portfolio of housing options that meets individual needs

Further information is provided in section 2.5 of this plan 'Case of Change' and in section 4.4 which describes how current commissioning arrangements will change.

4.7 How will people be fully supported to make the transition from children's services to adult services?

The SHIP TCP Plan aims to support Children and Young people through the use of thorough person centred planning, involving their families/circle of support to fully understand them, how they communicate and how they can be supported using Positive Behaviour Support (PBS). This plan aims to remove the 'cliff-edge' for Young People as they move through Transition to Adults. C&YP will be at the heart of service planning and design.
Existing services such as Intensive Support will be extended to those aged 14 and above and will require CAMHS and local Mental Health Trusts to work together to deliver seamless mental health services to Young People.

This plan will ensure C&YP are included in developing;

- Early Intervention and Prevention Plans
- Improved physical health
- Robust Community Services for both commissioned health and social care support and services available to people who have a Personal Budget
- A skilled local workforce
- A Housing Strategy that offers people a portfolio of housing options and that enables young people to access housing below the age of 18.

C&YP will be offered Personal Budgets to enable greater flexibility in how they are supported, where and by whom and will enable Young people to retain services and support staff as they transition to

adulthood. As described in section 1.3 (page 28).

4.8 How will you commission services differently?

This is described in Sections 4.1, 4.2 and 4.2 of this plan.

4.9 How will the SHIP TCP local estate/housing base need to change?

The SHIP TCP recognises the lack of housing options for people, currently there is a greater provision of residential care opposed to single person services, extra care models or supported living accommodation. Local commissioners are trying to change the local provider marker by working with residential care homes to de-register and provide supported living accommodation thus providing assurance of tenure to individuals rather than being at risk of a provider giving very short notice e.g. 7 days to leave a property. This results in temporary moves to alternative accommodation which is unsettling to a person which has resulted in a deterioration in mental health and being sectioned under the Mental Health Act requiring a hospital admission.

An key outcome for this plan is to develop a portfolio of housing options for individuals the SHIP TCP working with local housing departments, will develop a joint Regional approach to Housing Development. This will include working with the Housing and Support Alliance http://www.housingandsupport.org.uk/home who have launched a programme of support for commissioners and providers which helps people to move from specialist learning disability hospital units and how people can be supported to remain in their communities with the housing and support that works for them. This work will support Principle 5 of 'Building the Right Support'.

Locally Hampshire is working with NHS Property Services to seek authorisation to dissolve existing legal charges on properties and to recycle the capital monies back to the local area for the learning disability population.

To deliver the Community Forensic Rehabilitation service it has been identified that accommodation will be required in order to support people. This bid includes capital funding required within the finance and activity schedule as well as capital required for more supported living models of accommodation.

The following objectives have been identified to develop the housing provision:

- To identify current housing options and through co-production collate information and map what type and where people want accommodation in the SHIP region.
- Hold a Housing Workshop within the first year to understand the current situation and the need. This will involve service users.
- Develop a portfolio of sufficiently high quality housing options for individuals, working with local housing departments.
- Establish a programme of de-registration of residential care settings to supported living

models of care and support.

- Provide clear easy read guidance for individuals and their families/carers that outlines the local options available, how to access this accommodation and what ongoing support will be provided e.g. tenancy advice etc.
- Develop a common application/bidding process for local authority housing with reasonable adjustments i.e. type of photo id required and proof of residency that breaks down barriers and delays to accessing accommodation.
- Work with the Housing and Support Alliance http://www.housingandsupport.org.uk/home who have launched a programme of support for commissioners and providers which helps people to move from specialist learning disability hospital units and how people can be supported to remain in their communities with the housing and support that works for them.
- Work with NHS Property Services to seek authorisation to dissolve existing legal charges on properties and to recycle the capital monies back to the local area for the learning disability population.

4.10 Repatriation/Re-settling of People

Commissioners have been actively facilitating discharges for people with a learning disability to local based services. This has seen the repatriation of people back to the local area either to bespoke support services or a hospital transfer to a local based hospital. Care and Treatment Reviews have been valuable in determining the purpose of why someone is in hospital, what treatment they are receiving, discharge plans and most importantly how they have been involved in their own care planning as well as their Families/Carers and where appropriate friends.

Putting people and their families/carers at the heart of care and support planning enables the right housing options to be identified to support discharge and ensuring the level of support will enable an individual to keep well and prevent a re-admission to hospital.
In future people who are in hospital will be offered Personal Budgets for their Sec.117 aftercare support needs given them the same flexibility and choice as people who have not been detained under the Mental Health Act.
The Early Intervention and Prevention work stream will ensure care planning includes any relapse prevention plans and direct access to services when they are needed without having to be referred to services.

Table: Number of people with a Learning Disability who have been in hospital for more than three years

Fareham & Gosport CCG	North East Hampshire & Farnham CCG	North Hampshire CCG	South East Hampshire CCG	West Hampshire CCG	Portsmouth CCG	Southampton CCG	Isle of Wight CCG
0	0	3	0	2	1	1	0

4.11 How does this transformation plan fit with other plans and models to form a collective system response?

The SHIP TCP Plan for people with a learning disability and/or autism will support both national and local plans including but not limited to;

National;

- Transforming Care Programme (formerly Winterbourne View Joint Improvement Programme)
- Autism Strategy - Fulfilling and Rewarding Lives' and subsequent update 'Think Autism' (2014)
- Delivery against 4 of the NHS Outcomes Framework Domains and indicators
- Adult Social Care Outcomes Framework (ASCOF)
- NHS Five Year Forward View – Sustainability and Transformation Plans
- Increasing the offer and uptake of Personal Budgets
- Building the Right Support and the new model of care
- SEN Reforms (EHCPs)
- Mental Health Crisis Concordat - Parity of Esteem & No Health without Mental Health

Local Plans;

- Learning Disability Plans
- Autism Strategies
- Joint Health and Wellbeing Board strategies
- IPC Demonstrator site work
- Developing the 'local offer' for Children, Young People and Adults
- Better Care Fund & Vanguard Site Plans
- HIOW Devolution for the People of Hampshire & The Isle of Wight: A Prospectus for discussion with Government

5.Delivery

5.1 What are the programmes of change/work streams needed to implement this plan?

The aim of the SHIP TCP Plan is to have equity of service provision across the area focusing on;

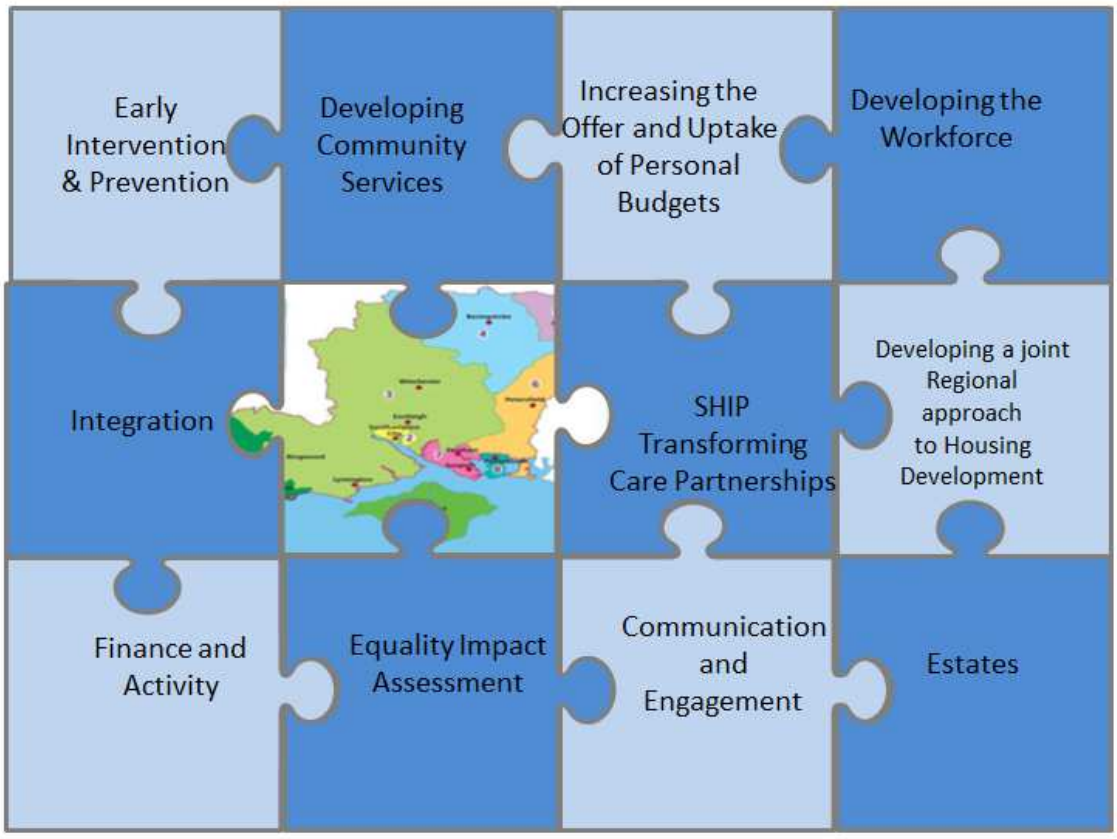
- Early Intervention and Prevention
- Improved physical health
- A more inclusive society with 'learning disability friendly' places e.g. GP practices
- Robust Community Services for both commissioned health and social care support and services available to people who have a Personal Budget
- A skilled local workforce whereby Positive Behavioural Support is enabled as a way of life for individuals and not as a means of managing behaviour that challenges
- A Housing Strategy that offers people a portfolio of housing options

Draft Project Briefs / Initiation Documents have been drafted which outline the Scope, Objectives, Method of Delivery, Assumptions, Interfaces etc. Due to the timescales for the submission of this revised draft plan, some further plans need to be developed;

Work Programmes & Plans	
Early Intervention & Prevention	SHIP TCP - Early Intervention & Prevei
Developing Community Services	SHIP TCP Plan - Developing Communit
Increasing the Offer and Uptake of Personal Budgets	SHIP TCP Plan - Personal Budgets PID
Workforce Development	v2 SHIP TCP Plan - Developing the Workf
Developing a joint Regional approach to Housing Development	(V2) SHIP TCP Plan - Developing a Joint Hc

Communication and Engagement	SHIP TCP Plan - Communications and I
Estates Plan	SHIP TCP Plan - Estates PÍD.doc
Equality Impact Assessment	SHIP TCP Plan - Equality impact asses
Finance and Activity	SHIP TCP Plan - Finance and Activity I
Integration	SHIP TCP Plan - Integration PÍD.doc

SHIP Transforming Care Partnerships Workstreams



Workforce development - In order to ensure this meets the needs of the local population this needs to be co-produced with people who have lived experience. The local plan will include;

- Training and development; for staff / personal assistants to build more robust support for people who are complex and whose behaviour is challenging and for families/carers
- Working with local agencies to promote caring/personal assistants as a career with continuous personal/professional development pathways.
- Extending the FACES (Friendship, Assertiveness, Choice, Empowerment and Social Skills) programme across the SHIP TCP
- Working with providers in the use of positive behaviour support rather than physical interventions
- Developing a career pathway for the Personal Assistant workforce
- Having 'Learning Disability Friendly' GP Practices
- Developing an accredited training module for health and social care commissioners with Health Education Wessex

Estate Plans – The SHIP TCP will need to engage with current NHS Mental Health Providers and Independent Hospitals to develop these plans and will be required to work with NHS Property Services in relation to those properties which the NHS hold a legal charge to enable capital receipts to be re-invested back to the local area.
This plan will also link to the 'Devolution for the People of Hampshire & Isle of Wight Prospectus' in the development of a rationalisation programme for NHS sites and assets to bring services closer to communities, exploring how to further develop single, locality based 'public service' hubs and 'pump priming' service reconfiguration through estates development funds.

Communications & Engagement – This will be developed via the SHIP TCP Board and will include people with lived experience and local advocacy organisations to ensure people with a learning disability and/or autism are really involved in the TCP Plan.

Equality Impact Assessment – This will be undertaken with the support of Nick Birtley, Inclusion and Equality Lead for West Hampshire CCG and in partnership with Children, Young People and Adults with a learning disability and/or autism and their families/carers. This will ensure people with a learning disability are not disadvantaged through new commissioning approaches.

5.2 Who is leading the delivery of each of these programmes, and what is the supporting team.

The SHIP TCP Board is described in Section 1.5 of this plan.
The individual workstreams and leads for these programmes of work were agreed at the inaugural Transforming Care Partnership Board on 15th February 2016;

Early Intervention & Prevention	Jess Hutchinson & Alison Froude (HCC)
Developing Community Services	Michelle Stickland (WHCCG)
Increasing the Offer and Uptake of Personal Budgets	Paul Turner (WHCCG)
Workforce Development	Sue Lightfoot (IOWCCG) and Dr Jennifer Dolman (Health Education Wessex)
Developing a joint Regional approach to Housing Development	Kate Dench (SCC & SCCG)
Communication and Engagement	Beverley Meeson (WHCCG)
Estates Plan	Nicky MacDonald (SHFT)
Equality Impact Assessment	Nick Birtley (WHCCG)
Finance & Activity	Brain Maxton (WHCCG)
Integration	Jess Hutchinson (HCC)

The resulting project plans/business cases will identify the key enablers to success and resources required.

5.3 What are the key milestones – including milestones for when particular services will open/close?

The key areas for development will be agreed at the SHIP TCP Board, finance and activity is provided in the template provided showing a reduction in the use of in-patient beds by CCGs and NHSE over a 3 year period. The work stream plans will identify key milestones to indicate when services will open/close and will include;

- agreeing the milestones for re-configuration of existing services
- commissioning new services
- dis-investment from existing 'block contracts'
- agreeing de-registration of residential providers to supported living schemes
- accelerating discharge plans where appropriate for people who are currently in hospital

5.4 What are the risks, assumptions, issues and dependencies?

Each of the key work programme plans will identify risks, assumptions, issues and dependencies specifically in relation to;

- Early Intervention and Prevention
- Developing Community Services
- Developing the Workforce
- Increasing the offer and update of Personal Budgets
- Housing

Risks as described in the attached risk register.

SHIP TCP Risk Register.xls

5.5 What risk mitigations do you have in place?

As described above in Section 5.4 the key work programme plans will identify risks, issues and mitigation required to manage risk. These will be developed over the next few weeks following the SHIP TCP Board when the key work programmes are agreed. These will include;

- Reputational
- Legal
- Safety
- Financial & Delivery
- Contingency

6.Finances

Please complete the activity and finance template to set this out (attached as an annex).

TCP Activity and finance annexes upda

Appendix 1

Joint Health & Social Care Assessment Framework – Local Area Data				
Population Data	**SHIP Area**			
	Southampton[1]	**Hampshire[2]**	**Isle of Wight**	**Portsmouth[3]**
How many people have a learning disability?				
Aged 0-13	184	195	41	37
Aged 14-17	134	189	45	25
Aged 18-34	792	1,664	313	139
Aged 35-64	1046	2,238	430	302
Aged 65 & Over	170	371	77	61
Total	**2,326**	**4,657**	**906**	**564**
How many people have LD with complex or profound disability?				
Aged 0-13	22	5	5	-
Aged 14-17	26	5	5	-
Aged 18-34	56	8	42	7
Aged 35-64	54	38	76	18
Aged 65 & Over	8	11	15	-
Total	**166**	**67**	**143**	**25**
How many people with LD with Autistic Spectrum Disorder?				
Aged 0-13	40	36	13	6
Aged 14-17	30	75	15	8
Aged 18-34	94	424	82	22
Aged 35-64	22	145	45	11
Aged 65 & Over	-	5	-	9
Total	**186**	**685**	**155**	**56**

1 Data extracted from GP clinical systems using the Read codes as stated in the technical guidance for the LD enhance service scheme
2 Taken from GP QOF registers via Hampshire Health Record
3 Data provided by 15 out of 24 practices in Portsmouth

Appendix II

My Life My Way Co Production Agreement

My Life My Way is the Hampshire Integrated Personal Commissioning programme. This is partners working together in Hampshire to help children, young people and adults who have a disability and their families live the lives they want. Everyone involved has signed up to working together to make this happen.

Co- production is;

Co-production is about people who use services, carers and professionals working together as equals. Being equal means nobody is more important than anyone else.

SCIE Co-production in social care

A way of working, whereby everyone works together on an equal basis to create a service or come to a decision which works for them all.

National Co-production Advisory Group and Think Local Act Personal

How we will work

- Everyone involved is committed to co-production and will work to make it happen.
- Everyone involved has an equal right to have a say and be listened to.
- We will make sure we have different ways for people to be involved that work for them.
- When there are decisions to be made everyone can say what they can agree to and what they can't.
- Sometimes we may not all agree on a decision, we will record when this happens.
- We will follow the Memorandum of Agreement that Hampshire County Council and Parent Carer Network have in place and the 5 Steps to Co-production 2010/2012.
- We will follow the Top Ten tips from the National Co-production Advisory Group (NCAG) and Think Local Act Personal (TLAP)
- New partners will be asked to sign up to our co production agreement.
- The Co-Production group will check that we are all working together to make My Life My Way happen.

January 2016

Appendix III

Joint Health & Social care Assessment Framework- Local Area Data

	SHIP Area			
	Southampton	**Hampshire**	**Isle of Wight**	**Portsmouth**
Staying Healthy – GP registers (Q1): The Learning Disabilities Quality and Outcomes Framework register in Primary Care.				
Staying Healthy – Long Term Health Conditions (Q2): Finding and Managing Long Term Health Conditions: obesity, diabetes, cardiovascular disease, epilepsy.				
Staying Healthy – Annual Health Checks (Q3)	**188**	**1467**	**353**	**200**
Staying Healthy – Health Action Plans (Q4): Health Action Plans are generated at the time of Annual Health Checks (AHC) in primary care.				
Staying Healthy - Cancer Screening (Q5)	**352**	**687**	**107**	**84**
Staying Healthy – Primary / Secondary Care Communication (Q6): Primary care communication if LD status to other healthcare providers.				
Staying Healthy – Acute LD Liaison Function (Q7): Learning disability liaison function or equivalent process in acute settings.				
Staying Healthy – Reasonable Adjustments in primary care (Q8): Considering NHS commissioned primary care services- dentistry, optometry, community pharmacy and podiatry.				
Staying Healthy – Offender Health and the Criminal Justice System (Q9)				
Keeping Safe – Individual health and social care package reviews (Q1): Commissioners know that all funded individual health and social care packages for people with learning disability, across all life states, are reviewed regularly.				
Keeping Safe – Learning disability services contract compliance (Q2): Contract compliance assurance for services primarily commissioned for people with a learning disability and their family carers.				
Keeping Safe – Monitor Assurances (Q3): Assurances given regularly in Monitor Assessment Framework for Foundation Trusts.				
Keeping Safe – Adult Safeguarding (Q4): Assurance of safeguarding for people with a learning disability.				
Keeping Safe – Involvement of Self-Advocates and Carers in training and recruitment (Q5)				

Appendix III

Joint Health & Social care Assessment Framework- Local Area Data

	SHIP Area			
	Southampton	**Hampshire**	**Isle of Wight**	**Portsmouth**
Keeping Safe – Compassion, dignity and respect (Q6): This item us answered by family, carers and self-advocates. Family carers and people with a learning disability agree that providers treat people with compassion, dignity and respect.				
Keeping Safe – Commissioning Strategy Impact Assessments (Q7): Commissioning strategies for support, care and housing are the subject of Impact Assessments and are clear about how they will address the needs and support requirements of people with learning disabilities.				
Keeping Safe – Complaints lead to changes (Q8): Commissioners can demonstrate that all providers change practice as a result of feedback from complaints, whistleblowing experience.				
Keeping Safe – Mental Capacity Act and Deprivation of Liberty Safeguards (Q9): Appropriate use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).				
Living Well – Effective joint working (Q1): Effective joint working across health and social care.				
Living Well – Local amenities and transport (Q2)				
Living Well – Arts and Culture (Q3)				
Living Well – Sport and leisure (Q4)				
Living Well – Employment (Q5): Supporting people with learning disability into and in employment				
Living Well – Transition to Adulthood (Q6): Preparing for Adulthood in Education, Health and Social Care				
Living Well – Involvement in service planning and decision making (Q7): People with learning disabilities and family carers are involved in service planning and decision making.				
Living Well – Carer satisfaction rating (Q8)				

Appendix III

Joint Health & Social Care Assessment Framework – Local Area Data

Screening Data	SHIP Area			
	Southampton[4]	Hampshire[5]	Isle of Wight	Portsmouth[6]
Cancer Screening: Cervical cancer screening in each case enter the number of women are there in the age range 25 to 64 inclusive who have not had a hysterectomy				
Eligible women aged 25-64 – all whether or not they have a learning disability	132,570	266,122	32,609	34,561
Eligible women aged 25-64 – all whether or not they have a learning disability who have had a cervical screening test within the prescribed period	82,786	180,012	22,500	22,437
Eligible women with a learning disability aged 25-64	624	1,090	211	144
Eligible women with learning disability aged 25-64 who have had a cervical screening test within the prescribed period	204	314	59	42
Cancer Screening: Breast Cancer Screening				
How many women are there in the age range 50-69 inclusive (includes women with and without learning disability)	44,764	183,817	21,193	14,160
How many eligible women are there in the age range 50-69 inclusive (includes women with and without learning disability) who have been screened in past three years?	23,162	94,888	12,500	8,920
How many women are there in the age range 50-69 inclusive with learning disability?	284	515	84	65
How many eligible women are there in the age range 50-69 inclusive with learning disability who have been screened in past three years?	112	204	33	32
Cancer Screening: Bowel Cancer Screening				
How many people are there in the age range 60-69 inclusive (includes people with and without learning disability); Eligible people 60-69	43,982	166,380	21,440	12,479
How many people are there in the age range 60-69 inclusive (includes people with and without learning disability) Eligible people aged 60-69 and screened in the past two years?	15,354	76,656	9,414	4,795
How many people are there in the age range 60-69 inclusive with learning disability?	234	412	75	71
How many people are there in the age range 60-69 inclusive with learning disabilities and screened in the past two years?	36	169	15	10

4 Data extracted from GP clinical systems using the Read codes appropriate to screening
5 Taken from GP QOF Registers via Hampshire Health Record
6 Data provided by 15 practices out of 24 in Portsmouth

Appendix III

Joint & Social Care Assessment Framework - Local Area Data

Secondary Care Data	SHIP Area			
	Southampton[7]	Hampshire[8]	Isle of Wight	Portsmouth[9]
General Hospital Services				
Inpatient Secondary Care How many HOSPITAL PROVIDER SPELLS of inpatient Secondary Care were received under any consultant speciality EXCEPT the psychiatric specialities (Speciality Codes 700-715) between 1st April 2013 and 31st March 2014? Persons with LD	196	317	80	176
Inpatient Secondary Care How many HOSPITAL PROVIDER SPELLS of inpatient Secondary Care were received under any consultant speciality EXCEPT the psychiatric specialities (Speciality codes 700-715) between 1st April 2013 and 31st March 2014? All persons	36,834	323,229	24,598	46,329
Outpatient attendances How many secondary care Outpatient ATTENDANCES were received by people under any consultant speciality EXCEPT the psychiatric specialities (Speciality codes 700-715) between 1st April 2013 and 31st March 2014? Persons with LD	377	997	643	0
Outpatient attendances How many Secondary care Outpatient ATTENDANCES were received by people under any consultant speciality EXCEPT the psychiatric specialities (Speciality Codes 700-715) between 1st April 2013 and 31st March 2014? All persons	72,878	2,021,558	13,882	149,162
A&E Attendances How many ATTENDANCES at Accident & Emergency between 1st April 2013 and 31st March 2014? Persons with LD	239	245	329	0
A&E Attendances How many ATTENDANCES at Accident & Emergency between 1st April 2013 and 31st March 2014? All persons	64,539	316,880	40,705	33,639
A&E people with 3 or more attendances How many PEOPLE have attended Accident & Emergency 1st April 2013 to 31st March 2014 more than 3 times? (only required for persons with LD) Persons with LD	59	158	28	0

7 Data Source – Clarity patients web tool

8 Taken from GP QOF Registers via Hampshire Health Record

9 A&E do not have a code for LD – only overall numbers available

Appendix III

Joint & Social Care Assessment Framework- Local Area Data

Wider Health Data	SHIP Area			
	Southampton[10]	Hampshire[11]	Isle of Wight	Portsmouth[12]
General Health and Healthcare				
BMI Recorded On the 31st March 2014 – How many people are there aged 18 and over with learning disabilities who have a record of their body mass index?	1,726	3,107	535	361
BMI 30 and Over On the 31st March 2014 – How many people are there aged 18 and over with learning disabilities who have a body mass index in the obese range (30 or higher)?	166	1,105	209	178
BMI less than 18.5 On the 31st March 2014 – How many people are there aged 18 and over with learning disabilities who have a body mass index in the underweight range (where BMI is less than 18.5)? (Note threshold changed from SAF 2014 to align with national obesity observatory work and international standards)	22	5	27	6
Coronary Heart Disease How many people with learning disabilities aged 18 and over are known to their doctor to have coronary heart disease? As per the QOF Established Cardiovascular Disease Primary Prevention Indicator Set	50	25	8	11
Diabetes On the 31st March 2014 – How many people of any age with learning disabilities are known to their doctor to have diabetes (include both type 1 and type II diabetes)? As per the QOF Established Diabetes Indicator Set	192	254	60	53
Asthma On the 31st March 2014 – How many people of any age with learning disabilities are known to their doctor to have asthma? As per the QOF Established Asthma Indicator	446	235	147	91
Dysphagia On the 31st March 2014 – How many people of any age with learning disabilities are known to their doctor to have dysphagia?	234	116	26	11
Epilepsy On the 31st March 2014 – How many people of any age with learning disabilities are known to their doctor to have epilepsy? As per the QOF Established Epilepsy Indicator Set?	188	416	147	126

10 Data extracted from GP clinical systems using the Read codes appropriate to the LTC. Also using Clarity patients web tool
11 Taken from GP QOF Registers via Hampshire Health Record
12 Data provided by 15 out of 24 practices in Portsmouth

Autism Self-Assessment Framework - Local Area Data

Appendix IV

	SHIP Area			
	Southampton	**Hampshire**	**Isle of Wight**	**Portsmouth**
Planning (Q4) - Is Autism included in the local JSNA?				
Planning (Q4) - Does your local JSNA specifically consider the needs of children and young people with autism?	Yes	Yes	No	Yes
Planning (Q5) – Have you now started to collect data on those people referred to and/or accessing social care and/or health care and does your information system report data on people with a diagnosis of autism, including as a secondary condition, in line with the requirements of the social care framework?				
Planning (Q6) – Do you collect data on the total number of people currently known to social care services with a diagnosis of autism (whether new or long-standing) meeting eligibility criteria for social care (irrespective of whether they receive any)?	Yes	Yes	Yes	No
Planning (Q6) - The total number of people meeting social care eligibility criteria with autism?	286	927	133	0 data not available
Planning (Q6) - The number of people meeting social care eligibility with autism who also have learning disabilities?	129	675	98	0 data not available
Planning (Q6) - The number of people meeting social care eligibility criteria with autism who also have mental health problems?	17	180	5	0 data not available
Planning (Q6) - The numbers assessed as having autism but not meeting eligibility criteria?	0	68	29	0 data not available
Planning (Q7) - Does your local Joint Strategic Commissioning Plan reflect local data and needs of people with autism?	Yes	Yes	Yes	Yes
Planning (Q8) – Is your local CCG(s) (including the support service) engaged in the planning and implementation of the strategy in your local area?				
Planning (Q9) - How have you and your partners engaged people with autism and their carers in planning?				
Planning (Q10) – Have reasonable adjustments been made to general council services to improve access and support for people with autism?				
Planning (Q11) – In your area have reasonable adjustments been promoted to enable people with autism to access public services?				
Planning (Q12) – How do your transition processes from Children's services to Adult services take into account the particular needs of young people with autism?				
Planning (Q12) - How many children with autism are currently identified and receiving assistance in the transition ages (14 to 17) in the year to end of March 2014?	5	315	57	14
Planning (Q12) - How many children with autism have been through the transition process in the year to the end of March 2014?	-	81	25	13
Planning (Q13) – How does your planning take into account the particular needs of older people with autism?				

Autism Self-Assessment Framework - Local Area Data				Appendix IV
	Southampton	Hampshire	Isle of Wight	Portsmouth
Training (Q1) - Have you got a multi-agency autism training plan?	Yes	Yes	Yes	Yes
Training (Q2) – Is autism awareness training being made available to all staff working in health & social care?				
Training (Q3) – Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?				
Training (Q4) - Do CCGs ensure that all primary and secondary healthcare providers include autism training as part of their ongoing workforce development?	No	No	Yes	No
Training (Q5) - Criminal Justice Services. Do staff in the local public service engage in autism awareness training?	Yes	Yes	Yes	Yes
Training (Q6) - Criminal Justice Services. Do staff in the local court services engage in autism awareness training?	No	No	No	Yes
Training (Q7) - Criminal Justice Services. Do staff in the local probation service engage in autism awareness training?	Yes	Yes	No	Yes
Diagnosis (Q1) - Have you got an established local autism diagnostic pathway?				
Diagnosis (Q1) - Does the pathway meet people with autism's needs regardless of whether or not the person meets the LD criteria?			Yes	Yes
Diagnosis (Q2) - If you have got an established local autism diagnostic pathway, when was the pathway put in place?	2013/14	2011	2013/14	2013
Diagnosis (Q3) - In the year to end of March 2014, how many people were referred out of area for diagnosis despite a local diagnostic pathway being in place	0	0	0	0
Diagnosis (Q4) - In weeks, how long is the average wait between referral and assessment? (Note this should include all people referred irrespective of prioritisation streams)	4 weeks	18	13 weeks	10
Diagnosis (Q5) - How many people have been referred for an assessment but have yet to receive a diagnosis?	26	74	32	8
Diagnosis (Q6) - In the year to the end March 2014 how many people have received a diagnosis of an autistic spectrum condition?	54	132	33	10
Diagnosis (Q7) - How many of the people receiving a diagnosis in the year to end March 2014 had moved on to appropriate services by end September 2014?	54	132	33	10
Diagnosis (Q8) - How would you describe the local diagnostic pathway i.e. integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?	Specialist	Specialist	Specialist	Specialist
Diagnosis (Q9) - In your local diagnostic pathway does a diagnosis of autism automatically trigger an offer of a Community Care Assessment (or re-assessment) if the person has already had a current community care assessment?	No	Yes	Yes	No
Diagnosis (Q10) – Can people diagnosed with autism access post diagnostic specific or reasonably adjusted psychology assessments?				
Diagnosis (Q11) – Can people diagnosed with autism access post diagnostic specific or reasonably adjusted speech and language therapy assessments?				

Autism Self-Assessment Framework - Local Area Data **Appendix IV**

	Southampton	Hampshire	Isle of Wight	Portsmouth
Diagnosis (Q12) – Can people diagnosed with autism access post diagnostic specific or reasonably adjusted occupational therapy assessments?				
Diagnosis (Q13) - Is post diagnostic adjustment support available with local Clinical Psychology or other services?	Yes	Yes	Yes	Yes
Care & Support (Q1) - No of adults assessed as being eligible for adult social care services and in receipt of a personal budget?	119	1201	85	2075
Care & Support (Q1) - No of those reported in 1 who have a diagnosis of Autism but not learning disability?	20	641	25	-
Care & Support (Q1) - No of those reported in 1 who have both a diagnosis of Autism AND Learning Disability	99	560	60	-
Care & Support (Q2) – Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism friendly entry points for a wide range of local services? (3 answers provided; General, Single & Autism-specific)	Autism-specific	Autism-specific	Autism-specific	Autism-specific
Care & Support (Q3) – Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?	Yes	Yes	Yes	Yes
Care & Support (Q4) – Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?				
Care & Support (Q5) – Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews or safeguarding processes have access to appropriately trained advocate?				
Care & Support (Q6) – Can people with autism access support if they are non-Fair Access Criteria eligible or not eligible for statutory services?	Yes	Yes	Yes	Yes
Care & Support (Q7) – How would you assess the level of information about local support across the area being accessible to people with autism?				
Care & Support (Q8) – Where appropriate are carers of people assessed as having autism and eligible for social care support offered assessments?				
Housing & Accommodation (Q1) – Does the local housing strategy specifically identify autism?				
Housing & Accommodation (Q2) – Do you have a policy of ensuring that local housing offices all have at least one staff member who has training in autism to help people make applications and fill in necessary forms?	Yes	No	Yes	No
Employment (Q1) – How have you promoted in your area the employment of people with Autistic Spectrum?				
Employment (Q2) – Do autism transition processes to adult service have an employment focus?				
Criminal Justice (Q1) – Are the Criminal Justice Services (police, probation and, if relevant court services) engaged with you as key partners in planning for adults with autism?				
Criminal Justice (Q2) – Is access to an appropriate adult service available for people on the autistic spectrum in custody suites and nominated 'places of safety'				

Appendix V

Key Milestones/Targets	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan – Mar 18	Apr to Jul 18	Aug to Dec 18	Jan to Mar 19	Apr to Dec 19
Early Intervention & Prevention																										
Draft Dynamic register of people 'at risk' of a hospital admission or a move to long term institutional type care (residential)																										
Agreed 'at risk' criteria for inclusion on the register and understood by community health and social care teams and agreed contingency plans																										
Agreed data and information governance methodology for collection and managing of data																										
Map existing pathways and identify the interaction points with different partners/organisations and the value and non-value areas																										
Business Case extending scope for Intensive Support Team from Adults only to those aged 14+																										
IST Service Specification development co-production workshop																										
Intensive Support Service extended from Adults only to those aged 14+																										
Hold Health & Prevention Fair for people with LD and/or Autism																										
New IST Specification negotiated into local contracts																										
Parity of Esteem Manager employed by WHCCG																										
Parity of Esteem Manager leads a review of existing health checks and works with Local Authorities and CCGs to develop alternative opportunities in e.g. Community Team Venues																										
Parity of Esteem Manager leads a review of transition arrangements and brings forward a set of recommendations for review to the TCP Board																										

Appendix V

Key Milestones/Targets	Apr-16	May 16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan – Mar 18	Apr to Jul 18	Aug to Dec 18	Jan to Mar 19	Apr to Dec 19
Reducing the Number of In-patient Beds																										
Paper outlining the work to commission 4 less beds and business case for recycling funding to go to the SHIP TCP area.																										
Consultation via local stakeholder groups for parents and carers to co-design and co-produce new local model following decommissioning of beds																										
By end of year 2017 reduction of 4 beds from 55 to 51																										
By end of Year 2018 reduction of 5 beds from 51 to 46																										
By end of Year 2019 reduction of 2 beds from 46 to 44																										
Develop one discharge pathway between NHS England and SHIP CCG Commissioners																										
By end 2016 where appropriate all long stay patients to be discharged and repatriated back to local community based services																										
Engagement & Communication																										
Review current communication and stakeholder involvement and develop a co-produced communication plan																										
Engagement and Communication Work Plan signed off by TCP Board																										
Liaise with stakeholders to create case studies produced in accessible formats to inform the development of the charter																										
LD led focus groups to develop a co-produced charter across local services developed with stakeholders that is based on best practice and meets the needs of the local population																										

Key Milestones/Targets	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan– Mar 18	Apr - Jul 18	Au- Dec 18	Jan -Mar 19	Apr -Dec 19
Develop and implement a tool to measure quality and customer satisfaction																										

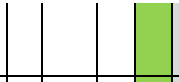
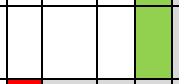
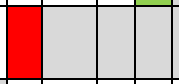
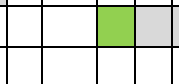
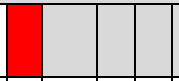
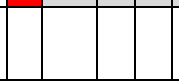
Appendix V

Key Milestones/Targets	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan– Mar 18	Apr - Jul 18	Au- Dec 18	Jan -Mar 19	Apr -Dec 19
Developing Community Services																										
LD Hospital Liaison Function in all acute trusts across SHIP *(dependant on funding)*																										
Undertake satisfaction survey and review data for current LD Acute Liaison Services																										
Visit LD Friendly Practice in New Forest																										
Define what an LD Friendly Practice looks like																										
LD Annual Health Check Awareness Campaign																										
No of people having a LD Annual health check at 55% or above																										
Map existing Community pathways including Primary Care and Acute Hospitals and identify the interaction points with different partners/organisations and the value and non-value areas																										
Workshop with stakeholders to co-produce local service requirements that reflect local need across the SHIP area																										
Undertake a survey around the current Epilepsy service and identify the gaps																										
Review of Epilepsy community nursing to identify gaps in service and make recommendations of how local services can be re-configured																										
Extended CLDT/CAMHS opening times																										
Business Case for LD Hospital Liaison Function to be signed off by TCP Board and local Boards where appropriate																										
Parity of Esteem Manager implements a project for 'LD Friendly' GP Practices																										
Meet with Forensic Service Clinician's to see how they would like the Community Forensic Service to work and run																										
Speak to Advocacy colleagues to how they think the Community Forensic service should work																										

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan – Mar 18	Apr to Jul 18	Aug to Dec 18	Jan to Mar 19	Apr to Dec 19
Speak to inpatients- this can't be done to soon as may disable their Forensic treatment. Jayne Jazz may be able to help us with this part.																										
Speak to those with lived experience in the community about what could have been different if their Forensic treatment was in the community o JB o SW																										
Community Forensic Rehabilitation / Relapse Prevention Service in Place																										
Map services for PWLD and/or autism aged 65+ to identify the interaction points with different partners/organisations a& the value/non-value areas																										
Develop a pathway for people with a LD aged 65+ using the model developed by the Strategic Clinical Network																										
Developing the Workforce																										
Identification of workforce development needs and how commissioners can support the ongoing development of the local workforce																										
Identification of support services to TCP to develop the local workforce																										
Business Case to be signed off by TCP for Workforce Development																										
Increasing the offer and uptake of personal budgets																										
Develop a single joint assessment of need across Health, Social Care & Education																										
Person Centred Life Planning Tools developed																										
Planning Co-ordinators recruited and trained																										
Review local offers in each of the SHIP areas and identify gaps in services																										

Appendix V

Key Milestones/Targets

Develop a workforce strategy for Personal Assistants (PAs) with the 'Workforce Development' workstream	
Identifying services to be de-commissioned from contracts e.g. therapies, SALT	
Health, Social Care and Education linked data sets for each of the SHIP areas	
Developing a Joint Housing Strategy	
Map current housing/accommodation provision across SHIP	
A co-produced Joint Housing Strategy for Young People and Adults with a learning disability and/or autism	
Finance & Activity	
Identify NHSE funding and agreeing how this will align with CCG and Social Care Budgets	
Develop Joint Commissioning Arrangements e.g. Section 75 agreements and aligned/pooled budgets to enable	

DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		DRAFT ALCOHOL STRATEGY		
DATE OF DECISION:		30TH NOVEMBER 2016		
REPORT OF:		Interim Director of Public Health		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Sarah Weld**	**Tel:**	**023 80 832638**
	E-mail:	**sarah.weld@southampton.gov.uk**		
Director	**Name:**	**Bob Coates**	**Tel:**	**023 80 83 3537**
	E-mail:	**bob.coates@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

Alcohol plays an important role in the social lives of many of us, and in the economy and culture of the city. However, there are health risks associated with drinking too much, and strong links between alcohol, domestic abuse, crime and disorder. The draft Alcohol Strategy has been developed by representatives from member organisations of the Health and Wellbeing Board and the Safe City Partnership together with other agencies in the city with a role in reducing alcohol related harm.

It sets a vision for:
"A safe, healthy and vibrant city where people who choose to drink alcohol do so without harm."

It has been proposed that the strategy is jointly owned by the Health and Wellbeing Board and Safe City Partnership. The Health and Wellbeing Board is asked to review the draft strategy and provide feedback on the proposed priorities and outcomes and provide a view on proposed joint ownership of the strategy with the Safe City Partnership.

The draft strategy is high level and sets direction for three priorities identified from data in the Alcohol Health Needs Assessment 2016 and the Joint Strategic Needs Assessment and Safe City Strategic Assessment:

The priorities are:

- Safe - reduce alcohol-related crime and disorder in the city.
- Healthy - raise awareness of and reduce the short and long-term harmful effects of alcohol on health.
- Vibrant - develop a vibrant city with a responsible culture towards alcohol and a diverse and welcoming night time economy.

Success will be measured through data included in the Southampton Safe City Strategic Assessment and Joint Strategic Needs Assessment as well as the Southampton City Survey. This will include analysis and use of data to understand how alcohol harms are distributed within our communities and benchmarks to other

areas.		
RECOMMENDATIONS:		
	(i)	Review the draft strategy and provide feedback on the proposed priorities and outcomes.
	(ii)	Provide a view on proposed joint ownership of the strategy between the Health and Wellbeing Board and the Safe City Partnership, and how implementation of health elements will be monitored by the Health and Wellbeing Board.
REASONS FOR REPORT RECOMMENDATIONS		
1.	Reducing alcohol related health harm has been identified as a priority in Southampton in the Alcohol Needs Assessment 2016 and the JSNA and is a NHS Five Year Forward View priority.	
2.	Southampton does not currently have a city wide alcohol strategy. Implementing a new strategy which is owned jointly by the Health and Wellbeing Board and Safe City Partnership presents significant opportunities for partnership working and maximising use of resources to reduce alcohol harm in the city.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	Having no Southampton Alcohol Strategy. There is no statutory requirement for the Health and Wellbeing Board to have an Alcohol Harm Reduction Strategy, but it is considered best practice.	
DETAIL (Including consultation carried out)		
1.	Southampton does not currently have a city wide strategy which addresses alcohol harm reduction. The Safe City Partnership identified this as a key gap in 2015 and recommended the development of a partnership strategy. Alcohol has also been identified as a key concern by the Health and Wellbeing Board and is included as a priority in the draft Health and Wellbeing Strategy.	
2.	Evidence about the impact of excessive alcohol consumption in the city is available through the Joint Strategic Needs Assessment and Community Safety Strategic Needs Assessment. They show that excessive alcohol consumption has significant impacts on the health of residents and is a key criminogenic factor in the city.	
3.	Alcohol is a risk factor for a number of shorter and longer term mental and physical health problems. An estimated 30,000 Southampton residents drink alcohol at levels that increase their risk of physical and mental harm, with a further 10,000 drinking at levels that place them at significantly higher risk of long term disease. Statistically Southampton is worse than the national average for hospital admissions and deaths involving alcohol. In 2015/16 alcohol related Emergency Department attendances in Southampton cost £243k and hospital admissions £2.37m	
4.	There are strong links between alcohol misuse use, domestic abuse and other types of violence and evidence of increased risks to children and young people where domestic abuse co-exists with adult mental health and/or alcohol misuse.	

5.	The harm generated through excessive alcohol consumption impacts on both the health and wellbeing, and the safety of residents, and is an issue that crosses both the Health and Wellbeing Board and the Safe City Partnership's strategic priorities and terms of reference. The Alcohol Strategy will therefore need to report updates to both partnerships and it is proposed that it is jointly owned by them.
6.	The draft strategy has been developed through three workshops and follow-up meetings with representatives from member organisations of the Health and Wellbeing Board and the Safe City Partnership together with other agencies in the city with a role in reducing alcohol related harm.
7.	Priorities and outcomes included in the strategy have been informed by the Alcohol Needs Assessment published earlier in the year, a review of evidence for effective interventions to reduce alcohol related harm and local data about population need included in the Southampton Safe City Strategic Assessment and Joint Strategic Needs Assessment.
8.	Local people's views about alcohol and its impact have been considered using data from the Southampton City Survey and public engagement undertaken earlier in the year to inform the development of the draft Health and Wellbeing Strategy and health improvement and behaviour change service redesign.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	There are no resource or financial implications at this stage. A key aim of strategy development will be to map existing resources in place within the city and build a partnership of all those involved to maximise resource use.
Property/Other	
	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	There is no statutory requirement for the Health and Wellbeing Board to have an Alcohol Harm Reduction Strategy, but it is considered best practice. Alcohol has also been identified as a key concern by the Health and Wellbeing Board and is included as a priority in the draft Health and Wellbeing Strategy. The Safe City Partnership has also recommended the development of a partnership strategy.
	Local authorities have a statutory duty to operate an alcohol licensing regime under the Licensing Act 2003. Since 1 April 2013 Local Authorities have been responsible for improving the health of their local population and for commissioning public health services including services aimed at reducing drug and alcohol misuse under the Health and Social Care Act 2012. Development of a local strategy presents an opportunity to bring delivery of these two duties closer together.
Other Legal Implications:	
	None

POLICY FRAMEWORK IMPLICATIONS	
	The draft strategy includes high level actions to support all four Council priority outcomes • Strong and sustainable economic growth • Children and young people get a good start in life • People in Southampton live safe, healthy and independent lives • Southampton is an attractive and modern city, where people are proud to live and work The new strategy will be a Level 2 Strategy that supports all the four Council priorities and will reflect the importance of health and wellbeing as well as economic growth for the city.
	The NHS Five Year Forward View has called for a radical upgrade in prevention and public health to improve healthy life expectancy, reduce inequalities and ensure the sustainability of the NHS and the economic prosperity of the country. Actions proposed include those to reduce alcohol related harm and associated health care costs. The Hampshire and Isle of Wight Sustainability and Transformation Plan includes action to increase identification of those drinking too much and ensure appropriate signposting and support is available locally for those who do.
	Southampton does not currently have a city wide strategy which addresses alcohol harm reduction. The Safe City Partnership identified this as a key gap in 2015 and recommended the development of a partnership strategy. Alcohol has also been identified as a key concern by the Health and Wellbeing Board and is included as a priority in the draft Health and Wellbeing Strategy.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices	
1.	None
2.	
Documents In Members' Rooms	
1.	None
2.	
Equality Impact Assessment	
Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:** Southampton JSNA – Taking Responsibility for Health Southampton Safe City Strategic Assessment		
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.		
2.		

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DECISION-MAKER:		**Health and Wellbeing Board**		
SUBJECT:		CCG Primary Care 5 year strategy		
DATE OF DECISION:		30th November 2016		
REPORT OF:		Southampton City CCG		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Alison Howett, Head of Primary Care**	**Tel:**	**02380296062**
	E-mail:	**Alsion.Howett@southamptoncityccg.nhs.uk**		
Director	**Name:**	**Sue Robinson (CCG Chair)**	**Tel:**	
	E-mail:	**Sue.robinson8@nhs.net**		

STATEMENT OF CONFIDENTIALITY
NONE

BRIEF SUMMARY
The primary care strategic plan has been developed in response to national and local challenges and the need to secure sustainable GP services for the population in the future. The strategy sets expectations about how primary care delivery will change to reflect the model of care outlined in NHS England's Five Year Forward View and General Practice Forward View. It also acknowledges the local workforce challenge, which reflects the national position. The primary care strategy is aligned to Better Care, Southampton and the Hampshire and Isle of Wight Sustainability and Transformation Plan. The document has been developed after a period of research and engagement spanning more than one year. It has been influenced by feedback received from local GPs and practice staff, patient representative groups and individuals and other local stakeholders. The strategy is being shared with the Health and Wellbeing Board (HWB) for information.

RECOMMENDATIONS:		
	(i)	The board are asked to note the themes and direction in this document.
	(ii)	

REASONS FOR REPORT RECOMMENDATIONS	
1.	The HWB is a statutory body with responsibility for health therefore may find oversight of this document useful and should be used as relevant by the HWB to inform its future work. Primary Care is central to many of the changes in

	better Care being led by HWB.
2.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
3.	N/A
DETAIL (Including consultation carried out)	
4.1	The transforming primary medical care strategy was born out of the need to respond to a number of key challenges, including financial and workforce constraints in general practice. It has been developed by a working group including five GPs and has been influenced by a period of information gathering and engagement with GPs, practice staff, patients and service users, local providers including the voluntary sector, and other stakeholders, via the GP forum, surveys and a stakeholder workshop. A survey was conducted which was distributed via the practice communications networks and the CCG patient involvement network. The future of primary care has been a key agenda item at various patient group meetings including; HealthWatch, Consult and Challenge Group, the CCG Communications and Engagement Group, the CCG Equality Reference Group and the Pensioners Forum.
4.2	The document will be going to CCG Governing Body for approval on 30th November 2016
4.3	The purpose of the strategy is to address the expectations that the way in which care is delivered will change, as outlined in NHS England's Five Year Forward View and GP Forward View, in order to meet the needs of people and support the delivery of Better Care and the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) locally.
4.4	The strategy also acknowledges the workforce challenge and recognises the importance of building a strong team of motivated and engaged health and care professionals across a range of disciplines with the GP at the core.
4.5	The future model of Primary Care will integrate the roles of other professional groups such as clinical pharmacists, dentists and ophthalmologists. This will form the basis of further strategic development following the adoption of this strategy. This strategy is presented as a key building block for wider system reform recognising general practice is at the heart of the health system. The primary care strategy aims to capture the core objectives of what the future model of general practice in Southampton should look like but is not an implementation plan.

4.6	A delivery plan will form Phase 2 of the change process and actions will be developed across access, quality, workforce, infrastructure and collaboration.
4.7	This strategy recognises the value of the traditional partnership model of General Practice, and seeks to build upon those strengths, whilst offering an alternative option.
RESOURCE IMPLICATIONS	
Capital/Revenue N/A	
	Not Applicable
Property/OtherN/A	
	Not Applicable
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	Not Applicable
Other Legal Implications:	
POLICY FRAMEWORK IMPLICATIONS	
	Not Applicable

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	
2.	
Documents In Members' Rooms	
1.	

2.		
Equality Impact Assessment		
Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.		
2.		

Transforming Primary Medical Care in Southampton

Five Year Strategy

2016-2021

Southampton City Clinical Commissioning Group

"The secret of **change** is to focus all your energy not on fighting the old, but **building the new**"

Socrates

Contents

"A plan for general practice needs to ensure that the people of the city have access to high quality, consistent, sustainable primary care that meets their needs, whilst being attractive to support recruitment and retention of GPs and their allied staff."

Foreword

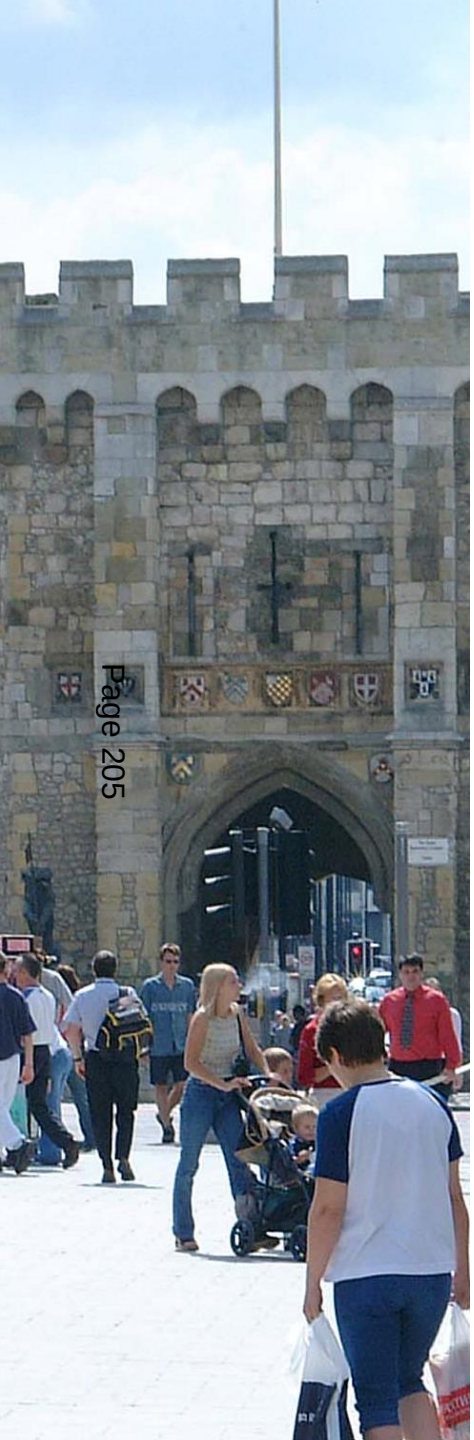
We know that general practice is the foundation upon which effective patient care rests. We also know that there are not enough GPs to provide care in the way it has traditionally been delivered – it will need to be GP led rather than always GP delivered. Indeed, the focus on person-centred, collaborative care means that GPs are increasingly working as part of a team which includes social care and the community. This approach allows GPs to use their skills in co-ordinating and managing the medical care of people with often complex medical and social issues, whilst being supported by a team who can offer very different skills and resources to complement the traditional medically focussed care delivered in primary care. We want to build on the fundamental strengths of general practice, such as the ongoing relationship with patients, continuity of care and the GP role as a trusted professional with an overview of patient care.

The GP Forward View, NHS England's five year plan for primary care, makes it very clear that, in future, services for people will be developed at a neighbourhood population level (such as a Locality Cluster, of which we have six in Southampton), rather than at a practice level. Where the partnership model is working well, this will be supported to continue, recognising the value of the this and the continuity that it provides. However, we do need to develop alternative models for those people and practices for whom the traditional model of general practice partnership is not attractive or sustainable.

A plan for general practice needs to ensure that the people of the city have access to high quality, consistent, sustainable primary care that meets their needs, whilst being attractive to support recruitment and retention of GPs and their allied staff, e.g. nurses or therapists. GP Practices (specifically, the partners) are responsible for ensuring that their organisation is able to deliver the primary medical services for which they are paid, despite the challenge of recruiting and retaining appropriate staff. The priority for the city is to shape a different model of general practice which will help GPs to fulfil these responsibilities and manage the risks to both services and the practice as a business entity.

This plan has been developed following contributions from city GPs, as well as other interested groups and organisations during a number of engagement events across the city. It has a dual purpose in that it sets out the future direction of primary care planning and delivery whilst also providing a basis for a strategy for sustainability that GP Practices lead and own.

Dr Sue Robinson
Clinical Chair and GP, NHS Southampton City Clinical Commissioning Group (CCG)



Introduction and context

Purpose of this strategy

The transforming primary medical care strategy was born out of the need to respond to a number of **key challenges**, including financial and workforce constraints in general practice. It has been developed by a working group including five GPs and has been influenced by a prolonged period of information gathering and **engagement** with GPs, practice staff, patients and service users, local health and care providers including the voluntary sector, and other interested groups and organisations, via the GP Forum, surveys and a workshop.

The purpose of the strategy is two-fold. **Firstly**, it addresses the expectations that the way in which care is delivered will change, as outlined in NHS England's *Five Year Forward View* and *GP Forward View*, in order to meet the needs of people and support the delivery of Better Care and the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) locally; and **secondly**, it acknowledges the workforce challenge and recognises the importance of building a strong team of motivated and engaged health and care professionals across a range of disciplines with the GP at the core.

The intention is to produce one document that will appeal to everyone, recognising that individual elements will be of more or less interest to specific audiences.

What is the primary care strategy not?

The future model of Primary Care will integrate the roles of other professional groups such as clinical pharmacists, dentists and ophthalmologists. This will form the basis of further strategic development following the adoption of this strategy. This strategy is presented as a key building block for wider system reform recognising general practice is at the heart of the health system.

The primary care strategy aims to capture the core objectives of what the future model of general practice in Southampton should look like but is not an implementation plan – a delivery plan will form Phase 2 of the change process and actions will be developed across access, quality, workforce, infrastructure and collaboration. This strategy recognises the value of the traditional partnership model of General Practice, and seeks to build upon those strengths, whilst offering an alternative option. No practice will be compelled to enter into any new contract against their wishes.

How does this strategy align to the CCG's vision and transformation programmes?

Southampton City CCG believes that general practice provides the **foundation** for all other health services and that a strong and sustainable general practice is crucial to securing health care services in the future. Here in Southampton, there are significant programmes of transformation underway. General practice is one of the key strategic work programmes for Southampton City CCG in 2016/17 and beyond and will support the delivery of the CCG's overall vision to deliver *"A Healthy Southampton for All"*.

Our latest **GP patient experience survey** (July 2016) shows that we have strong local practices and are achieving comparable success in some elements of access to appointments;

- → **96%** have confidence and trust in their GP *(95% nationally)*
- → **97%** have confidence and trust in the nurse they saw *(97% nationally)*
- → **92%** were able to get a convenient appointment *(92% nationally)*
- → **63%** were able to see their preferred GP always or a lot of the time *(58% nationally)*

However, general practice in Southampton is under the same pressures as observed nationally and will need to work differently in order to remain sustainable– **workforce challenges, increasing elderly population, rise in prevalence of long-term conditions, increasing costs and increasing patient expectation** means that general practice needs to change radically if it is to be sustainable and meet the needs of our population.

Case for change

Case for change

National drivers for change

General practice is facing significant challenges which, if not resolved, will significantly impact the whole **health and social care system** and our ability to care for people effectively at home and in the community. It is the first port of call for the vast majority of the population, with over **90% of all contacts with the NHS taking place in general practice**, and if it fails the whole NHS will fail.

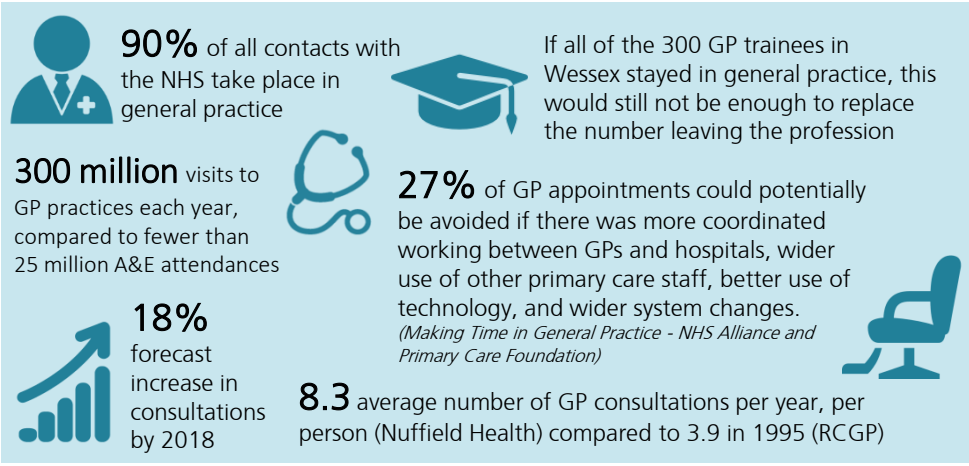
The GP workforce has expanded more slowly than the acute, hospital-based medical workforce and there is national concern around the intensity of workload in primary care. Total direct face-to-face and telephone contacts with patients increased by **15.4%** across all clinical staff groups between 2010/11 and 2014/15. During the same period, the average patient list size increased by **10%**. This is compounded by significant **workforce issues** - over the last five years there has been an increasing issue with the recruitment and retention of GPs, practice nurses and practice managers. In addition, there is a national shortage of GPs with many **retiring** early – some in their 50s.

General practice services also need to meet expectations to be more **accessible** to the population. For example, in a recent survey of patients in Southampton, feedback showed that high numbers of patients would like to see more evening and weekend appointments.

As also seen in the acute sector, the **population is becoming over-reliant** on general practice and we need to support our population to build independence and take responsibility for managing their own health wherever possible. National studies suggest that as many as **27% of face to face GP appointments could be avoided** given appropriate resources (including 7% of people who could be seen by another health professional and 6% who could self-care, i.e. manage their illness themselves). A survey of local practice managers suggests that the figure could be even higher.

An effective general practice model is critical to improving the health and wellbeing of our population and enabling people to be cared for at home. It is therefore important that the ***GP Forward View*** is delivered at a local level and resources are made available to support practices. This will require investment in general practice.

To help with the demand in hospitals and to cope with the rising demand in the community, the workforce both in general practice and supporting general practice, must be increased in addition to finding better ways of working that are more efficient. Increasing the number of GPs will only be achieved if general practice becomes a better place to work whereby those who feel they have lost control of their working days regain that control. The workforce must be further expanded by investing in other care professionals such as nurse practitioners, pharmacists, mental health workers. Social workers should also be aligned to general practices and work as members of an integrated health and social care team wrapped around the practice.



The ***Five Year Forward View*** outlines objectives around focussing on preventative care, empowering patients and puts forward a number of new innovative models of care which encourage integration and a whole person approach to delivery of care. It states that strong general practice and primary care services are essential for a high quality and responsive NHS, fit for the future.

GPs and practice teams provide vital services for people. They are at the heart of our communities, the foundation of the NHS and internationally renowned. However, with limited financial resources and a national workforce recruitment challenge, coupled with unprecedented pressure, it is clear that action is needed. It has been widely accepted for some years that the NHS is faced with the challenges of an increasingly elderly population with an associated rise in the prevalence of long-term conditions, increasing costs and increasing patient expectation and will need to change radically if it is to be sustainable and meet the needs of the population in the 21st century.

Case for change

Local drivers for change

In Southampton, primary care is under the same pressures as observed nationally. General practice still largely operates in small independent businesses and these have provided good care, particularly holistic and continuing care. However, it increasingly appears that this business model is unsustainable because of our local challenges;

Southampton's workforce challenges:

1 in 5 of the Southampton GP workforce is **aged 55+**, with many retiring early

Insufficient numbers of GPs in **training**

Ageing practice nurse workforce

Recruitment is difficult; practices carrying **vacancies**

Our quality and infrastructure challenges:

- Patient experience remains low compared to other city populations
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- Variations in the premises from which primary health care is delivered
- Information sharing across health and social care IT systems is suboptimal

Southampton's demography challenges:

15% increase in **over 65s** (2015-21)

20% increase in **over 85s** (2015-21)

12% of the population is aged **20-24** (Higher than average student/younger population)

11,282 (4.6%) forecast increase in **the overall population** (2015-21)

People **die earlier** in the most deprived areas than those in the least deprived:

Women **3.2 years earlier**

Men **6.7 years earlier**

23% of the population live in the **most deprived** small geographical areas **in England** (known as LSOAs – Lower Super Output Areas)

22.3% of the population have a recorded ethnicity of **other than white-British**

17.6% of the population were **born outside the UK**

300% increase in the population recorded in the **other white** ethnic group in the last 10 years

PASS

Southampton's health challenges:

20.3% of **children** in Year 6 are **obese**

25% of **adults** are **obese**

22% of **adults** are **smokers**

75% of the over 65s population is living with **2 or more long term conditions**

32% of the population (all ages) **have a long term condition**

29,000 adults are registered with **hypertension**

5,500 adults are registered with **COPD**

12,000 adults are registered with **diabetes**

490 deaths from **cancer** (2014)

483 deaths from **respiratory disease** (2014)

15,000 adults are registered with **depression**

Listening to our GPs and patients

GP feedback

- In late 2015, we ran a survey and asked Southampton GPs for **their biggest challenges or frustrations in their day-to-day work**.
- This is what they told us and the key themes that came out;

TIME WITH THE PATIENT AND COMPLEXITY

"10 minute appointments are **never long enough** for most patients, they either have a list of problems or complex multi-morbidity"

"Over-running on a regular basis due to more and more **complex patients**, and those requiring more time"

CAPACITY AND WORKLOAD

"Not enough **time** in the day, too many targets to reach that takes time away from patients"

"So **busy** sorting the day-to-day stuff I can't look forwards"

PATIENTS

"Too many patients seeking medical appointments for social/non health related problems"

"Unrealistic and **unreasonable demands** from the public. General lack of common sense, inability to cope with minor illness"

INTEGRATED WORKING

"**Poor interface** between primary, secondary and community care. Time wasted trying to ring back social workers and members of community psychiatric services"

STAFFING

"We are running so tight that any unplanned sick leave or annual leave completely throws the practice"

SATISFACTION

"Each day is **14 hours** long with a minimum of 3-4 hours of **administration**"

"Having to spend so much time dealing with minor problems by telephone triage and proportionally less time dealing with medical problems that use my experience"

DEVELOPMENT

"Lack of **support** for GP's wishing to develop leadership **skills** to fill gaps left as our Senior colleagues retire in next 5 years"

Patient feedback

- We also ran a survey and asked Southampton patients for the **three things they most value about their GP service**.
- The three areas below received the most votes and this is what they told us;

APPOINTMENTS (ACCESS)

"Get an **urgent**, **same day** appointment when I need one"

"Speaking to a GP on the **phone**"

"Making an appointment for a non-urgent matter in advance, at a **convenient** time"

"**Early** and **late** appointments for workers"

"Having a GP practice **close to my home**"

SERVICE

"Caring and **person-centred** approach"

"**Preventative** measures, such as injections for influenza"

"Personalised services"

"Good organisation and **communication** between staff and patients"

CONTINUITY

"Seeing my **GP who knows me**, or seeing an alternative GP who has enough **information** in front of them to know about me and what's going on with me"

"Records **sharing** between GPs and other health staff"

"My GP reviews the **whole picture** of all of my long term conditions, not just the one thing I'm seeing her about today"

Our vision

Our vision on a page

Our Vision

Building a model of general practice in our city that will be the strong, effective and sustainable foundation of our integrated health and social care system.

Our Objectives

- Primary care services that are responsive to change and working effectively as part of a **whole system** to meet the needs of the population;
- Equitable, **person-centred** primary care for a registered list of patients benefiting from improved access to services and **continuity of care** where needed;
- **Collaborative** model that appeals to professionals;
- System-wide culture of **learning** and **continuous improvement**;
- People are educated and empowered to take responsibility for **managing their own health,** with a particular focus on **prevention;**
- Health and social care based around **clusters of practices** in a neighbourhood;
- Primary care system based on **quality** and reducing health inequalities where possible;
- **Technology** options are readily available to support the care of those people who prefer that option.

Our key areas of focus and outcomes

Access

- ✓ People can access their surgery **8am to 6.30pm**, Monday to Friday
- ✓ Pre-booked and same day appointments, **7 days** a week
- ✓ Integrated community based primary care pathway for **urgent care** 24 hours and 7 days a week
- ✓ Patients are encouraged, educated and empowered to **manage their own health**
- ✓ Innovative **technological solutions** to support access are embedded

Quality

- ✓ Reduced **variation** in the quality of care delivered across all practices
- ✓ Standards for **screening** and **immunisations** are achieved
- ✓ Improved patient **satisfaction** and **experience**
- ✓ Health professionals have all the **clinical knowledge and skills** required to deliver safe and effective care
- ✓ Practices are engaged in **incident/event reporting**
- ✓ Practices are **rated good/outstanding** by the CQC

Workforce

- ✓ Practice teams are **motivated and engaged**, incorporating a range of skilled professionals
- ✓ Professional **development** and **succession** planning are embedded principles
- ✓ GPs and other health and care professionals working in the city are **supported** to achieve their preferred **career pathway** and develop special interests, so facilitating recruitment

Infrastructure (Estates and technology)

- ✓ Modern premises that are **fit for purpose**
- ✓ Flexible, **multi-use space** is available which is adaptable to service needs
- ✓ A **resource centre** is located in each of the six clusters across the city
- ✓ Clinical **computer systems** are **interoperable**, i.e. provider systems are connected, facilitating communication and information sharing
- ✓ Innovative **technological solutions** which empower people to manage their health

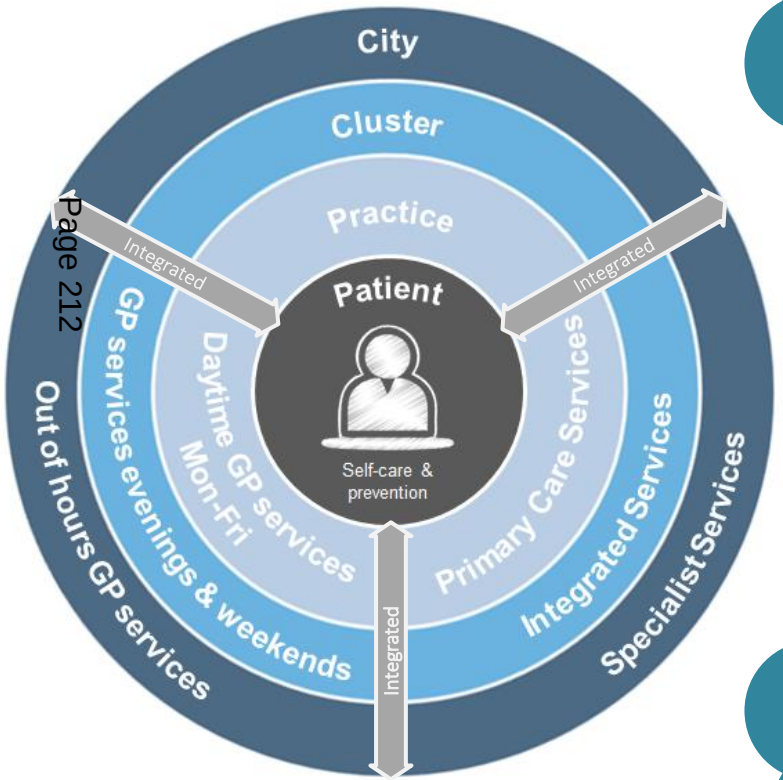
Collaboration

- ✓ GP practices operating within a business framework that ensures **sustainable** primary care
- ✓ Practices are **working together** to build a resilient service which operates **at scale** but remains focused on the registered population
- ✓ Primary care is fully engaged with the local **integrated provider** group, i.e. the cluster.
- ✓ The **operating model** delivers improvements to health outcomes, patient experience, access and workforce

The future model of primary medical care

At the centre of this model is the **patient**.

To meet the needs of a changing population and those of an evolving health and social care system, primary care in Southampton must:



1. Generate a **viable**, **sustainable** service that is, and continues to be, responsive to the needs of all registered patients, recognising the variety and diversity of those communities and their needs, and providing them with access to the level of care that they need at the appropriate time.
2. Be creative in the approach to service provision, **working in collaboration** as required to balance same day access for treatment of acute illness with **continuity of care** and **proactive care planning** for those with routine or ongoing health needs, providing services in the **evenings** and at the **weekend** in a way which is simpler to access and navigate.
3. Take a **multi-disciplinary** approach to the provision of primary care services, with other health professionals such as nurses (including mental health), clinical pharmacists and therapists actively caring for patients as part of an **extended practice team** and supporting the delivery of Better Care and the STP.
4. Ensure that people have **access in a primary care setting,** such as a GP surgery or health centre, to the health professional best able to support them, with co-ordination and oversight provided by the GP, recognising the health benefits to be gained by **working more closely with other primary care services**, such as optometrists, dentists and community pharmacists.
5. Focus on **improving quality and health outcomes**, with particular emphasis on **preventing illness, safe care, proactive care planning, self-management** and using the principles of **making every contact count**, with the patient firmly at the centre of their care arrangements.
6. Embrace **innovation** and utilise **technology** to provide alternative solutions to traditional methods of delivering care.
7. Create a structure that supports **workforce development** by providing entry points and learning opportunities at all stages in the professional career pathway, supported by flexible contracting arrangements (independent or employed) that meet the needs of individuals.

The future model – key areas of focus

Access	▪ Patients are still registered with a **local practice** which has its own team of doctors, nurses and other staff. ▪ Improved access arrangements mean that people can book a planned appointment in their own surgery during normal working hours or they can choose a more **convenient** time in an alternative location within the cluster across **7 days** a week. ▪ Having an **extended primary care team** to absorb some of the more routine work means that GPs have more time to spend with people with long-term chronic illness or complex health needs who need more support (GP led rather than GP delivered).	▪ GPs, practice nurses and other practice staff work mainly in their own practice but may also spend time working as part of a **cluster or city-wide arrangement** which provides services 7 days per week and out of hours. ▪ Access to **urgent primary care** will be simplified across the system.
Quality	▪ Consistency of care to **reduce health inequalities** and support patient empowerment for **self-care** impacting on population health and wellbeing. ▪ Through clinical and management leadership providing **best care and best experience** for people and carers across all health and social boundaries. ▪ Practices throughout the city are rated as **good/outstanding by the CQC.**	▪ Adopting **new technologies** and innovations in healthcare to enhance patient care and quality of life. ▪ Developing key **skills, knowledge and experience** of all general practice staff to support right care, in the right place by the right person .
Workforce	▪ Nurses and other health professionals have an **extended role** in the primary care team, including; nurse triage for same day appointment requests; medication reviews and nursing home support from clinical pharmacists; management of musculoskeletal conditions by a physiotherapist or extended scope practitioner; a mental health worker to support people with low-level mental health needs.	▪ There is plenty of **opportunity** for GPs and practice nurses to develop special interests and work closely with specialists.
Infrastructure	▪ Practice premises are **modern, accessible and efficiently** run. ▪ Fully **digital primary care pathways** will be in operation and working effectively as part of the local health system, such as; online assessment and self-help advice; online consultation; online appointment booking and prescription ordering and tracking; home monitoring and tele-healthcare. Patients and staff will be supported to make best use of these options.	▪ IT systems are fully **integrated** across primary, community and secondary care services and, with patient consent, clinicians have access to a patient's electronic medical record regardless of which service is being used.
Collaboration	▪ GPs work **collaboratively** in a new workforce structure that allows them to spend more time with their patients, to meet the growing demands of an aging population and fulfil the expectations of a more accessible service. ▪ An acute **home visiting service** operates during working hours, so GPs now only visit people who have complex problems or who need end of life care. Housebound people and those in nursing and residential homes are looked after by a special team which includes a GP, a community matron and a physician for older people. ▪ All practices are part of a wider cluster network of services, along with other practices in the neighbourhood. This helps to provide access to a broader range of specialist clinical staff and services close to the patient's home.	▪ An **integrated primary, community and social care team** work together to care for people with long-term chronic conditions. The GP and other health professionals involved in a person's care work together to agree a care plan which is accessible at all times. The plan includes the person's personal health goals, guidance and support on managing their condition themselves and advice on what to do if they become ill.

The future day in the life of a patient...

I have a new medical problem...

→ I need some advice about a new medical problem and I go online to my surgery website. I'm taken through an **online assessment** which gives me some initial advice and guidance on **managing my condition myself** and takes account of my pre-existing conditions.

→ If I need support from a health care professional I will be directed to the member of the **primary care team who can best meet my needs**. This may be a GP, nurse, pharmacist or other health or care professional. Today I am advised to see a GP who will be able to see the assessment I have already done.

My consultation options...

→ There are a number of consultation options open to me such as **online consultation, telephone support or surgery appointment**, all of which are bookable online via the surgery website or by telephone.

→ I have a **choice of day, evening or weekend** appointments either at my own surgery or at another location in my neighbourhood.

During my consultation...

→ There is **sufficient time** given for my consultation to meet my needs. My doctor suggests investigations and discusses **a management plan** with me. I am able to have the **blood tests straight away**, and the physician's assistant is able to organise the **onward referral** for hospital-based investigation with me, rather than the doctor.

→ If I have any investigations, I am able to either check that they are all normal by **logging onto the practice App**, or will be contacted by the physicians assistant to explain the issues and arrange any further follow-up needed.

My prescriptions...

→ I enquire about a repeat prescription at reception; it has been sent **electronically** to my preferred pharmacy. The surgery pharmacist suggests I book in with her for a **medication review**.

My feedback...

→ After my appointment I get an email from the surgery **asking for feedback on my experience t**o help them improve their services, which I take a few minutes to complete and send back to them.

Later that evening...

→ If my condition deteriorates at 9 o'clock that evening, I contact **NHS 111** and after completing an assessment process I am put through to an experienced GP who is able to **access my complete medical records**. I am offered an appointment at my **local cluster hub**, so it is not too far for me to travel.

→ The out of hours doctor **updates directly into my own GP's records** and notifies the practice that I have been seen and sends a separate alert of any urgent actions which need to be taken.

→ I know that, unless it is a life threatening emergency when I would need to be seen in the emergency department, **all of my care is centred around my GP practice**, which I will contact with any concerns.

→ If I need to be seen outside the normal surgery hours of 8am to 6.30pm or I opt for a more convenient evening or weekend appointment, I understand **that I may have to travel a short distance to my local hub**, of which there are three across the city.

My overall experience...

→ My experience of using primary care services today has been **very positive**. I have been able to access both advice and services in a way that not only addresses my needs but also suits my preferences.

The future day in the life of a GP...

Consultations and home visits...

→ There is a **designated doctor** available to deal with **urgent** patient enquires, clinical queries and calls from other health professionals. This may be in my practice or provided by a central service in the evenings.

→ The people I consult with today will already have been through a **triage process or online assessment**, the details of which are available to me in the clinical record. My consultations are a mix of **surgery visits, telephone calls and online consultations**.

→ The **health professionals** who manage the routine care of my housebound patients and nursing or care home residents are a critical part of my practice team. My home visits are now focused on providing end of life care and responding to requests from clinical colleagues.

→ Acute home visiting is now managed on a **locality basis** and the GP working in that service can view medical records with patient consent and **update directly into the record**. I am alerted to any follow up actions requiring attention.

Collaboration...

→ My primary care team includes **other clinical disciplines** which allows my patients with complex needs to schedule one appointment to review their medical, nursing, pharmaceutical and care planning needs at a single visit.

→ I no longer have to spend time trying to sort out system wide problems because there appears to be nobody else willing to take responsibility. The wider integrated primary, community and social care **multidisciplinary team (MDT)** now collectively takes responsibility for each patient and has an **allocated care manager** responsible for coordinating their care.

→ I also have meetings about **significant events** with my MDT colleagues.

My time...

→ I have more time to spend with **patients with more complex needs** now that people are better supported to **self-manage** and some of my workload has moved over to other practitioners. I also have time for reviewing test results, correspondence and emails.

→ Any tests or investigations I have ordered today were arranged **electronically** to avoid delay and duplication of effort.

→ At the end of the day there is **time to catch up** with colleagues and complete outstanding admin and paperwork.

→ My days remain full but they are **manageable** and I am less frustrated as the interface between services is working effectively and demand is more reasonable.

My development...

→ Not only do I provide clinical sessions in my practice but I also work additional sessions **in other specialist areas** that interest me and keep our health system thriving. I am involved in **GP training** and a **mentoring programme** which encourages GP growth and development opportunities.

Key areas of focus

Access

Quality

Workforce

Infrastructure (Estates and IT)

Collaboration

Access

Overall objective: People are provided with access to the level of care that they need at the appropriate time, with same day access and services available in the evenings and at the weekend, 7 days a week.

What will success look like?

- People can telephone or visit their surgery any time between **8am and 6.30pm**, Monday to Friday.
- Pre-booked and **same day** appointments are structured across **7-days per week** to meet peoples' needs.
- Providers of primary and secondary care services work together to co-ordinate a fully integrated community based primary care pathway for **urgent care 24 hours a day, 7 days** a week.
- Patients are encouraged, educated and empowered to **manage their own health** and understand when clinical intervention is needed.
- Innovative and **technological solutions** to support access, for example online consultations, apps, home monitoring and telemedicine, are embedded as part of core primary care service delivery.

Creating sufficient capacity within primary care will ensure people have a good experience and encourage them to choose primary care as their first point of contact. Whilst patients may continue to access non-urgent or routine care from the surgery where they are registered, they may also choose a more convenient appointment in the evening or at the weekend at a different location.

Professional clinical advice will be available to all patients within Southampton 24 hours a day, 7 days a week to meet urgent medical needs. The challenge moving forward is to integrate and simplify services in a way which enables patients to understand where and how to access care when they need it. This may be at their surgery during the day or at a hub or primary care centre outside of surgery hours.

Prevention, self-management and care planning are key factors in managing demand. People will be supported to manage their own health where possible and to access professional advice when needed. Adoption of digital ways of working will be promoted to support this. This includes digital access to appointment booking, online assessment for acute problems, prescription ordering and medical records, as well as encouraging people to manage their health and wellbeing through easy access to advice and self-care tools. Self-referral routes will be available to support direct access to appropriate specialist services without the need to see a GP first.

Long term illnesses will be supported by digitally enabled pathways of care, for example allowing people to self monitor conditions using their own devices (such as phone, computer or medical device) and share data with their NHS record. This will enable online assessments to be completed to streamline the annual review process for both patient and practice.

Quality

Overall objective: People are provided with high quality care which is safe and effective, meeting their needs. People have a positive experience, which is dignified, compassionate and focused on them as a person.

What will success look like?

- The quality framework shows evidence of **reduced variation in the quality of care** delivered across all practices
- Expected standards for **screening** and **immunisations** are achieved across the whole population, using the principle of making every contact count
- Patient reported outcome measures such as the GP Patient Survey and Friends and Family Test demonstrate improved **satisfaction** and **experience**
- Health professionals have all the **clinical knowledge and skills** required to deliver safe and effective care to meet the needs of the population
- There is evidence that practices are engaged in **incident/event reporting** and peer review to support a culture of ongoing **learning** and **development**
- Practices throughout the city are rated **good/outstanding by the CQC**

Some variation is to be expected as a result of individual needs and preferences and the variability of populations; however, it is important to ensure that any unmet needs are addressed. Exploring and understanding variation between practices allows sharing of best practice and helps to narrow the gap.

There are a number of factors that may influence outcomes and create variation including; clinical knowledge and skills, patient preferences and choice, and availability or proximity of services.

A good example of how quality variation is being addressed is through the Diabetes Accreditation Scheme. Diabetes continues to be a priority for the city and work is ongoing to improve outcomes.

The CCG is developing a quality framework model for general practice to identify core standards of quality and provide an opportunity for continuous improvement. The high level indicators to identify the domains of quality will be;

- Leadership – corporate responsibility and accountability for service delivery and improvement in general practice
- Patient safety and experience – ensuring safe and compliant services in a patient focussed system
- Workforce and workload – supporting the management of service demands, competence and capability of staff and improvement in general practice
- Population outcomes – responsibility for the health and wellbeing of population
- Performance – accountability for delivery of indicators and targets as agreed

The quality framework model is still in development and is taking account of both national and other CCGs' best practice. A wider discussion with local GPs is planned over the next few months before the model is adopted by the CCG. Once agreed it will be a valuable asset to monitoring progress of transforming general practice in Southampton.

Workforce

Overall objective: Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers.

What will success look like?

- Practice teams are **motivated** and **engaged**, incorporating a range of **skilled professionals** delivering the appropriate level of care to meet patients' needs.
- Professional **development** and succession planning are embedded principles for all providers.
- GPs and other health and care professionals working in the city are supported to achieve their preferred **career pathway** and develop special interests, so facilitating recruitment.

20% of the Southampton GP workforce is over 55, with many taking early retirement (GP workforce audit 2015). This coupled with a shrinking GP talent pool at national level, calls for modernisation of the workforce model locally to ensure the city can successfully compete in the skills market.

The future primary care workforce model includes a range of skilled professionals including GPs, nurses, pharmacists and allied health professionals. These will be assisted by trained support staff including health care assistants, mental health workers, clinical support workers and other similar roles. The emergent new model of primary care will help to attract professionals into the area and build resilience into the primary care system. Career development opportunities will be available across all disciplines allowing professionals to build a portfolio career, gaining experience in other specialist areas. The workforce structure will allow flexible working arrangements that improve work/life balance.

The plan requires strong leadership for successful implementation and local providers are asked to adapt to meet the changing needs and work to create these new roles.

Infrastructure (estates and technology) 20

Overall objective: Fit for purpose premises which enable access to clinical services out of hospital, 7 days a week. Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care.

What will success look like?

- Completion of a **modernisation programme** ensuring that primary care premises are fit for purpose, provide increased capacity and enable services to be delivered 7 days per week.
- Flexible, **multi-use space** is available which is adaptable to service needs and can accommodate innovative and collaborative projects for health and social care provision in partnership with other agencies.
- A **resource centre** is located in each of the six clusters across the city providing; a multi-occupancy base for the integrated team supporting all practices in the cluster; multi-use space for training, outreach services and other local initiatives; and information and tools to support people to manage their own health.
- **Premises** and **technology** developments support a culture of learning and education for both staff and patients.
- Clinical computer systems are **interoperable**, facilitating communication and information sharing between all parts of the health and care system.
- Creative and innovative **digital solutions** which support and empower people to manage their own health are embedded.

Across Southampton, there is variation in the standard of general practice premises. Some practices have insufficient space to deliver care that consistently improves outcomes for patients, including meeting regulatory core standards. Premises are also a limiting factor in plans to enable collaborative working, including extended hours and reducing reliance on hospital services. Delivering the ambitious plans for collaboration and primary care working at scale will be dependent upon having an estates infrastructure that is capable of supporting this new arrangement.

Resource centres will be co-located with a practice in a central location within each cluster and have easy geographical access. The facilities provided will support and empower peoples' self-help, education and healthy lifestyle with a view to managing their own health and wellbeing. This will include self-monitoring (blood pressure, weight etc.) and also online and printed information and tools to help with self-management of specific conditions. A modernisation programme will ensure that these facilities and the other practices that they support are suitable for delivering primary medical services today and into the future.

The government has made a commitment that all patient and care records will be digitally interoperable and paperless by 2020 and CCGs are required to have a digital roadmap (local technology plan) by the summer of 2016 to deliver this. This will reduce risk, waste and inefficiencies within the system, leading to a better experience for people and clinicians alike. Technology is a key enabler to deliver:

- proactive care, for example through online wellbeing assessments, health improvement resources or support communities,
- better access, for example with online service portals, telephone assessment and email appointment systems,
- better coordination, with interoperable systems allowing clinicians to share agreed information across organisational boundaries,
- modern care, for example, remote monitoring and diagnostic devices.

Collaboration

Overall objective: Sustainable and resilient GP services support delivery of integrated care in the city.

What will success look like?

- GP practices operating within a **business framework** that ensures sustainable primary care.
- Practices are **working together** to build a resilient service for the future, which operates at scale but remains focused on the registered population.
- Primary care is fully engaged with the **local integrated provider group** to deliver true person centred, integrated care.
- The **operating model** delivers improvements to health outcomes, patient experience, access and workforce development.

Collaboration, i.e. practices working together, is seen as a key enabler to the successful delivery of change initiatives. We are seeing GP practices throughout the country starting to work more closely together in order to maximise the use of their resources, be more innovative with the services they offer patients, and ultimately provide higher quality patient care. It is widely believed that new ways of working across general practice will be a key factor in ensuring a resilient service in the future and we firmly believe the development of collaborative working is essential. It will also facilitate the delivery of services that may not be easily delivered by an individual practice, such as such as appointments in the evening and at weekends, integration of extended access with out of hours and urgent care services, and other services developed at a population based level.

The move for new ways of working has been promoted by the NHS Five Year Forward View along with the NHS General Practice Forward View as the way forward for practices at a time when people are living longer and developing more complex health and care needs.

Our vision for primary care will only be possible if the service is supported by a robust and viable business model. Where the partnership model is working well, this will be supported to continue. However, we do need to develop alternative models for those people and practices for whom the traditional model of general practice partnership is not attractive or sustainable. The voluntary multispecialty community provider contract is one option and will be available from April 2017. Practices can opt to remain outside this alternative contract. All changes to practice service delivery are subject to NHS policy and require approval from the CCG.

In Southampton, primary care is under the same pressures as observed nationally and we are already beginning to see collaboration in action; for example, practice mergers. The numerous benefits include:

- by combining office functions, supplier contracts and administrative and management processes, the practice becomes more financially viable.
- as a result, smaller practices can benefit from services that have traditionally only been affordable for a larger practice such as nurse practitioners or phlebotomists.
- a larger practice is able to offer a wider range of wellbeing services which support people with complex health and care needs.
- pooling clinicians means that a wider range of hours can be covered thus offering patients greater choice.
- a larger support team can lead to a reduction in administration time for clinicians allowing them to concentrate on patient care.
- there is a bigger support network for new GPs which can make a practice a more attractive prospect in the job market.
- pooling resources allows creativity and innovation to flourish which leads to a better experience for patients and a better working environment for staff.

Next steps – planning for successful delivery

Next steps – planning for successful delivery

The transforming primary medical care strategy aims to capture the core objectives of what the future model of general practice in Southampton should look like. In starting to explore how we can influence real transformational change in general practice across Southampton, we need to consider funding and workforce requirements, GP ownership and the development of a delivery plan.

Next Steps	
Funding	▪ The *General Practice Forward View* recognises that primary care has been underfunded compared to secondary care over a period of years. ▪ The changes required to deliver this strategy, such as workforce and estates, cannot be made without significant investment. ▪ Financial resources will be available to deliver change programmes, not to support the existing arrangements ▪ The government has pledged to invest a further £2.4 billion per year into general practice by 2020/21. For Southampton, this means that over the next five years the CCG will receive growth in primary care funding of £6.93m. This is, over those five years, a 22% increase on 2015/16. This increase assumes a growth of 2.93% in our list size over this period. ▪ In addition to this increase, further funding will be made available to support the development of new models of care as described in the *Five Year Forward View*. Access to this funding will be linked to transformational change programmes designed to deliver general practice at scale. ▪ Capital funding will be available to develop the infrastructure necessary to support these change programmes.
Workforce	▪ A workforce of appropriate number, skills and roles is imperative for transforming care. ▪ In January 2015, a national £10m ten point plan was released, focussing on recruitment, retention and supporting those who wish to return to general practice. ▪ To compete successfully in the recruitment market, we must create an infrastructure which will support and encourage learning, growth and development of all primary care practitioners and also provide flexibility and career development options to meet the needs of a new generation of health care professionals.
Leadership	▪ Given the national drivers and the impact these are having on practices locally, there is a certain inevitability to change. ▪ Culture and behaviour change is a key factor in success. It requires ownership of both the problems and the solutions by everyone involved including patients, GPs and all other clinicians and staff. ▪ Successful implementation of Transforming Primary Medical Care in Southampton will require the enthusiasm, commitment and support of all GPs and practice staff working in the city. ▪ There will be continuous engagement with patients and other stakeholders throughout the life of the strategy, to ensure a co-productive, i.e. joint, approach and to influence behaviours, perceptions, expectations and cultures to support the new model. ▪ Recognising the need for change is the first step on the transformation journey. Examples of initiatives that are delivering results in other areas are already emerging, for example Making Time in General Practice. There are also a range of organisational development tools available to support practices in identifying areas where change can make a positive difference.
Delivery plan	▪ Development of a detailed delivery plan is in progress and will form phase two of the change process. The delivery plan will be submitted to NHS England on 23rd December to demonstrate the CCG's plan to implement the General Practice Forward View (GPFV). ▪ Actions will be identified in each of the five key areas of focus; access, quality, workforce, infrastructure and collaboration. The markers of success identified for each of these areas will be used to map the changes necessary for achievement. ▪ Communications and engagement will be an integral part of every element of the delivery plan.

Who's who?

Who's who?

NHS Southampton City Clinical Commissioning Group (CCG)

Our purpose as a CCG is to help meet the health and care needs of local people. Southampton City CCG is allocated a budget of around £350 million a year to achieve this and use it to plan and pay for (or 'commission') health and care services from a number of service providers (such as hospital, mental health and community trusts). CCGs were established in April 2013 with a clear remit to ensure that family doctors and other clinicians play a leading role in deciding and directing how local NHS resources should be used.

Southampton City Council and other health and care partners

The CCG works closely with the Council and other partners to ensure the right services are in place for the community. The CCG pools £68 million of their budget with £28 million from the Council in order to progress the vision for Better Care in Southampton, to integrate health and care services in order to improve people's quality of life.

Southampton Primary Care Limited

Southampton Primary Care Limited was formed as a legal entity in November 2014. It is a federation of 29 of the 31 city GP practices; the member practices are the shareholders with voting rights linked to the practice population (1 per 1,000 registered patients with a maximum of 10 votes per practice).

NHS England

NHS England sets the priorities and direction of the NHS, shares out more than £100 billion in funds and holds organisations to account for spending this money effectively for patients and efficiently for the tax payer. This includes the commissioning of contracts for GPs, pharmacists, and dentists and they support local health services that are led by CCGs.

STP

Every health and care system in England has produced a Sustainability and Transformation Plan, showing how local services will evolve and become sustainable over the next five years. Southampton is part of the STP being developed for the whole of Hampshire and the Isle of Wight.

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