Public Document Pack

NHS
Southampton City
Clinical Commissioning Group

Joint Commissioning Board

Thursday, 19th December, 2019 at 9.30 am

PLEASE NOTE TIME OF MEETING

Conference Room, CCG HQ, Oakley Road, Southampton

This meeting is open to the public

Members

Dr Kelsey (Chair)
John Richards
Councillor Hammond (Vice-Chair)
Councillor Fielker
Councillor Shields
Matt Stevens

Please send apologies to:

Emily Chapman, Board Administrator,

Tel: 02380 296029

Email: emilychapman1@nhs.net

PUBLIC INFORMATION

Role of the Joint Commissioning Board

The Board has been established by the City Council and Clinical Commissioning Group to commission health and social care in the City of Southampton. It will encourage collaborative planning, ensure achievement of strategic objectives and provide assurance to the governing bodies of the partners of the integrated commissioning fund on the progress and outcomes of the work of the integrated commissioning function

Public Representations

Save where an Item has been resolved to be confidential in accordance with the Council's Constitution or the Freedom of Information Act 2000, at the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest.

Benefits from Integrated Commissioning

- Using integrated commissioning to drive provider integration and service innovation.
- Improving the efficiency of commissioned services
- Increasing the effectiveness of commissioning – across the whole of the commissioning cycle.

Smoking policy – the Council and Clinical Commissioning Group operates a no-smoking policy in all of its buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Fire Procedure – in the event of a fire or other emergency an alarm will sound and you will be advised by lofficers what action to take.

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

Dates of Meetings: Municipal Year 2019/20

2019	2020
21st March	20th February
20th June	
15th August	
17th October	
19th December	

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the Board are contained in the Council's Constitution and the Clinical Commissioning Group Governance Arrangements.

Business to be discussed

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

Rules of Procedure

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

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 4 with a minimum of 2 from the City Council and the Clinical Commissioning Group.

Disclosure of Interests

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship

AGENDA

1 WELCOME AND APOLOGIES

2 DECLARATIONS OF INTEREST

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship

3 MINUTES OF THE PREVIOUS MEETING/ ACTION TRACKER (Pages 1 - 8)

Lead	**Item For: Discussion Decision Information**	**Attachment**
Dr Mark Kelsey	Decision	Attached

4 INTEGRATED ADVOCACY SERVICE (Pages 9 - 44)

Lead	**Item For: Discussion Decision Information**	**Attachment**
Carole Binns	Decision	Attached

5 ESTABLISHING A REGIONAL CONSORTIUM FOR THE COMMISSIONING OF INDEPENDENT FOSTER CARE (Pages 45 - 52)

Lead	**Item For: Discussion Decision Information**	**Attachment**
Christopher Pelletier	Discussion	Attached

6 5 YEAR HEALTH AND CARE STRATEGY

Lead	**Item For: Discussion Decision Information**	**Attachment**
Stephanie Ramsey	Information	Verbal

7 **PERFORMANCE REPORT** (Pages 53 - 62)

Lead	**Item For: Discussion Decision Information**	**Attachment**
Stephanie Ramsey	Information	Attached

8 **BETTER CARE STEERING BOARD MINUTES** (Pages 63 - 68)

Lead	**Item For: Discussion Decision Information**	**Attachment**
Dr Mark Kelsey	Information	Attached

9 **ANY OTHER BUSINESS**

Wednesday, 11 December 2019

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SOUTHAMPTON CITY COUNCIL ®

NHS Southampton City Clinical Commissioning Group

Meeting Minutes

Joint Commissioning Board - Public

The meeting was held on 17th October 2019, 09:30 – 11:00
CCG Room C&D, NHS Southampton HQ, Oakley Road, SO16 4GX

	NAME	INITIAL	TITLE	ORG
Present:	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	Councillor Dave Shields	Cllr Shields	Cabinet Member - Health and Sustainable Living	SCC
	Councillor Lorna Fielker	Cllr Fielker	Cabinet Member – Adult Social Care	SCC
	Matt Stevens	MS	Lay Member for Patient and Public Involvement	SCCCG
In attendance:	Stephanie Ramsey	SR	Director of Quality & Integration	SCCCG / SCC
	James Rimmer	JR	Managing Director	SCCCG
	Richard Crouch	RC	Chief Operating Officer	SCC
	Beccy Willis	BW	Head of Governance	SCCCG
	Keith Petty	KP	Finance Business Partner	SCC
	Sandy Jerrim	SJ	Senior Commissioning Manager	ICU
	Jamie Schofield	JS	Senior Commissioning Manager	ICU
	Judy Cordell	JC	Democratic Support Officer	SCC
	Emily Chapman (minutes)	EC	Business Manager	SCCCG
Apologies:	Claire Heather	CH	Senior Democratic Support Officer	SCC
	Maggie MacIsaac	MM	Chief Executive Officer	SCCCG
	Sandy Hopkins	SH	Chief Executive	SCC
	Councillor Chris Hammond	Cllr Hammond	Leader of the Council	SCC

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted.	
2.	**Declarations of Interest**	
	A conflict of interest occurs where an individual's ability to exercise	

	judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship No declarations were made above those already on the Conflict of Interest register.	
3.	**Previous Minutes/Matters Arising & Action Tracker**	
	The minutes from the previous meeting dated 20th June 2019 were agreed as an accurate reflection of the meeting. **Matters Arising** Transforming Health and Care – Southampton City five year Health and Care Strategy –implementation will be overseen by Better Care Steering Board and reported to Joint Commissioning Board. **Action Tracker** There were no outstanding actions.	
4.	**Direct Payment Support Services**	
	SJ attended the meeting to present the Direct Payment Support Services paper and outlined the highlights to the Board. MK queried if we want an increase for people up taking this service. SJ responded that there was a need to review the way people were encouraged to take up a direct payment. The model within the paper outlines the costing for how this will be done. Cllr Shields raised 308 people are currently on the scheme, if we adopt this proposed model then this will be more cost effective. Do we have an idea of future projections/costs and will it help achieve a saving using this formula. SJ responded, what is being asked is for a direct payment support service which is a two year pilot and this will be reviewed to see if it increases efficiency, free up capacity for support staff and also encourage people to take up direct payments. Cllr Fielker provided clarity that direct payments are about quality and choice, not about savings. SR raised the benefit is that more Personal Assistants (Pas) coming on board may help with more home care availability. RC asked for clarity on the budget particularly around adult social care. RC also asked in relation to procurement have we reviewed what is taking place elsewhere in the system. SJ responded that in the report the financial impact and costing is included. This decisions cost impact is only related to the budget for the support service and this is within the ICU budget.	

	SJ also raised that work has taken place closely with Hampshire, and also reviews have taken place across other areas and what has taken place. Councillor Fielker agreed the following recommendations: (i) That the Board note the recommendation from the Joint task Force to carry out a procurement of a Direct Payment Support Service. (ii) The Leader of the Council delegates authority to the Director of Quality & Integration, following consultation with the Leader and Cabinet Member for Adult Social Care to decide on the final model of a commissioned Direct Payment Support service. **(iii)** The Leader of the Council delegates authority to the Director of Quality & Integration following consultation with the Service Director Legal & Governance to carry out a procurement process for the provision of a Direct Payment Support service and to enter into contracts in accordance with the Contract Procedure Rules. SJ left the meeting.	
5.	**Proposal for the Mainstreaming of Hospital Discharge Pathway 3 for Patients/Clients with Complex Needs**	
	JS attended the meeting to present the Proposal for the Mainstreaming of Hospital Discharge Pathway 3 for Patients/Clients with Complex Needs paper. JS outlined the highlights of the paper. JR queried the pooled fund, if this overspends or underspends what happens? JS responded this should be a fixed cost and there is a budget for spot purchasing. JR raised the current budget for discharge to assess includes a nurse. JS responded that this is currently funded within the budget. JS also highlighted that there would need to be a permanent member of staff rather than the current ongoing use of agency staff. It was clarified that the staffing and beds should be within the cost proposed today and that this is a fixed contribution by partner. KP raised we would have a cap so there would be no overspend, and then underspend would be separated by contribution. SR raised if we didn't support this pilot then Delayed Transfers of Care (DTOC) would increase. Cllr Fielker raised this piece of work has a lot of evidence to support it, and agreed this is important to take forward.	

	Councillor Fielker and the CCG agreed with the amendment to change the world "pooled fund" to "fixed contribution by partner": (i) To give approval to proceed with the preferred future Pathway 3 Discharge to Assess option for potential Continuing Health Care (CHC) patients/clients and those with complex social care needs leaving hospital who require a period of assessment. (ii) To approve establishment of a pooled fund under S75 partnership arrangements of the Health Act with contributions of £229,183 per annum from Southampton City Council and £421,041 per annum from Southampton City Clinical Commissioning Group to fund the assessment placements required for the operation of the Discharge to assess scheme. JS/JC left the meeting.	
6.	**Quality Report**	
	The Board received the quality report and SR outlined the highlights of the paper. SR drew the Boards attention to the Continuing Health Care Disputes Resolution Procedure which has been developed jointly between the CCG and SCC. It has had legal input from both organisations. RC queried in the disputes resolution and asked if there are partners in other systems who may support before reaching stage 4 of arbitration. SR responded the dispute panel would do an element of that support. As part of normal processes we would discuss the case with clinical leads. ACTION: this to be strengthened within the process. Cllr Fielker raised the issues around quality and workforce levels at Antelope House which are ongoing. SR responded as one of the work streams in better care, there is work to concentrate on improving this area. Progress is being made on actions that have been put in place. There is also work taking place to look at step down level accommodation. MS raised the issue of recruitment and retention of staff at Southern Health Foundation Trust (SHFT). SR responded there are contract review meetings with SHFT and we have received a detailed plan around their recruitment and retention. **Action: SR to provide a briefing at a future meeting on staffing / workforce within Mental Health / SHFT** **ACTION: Deep dive session to take place on Mental Health.** The Board agreed the CHC Disputes Resolution Procedure.	 **SR** **SR**

7.	**Performance Report**	
	The Board received the performance report for information and SR outlined the highlights. **ACTION: deep dive session to take place at a future meeting for the Associate Directors to talk through each of their areas** Cllr Fielker left the meeting. MS asked if there is a measure on waiting times for CAMHs. SR responded that there is detailed performance data behind this summary. The waiting time is 12 weeks.	**SR**
8.	**Highlight Report: Better Care Steering Board (BCSB)**	
	The Board received the highlight report for the Better Care Steering Board for information. Updates will continue to be brought to future Board meetings. Cllr shields asked about urgent care and signage for the urgent treatment centre at the RSH and also the messaging/communications and links with local authority and My Journey. SR responded that it would be useful to link this with My Journey. The board also discussed the electronic descriptions such as google maps. MS raised measuring quality within primary care. There are work streams in place to work on a dashboard for Primary Care Networks and data is being submitted to the Primary Medical Care Commissioning Committee and how they link to Better Care. Cllr Shields raised the primary care estates review, and it is a critical programme of work and would be useful to see updates at this Board going forward. **ACTION: MS to bring an update to this Board and Better Care Steering Board on the Primary Care Estates review.**	**MS**
9.	**Better Care Steering Board Minutes**	
	The Board received the Better Care Steering Board meeting minutes from the 28th August 2019 for information.	
10.	**Any Other Business**	
	It was noted that this would be Richards last meeting. The Board thanked RC for this contribution to this meeting and wished him well in the future.	

11.	**Next Meeting Date**	
	19th December 2019, 09:30 – 11:30, Conference Room, NHS Southampton HQ, Oakley Road, Millbrook, SO16 4GX	

Joint Commisioning Board - Action Tracker (Public)					
Date of meeting	**Subject**	**Action**	**Lead**	**Deadline**	**Progress**
17/10/2019	Quality Report	SR to provide a briefing at a future meeting on staffing / workforce within Mental Health / SHFT	Stephanie Ramsey	Apr-20	Scheduled for March 2020 meeting
17/10/2019	Quality Report	Deep dive session to take place on Mental Health.	Stephanie Ramsey	Apr-20	Scheduled for March 2020 meeting
17/10/2019	Performance Report	Deep dive session to take place at a future meeting for the Associate Directors to talk through each of their areas	Stephanie Ramsey	Apr-20	Scheduled for February 2020 meeting
17/10/2019	Highlight Report: Better Care Steering Board (BCSB)	MS to bring an update to this Board and Better Care Steering Board on the Primary Care Estates review	Matt Stevens	Apr-20	Scheduled for March 2020 meeting

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DECISION-MAKER:		CABINET MEMBER FOR ADULT CARE FOLLOWING CONSULTATION WITH THE JOINT COMMISSIONING BOARD		
SUBJECT:		AWARD OF THE INTEGRATED ADVOCACY SERVICE		
DATE OF DECISION:		19TH DECEMBER 2019		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	Name:	Jackie Hall	Tel:	023 8083 4258
	E-mail:	Jackie.hall@southampton.gov.uk		
Director	Name:	Stephanie Ramsey	Tel:	023 8029 6075
	E-mail:	Stephanie.ramsey1@nhs.net/stephanie.ramsey@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY		
N/A		
BRIEF SUMMARY		
The report of the Director of Quality and Integration detailing a decision to issue a contract for provision of an Integrated Advocacy Service following a tender process. Tenders will be evaluated according to the most economically advantageous criteria, taking into consideration best quality at the best price.		
RECOMMENDATIONS:		
	(i)	To delegate authority to the Director of Quality and Integration, following consultation with the Cabinet member for Adult Care, to award the contract for the Integrated Advocacy Service to the preferred bidders as set out in the report and to enter into contracts in accordance with contract procedure.
	(ii)	To delegate authority to the Director of Quality and Integration to progress to contractual and financial close of commissioned services for Integrated Advocacy Services and exercise all further decision making in relation to this re-commissioning.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The current Integrated Advocacy Service, which commenced on 1st April 2015, will end on 31st March 2020 when the current contract expires. Following a service review, agreement was given at Integrated Commissioning Unit Management Team (ICUMT) on 9th August 2019 to explore the possibility of a joint procurement approach with Hampshire County Council (HCC), in order to achieve improved cross authority consistency of service and efficiencies that offer the authorities improved	

	value for money. It was agreed that HCC would lead the procurement with an ICU commissioner and ICU senior sourcing and contract manager contributing to the procurement project group, with advice being taken from SCC legal as applicable. The tender was advertised in November 2019 and the Invitation to Tender (ITT) stage will be open until 12th December 2019. The evaluation stage will be completed by 18th December 2019. It is now requested that a decision is made to award the tender aligned to the end date of 31st March 2020.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	Other commissioning options were considered prior to the decision to jointly tender, for example, continuing to contract with the current provider. However, this was rejected as it did not comply with The Council's Contract Procedure Rules and the European Procurement Regulations. The advantages and disadvantages of each option were fully considered by the Integrated Commissioning Unit Management Team (ICUMT) and the procurement approach agreed.
3.	The possibility of tendering the service as a single Local Authority was considered. However, the opportunity to jointly commission with Hampshire County Council (HCC) was appraised as being the most favourable option because of the following reasons: • Potential economies of scale and • Access to a bigger market • Shared procurement resource with HCC taking a lead role in the procurement • Increased access to expertise by pooling resource across SCC and HCC commissioning Initial conversations confirmed that: o HCC are procuring in a similar timescale and expressed interest in co-commissioning o Flexibility was agreed to ensure there are no restrictions on each authority (both authorities' commission statutory and (different) non-statutory services.) o Possibility to have one single contract or separate contracts if that was the preferred option o Consistency of advocacy relationship could be maintained, for example, where a patient is discharged from Southampton General Hospital to a Hampshire residence

DETAIL (Including consultation carried out)

4. The Integrated Advocacy service is a holistic advocacy service commissioned to offer a single point of access for, and to meet the needs of, all eligible referrals.

"Advocacy" is defined as: "Taking action to help people say what they want, secure their rights, represent their interests and obtain services they need".

The service provides parity of access to all eligible individuals, regardless of their needs, their reason for seeking advocacy support, or what community they are from. This includes individuals with learning disabilities, autism, mental health issues, physical and sensory disabilities and long term conditions. The service encompasses both statutory and non-statutory advocacy however meeting the demands in relation to statutory advocacy are at all times prioritised over the non-statutory elements of the service.

Demand for advocacy has been steadily growing since the service started in 2015:

The service has, over the course of this contract, seen an 84% increase in referrals for statutory and non-statutory advocacy combined.

Period	**Referrals received**	**Number per month**	Percentage increase	
			From contract start	from last period
2015/16	461	38.41	n/a	n/a
2016/17	647	53.91	40.35%	40.35%
2017/18	883	57.58	91.54%	36.48%
2018/19	849	70.75	84.16%	-3.85%

New legislation in the form of the Mental Capacity (Amendment) Act is due to be introduced in 2020 which will have an impact on demand for the service. This makes it difficult to predict demand in the immediate future. However, potential providers are aware of the imminent changes and the service will be reviewed robustly in order to assess impacts on capacity.

5. This contract is for a joint service to deliver advocacy to meet the requirements of:

- The Mental Health Act 1983 (as amended)
- The Local Government and Public Involvement in Health Act 2007 (as amended)
- The Care Act 2014
- Time limited spot purchased advocacy for other purposes

6. The new service model was developed jointly with Hampshire County Council

	(HCC). Stakeholder and provider engagement has been undertaken in Southampton and Hampshire and the results of this used to inform the new service specification.
7	The Integrated Advocacy service supports and contributes towards achieving one of the four key aims contained in the Southampton City Council Strategy 2016-2020, most significantly "People in Southampton live safe, happy, independent lives". The overriding purpose of an Advocacy service is to enable individuals to take more responsibility for themselves and reduce their dependency on other people. Empowering individuals to self-manage and to take control of their own lives is central to the advocacy support provided as part of this Service. Several other of Southampton's strategies and policies make reference to the provision of advocacy including the Adult Social Care and Support Planning Policy 2016 – 2020, and the Southampton Better Care Plan 2017 - 2019.
8.	An option appraisal was undertaken to decide the procurement route for the Integrated Advocacy Service and was considered by the Integrated Commissioning Unit Management team. The decision to tender was taken in order to : a. Meet the council's procurement rules. b. To achieve best quality at the best price.
9.	Tenders will be assessed and providers identified in accordance with the "most economically advantageous" criteria, which take into consideration both quality and price. The quality/price weighting has been agreed as 80% Quality/20% Price, through discussions with Hampshire County Council. This has been agreed due to the need to maintain and improve the quality of services locally where possible and in recognition that poor quality services have a cost in relation to service users requiring services for longer and for more complex conditions if early intervention and prevention is unsuccessful. It is recognised that obtaining the best value for money is also a key consideration.
10.	Outcomes - The appointed providers will work in partnership with Southampton City Council and the Commissioners and will contribute towards the delivery of the following outcomes which are consistent with local and national strategies. • Improved health and emotional wellbeing as a result of advocacy intervention • Increased confidence to be able to speak for themselves in future • In relation to Care Act advocacy - the service user is enabled by the advocate to participate in any health and social care process with which they need assistance and support in order to successfully engage in the proceedings and articulate their wishes.

RESOURCE IMPLICATIONS	
Revenue	
11	The annual funding available for this tender in 2020/21 is as follows: Advocacy — £267,827 Learning Disabilities Housing Advocacy — £14,157 Substance Use Disorder Advocacy — £15,000 **Total per annum — £296,984** The budget available for the two year period of the contract is therefore £593,968. There is an option to extend the contract for up to two years. If this option is exercised the total cost of the contract across the four year period is £1,187,936.
Property/Other	
12.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
13.	The Council has the power to offer Advocacy services in accordance with s.1 Localism Act 2011 (the General Power of Competence) subject to complying with the Council's Contract and Financial Procedure Rules as set out in the Council's Constitution.
Other Legal Implications:	
14.	The services provided on behalf of the Council will be required to be delivered in accordance with the Equalities Act 2010, the Human Rights Act 1998 and the Council's duties under the Care Act 2014, The Mental Health Act 1983 (as amended), The Local Government and Public Involvement in Health Act 2007 (as amended), The Mental Capacity Act (2005)
CONFLICT OF INTEREST IMPLICATIONS	
15.	N/A
RISK MANAGEMENT IMPLICATIONS	
16.	The Integrated Advocacy service undertakes statutory requirements within relevant legislation and statutory guidance (see below Policy Framework implications). Therefore, failure to provide this service would carry with it significant risks for the Council including delivery of a statutory responsibility and delivery of key outcomes and operational activities. Failure to provide this service would also have significant reputational risk to the Council as it is likely to have significant levels of stakeholder, service user and family and carer concern and interest as the service supports vulnerable

Advocacy	£267,827
Learning Disabilities Housing Advocacy	£14,157
Substance Use Disorder Advocacy	£15,000
Total per annum	**£296,984**

	service users, often with complex needs. The current contract for the service is due to expire on 31st March 2020 In order to avoid either non-compliance or a break in service the preferred bidder will be appointed on 19th December 2020, following the decision of the Joint Commissioning Board (JCB) and the delegation of authority to the Director of Integration and Quality in consultation with the Cabinet Member for Adult Social Care. This will allow sufficient time for new service mobilisation and implementation to be completed with service commencement on 1st April 2020.
POLICY FRAMEWORK IMPLICATIONS	
18.	**Statutory Advocacy** This Service is commissioned to meet all statutory requirements with regards to advocacy support outlined within relevant legislation and statutory guidance. This includes the provision of: • Independent Mental Health Advocates (IMHA) under the Mental Health Act (2007) • Independent Mental Capacity Advocates (IMCA) under the Mental Capacity Act (2005) • Deprivation of Liberty Safeguards (DOLS) under the Mental Capacity Act (2005). This includes the provision of the Paid Relevant Representative Role. • Independent Advocacy provided under the Care Act (2014) • Advocacy to support those with Special Educational Needs under the Children and Families Act (2014). **Non Statutory advocacy** The Service additionally offers non statutory advocacy in order to support eligible individuals to have their views and wishes heard and acted upon in relation to a variety of issues. This element of the Service is needs led and models of delivery are therefore flexible. The provision of non-statutory advocacy includes but is not limited to: • Supporting parents who have a learning disability and whose child is subject to child protection proceedings • Supporting self-advocacy groups and self-advocates to lead the advocacy support that they receive, attend forums and meetings across Southampton and to understand and have a say over the issues which impact their lives • Supporting individuals to become peer advocates, enabling people with a shared experience to support and empower each other • Supporting individuals through the hospital discharge process and decision making about discharge and support options • Providing advocacy support to individuals and groups as part of strategic service reviews and system redesign undertaken by public sector bodies. **Learning Disabilities Housing Advocacy** The provision of advocacy for individuals with a complex needs is also

	covered by this service. The Service is supporting individuals through the process which for some will mean a move from living in residential, nursing or other settings to supported living services or more independent settings; enabling them to have their say and ensuring that their views and wishes are taken into account.

KEY DECISION?	**Yes**
WARDS/COMMUNITIES AFFECTED:	**All**

SUPPORTING DOCUMENTATION

Appendices	
1.	Appendix 1 - – Equality Impact Assessment
2.	Appendix 2 – Data Protection Impact Assessment
3.	
4.	
5.	

Documents In Members' Rooms

1.	
2.	
3.	

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**Yes**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**Yes**

Other Background Documents
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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Equality and Safety Impact Assessment

The **Public Sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with Section 17 of the Crime and Disorder Act and will enable the Council to better understand the potential impact of proposals and consider mitigating action.

Name or Brief Description of Proposal	Recommission the provision of an Integrated Advocacy Service to start 01 April 2020
Brief Service Profile (including number of customers)	
Advocacy is defined as "Taking action to help people say what they want, secure their rights, represent their interests and obtain the services they need". The Integrated Advocacy service is a holistic advocacy service commissioned to offer a single point of access for and to meet the needs of all eligible referrals. The service provides parity of access to all eligible individuals, regardless of their needs, their reason for seeking advocacy support, or what community they are from. This includes individuals with learning disabilities, autism, mental health issues, physical and sensory disabilities and long term conditions. The service encompasses both statutory and non-statutory advocacy however meeting the demands in relation to statutory advocacy are at all times prioritised over the non-statutory elements of the service. The Service supports and develops the ability of individuals to self-advocate, increasing their confidence and assertiveness skills and enabling them to support themselves as far as is possible in future. This includes providing the opportunity for individuals to train as peer/volunteer advocates, offering additional support to local people. The Service will adhere to principles of personalisation and will be delivered flexibly in a way that offers choice and control to individuals with regards to the advocacy support that they receive, recognising that those receiving support have the most specialised knowledge of their needs.	

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The current service received a total of 849 referrals in 2018/19

Statutory Advocacy

This Service will meet all statutory requirements with regards to advocacy support outlined within relevant legislation and statutory guidance. This includes the provision of:

- Independent Mental Health Advocates (IMHA) under the Mental Health Act (2007)
- Independent Mental Capacity Advocates (IMCA) under the Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards (DOLS) under the Mental Capacity Act (2005). This includes the provision of the Paid Relevant Representative Role.
- Independent Advocacy provided under the Care Act (2014)
- Advocacy to support those with Special Educational Needs under the Children and Families Act (2014).

Independent Advocacy under the Care Act (2014) will require close joint working and flexibility between the Service Provider and the council's operational and commissioning teams. This aspect of the Service is targeted at individuals who require support to be engaged with care assessment and support planning processes and decisions about their needs and wishes in order to secure their rights, represent their interests and obtain the care and support they need. This element of advocacy also includes supporting eligible individuals through Safeguarding Adults Reviews and safeguarding processes.

During the lifetime of the Service, meeting the demands in relation to statutory advocacy will at all times be prioritised over non statutory advocacy.

Non Statutory advocacy

The Service will offer non statutory advocacy in order to support eligible individuals to have their views and wishes heard and acted upon in relation to a variety of issues.

This element of the Service will be needs led and models of delivery will be flexible and developed over time in order to meet the needs of individuals within Southampton in the most effective and appropriate way as demands change.

The Service Provider will be required to manage access and provision of non-statutory advocacy in order to maximise the available resources efficiently and ensure that those most in need receive support. This includes the need to prioritise those at risk, issues relating to safeguarding and those experiencing major life changes.

The provision of non-statutory advocacy may include but is not limited to:

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- Supporting parents who have a learning disability and whose child is subject to child protection proceedings. This element of provision will involve supporting individuals through the process of child protection proceedings and within a variety of settings, including in Court should this be required.
- Supporting self-advocacy groups and self-advocates to lead the advocacy support that they receive, attend forums and meetings across Southampton and to understand and have a say over the issues which impact their lives. Self-advocates will be supported to interact with all relevant forums, services and individuals such as commissioners, elected council members, public and voluntary sector service Providers and local decision making boards. This may require the Service Provider to continue the work of self-advocacy groups that are already running in the city and to create new opportunities for individuals to be involved in areas of identified need. There is also a requirement to support self-advocates to attend Southampton's Learning Disabilities Partnership Board.
- Supporting individuals to become peer advocates, enabling people with a shared experience to support and empower each other. This can be in a one to one or group setting. Peer advocacy can often be natural (it is not officially arranged) or unplanned and this may come from creating a network of self-advocates.
- Supporting individuals through the hospital discharge process and decision making about discharge and support options.
- Providing advocacy support to individuals and groups as part of strategic service reviews and system redesign undertaken by public sector bodies. This may involve supporting people to have a voice within statutory consultations or co-production exercises.

Learning Disabilities Housing Advocacy

Included within the scope of this service is the provision of advocacy to support individuals with complex needs who are currently living in residential, nursing or other settings which are not the most appropriate in order to meet individual need.

This may mean a move towards supported living services or other more independent settings. The Service will support individuals through the process, enabling them to have their say and ensuring that their views and wishes are taken into account.

As this project is working with a number of complex individuals it is expected that advocates supporting this project will need experience of:

- Working alongside Best Interest assessments and processes
- Court of protection
- Individuals who have difficulty communicating

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Substance Use Disorder (SUDS) Advocacy:

The Service Provider shall facilitate individuals, engaging with, or seeking to engage with treatment for substance use disorders, by;

- Recruiting, training and supporting volunteers to advocate with and/or on behalf of people who are experiencing barriers to accessing the services for which advocacy can provide a solution. It is expected that volunteer advocates will include people with lived experience of substance use disorders and SUDS
- Receiving self-referrals and referrals from SUDS and other stakeholders
- Providing drop in sessions within SUDS and in other venues where need is identified
- Delivering one to one advocacy support
- Negotiating and seeking solutions to any barriers to engagement with SUDS with and/ or on behalf of the individual seeking support
- Signposting and/ or refer people into support and treatment

The Service Provider will be required to develop new and innovative approaches to the delivery of advocacy services during the lifetime of the contract in order to increase capacity and access to services within the available resources.

Eligibility criteria is for residents of Southampton City aged 18 years upwards, who are meet the relevant criteria for the service.

Summary of Impact and Issues

The service specification for the provision of Integrated Advocacy remains largely unchanged but has been reviewed and updated to reflect best national practice; it includes robust management information, performance indicators, service and individual outcomes.

The various forms of statutory advocacy provided by the service, supports adults with disabilities, ensuring that their views and opinions are heard and taken into consideration during care planning, safeguarding, and/or or decisions made on their behalf under legislation (e.g. Mental Capacity Act, Mental Health Act, Children Act).

Non-statutory advocacy supports service users with a wider range of issues e.g. supporting them with benefits tribunals or applications for housing or support for clients with a learning disability to participate in a child protection proceeding.

Potential Positive Impacts

The Care Act 2014 imposes various statutory duties on Local Authorities when exercising Adult Social Care functions including the requirements to commission appropriate, efficient and effective services and encourage a wide range of service

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provision to ensure that people have a choice of appropriate services and an emphasis on enabling people to stay independent as long as possible. The act stipulates that individuals may require care and support.

Implementation of an updated services specification has the potential to promote the following:

- implement best national practice into local services
- include more outcome based approaches in the design
- invite innovation/new ideas from service providers
- achieve best value for money

Statutory advocacy and Non-statutory advocacy provides parity of access to all eligible individuals, this will include individuals with mental health issues, a learning disability, autism, physical and sensory disabilities, substance use disorder and long term conditions. There is no entitlement to statutory advocacy by virtue of gender, sexual orientation, gender identity, pregnancy, marital status or age alone.

As indicated above, advocacy provides vulnerable people with complex and enduring health or mental health issues with the means to ensure that their voice is heard in any forum and that their needs and wishes are considered and acted upon. Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice.

Commissioning a new Advocacy service will offer an opportunity to test the market for new and innovative providers and to obtain best value for money. These proposals will encourage the new service to improve awareness of the provision to ensure that those eligible for the service have access to it, including those with protected characteristics.

Responsible Service Manager	Jackie Hall, Commissioner, Quality & Commissioning
Date	
Approved by Senior Manager	Carole Binns, Director of Adult Social Services, Chief Executive
Date	

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	The service is open to all aged 18 and upwards.	There will not be any changes to the eligibility criteria based on age.

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Disability	People with a mental illness, learning disability, autism, physical and sensory disabilities, substance use disorder and long term condition. Any changes could affect continuity of care if there is a change of provider. This proposal will impact individuals with a mental illness, learning disability, autism, physical and sensory disabilities, substance use disorder and long term condition. Any changes could affect current continuity of care if there is a change of provider. Continuity of care and expertise around these disabilities is important to some of these groups. There is also the potential for positive impacts for this group of people as the new contract will include an improved specification with greater focus on promoting and facilitating access to existing services that will minimise relapse and the need for more intensive support.	Any change in provider would be subject to a transition plan, this will ensure the management of the transfer is completed in a way that places high priority in providing reassurance to individuals. A communications plan will be developed which will include ensuring all individuals (and their carers) are kept informed of any changes, the timescale and who to contact with any concerns. An implementation period (3 months) has been factored into the timescales that will allow transfer of support where necessary. Staff delivering the current services are likely to be entitled to TUPE opportunities if a new provider were appointed. This will provide continuity of care to individuals.
Gender Reassignment	No specific detrimental impact upon individuals undergoing gender dysphoria or reassignment. Culturally appropriate services will be delivered by the provider. This protected group are often subject to discrimination and there is a risk that they would be disproportionately affected by a change in care away from agencies and individuals with whom they have built up trust.	Service specifications include a requirement for services to work with people with a range of needs including issues of diversity. Transition arrangements will consider any individual need in relation to diversity and continuity of care will be actively considered e.g. where TUPE arrangements apply.

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Marriage and Civil Partnership	No identified impact	
Pregnancy and Maternity	No identified impact	
Race	No specific detrimental impact upon individuals related to ethnicity or race issues is anticipated. This protected group are often subject to discrimination and there is a risk that they would be disproportionately affected by a change in care away from agencies and individuals with whom they have built up trust.	Service specifications include a requirement for services to work with people with a range of needs including issues of diversity. The provider will be expected to support and match individuals' cultural needs such as language and support etc.
Religion or Belief	No specific detrimental impact upon individuals related to religion or belief issues is anticipated.	Service specifications include a requirement for services to work with people with a range of needs including issues of diversity. The provider will be expected to support and match individuals' cultural needs such as language and support to access religious activities/requirements.
Sex	Men and women might have similar needs and issues which they need support with, the provision does not include priority need based on sex.	There will not be any changes to the eligibility criteria based on sex. There will be consideration of personal choice for gender of key worker where possible.
Sexual Orientation	No specific detrimental impact upon individuals related to their sexual orientation is anticipated. This protected group are often subject to discrimination and there	Service specifications include a requirement for services to work with people with a range of needs including issues of diversity.

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	is a risk that they would be disproportionately affected by a change in care away from agencies and individuals with whom they have built up trust.	Transition arrangements will consider any individual need in relation to diversity and continuity of care will be actively considered e.g. Where TUPE arrangements apply.
Community Safety	The service will work with individuals to reduce their vulnerabilities enabling people to keep themselves safe.	Improved joint working between agencies to ensure individuals have access to support services linked to prevention and intervention.
Poverty	Provision of this service is not subject to Southampton City Council charging policy; this tender does not involve any changes to that policy. People covered by these proposals are at risk of poverty, the provision may relieve the impact of that potential poverty by offering signposting support to address practical needs such as helping with benefits and developing life skills.	Signposting individuals to support in developing life skills and managing finances. The specification includes approaches to support those experiencing social financial issues.
Health & Wellbeing	The service will work with individuals to reduce their vulnerabilities enabling people to keep themselves safe.	Improved joint working between agencies to ensure individuals have access to support services linked to prevention and intervention.
Other Significant Impacts	No identified impact	

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SOUTHAMPTON CITY COUNCIL

Data Protection Impact Assessment

What is a Data Protection Impact Assessment?

A Data Protection Impact Assessment ("DPIA") is a process that assists organisations in identifying and minimising the privacy risks of new projects or policies. Projects of all sizes could impact on personal data.

The DPIA will help to ensure that potential problems are identified at an early stage, when addressing them will often be simpler and less costly.

Conducting a DPIA should benefit the Council by producing better policies and systems, and improving the relationship with individuals.

Why should I carry out a DPIA?

Carrying out an effective DPIA should benefit the people affected by a project and also the organisation carrying out the project.

Not only is it a legal requirement in some cases, it is often the most effective way to demonstrate to the Information Commissioner's Officer how personal data processing complies with data protection legislation.

A project which has been subject to a DPIA should be less privacy intrusive and therefore less likely to affect individuals in a negative way.

A DPIA should improve transparency and make it easier for individuals to understand how and why their information is being used.

When should I carry out a DPIA?

The core principles of DPIA can be applied to any project that involves the use of personal data, or to any other activity that could have an impact on the privacy of individuals.

Answering the screening questions in Step 1 of this document should help you identify the need for a DPIA at an early stage of your project, which can then be built into your project management or other business process.

Who should carry out a DPIA?

Responsibility for conducting a DPIA should be placed at senior manager level. A DPIA has strategic significance and direct responsibility for the DPIA must, therefore, be assumed by a senior manager.

The senior manager should ensure effective management of the privacy impacts arising from the project, and avoid expensive re-work and retro-fitting of features by discovering issues early.

A senior manager can delegate responsibilities for conducting a DPIA to three alternatives:

a) An appointment within the overall project team;
b) Someone who is outside the project; or
c) An external consultant.

Each of these alternatives has its own advantages and disadvantages, and careful consideration should be given on each project as to who would be best-placed for carrying out the DPIA.

How do I carry out a DPIA?

Working through each section of this document will guide you through the DPIA process.

The requirement for a DPIA will be identified by answering the questions in Step 1. If a requirement has been identified, you should complete all the remaining sections in order.

After Step 5, the Information Lawyer (Data Protection Officer) will review the DPIA within 14 days of receipt, and complete the rest of the assessment within 28 days. The DPO will identify any privacy risks, and proposed measures to address them.

These measures must then be agreed by the project lead, Information Asset Owner or Administrator, and, in some cases, the Senior Information Risk Owner.

Advice can be found at the beginning of each section, but if further information or assistance is required, please contact the Information Lawyer (Data Protection Officer) on 023 8083 2676 or at information@southampton.gov.uk.

Project Details

Name of Project

Integrated Advocacy service

Brief Summary of Project

The project aims to commission a new Integrated Advocacy service for Southampton, replacing an existing commissioned service, whose contract expires on 31st March 2020.

Once commissioned, the new service will provide a holistic Integrated Advocacy service that will meet the needs of all eligible individuals within Southampton. This will include individuals of all age groups with learning disabilities, autism, mental health issues, physical and sensory disabilities and long term conditions.

Estimated Completion Date

1.4.2020

Name of Project Lead

Amanda Luker, Senior Commissioner

Details of Person Conducting DPIA

Name

Jackie Hall

Position

Commissioner

Contact Email Address

Jackie.hall@southampton.gov.uk

Step 1: Identify the need for a DPIA

Does your project involve… (tick all that apply)
☒ The collection of new information about individuals
☐ Compelling individuals to provide information about themselves
☒ The disclosure of information about individuals to organisations or people who have not previously had routine access to the information
☐ The use of existing information about individuals for a purpose it is not currently used for, or in a way it is not currently used
☐ Contacting individuals in ways which they may find intrusive
☐ Making changes to the way personal information is obtained, recorded, transmitted, deleted, or held
☐ The use of profiling, automated decision-making, or special category data[1] to make significant decisions about people (e.g. their access to a service, opportunity, or benefit).
☐ The processing of special category data[1] or criminal offence data on a large scale.
☐ Systematically monitoring a publicly accessible place on a large scale.
☐ The use of new technologies.
☐ Carrying out profiling on a large scale.
☐ Processing biometric or genetic data.
☐ Combining, comparing, or matching data from multiple sources.
☐ Processing personal data without providing a privacy notice directly to the individual.
☐ Processing personal data in a way which involves tracking individuals' online or offline location or behaviour.
☐ Processing children's personal data for profiling or automated decision-making or for marketing purposes, or offer online services directly to them.
☐ Processing personal data which could result in a risk of physical harm in the event of a security breach.

[1] personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation

If you answered "yes" to any of these, please proceed to Step 2.
If none of these apply, please tick the below box, and return the form to the Information Lawyer (Data Protection Officer) at information@southampton.gov.uk
☐ None of the screening statements in Step 1 of this document apply to the project, and I have determined that it is not necessary to conduct a Data Protection Impact Assessment

Step 2: Describe the processing

The nature of the processing
How will you collect data?
The provider will collect information from referrals received (sources identified in the section above). Southampton City Council and other referring agencies (including self-referrals or referrals from carers, friends, members of the public) will send information via the prescribed referral routes. The provider will be a data controller. The provider will use information received in order to make contact with referred individuals in order to offer appropriate advocacy services. Service users may be eligible for more than one statutory advocacy service in additional to non-statutory advocacy so may seamlessly move between different elements of the service. For example a service user may be referred for an IMCA due to lacking capacity to make the decision to move from general hospital to residential care. Inherent within that there may be a requirement to assess their needs under the Care Act 2014 and so they may also be eligible for Care Act advocacy as well as for an Independent Mental Capacity Advocate. The provider will make decisions on eligibility for aspects of the service based on information received in the referral and additional information gathered in its own assessment of the individual's circumstances. Personally identifiable information (PII) will only be shared by the provider with others where it is necessary in order to advocate on their behalf and where they have the consent of the service user to do so (or where they have a lawful basis to do so e.g. under the Mental Capacity Act in order to fulfil the advocacy role). No PII will be shared with Southampton City Council except by exception (for example to report a safeguarding adults or safeguarding children's issue). This will be on a case by case basis and via the most appropriate method (e.g. phone call or secure email to the MASH team or to the allocated social worker). Anonymous service usage data will be shared with the commissioner on a quarterly basis. This does not contain any PII. Southampton City Council is not prescriptive on how the provider will store information – only that its systems for doing so are compliant with GDPR. The contract will also specify compliance with record retention lengths and the requirement to delete information once retention periods have been met. The highest data processing risk is the sending of PII information via non secure email either from referrer to the provider or from the provider to another agency. The provider will be required to ensure that they send information securely and referral information will make clear that information must be sent securely to them or if that is not possible to refer by phone. The potential for an online web based referral form removing the necessity for referrals via email will be explored with the new provider. The provider may receive a referral for an adult with capacity to make a decision about the receipt of advocacy services where they have not provided consent to be referred.

The contract will need to ensure that the provider has procedures in place to check that informed consent was provided before referral and to check on first contact with individuals that they have consented to the referral.

If the individual states that they did not/do not consent to the referral – the provider will have systems in place in order to delete all information held on that individual unless there is a lawful basis to proceed without consent (for example the individual lacking capacity to make the decision on consent – and a best interests decision under the Mental Capacity Act affirms the necessity to proceed).

If the client has consented and withdraws their consent for their information to be held/processed by the provider – then the provider will need to ensure that they have systems in place to manage this scenario and delete the individual data. Additionally appropriate mechanisms will be required to capture anonymous service usage data if the service user has received an advocacy service prior to consent being withdrawn.

Where appropriate and the service user has capacity, advocates are encouraged to complete an Advocacy Agreement form with their clients, setting out the issues that will be dealt with by the advocate. This document can be reviewed at any time, and advocates are always clear with service users about the issues they can and can’t deal with. Wherever possible, if an issue is not appropriate to be dealt with by an advocate, the service user will be signposted to another agency.

Individuals will be asked to complete a permission to share agreement at the point of engagement with the service and at regular intervals thereafter, but no less than annually.

Information will be held in accordance with the commissioned providers data protection policies, which in turn will be compliant with the terms and conditions of the contract.

How will you use the data?

Data will be used to offer an appropriate Advocacy service to eligible individuals who require it.

The Service will protect the confidentiality of all individuals receiving support whilst ensuring that information is shared where required within relevant safeguarding and operational policies as outlined within the Terms and Conditions to this Agreement.

How will you store the data?

Personal data will held by the providers. Storage will be, at a minimum compliant, with relevant legislation as set out in the terms and conditions of the contract. Providers will hold electronic and paper files to support the delivery of integrated advocacy services.

A number of IT systems or applications are available to providers. The specific system will be secured by the provider once the contract is awarded. IT systems will need to reflect the requirements as set out in the service specification.

How will you delete the data?

Retention periods and the destruction of personal data will be set by the providers own data protection policies but will be, at a minimum compliant, with relevant legislation as set out in the terms and conditions of the contract.

If the individual states that they did not/do not consent to the referral – the provider will have systems in place in order to delete all information held on that individual unless there is a lawful basis to proceed without consent (for example the individual lacking capacity to make the decision on consent – and a best interests decision under the Mental Capacity Act affirms the necessity to proceed).

If the client has consented and withdraws their consent for their information to be held/processed by the provider – then the provider will need to ensure that they have systems in place to manage this scenario and delete the individual data. Additionally appropriate mechanisms will be required to capture anonymous service usage data if the service user has received an advocacy service prior to consent being withdrawn.

What is the source of the data?

The source of the data will be the individual requiring the Advocacy service or member(s) of their family if appropriate.

Will you be sharing data with anyone?

INFO: If yes, please provide details

Individuals engaging with the service will asked to complete a permission to share form, which will set out the agencies and individuals with whom their information can be shared. The collection and sharing of information will be compliant with the terms and condition of the contract awarded to the provider by the city council.

At the first meeting with an advocate, confidentiality, information storage and information sharing will be discussed and agreed with the service user. The Permission to Share/Confidentiality form will be completed and signed. Where service users do not have capacity to understand or agree, advocates will follow the providers guidance and policy relating to sharing information. Advocates endeavour to secure permission to share and/or consent in accordance with GDPR and all data protection legislation.

If the Advocate is unable to gain permission from the client due to capacity issues or communication difficulties, they can ascertain the need to share on a best interest basis according to the Mental Capacity Act Code of Practice Guidance.

Service users are reminded about the limits of confidentiality at the beginning of every meeting with their advocate.

The Permission to Share agreement is reviewed when/if circumstances change, e.g. the service user wants information shared or withheld with a person or service not detailed on the form, or a new issue is identified. The service user has the right to withdraw permission to share with any party previously identified at any time (excluding disclosures made due to safeguarding concerns).

Information, via the permission to share protocol, is likely to be shared with health professionals (GP's, community nurses, hospital staff) and adult social care representatives (social workers).

Describe the scope of the processing
What is the nature of the data?
INFO: Detail the type of personal data being processed. List any fields that will be processed (e.g. name, address, data of birth, NHS number, video images)

The data collected is used to provide an advocacy service for the service user and as such includes the following, either to determine eligibility for the service or required in order to advocate effectively on behalf of the service user. The information required for referral to the service does include special category data:

- Name
- Date of Birth
- Address
- Contact details (eg phone number).
- Ethnicity
- Care Group (mental health, learning disability, autism, substance misuse, older person, physical disability or sensory impairment, carer (including young carer), young person aged 16-18 in transition to Adult Services).
- Details of the issues that the person requires advocacy support with.
- Details of their "substantial difficulties, including any communication difficulties and reasonable adjustments you have already made for them" (Eligibility question to determine whether they meet the criteria for an advocate).
- Referrer's details (name, contact details).
- Details of any professionals (including any existing advocates) involved with the person and any family/friends actively involved in their care.
- Any risks or behaviours that may affect lone working.

Data will be collected following every referral to the service.

- Data will be retained as per GDPR guidelines. Where a referral is made without the consent of the individual and where no legal basis exists to process that referral without consent, the provider will make contact with the individual to seek their consent. Where consent is refused the provider will immediately delete the individual's records.
- The contract covers all areas of Hampshire.
- Data will be collected on all referred eligible service users.

- The current contract provided an advocacy service to 4909 individuals in the 2018/19 financial year (not including the Independent Health Complaints Advocacy Service which is not yet part of this contract). The current provider has confirmed that this figure is representative of the yearly level of demand across the last 4 years.

The Independent Health Complaints Advocacy Service has supported 112 individuals in the last 6 months. Assuming demands remains constant this would equate to approximately 224 individuals on an annual basis.

Does it include special category or criminal offence data? Please provide details.

INFO: "Special category" data includes personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation.

Data concerning health, both mental and physical.

How much data will you be collecting and using?

Data collected will be proportionate with the needs of the individual. All data collected is proportionate and relevant to the service being provided.

The handling, storage and use of information will need to be compliant with the requirements set out in the terms and conditions of the contract. The terms and conditions of the contract clearly sets out the requirements to be compliant with data protection laws, including ensuring that only personal data that is adequate, relevant, and not excessive in relation to the purpose for which it is processed is collected.

How often will the data be collected and used?

Data will be collected and recorded as often as the individual in receipt of the service is seen by the Advocate. Frequency of visits will be variable depending on the needs of the individual and the complexity of the case.

How long will you keep it?

Retention periods will be set by the providers own data protection policies, but will be, at a minimum compliant with relevant legislation as set out in the terms and conditions of the contract.

If the individual states that they did not/do not consent to the referral – the provider will have systems in place in order to delete all information held on that individual unless there is a lawful basis to proceed without consent (for example the individual lacking capacity to make the decision on consent – and a best interests decision under the Mental Capacity Act affirms the necessity to proceed).

If the client has consented and withdraws their consent for their information to be held/processed by the provider – then the provider will need to ensure that they have systems in place to manage this scenario and delete the individual data. Additionally

appropriate mechanisms will be required to capture anonymous service usage data if the service user has received an advocacy service prior to consent being withdrawn.

How many individuals are affected?

Below is the number of service users currently being dealt with by the service but this is likely to change with the new Liberty Protection Safeguards legislation that is due to come into force in Autumn 2020.

Period	**Referrals received**	**Number per month**	Percentage increase	
			From contract start	from last period
2015/16	461	38.41	n/a	n/a
2016/17	647	53.91	40.35%	40.35%
2017/18	883	57.58	91.54%	36.48%
2018/19	849	70.75	84.16%	-3.85%

What geographical area does it cover?

Southampton City

Describe the context of the processing

What is the nature of your relationship with the individuals?

INFO: Detail who the data subjects will be (e.g. residents, carers, pupils, staff, professionals)

The overriding purpose of an Advocacy service is to enable individuals to take more responsibility for themselves and reduce their dependency on other people. Empowering individuals to self-manage and to take control of their own lives will be central to the advocacy support provided as part of this Service.

The Service will support and develop the ability of individuals to self-advocate, increasing their confidence and assertiveness skills and enabling them to support themselves as far as is possible in future. This will include providing the opportunity for individuals to train as peer/volunteer advocates, offering additional support to local people.

The Service will adhere to principles of personalisation and will be delivered flexibly in a way that offers choice and control to individuals with regards to the advocacy support that they receive, recognising that those receiving support have the most specialised knowledge of their needs.

The Service will be accessible to the wide diversity of communities within Southampton, respecting people's culture and religious beliefs and making reasonable adjustments to ensure that no individual will be excluded from accessing services on the grounds of ethnicity, culture, religion, class, gender, sexual orientation, disability, age, marital status or caring role.

The Service must establish links and work in partnership with others including public, independent and voluntary sector agencies to improve the overall quality and effectiveness of wider support services within Southampton.

The Service must assist individuals, staff, carers and agencies who are likely to make referrals to the Service to understand the role of advocates, with an emphasis on statutory elements of provision, in order for them to know how and when to access the service. This will include a targeted communications and publicity programme at the start of the contract.

The Service will protect the confidentiality of all individuals receiving support whilst ensuring that information is shared where required within relevant safeguarding and operational policies as outlined within the Terms and Conditions to this Agreement.

How much control will they have over their data?

Individuals will be asked to complete a permission to share agreement at the point of engagement with the service and at regular intervals thereafter, but no less than annually.

Consent to share information may be withheld in regards to specific areas of information, for example financial circumstances, or restrictions placed on who the information can be shared with, for example local voluntary agencies. This will be recorded and complied with by staff providing the service.

Individuals will be able to update and amend data at any time during the period that advocacy is requested and provided.

Would they reasonably expect the Council to use their data in this way?

INFO: Please provide details to support your answer

The provider will be a data controller. SCC will not hold personally identifiable information on service users (unless referrals have been made to Adults Services for assessment/provision of services – separately from any issue relating to this contract).

- All data processing in relation to this contract will be undertaken by the provider.
- The individual would be a recipient of one or more advocacy services from the provider.
- The individual has the option to refuse consent at any time and as such their data would subsequently be deleted (except in the cases of individuals assessed as lacking the capacity to make such a decision and a legal duty to provide the service under the Mental Capacity Act exists, or in the case of children where parental consent may be given).
- The collection and use of data is proportionate to the service being provided and would be expected.
- The service includes provision of advocacy to children and vulnerable adults.
- There are no prior concerns over this type of data processing, it is not novel and there are no issues of public concern.
- Relevant clauses relating to the receipt, processing and storage of data will be contained within the provider's contract.

The handling, storage and use of information will need to be compliant with the requirements set out in the terms and conditions of the contract.

The terms and conditions of the contract clearly sets out the requirements to be compliant with data protection laws, including ensuring that only personal data that is adequate, relevant, and not excessive in relation to the purpose for which it is processed is collected.
Do they include children or other vulnerable groups?
INFO: If yes, please provide details
Yes. People who are experiencing mental health issues or who lack mental capacity are particularly vulnerable and require a high level of safeguarding in order to ensure that they are offered the right care for their needs. Advocacy helps to ensure that these groups have their voices heard in any decisions made about them and that decisions are made in the best interests of the individual concerned.
Are you aware of any prior concerns over this type of processing or security flaws?
INFO: If yes, please provide details
No
Is the processing novel in any way?
INFO: If yes, please provide details
No. Southampton City Council has a statutory duty to provide advocacy services to its population and a discretionary duty to provide non-statutory advocacy services which are viewed as one mechanism to help meet its obligations under the Care Act 2014 to provide “early intervention and prevention” services. As such this service has been commissioned by Southampton City Council since 2015 and the new service will continue to provide both statutory and non-statutory services. There have been no prior concerns over this type of data processing, it is not novel and there are no issues of public concern.
What is the current state of technology in this area?
There are a number of IT systems that can be used for case recording and case management. The specific system will be secured by the provider once the contract is awarded. IT systems will need to reflect the requirements as set out in the service specification.
Are there any current issues of public concern that should be considered?
INFO: If yes, please provide details
People who are experiencing mental health issues or who lack mental capacity are particularly vulnerable and require a high level of safeguarding in order to ensure that they are offered the right care for their needs. Advocacy helps to ensure that these groups have their voices heard in any decisions made about them and that decisions are made in the best interests of the individual concerned.

Describe the purposes of the processing

What do you want to achieve?

Data will be processed by the provider in 2 main ways:

Purpose One: Provision of an advocacy service to the client:

Use of data in order to make contact with the individual with a view to arranging to meet them to discuss their circumstances, issue(s) they require advocacy for and what their wishes/views are.

Following on from this initial meeting, the data gained will be used in order to be able to advocate on their behalf using the information gained from meeting with them to advocate with relevant other professionals who are directly connected with the issues they require advocacy support with. This may involve discussions with others involved in their care to gain additional information (with their consent, or via a best interests decision where they lack capacity to give consent).

The intended effect for individuals is the receipt of an appropriate and effective advocacy service to support them. The benefits of processing for SCC are the delivery of an effective advocacy service to individuals which meets statutory requirements and assists the individual to effectively communicate their views and wishes.

Purpose Two: Provision of contract monitoring data to SCC:

The provider will collate information on service usage providing SCC with statistics for each element of the service.

No personally identifiable information is contained within the contract monitoring report, however the provider will need to process PII in order to produce the report for SCC.

The information provided is intended to allow SCC to monitor the provision of service delivery, specifically:

- ensuring that the service is being provided to the anticipated number of recipients;
- to monitor trends in service provision;
- receive information on and address any problems identified by the provider in delivering the service - such as:
    - under delivery
    - difficulties with partner agencies that may require commissioner assistance to resolve
    - service demand that exceeds ability to meet;
    - to note any complaints and compliments received by the provider and follow up as necessary
- to report on financial spend against the budget for the elements of the contract which are paid by activity.

For the second purpose – the effect for the individual is that SCC ensures the provider is delivering an effective advocacy service that is meeting assessed advocacy needs. The

benefits of processing for SCC are that it receives information that enables effective contract monitoring to ensure that provider is delivering the service according to the requirements of the service specification and that it is remaining in budget or where budgetary pressures are identified – to enable SCC to work with the provider in order to remain within budget or where this is not possible, to enable the commissioning manager to alert senior commissioners of expected financial pressures on the contract.

More broadly the information provided for effective delivery of an advocacy service to individuals and the effective contract monitoring of the service to ensure that effective delivery will have positive impacts across the health and social care systems as individuals are supported to express their views and achieve their outcomes. This sometimes results in the reporting of safeguarding adults issues which may have otherwise been undetected and also in the reporting of quality issues within provider organisations such as hospitals, residential or nursing homes.

The Integrated Advocacy service is to enable eligible individuals to take more responsibility for themselves and reduce their dependency on other people. Empowering individuals to self-manage and to take control of their own lives is central to the advocacy support to be provided as part of this Service.

What is the intended effect on individuals?

The Service will support and develop the ability of individuals to self-advocate, increasing their confidence and assertiveness skills and enabling them to support themselves as far as is possible in future. This will include providing the opportunity for individuals to train as peer/volunteer advocates, offering additional support to local people.

What are the benefits of the processing – for the Council, and more broadly?

To ensure that the statutory duties of the council are carried out in relation to:

Provision of statutory advocacy for vulnerable adults.

- Independent Mental Health Advocacy (IMHA) as determined by the Mental Health Act 1983 (MHA)
- Independent Mental Capacity Act Advocacy (IMCA), including Deprivation of Liberty Safeguards (DOLS) IMCA, as determined by the Mental Capacity Act 2005 (MCA) and from 1st October 2020 – IMCA for Liberty Protection Safeguards (LPS) as introduced by the Mental Capacity Amendment Act 2019.
- Paid Relevant Person’s Representative (Paid RPR), as determined by the MCA
- Care Act Advocacy, as determined by the Care Act 2014

Step 3: Consultation process

Consider how to consult with relevant stakeholders
Describe when and how you will seek individuals' views – or justify why it's not appropriate to do so
We intend to engage with professionals, stakeholders and service users as appropriate as part of an engagement/feedback exercise. This will be completed as soon as possible and before the end of September 2019. A questionnaire will be developed and sent out on-line and by e-mail, inviting responses which can be used to develop the service specification for the new service.
Who else do you need to involve, or have you already involved within the Council?
INFO: e.g. IT services, records management
Procurement, Legal services, Adult Safeguarding, DOLS Team
Do you need to ask your processors to assist?
INFO: Processors are third parties who will process the personal data on our behalf
The current service provider is providing a data report which will be used to assess the volume of work required over a 12 month period 1.10.18 – 30.9.19
Do you plan to consult information security experts, or any other experts?
INFO: Please provide details to support your answer
No, it is not deemed necessary to do so due to the nature of the processing.

Step 4: Assess necessity and proportionality

Describe compliance and proportionality measures
What is your lawful basis for processing? Please choose one of the following…
INFO: There should generally only be one legal basis for processing.
☒ The data subject has given consent ☐ The processing is necessary for the performance of a contract to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract ☐ The processing is necessary for compliance with a legal obligation to which the Council is subject

☐ The processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the Council

☐ The processing is necessary for the purposes of the legitimate interests pursued by the Council or by a third party

Does the processing actually achieve your purpose?

INFO: Please provide details to support your answer

The handling, storage and use of information will need to be compliant with the requirements set out in the terms and conditions of the contract.

Is there another way to achieve the same outcome?

INFO: Please details to support your answer

All data collected is proportionate and relevant to the service being provided.

How will you prevent function creep?

INFO: Function creep is where data collected for one purpose is used for another purpose over time.

The handling, storage and use of information will need to be compliant with the requirements set out in the terms and conditions of the contract.

How will you ensure data quality and data minimisation?

INFO: We should only use the minimum amount of personal data possible to achieve the purpose of the processing.

The handling, storage and use of information will need to be compliant with the requirements set out in the terms and conditions of the contract. The terms and conditions of the contract clearly sets out the requirements to be compliant with data protection laws, including ensuring that only personal data that is adequate, relevant, and not excessive in relation to the purpose for which it is processed is collected.

What information will you give individuals about the processing?

Individuals will be informed during their first engagement with the service and subsequent meetings whether face to face or over the telephone. The permission to share form will be the responsibility of the commissioned provider, but will be compliant with the requirements set out in the terms and conditions of the contract.

How will you help to support their rights?

INFO: Data subject’s rights include the right to access, rectify, erase, port, and restrict their data.

Access to files will be set out in the providers own policies and procedures but will be, at a minimum compliant, with relevant legislation as set out in the terms and conditions of the contract.

The service specification for the contract clearly outlines the services to be provided and contract monitoring processes oversee service delivery – part of which would monitor any expansion in scope (i.e. function creep). Contract monitoring includes service user feedback and the contract monitoring reports will demonstrate whether the provider is collecting information as required by the contract and to the standard expected.

The provider by virtue of the clauses within the contract will be expected to comply with GDPR and as such provide information in an accessible format to any individuals who use the service.

No international transfers of data would be expected, except perhaps in very rare occasions where an oversees relative/friend decides to make a referral into the service. The chances of this are extremely low and the provider would be expected to ensure that appropriate measures are put in place for the safe transfer of information as per GDPR

Individuals will be able to update and amend data at any time during the period that advocacy is requested and provided.

What measures do you take to ensure processors comply with the GDPR, and assist the Council in supporting individuals in exercising their rights?

INFO: E.g. will there be a contract in place with the processor that contains data protection obligations?

The handling, storage and use of information will need to be compliant with the requirements set out in the terms and conditions of the contract. The terms and conditions of the contract clearly sets out the requirements to be compliant with data protection laws, including ensuring that only personal data that is adequate, relevant, and not excessive in relation to the purpose for which it is processed is collected.

How do you safeguard any international transfers of personal data?

INFO: If there are no international transfers involved, please state this

There are no international transfers of data involved.

Step 5: Send DPIA Form to the Data Protection Officer

After completing this part of the form, please send the document to the Information Lawyer (Data Protection Officer) at information@southampton.gov.uk

The DPO will review the information provided, and identify and assess the privacy risks.

Step 6: Identify and assess risks (DPO to complete)

Describe source of risk and nature of potential impact on individuals. Include associated compliance and corporate risks as necessary.	**Likelihood of harm**	**Severity of harm**	**Overall risk**
1. N/A – all reasonable privacy risks identified and addressed	Remote Possible Probable	Minimal Significant Severe	Low Medium High

Step 7: Identify measures to reduce risk (DPO to complete)

Identify additional measures you could take to reduce or eliminate risks identified as medium or high risk in step 5			
Risk	**Options to reduce or eliminate risk**	**Effect on risk**	**Residual risk**
1.	N/A – all reasonable privacy risks identified and addressed	Eliminated Reduced Accepted	Low Medium High
Comments from the Data Protection Officer			
I am satisfied that all reasonable privacy risks identified and addressed.			
Comments from the Senior Records Officer			
No comments.			

Step 8: Sign off

Item	Date	Notes
DPO reviewed DPIA and provided advice on:	15th October 2019	DPO should advise on compliance, step 7 measures and whether processing can proceed
Senior Records Officer reviewed DPIA on:	4th September 2019	SRO should advise on records management matters
Measures approved by Project Manager on:	16th October 2019	Integrate actions back into project plan, with date and responsibility for completion
Comments from Project Manager:	No comments.	
Residual risks approved by Information Asset Owner / Administrator on:	6th December 2019	
Comments from IAO / IAA:	No comments.	
Residual high risks approved by the Senior Information Risk Owner on:	N/A	If accepting any residual high risk, consult the ICO before going ahead
Comments from SIRO:	N/A	

Step 9: Review

Item	Date	Comments
DPO reviewed DPIA on:		
Date of next review:		

DECISION-MAKER:		The Joint Commissioning Board		
SUBJECT:		Establishing a regional consortium for the commissioning of independent foster care		
DATE OF DECISION:		19 December 2019		
REPORT OF:		Chris Pelletier		
		CONTACT DETAILS		
AUTHOR:	**Name:**	Charis Froggatt	Tel:	023 80833589
	E-mail:	Charis.froggatt@southampton.gov.uk		
Director	**Name:**	Stephanie Ramsey	Tel:	023 80296941
	E-mail:	stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY

BRIEF SUMMARY

The Council's primary method of purchasing Independent Foster Care for looked after children in a manner that is compliant with procurement regulations is via the regional framework agreement procured by Southampton City Council from April 1st 2017, a contract that terminates on 31st March 2021. This arrangement has been highly successful and praised by both Independent Fostering Agencies (IFA) and Local Authority (LA) partners. Use of the Framework continues to increase and both LAs and IFAs are experiencing the benefits of standardised processes for engaging this market across the region and a centralised approach to contract/ performance management. Additionally, a significant proportion of placements are now being placed 'on-framework' with IFAs who previously had off-framework placements, indicating a growing preference for regional framework utilisation amongst both purchasers and providers.

RECOMMENDATIONS:

	(i)	It is recommended that regional LAs are invited to join a Southampton-led consortium for the purpose of commissioning a replacement to the current IFA framework agreement. It should be further noted as detailed in Appendix 1 that the project budget is £92,277, that Southampton's estimated contribution to the cost of this project (based on proportional utilisation, and assuming all current consortium LA's join the new consortium) is £10,169, with the balance to be paid by participating authorities. Southampton will additionally receive income of £13,031 per annum from consortium members during the contract term as remuneration for undertaking the tasks and functions associated with consortium leadership, and Southampton's estimated contribution to the cost of centralised contract management will be £15,480 p.a. during the contract term.

REASONS FOR REPORT RECOMMENDATIONS

1.	Through previous collaboration, we have seen evidence that through a collaborative procurement process, councils have achieved significant benefits when working together to commission independently provide foster care, including:

	• Improved outcomes for children • Better value for money with providers • Framework acts as a platform for block contracts • Reduced transactional costs • Shared procurement costs • Better placement stability • Streamlined placement matching processes • Improved market intelligence • Better working relationships with providers • Growth of trust between LAs and Providers • Reduced spot purchasing • Improved communication and partnership working. • Increases in the local supply of foster carers • Use of standard contracts and commissioning documents We want to build on the success of Southampton's track record on leading collaborative commissioning of children's services. The framework will additionally provide a single view of quality and stable/ predictable prices for the next 4-6 years.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	<u>Revert to Spot Purchasing</u> Cons: • Greater time intensive sourcing processes • Non-compliant with procurement regulations • Relies on informal provider relationships • Risk that unfixed pricing will cause average price to increase over time • Price of current placements may be inflated by the provider without warning • Low assurance of quality standards • Sufficiency shortfall in the current market Pros: • Requires no up-front effort • May be possible to negotiate better value on a case by case basis
3.	<u>Procure a Southampton-specific solution</u> Cons: • Southampton's demand for foster care in isolation exerts limited purchasing power on the market – market may show low level of interest/response to the tender • Market disenfranchised by lack of standardisation across the region • Sufficiency shortfall in the current market Pros: • Solution may be 100% tailored to Southampton's requirements without compromise • Formalised relationship with provider(s) established
4.	Although there are credible benefits associated both with spot-purchasing and the procurement of a Southampton-specific solution, it is thought that such benefits are outweighed by the risks associated with them, and on this basis the re-procurement of a consortia commissioning arrangement is recommended as it is the option most likely to secure assurance of best value and quality going forward.

DETAIL (Including consultation carried out)	
5.	Southampton City Council procured the IFA regional framework agreement in collaboration with 16 other Local Authorities. This contract commenced in April 2017, and will have been in place for 4 years when it expires in March 2021. Southampton has acted as lead commissioner in this consortium, having facilitated the design phase in collaboration with participating authorities, led on the procurement function, and provided consortium governance/ oversight over the life of the contract. Bournemouth, Christchurch and Poole Council (BCP) have provided the contract management function, which establishes and maintains relationships with IFAs on behalf of the consortium, conducts quality visits, and manages performance against contract KPIs. The market has reflected positively on this progressive working relationship at provider engagement events.
6.	The framework has been beneficial for both providers and consortium members. As such, the intention is to replicate the success of the previous service contract and partnership agreement and to also build upon those achievements by strengthening the terms of the consortium partnership agreement and working collaboratively with IFAs to better provide for the more complex and therapeutic needs of some looked after children. In particular, the activities associated with the lead commissioning role for both the current IFA and children's residential care framework agreements have proven over time to be more resource intensive than originally anticipated, and the financial model underpinning the partnership agreement will be revised to reflect this going forward. We have also learnt from the lack of market interest in Lot 4 of the current IFA framework agreement, (Alternative to Residential Care), that collaboration with IFAs at an earlier stage to ensure specialist foster care placements are specified in a manner that is both coherent from a provider perspective and provides the purchaser with sufficient assurance regarding child outcomes and value for money.
7.	Southampton's demand for IFA placements remains high in relative terms, with Southampton's IFA placement numbers being the 3rd highest in the consortium, with only Surrey/ Oxfordshire County Councils having greater demand for IFA placements. Supply of IFA placements remains, therefore, a key concern. All consortium members are finding it a constant challenge to source enough appropriate IFA placements due to a shortage of foster carers, and recent attempts to stimulate growth by offering IFA's guaranteed income through block contract have not been positively received by the market. However, consortium members do report that it is highly productive when workshops or working groups are created including IFAs in order to work through this concern, generating solutions to the lack of sufficiency in the market. When designing the next contract, we will also explore the possibility of including a similar quality standard such as an Ethical Care Charter, where providers have a minimum standard of support and investment in their staff. This has been shown anecdotally in other areas of social care to improve staff retention considerably and drive up quality standards, in turn improving sufficiency because more staff are attracted to these careers and less staff are leaving. It is also intended that market stimulation and direct work with regional IFAs to improve recruitment and retention of foster carers will be a key objective for the centralised contract management function provided on behalf of the consortium.
RESOURCE IMPLICATIONS	
Capital/Revenue	
8.	There is no upfront commitment for this re-tendering however if the contract proceeds on the current methodology, Southampton would be liable to pay the one

	off £10,169, share of the Project Management and Procurement cost and the annual Contract Management fee of £15,480. These costs are worked out using a methodology that calculates snapshot of the current IFA placements a Local Authority against the total number of placements all collaborating local authorities have and uses that percentage to calculate the share of the overall cost. The income for Southampton, should we lead the Procurement would be £92,277 (less our liability is £10,169), Southampton would also receive an income of £13,031 per annum in remuneration for the costs of acting as lead authority as well as legal and procurement expenses associated with reopening the contract annually.
Property/Other	
9.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10.	Southampton City Council has a statutory duty to meet the Sufficiency Duty placed on local authorities under 22 (G) of the Children Act 1989.
11.	The legal powers to pursue the procurement as outlined in this report are contained in the Local Government Acts 1972, 1999 and 2000. The procurement process itself is governed by the EU public procurement Directive (as embodied in UK law by the Public Contracts Regulations 2015).
Other Legal Implications:	
12.	None
CONFLICT OF INTEREST IMPLICATIOINS	
13.	N/A
RISK MANAGEMENT IMPLICATIONS	
14.	The primary risk associated with the proposal is not completing the procurement in advance of the current contract end date. This risk will be mitigated through robust application of project management principles and methodology.
POLICY FRAMEWORK IMPLICATIONS	
15.	The proposals contained in this report are in accordance with Article 4 of the council constitution local development framework and local area action plans

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	The proposals could affect looked after children, young people and parents/carers from any ward, and specifically relate to improving outcomes for those local children and young people living in the Council's care as a corporate parent.

Appendices	
1.	IFA Regional Commissioning Consortium Project Budget

Documents In Members' Rooms

1.	N/A

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

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

Other Background Documents **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.	N/A	

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Appendix 1 – Costing Matrix for IFA Procurement and Project Management Framework Fee charged by Southampton City Council to all

IFA Procurement and Project Management Framework Fee		
DESCRIPTION	COST	NOTES
PROCUREMENT PHASE		
Project Manager (including 20% on costs)	£43,014	SCC Grade 11 PTE based on 577 days from September 2019 through March 31st 2021 £
Venue hire and associated costs	£400	Based on one market engagement event
Administration support (including 20% on costs)	£9,322.56	SCC grade 6 one day per week between September 2019 through March 2021
Legal Costs	£24,750	Maximum of 450 hours @ £55ph, including fielding enquiries post award (approximately 2 week of time over the 4 years)
Advertising costs (including 20% on costs)	£531.36	Based on SCC Communications Officer grade 9 for maximum of 24 hours
Financial assessment of the tenders (including 20% on costs)	£804	Based on SCC Finance Officer grade 7 for a maximum of 50 hours
Procurement	£16,000	figures used are less than interim rate, as they are higher than salaries. Procurement 50 days broken down to: @ Procurement Manager level – circa £200 per day x 40 = £8,000 @ Head of Procurement level – circa £300 per day x 10 = £3,000 Includes annual re-opening. The tender will take 50% of a procurement managers time, there will be a tender management process and senior manager quality checking from the ITT publish date (tender out for circa 45 days); then there is management of the clarifications and evaluation periods so I would assume 50

		whole time equivalent days.
TOTAL ONE OFF UPFRONT FEE:	**£92,277.19**	
CONTRACT MANAGEMENT PHASE		
Oversight and governance of Contract Management Function	£5,072	Accountability oversight for framework coordination and contract management function.
Coordinating LA Costs (during and after tender process)	£7,130.22	Includes fielding queries after award, arranging and facilitating and hosting Board meetings etc). Includes SCC Contracts Officer approximately 8hrs per month of administrative and contracts tasks @ SCC grade 8 and Managerial staff time also.
Procurement	£670	The tender management/ sourcing portal £2,000 for a project.
Legal	£1028	Troubleshooting and queries post award (19 hours PA at £55ph, as has been recorded since April 2017)
SUB TOTAL	£13,900 PA	
TOTAL	£13,031 PA	This total reflects the sub total, less one sixteenth of the amount as a reflection of Southampton's contribution toward the fee

1. Integrated Commissioning Unit (ICU) Summary Performance Report — M9 (Dec) 2019/20

Achieving Transformation Change

Value	Target / Comparison	Measure
95%	Target ≥ 92%	% CAMHS routine assessments within 12 weeks
122	Target ≤ 132	Number of Permanent admissions to residential & nursing homes (65+)
44	Target ≤ 27	Average Daily Delayed Transfers of Care (DTOC) beds
15,841	Target ≤ 15,204	Number of Non-Elective Admissions
1,051	Prev 12 mths = 952	Falls (65+) & Fraity (75+) Short Stay Admissions <24hr

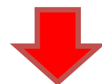
Quality

Value	Target / Comparison	Measure
62%	Target ≥ 80%	% Full Continuing Healthcare Assessments completed ≤28 days
93%	Target ≥ 85%	% Continuing Healthcare Assessments taking place in community
93%	Target ≥ 90%	% of placements that are sourced through the Care Placement Team
10.4%	Target ≥ 10.1%	% people with common mental health conditions accessing IAPT (YTD - local reporting)
31.9%	Prev 12 mths = 25.8%	Alcohol - % of clients completing treatment and not re-presenting

KEY

Compared to Previous Year

Better than previous year


Worse than previous year

Same as previous year

Compared to Target

2. ICU Workstream Progress

a. Achieving Transformation Change

High Intensity Users – working with West Hants CCG. Medically unexplained symptoms service went live in September, including telephone coaching. Mainstreaming of pathway 3 - to commission 4 (rather than 3) nursing home beds by November 2020 and 6 spot purchased beds.

Roll out of SoLinked (community solutions) including development of Southampton fund. Consultation underway on deregistration of 3 Dimensions residential homes, will impact 17 clients (estimated saving £150k). Eat Well procurement now completed and new contract in place. Enhanced Alcohol Care team at UHS

Development of Sufficiency strategy with children's services. CAMHS Local Transformation Plan refreshed. MH Support Teams in Schools commencing Jan 2020 to support schools in managing MH/emotional/behavioural difficulties. Work commenced to develop a more integrated model of pre-school provision for children with complex disabilities.

Delayed transfers of care remain high despite significant growth in the market (e.g. home care hours per week have moved from Sept 18 22,326 /Oct 18 22,598 to Sept 19 22,834/Oct 19 23, 094 and waits for home care have almost halved over the same period). Audit on data to be undertaken.

b. Procurement & Market Mananagement

Number of procurements in train including:
• Joint Equipment Store (max £11,260k for Southampton City) - procuring for both PCC and SCC, currently at evaluation stage. Award stage planned for December 2019 and service due to commence 01.07.20.
• Direct payment support (£512k)
• Play and Youth - commencement January 2020. (£914k)
• Southampton Peer support services (£480k) – commence April 2020
• ADHD diagnosis and support service to commence Nov 19
• Wheelchairs procurement – joint across all CCG's in Hampshire and Isle of Wight
• New falls exercise service goes live in October.
• Home care framework call off– additional hours using winter pressures
• Reopening Children's residential framework and working with consortium on reopening Independent Fostering Agency framework

c. Quality

A new metric requiring the CCG to complete Learning Disabilities Mortality Review (LeDeR) reviews within 6 months has been added, this has been back dated to September 2018.
Wheelchairs – not meeting waiting times targets. Challenge being clinical resource to undertake triage, assessment and handover. Active management of the contract.
Focus of Antidepressant work for 19/20 is improving the management of depression in the over 65yrs.
Monitoring the quality of care for patients in the Emergency Department, Cancer pathways and ophthalmology services at UHSFT continues, some improvements in waiting times have been noted but this remains an area of concern for the quality team.
Workforce concerns continue at Antelope House, contingency plans are in place to support the section 136 suite.
More than 95% of care home beds in Southampton are rated good by CQC

3. Key Performance Indicators

a. Integrated Care (Better Care)

	RAG Summary	
	Last Yr	Target
Green	7	5
Amber	3	1
Red	2	5
n/a	6	7

			Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M5	Average Daily DTOC beds	44	45	0	0%	27	18	66%
M6	Average Daily DTOC beds rate (per 100,000)	22	22	0	0%	13	9	66%
M1-6	Total Non-Elective Admissions	15,841	14,786	1055	7%	15,204	637	4%
M1-6	NEL Admissions (under 18s) - UHS only	1,592	1,564	28	2%			
M1-6	NEL Admissions (18 - 64 yrs old) - UHS only	6,692	6,810	-118	-2%			
M1-6	NEL Admissions (65+ yrs old) - UHS only	5,644	5,110	534	10%			
M8	Long Stay Admissions - Number of Patients 21+ days	66				77	-11	-14%
M8	Long Stay Admissions - Number of Patients 50+ days	12						
M8	Long Stay Admissions - Number of Patients 100+ days	2						
M1-6	Permanent admissions to residential homes aged 65+	122	153	-31	-20%	132	-10	-8%
Q2	% of People with Learning Disabilities receiving a Physical Health Check	23	23	0	-1%	28	-5	-18%
Q2	Childrens Wheelchairs - 92% seen within 18 weeks by Q4	38	22	16	70%	63	-26	-40%
M7	CAMHS - 92% of routine assessments within 12 weeks (YTD)	95				92	3	3%
Q2	60% of people with an SMI receiving a full annual physical check	18				32	-14	-43%
M7	% of people experiencing psychosis will be treated within 2 weeks of referral	80	100	-20	-20%	57	23	39%
M6	% of adults open to LD social care team who have had a Care Act assessment/review in the past 12 mths.	32	29	3	9%			
M6	Number of new Enhanced Health in Care Homes	18				18	0	0%
M6	% of clients in rehab/reablement who do not need ongoing care	50	49	1	1%			

Summary

DTOC - main issues affecting performance are:
- Overall increased complexity of patients: Actions to resolve include Bespoke work is carried out to support complexity and secure complex care, community OT in-reach to hospital to joint assess patients and greater consideration of how equipment and care technology could support people in the community to reduce levels of dependencies
- Discharge and community provision: trusted assessors are ongoing training to support Pathway 1, more investment in pathway 2 to increase reablement and invested in home care to increase capacity
- Hospital processes: UHS is developing an action plan to create greater consistency in hospital and CCG quality team are working with UHS to develop reporting to encourage grater transparency
- Community resource pre admissions - commissioners are working with Providers to become more preventative, community clusters are working with voluntary sector to develop 'social prescribing'

% with LD receiving a Physical Health Check - the annual target is 75% and the majority of checks are usually carried out in Q4 (>40% of checks carried out last year)

NEL Admissions -Unprecedented demand is continuing into 2019. Commissioners and UHS are currently investigating the causes of the increased activity, with a view to developing actions and mitigations. There is no one area or issue that is driving the increases. Investigation will continue through the Finance and Information Group, which reports to the UHS Performance Board. Additional activity is being experienced across a number of systems and indeed nationally. Over 65 year old admissions are particularly high - there is some concern that new SDEC pathways are resulting in more people now being coded as inpatient admissions

SMI full annual physical check - this is going to be an extremely challenging indicator to hit and partly reliant on practices signing up to the enhanced service, a number declined this year. We will be reviewing the offer to practices as well as exploring development of new HCA role to engage those not attending annual health check with possible point of care testing kits.

Wheelchairs - Performance management of the current contract was strengthened in April 2019 through revised KPIs to (a) allow the full review of the patient pathway to improve understanding and identify improvement areas in a more responsive manner, and (b) set clear and achievable targets to enable commissioners to accurately hold the provider to account for any performance issues. This has provided commissioners with a better understanding of where the challenges are within the service - the greatest challenge being clinical resource to undertake triage, assessment and handover. Commissioners, including quality representatives formally meet with the provider on a monthly basis to review performance and the quality scorecard. Commissioners also receive individualised updates for all long waiters and will scrutinise the list and identify areas for challenge at CRM. Outside of the contractual process, commissioners have also instigated meetings between Millbrook, SHFT and Solent to provide an opportunity to raise any patients of concern and agree action.

b. Prevention and Early Intervention

RAG Summary	Last Yr	Target
Green	4	4
Amber	2	0
Red	3	0
n/a	0	5

			Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M1-7	Falls (65+) & Fraity (75+) Short Stay Admissions (over 65s) <24hr	1051	952	99	10%			
Q2	IAPT - % with common mental health conditions accessing IAPT	10.4	8.4	2.01	24%	10.1	0.3	3%
Q2	IAPT - % who complete IAPT moving to recovery	50	52	-2	-3%	50	0	0%
M7	% LARC (all 4 methods) at Integrated Sexual Health Service (YTD)	44	35	10	28%	35	9	27%
M7	% of HIV tests completed as part of an STI screen (YTD)	85	79	6	7%	75	10	13%
Q2	% of pregnant women who cease smoking time of delivery (YTD)	18.3	18.7	0	-2%			
M7	Alcohol - % of all clients completing and not re-presenting	31.9	25.8	6	24%			
M7	Opiates - % of all clients completing and not re-presenting	3.7	6.7	-3	-45%			
M7	Non-opiates - % of all clients completing and not re-presenting	27.4	30.5	-3	-10%			

Summary

Falls – awaiting confirmation of a new QIPP Target to also include frailty. Work is ongoing to improve this including work with UHS & Solent to further integrate Fracture Liaison Service with Community Independence Team. Opportunities have been identified to increase efficiency in pathway and a business case for investment has been approved to take forward service development in the following areas.

- Pilot commenced on 1 May offering a 6 month Community Alarm (Gold) and Telecare service to patients with a falls risk and socially isolated. Approx 40 referrals by July
- To improve the identification and management of patients who have a falls risk, 3 practices have piloted the Keele University Tool with aim to roll out to city in Autumn
- Additional Investment into Community Independence Team (5WTE) to reduce waiting times to meet service specification targets
- Procurement of new exercise provider. Saints Foundation to commence new contract from 1st October
- Development of providing Community Transport SCiA) from ED, discharging to care of charity with follow up visits from Homecoming Service (Commnicare) to commence in Sep
- URS clinician in SCAS call desk to support call handlers in diverting to more appropriate community pathways that avoid hospital conveyance - went live beginning August

Substance Misuse -The new Substance Use Disorder Service contracts commenced on 1st of July 2019. This data reports the proportion of all people in treatment, who successfully completed treatment and did not re-present within 6 months. The figures presented in this table evidence activity from our previous contracts / system i.e. Successful completions that took place between the beginning of April 2018 until the end of March 2019 and Re-presentations up to the end of September 2019.
It is positive to note the improvement in performance for people with a primary alcohol use disorder, particularly, as this improvement has been made in line with a significant (87%) increase in the number of people with an alcohol concern accessing treatment and support over the same period. Commissioners are aware of the poorer performance for other cohorts and have been working jointly with the provider, an improvement plan is in place and this work is being overseen by Commissioners and CGL Directors. CGL are working on their improvement plans and delivering the service during a time of change. The service is working towards an improvement trajectory that will take some time to see performance fully recover to historical levels and matching our LA comparator performance levels.

c. Commissioning Safe & High Quality Services

RAG Summary	Last Yr	Target
Green	3	2
Amber	0	0
Red	2	2
n/a	0	0

			Previous Year			Target		
Period	Indicator	Actual	18/19	+ / -	%	Target	+ / -	%
M7	≥85% of CHC assessments taking place in an out of a hospital setting	93	85	8	9%	85	8	9%
M7	≥80% of Full CHC assessments completed within 28 days	55	85	-30	-35%	80	-25	-31%
M1-8	<44 cases of Healthcare Associated Infections (Community): Cdiff (cumulative)	16	21	-5	-24%	18	-2	-11%
M1-8	Zero cases of Healthcare Associated Infections (community): MRSA (cumulative)	1	2	-1	0%	0	1	0%
M7	% of Providers with a CQC Rating of good or above published in month (cumulative)	68	80	-11	-14%			

Summary

CHC Assessments within 28 days - To some extent the reduction in CHC reviews being reported in the data is a result of the change in our reporting system at the start of the 2019/20 year as we moved from CONI/QA+ to CHS/Care Track. The move to a new system has caused some data quality issues which we think has initially resulted in an under-reporting of our actual review activity but is also picking up some flaws in the previous system's data accuracy. The CHC team are working to ensure we have an accurate picture of the CHC reviews currently overdue and the review schedule for the patients that have been reviewed and will be working to ensure we have an action plan for any backlog to ensure we are back on track for achieving our 80% reviews due and completed target.

Care Home Beds - More than 95% of care home beds in Southampton are rated good by CQC

d. Managing and Developing the Market

RAG Summary	Target	Last Yr
Green	5	5
Amber	0	0
Red	1	0
n/a	0	1

			Previous Year			Target		
Period	**Indicator**	**Actual**	**18/19**	**+ / -**	**%**	**Target**	**+ / -**	**%**
Q1	≥90% contract reviews on schedule	95	92	3	3%	90	5	6%
M7	Care Placement - ≥90% placements are sourced via Team	93	81	12	15%	90	3	3%
M7	Avg days from referral received to placement start date (Home Care)	9	20	-11	-57%	14	-6	-39%
M7	Avg days from referral received to placement start date (Res/Nursing)	8	5	3	46%	14	-6	-44%
M7	Total number of home care hours purchased per week	23,094	22,598	496	2%			
M7	% Home Care clients using a non framework provider	19	22	-3	-14%	20	-1	-4%

Summary

4. High Level Risks/Issues to achieving project/programme delivery

Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Delayed transfers of care	Increasing complexity of clients will increase DTOC resulting in failure of plans, BCF targets and QIPP savings and this could compromise quality of care and outcomes for clients	V High	DC	DTOC remains a high priority and is closely monitored. Main challenges remain: o increasing levels of complexity amongst patients being discharged. There has been a strong push within the hospital to discharge patients earlier with higher levels of need which are more difficult to meet. o workforce capacity in the domiciliary care market particularly to support higher levels of need e.g. requiring calls at specific times or double up calls 3 or 4 times a day. o nursing home capacity to take more complex clients o increased requirement for housing adaptations and equipment to enable people to return home, which is resulting in increased spend on the Joint Equipment Service budget o people with low level health needs which are not specialist but require care staff to administer basic clinical tasks e.g. PEG feeds, collar care, eye drops. DTOC Peer Review organised by LGA took place on 30 April and has identified the following key actions which have been implemented: - Strengthening senior oversight and leadership by ensuring that there is a regular focus on DTOC performance at the monthly Better Care Steering Board meetings - there are now weekly Exec calls in place as well - Strengthening reporting processes and accountability so that on any one day performance can be tracked against each of the 3 discharge pathways (“simple” which is the responsibility of the hospital; “supported” which is the responsibility of Rehab and Reablement and “enhanced/complex” which is the responsibility of the IDB) - Organisation of a system wide workshop for 21 June with Hampshire colleagues to take a fresh look at the 8 High Impact Change Model for improving discharge and flow and identify key improvement areas for focus - following this a revised action plan is now in place Recent actions include: - further extension of the dom care retainer with a specific focus on facilitating timely discharge and working with URS to reduce extensions and thereby free up capacity in reablement - Roll out of low level health needs care (with the exception of diabetic care) which will start from Sept - plans to recruit an OT to review double up care with a view to freeing up capacity - budget issued to IDB to provide dedicated transport and other support to facilitate discharge e.g. deep cleans, handyman

KEY: SR - Stephanie Ramsey, DC - Donna Chapman, CB - Carole Binns, CA - Carol Alstrom, CP - Chris Pelletier

Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Make Care Safer	There is a risk that the sustainability of high quality Mental Health services in the City via Southern Health Foundation Trust (SHFT) and Solent NHS Trust will not be maintained	High	CA	CAMHS waiting times for first contact showing improvement, in July only one child waiting past 12 weeks. Southern Health have significant workforce challenges which is impacting on bed availability and opening of the Crisis lounge and S136 suites. Detailed recruitment and retention plan being implemented. Higher use of bank and agency staff who do not have direct access to recording systems - new leadership team are addressing this. Serious incident on Saxon Ward. External thematic review of whole of Antelope House Transfer of Eastleigh Southern Parish patients from the East Community Mental Health Team taken forward. Evidence that caseloads are now starting to reduce. Autism Services waiting list improvement now slowing due to increased referrals; further investigation underway The risk in relation to staffing continues at Antelope House, impacting on bed availability and opening of Crisis Lounge, and recent leadership changes have led to a further period of instability. Higher use of bank and agency staff, improvement in direct access to recording systems . Older Persons Mental Health service has recruitment challenges which may impact on bed capacity SHFT Contract Review meeting in July 2019 changed to a focused meeting on Antelope House staffing concerns ,to review again and ascertain the impact of actions being taken. Specific Workforce Clinical Quality Review Meeting (CQRM) was held with SHFT in September 2019. Overall assurance was provided around the strategic activity being undertaken across the Trust. Serious incident on Saxon Ward, external thematic review ongoing. Southern have CQC unannounced visit in November Solent NHS Trust CAMHS have recruitment challenges. Most providers have elements of challenge with recruitment of specialist roles. Retention and recruitment plans are being implemented and monitored for impact

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Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Wheel Chair Service	Waiting lists - financial, clinical and reputational risk. Risk of long waiting lists - leading to individuals at risk of harm in delay in service and reputation	V High	DC	This remains a key area of concern. Over the course of this year, referrals have remained higher than expected and we have seen an increase in the proportion of medium level need referrals and a corresponding reduction in low level need, signifying that complexity is increasing. Average waiting times remain high - 30 wees for adults and 21 weeks for children. Whilst this is not acceptable, it should be noted that this is a national issue primarily linked to challenges around recruitment and retention of clinical staff within wheelchair services. Actions that Millbrook are taking to improve performance include: - Increased operating hours of the customer service team (8-8) to improve appointment booking - enhancing availability of standard stock within the depot - Utilising equipment reps and additional clinic resource to improve & increase handover in clinic numbers - Collaboratively reviewed the service's eligibility criteria with clarified criteria went live in December 2018 - Undertaken a review of school clinic provision which has included engagement with children, parents, schools and school therapists. Recommendations arising from this review have been implemented and the first school clinic was held on 22nd January. -Wheelchair assessment & prescriber training for community therapists to increase the number of direct issue chairs and reduce unnecessary assessments for service users. Both Southern and Solent have taken up this offer and training took place in May. However uptake has been low owing to the low numbers of lower complexity patients that the community therapists see. We are therefore exploring the potential to train community therapists to directly prescribe equipment for patients with medium level complexity. - Children's waiting list initiative which commenced in March 2019 - however the service has struggled to recruit additional capacity to this resource because of the national shortage of wheelchair therapists and so impact has been limited. Performance management of the current contract was strengthened in April 2019 through revised KPIs to (a) allow the full review of the patient pathway to improve understanding and identify improvement areas in a more responsive manner, and (b) set clear and achievable targets to enable commissioners to accurately hold the provider to account for any performance issues. This has provided commissioners with a better understanding of where the challenges are within the service - the greatest challenge being clinical resource to undertake triage, assessment and handover. Commissioners, including quality representatives formally meet with the provider on a monthly basis to review performance and the quality scorecard. Commissioners also receive individualised updates for all long waiters and will scrutinise the list and identify areas for challenge at CRM. Outside of the contractual process, commissioners have also instigated meetings between Millbrook, SHFT and Solent to provide an opportunity to raise any patients of concern and agree action. In response to the workforce challenges, Millbrook are undertaking the following: - introducing a new staffing model - exploring whether therapy support can be brought in from other contracts - approaching suppliers for additional capacity - targeting locums outside the area with an agreed pay package to cover travel and accommodation costs - recruiting into apprenticeships - improved recruitment system

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Project / Programme	Description of Risk/Issue	Rank	Owner	Proposed Mitigation / Resolution
Dom Care	Risk that dom care market is unable to keep pace with increasing demand resulting from growing complexity (e.g. more QDS double up clients) and strategic drive to keep people independent. Risk of provider exits from the market adding to challenge around capacity. This is key system enabler and where there are sustainability, capacity and quality issues this impacts on patient choice, quality of care to clients, DTOC, use of residential care and ability to support other priority work areas such as the expansion of extra care housing	Moderate	CB	Action plan developed to address both short-term and long-term requirements has been implemented and has resulted in improvement. The new framework has increased capacity and additional hours are purchased from a 'retainer service' which provides rapid access and responds to peak need. The potential for short-term exits is a constant risk but the process for dealing with this is now well established and we also continue to see strong interest from new providers in entering the care market in Southampton, either through joining the framework or acting as a spot provider. The new framework allows an annual re-opening to encourage new entrants to the market and ensure any potential loss in capacity is mitigated. Whilst there remains high risk due to this market fragility and increasing complexity/demand , this is well managed through the action plan which is updated as the situation changes. . The establishment of 'lead provider' roles across the 5 areas in the city and provides a platform for further developmental work and sustainability in the city.These lead organisations are in strong position with both capacity and recruitment and are able to take on additional packages of care, reflected in the placements waiting list numbers being lower. However, we are mindful that although we are in a stronger position we need to be always alert to seasonal peaks and trends.

KEY: SR - Stephanie Ramsey, DC - Donna Chapman, CB - Carole Binns, CA - Carol Alstrom, CP - Chris Pelletier

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Better Care Southampton
working together to make a difference

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MINUTES

Meeting: **Better Care Southampton Steering Board on 25 September 2019 In the Seminar Room, Oakley Road, Ground Floor**

Present:

Dr Mark Kelsey (Chair)	Southampton City CCG Chair	SCCCG
Jo Pinhorne (JP)	Operations Director – Adults Southampton	Solent
Sarah Turner (ST)	Better Care Southampton Programme Lead	BCS
Jo Ash (JA)	Chief Executive	SVS
Stephanie Ramsey (SR)	Director of Quality and Integration / Interim Director of Adult Social Services	SCCCG / Southampton City Council
Jane Hayward (JH)	Director of Transformation	UHS
Dr Nigel Jones (NJ)	Locality Lead / GP	East Locality
Dr Fraser Malloch (FM)	Primary Care Network (PCN) Clinical Director / GP	Central PCN
Matt Stevens (MS)	Lay Member	SCCCG
Donna Chapman (DC)	Associate Director System Redesign	SCCCG
David Noyes (DN)	Chief Operating Officer	Solent / UHS
Dr Nicola Robinson (NR)	Locality Lead / GP	Central Locality
Julia Watts (JW)	Locality Lead	East Locality
Naz Jones (NJ)	Locality Lead	East Locality

In attendance:

Tom Sheppard (TS)	Head of Communications	SCCCG
Phil Aubrey-Harris (PAH)	Associate Director of Primary Care	SCCCG
Dan King (DK)	Service Lead – Intelligence and Strategic Analysis	SCC
Georgina Cunningham (GC)	Commissioning Manager	SCCCG

Apologies:

Dr Sara Sealey (SS)	Locality Lead / GP	East Locality

Item	Subject	Action
1.	**Welcome and apologies**	
	MK welcomed everyone to the meeting. Introductions were made and apologies for absence were noted, as above.	
2.	**Declarations of Interest** *A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship*	

	No declarations of interest were made to any items on the agenda.	
3.	**Minutes of the Previous Meeting and Matters Arising**	
	The minutes of the Better Care Southampton Steering Board on 28th August 2019 were approved.	
4.	**Communications strategy and plan**	
	Tom Sheppard presented an update Final agreement reached on a Communications support post to be hosted via CCG, fixed term until March 2020. Action plan approved by Board which identifies key areas for focus. This will be a framework for all Communications teams to be able to understand priorities. **Action – TS to circulate plan to all Communications leads.** Virtual Communications team across all organisations is not as effective as could wish for due to conflicting priorities and changing posts. **Action – all to flag Better Care as a priority with Communications leads.** This is not necessarily extra work but provides an ability to brand work already underway Draft strategy to be developed as a priority and getting the "message" out about Better Care work. **Action: TS to co-ordinate the development of the draft strategy** **Action: Monthly communications update to the Board**	 **TS** **TS** **TS**
5.	**Southampton Data Observatory**	
	Demonstrated by Dan King for information, please see attached presentation. It is an interactive tool that is continually refreshed. It is broken down into locality and practice health profiles as well. Not practice identifiable to public but the file is to be shared with practices so they can see it as this level of detail – Sarah Turner working with Dan King on this currently. FM queried if there could be progress towards a Primary Care Network (PCN) focus as well, need to identify what will be most helpful. MK raised link with Sustainable Transformation Programme (STP) wide work as	

	well, such as the system population health management tool being developed. Need to ensure linkages between types of data, how it is broken down, and how it is analysed. **Action: potential to use the existing data group to provide oversight. Dan King to facilitate** Action plans from localities may highlight additional data needs JA proposed city wide briefings to inform local communities and help them to understand the challenges to be able to develop their own responses and actions.	**DK**
6.	**Update on Primary Care Network (PCN) Development**	
	Update by Phil Aubrey-Harris. Keen to establish regular engagement with PCNs and Clinical Directors regarding: • commissioning and the implementation of Long Term Plan and the 5 year Health and Care framework, for example in the development of specifications. • PCN Organisational Development (OD), e.g. Julia Bowey's work to support PCNs to develop plans to access STP funding. • co-production of local commissioning plans – strategy / or more specifically Local Improvement Scheme (LIS) schemes (Nov) NHS England (NHSE) currently working with relevant stakeholders nationally to develop draft specs. These will be shared in the "Autumn" hopefully with some opportunity to feed into them, then national negotiations and published in February. Areas expected to be: • Structured medication reviews / optimisation • Enhanced Health in Care Homes (EHCH) • Anticipatory care • Personalised care • Early cancer diagnosis • CVD prevention & diagnosis – 2021 • Tackling Inequalities – 2021 Needs to be recognised that areas are not commissioning into a vacuum of as much work already underway. There will be Network Dashboard - minimum reporting requirements for the specifications to allow monitoring / benchmarking. There will be an Impact and Investment fund April 2020 with a	

	focus on reducing non elective admissions and on impact on Emergency Department targets. CCG very interested and keen to explore opportunities with PCNs PAH outlined CCG plans for Primary Care estates and access review which is commencing on the East of the City from now until March 2020.	
7.	**GP forum on PCN's and Better Care**	
	To be held Ageas Bowl, 5.30-8pm 1/10/19 – all Board invited. MK outlined agenda. Most of the session will concentrate on discussion in locality groups on what help PCN's and GPs need and what should be prioritised. Ideal opportunity to be using social media tools at the event **Action: SR to identify a Communications rep for the event**	**SR**
8.	**Feedback from High Intensity Users (HIU) Workshop**	
	Georgina Cunningham presented verbal update on workshop session. Good to collate issues and share information. Cross reference of HIU data – found 82 not already on a scheme out of the 200 reviewed. Needs further development of outcomes and actions. Primary care have own HIU work as well so need to consider how this can be addressed as a system. There is to be another workshop which will be widened to consider HIU in primary care and also include voluntary sector and So-Linked. Issues identified included the need for better communications between UHS and primary care. MK identified problem for practices in gaining access to plans held by UHS. Need better use of CHIE to improve information sharing. **Action: MK to follow up** Need for more protected time for clinicians to plan better with these individuals and a greater focus on earlier identification. **Action: DC to flag with JH re need to look at resourcing of A&E consultant to be able to continue to prioritise this work.**	**MK** **DC**
9.	**Workforce Update**	
	Sarah Turner provided an oversight of workshop held with representation from all organisations.	

	Initial analysis shared which reviewed the features of the workforce across providers in each locality. The Workforce group is developing actions to consider at November meeting. **Action: Workforce to return as agenda item**	**ST**
10.	**Age well subgroup**	
	Chris Sanford provided an update. Age Well group is drawing together strands re frailty. Developed a model – 4 tiers, working to understand flows of patients and avoid fragmentation. Priority to consider how SDEC and URS can work more together and be more community orientated. Looking at how to develop integrated care teams across the city and achieve dementia assessments working as single multi-disciplinary team. **Action: CS to increase PCN representation on Age Well group** Age well work programme was reviewed and supported. Stratification – agree as a principle SO suggested opportunity to consider proactive and reactive models from elsewhere, for example within Southern health and partnership with SCAS. Need to simplify system and description – risk being "victim of success" with many successful teams and initiatives but need multiple providers to work as one. Need to solve duplication and overlap, building on what we have got, by engaging with front line staff on how this works. Proposal to hold a workshop for staff in each locality to consider how to achieve this and identify what works best for each area as it won't be one size fits all. **Action: Agreed to use principle of subsidiarity – to do as much local level as practical.** Need to socialise the model with localities/PCN's. **Action: CS and Age Well group to attend localities/PCN meetings.**	**CS** **ST/CS** **CS**
11.	**RAID Log**	
	Risk and issues were noted	
12.	**Any Other Business**	
	None were raised.	

13.	**Close**	
	Meeting closed at 11:10.	
Date of next meeting: Wednesday 30 October 2019, Seminar Room, NHS Southampton City CCG, Oakley Road, Millbrook, Southampton, SO16 4GX		