Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 21st June, 2012
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 and 4 - Civic Centre

This meeting is open to the public

Members

Councillor Parnell
Councillor Baillie
Councillor Jeffery
Councillor Lewzey
Councillor McEwing
Councillor Pope (Chair)
Councillor Tucker

Contacts
Karen Wardle
Democratic Support Officer
Tel: 023 8083 2302
Email: karen.wardle@southampton.gov.uk

Caronwen Rees
Policy & Performance Analyst
Tel: 023 8083 2524
Email: Caronwen.rees@southampton.gov.uk

PUBLIC INFORMATION

Southampton City Council's Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

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

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

Public Representations

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.

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

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

Dates of Meetings: Municipal Year 2012/13

2012	2013
21 June 2012	24 January 2013
16 August	29 March
11 October	
29 November	

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the Audit Committee are contained in Article 8 and Part 3 (Schedule 2) of the Council's Constitution.

Business to be discussed

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

Rules of Procedure

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

Quorum

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

Disclosure of Interests

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

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Personal Interests

A Member must regard himself or herself as having a personal interest in any matter

(i) if the matter relates to an interest in the Member's register of interests; or

(ii) if a decision upon a matter might reasonably be regarded as affecting to a greater extent than other Council Tax payers, ratepayers and inhabitants of the District, the wellbeing or financial position of himself or herself, a relative or a friend or:-

  (a) any employment or business carried on by such person;

  (b) any person who employs or has appointed such a person, any firm in which such a person is a partner, or any company of which such a person is a director;

  (c) any corporate body in which such a person has a beneficial interest in a class of securities exceeding the nominal value of £5,000; or

  (d) any body listed in Article 14(a) to (e) in which such a person holds a position of general control or management.

A Member must disclose a personal interest.

Continued/……

Prejudicial Interests

Having identified a personal interest, a Member must consider whether a member of the public with knowledge of the relevant facts would reasonably think that the interest was so significant and particular that it could prejudice that Member's judgement of the public interest. If that is the case, the interest must be regarded as "prejudicial" and the Member must disclose the interest and withdraw from the meeting room during discussion on the item.

It should be noted that a prejudicial interest may apply to part or the whole of an item.

Where there are a series of inter-related financial or resource matters, with a limited resource available, under consideration a prejudicial interest in one matter relating to that resource may lead to a member being excluded from considering the other matters relating to that same limited resource.

There are some limited exceptions.

Note: Members are encouraged to seek advice from the Monitoring Officer or his staff in Democratic Services if they have any problems or concerns in relation to the above.

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

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

1 ELECTION OF VICE-CHAIR

To appoint a Vice-Chair to the Scrutiny Panel for this Municipal Year.

2 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

3 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

In accordance with the Local Government Act, 2000, and the Council's Code of Conduct adopted on 16th May, 2007, Members to disclose any personal or prejudicial interests in any matter included on the agenda for this meeting.

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

4 DECLARATIONS OF SCRUTINY INTEREST

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

5 DECLARATION OF PARTY POLITICAL WHIP

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

6 STATEMENT FROM THE CHAIR

7 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 29 March 2012 and to deal with any matters arising, attached.

8 SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY COMMITTEES: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION

Report of the Senior Manager, Customer and Business Improvement, seeking agreement to the arrangements for assessing substantial change in NHS provision, attached.

9 UPDATE FROM JOINT SEMINAR RE VASCULAR SURGICAL SERVICES

Report of the Chair of Health Overview and Scrutiny Panel, seeking to facilitate a locally negotiated solution to the future of vascular services which is both sustainable and achieves the best outcomes for patients, attached.

10 HEALTH AND SOCIAL CARE ACT - KEY IMPLICATIONS FOR LOCAL AUTHORITIES

Report of the Executive Director of Health and Adult Social Care, seeking to identify any issues for discussion at future meetings, attached.

11 SOUTHAMPTON CLINICAL COMMISSIONING GROUP ANNUAL PLAN AND PRIORITIES

Report of the Deputy Director, Southampton Clinical Commissioning Group, giving details of the priorities for the forthcoming year, attached.

12 SOUTHERN HEALTH NHS FOUNDATION TRUST ANNUAL PLAN AND PRIORITIES

Report of the Financial Director, Southern Health NHS Foundation Trust, seeking comments on the current services and vision for future services of Southern Health NHS Foundation Trust, attached.

13 SOLENT NHS TRUST ANNUAL PLAN AND PRIORITIES AND FOUNDATION TRUST CONSULTATION

Report of the Director of Strategy, Solent NHS Trust, giving details of priorities for the forthcoming year and seeking a response to the consultation, attached.

14 UNIVERSITY HOSPITAL SOUTHAMPTON ANNUAL PLAN AND PRIORITIES

Report of the Director of Nursing, University Hospital Southampton, giving details of priorities for the forthcoming year, attached.

Wednesday, 13 June 2012 HEAD OF LEGAL, HR AND DEMOCRATIC SERVICES

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 29 MARCH 2012

Present: Councillors Capozzoli (Chair), Parnell (Minute no's 26-31), Payne, Thorpe, Turner and Willacy

Apologies: Councillors Daunt

26. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

Apologies were received from Councillor Daunt. The Panel noted that Councillor Willacy had been appointed as a new Member of the Panel to replace Councillor Fitzgerald who had stood down from the Committee in accordance with Council Procedure Rule 4.3.

27. **STATEMENT FROM THE CHAIR**

The Chair reported that he was not standing for re-election in May and it was therefore his last meeting. He expressed his thanks and appreciation to Caronwen Rees, Policy and Performance Analyst for her hard work and support over the time he had been Chair to the Panel.

Councillor Parnell expressed his thanks to Councillor Capozzoli for his Chairmanship to the Panel. This was endorsed by the other Panel members.

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

RESOLVED that the Minutes of the Meeting held on 19th January 2012 be approved and signed as a correct record, subject to an amendment to paragraph no 21, "Adult Mental Health Redesign" to include a further recommendation, "that the Panel requested details of how the governors had been involved in the consultation process" which had been omitted from the minutes.

29. **WOODSIDE LODGE RESIDENTIAL HOME**

The Panel received and noted the report of the Cabinet Member for Adult Social Care, providing an update on the implementation of actions following an inspection by the Care Quality Commission of Woodside Lodge Residential Home. (Copy of the minutes circulated with the agenda and appended to the signed minutes)

The Panel received an update from Councillor White and Jane Brentor, Head of Provider Transformation.

It was reported that an action plan had been developed to resolve the issues raised as a result of the Care Quality Care (CQC) inspection. CQC had agreed that the Home had sufficiently addressed 3 out of 4 outcomes. The fourth outcome was almost compliant. The care plans for patients had been expanded and were more thorough to include the patients' background and history in order to assist staff understand the behaviour of the residents and adopt appropriate methods for working with them. This practice had been shared among other care homes.

The Panel questioned whether robust training was in place. They were assured that high quality training was provided and that robust systems had been put in place to identify and address any problems or issues that arose.

30. **UPDATE ON VASCULAR SERVICES**

The Panel considered the report of the Executive Director of Adult Social Care and Health and associated appendices, updating the Committee on vascular services since January. (Copy of the report circulated with the agenda and appended to the signed minutes)

Sarah Tiller, SHIP PCT Cluster was present and reported that since the last meeting of the Panel a decision had been taken to maintain the status quo of vascular services. A new vascular Services Monitoring Framework had been produced and would be completed on a routinely basis by the providers to ensure that safe, high quality services were delivered. The information would be reviewed by commissioners and considered by the SHIP PCT Cluster's Clinical Governance Committee. A Patient Reference Group had been established which included representatives from Southampton, Portsmouth and South Eastern Hampshire. The group would share patient feedback with the Clinical Governance Committee so that it would form part of the ongoing monitoring process. Action would be taken if reporting against the Framework gave reason for concern.

It was acknowledged that the statistics and data provision had been considered to be confusing, particularly when published by a number of different sources, often covering different time periods and different measures. The Chair of HOSP and LINK were offered a meeting to talk through the data which had been in the public domain. This would be supported by an independent vascular expert.

The Panel were extremely disappointed that it had taken so long to make a decision to maintain the status quo. The Panel were not convinced that this was the best outcome. It was noted that Hampshire had proposed an independent review. It was requested that a negotiated solution be sought and if this was not forthcoming they would support an expert led independent review.

Harry Dymond on behalf of LINK supported the approach proposed by the Panel.

RESOLVED

(i) that an urgent letter be sent to SHIP PCT Cluster from the Panel detailing the following:
- the Panel's disappointment that a decision had been taken to maintain the status quo of services and that it was felt this was not the best outcome;
- that a locally negotiated solution was sought; and
- that if a local solution which achieved the best outcomes could not be agreed, the Panel would not rule out exploring other options available to them;

(ii) that the offer by the SHIP PCT Cluster of a meeting to discuss statistics and data provision be accepted.

31. **PUBLIC HEALTH ANNUAL REPORT 2011**

The Panel received and noted the report of the Director of Public Health for the Panel to note the Public Health Annual report 2011. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received an update from Andrew Mortimore, Director of Public Health and Graham Watkinson, Public Health Consultant.

The main points from the report and update included the following:

- The Public Health Annual report 2011 had been agreed by the Board of the Southampton Clinical Commissioning Group on 28 March 2012;
- The report covered the following main headings:
    - The new public health system for England
    - Southampton's health … a changing picture
    - Lung health
    - Suicide
    - Health impacts of cold homes and fuel poverty
    - Progress on recommendations
- Lung health: The primary cause of lung disease was through smoking however it was also caused by pollution and occupational exposure;
- It was reported there would be a campaign on lung health to raise awareness of the issue and encourage early identification. Easier access to lung function testing was also being investigated;
- Suicide: It was reported that often suicide was related to the work life balance and the feeling of lack of power to change things. On average there were 26 suicide deaths in Southampton per year. There had been 6 reported suicide deaths in Southampton in the last 6 weeks;
- Data on suicide was not robust enough and that more detailed information was required from the coroner regarding the classification of death;
- Cold homes / fuel poverty: 18% of the population suffer from fuel poverty which put an additional burden on the health service. This had increased significantly in recent years.

The Panel expressed concern regarding the lack of action on the recommendations proposed in previous years. It was reported that some recommendations may not have been costed or mapped out how they could be addressed. There was a need to be more accountable to the recommendations in the future.

32. **ADULT MENTAL HEALTH REDESIGN UPDATE ON ABBOTTS LODGE TRANSFER**

The Panel considered the report of the Head of Engagement, Southern Health NHS Foundation Trust, providing the Committee with an update on the relocation of services from Abbotts Lodge, Netley Marsh to Antelope House on the Royal South Hants Hospital site. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received an update from Pam Sorensen, Head of Engagement, Southern Health NHS Foundation Trust.

The main points arising from the report and update included the following:

- Patients were transferred to Antelope House on 19 March 2012. The move had been successful and that no issues had arisen as a result of the move;
- Governors had been briefed on the move via emails and through meetings and engagement events. A task group had been established, chaired by a governor regarding the proposed move;

- Monitoring would be carried out to ensure there were consistent outcomes through Care Quality Care (CQC) inspections and the involvement of LINK. CQC would be supported by Healthwatch when it was established. Robust systems were in place and the commissioners would ensure that the right thing was carried out at the right time.

Joe Hannigan, Southampton Local Involvement Network was present and with the consent of the Chair addressed the meeting. He asked whether there had been any negative effect as a result of the increased patient mix at Antelope House following the integration with Abbotts Lodge patients.

RESOLVED

(i) to note the successful transfer of clients and the service from Abbotts Lodge to Antelope House;

(ii) that the Panel requested a response to the question from Joe Hannigan regarding the impact (on either client group) as a result of the increased patient mix at Antelope House.

DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY COMMITTEES: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION
DATE OF DECISION:	21 JUNE 2012
REPORT OF:	SENIOR MANAGER, CUSTOMER AND BUSINESS IMPROVEMENT
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This paper seeks the agreement of the new Health Overview and Scrutiny Panel (HOSP) to the existing framework for assessing substantial change in NHS service provision across the SHIP region.

RECOMMENDATIONS:

(i) The Panel agree the Arrangements For Assessing Substantial Change in NHS Provision as previously agreed by HOSC's and providers across the SHIP region.

REASONS FOR REPORT RECOMMENDATIONS

1. To agree a consistent way of working across the SHIP region in relation to health scrutiny arrangements.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. The framework will be update early in 2013 to reflect the changes in health structures that will come into place at this time.

DETAIL (Including consultation carried out)

3. The purpose of this document attached at appendix 1 is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Authority areas. It describes the actions and approach expected of both the NHS and Local Authority Health Overview and Scrutiny Committees (HOSCs) when proposals that may constitute substantial service change are being developed and outlines the principles that will underpin the discharge of each parties' role and responsibilities.

4. This framework was previously agreed across the HOSCs and all local NHS organisations in the SHIP area with advice and support of the Independent reconfiguration Panel. The purpose of this paper is to seek the agreement of the new HOSP to the principles set out in the document.

RESOURCE IMPLICATIONS

Capital/Revenue

None

Property/Other

None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

AUTHOR:	Name:	Caronwen Rees	Tel:	023 8083 2524
	E-mail:	Caronwen.rees@southampton.gov.uk		

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY COMMITTEES: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION.
2.	

Documents In Members' Rooms

1.	
2.	

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

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

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	
2.	

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Southampton, Hampshire, Isle of Wight and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS provision.

Purpose and Summary

1) The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Authority areas.

2) It describes the actions and approach expected of both the NHS and Local Authority Health Overview and Scrutiny Committees (HOSCs) when proposals that may constitute substantial service change are being developed and outlines the principles that will underpin the discharge of each parties' role and responsibilities.

3) The document refreshes the 'Framework for Assessing Substantial Service Change' originally developed with advice from the Independent Reconfiguration Panel (IRP) and updates the guidance relating to the key issues to be addressed by the NHS when service reconfiguration is being considered. Emphasis is placed on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit to our respective communities from doing so.

4) The legal duties placed on the NHS and the role of the HOSCs are included to provide a context to the dialogue that needs to be taking place between NHS organisations and the relevant HOSC(s) to establish if a proposal is substantial in nature.

5) It is intended that these arrangements will support:

   - Improved communications across all parties
   - Better co-ordination of engagement and consultation with service users carers and the public
   - Greater confidence in the planning to service change to secure improved outcomes for health services provided to communities across Southampton, Hampshire, the Isle of Wight and Portsmouth.

Background legislation

6) Section 242 of the NHS Act 2006 (formerly Section 11 of the Health and Social care Act 2001) places a statutory duty on commissioners and providers of NHS services to engage and involve the public and service users in :
   - Planning the provision of services
   - The development and consideration of proposals to change the provision of those services
   - Decisions affecting the operation of services.

7) This duty applies to changes that affect the way in which a service is delivered as well as the way in which people access the service.

8) Section 244 of the NHS Act 2006 (formerly Section 7 of the Health and Social Care Act 2001) places a statutory duty on commissioners and providers of NHS services to consult Local Authority HOSCs on any proposals for significant development or substantial variation in health services. NHS organisations will note that this duty is quite distinctive from the routine engagement and discussion that takes place with Local Authorities as partners and key stakeholders.

9) Significant development and substantial variation are not defined in the legislation but supporting guidance is clear that the NHS body responsible for the proposal should initiate early dialogue with the HOSC(s) affected by the proposal to determine:

   a) If the HOSC(s) consider that the change constitutes a significant development or substantial variation in service

   b) The timing and content of the consultation process.

10) Where it is agreed that the proposal does constitute a substantial change the response of the HOSC(s) to the subsequent consultation process will be shaped by the following considerations:

   a) Has the development of the proposal been informed by appropriate engagement and involvement of local people and those using the service. This should take account of the relevant equality legislation and be clear about the impact of the proposal on any vulnerable groups.

   b) The extent to which GP commissioners have informed and support the change

   c) The strength of clinical evidence underpinning the proposal and the support of senior clinicians whose services will be affected by the change.

   d) How the proposed service change affects choice for patients, particularly with regard to quality and service improvement

11) NHS organisations will also wish to invite feedback and comment from the relevant Local Involvement Networks (LINKs) which were established by legislation to facilitate the involvement of people using health and social care services in their area. The LINk has specific legal powers, including the ability to refer issues of concern to the HOSC(s) and to enter and inspect health and social care premises. Locally good working relationships exist with LINKs and HOSCs will normally expect evidence of their contribution to any proposals for varying health services from the NHS.

12) The framework attached at Appendix One identifies a range of issues that may inform both the discussion about the nature of the change and the response of the HOSC to the consultation process. The intention is that this provides a simple prompt for assessing proposals, explaining the reasons for the change and understanding the impact this will have on those using, or likely to use, the service in question.

13) The framework is not a 'blueprint' that all proposals for changing services from the NHS are expected to comply with. The diversity of the health economy across the SHIP area and the complexity of service provision need to be recognised, and each proposal will therefore be considered in the context of the change it will deliver. The framework can only act as a guide: it is not a substitute for an on-going dialogue between the parties concerned. It is designed for use independently by the NHS in the early stages of developing a proposal, or provide a basis for discussion with HOSCs regarding the scope and timing of any formal consultation required.

14) The development of the framework has taken into account the additional key tests for service reconfiguration set out by Sir David Nicholson in July 2010 and included in the revised operating framework for 2010-11.

15) Although it remains good practice to follow Cabinet Office Guidance in relation to the content and conduct of formal consultation HOSCs are able to exercise some discretion in the discharge of this duty. Early discussions with the HOCS(s) whose populations are affected by a proposal are essential if this flexibility is to be used to benefit local people.

16) Any request to reduce the length of formal consultation with the HOSC(s) will need to be underpinned by robust evidence that the NHS body responsible for the proposal has engaged, or intends to engage local people in accordance with Section 242 requirements. These require the involvement of service users and other key stakeholders in developing and shaping any proposals for changing services. Good practice guidance summarises the duty to involve patients and the public as being:

    a) Not just when a major change is proposed, but in the on-going planning of services

    b) Not just when considering a proposal, but in the development of that proposal, and

    c) In decisions that may affect the operation of services

17) All proposals shared with HOSCs by the NHS – regardless of whether or not they are considered substantial in nature - should therefore be able to demonstrate an appropriate consideration of Section 242 responsibilities.

18) Individual HOSCs will come to their own view about the nature of change proposed by the NHS. Where a proposal is judged to be substantial and

affects service users across HOSC boundaries the HOSCs concerned are required to make arrangements to work together to consider the matter.

19) Although each issue will need to be considered on its merits the following information will help shape the views of the HOSC(s) regarding the proposal:

a) The case of need and evidence base underpinning the change taking account of the health needs of local people and clinical best practice.

b) The extent to which service users, the public and other key stakeholders including GP commissioners have contributed to developing the proposal. Regard must be given to the involvement of 'hard to reach groups' where this is appropriate, including the need for any impact assessment for vulnerable groups.

c) The improvements to be achieved for service users and the additional choice this represents. This will include issues relating to service quality, accessibility and equity.

d) The impact of the proposal on the wider community and other services. This may include issues such as economic impact, transport issues and regeneration as well as other service providers affected.

20) This information will enable the HOSC(s) to come to a view about whether the proposal is substantial, and if so, whether the proposal is in the interest of the service users affected.

21) The absence of this information is likely to result in the proposal being referred back to the responsible NHS Board for further action.

22) If NHS organisations consider there is a risk to the safety or welfare of patients or staff then temporary urgent action may be taken without consultation or engagement. In these circumstances the HOSC(s) affected should be advised immediately and the reasons for this action provided. Any temporary variation to services agreed with the HOSC(s), whether urgent or otherwise, should state when the service(s) affected will reopen.

23) If the HOSC(s) affected by a proposal are not satisfied with the conduct or content of the consultation process, the reasons for not undertaking a consultation (this includes temporary urgent action) or that the proposal is in the interests of the health service in its area then the option exists for the matter to be referred to the Secretary of State. Referrals are not made lightly and should set out:

- Valid and robust evidence to support the HOSC(s) position

- Confirmation of the steps taken to secure local resolution of the matter.

Guiding Principles

24) The four HOSCs in Southampton, Hampshire, the Isle of Wight and Portsmouth have worked closely to build effective working relationships and share good practice.

25) HOSCs will need to be able to respond to requests from the NHS to discuss proposals that may be significant developments or substantial variations in services. Generally in coming to a view the key consideration will be the scale of the impact of the change on those actually using the service(s) in question.

26) Early discussions with HOSCs regarding potential for significant service change will assist with timetabling by the NHS and avoid delays in considering a proposal. Specific information about the steps (whether already taken or planned) in response to the legislation and the 4 tests outlined by Sir David Nicholson will support discussions about additional information or action required.

27) Some service reconfiguration will be controversial and it will be important that HOSC members are able to put aside personal or political considerations in order to ensure that for the scrutiny process is credible and influential. When scrutinising a matter the approach adopted by the HOSCs will be:

a) Challenging but not confrontational

b) Politically neutral in the conduct of scrutiny and take account of the total population affected by the proposal

c) Based on evidence and not opinion or anecdote

d) Focused on the improvements to be achieved in delivering services to the population affected

e) Consistent and proportionate to the issue to be addressed

28) It is acknowledged that the scale of organisational change currently being experienced in the NHS coupled with significant financial challenges across the public sector is unprecedented. Consultation with local people and the HOSC(s) may not result in agreement on the way forward and on occasion difficult decisions will need to be made by NHS Boards. In these circumstances it is expected that the responsible NHS Board will apply a 'test of reasonableness' which balances the strength of evidence and stakeholder support and demonstrates the action taken to address any outstanding issues or concerns raised by stakeholders.

29) If the HOSC(s) is not satisfied that the implementation of the proposal is in the interests of the health service in its area the option to refer this matter to the Secretary of State remains.

30) All parties will agree how information is to be shared and communicated to the public as part of the conduct of the scrutiny exercise.

Appendix One

Key questions to be addressed

Each of the points outlined above have been developed below to provide a checklist of questions that may need to be considered. This is not meant to be exhaustive and may not be relevant to all proposals for changing services

The assessment process suggested requires that the health body responsible for taking the proposal forward co-ordinates consultation and involvement activities with key stakeholders such as service users and carers, the relevant Patient and Public Involvement Forums, District Councils and other service providers affected by the proposal. The relevant HOSCs also need to be alerted at the formative stages of development of the proposal. The questions posed by the framework will assist the NHS and HOSCs in determining if a proposal is substantial, identify any additional action to be taken to support the case of need and agree the consultation process.

Name of Responsible (lead) NHS Body:

Brief Description of the Proposal:

Description of Population affected:

Confirmation of Health Overview and Scrutiny Committees contacted:

Name of Key stakeholders supporting the Proposal:

Date:

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Case for Change 1) Is there clarity about the need for change (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement) 2) Has the impact of the change on service users, their carers and the public been assessed? 3) Have local health needs and/or impact assessments been undertaken 4) Do these take account of : a) Demographic considerations b) Changes in morbidity or incidence of a particular condition		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
c) Impact on vulnerable people and health equality considerations d) Potential reductions in care needs (e.g. falling birth rates) e) Comparative performance across other health providers 5) Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to service quality or the patient experience? 6) Do the clinicians affected support the proposal 7) Is any aspect of the proposal contested by the clinicians affected 8) Is the proposal supported by GP commissioners		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
9) Will the proposal extend choice to the population affected? **Impact on Service Users** 10) Will there be changes in access to services as a result of the changes proposed. 11) Can these be defined in terms of a) waiting times b) transport (public and private) c) travel time d) other (please define) 12) Is any aspect of the proposal contested by people using the service?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Engagement and Involvement 13) How have key stakeholders been involved in the development of the proposal 14) Is there demonstrable evidence regarding the involvement of a) Service users, their carers or families b) Other service providers in the area affected c) The relevant Local Involvement Network (s) d) Staff affected e) Other interested parties (please define)		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
15) Is the proposal supported by the key stakeholders 16) Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this **Options for change** 17) How have service users and key stakeholders informed the options identified to deliver the intended change 18) Were the risks and benefits of the options assessed when developing the proposal 19) Have changes in technology, including new drugs been taken into account		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
20) Has the impact of the proposal on other service providers been evaluated 21) Has the impact on the wider community affected been evaluated (e.g. transport, housing, environment) 22) Have the workforce implications associated with the proposal been assessed 23) Have the financial implications of the change been assessed in terms of: a) Capital & Revenue b) Sustainability c) Risks 24) How will the change improve the health and well being of the population affected?		

DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	UPDATE FROM JOINT SEMINAR RE VASCULAR SURGICAL SERVICES
DATE OF DECISION:	21 JUNE 2012
REPORT OF:	CHAIR, HEALTH OVERVIEW AND SCRUTINY PANEL
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

The Health Overview and Scrutiny Panel received an update on vascular services and in January 2012 and again in March 2012. In order to continue working to achieve a locally negotiated solution to this issue the Chair agreed to attend a meeting Chaired by the Cluster with HOSC's, CCGs, SHIP area LINks, both Portsmouth and Southampton Trusts and an independent expert.

RECOMMENDATIONS:

(i) The Panel agrees it maintains the view that it would like a locally negotiated solution to the issue to be reached as soon as possible and it will continue to work with the PCT Cluster, HOSCs and Providers to achieve this. However, the Panel does not rule out exploring other options available to us including referral to the Secretary of State if progress is not made locally.

(ii) The Chair writes to the PCT Cluster to ask how much money has been spent so far on the review of vascular services from the start of the process up to and including the meeting on 11 June.

(iii) The Chair also asks the PCT Cluster to provide full details of all the network models that have been proposed to date and the reasons provided by providers as to why they have not been agreed.

(iv) The Chair also asks the PCT Cluster to provide details of the results of monitoring against the 'Clinical Governance Framework to monitor Portsmouth Hospitals NHS Trusts' arrangements for the provision of Vascular Surgery to date and on an ongoing basis.

(v) The Chair writes to both Southampton University Hospitals Foundation Trust and Portsmouth Hospitals NHS Trust to seek clarity on the staffing (whole clinical team not just consultants) requirements and finance modelling for each of their proposed models.

REASONS FOR REPORT RECOMMENDATIONS

1. To facilitate a locally negotiated solution to the future of vascular services which is both sustainable and achieves the best outcomes for patients.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. A seminar was held on 11 June 2012, Chaired by the PCT Cluster to discuss

vascular services. It was attended by representatives of Southampton, Hampshire and Portsmouth HOSCs, Southampton Portsmouth and Hampshire LINks, managers and clinicians from both University Hospital Southampton Foundation Trust (UHS) and Portsmouth Hospitals NHS Trust, Specialised Services Commissioning, the SHIP cluster, Public Health, both Southampton and East Hampshire CCGs and a representative of the National AAA Screening Programme.

4. The seminar provided an opportunity for the PCT Cluster and both Providers to put forward their points of view. A report of the meeting is being prepared by the PCT Cluster and will be available to members before the Panel meeting on the 21 June.

RESOURCE IMPLICATIONS

Capital/Revenue

5. None

Property/Other

6. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

7. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

8. None.

POLICY FRAMEWORK IMPLICATIONS

9. None.

AUTHOR:	Name:	Caronwen Rees	Tel:	023 8083 2524
	E-mail:	Caronwen.rees@southampton.gov.uk		

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	
2.	

Documents In Members' Rooms

1.	
2.	

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

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

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	HEALTH AND SOCIAL CARE ACT 2012 – KEY IMPLICATIONS FOR LOCAL AUTHORITIES
DATE OF DECISION:	21 JUNE 2012
REPORT OF:	EXECUTIVE DIRECTOR OF HEALTH AND ADULT SOCIAL CARE
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

The Health and Social Care Act 2012 is a major piece of legislation which was enacted in the spring after extensive debates in the Houses of Parliament. Whilst much of the media attention was focussed on issues directly affecting the NHS, the Act also has significant implications for local authorities. This report highlights some of the key issues in respect of:

- The continuing role of the health overview and scrutiny function
- Health and Wellbeing Boards
- Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
- Local Healthwatch
- Transfer of public health to local authorities

RECOMMENDATIONS:

(i) That the scrutiny panel notes the information set out in this report and identifies whether there are any issues it would wish to examine in further detail at future meetings.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Scrutiny Panel to reflect on the key implications of the Act for local authorities and to provide an opportunity for more detailed discussion at a later date.

DETAIL (Including consultation carried out)

The continuing role of Health Overview and Scrutiny Committees

2. The initial White Paper published by the government in July 2010 proposed the abolition of health overview and scrutiny committees, but following the "listening exercise" in the spring of 2011 and extensive lobbying by the Local Government Association the continuing role of health overview and scrutiny been recognised in the Act. It is for each local authority to determine how to discharge this responsibility. The previous legislation governing health scrutiny has been modified to reflect the changes in structure to the NHS introduced by the Act. It enables officers and members of NHS bodies and providers to be called to account. In practice this means councils have the power to engage with the local clinical commissioning group (CCG), which is

responsible for commissioning many of the local health services, NHS provider trusts delivering services to local people, independent sector providers, and the NHS Commissioning Board in respect of services commissioned for local people, which will include GP services, dentistry and a significant range of specialist services.

Health and Wellbeing Boards

3. All upper tier local authorities are required by the Act to establish a Health and Wellbeing (HWB). The boards will take up the powers from April 2013, and had to be established in shadow form from April 2012. The minimum membership of the boards is prescribed with the facility for local authorities to include such other members as they see fit. They will function as committees of the council. Three statutory officer appointments are included: the Director of Children's Services; the Director of Adult Social Services; and the Director of Public Health. This is the first time that officers will statutorily serve on a committee on an equal footing with elected members, and secondary legislation is currently being developed to establish a framework for this to operate in. At least one elected member has to be appointed, along with at least one representative from each CCG operating in the area and a representative of local healthwatch. Local authorities are able to allocate any other powers it considers appropriate to the board in addition to those required under the Act.

4. The membership framework for Southampton's shadow health and wellbeing board was established following a stakeholder workshop in the summer of 2011. The current membership following the annual meeting of the council in May 2012 is made up as follows:

- The Cabinet Member for Communities
- The Cabinet Member for Adult Services
- The Cabinet Member for Children's Services
- A representative from the Conservative group
- A representative from the Liberal Democrat Group
- The Chair of Southampton City CCG
- The Executive Director of Children's Services and Learning
- The Executive Director of Health and Adult Social Care
- The Director of Public Health
- The Chair of Southampton Local Involvement Network (S-LINk)
- A representative from the SHIP PCT Cluster

5. One of the key purposes envisaged for the health and wellbeing board is to develop integrated working across health and care systems, and the Act places this duty in the board thus: "A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner". This is a significant

challenge, and one that the scrutiny panel may wish to assess the effectiveness of in due course.

6. Other key duties of the Health and Wellbeing Boards are the production of a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy which are summarised below.

Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS)

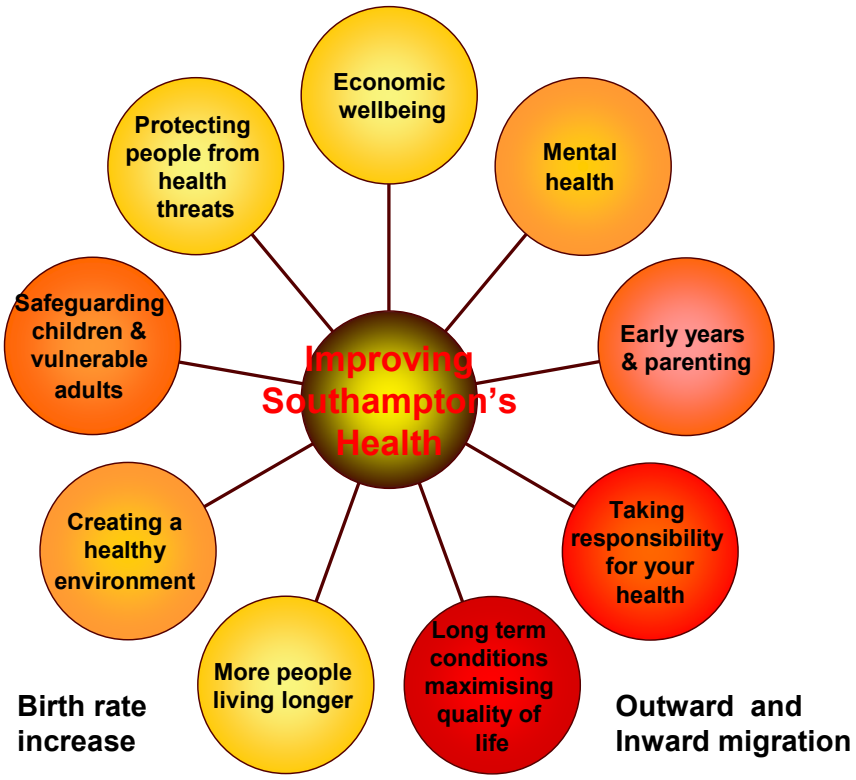
7. The Health and Social Care Act places a duty on the council and the clinical commissioning group (CCG) to jointly produce a JSNA and use that to inform the development of a JHWS. In March 2012 the Department of Health Published draft guidance, and the final guidance is now awaited. The duties to undertake these activities come into force when the CCGs take over their responsibilities from April 2013. However, throughout the passage of the Health and Social Care Bill through Parliament there has been a strong steer from the Department of Health to use the shadow period to work on these matters.

8. The Department of Health has described the JSNA as:

- Describing a process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness; and
- Identifying “the big picture” in terms of the health and wellbeing needs and inequalities of a local population

The council has worked with the PCT to produce 2 JSNAs, the second one being approved by the Cabinet in September 2011. The CCG have received briefings on the JSNA and GPs were consulted on the development of the 2011 JSNA. Following a review of best practice the current JSNA is a web-based resource. The key benefit from this is that new data can be added as it is generated, thereby providing the best information for commissioners.

9. 9 key themes were identified during the process of developing the 2011 JSNA as shown in the diagram below.



10. The Department of Health in its recent draft guidance has identified a number of principles underpinning JSNAs and JHWS.

- They should be strategic and must take account of the current and future health and social care needs of the entire population.
- Real gains can be made if health and wellbeing boards look beyond *needs* to examine how local assets, including the local community itself, can be used to meet identified needs. Not only does this approach generate energy and make the best use of all available resources, but it also stimulates innovation, for example through joining up services, to find truly local solutions to address local issues.
- JSNAs and joint health and wellbeing strategies are key to understanding inequalities in the local area and the factors that influence them such as poor housing, worklessness or crime; and how these impact on health and wellbeing outcomes across the community. (As can be seen, this is reflected in the themes identified in the JSNA.) This can be assisted by involving the relevant sectors who can help to address the wider factors that impact on health and wellbeing.
- There should be a focus on the things that can be done together. These can be identified by health and wellbeing boards working with other local partners and understanding the added value of pooling resources (including people) in order to achieve a greater impact across the local system, to deliver improvements in health and wellbeing outcomes for the whole community; as well to avoid duplication or bureaucracy.

- Joint health and wellbeing strategies should prioritise the issues requiring the greatest attention, avoiding the pitfalls of trying to take action on everything all at once. They will not be a long list of everything that might be done; they will focus instead on key issues that make the biggest difference.

11. At its meeting in March 2012 the shadow Health and Wellbeing Board approved the following themes from evidence in the JSNA to include as priorities in the draft JHWS:

1. Sustaining work to support vulnerable families with young children

2. Taking action to reduce the harm to individuals and society caused by misuse of alcohol and drugs

3. Working with employers and local education providers to support people into employment and prevent people falling out of employment due to ill health

4. Reducing admissions to hospital from preventable causes of both mental and physical ill health

5. Helping people grow old and stay well

12. A draft JHWS is being taken to an informal board meeting on 13th June. A period of engagement will then be undertaken, following which the HWB will then consider an updated document reflecting the feedback from the engagement, and this will then feed into the Cabinet and the clinical commissioning group for final decision. The scrutiny panel will have an opportunity to comment on the consultative strategy at a future meeting.

Local Healthwatch

13. Local Healthwatch and Healthwatch England are to be established to represent the views of the public and service users, and the existing Local Involvement Networks (LINks) will cease to exist. Local authorities are responsible for establishing local Healthwatch. The scrutiny panel last discussed Healthwatch in January 2012. It needs to be established by April 2013 and since the scrutiny panel last considered the matter the Act has clarified that local Healthwatch will undertake the following activities:

- Make the views and experiences of people known to Healthwatch England helping it to carry out its role as national champion;
- Make recommendations to Healthwatch England to advise the Care Quality Commission to carry out special reviews or investigations into areas of concern;
- Promote and support the involvement of people in the monitoring, commissioning and provision of local care services;

- Obtain the views of people about their needs for and experience of local care services and make those views known to those involved in the commissioning, provision and scrutiny of care services
- Make reports and make recommendations about how those services could or should be improved.
- Be represented on the Health and Wellbeing Board
- Provide information and advice to the public about accessing health and social care services and choice in relation to aspects of those services.

14. A key to establishing a successful local Healthwatch is understanding the aspirations of local people. Since February the Council has been working with Southampton Voluntary Services (SVS) to hold a series of stakeholder workshops to engage the voluntary sector. These sessions covered patient and public engagement, signposting, and advice and advocacy. They were well supported, with high levels of engagement from participants, and have yielded valuable data which will help to inform the service specification.

15. In terms of general public engagement SVS has also hosted and promoted a questionnaire survey which has collected data on how the public express views and opinions on health services and offers an opportunity to express a view on what they would expect from local Healthwatch. Additional work is being undertaken with the LINk, who are holding a public meeting on 18th June specifically designed to capture views on how Healthwatch might be best shaped in Southampton to meet the needs and expectations of local people.

16. A key aspiration for the development of local Healthwatch is to capture and retain the legacy of the knowledge, expertise, learning and success of the LINk. Regular discussions have taken place with the LINk about how to achieve this, and it has been kept informed of the plans for developing local Healthwatch. The government believes that volunteers will continue to have a significant role in contributing to Healthwatch successes and outcomes.

17. The key elements in the timetable to secure local Healthwatch are:
    - Spring 2012 – Stakeholder engagement
    - Summer 2012 – Tender specification
    - Autumn 2012 – Tender process
    - End 2012 – Tender evaluation
    - April 2013 – Local Healthwatch established

18. Local authorities are waiting for the publication of regulations on several key issues, in particular the details of the type of organisational structure Healthwatch can be, and sub-contracting arrangements. These are expected to be in place by October 2012.

Transfer of Public Health to Local Government

19. Another key feature of the Act is the transfer of the public health function to local authorities. This takes place from April 2013. The Cabinet and the Strategic Health Authority have both approved a transition plan that provides a framework for transfer. The Director of Public Health now has an office in the Civic Centre, and the public health team have been re-located to the civic centre. The public health budget will initially be ring fenced. The government's vision is that the Director of Public Health will be "ideally placed to embed public health across the work of the authority, acting corporately but exercising the appropriate professional independence where necessary to advocate for the health of the local population."

20. A national public health body called Public Health England is being created. Pubic Health England will have responsibility for delivering a number of services including protection for infectious diseases and hazards, emergency preparedness, resilience and response; national public health information and intelligence; and the delivery of nationwide communications and interventions to support the public to protect and improve their health. Public Health England will also be responsible for developing the public health workforce and leading for public health, supporting health ministers, the Department of Health and the Chief Medical Officer in working across government on public health issues.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

21. None. The activities outlined in this report are statutory duties on local authorities.

RESOURCE IMPLICATIONS

Capital/Revenue

22. None in 2012/13. Activities outlined in this report being undertaken in 2012/13 are being accommodated within existing budgets. The 2013/14 funding for local Healthwatch is expected to be announced by the Department of Health in December 2012. As previously reported to the Scrutiny Panel in a consultation document on the funding of local Healthwatch the following indicative figures were given for Southampton:

- Existing funding LINks, currently held within the Council budget - £140,000pa

- New funding from Department of Health in respect of
    - PCT PALS – Estimated at £120,000 a year from 13/14.
    - NHS complaints advocacy service - Estimated at £60,000 a year from 13/14.
    - PCT DOLS (Deprivation of Liberty Safeguards) - Estimated at £7,000 a year from 13/14.

Property/Other

23. The public health team has already been re-located to the civic centre.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

24. The matters described in this report are all set out in the Health and Social Care Act 2012. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

25. None

POLICY FRAMEWORK IMPLICATIONS

26. None

AUTHOR:	Name:	Martin Day	Tel:	023 8091 7831
	E-mail:	Martin.day@southampton.gov.uk		

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

	None

Documents In Members' Rooms

	None

Integrated Impact Assessment

Do the implications/subject/recommendations in the report require an Integrated Impact Assessment to be carried out.	/No

Other Background Documents

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

1.		
2.	None	

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

WARDS/COMMUNITIES AFFECTED:	

Report Tracking

VERSION NUMBER:	1
DATE LAST AMENDED:	12/6/12
AMENDED BY:	MJD

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DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	SOUTHAMPTON CLINICAL COMMISSIONING GROUP ANNUAL PLAN AND PRIORITIES
DATE OF DECISION:	21 JUNE 2012
REPORT OF:	STEPHANIE RAMSEY, DEPUTY DIRECTOR
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This report provides an update on the development of Southampton CCG and the commissioning priorities for the coming year.

RECOMMENDATIONS:

(i) The panel are asked to note the update from Southampton City CCG

REASONS FOR REPORT RECOMMENDATIONS

1. To provide an introduction to the CCG for new HOSC panel members

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. **Background**

The current NHS reforms set out a clear strategic vision around transforming service delivery so that it is focused on better outcomes for patients with real decisions increasingly being taken by patients and their GPs and services being held to account by them. Delivery of high-quality services, based on clinical decision making and integrated care for patients and service users, will provide a strong platform for future years.

The development of Clinical Commissioning Group's (CCG) is a key element of this. CCG's will become fully authorised by April 2013. Prior to this the 8 local CCG's are working as part of the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) PCT Cluster.

Southampton City CCG supports the needs of 267,500 registered patients. It has the benefit of being co-terminus with the City Council. The CCG comprised 37 GP practices. A shadow Board is in p land and a transition plan is being implemented.

4. **Health Needs**

The overall health of the population in the city has improved greatly over the past 50 years. However there are still many key issues as illustrated in the Joint Strategic

Needs Assessment, please see appendix 1

5. **Our Vision and Strategy**

The CCG's Mission is to become:

An organisation that is focussed on our communities, striving to make healthcare decisions relevant to those we serve. We will engage meaningfully with patients and the public to seek greater ownership of and personal responsibility for health choices to achieve our goal of a healthy City for all

Southampton CCG's purpose is to deliver improved health and wellbeing for all in the City

- Better health outcomes
- Reduced inequalities in health and in access to services
- We will make a full contribution as partners in tackling the wider determinants of health and wellbeing and subscribe fully to the goals of Southampton's Health and Wellbeing Board; we also have a specific role in leading the local health system. Thus…

Our Goal is to have

- A healthy and sustainable system
- Working in productive partnerships with patients, communities, the local authority and health and social care providers
- Delivering excellent care and living within our means
- Care that is integrated and designed to meet the needs of patients

Our approach

- The CCG will make a real difference by achieving true clinical ownership of the quality and costs of healthcare
- We will provide leadership to the system by creating an environment of mutual accountability and trust
- We will liberate the creativity of our people and encourage them to rethink healthcare
- We will arm the innovators with relevant intelligence to help them understand local demand and with evidence of what works
- We will set out challenging but realistic plans and be held accountable for delivering them: we will do what we promise

We will know we have achieved our goal of a healthy and sustainable system when:

Patients and carers say:

- they are empowered
- Have access to right services at right time in right place
- Have a good experience of health care
- Experience good health and wellbeing

Health and social care staff are:

- Working together operationally and strategically

Practices are:

- The 'Hub' of health care, combining care provision and commissioning
- Working together in localities
- 'Connected' to the CCG
- Feeling they own the CCG and subscribe to its goals

The CCG is serving communities by:

- Working constructively and imaginatively with partners in the Health and Wellbeing Board
- Involved in developing the JSNA and acting on its findings

We will then be able to meet our strategic aims by

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care (in their place of choice)
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- Striving to reduce health inequalities across the city

6. **Strategic Priorities**

- Ensuring effective transition to the new NHS commissioning arrangements

in achieving CCG authorisation

- Managing increasing demand (older people, birth rate) whilst ensuring system affordability
- Developing an effective provider market which meets local commissioning priorities and offers choice and sustainability (ISTC contract management, Foundation Trust development, Any Qualified Provider)
- Developing responsive primary care services
- Ensuring a sustainable, affordable and high quality Unscheduled Care System
- Implement effective processes for elective referrals
- Developing our partnership with Local Authority to achieve mutual priorities and make best use of total resource
- Maximising opportunities to prevent ill health and health care needs
- Contribute effectively to safeguarding vulnerable children, young people and adults
- Achieving successful procurement of Out of Hours service and NHS 111
- Managing the impact of implementing Trauma Network recommendations, Stroke Strategy and other cross SHA strategies such as improving diagnostic services access for Pathology and Radiology

7. **QIPP**

QIPP is the way in which the NHS is trying to drive up quality, improve productivity, prevent illness and be innovative in the delivery of health care. It is how we can improve patient care, whilst increasing value for money and delivering our financial responsibilities. Key to QIPP is changing the way we use healthcare services, improving the way in which it is provided and ensuring it is being clinically driven. This is based on:

- Quality – Focusing on improving poor outcomes
- Innovation – Delivering healthcare in the most appropriate setting with minimal intervention
- Productivity – Improving value for money
- Prevention – Keeping people healthy

<u>Planned Care</u>

- 2.7mm QIPP saving in 12/13
- £0.8mm QIPP saving in 13/14 via
- The review and commissioning of high quality elective pathways that achieve the best possible clinical outcomes
- Shift and reduce activity to the most appropriate point of delivery that achieves value for money
- Implement 'enablers' that support pathway redesign including patient decision aids

Unscheduled Care

- £0.9m QIPP saving in 12/13
- £1.1m QIPP saving in 13/14 via:
- Managing patients closer to home via multi-agency community teams
- Managing down frequent ambulance users and only conveying those patients who really need to enter hospital
- Implementing an integrated falls service
- Integrate a Primary Care triage into Emergency Dept

Maternity and Child Health

- Development of Health Visiting
- Increase integration across community & acute pathways
- Implement recommendations from maternity services review
- Implementation of integrated disability services and re-design of therapies

Mental Health

- £1.8m QIPP saving in 12/13 via:
- Re-modelling of AMH acute and rehab. beds
- Re-design of the AMH pathway
- Reducing the impact of harmful alcohol use
- Using joint commissioning flexibilities to optimise LD services
- Contract cost reductions in CHC

Prescribing

- 2.1m QIPP saving in 12/13
- £2.2m QIPP saving in 13/14
- £2.2m QIPP saving in 13/14 via:
- Application of 'Prescribings Menu'
- 'Category M' savings

8. **Quality**

Southampton City CCG will work with our providers and SHIP Cluster to ensure that patients' quality of care improve further in line with the three quality framework domains: Patient Safety, Patient Experience and Clinical Outcomes.

The measurements in the NHS Outcome Framework (amongst others) will be linked to the CCG QIPP plan to drive quality improvements. We will also use the Commissioning for Quality Initiatives (CQUIN) framework to incentivise providers to improve quality care across care-pathways without duplicating minimum expectations set-out in the provider quality contracts.

The CCG will focus on the following themes:

Theme 1: Improving outcomes for the most vulnerable in our communities

- Reducing suicides of patients in receipt of mental health services
- Reducing premature death in people with serious mental illness.
- Reducing premature death in people with dementia.

Theme 2: Getting the basics right every time-including care of people living with dementia

- Tackling inappropriate prescribing of antipsychotic medication
- Increasing diagnosis rates for dementia- the latter being incentivised through the introduction of a national CQUIN

Theme 3: Ensuring harm free care

- Increasing the number of carers with care plans

Theme 4: Transition and legacy

- Improving scores for being treated with dignity in national inpatient survey

Theme 5: Innovation

- Achieving the absence of pressure ulcers, falls, venous thrombo embolism,

catheter line infections, medication errors

- Reducing incidence of community acquired C Difficile

9. **Finance**

12/13 Operating Budget – this is based on a 2% allocation growth per annum

Southampton CCG Budget 2012/13

	Annual Budget Southampton		
	Total £m	Delegated £m	Non-Delegated £m
NHS Commissioning			
PHT	1.3	1.3	0.0
SUHT	142.2	142.2	0.0
WEHT	1.1	1.1	0.0
BNHFT	0.1	0.1	0.0
FPFT	0.1	0.1	0.0
IOW	1.1	1.1	0.0
Other NHS Acute	2.8	2.8	0.0
HPFT	50.2	50.2	0.0
SHFT	27.5	27.5	0.0
Spec Services	24.3	0.0	24.3
SCAS	8.0	8.0	0.0
Other NHS	18.8	18.8	0.0
Non NHS Commissioning			
Continuing Care	22.6	22.6	0.0
Other non NHS	19.2	19.2	0.0
Primary Care			
Primary Care	56.7	0.0	56.7
Prescribing	34.6	34.6	0.0
HQ & Hosted Costs			
HQ & Hosted Costs *(TBC)	18.3	18.3	0.0
Balance Sheet Items			
Contingency	4.0	0.0	4.0
Investments, Reserves, Other	7.8	0.0	7.8
TOTAL OPERATING COSTS	**440.8**	**347.9**	**92.9**

10. **Performance**

Southampton City delivered overall financial targets for 11/12, there was over performance on UHS contract but this was offset by contingency and investment slippage

- Referral to Treatment time targets were delivered in 11/12 Q4 but risk remain with 12/13 delivery for some specialities, Orthopaedics/Neuro/ENT
- Emergency Department 4 hour target was missed in Q4 last year and remains a risk on non delivery into 12/13. Remedial actions have been agreed to ensure delivery
- QIPP – 11/12 delivered fully in Mental Health/LD and MACH, well in Planned Care but significantly behind plan on Unscheduled Care

11. **Authorisation**

The CCG is working towards achieving authorisation by the end of 2012 in

readiness to take on full accountability when the current SHA/PCT structure is abolished in April 2013. This will be based on:

- A strong clinical and multi-professional focus which brings real added value
- Meaningful engagement with patients, carers and their communities
- Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national requirement (including excellent outcomes) and local joint health and wellbeing strategies
- Proper constitutional and governance arrangements with the capacity and capability to deliver all their duties and responsibilities including financial control as well as effectively commissioning all the services for their they are responsible
- Collaborative arrangement for commissioning with other CCG's, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support and
- Great leaders which individually and collectively can make a real difference

RESOURCE IMPLICATIONS

Capital/Revenue

12 None

Property/Other

13 None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14 The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

AUTHOR:	Name:	Stephanie Ramsey	Tel:	023 8029 6002
	E-mail:	Stephanie.ramsey@scpct.nhs.uk		

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed

on-line

Appendices

1.	An overview of Health in Southampton – key issues	
2.	JSNA Key Themes	

Documents In Members' Rooms

1.	
2.	

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

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

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	
2.	

Appendix 1:

An overview of Health in Southampton – key issues	
Dramatic health inequalities are still a dominant feature of health in Southampton	Levels of teenage pregnancy, GCSE attainment (despite improvement) and tooth decay in children are worse than the England average (2010)
Premature (under 75) deaths are 58.7% higher in priority neighbourhoods and increasing	Life expectancy is 7.7 years lower for men in the most deprived areas of Southampton than in the least deprived areas
Life expectancy is not significantly different from the national average, but disability free life expectancy is significantly lower for both males and females	Priorities in Southampton include violent crime, drug and alcohol misuse and obesity
Children and young people Obesity rates in year R and year 6 children are similar to national average	**Diabetes** Estimated prevalence of diabetes if around 4.2% and growing due to better reporting and early diagnosis
Older people Rates of emergency of admissions for fractured neck of femur increase yearly and are slightly higher than national average	**Respiratory disease** Estimated prevalence of COPD in Southampton is high Mortality rates from COPD in Southampton are relatively high and worse in priority neighbourhoods.
Lifestyle Adult smoking rates are reducing but remain higher than the SE average Poor diet and lack of physical activity remains and issue	**Cardiovascular disease** Early deaths from smoking, heart disease and stroke are higher than the England average
Cancer Early deaths form cancer are high especially in priority neighbourhoods Breast, bowel and cervical cancer screening uptake is challenging	**Mental Health** Depression crude prevalence rate of 8.9% for the city which is significantly higher than the national figure of 8.5% but about average compared the city's peer authorities

Appendix 2:

JSNA Key Themes

Birth rate increase

Outward and Inward migration

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DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	SOUTHERN HEALTH NHS FOUNDATION TRUST ANNUAL PLAN AND PRIORITIES
DATE OF DECISION:	21 JUNE 2012
REPORT OF:	DAVID ROBERTSON, FINANCE DIRECTOR SOUTHERN HEALTH NHS FOUNDATION TRUST
STATEMENT OF CONFIDENTIALITY	
Not applicable	

BRIEF SUMMARY

To brief the new membership of Southampton Health Overview and Scrutiny Panel on the current services provided by Southern Health NHS Foundation Trust (SHFT) and to share the Trust objectives and priorities for 2012/13.

RECOMMENDATIONS:

(i) To note and comment with regard to the current services provided by SHFT

(ii) To note and comment with regard to the Trust vision for future services

REASONS FOR REPORT RECOMMENDATIONS

1. To be assured that SHFT are working closely with partner organisations in the local area ensuring Healthcare planning continues to involve the whole NHS community, patients, carers and the public.
2. To be assured SHFT continues to deliver relevant care for their population, purchased by locally based commissioners.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

N/A

DETAIL (Including consultation carried out) None

3. Please see Appendix 1, Southern Health Foundation Trust's Annual Plan 2012/13.

RESOURCE IMPLICATIONS

Capital/Revenue

None

Property/Other

None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

None

POLICY FRAMEWORK IMPLICATIONS

None

AUTHOR:	Name:	Pam Sorenson	Tel:	023 8087 4058
	E-mail:	Pamela.Sorensen@southernhealth.nhs.uk		

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	Southern Health Foundation Trust's Annual Plan 2012/13.
2.	

Documents In Members' Rooms

1.	
2.	

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

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

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1.		
2.		

Agenda Item 12
Appendix 1

Southern Health NHS
NHS Foundation Trust

Quality care, when and where you need it.

Our Plan 2012/13

www.southernhealth.nhs.uk

Our **aim** is to improve the **health, wellbeing** and **independence** of the people we serve.

In this booklet

Quality care, when and where you need it

About Southern Health

We provide community health, mental health, specialist learning disability and social care services for people across Hampshire and its surrounding area.

Serving a population of around 1.3 million people, we are one of the largest providers of these types of services in the UK. We provide care from over 150 sites including community hospitals, health centres, inpatient units and social care locations. In 2011/12 we supported 251,000 people with 1,198,000 community contacts, 302,000 outpatient appointments and 267,000 occupied bed days.

Whilst we are a large organisation patients and service users must remain at the centre of everything we do. Being person centred is one of our six Trust values. Our aim is to improve the health, wellbeing and independence of the people we serve.

Meeting the needs of the people we serve

Southern Health is an NHS Foundation Trust which means we are well placed to serve the people of Hampshire and beyond. We are answerable to our members who represent the people we serve and elected Governors make sure that their views are known. We are also funded in a way that gives us the flexibility to invest in services that are responsive to the needs of local communities.

So that we meet the needs of the people we serve Southern Health is committed to involving patients and services users in the development of our organisation and the development of the services that we provide. We must also ensure that the way in which we communicate with patients, services users their carers and families is relevant and clear. We will continue to develop innovative ways to involve different service user groups so that we truly understand what people want.

Quality and Safety

In 2011/12 we developed clinical outcome measures for all of our services. We will start to use these measures in 2012/13 to better understand how the care that we provide is improving the quality of life of our patients and services users. We also want patients and service users to have an excellent experience when we care for them. Our plan for 2012/13 sets out our Customer Service Charter and how we will get feedback about the experience that people have had so that we can always be improving.

These are tough economic times and the NHS is no exception but we must not let this impact on the quality or safety of the services that we provide. High quality safe care will always be our number one priority.

Our customer service charter

We have worked with our staff, our Governors, and our service users to develop a Charter of Customer Service Standards.

As staff, we will be:

- Respectful
- Approachable and easy to talk to
- Pleasant and friendly at all times
- Willing to listen and really hear
- Aware of individuals' varying needs
- Dressed professionally

As an organisation, we commit to:

- Involve and inform patients and service users, their families and carers, about their care
- Wear name badges; introduce ourselves to the patient, service user, their families and carers.
- Answer the telephone; all calls should be answered by a member of staff or forwarded to a messaging service which will deal with you in a prompt and efficient manner
- Help individuals access the right care and the right person to contact
- Always protect individuals' privacy and their confidential information
- Take action; if we see something that needs doing, we will never say "it isn't my job"
- Respond promptly to patients' and service users' needs; put them first
- Listen to feedback; complaints and concerns are welcomed

These standards are expected across our organisation, so that whatever care is delivered, wherever it is provided, our patients and service users should expect the same high standards.

The people we serve

Samantha's health visitor

"I really wasn't sure what to expect from my health visitor, I was terrified that this health professional was going to tell me that I was doing everything wrong. I quickly learnt that health visitors are not there to judge your parenting skills but to offer advice, guidance and reassurance. Sandra visited me just after Callum was born, she was full of confidence and praise, and reassured me that how I was feeling was perfectly normal. I really don't know what I would have done without her.

I saw Sandra at home and at my local baby clinic on a regular basis. She gave me advice on my baby's weight, his sleeping and feeding, nappy changing and general patterns of behaviour. She was really supportive and really cared about our welfare; she even checked that I was getting enough support at home from my partner.

I really valued the experience and the support that my health visitor provided. She helped reassure me that everything was ok and also helped to highlight things that I did need help with. She was always there when I needed her."

"I really don't know what I would have done without her."

B's social care success story

"B had been living in a treatment and assessment unit for over five years. This was a very restrictive environment for him and although he was ready to move to a home that he could live in on his own, with space and easy access to country walks, it had been very difficult to find suitable accommodation for him.

B has failing eye sight, finds it difficult to tell us what he likes and doesn't like and his balance can be a little unsteady at times. Winchester City Council contacted Southern Health to inform us that they had a property available for B. After a considerable amount of assessment work and adaptations to the property, the social care team successfully supported B move in to his new home. This involved close working with his named nurse, advocate, and Winchester City Council.

B loves going for long walks and his new home has allowed him easy access to the outdoors. B has been to the village shop, something he hasn't done in a long time.

The team is continually creating new activities for B to experience. He loves sensory sessions, having his nails done, his head massaged, or relaxing to music with his sensory lights on. B continues to surprise his support team with all the different things he is achieving, things he hasn't had the opportunity to do for a long time.

The amount of effective joint assessment, planning and working has paid dividends in making this an exciting and life changing experience for B; the change in him is brilliant."

Our Values: the culture we aspire to

- Person & Patient Centred
- Forging Relationships
- Releasing Ambition
- Driving Innovation
- Delivering Value
- Valuing Achievement

> **The help, patience and understanding of all the staff was invaluable.**

Paul's recovery

"Today I will eat three meals and a snack before bed. I won't run.

When I was first referred to the Southern Health Eating Disorders Service that scenario would have been impossible to imagine, never mind achieve.

In early 2009, after years of descending further into the grip of anorexia and an addiction to exercise I finally admitted to my mum that I was struggling.

The next step was to see my GP, and then a referral to Southern Health.

Being able to open up about my problems and gain an understanding of what was happening to me was a huge relief. It was the beginning of a long, and ongoing, battle to overcome my problems.

Initial one-to-one counselling was invaluable but it quickly became apparent I needed further help.

I took a lot of persuading to agree that I should be treated on the Trust's 'Intensive Support Programme'.

This involved attending the service four times a week. On these days I would eat three meals with other patients, and take part in group and individual therapy.

The help, patience, and understanding of all the staff working at the Eating Disorders Service was invaluable. Equally important was the opportunity to spend time with other eating disorder sufferers and the support we could offer each other.

After my three months on the Intensive Support Programme I received weekly individual counselling which continued my recovery.

Without the help I received throughout my treatment at the Eating Disorders Service I would not have had the capability or strength to recover to the extent that I have to date.

Furthermore, I fully believe that all the experience I gained throughout this time will help me take the final steps to a complete recovery."

Our Plan

Meeting the highest standards of quality and safety

We will:

Constantly check whether standards are being achieved and where we find room for improvement in the quality or safety of our services, we will act swiftly and decisively to make things better.

Measure our success in terms of the improvements we make to clinical outcomes and experience of our patients and service users, their carers and families.

Work efficiently and innovatively to deliver our services within our agreed budget without compromising on quality or safety.

Developing our people

We will:

Invest in leadership at all levels in our organisation so that we are ready to meet the challenges we face.

Recognise, nurture and reward the most talented employees, as these are our champions for improving services.

Develop our staff so that they have the right training and skills to always deliver safe and high quality care.

Transforming our services for the better.

We will:

Transform community health care by working more closely with other organisations to provide joined up care for the individual.

Transform mental health care by providing more services in the community or at home.

Provide specialist learning disability services that are tailored to the individual, enabling them to be as independent as possible.

Offer a growing range of social care services that enable individuals to remain independent and supported in their community.

Expand our learning disability and social care services through integration with Oxfordshire Learning Disability Trust.

Developing as an organisation

We will:

Improve the way we communicate with and involve the people we care for, our staff and all the other groups who are affected by what we do.

Make sure that our premises are all safe, pleasant and appropriate for the delivery of care.

Improve our business skills so that we can operate successfully in a more commercial 'health economy'.

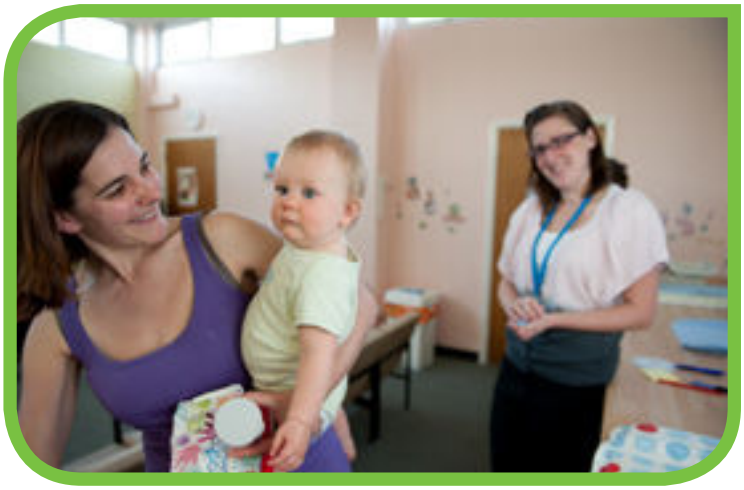
Be innovative and invest in technology, wherever it will deliver better quality care in a more efficient way.

Our Services

(and how we're transforming them for the better)

All our services must deliver safe high quality care, meeting the essential standards in the Health and Social Care Act 2008 and all other regulatory requirements. However, we are transforming our services to deliver more than essential standards.
We want to build a reputation for excellence, being recognised as a provider of health and social care services which deliver constantly improving care and patient experience.

We will work with other health and social care organisations and the voluntary sector to ensure care is 'joined up' so that people's experience of every aspect of their care is positive. We will also seek to expand our services in or beyond Hampshire where it means we can offer better care for people or we can be more cost effective. Our plan is to transform our services so that Southern Health becomes the organisation that both individuals and commissioners choose to provide their care.



Community Health Services

From before birth to end-of-life, we offer a range of services to promote and improve physical health and wellbeing. We work closely with local doctors to provide care both in people's homes and in our community clinics and hospitals across Hampshire. Our services include health visiting (working with parents to give babies the best start in life), care for people with diabetes, dental services, occupational therapy, physiotherapy and we also deliver Quit4Life, Hampshire's stop smoking service.

We will transform community health care by working more closely with other organisations that also provide services to our patients and service users, delivering more joined up care for the individual.

We will provide a range of services which support people to remain as healthy and independent as possible in their community, which may be in their homes or close to those who care for them. In 2012/13 we will continue to develop our services and integrate them more closely with the services that other organisations provide to our patients and services users. This will mean that individual patients receive more joined up care and overall the cost to the NHS is less.

In 2012/13 new Clinical Commissioning Groups, who are made up of groups of General Practitioners, will start to select and fund local healthcare. We will continue to strengthen the relationships that we have developed with these groups, working closely to ensure that redesigned and integrated services bring real benefits to the people we serve.

We will complete the implementation of our community care model across Hampshire which includes 24 hour access to community care, the redesign of community hospitals, the opening of community clinics and the development of individual services, such as wound care. We are increasing the numbers of patients and service users we see and treat in our community clinics as there are clear benefits to seeing them in these settings. These benefits include better access to health and social care services, improved health and wellbeing and improved treatment recovery times. Southern Health is building on this community care model, developing a vision for fully integrated care in Hampshire and in 2012/13 we will share this vision with our partners and other key stakeholders.

“By 2015 we will have doubled the number of our health visitors to over two hundred and forty”

The community services that we provide to children and families are closely linked to local authority safeguarding and the promotion of health and wellbeing. By 2015 we will have doubled the number of our health visitors to over two hundred and forty. This is in line with government targets and will allow us to increase the contact we can have with families before the birth of a child and through that child’s early years. We are also building stronger links to general practices ensuring that all practices have a designated health visitor.

Odiham Cottage Hospital

In July 2011, Odiham Cottage Hospital in the north of Hampshire faced an uncertain furture as its doors were closed.

A combined effort from Southern Health, the local clinical commissioning group and a passionate local community has now breathed new life into the Hosptial, when in April 2012 new community clinics started operating from the site.

We have plans to expand these clinics in the coming months to include phlebotomy and leg ulcer care, as well as running workshops for people with long term conditions and dementia.

St Michael's Hospice is working alonside us at Odiham Cottage Hospital to complement the care we provide, as too is a local day centre for elderly people.

In addition, Odiham Cottage Hospital will soon be the home for an integrated care team - which will include social workers from Hampshire County Council as well as community and mental health nurses from Southern Health, working together to offer a more joined up health and social care experience for local peole.

Odiham Cottage Hospital is a great example of how we can work more closely with partner organisations, GPs and voluntary services to find innovative ways of surrounding people with a complete range of health and social care in their communities.

What we achieved

2011/12

- Continued to implement our new community care model focusing on the development of clinical skills within our community teams, a good example being an increase in the intravenous therapies we administer in patients' homes. This has led to more care close to home and better outcomes for patients and service users
- Established a network of Rapid Assessment Units, we now have six across Hampshire, which are at the heart of our new model of community care. Rapid Assessment Units mean that patients can be seen quickly, usually within 48 hours, without the need for referral to an acute hospital. These units provide a range of services including x-rays, scans, medication and blood transfusions
- Established the Portsmouth Older People's Partnership to improve services for older people in the South East of Hampshire. Working with our colleagues in acute care we are transforming the way we collectively care for frail and elderly patients. In 2011/12 we focused on how people are looked after when they arrive at the Queen Alexandra Hospital ensuring that they are seen by a consultant geriatrician, who can assess all of their needs, as soon as possible
- Worked in partnership with our colleagues in Basingstoke Hospital and social care to streamline the management of care for people with long term conditions. This has delivered more 'joined up' care for those needing continuous healthcare
- Developed the role of area matrons to support our community care teams. Area matrons oversee the work of our experienced community matrons, they often have specialist clinical skills and they focus on ensuring essential standards are being met and are improving over time. We currently have seven area matrons across Hampshire
- Introduced self referral by patients and service users, avoiding the need to see a general practitioner, for our occupational therapy, physiotherapy and podiatry services
- Fareham leg care centre won a Beacon award, being recognised for delivering excellent care in a community clinic setting
- End of life services have increased the number of people dying in their preferred location, most often at home. In 2011/12 80 per cent of our patients died in their preferred location.
- Established an acute occupational therapy service in South East Hampshire

Our goals

2012/13

- Further develop the skills of our community care teams enabling the provision of more complex care at home, reducing the need for patients and service users to visit a hospital
- Increase the number of people being treated in our Rapid Assessment Units and open additional units where we establish the clinical benefits of doing so. We will work closely with our colleagues in acute hospitals to bring further benefits to patients and service users
- Further develop the Portsmouth Older People's Partnership by changing our services so that patients and service users spend less time in hospital and ensuring that the benefits of the partnership are available across the whole of South East Hampshire
- Develop the model of integrated older people's care developed in the Portsmouth Older People's Partnership across other parts of Hampshire. We are in discussion with three acute care providers about the benefits to frail and elderly people of this approach to care
- Extend our partnership approach to managing continuing healthcare care, delivering more coordinated care to people living with long term conditions
- Further develop the role of area matrons ensuring they become an integral part of our model of community care. Area matrons provide clinical leadership for our "front line" staff ensuring high quality care. We will also appoint additional area matrons in 2012/13 where it is appropriate to do so
- Increase the number of nurses with the extension of our heart failure, respiratory and therapy services across Hampshire. Increased specialist nursing capacity, and the range of services that these specialists can provide leads directly to an increase in the amount of care that can be provided close to home
- Work with general practitioners to bring more outpatient appointments directly to our community hospitals across Hampshire, avoiding the need to visit an acute hospital
- Expand our pain management services across the south of Hampshire helping more people to cope with chronic pain

Mental Health Services

We provide a diverse range of services for working age adults with severe and enduring mental illness. We focus on recovery and re-ablement, giving people the support and treatment they need to achieve their goals and helping people regain skills they have lost due to an illness or accident. We do this both in the community and in our dedicated psychiatric hospitals.

We are at the forefront of medical research into dementia and we offer extensive services for older people with a mental illness. We support people in their own homes, in our hospitals and we also work closely with our colleagues in private care homes to make sure they are providing the best support for residents with a mental illness.

We also provide a range of specialist mental health services including secure settings for those who need them, and some very specialised services for children and young people with mental health needs.

We will transform mental health care by providing more services in the community, so that service users stay mentally healthy and maintain their wellbeing and independence.

Traditionally, people who were ill were cared for in hospitals. Service users have told us they would rather be close to their homes and families and this also speeds recovery, so we are changing how we provide care. Medications and therapies have also improved, so our aim is to care for as many patients and service users as possible in their communities, often at home. This new approach, in line with national and international best practice, will enable service users to stay mentally healthy and maintain their wellbeing and independence, as well as being more affordable for the NHS as a whole.

The focus of our services for people with a mental illness will be to provide more care in the community and less in inpatient beds, though there will always be inpatient beds available for those who are severely ill and cannot be treated safely outside hospital. We will develop our community mental health teams and integrate the care they provide more closely with our primary, acute and social care partners, delivering more joined up services locally.

Delivery of mental health services has traditionally been organised around age groups. Whilst this works for most people we understand that there are people whose needs are not age related and we are developing our services to ensure that age is not a barrier to accessing the right services. We will do this while still recognising that as we grow older the types of mental health services that we are likely to use will change.

The population over the age of 65 will increase by 15% over the next ten years and those over 85 by 27%. By 2026 it is predicted that the only increase in the numbers of people with any form of mental health illness will be as a result of age. We also know that the prevalence of depression, dementia and other mental health problems is highest among older people. In response to this we will continue to develop our dementia services, ensuring they are closely integrated with the services provided by other health and social care organisations. This is an area where we see the opportunity to improve health and wellbeing by working closely with the voluntary sector.

We also see an opportunity for Southern Health to expand its specialist mental health services, providing more care in Hampshire for patients and service users from Hampshire, rather than their care being provided in other counties or in the private sector. We believe that patients and service users want to be looked after close to their homes, this can aid their recovery and gives better value for money as other options can be very expensive.

> **“Our approach will enable people to stay mentally healthy and maintain their wellbeing and independence”**

Our new community mental health services

People recover faster and more thoroughly when they are in their own homes, surrounded by their family and friends.

We are working with our colleagues in primary care and now offer a single point of contact for those wishing to refer people into our services.

Launched in April 2012, we now provide three levels of care to people in their communities, with each level provided by a specialised team.

The **Access and Assessment Team** is the single point of access for people who first come into contact with our services (usually through their GP). This team carries out a detailed assessment of a person's needs and provides short term care for up to 12 weeks, as well as

What we achieved 2011/12

- Became one of six pilot sites for the national Implementing Recovery Through Organisational Change (ImRoc) programme which is changing the partnership between service users (experts by their experience) and their care professionals (experts by their professional training)
- Launched our programme to transform our adult mental health services completing a public consultation on our proposed service redesign in December 2011
- With our colleagues in social care we redesigned the services that we provide at Crowlin House supporting its residents to live more independent lives
- We converted space at Southfields into two flats so that people preparing to leave the unit can practice their independent living skills
- Trained support staff in hospitals, ambulance and community services so that they can recognise mental health problems in older people
- Expanded our psychiatric liaison services in the Queen Alexandra Hospital Portsmouth and hospitals in Southampton and Winchester giving faster access to psychiatric care
- Opened a third ward at Bluebird House for young people who need care in a secure setting
- Completed the transfer of services provided in the Tom Rudd unit to the provision of services in the community with the support of community mental health teams

signposting people to voluntary services and our iTalk service, which provides improved access to psychological therapies. We deliver this service in partnership with Solent Mind.

If people require more care after the initial 12 week period, this will be provided by the **Community Treatment Team**. These teams are located thoughout Hampshire, and offer longer-term treatments and interventions in people's homes or at local clinics.

We also provide care to people who are acutely unwell, but still in their own community, through our **Hospital at Home** (H@H) service. The purpose of this service is to provide intensive support to people to prevent the need for a hospital admission. Working closely with our psychiatric hospitals, the H@H team also makes sure that people who are ready for discharge are carefully supported back into their homes, or that suitable accommodation is found quickly.

2012/13

Our goals

- Conclude our Implementing Recovery Through Organisational Change (ImRoc) pilot continuing with our work to change our culture so that we better recognise the experience of service users
- Continue our programme to transform our adult mental health and older people's mental health services expanding our capacity in the community and reducing the need for hospital beds
- Provide greater access to iTalk, our Improving Access to Psychological Therapies (IAPT) service supporting people with mild to moderate mental health needs (for example, anxiety and depression) as well as expanding our range of interventions in line with the national plan
- In 2011/12 we successfully piloted an intensive support service in the New Forest, giving access to therapies in a community setting. During the pilot we supported in excess of 120 people in the community and we will now expand this service across a wider area
- Establish a new community team, providing services for people who have offended, are likely to offend or who have come into contact with the criminal justice system
- Expand our specialised services to include services for people with acute mental health problems who need a secure setting
- Further improve access to specialist assessment and treatment services for people with early memory loss
- Our mental health services will continue to seek opportunities to work more closely with partner organisations and other healthcare professionals, a good example being our plans to work with health visitors to identify mental health need
- Increase the work we do with partner organisations, such as organisations in the voluntary sector, to coordinate support for older people with physical frailty and complex mental health needs allowing them to remain independent

Learning Disability Services

We specialise in offering care that is tailored to the individual, making sure that their unique needs are met and enabling them to be as aspirational and independent as possible. In addition to working with people in their homes and communities, we have a number of specialist low secure settings to help people with complex needs and challenging behaviour who have been involved in the criminal justice system.

We will provide specialist learning disability services that are tailored to the individual, making sure that their unique needs are met and enabling them to be as aspirational and independent as possible.

We intend to expand our learning disability services beyond Hampshire so that they are more sustainable and cost effective and so we can improve the care provided even further. We will continue the work we have started to promote independence and provide more care at home rather than in inpatient units, although these will always be available when needed.

We provide high quality assessment and treatment by specialist learning disability health professionals and we will continue to develop these services to enable other health professionals, such as general practitioners to work more effectively with people with learning disabilities. In 2012/13 we will continue to develop our acute in-reach service, providing intensive support for people with learning disabilities who are in hospital. We will also develop our autism services.

We will extend our Seamless Solutions service which gives ongoing support to patients and service users and puts them at the centre of care tailored to their individual needs. This approach also helps people "step down" to lower levels of health and social care support. Seamless Solutions was developed collaboratively with patients, service users and their carers and has been recognised as a model of best practice which we are now using to support people with some of the most complex needs.

In March 2012 we were announced as the preferred NHS Trust to integrate our learning disability services with Oxfordshire Learning Disabilities Trust, also known as the Ridgeway Partnership. We expect this integration to be completed by the end of 2012. This will transform our learning disabilities service, doubling it in size, extending our geographical reach and giving us the opportunity to become recognised as a world leader in learning disability services. Find out more on page 24.

Our new assessment and treatment centre

In June 2012 we will open a new, state of the art assessment and treatment centre for people with a learning disability and behaviours which challenge.

The centre will have six beds and offer a highly specialised service to adults (male and female) who require assessment and treatment which cannot be provided in the community.

A multi-disciplinary team will work together in the assessment and treatment of those within the centre. The team will consist of nurses (including a 'behavioural specialist' nurse), psychiatrists, speech and language therapists, psychologists and occupational therapists.

The assessment process is designed to understand the specific needs of the individual. Assessment of the challenging behaviours uncovers the meaning of the behaviour, the causes, and possible treatments.

Treatment consist of two main strands. Firstly, meeting the needs of the service user; ensuring they are supported in the most effective way. Secondly, reducing behaviours which challenge by developing an alternative range of behaviours and skills for the person.

To help with treatment, we will create a 'sensory integration suite' which is designed to provide the best sensory environment to help reduce challenging behaviour. This suite can be transformed for each person that uses it.

The new assessment and treatment centre will operate 24 hours a day, and accept referrals from care providers and local authorities across Hampshire and beyond.

What we achieved (2011/12)

- Implemented the 'triangle of care' model which gives increased access for people with a learning disability to general health services, maximising the time our learning disability professionals can spend supporting service users. This model of care educates and raises awareness of learning disabilities amongst other healthcare professionals. A good example of this is the support given by our learning disability nurses to general practitioners which has resulted in improved access to smear tests
- Trained our clinical staff in new interventions keeping their practice skills up to date. This includes the training of some of our nurses on a new tool for the assessment of people with a learning disability who also have mental health needs
- Established an intensive support service for people with a learning disability whose behaviour is challenging, so that they have other options beyond admission as an inpatient
- Developed a new screening and diagnostic service to identify people with a learning disability and autism

Our goals (2012/13)

- Work with Ridgeway to ensure that we integrate our learning disabilities service in Hampshire with theirs in Oxfordshire, Buckinghamshire, Wiltshire, Dorset and beyond. We will work to realise the benefits of working in partnership, offering an excellent learning disabilities service across southern England
- Further increase service user and carer involvement in making plans for their services. This will include encouraging people to attend existing local involvement groups, holding a user-led conference and getting feedback on the information we provide through workshops and story telling
- Open our new assessment and treatment service to people with a learning disability and behaviours which challenge
- We will redesign our autism service to include adults with Attention Deficit Hyperactivity Disorder
- Make our new sensory integration facilities in our assessment and treatment centre available to day patients. Sessions will be supported by qualified occupational therapists.

Social Care Services

TQtwentyone, the part of Southern Health which provides social care services, supports people to live independent and fulfilling lives. We provide social care services to people with a learning disability or mental health needs. TQtwentyone supports nearly 400 people across Hampshire and the Isle of Wight providing domiciliary care, supported living, tenancy support, holidays and short breaks, day opportunities and specialist residential care.

We will offer a growing range of social care services that enable individuals to remain independent and supported in their community.

We will continue to work with the people we support, their relatives and carers to improve our services and build our reputation for providing care that is tailored to an individual's needs. We want to be an organisation that is leading on providing personalised care, ensuring our service is responsive to the needs of the increasing number of people purchasing their own services.

We will offer ever better value for money making sure that our prices are always competitive in the social care market. We are always looking for ways to operate more efficiently and we recognise that managing and building our workforce is central to this. Our front line staff are at the heart of providing quality care and a stable workforce means people who use our services are supported by staff they know and trust. We have nearly eradicated the use of agency staff (currently less than 1%) and we will continue to focus on the wellbeing of our staff further reducing sickness levels.

In March 2012 we were announced as the preferred NHS Trust to integrate with Oxfordshire Learning Disability Trust, also known as The Ridgeway Partnership. This will transform our business and will be the focus of our growth in 2012/13 but we are also investigating opportunities to offer our services to other people, such as older people and young people moving from children's to adult services. Find out more about our integration with the Ridgeway Partnership on page 24.

Our service user charter

Working closely with our Service User Reference Forum (SURF), we launched our service user charter at the end of 2011.

The charter outlines what people can expect from our service and is written in a way that can be understood by our service users.

We will:

- Offer you a personalised service
- Tell you how much it will cost
- Respond to your queries within two working days
- Ensure your Support Worker is trained
- Make sure your Support Worker can understand you and that you can understand them
- Provide you with a Support Worker who is police checked
- Ask you for your ideas
- Share our inspection reports with you.

We won't:

- Share your information with other organisations without talking to you
- Leave you unsupported when your Support Worker is on holiday or sick
- Charge you for things you have not asked for
- Send strangers to your home.

What we achieved (2011/12)

- Launched the TQtwentyone charter, our promise to people supported by TQtwentyone
- Established a social care mental health re-ablement service at Crowlin House, supporting people to regain skills they have lost due to an illness or accident.
- Helped 41 people to move from NHS accommodation to their own homes in the community with ongoing support from TQtwentyone.
- Succeeded in winning the opportunity to provide services in Southampton and the Isle of Wight
- Supported an increasing number of people to purchase services from us with a personalised budget
- Turnover grew by 9% in 2011/12 as we increased the number of services that we provide to the people we support.

Our goals (2012/13)

- Work in partnership with Ridgeway to ensure we offer excellent social care services at a competetive price across Hampshire, Oxfordshire, Buckinghamshire, Wiltshire, Dorset and beyond.
- Ask the people that we support how we can improve our services so that we can move our measure of service user satisfaction from 93% to 95%.
- Increase our re-ablement services (supporting people to regain skills lost due to illness or accident) to include people with physical health needs, older people with mental health needs and young people moving from children's to adult services
- Support the remaining people who live in NHS accommodation to move into their new homes in the community
- Increase the number of people who purchase their domiciliary care directly from us to 30%
- Continue to realise the benefits of being part of Southern Health, focussing on the social care opportunities that come from working with colleagues in Community Care and our Older People's Mental Health services
- Expand into new social care markets where this growth supports our strategic objectives. We will consider opportunities in a number of potential markets including services for the old and frail and services for young people who have been involved in the criminal justice system.

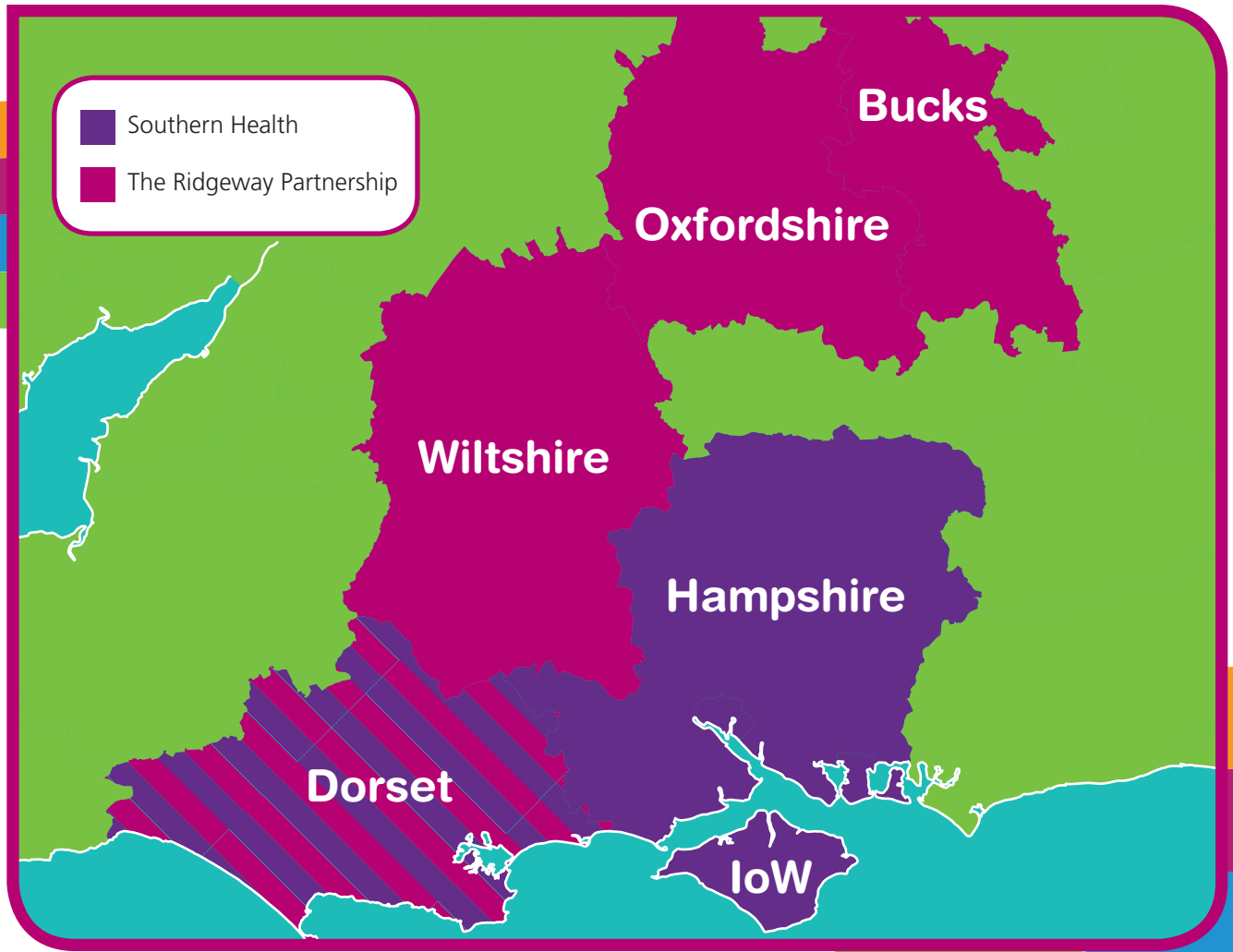
We will expand our learning disability and social care services through integration with Oxfordshire Learning Disability NHS Trust, also know as the Ridgeway Partnership.

"I am delighted that we have been chosen as the preferred bidder for the Ridgeway services. Over the past six months, we have met with service users, staff, carers and learning disability support organisations, and we have been so impressed with Ridgeway's commitment and energy in developing truly patient-focused services. This is precisely what Southern Health believes in and stands for and my Board and senior teams cannot wait to start work on bringing these important learning disability and social care services together for the benefits of service users and patients."

Katrina Percy
Chief Executive of Southern Health

The Ridgeway Partnership provides health and social care services to people with learning disabilities within Oxfordshire, Buckinghamshire, Wiltshire and Dorset. The Trust has approximately 1,200 staff who support over 3,300 people with learning disabilities, their families and carers. Integration with the Ridgeway Partnership supports one of Southern Health's objectives of growing business where it means the Trust can deliver better outcomes, better patient experience and be more efficient.

The partnership between Southern Health and the Ridgeway Partnership brings a number of benefits including the opportunity to become a world leader in the delivery of learning disability services. Our combined organisations will have a unique user led research and development capability and the ability to influence learning disability policy at a national and local level. The partnership also means our combined learning disability services will become more efficient in the long term as we can save money by sharing support services.



www.ridgeway.nhs.uk

World class learning disability services

The Ridgeway Partnership specialises in providing services for adults with moderate to severe learning disabilities, but also provides services to people with milder disabilities as well as community based services for children. Combining our services will enhance the quality of health and social care provided to people with learning disabilities across southern England. We will do this through combining the best of our services and realising the benefits of becoming a single organisation.

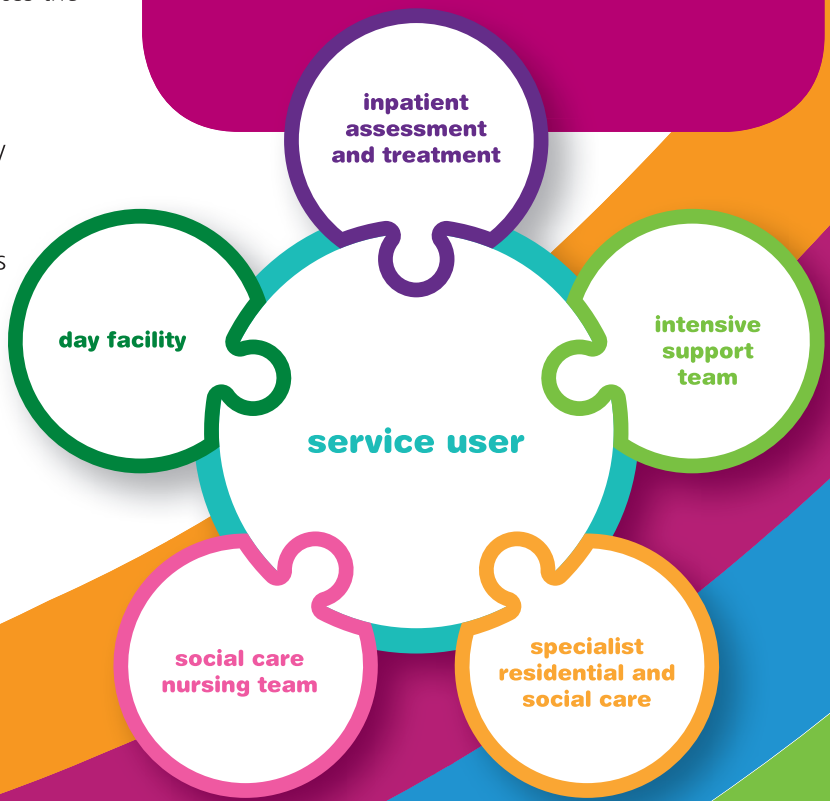
Service users will benefit from:

- Access to a wider range of services
- Redesigned services which wherever possible move care out of hospitals and into the community
- A full forensic service, for people who have offended, are likely to offend or who have come into contact with the criminal justice system, across the region
- Improved access to specialist social care support
- A user-led research and development facility to promote developments in supporting people with learning disabilities
- Increased influence with other organisations and bodies providing learning disabilities support to our service users
- A louder voice for people with learning disabilities

Seamless healthcare provision

Southern Health has developed a Seamless Solutions service which gives ongoing support to patients and service users and puts them at the centre of care tailored to their individual needs. This approach also helps people 'step down' to lower levels of health and social care support.

Health and social care packages are designed by the individual and an intensive support team, offering choice to the individual of what treatment they receive, when it is delivered, where they are treated and who delivers the care. To do this we work with all of the health and social care providers concerned with treating an individual. We will make this service available to all of our service users with learning disabilities.



Meeting the highest standards of quality and safety

(and doing it efficiently)

Southern Health is committed to using evidence as the basis for improving care. By this we mean using research and a focus on outcomes to improve the effectiveness of our services for patients and service users.

Research is an essential part of our organisation and we want to offer patients and service users the opportunity to take part in this research. Research underpins our work on clinical outcomes, helping us to identify those that matter to our patients and service users. Outcomes can also show our staff how the work they do improves the lives of the people they care for.

Finally, our work on customer standards and experience is an essential way for us to get feedback on our care from those who matter the most, the people we serve.

We will constantly check whether standards are being achieved and where we find room for improvement in the quality or safety of our services, we will act swiftly and decisively to make things better.

In 2011/12, through a combination of external review and our own internal assessments we identified that the quality and safety of some aspects of our services needed to be improved. During 2011/12 Southern Health was inspected by the Care Quality Commission (CQC) and these inspections identified that we were not meeting some essential standards. These findings and our own assessment of our assurance processes led to our Monitor Governance Rating moving from Amber/Green to Amber/Red.

We immediately established a Quality Assurance and Improvement programme reporting to our Assurance Committee and Board. The programme focussed on the following:

- Responding to CQC findings and agreeing action plans to address their concerns
- Collation and triangulation of a wide range of quality and safety information
- Co-ordination of all improvement activity arising from concerns
- A programme of unannounced visits by a dedicated inspection team with independent representatives (mock CQC inspections)
- Identification of leadership development requirements
- Cultural change to promote internal whistle blowing where staff have concerns

We tackled the immediate issues quickly and effectively and we are now working to strengthen our governance systems. We retained Deloitte to undertake an independent quality assurance review, they reported in March 2012 and a new quality governance framework is now in place.

We will continue our Quality Assurance and Improvement programme into 2012/13 and by June our mock CQC inspection programme will have conducted un-announced visits across all of our services. We will embed learning from this programme and we will further develop new quality and governance processes.

At the end of 2011/12, our Monitor Governance Rating was Amber/Green. Ensuring that all of our services are operating to the high standards that we, our patients and service users and our commissioners would expect is our highest priority.

Research

We believe that research is a critical component of a successful NHS provider organisation and we have a number of on-going trials, both at a local and international level. In general, research trials are used to help us to understand how to diagnose, treat, cure or prevent disease and illness. This may involve comparing existing treatments or looking at new ones. They are important to ensure that the best advice and treatments are being provided to patients. Most importantly, clinical research is the key to improving patient care.

- The Memory Assessment & Research Centre (MARC) runs research trials into dementia. At the moment, all of the trials we run are looking into Alzheimer's. The majority of these trials are investigating the effectiveness of new drug treatments, although some trials look at other aspects associated with Alzheimer's such as depression and sickness behaviour. MARC is one of the leading centres in Europe for dementia research: Dr David Wilkinson and Professor Clive Holmes are internationally renowned for their expertise in this area.
- Southern Health also hosts the south coast Dementias & Neurodegenerative Diseases Research Network (DeNDRoN) one of seven local research networks which are placed throughout the UK. DeNDRoN carries out research and clinical trials into dementias (including Alzheimer's disease), Parkinson's disease, Huntington's disease and Motor Neurone disease.

The Southern Health research team supports research in a number of disease areas. In the past our main focus was upon mental health research but we are developing research into more community based care, such as continence care, leg ulcer care, and evaluations of our integrated community services.

We will measure our success by the improvements we make to the clinical outcomes and experience of our patients and service users, their carers and families.

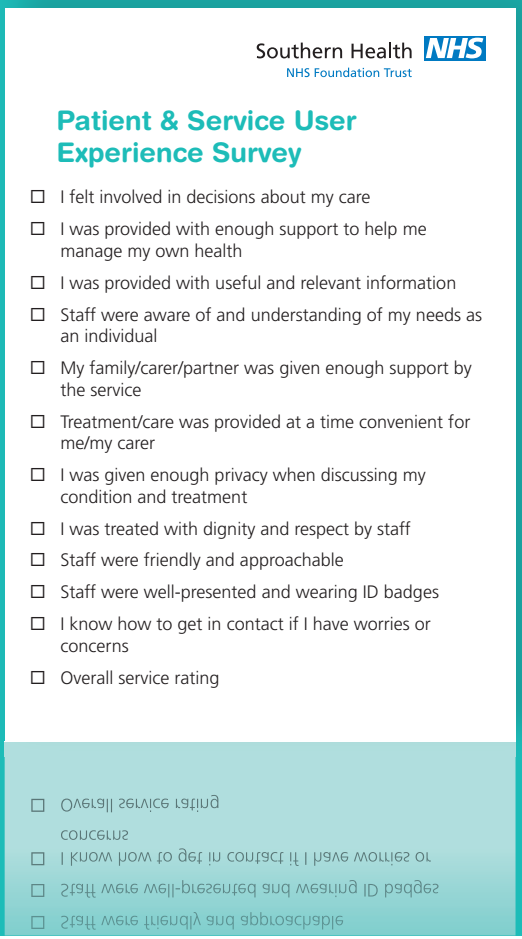
There are many measures used in the NHS to assess the performance of NHS organisations and the impact of care upon our patients and service users. In the past, these have tended to focus upon activity or processes, for example how often does a nurse provide a particular treatment. These measures do not always relate to what matters to patients, services users and their carers or families.

We are working to change the way we look at the care we provide by looking at outcome-focused measurement. What this would mean is rather than focus upon a specific piece of care provided, for example a leg ulcer dressing, we want to shift the emphasis to what we want to achieve for that patient, for example rapid healing of ulcers to maximise function and improve quality of life.

We will continue to use the measures and indicators we have to provide to our regulators and commissioners, as these ensure we are providing a safe, reliable service. However, we will use these along side other information so that we have a better picture of how the care we provide relates to outcomes.

- Input from Governors by area
- Service user forums
- Annual quality survey
- User involvement groups
- Service user experience surveys
- Focus groups for indepth feedback
- Carer surveys
- Staff surveys
- Safety data
- Clinical audit data
- Compliments, complaints, concerns
- Customer service standards

Outcomes & Experience



Southern Health NHS
NHS Foundation Trust

Patient & Service User Experience Survey

- ☐ I felt involved in decisions about my care
- ☐ I was provided with enough support to help me manage my own health
- ☐ I was provided with useful and relevant information
- ☐ Staff were aware of and understanding of my needs as an individual
- ☐ My family/carer/partner was given enough support by the service
- ☐ Treatment/care was provided at a time convenient for me/my carer
- ☐ I was given enough privacy when discussing my condition and treatment
- ☐ I was treated with dignity and respect by staff
- ☐ Staff were friendly and approachable
- ☐ Staff were well-presented and wearing ID badges
- ☐ I know how to get in contact if I have worries or concerns
- ☐ Overall service rating

Tell us how we're doing

In order to measure how well we are doing, or identify areas where we need to improve, we have introduced patient and service user experience surveys across our services. We have ensured a number of questions are common across all of our services, so that we can know how we are doing as an organisation. These questions are based on national evidence and local workshops.

We are making it as easy as possible for patients and service users to provide feedback including Freepost mail surveys, web-based surveys, interactive symbol surveys (important for adults with learning disabilities), workshops with groups of service users and service users themselves collecting information from each other.

We are also working to make sure we obtain feedback from a wide range of sources on the different aspects of the services we provide. This may be cleanliness in an inpatient unit or the provision of specialist equipment by a particular service, for example occupational therapy. With the broadest possible feedback on our services we will be able to constantly improve the quality of the care we provide.

We will work efficiently and innovatively to deliver our services within our agreed budget without compromising on quality or safety.

It's a tough economic period for the UK and the NHS is no exception. It is important that we manage the funding that we are given by our commissioners carefully, delivering value for money and safe high quality care. Monitor, the Foundation Trust regulator, expects all Trusts to be financially healthy organisations. We will work efficiently and innovatively to deliver our services within our agreed budget.

We are regulated against a set of guidelines which tell us what we have to do to remain a Foundation Trust. This includes making sure we have a planned level of surplus at the end of each year. We are planning to reach a surplus of £4.8m at the end of 2012/13 and £6.4m by the end of both 2013/14 and 2014/15. By achieving this we will be able to:

- Re-invest in services in order to continually improve the quality of care provided
- Manage any financial risk (especially in the current economic climate)
- Assure our Board, governors, members and the local community that we are keeping our Foundation Trust status

One of the ways that we plan to re-invest in services is by improving the way we use new technologies. We use a range of technologies including specialist telehealth technology which allows patients and service users to be monitored in their own homes. We are also increasing the number of our staff with mobile technology, allowing them to spend more time caring for people in the community. We continually invest in the premises where patients and service users are cared for so that they are safe and have the best possible environment for their care.

Our financial plans show how we will manage our money during this tough economic period, delivering cost savings of 4% year-on-year, and maintaining a Monitor Financial Risk Rating of at least 3. Monitor use the Financial Risk Rating to assess financial stability and viability, on a scale of 1 to 5, where 1 is high risk and 5 is low risk.

Where our money comes from...

Most of our income (74%) comes from three main organisations that are part of the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Primary Care Trust cluster:

- NHS Hampshire
- NHS Southampton City
- Specialised Services Commissioners (a group of Primary Care Trusts within the South of England Strategic Health Authority who buy specialist health services).

The way services are commissioned will be changing in 2012/13 with Clinical Commissioning Groups, led by General Practitioners, increasingly commissioning the services we provide. There will also be a national NHS Commissioning Board, which will oversee all of the commissioning arrangements and will lead on the commissioning of the more specialised services we provide in mental health.

- 59% NHS Hampshire (£197.8m)
- 9% Specialised services commissioners (£28.1m)
- 8% NHS Southampton City (£27.4m)
- 7% Local Authority income (£22.2m)
- 6% Other commissioners (£21.0m)
- 6% Other operating income (£20.9m)
- 5% The Ridgeway Partnership (£15.5m)

...and how we spend it.

Our services are provided by Divisions that focus on meeting the needs of specific groups of patients and service users. The diagram shows how we plan to spend our money over the coming year by Division.

For more details of how our money has been spent in the past, our Annual Report and Accounts can be viewed on our website, www.southernhealth.nhs.uk

- 24% Adult Community services (£80.1m)
- 18% Adult Mental Health services(£61.0m)
- 13% Capital charges and premises costs (£42.4m)
- 9% Social Care (TQtwentyone) (£28.6m)
- 8% Corporate services (£27.7m)
- 8% Learning Disability services (£26.0m)
- 8% Older People's Mental Health services (£24.9m)
- 7% Specialised Mental Health services (£22.0m)
- 5% Children's Community services (£15.4m)

Developing our people

We will invest in leadership at all levels in our organisation so that we are ready to meet the challenges we face.

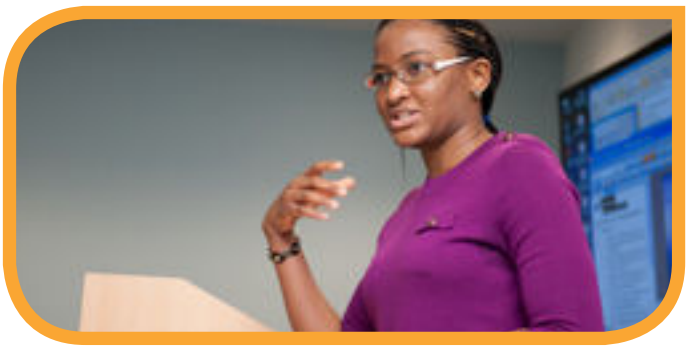
We recognise that our workforce is the key to delivering high quality, outcome focused health and social care services. We will ensure that our staff are informed, empowered, competent, confident, accountable and supported so that they have the capacity and capability to deliver safe, high quality care.

We are committed to leadership development and see this as a key strength of our organisation. We are investing in leadership development at all levels in the Trust including the Board, the Executive Team, the Directors of our services, senior clinicians and team leaders to ensure that all are able to meet the challenges they face.

We have initiated leadership development programmes for our executive team and in 2011/12 thirty six of our divisional, clinical and associate directors attended our Leadership Development Centre. By the end of May 2012 over seven hundred managers will have completed our new appraisal training. In 2012/13 we will run an eight day leadership development programme for three hundred and fifty of our managers and we will expand our coaching programme for managers at all levels in the organisation.

Our aims are to:

- find and create the leaders of the future
- embed leadership qualities to deliver better patient and service user outcomes
- develop the capability of our leadership population to deliver key objectives
- ensure all leadership development activity is aligned to our goals
- give the support required to ensure our leaders can perform



We will recognise, nurture and reward the most talented employees, as they are our champions for improving services.

Inspiring and nurturing talent is at the centre of our approach to people development. We will identify and 'fast-track' those members of staff with the greatest potential to develop and contribute to improving the services that we provide.

We will provide in depth feedback to individuals and create development plans, establishing where talent lies and where personal development needs exist. Strong talent management will lead to greater workforce productivity, and will support recruitment and retention of staff.

Valuing achievement and driving innovation are two of the Trust's core values and we recognise the importance of rewarding and recognising the contribution made by staff. The Star Awards celebrates success and acknowledges individual and team contributions.

We will continue to develop our approach to managing talent recognising those who have made a positive impact on the quality of patient and service user care.

Meet our staff

Lesley Munro

Lesley is Area Director for Community Services in South East Hampshire and has worked in the NHS for all of her career. After 13 years in an acute hospital Lesley joined Southern Health and quickly identified that she needed career development support to achieve her goals.

"It was only when I moved to Southern Health that I began to truly realise my potential. Until this point no-one had really given me meaningful feedback and as one of Southern Health's core values is developing talent I had an opportunity to work with a coach"

Lesley has transformed community services in South East Hampshire by implementing a new workforce model, developing rapid assessment services and she is currently piloting integrated working across primary, acute and social care. Lesley is now passionate about coaching and embedding its use across the organisation.

"I believe over the next 1-2 years we need to challenge ourselves to truly realise the potential in our staff and colleagues who might be internal, external, commissioners or providers".

Renee Lima

Renee joined Southern Health in 2010 as an apprentice and completed an advanced apprenticeship in business and administration. With the changes in NHS workforce requirements we recognised the need to increase the number of staff completing Foundation Degree and Apprenticeships and in August 2011 Renee was appointed into a full time role in our Learning, Education and Development department to help support other potential candidates who are completing apprenticeships.

"A key part of my role is to share my experience and in time I hope to act as a mentor to newly recruited apprentices".

In December 2011 Renee achieved a teaching qualification 'Preparing to Teach in Lifelong Learning' and is now studying for two Open University modules in Business, her aim being to complete a degree in Business.

We will develop our staff so that they have the right training and skills to always deliver safe and high quality care.

We have carefully considered the types, skills and capabilities of our people in order to deliver the goals of the Trust. We will develop our workforce so that we have the right number of people equipped with the skills and competencies they need to deliver improved clinical outcomes and patient experience.

We must always ensure staff training meets statutory requirements and this is complemented with tailored packages of training, including training for our clinical specialists. We will always ensure that training provides a sound framework within which we can meet and excel in the standards required by the Care Quality Commission and other regulators.

We will continue to develop innovative ways of delivering training to our staff, including the use of online learning, e-assessment and mobile applications to minimise the time spent away from providing care to our patients and service users. We are increasingly using competency based assessment when we recruit people in order to select those most likely to impact on the quality of care and our operational performance.

We work closely with our local higher education institutions to influence the way in which professional trainees of the future learn and we are developing our own foundation degree course with modules on community care and learning disabilities.

Carol Barnard

Carol is the Clinical Manager of Hollybank, which is an Adult Mental Health Recovery Unit based in Havant. The unit has twenty staff and offers support to service users, helping them to take greater control of their lives. Carol was one of the first managers to attend the new appraisal training.

"The new appraisal training day for managers was by far the best training I have attended for some time. It was interactive, engaging and very user friendly.

I have started appraising my team and found the system very much more meaningful as it allows me to have the sometimes difficult conversations in a supportive and focused way, whilst still enabling personal development. I particularly like the way the unit's objectives are cascaded down through the team to give a more meaningful and unified approach.

All staff so far appraised have commented on how much more included and involved they feel with clear objectives for the future."

Fiona Holdcroft

Fiona works as an Outpatient Physiotherapist based at Chase Hospital, Bordon. Fiona assesses musculoskeletal patients using a wide range of treatment techniques, including exercise and electrotherapy, to support general and post operative rehabilitation.

In April 2011 Fiona began the first year of a three year Masters in Advanced Physiotherapy (Neuromusculoskeletal) with the University of Hertfordshire.

"The course has provided me with advanced skills and knowledge in neuromusculoskeletal physiotherapy which is based on the current best available evidence. This has helped me to undertake specialised outpatient physiotherapy assessments and develop a comprehensive management plan to promote patient recovery, close to the patient's home, within the shortest possible time frames".

Developing our organisation

We will improve the way we communicate and involve the people we care for, our staff and all other groups who are affected by what we do.

Our aim is to maximise the involvement of our stakeholders in what we do and how we do it. We will do this by improving the way we communicate and engage with our patients, service users, carers, our staff and the public. We will make it easy for people to give their opinions, and we promise to listen, act upon feedback, and where we make changes we will make sure they have worked.

The Trust takes very seriously its role in involving patients and service users in the development of the organisation and ensuring they have every opportunity to have a say in their care. We value the views of those using our services when taking decisions about how services are developed. We also recognise the importance of the views of carers and families.

We encourage patients and service users to share their views through stakeholder groups. In older adult mental health services, we have invited patients and carers to attend listening events ahead of formal consultation so we can be sensitive to their needs and wishes. This highlighted an important concern about the implications of service moves on travel, and we have been able to address this ahead of the formal consultation period.

Service user involvement is particularly important in learning disability and social care services where our aim is to enable people to live independently, so their decision making is central to making this happen. We encourage patients and service users to sit on working groups, and participate on interview panels for staff recruitment. Recognising the importance of good physical health and mental health we also support a service user football team and publicise and promote their activity to help combat stigma in society.

Members and Governors

Governors represent the views of our 17,500 members and are able to participate in the work of the Trust in a variety of ways, from taking part in mock-CQC inspections, to involvement in the appointment process for the new Chair. We have also formed a Communications Advisory Group to work with the Communications team to improve the quality of our written materials by using straightforward and accessible language.

Governors have been involved in our planning for the year ahead, by sharing their views and helping us shape our priorities. We hold Constituency days to enable Governors and Members to meet with executives and clinicians and raise any queries or concerns they might have. Council of Governors' meetings are public meetings in the interests of openness and transparency.

Southern Health online

We will launch a new website in April 2012 which will include more information about our services and have a more accessible design and layout. Staff, patients and service users were asked to contribute to this redesign by commenting on what could be improved about the current website and testing some of the new features for ease of use. Their contribution will assist in having a website which is built to the meet the needs of those who use it, ensuring it meets their high expectations.

We will make sure that our premises are all safe, pleasant and appropriate for the delivery of care.

It is important that we provide our services from premises which are safe, in good condition, well designed and that support delivery of high quality care. We also recognise the therapeutic benefits of good quality premises which are pleasant to be in.

After the merger of Hampshire Partnership NHS Foundation Trust and Hampshire Community Healthcare Care we initiated a full review of our estate. We quickly established that we needed to improve the quality of a number of our community premises and that there was the opportunity to reconfigure and rationalise our estate to improve access for our patients and service users and give better value for money. At the end of 2011/12 we agreed a plan to realise these benefits and we will work to deliver this plan from 2012/13 onwards.

We operate from **172 buildings** spread across 156 sites comprising community hospitals, health centres, mental health and learning disabilities specialist inpatient units, community inpatient units and social care locations.

Managing and developing our sites

Our premises must provide us with value for money which means they must be run as economically as possible and be in the right place. We must also ensure that we comply with relevant regulatory requirements including healthcare standards and codes of practice.

The NHS Estates Strategy Guidance provides a framework to measure the performance of important aspects of our estate. Currently, approximately 15% of our estate falls below these standards and our aim is that all of our premises are rated B (with A being a new premise) as a minimum and are fully utilised.

We also have a consistent approach towards energy efficiency across our premises and review the energy efficiency of buildings to ensure they are operating to modern standards. We are committed to minimising our environmental impact and reducing carbon emissions wherever possible and have adopted a 2.5% per annum carbon reduction target in addition to an overall 10% reduction target by 2015/16 as recommended by the NHS.

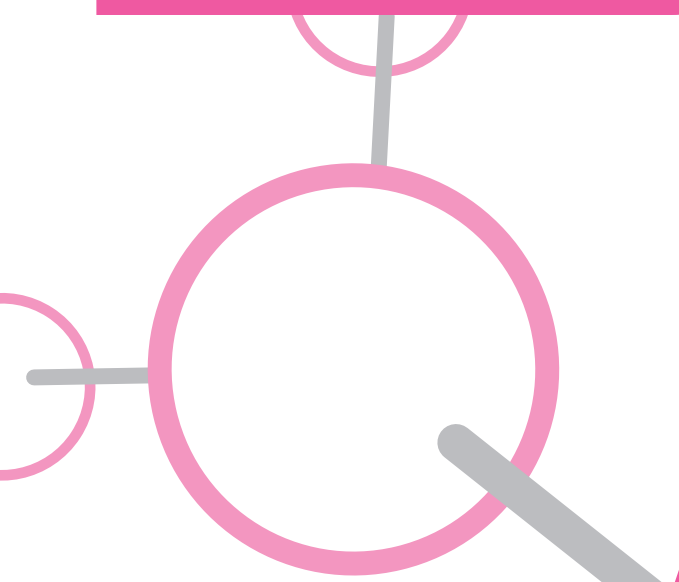
We have adopted a **carbon reduction target of 2.5% per year** together with an overall reduction target of **10% by 2015.**

Our hub and spoke model

The Trust has developed a hub and spoke model to support the increasing integration of community and mental health services. This model will enable us to be flexible about where services are located and will support patients and service users to remain more independent in their communities.

Many clinical services are provided in people's homes or in GP surgeries, village halls or health centres. Our approach means services are organised around local communities and are supported by local administrative hubs in or near to the communities that we serve. Area hubs support delivery of services across a number of localities and we also deliver some services across the whole of Hampshire.

This model enables us to be flexible in the way we provide our services. If a need is identified for a new service in an area not already covered another 'spoke' can be added and supported by an existing hub without disruption to services in other areas. We want all our hubs to be easily accessible and our aim is to provide our services within 15 minutes drive of 80% of the people needing them.



3

Spokes

Community teams working in local 'spokes' with primary care colleagues.

2

Local Hub

A vibrant hub for the local community providing a range of co-located health & social care services, provided by a mix of public, private and voluntary sector partners.

1

Area Hub

More specialist diagnostics, specialist clinics and specialist team locations.

We will improve our business skills so that we can operate successfully in a more commercial 'health economy'.

Health and social care is changing. Developments in the health and social care economy are driving increased competition and collaboration and Southern Health is responding to both.

The Health and Social Care Act 2012 and a number of other initiatives are driving a more commercial environment for health and social care services. These changes include:

- A much tighter financial environment which is driving commissioners to demand changes in the way care is paid for and delivered, including reducing the numbers of patients being treated in hospitals and moving that care into the community
- A new commissioning structure in which general practitioners are taking a leading role in specifying and purchasing care on behalf of their patients and service users. This will require us to work with many more commissioners, each requesting different types of services for their local populations
- A 'blurring' of the traditional separation between public and private sector organisations. The emergence of social enterprises in which NHS staff deliver NHS services through a private organisation is a good example of this. We have also seen the management of Hinchingbrooke Hospital, an NHS hospital, transfer to Circle, a private sector organisation
- The introduction of initiatives such as Any Qualified Provider, in which any certified and approved organisation can compete to deliver specific services
- The introduction of a new payment currency in mental health services where we will be paid for each episode of care we deliver rather than being paid to support a population

Competition

Market-testing for services by commissioners has become the rule and as a result we are seeing increased involvement of the private sector in healthcare and greater competition amongst public sector organisations.

This is also changing the model of how services are delivered to one that is increasingly led by patients and service users. This means that we will need to market our services directly to patients and general practitioners.

How we are responding

- We are improving how we engage with stakeholders such as patients and commissioners so we can respond better to their concerns and aspirations
- We are working with commissioners to develop new pricing mechanisms for a number of our services
- We are reviewing how we market our services to patients and service users, general practitioners, commissioners and other stakeholders
- We are identifying which of our services deliver most value to patients and service users, allowing us to prioritise investments to the services which deliver the most benefit
- We are taking a more rigorous approach to identifying and prioritising those opportunities for which we will compete
- We have improved the way we bid for contracts so we can now compete against the very best
- We are developing a comprehensive training programme to improve commercial awareness across Southern Health

Collaboration

Advances in healthcare technologies and changes in the needs of our patients mean that healthcare is becoming more complex. An ageing population also means there are more patients with long term needs who require joined up care from a number of different providers. We are responding to increasing complexity by working in partnership with other providers so that more comprehensive services can be delivered to meet the needs of the individual.

Some of our partnerships:

- We are working with Portsmouth Hospitals NHS Trust and other providers in Portsmouth and south east Hampshire to deliver an innovative model of care for older people
- We have partnered with Solent MIND, a local charity, to improve access to psychological therapies through a joint service called iTalk
- We are exploring how we can work more closely with local out of hours services to improve information sharing and provide faster, easier access to our services

We will be innovative and invest in technology, wherever it will deliver better quality care in a more efficient way.

Delivery of high quality care by Southern Health is underpinned by the use of technology. We use a range of technologies including specialist equipment which supports the needs of patients and service users directly and every day most of our 8,000 staff use our systems to deliver services. We are committed to investing in technology in order to reduce costs, improve access to our services and ensure all our staff have the technology they need to support patients and service users in the community. In 2012/13, as part of a three year programme to introduce new ways of working, we will invest £4.8m in new technology.

Improvements for patients and service users

We plan to use technology to increase patient and service user participation, one way being the introduction of on-line anonymous feedback on the quality of our services and the experience of using them.

By autumn 2012 most patient records will be held electronically providing clinicians with up to date information for faster diagnosis and improved treatment or support. Where patients receive care from a number of organisations we are working to ensure that relevant information is accessible to all those who are involved in that care. We will always ensure that information is kept confidential and is only made available to those clinicians who are providing care to the patient or service user.

We are also introducing electronic booking which will improve access to our services by enabling patients and service users to book and change appointments more easily. This will include self check-in by patients and service users and the sending of important information by text message, such as appointment reminders.

Supporting staff

Southern Health is committed to ensuring that the amount of time staff have available to spend with patients and service users is maximised. To support this commitment clinical staff are being provided with laptop computers so that they can access patient records at the point of care. This technology will reduce travel time, administration, improve communications and give better value for money. This will be particularly helpful where patients are being treated in their own homes and clinical staff are able to access the Trust's electronic records remotely.

We also plan to increase the use of technology to support our learning and development programme by enabling eLearning, virtual classrooms and distance learning. We are supporting the development of on line training materials so that staff can access these when convenient and can record course completion and the attainment of standards.

Contact us

Telephone: 023 8087 4106
Email: communications@southernhealth.nhs.uk

Find us on Facebook at **southernhealthnhs**
Follow us on Twitter at **@southern_nhsft**

www.southernhealth.nhs.uk

Quality care, when and where you need it

Published by the Southern Health NHS Foundation Trust Communications & Engagement Team

DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	SOLENT NHS TRUST ANNUAL PLAN AND PRIORITIES AND FOUNDATION TRUST CONSULTATION
DATE OF DECISION:	21 JUNE 2012
REPORT OF:	SARAH AUSTIN, DIRECTOR OF STRATEGY
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This report outlines the role of Solent NHS Trust, its priorities for the forthcoming year and the current public consultation concerning Solent NHS Trust application for Foundation Trust status.

RECOMMENDATIONS:

(i) The panel are asked to formally respond to the consultation.

(ii) The panel are asked to note the update from Solent NHS Trust.

REASONS FOR REPORT RECOMMENDATIONS

1. To ensure panel members are up to date with progress at Solent NHS Trust

2. To seek formal feedback from the panel on our consultation

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. N/A

DETAIL (Including consultation carried out)

4. **About Solent NHS Trust**

We are in our second year as an NHS Trust and our third year as a merged community and mental health provider, delivering high quality care and working in partnership to make things better for children and families, adults and older people.

We have annual revenue of £183m at the start of 2012/13, over 3,800 staff and delivering over 1.5 million contacts per annum. Our services are provided from over 100 different locations, including Community Hospitals and Day Hospitals; as well as numerous outpatient and other settings within the community such as Health Centre's, Children's Centres and within service users' homes.

Solent NHS Trust was established as an organisation whose primary objective is to manage care in the community. We support clients' independence and self care by providing integrated physical and mental health and social care services around GPs and their practice populations. We specialise in providing integrated services to urban communities with complex health and social care needs and work in partnership with others

whose focus is on improving the health of our population.

Our services are focused on city region populations where there are complex health and social needs and where there is a need for a deep partnership with primary and social care to address these.

5. **Our finances**

We are planning to achieve a 0.4% surplus in 2012/13, as illustrated in our financial summary, below.

	Mar-13 £m
Operating Revenue and Income, Total	183.30
Operating Expenses, Total	(181.96)
EBITDA	**1.34**
EBITDA margin	0.8%
Total Depreciation & Amortisation	(0.58)
Net Surplus/(Deficit)	**0.75**
Surplus Margin	**0.4%**

6. **Our performance**

Our performance over a range of measures has improved significantly over the last 12 months. The Trust is now achieving all its 18 week Referral to Treatment Time indicators as well as all other relevant nationally reported KPIs and has a challenging programme in place to roll out directly bookable clinics through Choose and Book to all consultant and therapist-led services.

Safety continues to be a priority. 90% of service users reported positively on feeling safe within their clinical environment. Within Mental Health services, 99% of service users were followed up within 7 days of discharge and 100% of all elective admissions were screened for MRSA. Working hard with other healthcare organisations, significant progress has been made in reducing the rates of MRSA and C Diff. There have been large reductions in rates across Solent NHS Trust; in Southampton City there has been a 78% reduction and Portsmouth City a reduction of 60% in the number of C Diff cases in 2010/11, compared to 2008/09. Solent NHS Trust is striving to decrease rates of avoidable infections and aims to have zero levels of infection.

The 2010 service user survey reported a 90% positive response rate from customer surveys.

Our PEAT (Patient Environment Action Team) scores, which assess the

service user environment, demonstrate standards that are good or excellent across all our main hospital sites.

7. Our vision and strategy

The Trust's strategy over the next three years is to work closely with Clinical Commissioning Groups and local Health and Wellbeing Boards to lead a whole system change in the delivery of services; **our vision is to lead the way in local care.**

We are already providing integrated health and social care but will further develop the model to provide integrated pathways with primary care, in-reaching into the acute trusts. By combining with primary care, users will experience home-based services that are reliable and available 24/7; **our mission is to provide services in partnership to deliver better health and local care.**

Long term conditions care pathways will be coordinated and delivered by single clinical multidisciplinary teams using the latest health technology. Users will experience services that are better integrated and delivered from one stop shops in community campuses. Admission to acute trusts will only be necessary for those that require the particular skills and infrastructure that only an acute environment can provide.

Solent NHS Trust will enable all care that can safely be provided out of hospital to be moved to a primary/community-led organisation. Staff from other sectors will be encouraged to provide services into the integrated pathway. Increasingly, service users will not be admitted into acute hospitals (except in an emergency) without having first been referred to Solent community services. Solent will increasingly become the single point of referral for all the population.

We aim to expand incrementally from the Trust's initial geographic and service footprint by exploring county-wide and cross-county border opportunities. We intend to increasingly provide social care services.

The services we provide will be realistic alternatives to acute hospital care, rather than duplication of services. Solent NHST would expect to make a significant impact on the local system as demonstrated by our strategic objectives and outcome measures.

8. Our strategic objectives

Our approach to quality strongly influences both the longer term direction and the day-to-day operation of the trust. At the heart of the organisation's strategy is **the quality promise**:

Safety is everyone's highest priority and we have a 'no harm' culture ensuring our staff do the right thing for every person, every time.

We will improve **experience** by putting people at the heart of services and listening to people's views, gathering information about their perceptions and personal experience and using that information to further improve care.

Optimum **clinical effectiveness and outcomes** will be ensured by the application of evidence and best practice in accordance with NICE guidelines and all other national guidance.

We will achieve **regulatory compliance** by ensuring the governance and risk management framework is fit for purpose at all levels; being clear, understandable and seamless whilst supporting continuous quality improvement; meeting the requirements of our regulators and managing clinical risk.

9. The Board has agreed **three strategic objectives** which flow from the Trust's vision and mission. These strategic objectives say what we will do over the next five years to help us to achieve our vision.

10. ***Strategic Objective 1:***
To provide services which enable improved health outcomes with particular focus on areas of known health inequality

Solent NHS Trust will provide commissioners with services that help improve the overall and individual health outcomes of the local populations that we serve and to improve those at the weakest end of health inequalities fastest, in each and every one of our services

11. ***Strategic Objective 2:***
To deliver care pathways that are integrated with local authorities, primary care and other providers

Solent NHS Trust will lead (or contribute to) integrated care pathways which address health and social care needs. The design of services will interface with primary care so that GPs know and work with local teams in core services.

12. ***Strategic Objective 3:***
To maintain profitability in core business by offering best value alternatives to acute hospital admission

Solent NHS Trust will provide commissioners with a range of best value, evidence based community alternatives to acute admissions. This will provide whole-system value benefits and thereby enable the Trust to maintain profitability by incrementally increasing the value of income in profitable services lines. This will be achieved through the retention of existing contracts, the expansion of core business in local urban areas and planned growth beyond the current geographical footprint. Non-profitable service lines will be reviewed and where appropriate discontinued.

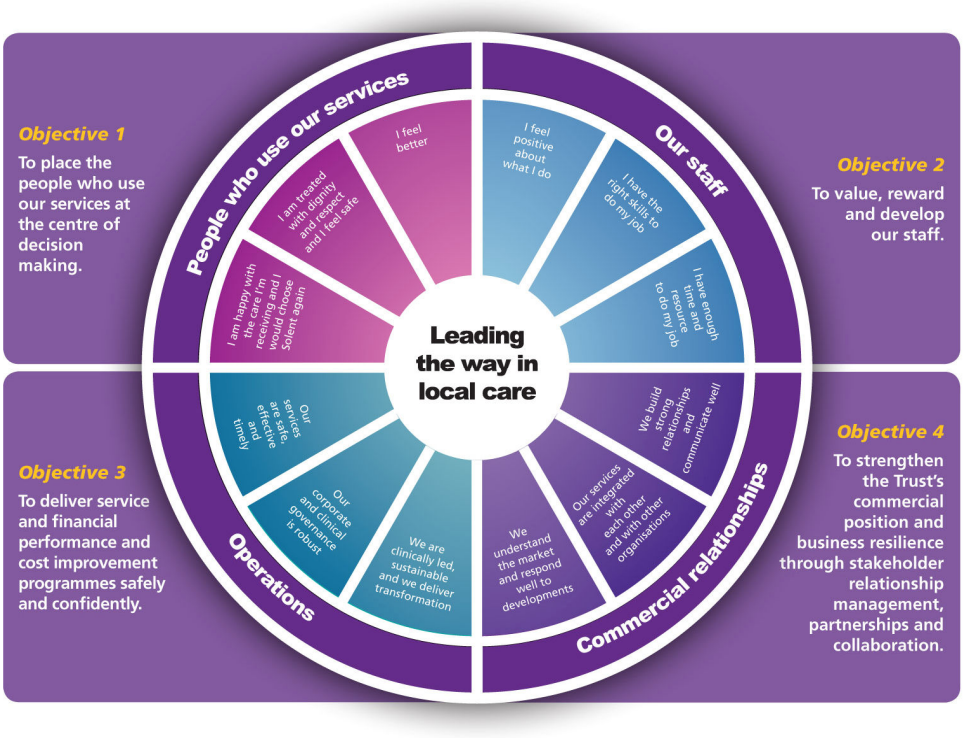
13. Delivery of the Trust's strategic objectives is dependent on a strong organisational culture focused on the delivery of excellent services and a high-performing organisation that achieves commissioner and regulatory compliance through business and clinical excellence.

Clinical Excellence	*Business Excellence*	*Meeting Commissioner Requirements*	*Regulatory Compliance*

These **four underpinning requirements** are reinforced in annual and individual objectives and there is a continuous programme of alignment of the Trust's objectives at every level of the organisation.

14. **Our priorities for 12/13**

Our Operating Plan sets out our four priority work streams for the next year. These work streams form our annual objectives framework – the 'Solent Wheel' – a key enabling tool which we have developed to ensure that the Trust's annual objectives are clearly understood and highly visible at all levels of the organisation and are reflected in divisional, service and individual level objectives. The Solent Wheel is shown below.



15. ***Objective 1:*** *To place the people who use our services at the centre of decision making*

We will focus on:

- Delivering evidence-based practice and demonstrating the success and quality of our services
- Reducing variation in clinical practice and performance as evidenced with benchmarking
- Implementing our Operating Model including a Single Point of Access (SPA) and virtual ward infrastructure
- Maintaining our quality standards
- Implementing Telehealth solutions
- Embedding user experience into forward planning

16. ***Objective 2:*** *To value, reward and develop our staff*

We will focus on:

- Prioritising clinical leadership and supervision
- Increasing focus on evaluation and clinical audit
- Incentivising research and new models of care,

- Training staff in transition management

17. ***Objective 3:*** *To deliver service and financial performance and cost improvement programmes safely and confidently*

We will focus on:

- Increasing our IT capability with the purchase of performance management and clinical systems to enhance interoperability
- Expanding mobile working
- Rationalisation of our estate
- Delivery of contracts and Cost Improvement Programmes (CIPs)

18. ***Objective 4:*** *To strengthen our commercial position and business resilience through relationship management partnership and collaboration*

We will focus on:

- Developing and delivering five-year transformation and market development plans
- Brand awareness and management
- Achieving system wide support for our operating model
- Undertaking systematic periodic stakeholder feedback on the Trust's reputation and leadership role,
- Embedding relationship management
- Expanding our research portfolio

19. **Our future**

We are working towards achieving Foundation Trust status by 1 April 2013. We believe that authorisation as a Foundation Trust should be the outcome of delivering clinical and business excellence within the organisation and the culture which underpins this.

We are on target with our tripartite formal agreement which confirms the commitments being made by the Trust, the South Central Strategic Health Authority (SHA) and the Department of Health (DH) that will enable achievement of NHS Foundation Trust (FT) status before April 2014.

As part of our application we have been undertaking a 12 week formal consultation. The consultation provides us with the opportunity to understand what the people who use our services, patients, members of the public, partners and other stakeholders think about our proposals. The consultation does not ask the question about whether or not the Trust should become a Foundation Trust, but rather it asks what people think of our proposed governance arrangements and the Trust's future plans.

The consultation covers three broad areas including:

- our vision and future plans
- our membership
- our Council of Governors.

20. The Health Overview and Scrutiny Panel are asked to consider the consultation which asks the questions highlighted below:
    - What do you think of the objectives for the Trust?
    - Do you agree that people who are aged 14 should be able to become a member?
    - What do you think of our plans to have a single constituency which includes people who use our services and their carers?
    - What do you think of our proposed public and staff constituencies? Do you think that they are representative of the communities we serve?
    - What do you think of our plans for the Council of Governors?

    Responses from the consultation will be used to refine our Foundation Trust application and a summary report, outlining the responses received and the changes we have made to our plans as a result of the comments received, will be produced in the summer.

RESOURCE IMPLICATIONS

Capital/Revenue

21. NA

Property/Other

22. NA

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

23. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

24. NA

POLICY FRAMEWORK IMPLICATIONS

25. NA

AUTHOR:	Name:	Sarah Austin, Director of Strategy	Tel:	023 8060 8819
Sarah Austin	E-mail:	sarah.austin@solent.nhs.uk		

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	NA

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	Operating Plan 2012/13 (and 2014,2015)
2.	Foundation Trust consultation document

Documents In Members' Rooms

1.	
2.	

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

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

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

Solent NHS Trust

Solent NHS Trust Operating Plan

2012/13 (and 2014, 2015)

Better health, local care

Contents

Tables

Section 1: Strategy

A) About Solent NHS Trust

Solent NHS Trust is an ambitious and innovative provider of community and mental health services, leading the way in local care across Southampton, Portsmouth and southern Hampshire.

We are in our first year as an NHS Trust and our second year as a merged community and mental health provider, delivering high quality care and working in partnership to make things better for children and families, adults and older people.

With annual revenue of £183m at the start of 2012/13, over 4,100 staff and delivering over 1.5 million contacts per annum, Solent NHS Trust is one of the largest community and mental health providers in the NHS. Services are provided from over 100 different locations, including Community Hospitals and Day Hospitals; as well as numerous outpatient and other settings within the community such as Health Centre's, Children's Centres and within service users' homes.

Solent NHS Trust was established as an organisation whose primary objective is to manage care in the community. We support clients' independence and self care by providing integrated physical and mental health and social care services around GPs and their practice populations. We specialise in providing integrated services to urban communities with complex health and social care needs and work in partnership with others whose focus is on improving the health of our population.

Our services are focused on city region populations where there are complex health and social needs and where there is a need for a deep partnership with primary and social care to address these.

Our performance over a range of measures has improved significantly over the last 12 months. The Trust is now achieving all its 18 week Referral to Treatment Time indicators as well as all other relevant nationally reported KPIs and has a challenging programme in place to roll out directly bookable clinics through Choose and Book to all consultant and therapist-led services.

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This year we have formally joined the national Foundation Trust (FT) development programme and are working towards achieving Foundation Trust status by April 1st 2013. We believe that authorisation as a Foundation Trust should be the outcome of delivering clinical and business excellence within the organisation and the culture which underpins this.

We are on target with our tripartite formal agreement and expect to be assessed as green by the SHA for our FT trajectory.

B) Our Vision and Strategy

The Trust's strategy over the next three years is to work closely with Clinical Commissioning Groups and local Health and Wellbeing Boards to lead a whole system change in the delivery of services; **our vision is to lead the way in local care.**

We are already providing integrated health and social care but will further develop the model to provide integrated pathways with primary care, in-reaching into the acute trusts. By combining with primary care, users will experience home-based services that are reliable and available 24/7; **our mission is to provide services in partnership to deliver better health and local care.**

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The services we provide will be realistic alternatives to acute hospital care, rather than duplication of services. Solent NHST would expect to make a significant impact on the local system as demonstrated by our strategic objectives and outcome measures.

C) Our Strategic Objectives

Solent's approach to quality strongly influences both the longer term direction and the day-to-day operation of the trust. At the heart of the organisation's strategy is **the quality promise**:

Safety is everyone's highest priority and we have a 'no harm' culture ensuring our staff do the right thing for every person, every time.

We will improve **experience** by putting people at the heart of services and listening to people's views, gathering information about their perceptions and personal experience and using that information to further improve care.

Optimum **clinical effectiveness and outcomes** will be ensured by the application of evidence and best practice in accordance with NICE guidelines and all other national guidance.

We will achieve **regulatory compliance** by ensuring the governance and risk management framework is fit for purpose at all levels; being clear, understandable and seamless whilst supporting continuous quality improvement; meeting the requirements of our regulators and managing clinical risk.

The Board has agreed **three strategic objectives** which flow from the Trust's vision and mission:

Strategic Objective 1:
To provide services which enable improved health outcomes with particular focus on areas of known health inequality

Solent NHS Trust will provide commissioners with services that help improve the overall and individual health outcomes of the local populations that we serve and to improve those at the weakest end of health inequalities fastest, in each and every one of our services

Strategic Objective 2:
To deliver care pathways that are integrated with local authorities, primary care and other providers

Solent NHS Trust will lead (or contribute to) integrated care pathways which address health and social care needs. The design of services will interface with primary care so that GPs know and work with local teams in core services.

Strategic Objective 3:
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Solent NHS Trust will provide commissioners with a range of best value, evidence based community alternatives to acute admissions. This will provide whole-system value benefits and thereby enable the Trust to maintain profitability by incrementally increasing the value of income in profitable services lines. This will be achieved through the retention of existing contracts, the expansion of core business in local urban areas and planned growth beyond the current geographical footprint. Non-profitable service lines will be reviewed and where appropriate discontinued.

Delivery of the Trust's strategic objectives is dependant on a strong organisational culture focused on the delivery of excellent services and a high-performing organisation that achieves commissioner and regulatory compliance through business and clinical excellence.

Clinical Excellence	*Business Excellence*	*Meeting Commissioner Requirements*	*Regulatory Compliance*

These **four underpinning requirements** are reinforced in annual and individual objectives and there is a continuous programme of alignment of the Trust's objectives at every level of the organisation.

D) Key Priorities over the next 3 years

Solent NHS Trust's Operating Plan sets out our four priority work streams for the next 3 years. These work streams form our annual objectives framework – the 'Solent Wheel' – a key enabling tool which we are developing to ensure that the Trust's annual objectives are clearly understood and highly visible at all levels of the organisation and are reflected in divisional, service and individual level objectives. The draft Solent Wheel is shown below.

Priority 1: *To place the people who use our services at the centre of decision making*

We will focus on:

- Delivering evidence-based practice and demonstrating the success and quality of our services
- Reducing variation in clinical practice and performance as evidenced with benchmarking
- Implementing our Operating Model including a Single Point of Access (SPA) and virtual ward infrastructure
- Maintaining our quality standards
- Implementing Telehealth solutions
- Embedding user experience into forward planning

Priority 2: *To value, reward and develop our staff*

We will focus on:

- Prioritising clinical leadership and supervision
- Increasing focus on evaluation and clinical audit
- Incentivising research and new models of care,
- Training staff in transition management

Priority 3: *To deliver service and financial performance and cost improvement programmes safely and confidently*

We will focus on

- Increasing our IT capability with the purchase of performance management and clinical systems to enhance interoperability
- Expanding mobile working
- Rationalisation of our estate

- Delivery of contracts and Cost Improvement Programmes (CIPs)

Priority 4: *To strengthen our commercial position and business resilience through relationship management partnership and collaboration*

We will focus on

- Developing and delivering five-year transformation and market development plans
- Brand awareness and management
- Achieving system wide support for our operating model
- Undertaking systematic periodic stakeholder feedback on the Trust's reputation and leadership role,
- Embedding relationship management
- Expanding our research portfolio

Further detail for each of these priorities is provided in the table below.

Table 1: Key priorities to be achieved in 2012/13, 2013/14 and 2014/15

Key Priorities	How this Priority underpins the strategy	Key Milestones (2012-13)	Key Milestones (2013-14)	Key Milestones (2014-15)
1. PEOPLE WHO USE OUR SERVICES				
1A. Delivering evidence-based practice and demonstrating the success and quality of our services	Solent is focused on the delivery of improved outcomes with quality as the Trust's overriding strategy	Appoint innovations champion and review strategic approach to innovation Define pathway standards across the organisation with identified outcome measures and audit (Phase 1) Focus above on diabetes, dementia, falls, COPD Ensure delivery of CQUINs including high impact innovations	Define pathway standards across the organisation with identified outcome measures and audit (Phase 2) Ensure delivery of CQUINs including high impact innovations	Define pathway standards across the organisation with identified outcome measures and audit (Phase 3) Ensure delivery of CQUINs including high impact innovations
1B. Reducing variation in clinical practice and performance as evidenced with benchmarking	All Solent services need to be consistent and reliable to assure our commissioners of our comparative outcomes	Develop benchmarking systems Use systems and results of audit to monitor performance of clinicians	Provide data and analysis to assist in revalidation of doctors	Provide data and analysis to assist in revalidation of doctors
1C. Enhanced implementation of our Operating Model including a Single Point of Access (SPA) and virtual ward infrastructure	Health and social care teams and a single point of access are fundamental to our delivery model and success Improve operational effectiveness Improves quality of care for service users	SPA fully implemented and effective Agree adult services model for locality teams with primary care and local authorities Develop paediatric single point of referral Link to mobile working and estates rationalisation	Further expansion of virtual wards and LTC hubs Phase 2 of mobile working roll out	Fully developed health and social care model fully aligned to primary care realising benefits

Key Priorities	How this Priority underpins the strategy	Key Milestones (2012-13)	Key Milestones (2013-14)	Key Milestones (2014-15)
1D. Maintaining our quality standards	Quality is the leading strategy for the Trust and underpins all our services	Implement early warning system at service and organisational level to identify quality risks Ensure full compliance against all 26 CQC standards maintained Review Patient Experience and structure and embed user feedback into transformational planning Publish Quality Accounts (June) Establish the non-medical and professional leadership model at divisional level Fully establish the Quality Impact assessment processes ensuring risk management in place floor to board to support change	Maintain external ratings assessment from regulators % improvement in Quality Risk Profile Demonstrate patient experience has informed change, innovation and transformation to effect improved outcomes and efficiency Publish Quality Account - June Demonstrate effectiveness of model and audit against the Nursing and AHP Strategy Demonstrate effective and safe delivery of change	Achieve NHSLA level 2 Maintain external ratings assessment from regulators % improvement in QRP Demonstrate patient experience has informed change, innovation and transformation to effect improved outcomes and efficiency Publish Quality Account - June Demonstrate effectiveness of model and audit against the Nursing and AHP Strategy Demonstrate effective and safe delivery of change
1E. Implementing Telehealth solutions	Supports self care and management at home	All case managed service users and those with LTC to be offered Telehealth	Major deployment of Telehealth	
2. OUR STAFF				

Key Priorities	How this Priority underpins the strategy	Key Milestones (2012-13)	Key Milestones (2013-14)	Key Milestones (2014-15)
2A. Prioritising clinical leadership and supervision	Clinical leadership is fundamental to the delivery of safe and effective services	Business objectives and appraisal for clinical leads Establish clinical senate Appropriate supervision in place across all services	Business objectives and appraisal for clinical leads Refreshed reward system	
2B. Increasing focus on evaluation and clinical audit	Underpins continuous quality improvement and evidences quality standards	Research and audit have a higher profile in every day business Audit used to support revalidation and service improvement	Multi-source feedback embedded in appraisal of medical and senior nursing/AHP staff	Appraisal of staff fully linked to individual and team clinical outcomes
2C. Incentivising research and new models of care,	Increases volume and depth of research and will generate more income and raise the profile of individuals and the Trust Faster introduction of new evidence	Incentive scheme for research and new organisational model Second Annual VIP Awards with special awards for staff living our values	All CLNR targets met	All CLNR targets met
2D. Training staff in transition management		Staff training in transition management for all leaders	Evidence of successful implementation	
3. OPERATIONS				

Key Priorities	How this Priority underpins the strategy	Key Milestones (2012-13)	Key Milestones (2013-14)	Key Milestones (2014-15)
3A. Increasing our IT capability with the purchase of performance management and clinical systems to enhance interoperability	IT capability and interoperability underpins key objective to deliver integrated services	Purchase performance and outcomes information system Commence procurement of clinical systems to enable Solent service interoperability and single health record Focus primary care interoperability in Southampton Deliver single sexual health IT system	Focus primary care interoperability on Portsmouth and Hampshire systems	
3B. Expanding mobile working to increase service productivity and support estate rationalisation	The deployment of mobile working solutions is a key enabler to the Trust's strategy to: Implement step change in domiciliary and clinic based service delivery to increase productivity and optimise patient-facing time Underpin delivery of centralised SPA and Choose & Book systems Support rationalisation of clinic sites to increase efficiency and reduce estate costs Delivery of financial savings through increased productivity (£4.4m over 2 years)	Implement Phase 1 of mobile working strategy to include Establish IT software to support mobile working infrastructure - Desktop virtualisation, VOIP, OCS etc Deployment of mobile working solutions Enhanced SPA infrastructure and system interoperability Identification of strategic hub and spoke sites for multiple Solent services and 'touch down' facilities for domiciliary staff Year 1 Productivity review programme (service-level)	Embed Phase 1 and implement Phase 2 of mobile working strategy to include: Roll-out patient based systems (electronic records) which are complimentary to primary care Deployment of mobile working solutions Enhanced SPA infrastructure and system interoperability Implementation of Solent hub/spokes and 'touch down' centres Year 2 Productivity review programme (service-level)	Embed, evaluate and refresh Phases 1 and 2 solutions Expand SPA infrastructure/ system interoperability Implementation of Solent hub/spokes and 'touch down' centres

Key Priorities	How this Priority underpins the strategy	Key Milestones (2012-13)	Key Milestones (2013-14)	Key Milestones (2014-15)
3C. Rationalisation of our estate	Estates rationalisation critical to deliver high quality efficient estate that customers want to use	Identification of rationalisation plans and delivery of year 1 Acquisition of estate	Deliver estates rationalisation plans and realise benefits	Further rationalisation of footprint towards 30% reduction
3D. Delivery of contracts and cost improvement programmes	Effective CIP delivery builds credibility in the market and strengthens partnership working	Service Line reporting implemented Deliver contracts Deliver £5m CIPs with QIA embed best practice CIPs delivery	Deliver regulator and commissioner requirements Deliver 7m CIPs with QIA	Deliver regulator and commissioner requirements Deliver 7m CIPs with QIA Embed service line management
4. COMMERCIAL RELATIONSHIPS				
4A. Developing and delivering five-year transformation and market development plans	The trust needs to maintain and grow profitable services to sustain the business model	In year and 5 year transformation and Market development plans	Whole system contracting/ year of care/ pathway contracts	Embedding core model into urban areas with specialist expansion to wider geography
4B. Brand awareness and management	As a new trust, business growth is dependant on reputation and brand awareness	Major brand campaign launches	Targeted campaigns based on market plans	Targeted campaigns based on market plans
4C. Achieving system wide support for our operating model	The Solent delivery model needs the continuing engagement of social care and alignment and support from primary care to be effective	Deliver locality teams for frail elderly and LTC and children that are support by primary care and LA H&SC integration phase 1: Formal agreement for future model of integration of health and social care services with SCC	H&SC integration Phase 2: legal framework agreed in phase 1 moves to implementation in SCC. Progress similar approach in PCC	Extended our market reach to other urban areas and AMH in Southampton Locality teams working out of hubs with LTC embedded
4D. Embedding relationship management	Partnership and Collaboration are key to our business USP of integrated care	Embed account management methodology	Development of shared objectives for the future	Extend account management to wider area

Key Priorities	How this Priority underpins the strategy	Key Milestones (2012-13)	Key Milestones (2013-14)	Key Milestones (2014-15)
4E. Expanding our research portfolio	Increases volume and depth of research and will generate more income and raise the profile of individuals and the Trust Faster introduction of new evidence	Meet CLRN targets Joint working with other Trust	Develop further research relationships with the comprehensive local network, industry and universities Provide CCGs with research governance support	Recognition as major community research organisation
4F. Undertaking systematic stakeholder feedback	Relationship management underpins future growth and profitability	Undertake 360 feedback and build results into market plan	Use feedback from our members and governors to inform the business	

Section 2: External Environment

Table 2: Key External Impacts

Key External Impact	Risk to/Impact on Strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
System wide financial pressures, less money to go round, more fragmented commissioning with new entrants	Risk to income plans and profitability Partner organisations need to achieve stringent CIP's	Major emphasis on relationship management and account management Staying close to commissioners; working collaboratively over QIPP plans Improved contracting capability and commissioner responsiveness Financial planning and controls; CIPs delivery	Delivery of system wide QIPP and collaborative working over CQUIN; earn our share £15m CIPs, surplus as planned	Contracts signed Progress on business income Analysis of commissioner perceptions of Solent Reduction in Performance Notices Financial performance on plan
Lack of alignment with local authorities and primary care undermines operating model	Risks to our operating model and our USP Little resource in the system to 'spend to change'	Agreed joint objectives for operating model/ locality teams Account management to be in place	Agreed objectives for locality teams Shared provision with LA	Relationship management feedback Business acquisition
The system continues to purchase fragmented care which stops Solent taking a system leadership role for the whole pathway – commissioners fail to commission interdependent services for continuity of care	Undermines the core business of Solent Doesn't deliver system reform Reduced VFM across public sector	Strategic and tactical dialogue with CCGs and SHIP encouraging integrated care commissioning Building relationships with new CCGs Delivery of admissions avoidance in partnership with other providers	Development of strategies for LTC, elderly and children Increase in Solent led integrated care pathways Delivery of system wide QIPP	Business reviews to Board QIPP delivery

Key External Impact	Risk to/Impact on Strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Risk that acute trusts and clinicians wont collaborate and that commissioning intentions break up pathways	Undermines integrated care model	Commercial heads of terms with other providers Account management Development of LTC strategies with clinician leadership	Agreed integrated pathways with other providers	QIPP report to Board
Loss of Core business – potential competition from others including AQP.	Undermines profitability, reduces income and contribution to fixed costs	Relationship Management Collaborative working with CCGs Further development of the Market Strategy Lifecycle market planning Clear pricing model Growth and retention based on service line and market analysis	5 year market development plan Clear analysis of service line profitability and growth potential	Business won and lost
Solent brand not known, Trust fails to prove impact	Undermines market development	Why Solent campaign	Improved brand recognition	360 feedback results

Section 3: Financial Plans

A) Income

At the start of 2012/13, Solent NHS Trust is confirmed to receive income to the value of £183.3 million. A summary of major income sources is provided below

Table 3 2012/13 income by commissioner

	£000	
Income	183,315	
NHS Portsmouth	63,305	35%
NHS Southampton	51,637	28%
NHS Hampshire	37,487	20%
Local Authorities	9,168	5%
Other income	21,718	12%

B) Cost Improvement Plans

Solent NHS Trust will deliver Cost improvement Plans to the value of £13.4m in 2012/13. The table below summarises the major work programmes to deliver the CIPs with further detail on individual schemes provided at Appendix B

Table 4 Cost Improvement Plans (CIPs)

CIP Programme	2012/13 £'000
Productivity	5,526
Transformation	2,571
Management Costs	2,967
Estates	1,338
Procurement	840
Income Generation	105
Total	13,348

C) Workforce

Solent NHS Trust's Workforce and Organisational Development Strategy is designed to respond to the challenges of the changing environment and support delivery of the Trust's strategic objectives including delivery of the transformation agenda and achievement of Foundation Trust status. The three key priority areas for workforce and organisational development are summarised below:

Table 5 Key Workforce Priorities

Key workforce priorities	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Strengthen the culture	To create commercial and a performance driven culture and one whereby staff feel valued, involved and proud	Achieve IiP re-accreditation Ensure everyone has an annual appraisal and objectives derived from the corporate objectives Maintain place in top quartile of Top 100 Healthcare Employers Deliver VIP/Celebrating Success event Investigate options for reward and recognition framework for high performing individuals	HRD HR Business Partners Directors ADs Heads of Service Managers Staff Side	2012-13 IiP accreditation Deliver 2012-13 VIP event
Develop the capability	To define and develop the skills and capabilities at all levels to lead transformational change and deliver affordable, high quality sustainable community services whilst competing confidently and competently in the market	Deliver Transformational Change Management training for all leaders Development of talent management and succession plans for key senior manager posts Deliver Leadership & Management Development Programmes Recruit & retain best staff Improve people management capability Develop clinical	HRD Learning & Development Team HR Business Partners Directors ADs Heads of Service Managers Staff Side	2012-13 Deliver 'Licence to Manage' programme 2012-13 introduce new integrated management structures across services 2012-3 Prepare for medical revalidation 2013-4 30-40% medical revalidation complete

Key workforce priorities	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
		leads as corporate and management leaders Deliver customer care training as a mandatory requirement for all staff Play active part in development of LETB to influence outcomes for clinical and non-clinical training provision		2013-4 Introduction of nursing revalidation
Build the capacity	To ensure internal capacity and infrastructure exists to transform the organisation to deliver business and clinical excellence recognising that the base case long term financial plan requires a reduction in workforce cost.	Maintain robust workforce controls to deliver workforce plan/KPIs. Develop 5 year workforce plan Extend implementation of e-rostering to maximise effectiveness of rota management Performance manage delivery of workforce reductions in CIPs Reduce days lost due to sickness absence to 3%	HRD Workforce & Performance Team HR Business Partners Directors ADs Heads of Service Managers Staff Side	Deliver 2012-13 Workforce KPIs and CIPs Workforce reductions:- 2012-13 284.9 wte 2013-14 108.5 wte 2014-15 108.5 wte 2015-16 108.5 wte 2016-17 108.5 wte

D) Capital Programmes (including estates strategy)

Solent NHS Trust has identified a capital expenditure programme to the value of £2.5m in 2012/13. These schemes are summarised in the table below:

Table 6 Key Capital Expenditure

Capital scheme	2012/13 £'000
Sexual Health Mobilisation	901
IT Replacement Programme	283
Equipment replacement programme	300
IT Infrastructure	1,029
Total	2,513

E) Clinical Plans

Solent NHS Trust's clinical plans are focused on the delivery of evidence based practice, embedding national standards across our services and measuring our performance through audit of outcomes that are meaningful to both clinicians and service users.

Our clinical plans for the next 3 years are aligned to our quality and care group strategies and are prioritised in the table below

Table 7 2012/13 Clinical Plans by Care Group

Objective	Key Deliverables in 2012/13
A. Adult & Long Term Condition Services	
A1. Joint Health and Social Care Development To lead the delivery of integrated Health and Social Care Locality services including the new model for Community Rehabilitation Beds and Virtual Wards.	• Section 113/75 in place for Rapid Response/PRRT and co-location of locality teams in the East
A2. Single Point of Access To expand our Single Point of Access (SPoA) to cover access to unscheduled and scheduled care services and act as a conduit to commence care and treatment interventions. This will ensure that emergency access is achieved 24/7, complemented by direct and on-going care in the localities as required in co-ordination with Primary Care. To develop our Single Point of Access to provide the 111 service for Hampshire.	• All Adult services to be contactable via SPoA for first contact and ongoing service appointment bookings

Objective	Key Deliverables in 2012/13
A3. Long Terms Conditions To deliver integrated Long Term conditions outpatients and Primary Care provision within the Localities. To promote flexibility and choice in the delivery of care for patients with long term conditions and complex health needs.	• Establish 6 LTC hubs in the East and West to cater for LTCs and co-morbidities.
A4. Admission Avoidance To work with our partners through the provision of community based alternatives to hospital admission, increase capacity in our unscheduled care services and increase clinical confidence in community based models of care. To develop capacity within Community Unscheduled Care services, working with partners to develop alternative pathways to conveyance and providing alternative models for the management of minor injuries and ailments	• Achievement of RSA and ED team targets • Model and maximise capacity in virtual wards to support whole systems pathways
A5. Frail Elderly/ Long Term Conditions Community Care To promote and extend the Common Assessment Framework (CAF) and Case-coordination to the management of Frail Elderly patients and those with Long Term Conditions. To prioritise caseloads through the application of proven stratification methodologies and to work with primary care partners to case co-ordinate/manage elderly/frail/vulnerable adults.	• Roll out ACG with GP practices across all localities complemented by weekly practice case management meetings. • All patients to have a CAF plan and AACP.
A6. End of Life, Palliative Care and Safeguarding To safeguard Vulnerable Adults and those with Long Term Conditions through vigilance and sensitivity to clients needs. Safeguarding Vulnerable Adults is at the heart of everything we do. Key objectives are therefore in partnership with our partner agencies to ensure that people are free from abuse and neglect, and are supported to die in their place of choice.	• All EOL patients to be on Gold Standards Framework and die in place of choice • All palliative care patients to be on Liverpool Care Pathways

Objective	Key Deliverables in 2012/13
A7. Telehealthcare and Technology To maximise IT advances embedding electronic records to enhance patient care and capitalising on advances in Telecare and Telehealth. The pathway team will build on an excellent track record of capturing patient experience and public engagement. Health Promotion and self-management of long term and complex conditions will be key to sustaining future models of practice.	• All Case managed patients and those with single LTCs to be assessed for Telehealth. • All Telecare users to be offered this functionality
A8. Interoperability To promote flows of information pertaining to the care of patients with long term conditions and complex health needs. To ensure that information is available to relevant health and social care professionals to inform clinical decision making at all relevant points in the pathway.	• TPP/RIO to be linked into the HHR to ensure patient records are accessible to primary care.
A9. Working to support the private sector To work more closely with Nursing Homes to meet the healthcare needs of their residents and support skills training and specialist advice. This will also assist with capacity management, delayed transfers of care, and admission avoidance.	• All Nursing home patients to have an AACP and CAF.
A10. New Business Opportunities To develop new business for our Adult and Older Persons Services division through consideration of emerging opportunities in line with our commercial strategy and on the basis of "fit" with our core business, clinical expertise, clinical risk and geographic proximity.	• III tender/RR Gosport/Countess Mountbatten House/ OPMH West services/ LTCs East to be pursued in next 12 months
B. Children and Family Services	
B1. Health Visiting Services To improve access to health visiting services through the delivery of the Implementation Plan for Action on Health Visiting	• Set up Solent NHS Trust steering group to monitor and manage the plan • Implement the 2 year check pilot (subject to evaluation) • Train 18 HV students in 2011/12 and 29 in 2012/12; complete training of 3 return to practice students in 2011/12 • Fill all new vacant posts through recruitment of students • 90% of HVs to complete minimum of 2 days CUSP training

Objective	Key Deliverables in 2012/13
B2. Sexual Health Services To improve patient access to and experience of sexual health services through the implementation of a clinical and cost effective integrated Sexual Health model.	• Complete staff skills review, implement CIP and a revised staffing structure • Develop and deliver a training and up-skilling programme for Doctors (30%), nurses (25%) and HCSWs (25%) to achieve dual competency • Design and open a new hub delivering integrated services in Basingstoke and Aldershot locality • Design, commission and implement an IT EPR and data capture and reporting system
B3. Children with disability & complex needs To increase parental satisfaction and improve outcomes for children with disability and complex needs through integrated and co-located service delivery	• Implement the new model of integrated services in Southampton – Children's Development Service(CDS) • Ensure multi professional clinical participation in workstreams to develop an integrated model for children with disability in Portsmouth • Scope requirements and influence business case for co-location in Portsmouth
B4. Avoidable hospital admission To reduce avoidable hospital admission for children and young people	• Evaluate the COAST pilot in Southampton • Evaluate the COAST pilot in Hampshire • Develop and submit business cases to permanently expand the COAST service to Hampshire and Southampton • Develop and submit business case for Intensive Home Treatment Service for children and young people with acute CAMHS needs to NHS Hampshire • Implement pilot project in Solent West working in conjunction with ED, HV service and Surestart to follow up frequent attenders
B5. General Paediatrics To improve access to care and treatment out of hospital for children and young people with non acute general paediatric health needs	• Implementation of the general paediatric Single Point of Access
B6. Patient Experience To Improve experience of young people accessing Solent NHS Trust services	• Develop a roll out plan to achieve You're Welcome accreditation for all services delivering advise, care and support to adolescents • Monitor the plan at Divisional Clinical Governance Group and take corrective action if required
B7. Health outcomes and inequalities To improve health outcomes and reduce inequalities	• Reduce waiting times for paediatric therapy in Hampshire through waiting list initiative and pathway redesign • Develop staff involvement programme to embed health promotion as everyone's business

Objective	Key Deliverables in 2012/13

B8. Evidence-based care
 	
To ensure implementation of the most up to date clinical evidence to deliver high quality, safe and effective care
	• Implement and evaluate a pilot of Group interventions in the Family Nurse Partnership (FNP) Programme in Southampton
	• Fully implement the FNP Programme in Portsmouth
	• Implement the new model of Speech and Language Therapy in Southampton
	  ○ Phase 1 pre school
	  ○ Phase 2 School age

B9. Safeguarding To ensure safe, high quality and effective safeguarding children services maximising capacity to respond to increasing demand	• Review and implement a new model for safeguarding children supervision for health visitors and school nurses • Implement a multi agency pilot to improve quality and efficiency of CYP reporting processes in Southampton (in partnership with children's social care and Hampshire constabulary)
B10. Clinical Governance To demonstrate robust clinical governance systems and processes that ensure safe, effective services	• Appoint CG medical and non medical leads with dedicated admin support • Establish Divisional Clinical Governance Groups for sexual health and children
C. Sexual Health Services	
C1. People who use our services To place people who use our services at the centre of decision making	• Participate in Solent NHS Trust Patient Experience Surveys and Privacy, Dignity and Respect audits • Perform additional surveys for Young People, patients with HIV, patients accessing Psychosexual Therapy • Signpost patients to the most relevant pathway/service to ensure excellent care
C2. Our Staff To value, reward and develop our staff	• Support staff to attend study leave, engage in training (clinical and leadership), share learning and participate in clinical supervision as identified in PDP • Clinical Leads to have allocated time in their job plans to perform their role • All staff (clinical and non-clinical) to receive feedback through 360, and compliments (verbal or written) are communicated and success is celebrated • Arrange away staff development days and staff meetings to involve, educate and network staff to meet service delivery requirements • Support staff to develop their skills to ensure continuous quality improvement and to meet service delivery requirements. e.g. some of our nurses are Non-Medical Prescribers, can fit coils and perform Ultrasound scans in early pregnancy

Objective	Key Deliverables in 2012/13
C3. Operations To deliver service and financial performance and cost improvement programmes safely and confidently	• Service is innovative and consistently reviews processes to maximise efficiencies and patient experience (e.g. touchscreen self-registration kiosks) • Pathways streamlined to ensure best patient experience (e.g. revising our Unplanned Pregnancy pathways to reduce the number of visits) • Complete care in a 'one stop shop' which avoids repeated visits and increases patient satisfaction e.g. assess and fit LARC at same clinic visit • Provide holistic care, including health promotion, Chlamydia Screening, Implementation Intention Formation, language difficulties, Risk Assessments for Young People, training of clinical staff • Audits against NICE Guidance for Long Acting Reversible Contraception • Evidence clinical outcomes, e.g. appropriate recording of BP and BMI for all Combined Hormonal Contraceptive prescriptions, recording of Batch Numbers and Expiry Dates for all drugs issued, medication issued under Patient Group Direction, offering of Chlamydia Screening, completion of Risk Assessments, Chaperones offered, Verbal Consent obtained, TOP complications, Condoms card offered • Active audit plan in place
C4. Commercial Relationships To strengthen our commercial position and business resilience through relationship management, partnerships and collaboration	• Pathways in place for integrated care • Interface successfully (email, telephone, meetings) with Primary and Secondary Care, both in sharing patient care and best practice/protocol, and providing advice to clinical queries • Support GPs (advice and training) who are signed up to the Sexual Health LES • Awareness of financial opportunities, e.g. introduction of Deep Implant Removal Service charged at 'Carpal Tunnel Release' rate
D. Adult Mental Health Services (including Substance Misuse Services)	
D1. Recovery To demonstrate improvements in recovery orientated services.	• Reduced Acute Pathway episodes (10%) • Increase community contacts (10%) • 90% of Service users report that they agree or strongly agree that they can identify a positive change since starting treatment. • Achievement of recovery specific targets (SMS)

Objective	Key Deliverables in 2012/13
D2. Care Planning To ensure service users are leading their care through involvement in care planning.	• 95% of service users having a signed care plan • A range of evidence that service users are involved in decision making; CQC feedback, Audits, Patient surveys.
D3.Partnership working To have effective partnership working within and outside the service	• Seamless interface between CMHT and ACP, demonstrated by 90% of service users allocated a care coordinator within 72 hours of request. • Develop on links to support service users back into education and or employment; eg; Job Centre Plus • Exceed commissioned targets linked to employment. • Review Dual diagnosis pathway. • Referrers only required to make one contact with service, once referral received AMH ensures it reaches the correct teams.
D4. Supervision / IPR To ensure a robust supervision / IPR structure is in place to meet the needs of staff	• 85% of staff in date with IPR and receiving regular supervision by Oct 2012. • Review of training opportunities available to staff to ensure that a minimum of 3 bespoke training events are delivered to meet needs of a range of staff
D5. Staff Sickness To reduce staff sickness through full utilisation of HR processes	• AMH / SMS to achieve 3% staff sickness across the service. • Each clinic area to identify a sickness reduction target to achieve.
D6. Clinical Governance To have an effective system of Clinical Governance that supports effective practice whilst ensuring evidence for compliance with CQC standards	• Clinical governance agenda demonstrating the role of governance in day to day practice. • Each team having a method of evidence collection, where evidence is available at 4 points throughout the year. • CQC inspections rate service as complying with standards.
D7. Financial Performance To ensure each service to achieve CRES savings plans for 2012/13	• Savings plans achieved across the service without determinately effecting commissioned targets and quality.
D8. Service Provision To ensure service users experience no drop in the quality of service provision during and after the AMH Community Transformation	• 100% of service users report that they have not noticed any negative change or loss in any parts of their care that can be attributed to the project.
D9. Service Reputation To ensure all services participate in national accreditation programmes where available	• Mental Health Liaison team to achieve reaccreditation within PLAN. • Orchards inpatient ward to work towards accreditation within AIMS.

Objective	Key Deliverables in 2012/13
D10. Performance SMS to work to achieve all performance targets for 2012/13 financial year	• All targets achieved to full satisfaction of commissioners.

G) Board Statement on Quality Governance

The Solent NHS Trust Board has overall responsibility for the scrutiny of the Trust's quality and clinical governance agenda and outcomes and for meeting all statutory requirements. The Board leads and directs quality and its governance through a combination of structures and processes at and below Board level. The clinical leadership structure (medical and non-medical) at Divisional level empowers the design and delivery of safe and effective high quality services at divisional and service levels. Patient Safety and Quality are high on the Board agenda and have focus and priority in the Business Assurance Framework (BAF) and SIC.

The Board achieves this through systems such as, but not exclusive to: the scrutiny of reports in respect of performance, outcomes and risk presented to Board, listening to stories from people who use our services and staff who deliver them through various methodologies including Board-to-Floor walkabouts.

Quality is safeguarded by external accreditation including CQC registration, NPSA, external and internal audit. Solent NHS Trust will simplify the policy and delivery landscape, aligning and re-enforcing shared priorities, and provide the appropriate balance between performance management and continuous improvement.

The Trust's quality governance framework establishes a shared understanding of quality and a commitment to place it at the heart of all business. The Trust will adopt the four component parts of Monitor's Quality Governance Framework as part of its continuous cycle of assurance:

- Strategy
- Process and Structures
- Capability and Culture
- Measurement

The arrangements for quality governance will complement and be fully integrated with all the other governance arrangements in place to ensure the Board is competent in fulfilling all of its statutory responsibilities. Correct processes and levers are in place to assure the executive team of a robust and credible reporting structure which will support the organisation throughout the Foundation Trust application pipeline.

Ultimately, the Trust Board is responsible for the quality of care delivered across all services provided by Solent NHS Trust, however responsibility will be delegated right through to individual staff members ensuring that quality improvement becomes the 'Golden Thread' in everything that the organisation does.

The Board will create a culture of openness and transparency in all dealings with customers from the ward to the board. All Managers will be expected to continuously improve care by listening to service users and learning from mistakes. Engagement and involvement of staff and patients at all levels will ensure that areas for improvement are continuously identified.

The Trust's Quality Account is Solent's annual public report on quality with the key objectives agreed and commented on by all internal and external stakeholders

Section 4 Regulatory Requirements

Table 8 Key Regulatory Risks

Key Regulatory risks	Key Lead	Nature of risk	Actions to rectify/mitigate and responsibilities	Measures 2012/13 2013/14 2014/15
CQC Registration Compliance – maintenance of registration for existing services	Judy Hillier	The Trust is currently registered without conditions; however there is a risk that the Trust could potentially breach aspects of its registration in year.	Monthly review of CQC compliance to the Assurance Committee (which then reports to the Board) – Judy Hillier	Ongoing
CQC Registration Compliance – for new business	Judy Hillier	Ensuring that plans to ensure CQC registration is factored in at an early stage into programme management governance processes	Enhance Programme Management Governance arrangements reporting through to the Trust using the Quality Impact Assessment tool. Trust Management Team meeting, to ensure that key regulatory compliance requirements associated with new business are incorporated and monitored – Judy Hillier	Ongoing
CQC Compliance – Fit for purpose estate	Judy Hillier / Ted Griggs	Failure to maintain estate to required standard (Dependent on whether estate transfers)	Planned preventative maintenance programme implemented with capital investment aligned. Monitoring safety and compliance for the organisation as the client via the Health and Safety subcommittee Strategic Estates Group to monitor programme	Ongoing
Quality Accounts	Judy Hillier	Failure to comply with objectives set by internal and external stakeholders	Monitoring via a bi-monthly Quality Account dashboard to measure progress against KPIs via Assurance Sub-Committee – Judy Hillier	Ongoing

Key Regulatory risks	Key Lead	Nature of risk	Actions to rectify/mitigate and responsibilities	Measures 2012/13 2013/14 2014/15
Monitor's Quality Governance Framework	Judy Hillier	Failure to meet the requirements of the quality governance framework and continuously improve quality of care	Bi-monthly monitoring of KPIs via Assurance Sub-Committee Quarterly monitoring of CQC Quality Review Process (QRP) to Board	Achieve Amber/Green or Green rating each year.
Monitor's: • Financial Risk Rating • Governance Risk Rating	Michael Parr – Finance Judy Hillier & Rachel Cheal – Governance	There is a risk that the Trust does not score green for the FRR and GRR	Self assessment via the Performance Assurance Framework in shadow form for 2012/13. FFR is reported each month to Board via Finance Report.	Shadow score FRR and GRR in PAF (2012/13) Green reporting of FRR and GRR for 2013/14 & 2014/15
Information Governance Toolkit	Michael Parr (Shelley Brown)	There is a risk that the Trust does not achieve the required Level 2 IG Toolkit score	Action plan to address key risk areas. IM&T and IG Subcommittee established to monitor action plan – reporting to the Trust Management Team Meeting. Scheduled updates on IG at Board.	All requirements for L2 met 2013/14 – all requirements for L2 met 2014/15 – all requirements for L2 met
Compliance with mandatory and commissioner KPIs/indicators (e.g. national targets and agreed contractual KPIs)	Dave Meehan – Operations Michael Parr – Contracting	Failure to meet mandatory targets	Weekly performance meetings. Development of integrated dashboards	All KPIs green for all 3 years. Integrated dashboards developed - ongoing
		Lack of IT system to support performance management and reporting agenda	Implementation of IT Strategy –procurement of suitable IT solution for performance monitoring/managing system a priority.	2012/13 – procure performance reporting tool 2013/14 & 2014/15 timely, accurate & complete reports and dashboards
Recruitment of Members	Sarah Austin	Failure to meet the required membership targets	Membership Strategy & implementation plan. Targeted recruitment to ensure representative membership across constituencies. Monitoring and	Quarterly membership Targets (Public): Jan –Mar: 1400 Apr-Jun:2190 Jul-Sep: 3050 Oct-Dec: 3740

Key Regulatory risks	Key Lead	Nature of risk	Actions to rectify/mitigate and responsibilities	Measures 2012/13 2013/14 2014/15
			reporting via the Membership Steering Group and FT Subcommittee.	
Election of Governors	Rachel Cheal	Failure to elect the minimum number of governors to establish the Council of Governors	Membership Strategy & implementation plan. Governor project plan – details promotional activity to encourage nominees, and nominee briefings.	2012/13 Council of Governors established with 25 Governors.
		Elections not held in accordance with model election rules	UK Engage appointed to conduct the independent administration of elections in accordance with Model election rules.	Elections held in accordance with MER 2012/13
Financial Stability, profitability & liquidity – potential fines	Michael Parr	Failure to meet contracted performance could result in financial penalties (inc. non performance/non achievement of agreed KPI or variations in agreed trajectories, failure to deliver CIP plan).	Weekly Performance Group chaired by DoF and COO reporting back to CEO Improved Contracting regards rationalisation of KPIs, service reviews, etc Stronger position on QIPP % & Proportionality of fines Improved Performance Management Software Finance Committee Chaired by NEDs with CEO & DoF in attendance	Set up Jan-12 Feb-12 Negotiation Capital Investment and Implementation Q1 2012-13 Set up Nov-11

A) Board Declaration of CQC compliance

The Board can declare full compliance with all CQC registration requirements; there are no identified areas for improvement in 12/13 in respect of compliance.

In 2011/12 the Trust had a number of unannounced CQC MHAC visits to the adult and older persons mental health services and whilst no quality assurance issues were identified, the minor operational issues were addressed and learning integrated into the organisational continuous improvement plan. The single community based CQC unannounced visit (Podiatry services in 2011/12) identified excellent practice in place.

Section 5: Leadership and Governance

Table 9 Leadership and Governance Priorities

Key leadership and governance priorities	Key Lead	Key risks (and gaps)	Action to rectify/mitigate	Milestones 2012/13 2013/14 2014/15
Ensure the Board has the key skills to deliver the Strategic Objectives and Annual Objectives	Ros Tolcher/ Alistair Stokes	Any gap in board capability would undermine delivery of the Trust's objectives or public confidence	Board Development programme being implemented KPMG review of board effectiveness (2010) used to inform board development programme and appointment of new NEDs and EDs Continually assess Board skills requirement and address needs as identified	Delivery of Board Development Programme 2012/13 Ongoing achievement of PDP and objectives as reviewed in appraisal process Board effectiveness and contribution to Board objectives reviewed at appraisal of EDs annually
Stability of the Board	Ros Tolcher / Alistair Stokes	A high rate of turnover in board members would undermine progress and delivery of strategic plan	Succession plans to be developed to ensure if Board members do leave, appropriate successors are recruited in a timely manner (and viable interim arrangements can be made) to ensure composition of Board is maintained and correct skills mix	2012/13 delivery of succession plan – and ongoing review/refresh as appropriate Appoint to vacant roles as necessary
Development & use of Board Assurance Framework	Ros Tolcher	Failure to utilise BAF appropriately - gaps in assurances/controls do not drive the Board agenda	Strengthen Board understanding of purpose of the BAF Monthly statement of affirmation from Board	2012/13 – Board briefing on BAF Ongoing evidenced consideration of identified gaps within Board minutes

Key leadership and governance priorities	Key Lead	Key risks (and gaps)	Action to rectify/mitigate	Milestones 2012/13 2013/14 2014/15
			BAF used to direct monthly board agenda planning	
Organisational Development and delivery of OD Strategy/Plan	Julie Pennycook	Risk of non-delivery of goals identified against the three strategic aims	Delivery action plan to be prepared and performance managed through Workforce & Development Sub-Committee	Delivery of action plan
Establish governance arrangements incorporating establishment of Council of Governors	Rachel Cheal	Risk that Board and CoG is unclear on roles and responsibilities	Governor project plan Board briefing at workshop on 23rd Jan 2012 Governance Arrangements document planned which will detail the Trust's governance structure	2012/13 – Delivery against key milestones in governor project plan Deliver Board briefing. Develop 'Governance Arrangements' document
Implementation of new workforce structure to meet CIP plan targets	Julie Pennycook	Failure to implement changes and or meet CIP plan targets	CIP implementation plan to be prepared and performance managed	Delivery of implementation plan

Appendices

Appendix A: Detailed Finance Summary

	Mar - 13
Revenue	
Protected/Mandatory Clinical Revenue (Block)	151.5
Protected/Mandatory Clinical Revenue (C&VC)	0.9
Protected/Mandatory Clinical Income (Other)	9.2
Other revenue	21.7
Non recurring revenue	
Total revenue	**183.3**
Expenses	
Employee Benefit Expenses	(122.8)
Non-Employee Benefit Expenses	(59.1)
Secondary Commissioning Expenses	
Non recurring expenses	
Total Expenses	**(182.0)**
Normalised EBITDA	**1.3**
EBITDA Margin (%)	1%
Normalised Net Surplus/(Deficit)	**0.8**
Reported net surplus margin (%)	0.4%
Cashflow from Operations	(5.0)
Capex	(2.6)
Cashflow before Financing	(7.6)
Net Cash Inflow / (Outflow)	(7.6)
Year End Balance Sheet cash position	4.1
Net current assets / (liabilities)	0.2
Overall Risk Rating	2.0

Appendix B: Cost Improvement Plans

Scheme name	Project Lead	Savings in 2012-13				RAG rating	Workforce impact (WTE)
		Pay expenditu	Non-pay expenditure	Misc income	Total saving		
CAMHS Productivity	Anne Fleming/Barbara Inkson	319	5		324	A	11.11
Disability & Complex needs Productivity	Angela Anderson/Jamie Schofield	105			105	A	2.77
Sexual Health Productivity	Sally Pastellas		75		75	A	
Sexual Health Transformation	Sally Pastellas	600			600	A	3.00
Health Promotion Productivity	Glenn Turner	60			60	G	1.50
Child & Family mobile working	Dave Meehan	383			383	A	10.00
Child & Family Productivity	Dave Meehan	82			82	A	2.20
HIV/LARC/HPV Productivity	Dave Meehan		500		500	A	
Child & Family management restructure	Dave Meehan	548			548	A	12.00
AMH Transformation	Kieran Kinsella	633			633	G	8.00
AMH Productivity	Don Muvuti	620			620	G	44.00
Substance Misuse Transformation	Dawn Roberts	45	175		220	G	1.00
SPA Transformation	Matthew Hall	785			785	G	26.10
SPA Productivity	Matthew Hall	10			10	G	0.30
OOHs Transformation	Matthew Hall	700			700	G	13.00
Mental Health mobile working	Dave Meehan	92			92	A	2.50
Mental Health Productivity	Dave Meehan	57			57	A	1.50
LTC Productivity	Dave Meehan	50	200		250	A	1.70
Primary Care Productivity	Mike Townson	20			20	G	1.00
Community Equipment Productivity	Lin Burton		25		25	G	
Health Centres Productivity	Toni French		137		137	G	
S&LT Productivity	Pippa Cook	40			40	A	
Podiatry Productivity	Mike Townson	35	15		50	G	1.00
Podiatry Income Generation	Mike Townson			50	50	A	
Physio Productivity	Christine Hayward	195			195	G	2.00
Offender Health Productivity	Jo Pinhorne	545	20		565	G	7.70
Outpatients Productivity		23			23	G	1.00
Primary Care Income Generation	Jo Pinhorne			10	10	A	
John pounds Productivity	Dave Meehan	250			250	A	
Physio Income Generation	Christine Hayward			15	15	A	
Prof & Spec Services Management restructu	Dave Meehan	1,234			1,234	G	34.75
Wheelchair service Productivity	Dave Meehan		100		100	A	
Prof & Spec Svcs sicknbess management	Dave Meehan	49			49	A	1.30
Adult Community Healthcare Transformatio	Jackie Chalwin	50			50	A	1.00
Adult Community Healthcare Productivity	Jackie Chalwin	154	10		164	A	1.50
Inpatient Services Productivity	Ellen McNicholas		20		20	A	
OPMH Productivity	Maggie Vilkas	157			157	G	6.50
LD/Neuro Rehab Productivity	Ged Kearney	150			150	A	3.50
Adult services mobile working	Dave Meehan	525			525	A	14.00
Adult services sickness management	Dave Meehan	146			146	A	3.90
Adult services productivity	Dave Meehan	108			108	A	2.90
Adult management restructure	Dave Meehan	1,104			1,104	G	25.59
Estates	Ted Griggs	353	277		630	A	
Corporate Management Costs	Michael Parr	937			937	G	18.57
Procurement	Michael Parr		550		550	A	
					-		
Unidentified					-		
					-		
TOTAL SAVINGS		11,164	2,109	75	13,348		266.89

Appendix C Membership Return at 16th February 2012

Membership Size and Movements

	2011/12
Public Constituency	
At year start (April 1)[1]	0
New Members	1084
Members leaving[2]	43
At year end (31 March)	1041
Staff Constituency	
At year start (April 1)	0
New Members	3670
Members leaving	0
At year end (31 March)	3670

Analysis of membership at 31 March 2012

Public Constituency	**31 Mar 2012 members**	**Eligible Membership**
Age		
0-16	11	339,255
17-21	147	118,588
22+	879	1,288,703
Unknown	4	
Ethnicity		
White	852	1,590,466
Mixed	10	13,751
Asian or Asian British	59	22,030
Black or Black British	18	6,549
Other	16	11,438
Unknown	86	
Socio-economic groupings		
ABC1	562	617,610
C2	183	190,204
D	216	180,628
E	79	44,181
Unknown	1	
Gender		
Male	394	860,824
Female	646	885,723
Unknown	1	
Staff Constituency		
Members	3670	3675

[1] Membership recruitment commenced in June 2012
[2] This cohort of patients moved from patient to public category as Trust decision to retain public category only

Appendix D Directors (as at 1st January 2012)

Role	Job Title	Name of Director	Tenure	Date appointed
Chair	Chairman	Alistair Stokes	Office Holder	01/04/10
Chief Executive	Chief Executive Officer	Ros Tolcher	Without Limit	01/04/11
Director of Finance	Director of Finance and Performance	Michael Parr	Without Limit	01/07/11
Medical Director	Medical Director	Tony Snell	Without Limit	25/07/11
Other Board Director	Director of Nursing and Quality	Judy Hillier	Without Limit	01/04/10
Other Board Director	Chief Operating Officer and Deputy Chief Executive	David Meehan	Without Limit	13/11/92
NED	Non Executive Director	Michael Tutt	Office Holder	01/04/10
NED	Non Executive Director	Elizabeth Bailey	Office Holder	01/04/11
NED	Non Executive Director	Barry Neaves	Office Holder	01/04/11
NED	Non Executive Director	Brad Roynon	Office Holder	01/03/11
NED	Non Executive Director	David Griffiths	Office Holder	01/04/11

Operational Directors

Other Director	Director of Strategy	Sarah Austin	Without Limit	28/11/11
Other Director	Director of HR and OD	Julie Pennycook	Without Limit	01/01/08

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5 March 2012 – 28 May 2012

Solent NHS
NHS Trust

Have your say

Public consultation on our application to become an NHS Foundation Trust

Better health, local care

Agenda Item 13
Appendix 2

Contents

Dr Ros Tolcher
Chief Executive

Alistair Stokes
Chairman

Solent NHS Trust is applying to become an NHS Foundation Trust from April 2013. We believe that becoming a Foundation Trust will bring important benefits to the communities we serve. We will be able to be more innovative and provide even better services to people.

As a Foundation Trust, we will have a membership and a Council of Governors. This means that the public, people who use our services, carers and staff will be able to shape the organisation and have even more of an influence in the way it is run.

This consultation document explains the benefits of becoming a Foundation Trust. It also shares our plans for the next five years, our governance and membership proposals and it lets you know how you can get involved with your local community and mental health trust.

Welcome

The consultation asks you questions which cover three areas:

- Our vision and future plans
- Our membership
- Our Council of Governors

We welcome your views. They will help shape the future of the Trust.

We also invite you to become a member, and possibly a Governor, of our Trust and have a greater say in how we are run, and how our services are provided.

Your views on our proposals will form part of our application to become an NHS Foundation Trust. Please have your say before 28 May 2012 by:

- filling in the form at the end of the document
- visiting our website and filling in our online form at www.solent.nhs.uk
- phoning us
- emailing us
- writing us a letter.

We would very much like to meet with you at one of our consultation events. For more information visit our website or call 023 8060 8937.

Thank you for taking the time to read our proposals. We look forward to receiving your comments.

About Solent NHS Trust

- We were created as an NHS Trust on 1 April 2011.
- We are the main provider of community services to the cities of Portsmouth and Southampton and to parts of Hampshire.
- We are the main provider of mental health services to people living in Portsmouth.
- We work in over 100 clinical sites spread across the areas we serve.
- We employ over 3,500 staff.
- We have an income of more than £175 million.
- We have over 1.5 million patient contacts each year.

Our services

We provide the following services across Southampton, Portsmouth and Hampshire.

Services	Provided predominantly to:		
	Portsmouth	Southampton	Hampshire
Adult Mental Health			
Adult Mental Health	•		
Neurological Inpatient Rehabilitation	•	•	•
Eating Disorders Service	•		
Chronic Fatigue Service	•		
Psychology / Psychological Therapies	•		•
Older Persons Mental Health Services	•		
Learning Disabilities (LD)	•		•
Children and Families			
Audiology and Newborn Hearing		•	•
Child and Adolescent Mental Health (CAMHS)	•	•	
Community Paediatric Medical Service	•	•	•
Community Children's Nursing Service	•	•	•
Children with LD Units		•	•
Health Visitors	•	•	
School Nurses	•	•	
Enuresis and Encopresis		•	•
Occupational Therapy (Paediatrics)	•	•	•
Physiotherapy (Paediatrics)	•	•	•
Child Clinical Psychology	•	•	•
Sleep Service	•	•	•
Speech and Language Therapy	•	•	•

Services	Provided predominantly to:		
	Portsmouth	Southampton	Hampshire
Sexual Health Services			
Sexual Health Services	•	•	•
Inscape and Southampton Gay Men's Health Promotion Service	•	•	•
Treetops Sexual Assault Referral Centre (SARC)	•	•	•
Primary Health Care Services			
GP Out of Hours	•	•	•
Dental Services		•	•
Endoscopy		•	
Nicholstown GP Surgery		•	
Adelaide GP Surgery		•	
John Pounds Medical Centre	•		
Paulsgrove and Wymering Healthy Living Centre	•		
Offender Health (HMP Kingston, HMP Winchester, IRC Haslar)			•
Homeless Healthcare		•	
Patient Contact Centre (Choose and Book)	•		•
Walk-in Centre		•	
Minor Injuries Unit		•	•

Services	Provided predominantly to:		
	Portsmouth	Southampton	Hampshire
Health Promotion			
Health Promotion Services		•	
Stop Smoking Services	•	•	
Promoting Independence/Care Closer to Home			
Community Equipment Service	•	•	
Community/ District Nursing (inc. Community Matrons, Continence and Stoma)	•	•	
Safeguarding Adults	•	•	
Specialist Palliative Care	•	•	
Continuing Care / End of Life Care (Jubilee House)	•		
Intermediate Care and Rapid Response	•	•	
Inpatient Rehabilitation Units			
Spinnaker, Rembrandt and Royal South Hants Hospital	•	•	
Stroke Rehabilitation Unit		•	•
Occupational Therapy (Adults)	•		•
Physiotherapy (Adults)	•	•	
Podiatry	•	•	•
Cardiac Nurses (inc Rehabilitation)		•	
Diabetes		•	
Substance Misuse Services	•		•

What do we do?

Our role is to provide community and mental health services to local people.

We work with families to help children have the best start in life. We provide community support when children are unwell and need extra help.

We work with adults and older people with physical or mental health problems. We provide care in the community.

By working together with GPs and social services, we bring services together to help people manage their condition better, to stop it getting worse and to help keep people at home.

We also promote health and well being. Our screening and health promotion services help people to lead a healthy lifestyle.

As part of the NHS family, we work closely with other Trusts to make sure that the people who use our services get the best possible care.

About Foundation Trusts

What is a Foundation Trust?

A Foundation Trust:

- is part of the NHS
- is answerable to local people who can become members and Governors, they will have even more of a say on how we do things
- has more freedom to provide services which meet the needs of local people
- still has to meet national standards for things like cleanliness and the quality of care
- is overseen by a national body called Monitor which can intervene if it thinks that rules are not being followed
- has more financial freedoms, and can keep money to invest back into services.

Five good reasons to become an NHS Foundation Trust

Why an NHS Foundation Trust?

1) Even more involvement of local people through membership

NHS Foundation Trusts are membership organisations. People like you can join as a member and help shape the future of our Trust and our services.

2) Staff will also have even more involvement

Staff will have even more opportunities to get involved in the direction of the Trust and will be able to stand for election as a staff Governor.

3) More opportunities for services to innovate

Our staff, the people who use our services and carers often know how we can make our services even better.

Whilst we have clear targets which we have to meet, becoming a Foundation Trust will give us even more opportunity to innovate and introduce new things to provide the best services we can.

4) More financial freedoms

As an NHS Trust we will have more financial freedom. This means that we will be able to make a surplus and re-invest this back into our services to benefit local people.

5) Well organised

The process of preparing to be become a Foundation Trust is very rigorous and involves us making sure that our organisation is delivering good quality and is fit for purpose.

Our vision and values

These are the things which help us get to where we want to be. Our vision… where we see ourselves in the next five years. Our values… how we will behave.

Our vision - To lead the way in local care.

Our values

I N S P I R E

- Involved
- Nurturing
- Striving for excellence
- Passionate
- Innovative
- Respectful
- Empowered

Our plans

Our Foundation Trust application includes a five year business plan, called the Integrated Business Plan (IBP). The IBP describes our vision for the Trust and health services in the local area. It also outlines our objectives and how we will achieve them.

Our future plans

We want to develop our services so that they meet the needs of local people.

We plan to provide more and more services in the community so that people can increasingly receive their care in, or close to, home.

We will work with family doctors, social services, and with the people who use our services and their families to provide home based, reliable services, 24 hours a day, seven days a week. We will also work with other NHS Trusts/Foundation Trusts so that people who move between organisations as part of their care, have a good experience.

With improved community care, our proposals will help patients with the most complex medical and social needs remain in their own home, when it is appropriate for them to do so, rather than having to be treated in hospital.

Quality promise

Our quality promise ensures that:

- services are safe
- people have a good experience of our services
- we use best practice to ensure better outcomes for our patients
- we meet national standards.

A patient-led organisation

Meaningful patient and public involvement is key to the success of the Trust. We will ensure that we continue to engage and involve the people who use our services, carers, partners and wider stakeholders in our services.

We will:

- raise awareness of our services and the work of the Trust
- create opportunities for involvement
- support and empower patients
- improve information for patients.

How will we get there?

Our vision is supported by three objectives. Our Objectives are based on what our partners, the people who use our services, staff and Commissioners tell us what they would like us to do.

Objective 1:

To provide services which enable improved health outcomes with particular focus on areas of known health inequality.

We will provide services which help improve the overall and individual health outcomes of local people to improve those at the weakest end of health inequalities fastest.

Ways in which we will achieve this include:

- Supporting people to stop smoking.
- Encouraging mums to breast feed.
- Helping substance misuse patients stay drug free.
- Helping people get back into employment.
- Helping people to manage their own health problems, sometimes using technology in the home.
- Putting services into people's homes to prevent them going into hospital when they don't need to.

Objective 2:

To deliver care pathways that are integrated with local authorities, primary care and other providers.

We will provide services, which address both health and social care needs.

Ways in which we will achieve this include:

- Creating teams of health and social care staff who can provide for all of the patient's needs.
- Identifying people who need special support in the community with complex conditions such as diabetes, heart or lung problems. By intervening early we will be able to keep people well for longer and stop their illness getting out of control.
- Ensuring our teams have specialist skills so that even complex care can be provided at home.
- Ensuring all of our services can be easily accessed through a single phone number and ensuring that we can respond to urgent needs 24/7.
- Sharing records of care between different health professionals and working collaboratively with other local NHS providers.

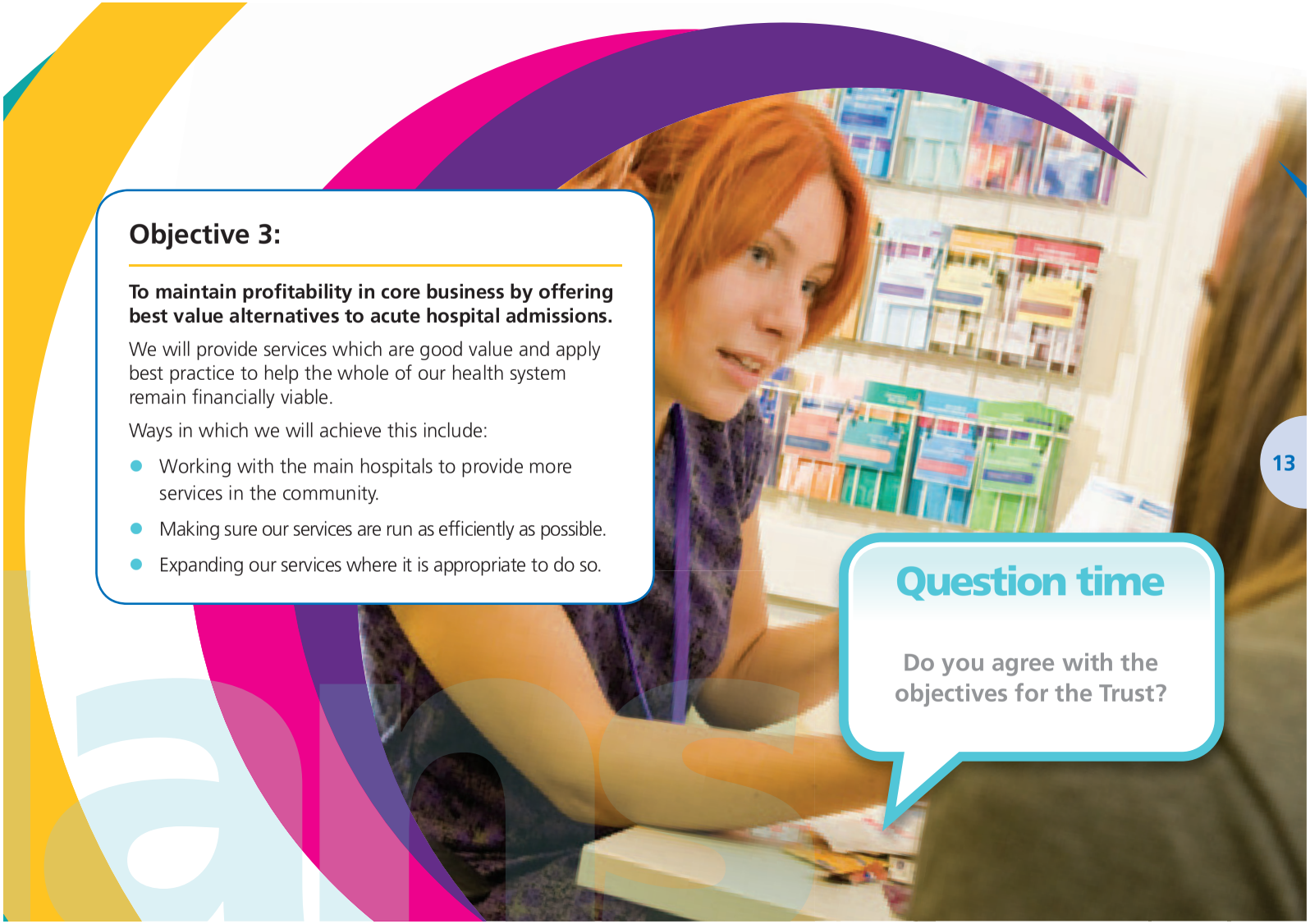
Objective 3:

To maintain profitability in core business by offering best value alternatives to acute hospital admissions.

We will provide services which are good value and apply best practice to help the whole of our health system remain financially viable.

Ways in which we will achieve this include:

- Working with the main hospitals to provide more services in the community.
- Making sure our services are run as efficiently as possible.
- Expanding our services where it is appropriate to do so.



Question time

Do you agree with the objectives for the Trust?

How will the Trust be run?

When we become a Foundation Trust, the way we run will change. Our governance, which describes how the Trust will operate, will have three main strands:

1) Membership 2) Council of Governors 3) Board of Directors

Membership

By becoming a Foundation Trust we will be accountable to our public and the local communities we serve through membership. We will have greater freedom and flexibility to determine how to deliver services which meet local priorities and deliver our aims. Through membership, we will listen to your views and opinions which will help influence decisions and the Trust's future.

Members will be able to elect a Council of Governors. The Council of Governors will advise our Board on how we should provide and improve services. This will be achieved by ensuring the views of local people (members) are taken into consideration when decisions about healthcare are made.

Members can:

- have a say in what we do
- help shape our future plans for services and the Trust
- receive the quarterly newsletter 'Shine for members'
- be involved in focus groups or surveys about our services
- be invited to events and health talks
- elect Governors to represent their views
- stand for election as a Governor
- be involved as much or as little as they wish.

Our aim is to recruit a diverse membership which is representative of the communities we serve.

Our targets for membership are:

- 7,850 members by April 2013
- 10,050 members by 2014

Who can become a member?

Public membership is open to anyone over the age of 14 living in Hampshire, Southampton or Portsmouth. We have chosen this lower age limit as we provide services to younger people and want to ensure we have representation from this age group.

Question time

Do you agree that people who are aged 14 should be able to become a member?

We plan to have two membership constituencies:

1) Public constituency

The public constituency will consist of three distinct constituencies (people who live in the areas of):

1. Portsmouth City
2. Southampton City
3. Hampshire

This constituency also includes people who have used our services and their carers. We are very keen to recruit members who have experience of using our services so we can develop them using their feedback.

We are not proposing that there is a separate constituency for people who use our services and their carers, as this may cause confusion about which constituency people belong to. A separate constituency also has the potential for people to decline membership if it identifies them with a particular patient group.

2) Staff constituency

All members of staff who have worked for the Trust for 12 months or more have been opted into staff membership, unless they have chosen to opt out. We will be inviting all bank staff and seconded staff to become a member.

We will ask other staff to become public members.

It is proposed that the staff category be subdivided into geographical constituencies. The three staff constituencies will be:

1. Staff who mainly work in Portsmouth
2. Staff who mainly work in Southampton
3. Staff who mainly work in Hampshire

Question time

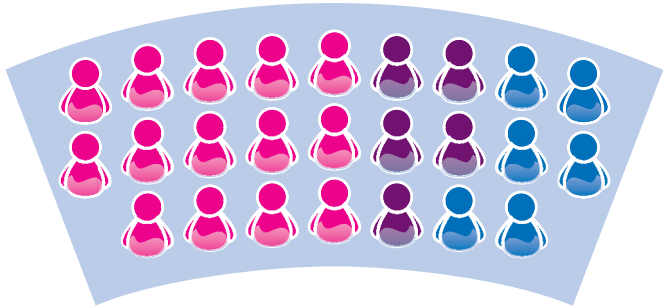
Do you agree with our plans to have a single public constituency which also includes people who use our services and their carers?

Question time

Do you agree with the proposed public and staff constituencies? Do you think that they are representative of the communities we serve?

Governors

The Council of Governors will be made up of people elected by our members to represent their views and by a number of appointed Governors from partner organisations. The number of elected Governors from each area reflects our service portfolio and the number of members in each constituency.



14 Public Governors

Southampton

Portsmouth

Hampshire

5 Staff Governors

Staff who mainly work in Southampton

Staff who mainly work in Portsmouth

Staff who mainly work in Hampshire

6 Proposed Appointed Governors

Local Authorities

Clinical Commissioning Groups

Universities

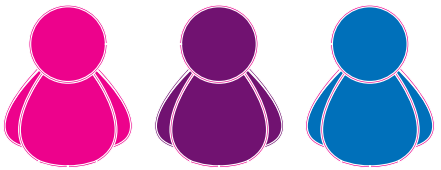
We propose to have a Council of Governors with 25 members. These include:

- 14 elected public Governors who represent the geographical areas elected by the public:
  - 5 public Governors from the Southampton constituency
  - 5 public Governors from the Portsmouth constituency
  - 4 public Governors from the Hampshire constituency
- 5 staff Governors who represent the geographical areas elected by staff members:
  - 2 staff Governors from the Southampton staff constituency
  - 2 staff Governors from the Portsmouth staff constituency
  - 1 staff Governor from the Hampshire staff constituency
- 6 non-elected Governors who will be appointed from partner organisations including:
  - Local Authorities
  - Clinical Commissioning Groups
  - Universities

The Council of Governors will:

- appoint (or remove) the Trust's Chair and the Non-Executive Directors
- approve the appointment of the Trust's Chief Executive
- appoint the Trust's external auditors
- agree the pay of Non-Executive Directors and the Chair
- receive the annual report and accounts
- advise the Board and represent members views about the strategic direction of the Trust
- help develop the Trust's membership strategy and help the Trust to recruit members.

The Governor's role does not include managing the day-to-day business of the Trust. This responsibility remains with the executives who ensure that the Council of Governors is fully involved in the future plans of the Trust.



Governor elections

Governors are elected through the first past the post method of voting, with the exception of appointed Governors. The electoral process will be carried out by a professional electoral company.

Question time

Do you agree with our plans for the Council of Governors?

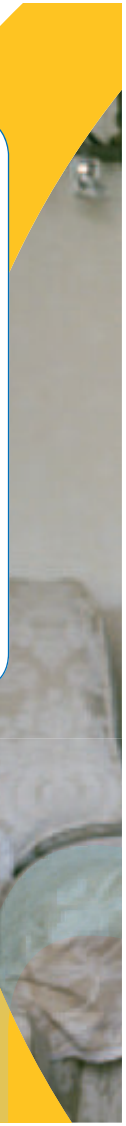
Board of Directors

All NHS Trusts are required to have a Board of Directors. The Board will always have a majority of non-executive directors.

The Board of Directors will include:

- a (non executive) chairman
- 5 non-executive directors
- 5 executive directors including: the chief executive, finance director, a registered medical practitioner or a registered dentist, and a registered nurse or midwife.

The Board of Directors is the accountable body for the running of the Trust. The Board of Directors is responsible for setting strategy and overseeing delivery of this. The delivery of the day-to-day business is the responsibility of the executives.



Have your say?

We would like to hear what you think of our plans to become a Foundation Trust. Your feedback will form part of our Foundation Trust application to the Secretary of State for Health.

You have until Monday 28 May 2012 to tell us what you think. You can share your thoughts by:

- visiting our website at www.solent.nhs.uk/ft and filling in our online feedback form
- completing the feedback form attached to the back of this document and sending it back to us at the Freepost address provided – no stamp needed.
- writing to us at:
  FREEPOST RSRU-ARZH-ACBZ
  Foundation Trust Consultation
  Solent NHS Trust
  Adelaide Health Centre
  William Macleod Way
  Southampton SO16 4XE
- emailing us at communications@solent.nhs.uk
- phoning us on 023 8060 8937

Community groups

If you are a member of a community group, school or university etc and would like us to come and speak to your group about our plans please either email us at communications@solent.nhs.uk or call 023 8060 8937. We would be happy to come and talk with you.

What happens next?

Once our consultation has ended (28 May 2012) we will review all the comments we receive. We will use your comments to refine our Foundation Trust application. We may not be able to make all the changes suggested by people but we will consider every response with an open mind.

We will prepare a summary document containing all the responses received and the changes we have made to our plans as a result of the comments received. The document will be viewable on our website or you can request a copy of the document from the Communications Team on 023 8060 8937.

Want to know more?

Come to one of our public events. We will be holding these during the course of the consultation.

The events and road show dates will be publicised on our website. For more information please visit www.solent.nhs.uk/ft or call 023 8060 8937.

Tell us what you think

We would like to know what you think about our proposals to become a Foundation Trust. Please share your views by completing this form and sending it back to us at FREEPOST RSRU-ARZH-ACBZ, Foundation Trust Consultation, Solent NHS Trust, Adelaide Health Centre, William Macleod Way, Southampton, SO16 4XE. You do not need to attach a stamp. Please respond by Monday 28 May 2012.

Do you agree with the objectives for the Trust?

Do you agree with the proposed public and staff constituencies? Do you think that they are representative of the communities we serve?

Do you agree with other plans to have a single public constituency, which also includes people who use our services and their carers?

Do you agree that people who are aged 14 should be able to become a member?

Do you agree with our proposals for the Council of Governors?

Do you have any other comments you would like to share?

Personal details

Are you ☐ Patient ☐ Member of public ☐ Member of staff ☐ Partner organisation ☐ Other

Name

Address

Telephone Email

Are you a member? ☐ Yes ☐ No If you are not a member would you like to become one? ☐ Yes ☐ No

Become a member

Have your say about local health matters by becoming a member of our Trust.

Membership provides even more opportunities for the local community, the people who use our services, staff and partners to get involved in our work, share experiences and have a much bigger say in the way the local health services are run.

You can decide how involved you would like to be. You might choose to receive updates, you might like to comment on our plans and take part in events. Alternatively, you may consider standing for election as a Governor. The choice is yours!

The larger and more involved our membership is, and the more closely it reflects the different communities we treat as patients, the better. We aim to make improvements to our services based on what you say. We need as many interested people as possible to join us – and we'd encourage you to be one of them.

You must be at least 14 years old to become a member.

Join us today

It's quick and easy and it won't cost you a penny.

To join either:

- complete the form attached to this document and pop in the post to:

  FREEPOST RSRU-ARZH-ACBZ

  Membership Team

  Solent NHS Trust

  Adelaide Health Centre

  William Macleod Way

  Southampton

  SO16 4XE

- fill in our online form at www.solent.nhs.uk/membership

Become a member using this form

You must be at least 14 years old.

Section 1: Your contact details

Title (e.g Mr, Mrs, Miss, Ms, Dr): _____

*These fields are mandatory

*First name:_____

*Surname: _____

Gender: ☐ Male ☐ Female

Date of birth: ___ /___ /_____ DD/MM/YYYY

Email address:

_____

(Where possible we ask you to provide an email address as this is the quickest, easiest and most cost effective way to communicate with you.)

*Address: _____

_____

_____

*Postcode: _____

Home telephone no: _____

Mobile telephone no: _____

Do you have any special information requirements?

Audio tapes ☐ Large print ☐ Braille ☐ Other

(please state) _____

Section 2: About you

This section is optional, however it will help us to build a membership that is representative of the community we serve.

Ethnicity

- ☐ White British
- ☐ White Irish
- ☐ White Other
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Mixed Other
- ☐ Chinese
- ☐ Indian
- ☐ Bangladeshi
- ☐ Pakistani
- ☐ Asian or Asian British Other
- ☐ Caribbean
- ☐ African
- ☐ Black or Black British Other
- ☐ I would rather not disclose this
- ☐ Any other ethnic group

Please specify _____

Disability

By knowing your disabilities or special needs, we can communicate with you better.

Would you describe yourself as having:

- ☐ A sensory disability
- ☐ A physical disability
- ☐ A mental health problem
- ☐ A learning disability
- ☐ Other (please state) _____

Section 3: Your membership

Please let us know what level of involvement you would like in the Trust?

Connection with the Trust

- ☐ Public
- ☐ Patient / service user / carer. Please tell us which service you have had contact with?
- ☐ Member of staff
- ☐ A former member of staff
- ☐ Member of a community group If so, which?

_____

I would like to: (tick all that apply)

- ☐ Receive regular information about the services provided by the Trust and be invited to meetings
- ☐ Respond to consultations and suggestions for changes
- ☐ Be invited to workshops and focus groups
- ☐ Stand for election as a governor

Which of our services are you interested in finding out more about? (tick all that apply)

- ☐ Care of the elderly
- ☐ Child and family services
- ☐ Long term health problems
- ☐ Adult services
- ☐ Mental health services
- ☐ Learning disability services
- ☐ General Trust information

Section 4: Declaration

I confirm that the information provided on this form is accurate, that I am at least 14 years old and that I have not been:

- involved in the previous five years in an act of assault, violence or harassment against any Trust staff or registered volunteers of the Trust
- convicted of offences against children or vulnerable adults.

Signature: _____

Date: _____ /_____ /_____ DD/MM/YYYY

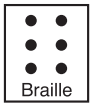
Section 5: Data Protection and the Public Registers

The information on this form will be kept by Solent NHS Trust and only used in connection with membership and public involvement. This is in accordance with the Data Protection Act 1998.

☐ Please tick this box if you do not want your name to be included on the public register of members.

Access to Communication

For a translation of this document,
an interpreter or a version in

large print or  or 

please contact Access to Communication

☎ 023 8024 1300

For an easy read version of this leaflet
please contact the Communications Team on 023 8060 8937.

www.solent.nhs.uk

DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	UNIVERSITY HOSPITAL SOUTHAMPTON ANNUAL PLAN AND PRIORITIES
DATE OF DECISION:	21 JUNE 2012
REPORT OF:	JUDY GILLOW DIRECTOR OF NURSING
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This paper provides background for the panel about University Hospital Southampton NHS Foundation Trust and summarises key issue for the year 2012/13.

RECOMMENDATIONS:

(i) That the panel notes and comments the briefing

REASONS FOR REPORT RECOMMENDATIONS

1. To provide an update to the new panel on SUHFT and the priorities for the future.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. n/a

DETAIL (Including consultation carried out)

3. University Hospital Southampton NHS Foundation Trust (UHS) was formed on 1 October 2011 when Southampton University Hospitals NHS Trust was licensed as a foundation trust by the regulator Monitor.

The Trust provides hospital services for people with acute health problems and is the local hospital for 650,000 people who live in Southampton, the New Forest, Eastleigh and the Test Valley. Its services are relied upon by residents of the Isle of Wight and the Channel Islands for some services.

As the major university hospital on the south coast, UHS provides the full range of tertiary medical and surgical specialties, with the exception of transplantation, renal services and burns, to more than three million people in central southern England.

4. UHS is a centre of excellence for training the doctors and nurses of the future and developing treatments for tomorrow's patients. Its role in research and education, developed in active partnership with the University of Southampton distinguish it as a hospital that works at the leading edge of healthcare developments in the NHS and internationally.

We are a nationally leading hospital for research into cancer, respiratory disease, nutrition, cardio-vascular disease, bone and joint conditions and complex immune system problems.

5. More than 9,000 people work at the Trust making it one of the area's largest employers. With an annual budget of over £540 million it plays a significant role in the economic prosperity of the region.

Our turnover in 2011/12 was £538 million. Our hospitals are: Southampton General Hospital; the Princess Anne Hospital; Countess Mountbatten House; New Forest Birth Centre. We lease space at the Royal South Hants hospital for the provision of some services.

6. Becoming a foundation trust is a pivotal moment for any hospital. It took four years for UHS to achieve this goal and in that time the landscape of the NHS and the economy changed significantly. While the NHS budget was protected from public spending cuts, the ever increasing demands placed on it need to be met within its existing resources. With ever more expensive drugs and technologies becoming available, particularly in hospitals such as ours, we are now facing one of the most significant management challenges in the history of the NHS.

7. **Quality**

Quality of care is central to our mission and was a defining feature of our application for foundation trust status. For us, quality of care is a product of safety, experience, outcome and access to services. These are the elements of care that our staff and patients place the highest value in.

Our patient care improvement framework which sets our goals and monitors our progress for improving quality is seen as a gold standard model for embedding the drive for higher quality within a hospital. Our achievement in delivering real results for our patients is widely recognised and we are often among the top performing Trusts in the country for quality and outcomes.

8. **Infection**

During 2011/12 we recorded just four cases of MRSA bacteraemia compared with five cases in 1010/11, seven cases in 2009/10 and 27 cases in 2008/09. We beat our target of five cases for the year.

Our MRSA rate places us in the top three university hospitals in England for performance.

In 2011/12 we agreed to reduce cases of C. difficile to below 85 and we have bettered this target recording 66 cases for the year. This is after treating more than 85,000 inpatients and our rate per 1000 admissions puts us in the top eight performing university hospitals in the country for this measure.

9. **Access to services**

One of our principal challenges is to provide quick access to our services for an increasing number of patients while continuing to improve quality and staying within the budget we have agreed with our commissioners. Maintaining our performance, which in the NHS means the time it takes us to treat our patients, has been one of the biggest challenges we have faced so far as a foundation trust.

The NHS constitution gives patients the right to receive their care in good time and they can expect to be treated within 18 weeks of their referral to our hospital for planned (or elective) care. Because the number of patients being referred here is growing (modestly for planned care but very significantly for urgent or emergency care) we are facing a constant challenge to provide services to all of our patients in good time. We do manage to do this for the vast majority, but doing so during 2011/12 has demanded a significant amount of our concentration, effort and management resource. In 2012/13 we plan to expand our capacity to deliver higher levels of service and meet the growing demand for our services from our local population.

10. **Balancing the finances**

Resource constraints in the local health economy continue to impact the Trust however, we have made the considerable achievement of delivering cost improvements of more than £26 million during the 12 months to 31 March 2012 at a time when activity levels of the hospital have continued to rise. This enabled us to deliver a pre-impairment surplus of £3.9 million for the six months ended 31 March 2012. This was achieved through productivity and efficiency gains in order to meet the efficiency targets built in to the NHS tariffs.

11. **Developing specialist services**

As a specialist centre we care for the sickest patients in the region. Very few of our patients need a doctor or a service which we can't provide. The centralisation of specialist services in the NHS to fewer, larger hospitals is a necessary step to improve quality, and brings some challenges but many rewards for a Trust like ours. It makes us an attractive place to work for committed and talented clinical staff.

12 **Service developments**

The Trust has been designated as a major trauma centre for children and adults and is waiting to hear whether it will be a centre for paediatric cardiac surgery (the announcement is expected on 4 July 2012). It is also developing as a paediatric neurosurgery centre and a centre for adults with congenital cardiac conditions.

RESOURCE IMPLICATIONS

Capital/Revenue

13 None

Property/Other

14 None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

15 The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

16 None

POLICY FRAMEWORK IMPLICATIONS

AUTHOR:	Name:	Alison Ayers Director of communications and public engagement	Tel:	023 8079 6241
	E-mail:	Alison.Ayres@uhs.nhs.uk		

KEY DECISION? Yes/No

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	
2.	

Documents In Members' Rooms

1.	
2.	

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

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

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		